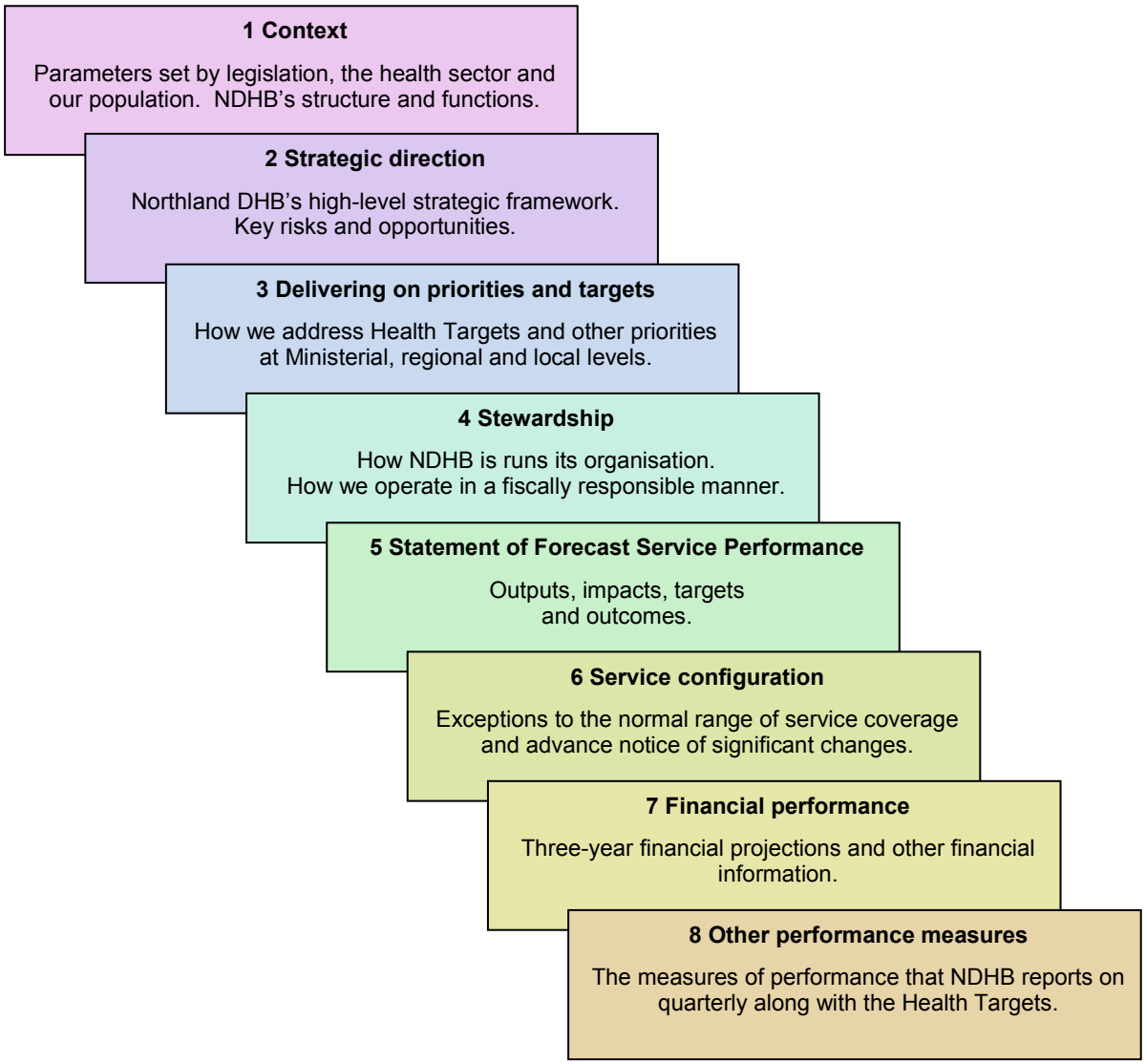
NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora A Rohe O Te Tai Tokerau

ANNUAL PLAN 2012/13

incorporating

STATEMENT OF INTENT 2012/13 - 2014/15



Annual Plan linkages

Links to national, regional and local priorities are colour-coded:

National	Northern Region Health Plan	Northland Health Services Plan
Links to Ministerial and other national priorities	*Described in 1.2 Health sector context and Appendix 2: NRHP overarching framework*	*Purpose and context are explained in 2.3 Northland Health Services Plan and Appendix 2: NHSP.*

Statement of Intent as a subset of the Annual Plan

Northland DHB's Statement of Intent is a subset of the Annual Plan. It can be assembled by combining sections 1, 2, 4, 5 and 7. The plan is also available as a separate document.

Contents

Minister's letter of approval

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

05 JUL 2012

Mr Tony Norman
Chair
Northland District Health Board
Private Bag 9742
WHANGAREI 0148

Dear Mr Norman

Northland District Health Board 2012/13 Annual Plan

This letter is to advise you I have approved and signed Northland District Health Board's (DHB) 2012/13 Annual Plan for three years.

I appreciate the significant work that goes in to preparing such a thorough annual planning document and I thank you for your effort. I look forward to seeing your progress over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2012, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to safeguarding and growing our public health services.

Health targets

Government Health Targets are selected to drive ongoing improvements in specific priority areas in order to meet the public's growing expectations of accessing quality health care.

I appreciate your DHBs efforts to deliver on the Health Targets and your progress in achieving these. Your plan acknowledges the changes in focus with regard to the cancer, immunisation and tobacco targets and identifies actions to support their achievement. I am satisfied the activities you have identified in your Annual Plan will deliver on these new targets, while building on current achievements for emergency departments, electives as well as cardiovascular disease and diabetes. I am particularly looking forward to following your improved emergency department and immunisation performance.

Shorter waiting times

The Government has made commitments to New Zealanders to deliver even faster access in a number of key areas including elective surgery, diagnostic tests, chemotherapy treatment and youth drug and alcohol services. Thank you for your work to support these commitments. I look forward to seeing your planned results in these priority areas.

Integrated care

I expect all DHBs to increase their focus on service integration, particularly with respect to primary care, ensuring the scope of activity is broadened and the pace significantly stepped up. I look forward to seeing an integrated care approach driving delivery and improved performance, especially in relation to unplanned and urgent care, long term conditions and wrap around services for older people.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan and movement towards more tangible actions to show how you will achieve real progress towards providing a better range of services in the community. I expect you to be active in advancing these improvements to the way primary and community services are delivered closer to home. The Ministry and National Health Board (NHB) will be working closely with DHBs to support the implementation of integration work programmes.

Living within our means

DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. Improvements through national, regional and sub-regional initiatives are expected to be a key focus for all DHBs.

Approval of your Annual Plan is conditional upon your Board fully supporting the investment required in Health Benefits Limited's Finance, Procurement & Supply Chain detailed business case. This is expected to follow completion of the current business case approval process with DHBs and shareholding Ministers.

I am pleased to see that your DHB is planning to break even for the next three years.

Savings from the community pharmaceutical budget

Earlier in the year, I directed DHBs to put the $30 million savings from the community pharmaceutical budget for 2012/13 towards the following initiatives:

- extending zero fees for primary care for children under six to afterhours;
- providing support for child and adolescent mental health services;
- implementing faster cancer treatment initiative;
- supporting smart investment home care for older people;
- providing an increase in aged care residential subsidy for bed day price, and for further improvements in dementia services.

I am interested to follow your progress in implementing these initiatives.

Health of older people

Our aging population poses many challenges to the health system and addressing these challenges is a government priority. DHBs are expected to develop wrap around services for older people and continue to invest in home and community support services, including post hospital discharge support to reduce acute admissions.

I am pleased to see detail in your Annual Plan on how you are planning to deliver health services for older people. I am particularly interested to follow your progress in relation to the provision of organised stroke services, services to reduce acute admissions, improvements in respite care and the development of dementia care pathways.

Regional Integration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities.

Included in these priorities are the achievements of regional workforce, IT and capital objectives that have been set, as well as your on-going support for the work of Health Benefits Limited, the National Health Committee and the Health Quality and Safety Commission. I look forward to seeing tangible benefits provided to patients as a result of these important regional initiatives being implemented.

It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan.

Whānau Ora

Whānau Ora is an inclusive interagency approach to providing health and social services in which DHBs play a key role. I expect your DHB planned actions to deliver on Whānau Ora to reflect the strategic change, confirmed support to selected Whānau Ora collectives; greater involvement of DHB leaders; and activities to improve performance and build mature providers.

Prime Ministers Youth Mental Health Project

The Prime Ministers Youth Mental Health Project cross-agency initiatives aim to prevent youth mental health problems developing and improve access to specialised treatment for those who need it. I would like to thank you for your demonstrated commitment to this government priority, including through your planned actions to build capacity and capability of specialist child and youth mental health and addition services, in order to improve service responsiveness.

Cardiac Services

The focus on improving access to cardiac surgery has resulted in very positive outcomes for patients over recent years. I am pleased to see your commitment to continuing progress in this area, through reducing waiting times and ensuring an appropriate level of access during 2012/13, not only for surgery, but across a wider suite of cardiac services.

The link between regional networks and cardiac providers is very important in this area, and I expect your local contribution to align with regional planning, and for regional collaboration to be strengthened to support delivery, waiting list management, and improved patient pathways.

Diabetes Care

This year each DHB has been asked to develop a Diabetes Care Improvement Package in consultation with primary care partners to better support prompt access to services and increasingly more effective management of people with diabetes.

These packages should enable innovation in service delivery, more focused activity to improve patient care where it is most needed and are to be built with strong evidence based best practice in mind. They should build on the good practice already provided through general practice to enhance and optimise outcomes for patients. I look forward to following the progress of these packages with your primary care partners.

Community Pharmacy Services Agreement

DHBs have undertaken to provide a well executed transition to the new Community Pharmacy Service Agreement. I know you will want to ensure your management confirms this happens locally.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

My acceptance of your Annual Plan does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2012/13 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

Finally, please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

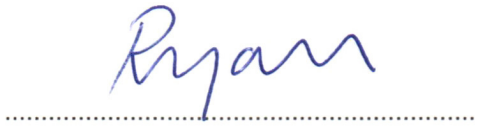
Yours sincerely

Hon Tony Ryall
Minister of Health

Signatories

Agreement dated this ..... day of 2012

between



[Minister]

Her Majesty the Queen
In right of her Government of New Zealand
Acting by and through the Minister of Health

and

Anthony Norman
Board Chair

Dr Nick Chamberlain
Chief Executive

Executive summary

Northland District Health Board will continue to improve the delivery of services during 2012/13 while living within our means. The Board has maintained a balanced financial position since 2003 and will continue to operate within a viable and financially sustainable cost structure.

We will maintain our performance improvement on the Health Targets. We sit among the best DHB performers for elective services and cancer treatment, and have shown sustained improvement in ED waiting times, supporting smokers in hospital and immunisation rates.

Northland DHB will continue to improve efficiency. This year's plan projects direct savings of $2.58m, about a third of which is derived from restructuring of shared services for the Northern Region.

Better integrated services is the key driver for this year's Annual Plan. Northland faces major challenges posed by our rapidly ageing population, the increasing prevalence of long term conditions and financial constraints, as well as the lowest GDP of any region in the country. Sticking with the status quo is not an option. The DHB knows it will not be possible to meet these demands unless all existing services – primary / community and hospital, NDHB and NGO – work together more effectively across unplanned and urgent care, long term conditions and wrap-around services for older people.

Awareness of these challenges was the springboard for the development of the Northland Health Services Plan, Northland DHB's foundation for future service improvement. The NHSP is the template for the future structure and provision of services across the whole health sector in Northland for at least the next five years. The plan was signed off by the Board in April 2012 and is set for immediate implementation.

The Northern Region Health Plan continues to be the basis of our strategic planning. Its Triple Aim of population health, patient experience and cost/ productivity formed the starting point for the NHSP. Regional performance measures have been integrated into the Annual Plan. Regional planning processes, in which NDHB staff have been intimately and prominently involved, continue to develop models, pathways and protocols to guide future improvement across all four DHBs.

The ageing population is driving Northland DHB's emphasis on services for older people. The Annual Plan focuses on quality home and community support services, comprehensive clinical assessment in residential care and home based support services, development of the dementia pathway, community specialist service teams and advanced care planning.

Several sections in the plan address the growth in long term conditions. These are founded on the work of the various regional workstreams and Northland's clinical governance structure. Extra attention in this year's plan has been given to maternity services and child and youth mental health.

Improving Maori health and reducing inequities continue to be driving forces. The Maori Health Plan 2012/13, contained within the Annual Plan, sets down key performance measures for health services, and Maori health and reducing inequities are addressed throughout the Annual Plan. NDHB is also strengthening internal and external monitoring systems so that all indicators, including Health Targets, can be reported by ethnicity.

The Annual Plan has been developed with the involvement of the Chief Executives of Northland's two PHOs, who are also members of NDHB's Executive Leadership Team.

1 Context

1.1 Legislative context

Northland DHB is one of 20 District Health Boards established in 2001 in accordance with section 19 of the Public Health and Disability (PHD) Act 2000. Section 22 of the Act requires Northland DHB, among other things, to:

(a) improve, promote, and protect the health of people and communities
(b) promote the integration of health services, especially primary and secondary health services
(c) promote effective care or support for those in need of personal health services or disability support services
(d) promote the inclusion and participation in society and independence of people with disabilities
(e) reduce health disparities by improving health outcomes for Maori and other population groups
(i) uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.

Amendments to the PHD Act in 2010 DHBs required them to collaborate regionally in planning and providing health services, and in preparing a jointly agreed Regional Health Plan (for Northland this means working with the Northern Region, of which we are a part along with the three Auckland DHBs). They also more clearly divided services according to whether their planning, funding and provision should occur at national, regional or local levels.

The Statement of Intent (SOI) has been prepared by the Northland District Health Board to meet the requirements of section 139(1) of the Crown Entities Act 2004 and sections 42 and 39(8) of the Public Health and Disability Act 2000.

The DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004. Section 49 of this act states that boards of governance must ensure that DHBs act in a manner consistent with their legislative objectives and functions, and their SOI.

1.2 Health sector context

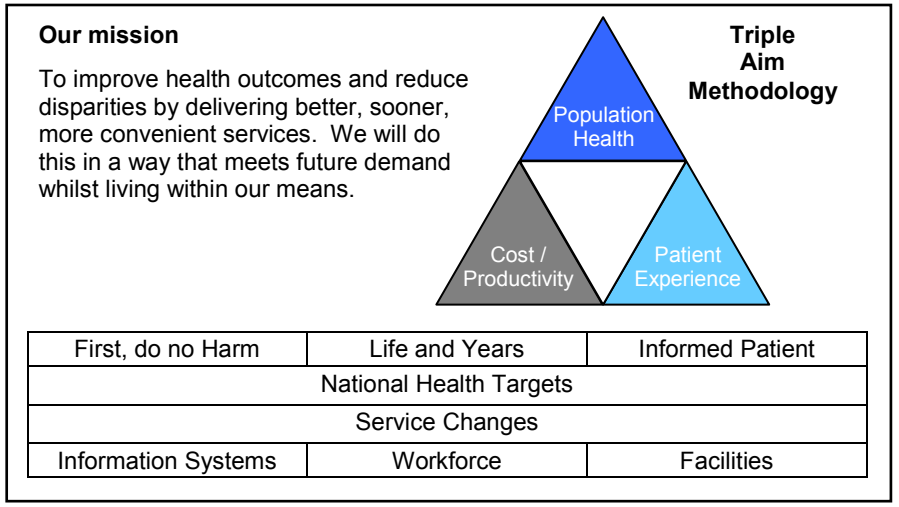
DHBs must meet other requirements besides legislative ones. They have a statutory responsibility under the Treaty of Waitangi to put into practice its principles of partnership, protection and participation. NDHB is acutely conscious that Maori, who comprise about a third of our population, suffer most from health and other inequities.

DHBs are required to adhere to the Ministry of Health's *Operational Policy Framework*, "a set of business rules as well as policy and guideline principles that outline the operating functions of DHBs", and the *Service Coverage Schedule*, a policy document that describes the types of services that DHBs must ensure are provided.

The Ministry *Statement of Intent* identifies what the health sector is expected to achieve within the context of whole-of-government expectations.

The Northern Region Health Plan referred to under 1.1 provides the strategic framework for Northland DHB's planning. Graphic 1 depicts its Triple Aim, which sets the platform for the Northern Region's direction of travel, as well as for the Northland Health Services Plan.

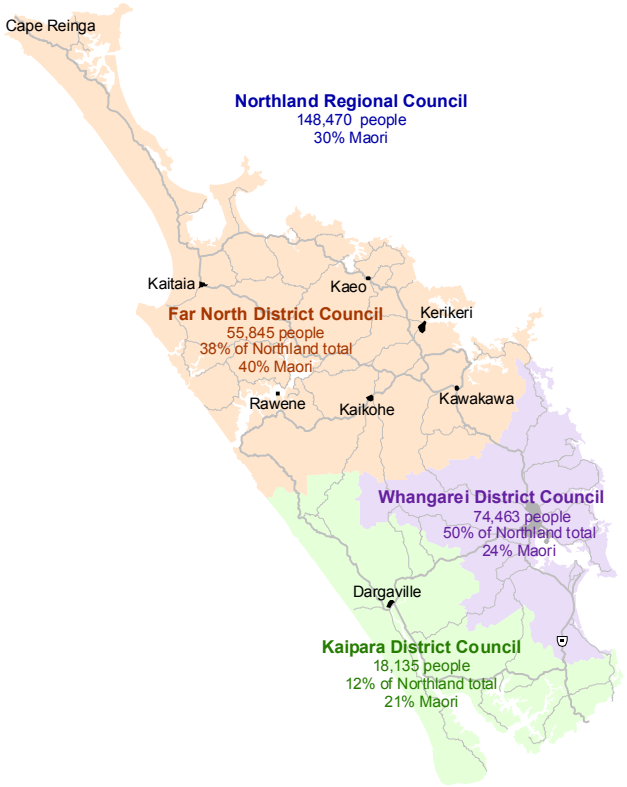
Graphic 1 Northern Region direction



1.3 Population profile

Population summary

Graphic 2 Northland population, 2006 Census



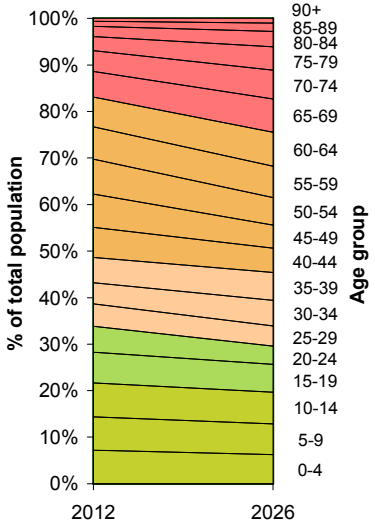
Northland's projected population for 2012 is 159,160, 3.6% of New Zealand's population.

Just over half live in Whangarei District Council, 37% in the Far North District Council and 12% in Kaipara District Council.

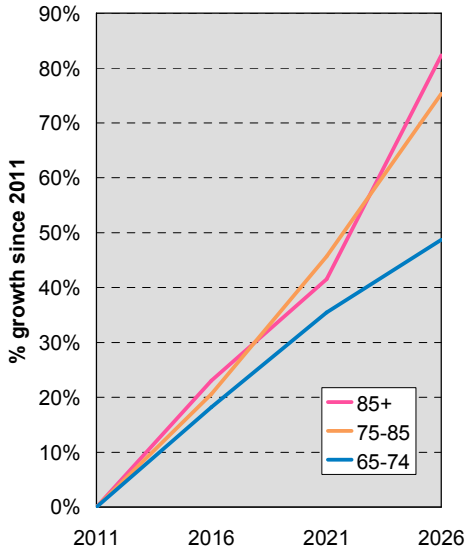
Nga Iwi o Te Tai Tokerau comprise 30% of Northland's population. Out of the total Maori population, about half live in the Far North District, 40% in Whangarei, and 10% in Kaipara. Iwi in Northland include Ngati Kuri, Te Aupouri, Ngaitatoko, Te Rarawa, Ngati Kahu, Whaingaroa, Ngapuhi, Ngati Wai and Ngati Whatua.

Ageing population

Graphic 3 Projected population composition by age, 2012 and 2026



Graphic 4 Percentage growth in older populations 2011-2026



Northland's population is 'ageing' because older age groups are increasing in both number and proportion, while those of children and youth are decreasing (Graphic 3). Between 2012 to 2026, 0-14 year olds are projected to drop from 21.6% of the population to 19.7%, while those aged 65 and older are projected to grow from 16.9% to 24.5%.

Nationally over the same period, the 65-pluses will increase from 13.6% to 18.9%, indicating that Northland's proportion of older people is not only higher than the national average, but is projected to grow at a faster rate. The average age of the population shows the same effect: between 2012 and 2026 Northland's will grow from 39.6 to 43.2 while New Zealand's will grow from 37.7 to 40.4.

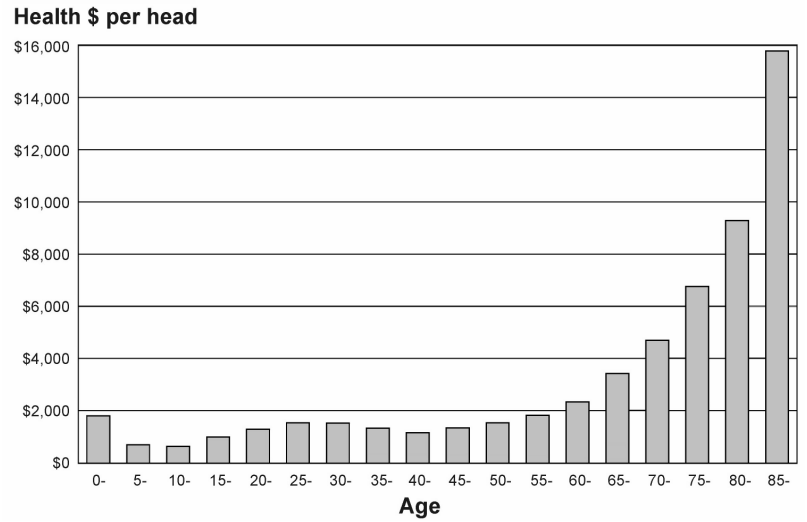
Graphic 4 indicates that the older the age group, the faster the growth.

Service use increases with age

Older age groups consume more resources (Graphic 5) because as people age they tend to develop more long term conditions such as cardiovascular

disease (heart disease and stroke), cancers, respiratory disease and dementia. These conditions already create the biggest load on the health system, so the prospect of an ageing population is a challenging one.

Graphic 5 Health expenditure by age in New Zealand

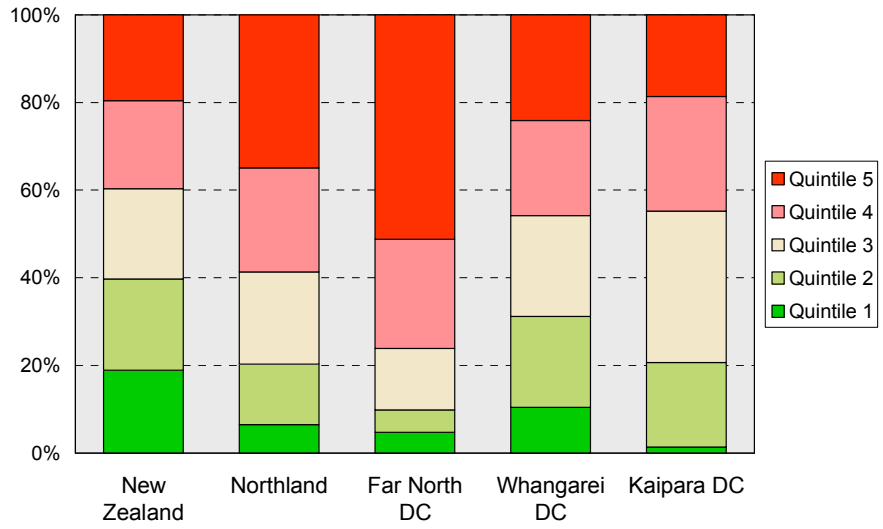


Adapted from: MoH, 2004. Population Ageing and Health Expenditure: NZ 2002-2051. Wellington: MoH.

Deprivation

Northland has one of the most deprived populations in the country (Graphic 6). While 20% of NZ's population is in the lowest quintile of the deprivation index, for Northland the equivalent figure is 35%. The most deprived local authority area is the Far North District Council with 51% in the lowest quintile. Within FNDC the most deprived areas are Hokianga 83%, Whangaroa 41% and north of the Mangamukas 55%.

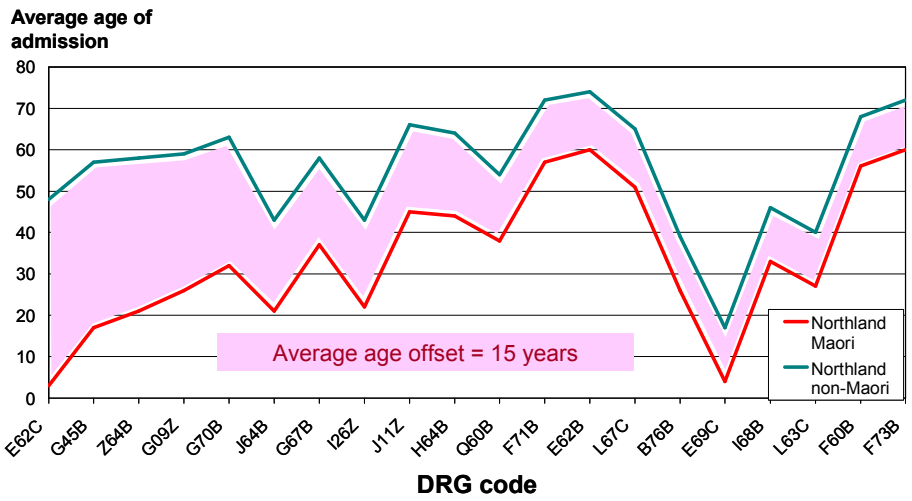
Graphic 6 Deprivation by area, NZ, Northland and its District Councils



Age offset for Maori

Graphic 7 depicts the twenty Diagnostic Related Groups (DRGs) with the highest number of admissions to Northland hospitals. On average, Maori are admitted 15 years younger. This is strongly related to higher rates of deprivation and early onset of long term conditions.

Graphic 7 Age offset of admission to NDHB hospitals, top 20 DRGs[1]



(Deloitte research commissioned by NDHB, 2006)

Rurality

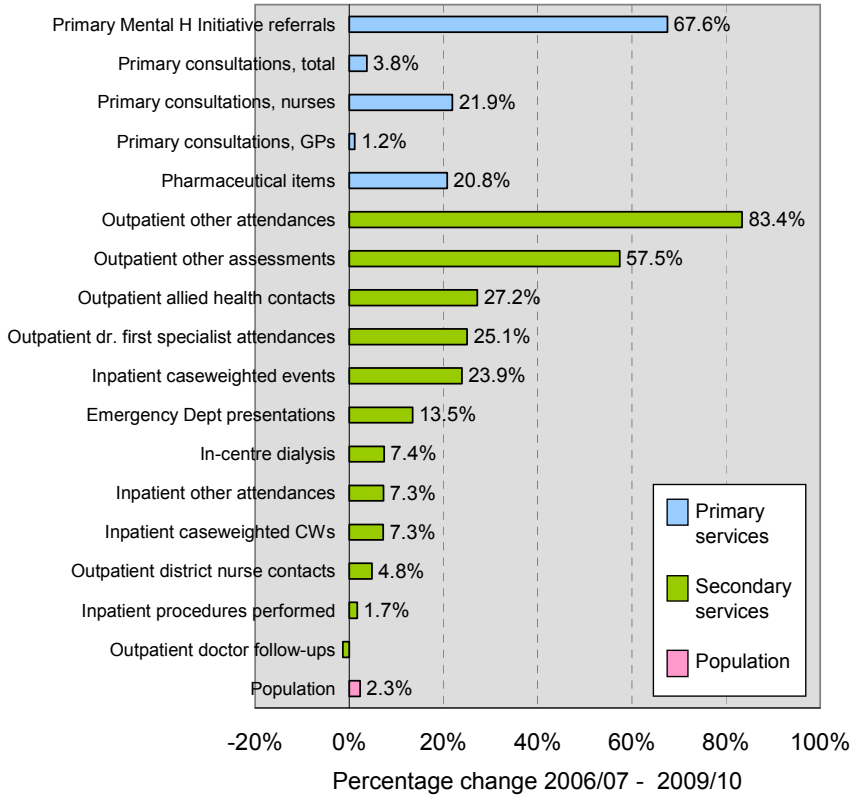
Northland's only true urban area is Whangarei, which contains about one-third of our population. The remainder live in towns (the largest of which are Kaitaia, Kerikeri, Kaikohe and Dargaville at about five thousand each) and rural areas across the district. Many of these are isolated; it takes over five hours to travel from Northland's northern to southern extremities and up to two hours west to east. Northland has the highest proportion of unsealed roads in New Zealand and public transport is very limited.

[1] Diagnostic Related Groups are groups of health conditions with broadly similar causes and level of need for services. In this context the codes themselves are not important; the point of the graph is to show, for the most frequently conditions seen in Northland hospitals, the differences in admission rates between Maori and non-Maori.

1.4 Health profile

Growth in demand for services

Graphic 8 Growth in key health services in Northland 2006/07 - 2009/10



Graphic 8 shows, across a comprehensive range of services, the rate of growth in volumes between 2006/07 and 2008/09. Volumes of nearly all types of service have increased more quickly than the Northland population. Only two types of service have grown more slowly than the population, both the result of deliberate strategies: outpatient doctor follow-ups, where there has been a plan to reduce follow-ups and increase first specialist assessments; inpatient procedures, more of which are being done in the outpatient setting or

they are now staying less than three hours and hence are not counted as inpatient admissions.

The Northland population's health needs

Key priority	Explanation
Long term conditions	The 'big 3' are diabetes, cardiovascular and cancer. 36% of Northlanders die from **cardiovascular disease** (heart disease and stroke). 22% of adult Northlanders have been told they have high blood pressure and 14% that they have high cholesterol, both known risk factors for cardiovascular disease. While **diabetes** is not a major killer in itself, it is a primary cause of heart disease and a great deal of unnecessary illness and hospitalisations are related to poor management of the condition. 39% of Northlanders die from **cancers**. The four most common sites are, in order, trachea-bronchus-lung, colorectal, prostate and breast.
Older people	Our ageing population is placing significant demands on health services provided specifically for older people (residential care, home based support services, day care). It also affects the prevalence of long term conditions which become more common with age.
Maori	Maori experience low levels of health status across a whole range of health and socioeconomic statistics. They comprise 30% of Northland's population, but 52% of the child and youth population, a key group for achieving long-term gains. Maori experience early onset of long term conditions, presenting to hospital services on average about 15 years younger than non-Maori (see Graphic 7).
Children and youth	The child and youth population in Northland is projected to decline over the coming years, but it remains a priority because healthy children make for healthy adults, and because a higher proportion of them is Maori. Children in Northland have higher needs than adults; areas whose deprivation rating is in the lower half of the scale contain 70% of Northland's adults but 85% of our children.
Oral health	Northland's 5-year olds have often had the country's highest average score of damaged (decayed, missing or filled) teeth and one of the lowest percentages of teeth without tooth decay (33% compared with the national 41%). Data for adolescent oral health is scanty, but it suggests a similar, if not worse, picture.
Lifestyle behaviours	The way people live their lives and the behaviours they exhibit have an enormous influence on health status. There are a wide range of influences, but key ones are smoking, diet, alcohol and other drugs, and physical activity.
Social influences	Many of the drivers of ill health are social and economic factors such as housing, education and economic prosperity. The health sector cannot affect these directly, but DHBs can work on them collaboratively with other government and local body organisations.

1.5 Operating environment

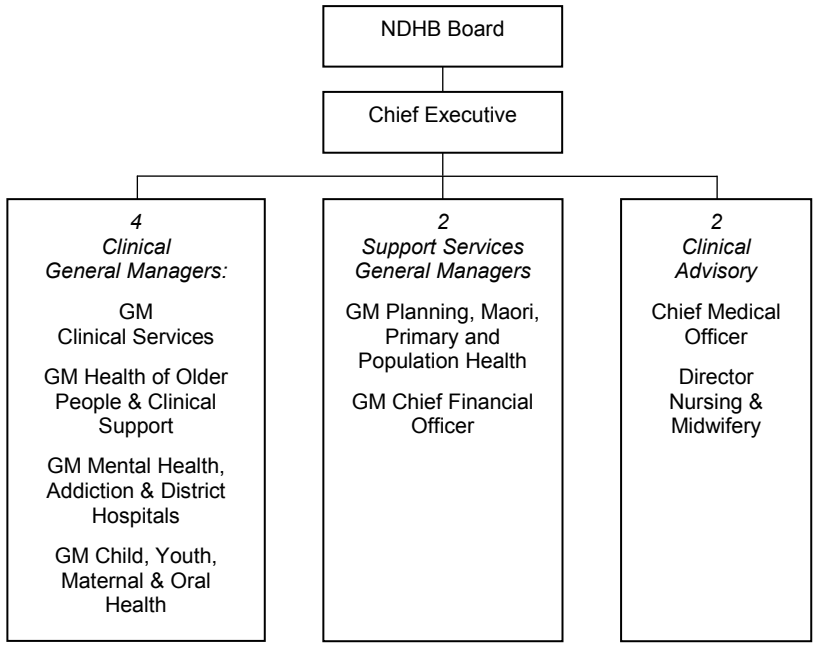
This section contains a high-level description of the structure and funding of Northland DHB and the key factors affecting the organisation's performance.

Structure of Northland DHB

Governance for NDHB is provided by a Board of eleven, seven elected and four appointed by the Minister of Health. Their role is to provide strategic oversight for the DHB, taking into account the Government's vision for the health sector and its current priorities.

The Chief Executive reports to the Board and is responsible for the organisation's performance.

Graphic 9 High-level organisational structure of Northland DHB



Reporting to the Chief Executive are six General Managers and two senior clinical advisory positions. The GMs are structured according to the DHB's two core functions of providing services and funding services (described in more detail in 1.6 Nature and scope of functions). The provision of services by NDHB is the responsibility of the clinical GMs, while planning falls under the GM Planning, Maori, Primary and Population Health. The other GM ensures financial and other support services for both provider and funder functions.

Factors affecting NDHB's performance

Northland DHB's performance is affected by a number of factors (explained more fully in 2.7 Key risks and opportunities), some of which are shared by all DHBs while others arise from Northland's distinctive characteristics:

Factors which affect all DHBs

- funding levels
- managing within budget
- demand-driven contracts
- Inter-District Flows (IDFs)
- regionalisation
- information systems and data
- new models of care
- employment costs and issues.

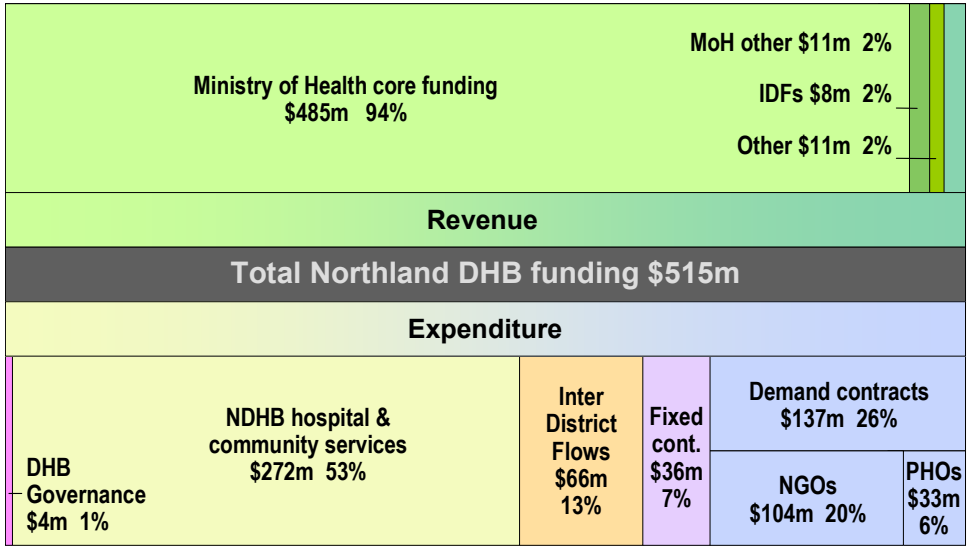
Factors more applicable to Northland DHB

- high-needs population
- new prioritisation tool.

1.6 Nature and scope of functions

Northland DHB has been charged by the government with responsibility for the health of all Northlanders (1.1 Legislative context). To fulfil this, Northland DHB has two overarching functions, the provision of services (section 1.6.1) and the funding and planning of services (section 1.6.2).

Graphic 10 Northland DHB funding 2010/11, revenue and expenditure



Graphic 10 explains this split by expenditure groups. In 2011/12 Northland DHB received $515M from Vote:Health, the total funding for health services for Northlanders paid from the public purse. Just over half of this goes to NDHB for its hospital and community services. Almost all the rest is spent on contracts with Northland's NGOs and the payment of Inter District Flows to other DHBs (both of which are explained under 1.6.1), with a small amount for governance.

1.6.1 Provision of health services for Northlanders

Publicly funded health services for Northlanders are provided by a combination of:

- the NDHB hospital and community services
- non-governmental organisations
- DHBs in Auckland
- national services.

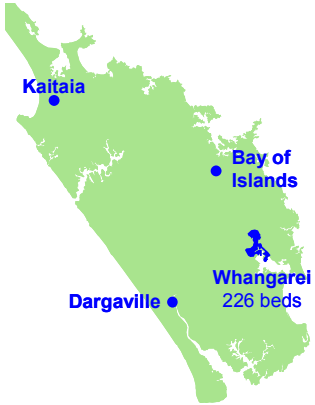
Each of the four provider types is described under its own subheading below. This is followed by a more detailed description of types of service by Output Class and type of provider in Graphic 13.

NDHB Provider

The NDHB Provider comprises three main parts (explained further under (a) to (e) in Graphic 13):

- hospital services (Graphic 11) and hospital-based community and outreach services
- Mental Health and Addiction Services
- community and primary services.

Graphic 11 Northland DHB's major facilities



Non-governmental organisations

Northland has 234 contracts with 178 NGOs who provide a wide range of public, primary and community services across Northland (Graphic 12). They consume about a third of NDHB's total budget.

DHBs in Auckland - Inter District Flows

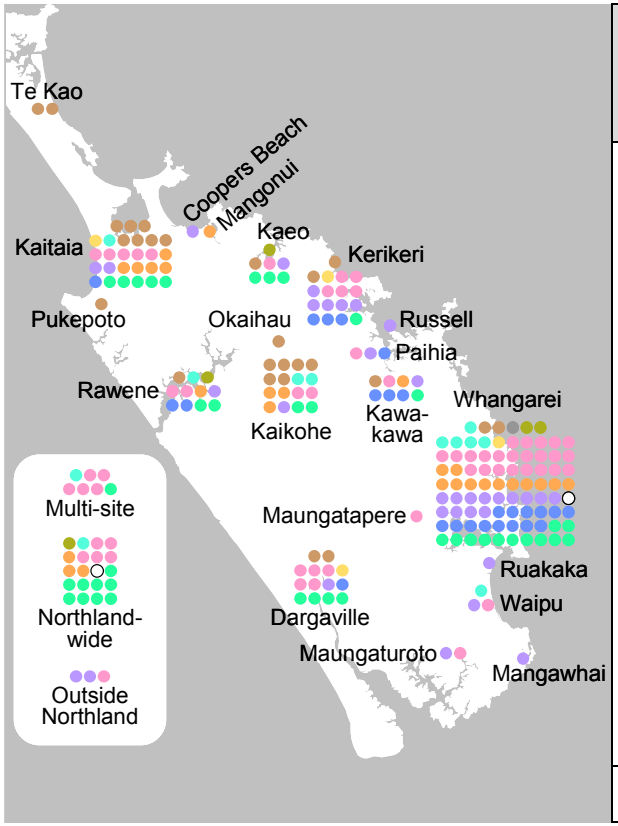
Hospitals in Auckland, primarily Auckland Hospital itself, provide more specialised (tertiary) services for Northlanders, mainly in cancer and cardiac care. Because of low patient volumes, these are too expensive for Northland DHB to provide. NDHB is charged for these services through the Inter District Flows mechanism which accounts for 13% of our total funding.

National services

Units in major urban centres provide highly specialised services that are planned, funded and monitored at national level by the National Health Board: clinical genetics, paediatric pathology, paediatric metabolic services, paediatric cardiology and paediatric cardiac surgery. The National Health Board also oversees the National Service Improvement Programme for some major clinical services: cardiac surgery, paediatric oncology, paediatric gastroenterology, neurosurgery and major trauma.

The Ministry of Health still holds a few national contracts with NGOs such as Plunket and St John.

Graphic 12 NGO providers and contracts, Feb 2011



Type	No. of contracts	No. of providers
Primary care	40	14
Oral health	25	21
Pharmacy	34	34
Laboratory	2	2
Mental health	26	20
Older people	59	50
Palliative care	4	4
DSS	12	12
Maori health	26	15
Pacific health	1	1
Public health	5	5
Total	234	178

Service coverage in more detail

A full range of health services for the Northland population is provided by a range of organisations as described in Graphic 13. More detailed descriptions of the services provided under each Output Class are provided in 5.1.3 Output Classes.

Graphic 13 Types of service by Output Class and type of provider

Type of provider	Output class						
	Prevention	Early detection & management	Intensive assessment & treatment				Rehab & support
			Secondary local	Secondary specialist	Tertiary	Quarternary	
NDHB provider	✓a	✓b	✓c	✓d			✓e
NGOs (funded by NDHB)	✓f	✓g					✓h
Community & voluntary	✓i	✓j					✓k
Other DHBs					✓l	✓m	

	Service type	Description and examples
a	MDHB population health services	Provided to the community at large (not to individuals): • *health promotion:* public health awareness, working with schools, etc • *health protection:* water and sewerage, licensing of premises, environmental monitoring etc • *collaborative work* with organisations outside the health sector on a number of initiatives.
b	NDHB community and primary services	Delivered to individuals by the Child, Youth, Maternal, and Oral Health Services arm of NDHB: • oral health services • home healthcare • well child and youth services (screening, immunisation, communicable disease tracing, sexual health, child protection, hearing and vision, mobile ear nursing services).

	Service type	Description and examples
c	District hospitals in Kaitaia, Bay of Islands and Dargaville	Inpatient and outpatient services for medical, paediatric and maternity services, surgery (Kaitaia only) and renal dialysis (Kaitaia and BOI).
d	Services at Whangarei Hospital	
	Inpatient beds, outpatient clinics and day services	Medical services, which include medical wards and a variety of specialties (eg cardiac rehab) and special units (eg Diabetes Service). Surgical specialties, which provide operations in theatre complexes (Whangarei and Kaitaia), and surgical wards. Child health services which include paediatric and neonatal services, as well as child health outpatient services including behavioural and developmental services. Secondary maternity services.
	Emergency departments	These exist at all hospital sites.
	Mental Health and Addiction Services	A full range of specialist inpatient and community services for people across all age groups who have a moderate to severe mental illness or addiction. These include inpatient services at Whangarei, subacute units in the Mid and Far North, a detoxification unit in Dargaville and community mental health and addiction teams in each geographical unit. Services are age-specific and there is a specific service designed to meet the needs of Maori clients.
e	*Needs Assessment and Service Coordination* (NASC)	(a) determines an older person's eligibility, (b) assesses their need for publicly funded disability support services (needs assessment) and (c) allocates services which are then delivered by third party providers (service coordination, which includes several of the services listed under (h) below).
	Assessment, treatment and rehabilitation services for older people	Includes an acute service at Whangarei Hospital and community rehab teams attached to each district hospital.
	Specialist palliative care liaison team (see (h))	Supports provision of generalist palliative care and support services for people receiving palliative care who have personal health needs.
f	NGO providers of population health services	Examples are social marketing for tobacco control and school-based health promotion programmes. Also includes a few community and voluntary organisations who receive funding from NDHB to implement targeted programmes, such as Maori community action to reduce obesity.
g	NGO providers of largely primary care services NGO providers of mental health services in the community	Largely made up of general practitioners, pharmacists, dentists and community laboratory.
h	Services for people assessed by the NASC service, (see (e) above	*Age-related residential care (ARRC):* rest home, hospital level and secure dementia services. *Aged residential hospital specialised services:* psychogeriatric care for older people delivered by two providers in Whangarei. *Home based support services:* community-based services that deliver household management and personal care services to older people living in the community. *Respite care* providers deliver short term care to older people with high needs so their carers at home can have breaks. *Day services* are community-based services which support people with age-related needs to remain in their own home, and/or provide support for their carers.
	Specialist palliative care providers	These provide specialist assessment from a multidisciplinary team including medical, nursing and social work health professionals, and coordination of care for people who have been diagnosed with a life-limiting condition. An 8-bed inpatient respite facility is available in Whangarei while community-based services operate in other areas.
	Community mental health services	Community-based supported accommodation for people with enduring mental illness who are stable most of the

	Service type	Description and examples
		time.
i, j, k	Community and voluntary organisations	Funded from outside Vote:Health and too numerous to list here.
l	Tertiary services	Hospitals in Auckland (primarily Auckland Hospital itself), which provide more specialised (tertiary) services for Northlanders, mainly in cancer and cardiac care. Low patient volumes make these too expensive for Northland DHB to provide. NDHB is charged for these services through the Inter District Flows mechanism (see Graphic 10 Northland DHB funding 2010/11 and the text that follows it).
m	Quarternary services	Units in major urban centres that provide highly specialised services (paediatric pathology, paediatric metabolic services, paediatric cardiology and paediatric cardiac surgery).

1.6.2 Funding and planning

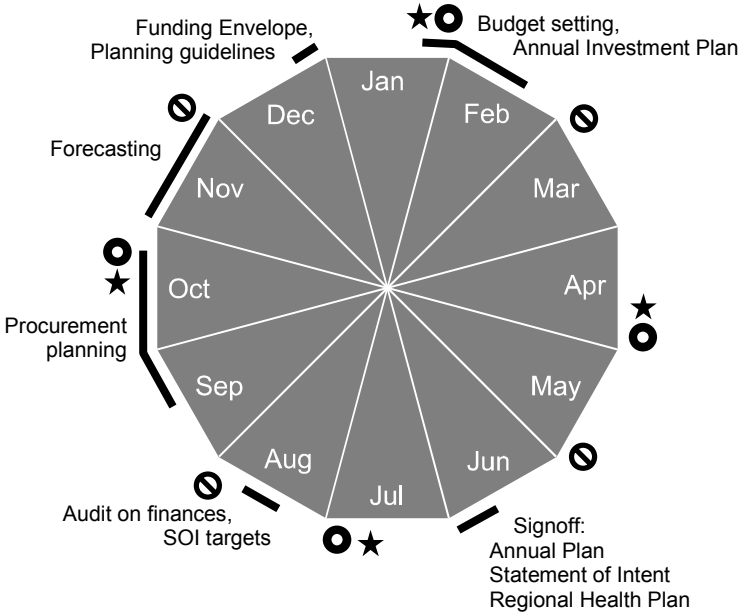
More than 99% of Northland DHB's funding goes on service provision (see Graphic 10 Northland DHB funding 2010/11), but the DHB also carries out funding and planning functions.

The *funding function* involves working with Northland's NGOs (Graphic 12), for whose performance Northland DHB is responsible. Our staff build relationships with them, negotiate contracts, ensure they are paid appropriately and monitor their progress.

The *planning function* addresses the way health services are organised and delivered to match need. It includes assessing the needs of the population, coordinating the development of plans and prioritising services. The planning team also enables Northland DHB monitor its performance. It coordinates quarterly reports to the Ministry of Health, which cover both Health Targets and 8 Non-Health Target performance measures and develops additional internal measures (such as a tool to monitor progress on the Annual Plan).

Key elements of the funding and planning cycle are depicted in Graphic 14.

Graphic 14 Key elements of the funding and planning cycle



★ *Quarterly deadline for performance monitoring reports to MoH*
O *Quarterly deadline for NDHB prioritisation proposals*
⊘ *Quarterly deadline for completion of NDHB proposal assessments*

2 Strategic direction

2.1 DHB vision

Northland DHB's vision is to "create a healthier Northland". We will achieve this by working towards improved health outcomes for all Northlanders, and by improving equity between Maori and non-Maori in Northland and between Northlanders and other New Zealanders. This is in line with the requirements of the Public Health and Disability Act 2001 quoted in section 1.1, particularly objectives (a) and (e).

Northland DHB's strategic direction embraces the one that drives the Northern Region Health Plan (Appendix 2: Northern Region Health Plan overarching framework). The vision of the NRHP is to add value to the health and lives of the 1.6 million New Zealanders in the region. The plan's rallying point is the Triple Aim, which addresses population health while delivering quality of patient experience and considering cost and productivity.

2.2 Maori health and reducing inequities

NDHB is committed to reducing inequities and improving Maori health and wellbeing. We want to maximise opportunities for Whanau Ora and contribute to whanau achieving optimal success. We acknowledge our statutory responsibility and obligations to Maori through developing working relationships based on the principles of partnership, protection and participation derived from the Treaty of Waitangi, and supporting the implementation by iwi of the Whanau Ora initiative.

Accordingly throughout this document we have identified specific actions and targets linked to reducing inequities. The plan has two companion documents. *Te Tai Tokerau Maori Health Strategic Plan 2008-2013* was developed jointly by PHOs, Maori NGOs and the DHB and seeks to address the building blocks of hauora regarding health, economic prosperity, education, research and development and the environment. The *Northland DHB Maori Health Annual Plan 2012/13* (Appendix 3: Maori Health Plan) will enable measurement of Northland's progress in improving Maori health and reducing inequities. The plan's focus on national priorities and indicators allows us to benchmark Northland against other DHBs.

Finally, we acknowledge the Iwi of Te Tai Tokerau (Te Aupōuri, Ngāti Kahu, Ngāti Kurī, Ngāpuhi, Te Roroa, Ngāpuhi ki Whāingaroa-Ngāti Kahu ki Whāingaroa, Te Rarawa, Ngāi Takoto, Ngāti Wai, Ngāti Whātua, and Te Uri o Hau). We confirm that NDHB will work collaboratively with Iwi to not only effect our responsibility under the Treaty of Waitangi but also to implement Whanau Ora for Whanau success.

2.3 Northland Health Services Plan

(Further detail: Appendix 2: Northland Health Services Plan summary.)

The Northland Health Services Plan 2012-2017 (NHSP) aims to provide the health sector in Northland with a template for the structure and provision of services over the coming five years at least. It is a plan for the whole health sector, not just for NDHB, and was assembled with involvement from major organisations including PHOs. It identifies key hotspots which need to be addressed if growing demand for services is to be managed and the health of the population improved. The NHSP will include plans developed for different localities within Northland in recognition that each area has specific needs and characteristics.

The plan has been assembled by taking both 'top-down' and 'bottom-up' approaches. It adopts a high-level system view incorporating Government priorities and the strategic approach of the Northern Region Health Plan, including its Triple Aim of Population Health, Cost and Productivity, and Patient Experience. The NHSP has also identified issues and solutions for priority areas by establishing workstreams whose membership was drawn from throughout the Northland health sector.

The NHSP was signed off at the April Board meeting. The AP incorporates material drawn from the NHSP wherever possible.

2.4 National service planning

A work programme to develop National Services and National Service Improvement programmes was introduced by the National Health Board in 2010. It was aimed at improving equity of access, quality, consistency and sustainability for vulnerable services, particularly high-cost, low-volume specialist services such as paediatric and congenital cardiac services.

Building on the NHB model, lead DHB providers were selected to be responsible for the provision and development of a national service, most of which were funded from "top slice". DHBs that were recipients of the service were expected to work collaboratively with the national service provider, supporting outreach clinic arrangements to improve access for their populations.

National Service Improvement programmes required the commitment of clinicians and managers within DHBs across a designated service pathway to identify areas of opportunity and work together on interventions to improve equity of access, quality, consistency and sustainability nationwide.

2.5 Strategic alignment

Graphic 15 shows how NDHB's strategic outcomes are consistent with the Government's priorities and the Northern Region Health Plan's high-level direction.

Graphic 15 Alignment of national, regional and local strategies

Minister of Health's expectations[2]	Northern Regional Health Plan[3]		Northland DHB's Statement of Forecast Service Performance[4]	Output Class			
	Strategic goals	Objectives		Prevention	Early Detection & Mngt.	Intensive Asses.& Treatment	Rehab & Support
Health Targets: ED waiting times Electives Cancer waiting times Immunisations Help and advice for smokers to quit Cardiovascular disease	Triple aim 1, Population health: Lift health outcomes of Northern Region population Life and years (longer, healthier, more independent lives) Reduce health inequalities.	Areas of focus: Diabetes Cancer Cardiovascular Child health Older people Respiratory disease Mental health and addiction Intent for each of these: Regional equity of access to care Improved treatment times Appropriate screening mechanisms Delivery of whole-of-system care High level objectives: 1.1 Achievement of outcome targets: 1.11 National Health Targets 1.12 Time: treatment timeframe 1.13 Demand: acute presentations, bed-day reductions 1.14 Identification of target population 1.15 Condition progression 1.16 Incidence of rates of significant events of interest	Outcome: Optimum quality of life for people with long term conditions Impact: Amelioration of disease symptoms and/or delay in their onset		✓	✓	
					✓	✓	
					✓	✓	
			Outcomes: Prevention of illness and disease; Optimum quality of life for people with long term conditions		✓		
			Outcome: Prevention of illness and disease Impact: Lower incidence of communicable disease	✓			
			Outcomes: Reversal of acute conditions; Optimum quality of life for people with long term conditions Impact: If cancer is curable, increased likelihood of survival; if incurable, reduced severity of symptoms			✓	
			Outcome: Prevention of illness and disease Impact: Lower prevalence of smoking-related conditions		✓	✓	
			Outcome: Better, sooner, more convenient services. Impact: More timely ED assessment, referral and treatment			✓	
			Outcome: Better, sooner, more convenient services.			✓	
			Outcome: Healthy population Impact: Reduced likelihood of acquiring long term conditions in later life Impact measure: Life expectancy gap between Maori and non-Maori is reduced by 2 years	✓			
Shorter waiting times:	Triple aim 2, Patient experience:	2.3 Appropriate health and disability services are able to be accessed in a timely manner when needed:					

[2] See Graphic 17 in 3 Priorities and targets, Ministerial priorities, whose text is reproduced in the first column.
[3] See Appendix 2: NRHP overarching framework.
[4] See 5 Statement of Forecast Service Performance.

Minister of Health's expectations[2]	Northern Regional Health Plan[3]		Northland DHB's Statement of Forecast Service Performance[4]	Output Class			
	Strategic goals	Objectives		Prevention	Early Detection & Mngt.	Intensive Asses.& Treatment	Rehab & Support
Surgery Diagnostics Cancer care	Better services First do no harm Informed choice Performance improvement	2.31 Rapid access for patients with acute needs 2.32 Improved access to elective services to restore or maintain peoples' functional independence 2.33 Maintain or reduce target wait times for patients accessing the hospital system					
Integrated care: Primary / secondary service integration Care pathways Integrated Family Health Centres Primary care direct referral to diagnostics	Triple aim 1, Population health: Lift health outcomes of Northern Region population Life and years (longer, healthier, more independent lives) Reduce health inequalities. Triple aim 2, Patient experience: Better services First do no harm Informed choice Performance improvement	Intent: Regional equity of access to care Improved treatment times Appropriate screening mechanisms Delivery of whole-of-system care High level objectives: 1.2 Integration of care across primary and secondary 1.3 Improved communication and collaborative approaches between health and other social agencies	Outcome: Better, sooner, more convenient services.		✓	✓	
			High level outcome: Improved equity		✓	✓	
			Outcome: Better, sooner, more convenient services.		✓	✓	
Health of older people: Integrated services Safe, independent living at home Dedicated stroke units Dementia	Triple aim 1, Population health: Lift health outcomes of Northern Region population Life and years (longer, healthier, more independent lives) Reduce health inequalities.	Addressed: • as a theme throughout long term conditions (CVD, diabetes, cancer, respiratory) • as a priority group within Triple aim 1.	Outcome: Independence for those with impairments or disability support needs. Impact: Older people requiring support or care receive services appropriate to their needs .		✓	✓	✓
Regional integration: Closer monitoring	Triple aim 3, cost & productivity:	High level objectives: 3.1 Regional resources are used effectively	High level outcome: Living within our means	✓	✓	✓	✓

Minister of Health's expectations[2]	Northern Regional Health Plan[3]		Northland DHB's Statement of Forecast Service Performance[4]	Output Class			
	Strategic goals	Objectives		Prevention	Early Detection & Mngt.	Intensive Asses.& Treatment	Rehab & Support
of objectives by NHB Efficiencies via Health Benefits Ltd, Health Workforce NZ, Health Quality & Safety Commission Productivity gains, esp in hospitals (workforce, primary-secondary integration, HOP) Clinical leadership	Ensure capacity to meet demand while living within our means	and services delivered efficiently with minimal wastage 3.2 Capacity and demand are aligned: 3.21 Focused action to reduce the demand from people entering 'downstream' care paths 3.22 Capacity requirement planning to meet future models of care 3.3 Infrastructure and assets are managed to ensure safe, efficient, effective and affordable services, evident by: 3.31 Regional collaboration on capital planning 3.32 Delivering major infrastructure developments on time within budget 3.4 Regional radiology services are improved by focus on access to and timeliness of radiology diagnostics 3.5 Work in partnership to influence health and wellbeing outcomes thru: 3.51 Improving involvement of internal and external partners in the planning and provision of health services 3.6 Investing in information systems and technology in priority areas: 3.61 Common patient administration system 3.62 Single clinical workstation 3.63 Regional clinical data repository 3.64 Population health data repository 3.65 IS infrastructure 3.66 Safe medication management 3.67 Shared care plan					

2.5 Key outcomes

To achieve these outcomes, NDHB, working in conjunction with our Northern Region colleagues, aims to achieve the following impacts.

Healthy population	Supporting people who are already healthy to stay healthy, and those who have undesirable lifestyle habits to remedy them before they create health problems.
Prevention of illness and disease	Employing screening services and health checks to pick up signs and symptoms as early as possible, hopefully before they develop into diagnosed conditions.
Reversal of acute conditions	Some conditions, depending on their type and severity, can be treated and reversed or even cured.
Optimum quality of life for those with long term conditions	Once a long term conditions is acquired, it can only be managed. Health checks, clinical support and appropriate lifestyles are then essential to prevent or delay any worsening of the condition.
Independence for those with impairments or disability support needs	People with physical, sensory, neurological, psychiatric or intellectual impairments have a right to a full life, but they often face barriers created by a society that does not take appropriate account of their needs.
Better, sooner, more convenient services	Everyone is entitled to good quality, safe services that are accessible and appropriate.

2.6 Key measures of performance

To monitor our performance on these impacts, NDHB uses the following measures. The impacts listed in the tables are a summarised version of fuller explanations described in 5.1.2 Impacts, outputs and progress.

Health Targets

Priority	Indicator	Medium-term impact
Smoking cessation	Smokers offered advice and help to quit	Providing brief advice to smokers has been shown to increase their chances of making a quit attempt. More quit attempts will lead to a reduction in both smoking rates and smoking-related diseases.
Immunis-ations	Eight-month-olds fully immunised	Improved immunisation coverage leads directly to reduced rates of vaccine preventable (communicable) disease.
Emergency care	Maximum 6-hour wait in ED	For patients, shorter waiting times in ED mean more privacy and dignity, and better clinical outcomes (such as reduced mortality, shorter lengths of stay for those admitted into hospital as inpatients).
Elective operations	Extra elective operations; maximum 6 month wait	Elective surgery increases people's functioning because it remedies or improves disabling conditions. More operations and earlier access to them will improve health and wellbeing.
Cancer	Maximum 4 week wait for radiotherapy and chemotherapy treatments	Cancer accounts for a significant proportion of death and disability. Earlier access to treatment improves the chances of survival.
Diabetes & CVD	Assessment of cardiovascular risk	CVD accounts for a significant proportion of death and disability. If more people receive assessments on time and their conditions are managed appropriately and consistently, improved health and independence will result.

Impact measures in the SFSP

5 Statement of Forecast Service Performance)

Priority	Indicator	Medium-term impact
Smoking	Proportion of smokers in Year 10 students, total population and pregnant women	Because smoking has such a profound effect on the rate of illness and death and exacerbates a whole range of diseases, its prevalence in the population is a crucial indicator of our overall state of health.
Child health	Infants fully and exclusively and breastfed at 6 weeks	Higher rates of breastfeeding in infancy correlate with a lower chance later in life of developing health problems, including long term conditions.
Oral health	Five-year-olds who are caries-free Average number of decayed, missing or filled teeth in Year 8 students	Oral health directly affects the state of health of the mouth, and the effects of tooth and gum disease can be lifelong. Significant rates of disease can also limit what children can eat, affect personal self-image and confidence, and create pain and discomfort.
Child protection	Referrals to CYFS of children suspected of being abused	Every child has the right to live in a safe, nurturing environment free from abuse and neglect.
Diabetes	People with diabetes receiving annual reviews, and of them, those with good blood sugar management	Early identification and appropriate management of diabetes prevents its symptoms from worsening, enabling health and functioning to be maintained for longer and preventing or delaying the development of complications and comorbidities.
Cancer	Breast cancer and cervical cancer screening rates Timeliness of treatment for radiotherapy, chemotherapy	Screening in the community to identify cancers as early as possible improves the chances of prevention or, if the condition already exists, recovery.
Mental health	Referrals from GPs to Primary Mental Health Coordinators Proportion of people with enduring mental illness aged 20-64 who are seen over a year	Mild to moderate disorders affect 20% of the population at any one time and 90% over a lifetime. Severe mental disorders and addictions require support and treatment by the specialised clinical workforce employed by NDHB. Mild to moderate disorders can be dealt with largely by primary care services, with support from specialised clinical services if conditions become unstable.
Quality	Measures of the quality and safety of services (complaints, infections, hand hygiene)	Quality systems enhance the nature of care experienced by patients. They also reduce risks, cut down errors, smooth flows between services, improve staff morale and minimise resource wastage, so they are an important contributor to productivity and efficiency.
Health of older people	Percentage of home based support services clients receiving interRai assessments Percentage of high and medium risk corrective actions arising from certification Respite care bed days utilised	Home based support services are coming under growing pressure because there is an increasing number of older people receiving them (currently approximately 12% of Northland's over 65 population). This growth will be sustainable only if we allocate resources to those most in need. Certification of aged residential care facilities is carried out to make sure they are adhering to health and disability sector standards. The better they do this, the longer the period of certification they receive. Respite care increases planned access to 'time out' services for older people being cared for in the community. This improves the health and wellbeing of informal carers and enables older people to stay at home longer, thus delaying entry to long-term residential care.

2.7 Key risks and opportunities

Graphic 16 takes a broad scan of the environment within which Northland DHB operates and identifies key factors which increase risks and/or provide opportunities for the organisation. Further details about our operating capability are in 4 Stewardship.

Graphic 16 Key risks and opportunities for Northland DHB

Factor	Risk / opportunity	NDHB response
Funding levels	About 96% of Northland DHB's revenue comes from the Ministry of Health. A DHB's share of Vote:Health is determined by its population size, weighted for factors that increase the need for health services (gender, age, ethnicity, rurality, deprivation). The application of this Population Based Funding Formula (PBFF) sees NDHB's allocation rise from a raw share of 3.7% of Vote:Health to a PBFF-weighted allocation of 4.2%.	While the extra 0.5% of Vote:Health may not sound much, it equates to about $60m of annual income. Northland DHB is acutely aware of using this resource wisely to help meet the needs of our population. Key factors are managing within budget, managing demand-driven contracts, regional relationships, the quality of information systems, the rigorousness of our prioritisation tool, new models of care, and attracting and retaining the right staff. All of these are addressed elsewhere in this table.
Increases in demand for services	Demand for health services is outstripping population growth (1.4 Health profile, Graphic 8 Growth in key health services in Northland 2006/07 - 2009/10), largely because of the ageing population and the increasing prevalence of long term conditions. Allied with increasingly expensive technologies, this poses significant challenges to meet demands and stay within budget.	Reduce costs and improve productivity of services, including working regionally with the Auckland DHBs under the third of the NRHP Triple Aims. Pursue approaches to improve the health of the population and reduce inequities, such as reducing the prevalence of smoking. Improve models of care to streamline patient flows and improve outcomes. Gather better data so we can determine more accurately how to make improvements. Be more rigorous about how NGO contracts are drawn up and services are monitored in both NGOs and within NDHB.
High-need population	As described earlier in 1.3 Population profile, the Northland population has one of the highest needs for services because it is one of the country's most deprived and has an older age profile.	Collaboration with government and local body agencies, such as through the Northland Intersectoral Forum, to address the social and economic factors underlying deprivation. Identify high-need populations and target services (a process helped by the new prioritisation tool described below). For high-need groups, continue to develop relationships with service providers, both Maori and mainstream, and negotiate requirements in their contracts. Analyse funding patterns, productivity and cost-benefits. For long term conditions, negotiate and introduce new models of care. For the ageing population, pursue tactics to keep older people's functionality as high as possible and maintain them in the community as long as possible.
Managing within budget	All DHBs are required to stay within budget, and the consequences for not doing so can be profound. This is especially challenging in the current funding environment because there are no real increases in funding for new services.	NDHB's system of financial management and monitoring of financial performance (4.2.1 Financial management systems). Northland DHB has a proud history of remaining in the black.
Demand-driven contracts	The majority of the Funder's expenditure (see Graphic 10 Northland DHB funding 2010/11) is demand-driven because it is based on health workers in the community requesting items of service	Continue to: • develop budgets that are as accurate as possible (budget calculations for each new year are based on historical expenditure and any known likely future impacts, though NDHB is still exposed to any

Factor	Risk / opportunity	NDHB response
	(prescription drugs, lab tests etc) to meet the needs brought to them by the public. There is no 'cap' on this spending. The Funder not only has limited control over this expenditure, it also has limited influence over the price per item because that is often determined nationally.	unknown or unpredictable fluctuations) • monitor expenditure. • maintain effective working relationships with providers • engage in regional and national activity.
Inter-District Flows (IDFs)	13% of all NDHB expenditure goes on IDFs, money we pay to other DHBs, mainly Auckland, for specialised (tertiary) services provided to Northlanders that we cannot provide here. This is a major risk to the DHB because: • referral is based on clinical need and therefore difficult to predict and control, especially with increases in demand for services, as noted above • for inpatient services (about 60% of total IDFs), each patient treated is paid for at a nationally-agreed price, and demand for these services has been growing much faster than growth in NDHB's population and funding.	Maximise the number of patients treated in Northland by: • maintaining and increasing the skill levels of NDHB's clinical staff • ensuring ready access by Northland staff to more specialised advice from tertiary providers • developing regional clinical protocols to specify when conditions should be referred (see next row in this table). Another option is to increase the range and complexity of services provided by NDHB, but setting up new services is expensive and complicated, and specialised staff can be difficult to attract (see employment issues section of this table).
Regionalis-ation	Before the emphasis in recent years on regional service planning and provision, Northland found it difficult to make its case heard. Northland comprises less than a tenth of the Northern Region's urban population, and there were no formal regional mechanisms through	Northern Region relationships have been strengthened over the years so that now there is commitment by regional services to achieve equitable access and health gain for everyone who resides in the Northern Region. Regional engagement is a two-way street. It also requires Northland providers, led by senior clinicians, to think more flexibly and up their game,

Factor	Risk / opportunity	NDHB response
	which to work.	in order to reconfigure and streamline services, information and patient flows.
Prioritis-ation tool	NDHB needs to be assured that all decisions we make regarding the services we provide and contract for will improve the health of our population and reduce inequities in health status.	NDHB's prioritisation tool takes a rigorous, quantified approach to assessing the effectiveness of services. It will be used for all decisions that involve allocation or reallocation of funding (including potential disinvestment) under the direct accountability of the DHB. This includes: decisions regarding Northland DHB provider services and NGO contracts; any service changes proposed by NDHB; new projects or initiatives; solicited and unsolicited funding proposals.
Information systems and data	The right sort of information is vital for defining needs, devising new service arrangements and monitoring performance. Key contributing factors are the type of data that systems are set up to generate and how different systems in the health sector 'talk' to each other. Key risks include: (a) time delays due to complexity of governance and regional and national consensus decision models; (b) the level of change and investment that is required to fully implement the regional and national IS strategy, which will require reprioritisation of capital and operational funding in DHBs.	Strengthen regional and national governance structures, improving capital planning and prioritisation at regional level. Support and participate in NRHP plans to improve information systems (4.2.2 Information Services). This will improve continuity of care for patients across primary, secondary and tertiary care. It relies on consistent and reliable access to core clinical documents and facts for all clinicians involved in patient care. From NRHP: *"Information systems are critical to support many of the proposed changes in models of care. It will however take several years to deliver on the prioritised initiatives. This may be slowed further by access to capital funding and affordability of proposed investments."*
New models of care	Introducing new ways of organising services to ensure they are better, sooner and	Initiatives to break down 'silos' and establish new ways of working, as described in NDHB's Workforce

Factor	Risk / opportunity	NDHB response
	more convenient could be interpreted as a potential threat by some in the health sector. The potential for more flexible workforce practices is constrained by national structural barriers such as employment agreements and employment law.	Strategy (3.15 Workforce Strategy). Service structures, workforce practices, contracts, info flows and methods of practice can be changed to smooth the patient journey, improve information flows, strengthen monitoring capabilities, enhance clinical leadership, use resources more productively and improve health outcomes. Consideration of new models of care should precede capacity planning, thus potentially reducing demand for capital funding. Continue involvement in and submissions to national processes that influence work practices.
Employ-ment issues	Around 70 percent of NDHB's provider expenses are staff-related, so any changes to nationally or regionally negotiated employment contracts have significant impacts on our costs. Northland DHB, as a relatively small player in the national health sector, often struggles to attract and retain appropriate staff, especially in some clinical specialist roles.	Northland has an appealing physical environment and warm climate which enhance our 'pulling power'. Continued and innovative attention to efficiencies, strict budget monitoring practices and close controls over workforce-related costs such as annual leave and use of locums. Continue to explore innovative "grow our own" solutions to workforce issues (such as Pukawakawa[5], scholarships in oral health and Maori health). From NRHP*: "Time is needed to grow the workforce to work in new fields and expanded roles. HWNZ funding had been anticipated in a number of areas, but it now appears that this is less likely given the reduction in their budget. Until the workforce role changes occur it will be*

Factor	Risk / opportunity	NDHB response
		hard to build momentum around some initiatives where current staff are already stretched to deliver in their current roles."

[5] An arrangement under which a group of fifth-year medical students from Auckland Medical School work in Northland as part of their training.

3 Priorities and targets

Clinical integration

The importance of integration and working with primary care and NGOs in the community so that a whole-of-system approach is taken to service planning and service delivery was highlighted in the Minister's Letter of Expectation. To deal with the impending increases in demand for health services, only by working integratedly will the health sector be able to make any impact on health outcomes.

Northland Health Services Plan 2012-2017

The Northern Health Services Plan (2.3 Northland Health Services Plan, Appendix 2: Northland Health Services Plan) targets greater clinical integration. The development of the NHSP and its detailed service plans involved strong commitment from NDHB's clinical staff, PHOs and other NGOs. It includes the following headline targets:

- life expectancy gap between Maori and non-Maori is reduced by 2 years
- unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017
- every Northlander with urgent health needs has same day access to primary care
- >95% of patients report they would recommend the service provided
- value for money savings of $5m achieved against projected cost increases every year
- Northland hospital labour productivity benchmarks in top 5 of DHBs

Focus areas are long term conditions, ageing population and unplanned and urgent care.

Long term conditions already place a major load on services, but the load these conditions generate will increase dramatically if we don't act swiftly and radically (for example, the Northland Health Services Plan predicts that if we carry on providing services the way we are, in 15 years time NDHB will need 170 extra beds (nearly the size of Whangarei Hospital currently).

Our rapidly ageing population (1.3 Population profile) will place enormous demands on community support and residential care services for higher-need older people. It is also compounding the pressure on services for long term conditions because they become more common as people age.

Unplanned and urgent care places a substantial and quickly growing demand on hospital services. Many hospital admissions are potentially 'avoidable' (about 9% of people admitted acutely to Northland hospitals have problems that could or should have been treated appropriately in the community) or in fact may be there inappropriately (20% of people who attend Whangarei's ED are in the triage 4 and 5 category and initially should have gone to primary care). As well, the number of people requiring urgent care has been growing rapidly (in the last four years, Whangarei's ED attendances have jumped by 13%, while the population has increased by only about 3%).

Change is urgent

If we don't do something to turn the curve soon, health services will become not only overwhelmed but unaffordable. In an era of tight financial restraint, gaining value for money from the health dollar is more important than ever. Hospital services are expensive; a day's stay in hospital costs about $2,000, while the net cost of a GP visit is about $60 to $70. We need to reduce demands by:

- using primary care and community-based services more effectively
- expanding the range of services provided in the primary and community setting by moving some of them out of hospitals
- improving our ability to intervene "upstream" to prevent people getting sick
- developing better ways of helping people managing long term conditions to delay the onset of complications as long as possible
- continuing to find improvements in efficiency and effectiveness .

What to do to achieve clinical integration?

To achieve this, we need change which must:

- develop new models of care
- integrate services better, especially across hospital and the primary health system
- initiate different ways of working, such as by developing new roles for staff
- break down the 'silos' in which services sit and redesign them from the patient's viewpoint

- develop care pathways and clinical protocols in both primary health/ community-based and hospital services
- improve service quality
- improve efficiency and effectiveness.

To enable these things to happen, we need transformational change which requires us to approach leadership and decision-making in a different, synergistic and shared way.

The Te Tai Tokerau Alliance for Health was formed in 2011 and established the Alliance Leadership Team (ALT) which comprises senior representation from the DHB, PHOs and NGOs, including Whanau Ora Collectives. ALT has recently confirmed its role as being to provide the overarching governance structure for sector integration, strategic direction and the broad vision of integration. In essence ALT will not 'do' alliance projects but rather it is the alliance.

For 2012-13 ALT's draft workplan will focus on:

Information system integration. In particular between GP and Maori health providers, and between hospital and primary health care

Long term conditions. People with long term conditions represent a significant proportion of our work, a load that is projected to increase. The development of services for this population group needs to widen its scope to include presymptomatic and preventive work.

Evidence-based *clinical pathway* development crossing organisational boundaries.

Development of *youth health*. Currently provision is fragmented with gaps in service and possible duplications.

Integration between Maori health providers, Whanau Ora Collectives and primary care.

Integration between hospital services and primary health care.

NDHB recognises integrated clinical service delivery will require the fostering of clinical partnerships between hospital and primary health clinical staff. NDHB has over the past 1-2 years formed a number of service planning groups which have clinical and managerial leads from hospital services and primary health care including NGOs. This has contributed to the development of a solid base of collaboration and shared vision encapsulated in the recent publication of the Northland Health Services Plan. Fully functioning integrated whole of sector planning teams have been established in the following areas:

- Long Term Conditions Clinical Governance Group, and the Long Term Conditions Clinical Reference Group (3.1 Long term conditions)
- Northland Diabetes Operational Workstream and participating in the Northern Region Diabetes Clinical Network (3.1.2 Diabetes)
- Northland CVD Network Workstream Group, and participation in the Northern Region CVD Clinical Network (3.1.1 Cardiovascular disease)
- Northland Cancer Control Steering Group (3.1.3 Cancer)
- Long Term Conditions Respiratory Workstream Group
- Northland DHB Tobacco Target Steering Group, Patu Puauahi Coalition (3.7 Better help for smokers to quit)
- Health of Older People Strategy Group (3.2 Health of older people)
- Primary Options – Northland (POPNs) development group (3.4 Primary care)
- Child and Youth Health Disability Advisory Group; Immunisation Steering Group; Child and Youth Mortality Review Group; Before Schools Check Clinical Governance Group (3.8 Child and youth health)
- Acute Care Reform Steering Group and primary care subgroup (mentioned in 3.3.1 Shorter stays in EDs)
- numerous mental health groups (3.10 Mental health)

Intersectoral integration

Integration does not only need to occur at sector wide level, intersectoral integration is also required to achieve the health outcomes to which we strive for the Northland population. In particular NDHB is an active member of:

- Whanau Ora Regional Leadership Group
- Te Tai Tokerau Whanau Ora Collective
- Maori Health Alliance
- regional oversight group for four regional Maori health GMs
- MSD Community Response Forum
- Northland Intersectoral Forum.

Actions identified for 2012/13

Clinical integration forms the backbone of the Annual Plan, particularly in Module 3 which addresses key priorities nationally (Health Targets and other Ministerial priorities), regionally (many of the planned actions emanate from

the Northern Region Health Plan) and locally (actions are consistent with the NHSP). Graphic 18 assesses all the actions from throughout Module 3 for their contribution to the types of clinical integration mentioned above.

The following list summarises key actions planned for 2012/13 to achieve clinical integration.

Risk stratification

Northland DHB stratifies our population according to its level of risk so that those who are most vulnerable may be addressed as the highest priority. The current focus is on Maori men (3.1 Long term conditions).

Integrated care pathway development

Maori patient pathways, LTC disease non-specific (3.1 Long term conditions)

Orthopaedics (3.6 Elective surgery).

Lung cancer (3.1.3 Cancer)

Bowel cancer (3.1.3 Cancer).

Dementia (3.2.3 Dementia pathway).

Hospital 2 Home (3.3 ED).

Model of care development

PHOs to support new models of care in diabetes for general practitioners highlighting variations between GP practices (3.4 Primary care).

Explore opportunity of an intersectoral youth space with new model of care (3.4 Primary care).

A whole-of-sector approach to make it the responsibility of all health providers to check the immunisation status of a child whenever the child makes contact with their services (3.8 Child and youth health).

IFHC/ network development in demonstration sites (3.4 Primary care).

Information sharing and information technology developments

Implementation of Testsafe (4.2.2 Information Services).

Various telehealth developments (3.14 Telehealth).

Implementation of primary care PREDICT in Diabetes Resource Centre (3.1.2 Diabetes).

Primary care data on immunisation provided at practice level to inform providers and support under-performing practices (3.5 Immunisation).

Diabetes management KPIs reported on by GP practice with the goal of supporting best practice across primary care (3.1.2 Diabetes).

Development of regional data repositories in cancer (3.1.3 Cancer), diabetes (3.1.2 Diabetes) and CVD (3.1.1 CVD).

Implement shared data system between general practices and EDs throughout the district (3.3.1 Shorter stays in EDs).

Implement the electronic multidisciplinary meeting referral form across the lung cancer service (3.1.3 Cancer).

Resourcing integration

To achieve integration and development of services outside of the hospital setting will require a refocusing of resources into the primary, community and Maori NGO arena, work that is now beginning in earnest. It is set against the backdrop of the Northland Health Services Plan where the development of a Strategic Investment Fund of a minimum of $3m per annum is to be established to shift DHB funding to population health programmes, prioritised services and cost effective primary and community models of care. Re-allocation of funding has been identified in the following areas for 2012/13.

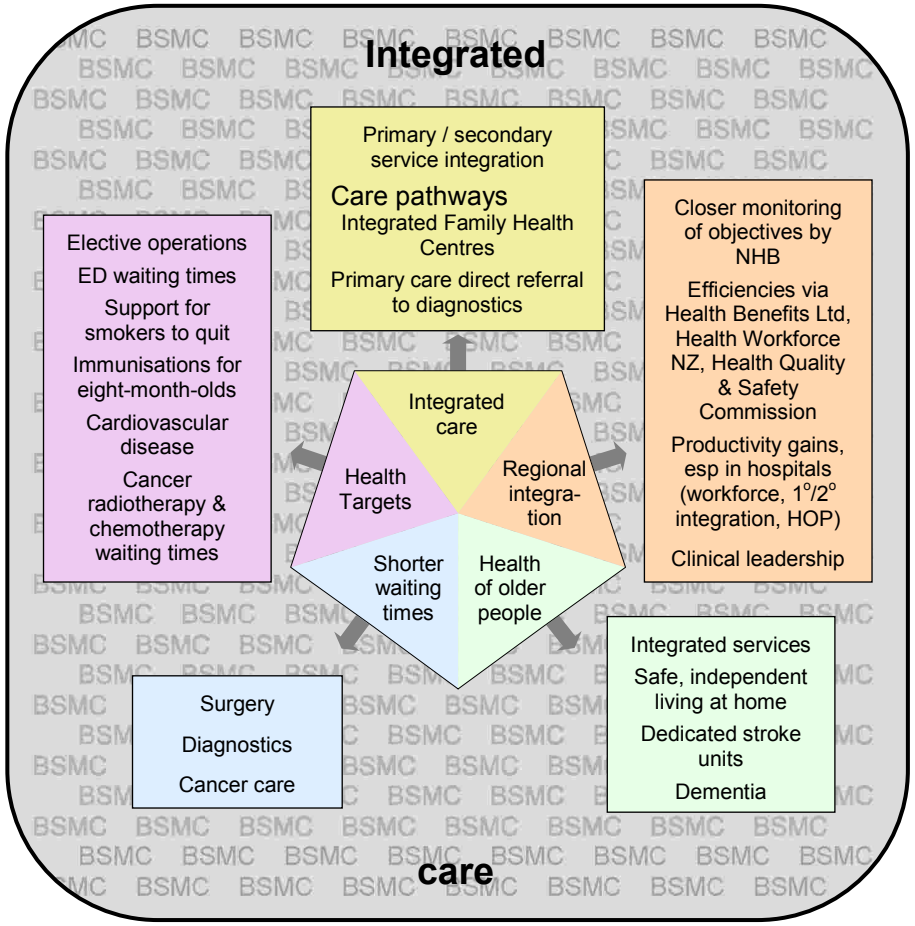
Action	AP section	New funding & volume
Continuation of GPwSI skin lesion programme	3.4 Primary care	$50k, approx volume 160
POPN	3.4 Primary care	$500k, minimum 1,500 volume. Baseline 2011/12 = 600.
Child and youth mental health and addiction services by NGO providers	3.9 Child and youth mental health	$1,036,569 (from $875,577 to $1,912,146). Baseline will be established during 2012/13 using Results Based Accountability framework, and outcome measures will

		be established
HOP Enablement Service	3.2.4 Community specialist HOP teams	$120k (volumes will be estimated during development of the proposal by 31 July 2012)
Multidisciplinary outpatient pulmonary rehab programmes into community	3.1.4 Respiratory diseases	Baseline being established so volumes can be set
Increase medical outreach services to 6 days a week	3.1.4 Respiratory diseases	Baseline being established so volumes can be set
Clinical pathway development (guideline development from appropriate international guidelines and software (eg Map of Medicine)		$50k

As well as shifting resources from the DHB into primary and community services, we will be investing in more of our own services to work in the community in high-priority areas such as HOP. The position below will increase the amount of specialist advice available to ARRC facilities and primary care providers, thereby enhancing quality of care.

Action	AP section	New funding & volume
1.0 FTE gerontology nurse specialist hours	3.2.4 Community specialist HOP teams	$90,500, est. 480 new clinical assessments

Graphic 17 Minister of Health's priorities from his Letter of Expectations for 2011/12



Graphic 18 Analysis of actions from Module 3 according to type of clinical integration initiative

Section	Brief summary of action *(in the same order as in their sections, where fuller, more explanatory text may be found)*	Type				
		New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
3.1 LTCs	Target high risk Maori men across LTCs		✓			
	Clinical pathway for heart failure		✓			
	Clinical pathway for COPD		✓			
	Clinical pathway for Maori patients		✓			
3.1.1 CVD	Support NRHP implementation (5 actions)	✓	✓	✓	✓	
	Implement CVD interface across community and hospital settings				✓	
	Strengthen cardiac outpt clinics, investigate telehealth		✓	✓		
	Implement NZ Clinical Guidelines		✓	✓		
Cardiac services	Performance measure report initiatives x3			✓		
	↑ CVD assessment & management rates in 1º & 2º services		✓			
	↑ access to cardiac rehab regionally		✓			
	Initiatives x8 to evolve new models of care					
3.1.2 Diabetes	New diabetes models of care in general practice	✓	✓			✓
	Urgent referrals seen by diabetes specialist service within 1 day		✓			✓
	80% of women with gestational diabetes checked at 6 weeks		✓			✓
	Early intervention & self management at WO & diabetes demo sites	✓				✓
	Diabetes Care Improvement Package	✓	✓			
	Manage & update diabetes register regionally			✓	✓	
	Train-the-trainers conversation maps across TTT PHO			✓		
	Survey training needs of all primary / community nurses			✓		
	Clinical champions & mentors in primary care		✓			
	Scope feasibility of ↑ prevention & risk actions					✓
	Further develop electronic patient management tools			✓		
3.1.3 Cancer treatment	Lung and bowel cancer: design new patient pathway for (5 actions) and implement (4 actions)		✓			
	Regional cancer service projects (4 actions)	✓	✓	✓	✓	
	Cancer Care Coordination codesign workshop	✓	✓			
	Cancer Consumer Community Network & Forum			✓		
	Review clinical representation on cancer & palliative care networks			✓		
	Review effectiveness of Palliative Care Generalist Guidelines		✓	✓		
	Advance Care Planning			✓		
	Develop follow up oncology clinics in Kaitaia	✓				
3.1.4 Respiratory diseases	Review contracts, align to national guidelines		✓	✓		
	Form Respiratory Workstream, develop work programme & protocols	✓	✓	✓	✓	
	Implement changes to pulmonary rehab (4 actions)		✓	✓		
	Strengthen discharge practices		✓			
	Increase coverage of medical outreach			✓		
	Develop self-management toolkit			✓		

Section	Brief summary of action (in the same order as in their sections, where fuller, more explanatory text may be found)	Type				
		New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
3.2 Health of older people	HBSS clients to receive comprehensive clinical assessment		✓	✓		
	Benchmarking of quality measures x2		✓	✓		
	↓ hospital admissions of older people		✓			
	Comprehensive clinical assessment in ARRC			✓		
	↑ specialist engagement with ARRC			✓	✓	
	Participate in regional dementia pathway activity		✓			
	New NDHB dementia pathway by Deb 2012		✓			
	Monitor & ensure appropriate access to dementia services		✓			
	Specialist advice & training for primary care, ARRC		✓	✓		
	↑ specialist FTE input to ARRC		✓			
	Implement TIA pathway		✓			
3.3.1Emergency Depts	6 bed unit	✓	✓			
	Patient flow meetings		✓			
	Radiology fast track		✓			
	↑ urgent appointments in primary care	✓	✓		✓	
	Survey of patients re expectations of ED	✓		✓		
	Integrate PHO & DHB records				✓	
	ED data shared with general practices				✓	
	Hospital 2 Home for cardiology & respiratory patients	✓	✓			
	Daily ED length-of-stay breach meetings		✓			
	Rapid ward rounds, electronic whiteboards in		✓			

Section	Brief summary of action (in the same order as in their sections, where fuller, more explanatory text may be found)	Type				
		New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
	medical wards					
	New process for booking beds from ED		✓			
	ED coordinator roles		✓			
	↓ youth presentations	✓				✓
	↓ admissions of older people	✓				✓
3.3.2 Reducing growth in service demand	Strengthen discharge planning, esp for older people and Maori	✓				
	Establish global trigger tool baselines, reduce adverse events			✓		
3.4 Primary care	Locality planning initiatives	✓			✓	✓
	Demo sites x6 throughout Northland	✓	✓		✓	
	Train 5 general practice assistants (Manaia PHO)	✓				
	New quality & funding framework proposal	✓		✓		
	Train-the-trainers model via Clinical Nurse Leaders Forum			✓		
	Standardised orientation for practice nurses			✓		
	Embed NZGG diabetes pathway in general practice		✓	✓		
	Intersectoral youth space				✓	
	↓ hospital admissions of older people		✓			
	Skin cancer clinics in four GP practices					✓

Section	Brief summary of action	Type				
	(in the same order as in their sections, where fuller, more explanatory text may be found)	New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
	Increase Primary Options Programme Northland	✓				
	Primary care and ED to work together to ↓ demand on ED services	✓			✓	
	Increase free after-hours care for under-6s		✓			✓
3.5 Immunis-ation	Whole-of-sector commitment to Immunisation Charter	✓			✓	
	Third trimester GP appointments for non-enrolled pregnant mums		✓			✓
	Whole-of-sector responsibility for checking imms status	✓	✓		✓	✓
	Early enrolment, triple referral by 4 weeks postnatal		✓			✓
	Practice-level monitoring of performance		✓			✓
	Quality systems in primary care			✓		
	Hospital-based vaccination as core business	✓	✓			✓
	NIR to be the hub for referrals to Outreach Immunisation				✓	✓
	Use geomapping to improve coverage of Outreach Immunisation		✓			✓
3.6 Elective surgery	Redesign of orthopaedic pathway		✓			
3.7.1 Smokers in hospitals	ABC support for Maori patients, esp ED & SAU		✓		✓	
	↑ staff understanding of process, standing orders, NRT		✓			
	Monitor effectiveness of Smokefree Champions		✓			
	ABC as part of standard clinical observations		✓			
	Follow-up where smokers not offered cessation advice		✓			

Section	Brief summary of action	Type				
	(in the same order as in their sections, where fuller, more explanatory text may be found)	New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
	Targeted advice to make ABC std practice in all wards & depts		✓			
3.7.2 Smokers in primary care	Enigma database to record & monitor smoking status			✓		
	ABC activity, targeted free access for high needs groups		✓			
	Whole-of-system approach through Tobacco Steering Group	✓	✓			
	LMC pregnancy pathway initiative		✓			
3.8 Child & youth health	↑ awareness among GPs re managing rheumatic fever			✓		
	School-based throat swabbing for children in high-risk areas				✓	
	Healthy Housing				✓	
	Initiatives x3 to↑ smoking cessation support for pregnant women			✓		
	Initiatives x5 to ↑ children's protection vs preventable conditions		✓	✓	✓	✓
	↑ enrolment & access to oral health services		✓			
	Better services for children of parents with mental illness		✓	✓		
	↑ referrals to CAMHS, use Incredible Years programme			✓		
	Initiatives x4 to ↓ sexual infections & pregnancies	✓		✓	✓	✓
	Initiatives x5 re referrals for violence & sexual abuse		✓		✓	✓
	Initiatives x4 to ↑ wellness among children				✓	✓
	Initiatives x4 to ↑ awareness re AOD & ↓ use					

Section	Brief summary of action	Type				
	(in the same order as in their sections, where fuller, more explanatory text may be found)	New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
	Initiatives x8 re disabled children		✓	✓	✓	
	Initiatives x 5 ↑ continuity of care for young people with disabilities	✓	✓	✓		
3.9 Child and youth mental health	↑ access to child & adolescent psychiatrists		✓			
	Colocate Kaitaia clinics to ↑ access for youth		✓			✓
	↑ access to Gateway assessments		✓		✓	✓
	Initiatives x3 to ↑ access to services in schools etc		✓		✓	
	New service agreements with govt depts		✓		✓	
3.10 Mental health	Initiatives x3 re postnatal depression	✓				✓
	↑ Maori involvement in 'Talking Therapies'		✓			✓
	Primary care screening & referral for AOD issues		✓			✓
	Initiatives x3 to ↑ client participation in primary care		✓			✓
	↑ access to AOD residential care & community treatment				✓	
	↑ provision of AOD treatment programmes for adults by NGO providers				✓	
	Initiatives x3 for co-existing problems (both MH & AOD)		✓			✓
	Smokefree policy in all NGO contracts					✓
	↑ smoking cessation support for clients					✓
	Develop social inclusion strategies x2	✓				
3.11 Advance care planning	Training for 21 NDHB and NGO staff	✓		✓		
	Regional community awareness campaign	✓				

Section	Brief summary of action	Type				
	(in the same order as in their sections, where fuller, more explanatory text may be found)	New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
3.12 Maternity	Maty Quality & Safety Standards Coordinator			✓		
	Maty Clinical Governance Group				✓	
3.13.1 Whanau Ora	Continue to provide feedback, maintain investment in WO Collectives, participate in forums, and explore integrated contracts with MSD (as described in more detail in 3.12.1)					
NHSP population health	Intersectoral actions (food accords, alcohol, gambling etc)				✓	✓
	Nurse-led mngt of health problems in high-Maori schools	✓				✓
	Hospital at Home, cmty nursing, case mngt for older people & Maori with LTCs	✓				✓
	↑ home-based restorative services, linkages with primary care				✓	
	Rapid-response phone & email advice for GPs, remote collab models	✓		✓		✓
	Action plans & coaching support for Maori patients with LTCs at risk of readmission	✓				
	Hospital at Home & telecare models for lower dependency patients	✓				
	Reinvigorate Primary Options Programme Northland	✓				
	↑ health literacy for those with LTCs		✓	✓		
NHSP patient experience	'Health Home' model initiatives:					
	WO implementation & navigation	✓				
	Establish IFHCs in Whangarei	✓				
	Extended twilight GP hours, esp for <6s, Maori, high needs	✓				
	Multidisciplinary care thru nurse-led LTC	✓				

Section	Brief summary of action	Type				
	(in the same order as in their sections, where fuller, more explanatory text may be found)	New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
	management					
	Shared info systems across 1°, community, 2° services	✓		✓		
	Consider ↑ step-up, step-down GP beds	✓				
	Consider centralised phone/online pt triage & booking system	✓				
	Patient safety & quality (medication review,		✓	✓		

Section	Brief summary of action	Type				
	(in the same order as in their sections, where fuller, more explanatory text may be found)	New models of care	Pathways & protocols	Quality improvements	Integrating services	Upstream, preventive
	infection control, fall reductions etc) initiatives x3					
	Design, implement, monitor clinical pathways for priority conditions		✓			
	All contracted NGOs to have policy on cultural competence		✓			

3.1 Long term conditions

Long term conditions (LTCs) account for 70-78% of all morbidity and mortality in New Zealand and consume a similar proportion of all healthcare spending. New models of care are required to move from acute reactive care to planned, proactive care with improved health outcomes and patient experience.

Northland DHB adopted the Long Term Condition Framework in December 2009 based upon the National Health committee (NHC) & World Health Organisation definition. A Long Term condition is "any on-going, long term or recurring condition that can have a significant impact on people's lives". The LTC Framework seeks to improve the health status of the Northland Population and more importantly, to improve equity especially between Maori and non-Maori and reduce inequities and disparities of health especially between Maori and non-Maori.

Northland DHB has appointed a Clinical Governance Group for LTCs. We have identified four key LTC priorities as having a significant impact on the Northland population: cancer, cardiovascular disease (CVD), diabetes, respiratory related conditions such as asthma and chronic obstructive pulmonary disease (COPD). Northland DHB continues to work with the Northern Region to align service modalities and information (clinical and patient) systems across the Northern Region. The Northland Health Service Plan outlines the long term direction and aspiration of a healthier Northland. The key outcomes for the population are to improve the life expectancy of Northlanders and improve the quality of life of those living with long term conditions within Northland.

This section of the priorities will seek to provide a whole of system, district wide approach to long term conditions management in accordance with the LTC Framework and will act as an overarching guide to improving service provision, improving clinical excellence and leadership and improving the health and quality of life of people living with long term conditions.

Outcome	**Actions to achieve target**	**Target(s)**	**Expected gains**	
			For health services	**For patients/ clients**
Risk stratification	Northland LTC Clinical Governance Group will target high-risk Maori men. Identify health professionals involved with the cohorts. Confirm the cohorts within the target group. Collect baseline data. Cohorts to be prioritised and agreed in partnership with primary care providers including Whanau Ora providers. Once cohorts and baseline data, including volumes, have been identified, develop community setting volumes in partnership with primary care providers, including Whanau Ora providers.	Sep 2012 Sep 2012 Sep 2012	Reduced use of hospital services for high risk Maori men by identifying them and implementing community based strategies for early management. Improved awareness of health literacy among health professionals. Strategies developed to improve relationships and engagement of their patients.	Maori men (leaders of their families) play a more active role in their families and live a healthy life. Increased life expectancy for Maori men.
Patient outcome measures	Develop KPIs in the following areas by Sept 2012: • increased cardiovascular interventions • increased medical compliance and risk management • reduced unplanned and potentially avoidable GP and hospital visits.	Sep 2012	Primary care practices and Whanau Ora providers able to identify how they will contribute to achieving the best care for the patient.	Improved mobility and quality of life for Maori men.

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
Clinical pathways	Three clinical pathways have been identified: • heart failure (3.1.1 Cardiovascular disease) • COPD (3.1.4 Respiratory diseases) • Maori patient pathway, LTC disease non-specific.		Strengthened relationships between GPs, Whanau Ora providers and pharmacists. Strengthened processes and data sharing.	Patients able to work with their preferred provider and continue to access diagnostic services, treatment and care management services from the provider of their choice. Improved service integration in the community setting.
Strategic and service programme planning and monitoring	Develop the implementation plan for the LTC focus. Identify and agree on reporting processes and mechanisms to support the implementation plan.	Dec 2012 Mar 2013	Clearly articulated plan for ongoing development.	Hope for improving care

3.1.1 Cardiovascular disease (HT6)

National links	NRHP links	NHSP links
Health Target. Priority in Minister's Letter of Expectations of better management of long term conditions.	The Health Target is a strategic priority. Priority under 'Life and Years'.	Headline actions for: • screening for LTCs • health literacy for LTCs • action plans for people with LTCs at high risk of hospital admission • clinical pathways for priority conditions (including LTCs)

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
Reduced growth and burden of CVD	Percentage of eligible population[6] will have had their CVD risk assessed in the last 5 years.	60% by July 2012 75% by July 2013 90% by July 2014	Strengthened understanding of national guidelines for CVD risk assessment and management and their impact on the workforce. Better integrated, whole-of-system care across Northland. Increased opportunities to address inequities.	Improved access to clinical support for cardiovascular disease. Improved access to specialist services for CVD. Improved access to cardiac rehabilitation services (3.10 Cardiac services).
	Build capacity and capability to meet the national Health Targets	June 2013		
	Support implementation of the Northern Region Health Plan for CVD. Develop platforms to support implementation across Northland. Implement self-management tools and resources. Contribute to the review and evaluation of capacity and capability to meet patient outcomes. Hospital care: • outpatients triaged to chest pain clinics to be seen within 6 weeks for cardiology assessment and/or stress test. Community care: • 75% of eligible patients will have had a CVD risk assessment in the last 5 years (rising to 90% in 2014).	June 2013 July 2013 Sep 2013 Dec 2012 70% by June 2012 June 2013	Implementation framework for the national guidelines for CVD risk assessment and management provided. Improved prevention, assessment, early diagnosis, best treatment and management and rehabilitation across the continuum of care. Clinical information systems will support interconnectivity and standardised IT systems. Tools and resources provided to health professionals to better	Individuals and family/ whanau will have health information that is understandable and appropriate to making health decisions. Improved health literacy for patients and their family/ whanau to improve the usability of health information and health services. Tools and resources provided for individuals that will encourage and enable them to develop strategies for their long term self-management of CVD risk
	Assess Northland's capacity and capability to deliver and maintain the following KPIs: • outpatient coronary angiograms to be seen within 3 months	85% by June 2013		

[6] Maori, Pacific and South Asian males 35–74 years; Maori, Pacific and South Asian females and all other ethnic group males 45–74 years; all other ethnic group females 55–74 years.

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
	• patients referred for angiography presenting with acute coronary syndrome to be seen within 3 days of admissions • 80% of patients presenting with ST-elevation myocardial infarction referred for PCI will be treated within 120 minutes.	70% by June 2013 80% by June 2013	manage and integrate CVD risk management into health systems. Knowledge and skills of providers built up so they can provide understandable and appropriate information to patients. Increased opportunities to address inequities.	and early self management. Reduction in multiple hospital admissions.
	Support the diabetes clinical network to implement the CVD interface across community and hospital settings.	June 2013	Build and strengthen clinical networks and professional relationships across multi-disciplines. Increased opportunities to address inequities	Improved access for patients with diabetes to cardiovascular services.
Telehealth objectives	Strengthen existing cardiac outpatient clinics and investigate telehealth utilisation across the district for CVD patients.	June 2013	Increased capacity because specialists will be able to provide support and follow-up across Northland.	Improved access, with clinical supervision, to self-management tools and support 24/7.
Primary and secondary care objectives for ABC	Implement the NZ Clinical Guidelines for stroke management 2010: • implement the acute TIA pathway and protocols • 6% of all stroke patients are thrombolysed • 80% of all patients who have had a stroke are admitted to a stroke unit. *(See also 3.2.4 Community specialist HOP teams.)*	NDHB optimises required capacity of 6 beds by June 2013 to achieve regional target. GAIHN pathway adapted by December 2012.	Strengthened patient pathways for stroke management Northland - wide.	Improved health outcomes, patient safety and quality of care for patients and families across Northland.

Cardiac services

National links	NRHP links	NHSP links
National priority in AP guidelines.	The subject of several targets under CVD.	•

This table is based on a draft plan by the Northern Regional Cardiology Network, which has not yet agreed on cardiology priorities. It therefore does not yet include target dates and is subject to changes made by the network.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
Optimised, evidence-based care.	Build on progress made over the last year, by continuing to: • develop more regional KPIs from existing datasets such as national dataset, DHBs' Performance Improvement Measures or equivalent, ANZACS acute coronary syndrome registry • evolve and utilise these regional KPI reports. • work with existing information to develop a register of patients with known CVD or at high risk of developing CVD. These reports and registries will support local and regional quality improvement programmes to optimise management.		Achieve regionally consistent monitoring and auditing of investigations and management. This will support quality improvement processes to achieve consistent standards of care and equity across the region's primary, secondary and tertiary services.	Patient outcomes will be monitored to ensure consistent access to and standards of care.
	Build on the progress made over the last year, such as by: • progressively improving CVD assessment and management rates in primary and secondary care, including: ▪ CVD risk assessment and communication in primary care, which encompasses the new national CVD risk assessment Health Target (3.6 HT6 Cardiovascular (and diabetes) services) ▪ quality improvement programmes in primary care (in collaboration with the Diabetes Clinical Network). Plan improved access to cardiac rehabilitation services including regional implementation of an integrated advanced cardiac nurses model of care (see sixth bullet in next row) that would: • work across primary and secondary services to strengthen cardiac rehab in the community • support practice nurses with CVD risk management, quality improvement and heart failure management.	70% of all outpatients triaged to chest pain clinics to be seen within 6 weeks for cardiology assessment and stress test. Maintain 85% of outpatient coronary angiogram waiting time to <3 months (MoH target). Provide coronary angiography within 3 days of admission to 70% of all patients presenting with an acute coronary syndrome who are referred for angiography. Provide percutaneous coronary intervention within 120 minutes in at least 80% of patients presenting with ST	Better management of the increasing burden of cardiovascular disease across secondary and primary services.	Adequate, timely and equitable levels of access to key cardiac assessment and management across the patient journey through primary and secondary care: • improved CVD risk management in primary care • streamlined management of patients presenting with suspected coronary artery disease to both primary and secondary care • improved management of cardiac patients post discharge.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
		elevation MI referred for this reperfusion modality. Maintain the nationally agreed cardiac surgical targets.		
	Build on the progress made over the last year, including: • use recommendations from the ongoing CVD risk management working group to support process improvements in CVD risk assessment and management across primary and secondary care • establish DHB-based ACS quality improvement regional workstreams that will be supported by the acute Predict monitoring tool • implement the acute Predict monitoring tool • continue development implementation of regional ACS guidelines: ▪ propagate the newly developed regional ST-segment elevation myocardial infarction (STEMI) guidelines ▪ develop non-STEMI guidelines • continue to develop the regional primary PCI service in collaboration with St John and ED staff to support more rapid transit of ST-elevation myocardial infarction patients directly to a PCI centre • work with primary and secondary care to finalise the draft regional integrated advanced cardiac nurses model of care that would work across primary and secondary and will specifically support: ▪ strengthening cardiac rehab in the community ▪ practice nurses with CVD risk management and heart failure management ▪ quality improvement activity at practice level, in collaboration with the Diabetes Clinical Network • scope the staffing requirements to support this primary-secondary cardiac nurse model of care that would also link with diabetes workforce planning (see 3.6.2 Diabetes, Regional Subgroup, especially fifth and sixth actions) • develop a regional plan for electrophysiology services to better meet patient demand.		New models of care will better use resources and enable growing demand to be managed.	New models of care will support better patient outcomes by: • reducing waiting times for FSAs, follow-ups and procedures • providing better support for patients discharged • reducing patient admissions • improving patient outcomes.

3.1.2 Diabetes

National links	NRHP links	NHSP links
Quarterly reporting measure PP20. Priority in Minister's Letter of Expectations of better management of long term conditions. *MoH outcomes:* NZers living longer, healthier and more independent lives; good health and independence are protected and promoted; people receive better health and disability services.	Priority under 'Life and Years'. Regional structure developed as part of regional plan to support diabetes across the Northern region.	Headline actions for: • screening for LTCs • health literacy for LTCs • action plans for people with LTCs at high risk of hospital admission • clinical pathways for priority conditions (including LTCs)

Outcome	Actions to achieve target	Indicator & target(s)	Expected gains	
			For health services	For patients/ clients
Optimum quality of life for those with long term conditions	Support the diabetes clinical network to implement the CVD interface across community and hospital settings by June 2013. Continue to remodel LDT into the Northland Diabetes Operational Workgroup (NDOW) with increased focus on clinical leadership and operational changes. PHOs support development of new models of care for general practices, highlighting variations between GP practices with the goal of supporting best practice across primary care. *(Funded by both PHOs)* 100% of urgent referrals from hospital will be seen by the diabetes specialist service within 1 working day. 80% of women with gestational diabetes will undertake a post-partum check for diabetes at 3 months by the specialist diabetes service. Whanau Ora CVD / Diabetes Demonstration Sites will implement early intervention and self management programmes to assess and manage the conditions. Implement primary care PREDICT system in the Diabetes Centre to assist with CVD and diabetes screening targets.	People receiving Diabetes Annual Reviews: Total 80% Maori 80% *MoH target (also in NRHP):* Diabetes patients to have HbA1C levels equal to or less than 64 mmol/mol: Total 80% Maori 80% *NRHP target:* Diabetes patients with microalbuminuria on ACE or ARB[7] medication: Total 80% Maori 80%	Increased opportunities to address inequities. Build and strengthen clinical networks and professional relationships across multi-disciplines. Improved linkage between primary and secondary care. Fewer hospital visits for people with diabetes as result of improved care. Increased confidence and competence in diabetes management. Patient health status is better managed and supported.	More equitable and accessible diabetes services. Improved management of diabetes. Early detection and management of the complications of diabetes. Improved health literacy. Improved self management. Improved access for patients with diabetes to cardiovascular services
	Diabetes Care Improvement Package (DCIP) proposal was completed in April 2012 and is included in full as Appendix 4.			

[7] Angiotensin-Converting-Enzyme (ACE) inhibitors and Angiotensin Receptor Blockers (ARB) are drugs used for the treatment of high blood pressure and congestive heart failure.

Outcome	Actions to achieve target	Indicator & target(s)	Expected gains	
			For health services	For patients/ clients
	Development of PHO detailed implementation plans of DCIP. Sign-off proposal and contract with lead PHO for implementation of DCIP. Implement DCIP.	June 2012 July 2012		
Diabetes Regional Health Plan Subgroup				
Optimum quality of life for those with long term conditions	Continue to work with Regional Diabetes Clinical Network. Clinical lead of network invited to become member of NDOW/ LDT for Northland.	July 2012	Strengthened alignment between Northern Regional clinical network and Northland diabetes operational group work.	Improved management of diabetes.
	Develop register of patients with or at risk of diabetes (and CVD). *(From NRHP)*	Register developed of patients with or at risk of diabetes.	Better able to plan for diabetes on a population health basis.	Timely and regular recalls for management overview.
	Work with Northern Region clinical network to identify KPIs. *(From NRHP)*	Further KPIs developed.	Better able to plan for diabetes on a population health basis.	Improved management of diabetes.
	Develop a regionally agreed patient education approach. *(From NHRP)* Roll out train-the-trainers diabetes conversation maps across all localities of Te Tai Tokerau PHO. *(Funded by TTT PHO)*	Agree on best practice model. Maps rolled out.	Consistent up-to-date information provided to patients with diabetes.	Increased understanding of impact of diabetes. Improved concordance with management plans.
	Develop and implement a workforce plan that addresses primary and secondary needs. *(From NHRP)* Survey training needs of all nurses working in primary and community services across Northland, using the National Diabetes Nursing Knowledge and Skills Framework.	Plan developed.	Support, education and training for health professionals better targeted to identified workforce needs. Development of workforce.	Patients have access to staff who have been trained to a consistent level with regard to diabetes management.
	Implement clinical champions and diabetes mentors in primary care. *(Funded by both PHOs)*	Champions and mentors established.		
	Scope feasibility of expanding prevention and risk actions, as determined by Northern Region Diabetes Clinical Network.	Scoping completed.	Reduced demands on health services.	Fewer people developing diabetes.
	Build business case to further develop electronic patient management tools (Electronic Care Planning for Chronic Disease). *(Funded by TTT PHO)*	Process and protocols developed.	Supports team-based approach to patient management.	Patient involvement in development of management plans means they are better understood.

Outcome	Actions to achieve target	Indicator & target(s)	Expected gains	
			For health services	For patients/ clients
	Develop retinal screening proposal for a sustainable increase in volumes. *(From NRHP)*	Business case developed.		

3.1.3 Cancer (HT3)

National links	NRHP links	NHSP links
Health Target for cancer (and smoking). Priority in Minister's Letter of Expectations of better management of long term conditions. Priority in Minister's Letter of Expectations of shorter waiting times. *MoH outcomes:* NZers living longer, healthier and more independent lives; the health and disability system and services are trusted and can be used with confidence.	The Health Target is a strategic priority. Priority under 'Life and Years'. Improving Waiting times for Diagnostic Services Colonoscopy. Lung and Bowel Tumour Streams. Cancer Services. National Lung Cancer Service Provision Standards. Priorities of informed patient and first do no harm. Respiratory disease priority.	Headline actions for: • screening for LTCs • health literacy for LTCs • action plans for people with LTCs at high risk of hospital admission • clinical pathways for priority conditions (including LTCs)

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
National Health Targets				
Improved access to diagnostic and cancer service treatments	100% of patients requiring radiation therapy will this within 4 weeks.	July 2012	Improved cancer systems and services. Regional collaboration.	Faster cancer treatment and greater access to cancer services.
	100% of patients requiring chemotherapy will receive this within 4 weeks.	July 2012		
Regional priorities				
Lung Tumour Stream	60% of patients referred urgently with high suspicion of lung cancer to first cancer treatment within 62 days	Sep 2012	Faster cancer treatment. Whole of system care delivered. Improved cancer pathways.	Improved access for patients to cancer services. Faster cancer treatment. Less non-productive time during the cancer journey.
	50% of patients referred urgently with high suspicion of lung cancer to first specialist appointment (FSA) within 14 days	Sep 2012		
	50% of patients with lung cancer as confirmed diagnosis who receives first cancer treatment within 31 days of decision to treat (all treatment types).	Sep 2012		
Colonoscopy	Improving wait times for diagnostic services for colonoscopy	July 2012		
	Patients accepted for diagnostic colonoscopy received their procedure: 60% within 2 weeks for priority 1 50% within 6 weeks for priority 2 Within 6 weeks for priority 3	 Sep 2012 Sep 2012 Sep 2012		

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
	Within 6 weeks for priority 4	Sep 2012		
	50% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	June 2013		
Delivering Faster Cancer Treatment	Measurement capacity developed	Sep 2012		
	Agree on the definitions to establish baseline data for the new "Faster Cancer Treatment" (PP17) indicator.	Sep 2012		
	Implement the agreed definitions and mechanisms to enable collection of the required information from quarter two of 2012/13 onwards.	June 2012		
	Improvements in cancer pathways for all cancers identified	Sep 2012		
	Service improvements identified for further development of the tumour stream pathways	Sep 2012		
	Support and participate in the development of the national tumour stream standards	Sep 2012		
	Capacity to develop cancer regional clinical data repository assessed	Mar 2013		
Delivery whole-of-system care	Commission the Bone Marrow Transplant Unit.	June 2013		
Northland DHB priorities				
Improved access to diagnostic and cancer service treatments	Lung & Bowel Cancer Patient Pathway project, Phase 2: review and evaluate patient pathway through Auckland diagnostic and support services:		Barriers to access services and establish protocols for KPI monitoring identified. Improved and timely utilisation of equipment and resources. Improved integration of support services with clinical pathways. All health professionals (community and hospital settings) will have access to the patient pathways.	Greater consistency in access to services. Greater involvement and support of the patient in decision making processes. Access to a map to better understand the cancer journey.
	Collect and review evidence and protocols of all Auckland based referral and discharge pathways.	Sep 2012		
	Agree, implement and monitor protocols with services departments.	Mar 2013		
	Review support service protocols and develop KPIs for Northland patients (including Hepatitis B, screening and immunisations, etc).	Mar 2013		
	Publish Lung and Bowel Patient Pathway map.	June 2013		
	Develop and promote the patient (diagnostic and referral) pathways and early symptom recognition protocols.	Dec 2012		

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
	Continue to support the implementation of the Lung and Bowel Tumour stream priorities: Review existing referral pathways and identify barriers. Agree Northland KPI protocols with each clinical and support service (Northland). Establish the reporting mechanism for monitoring and audit against KPIs. All lung and bowel tumour health professionals and support services attend Advance Care Planning training and introduce ACP planning for patients. Align NDHB multidisciplinary meetings (MDM) practices to the best practice guideline and framework to strengthen and support NDHB participation in regional MDMs.	 Sep 2012 Mar 2013 Mar 2013 Jun 2013 Throughout 2012/13	Information and reporting protocols for review of clinical performance and improvement developed. Strengthened health professionals' range of skills and techniques in managing challenging conversations.	Improved timeliness and coordination across the diagnostic and treatment pathways. Improved communication by health professionals with patients.
	Continue to support the implementation of regional cancer service projects: Participate in the development and Implementation of the electronic MDM referral form across the lung cancer service. Participate in the development of the new Medical Oncology model of care for Northland. Support the Shared Care Lung Cancer pilot. Participate in the development of the regional clinical data repositories.	 June 2013 Sep 2012 Sep 2012 Sep 2012	Northland health professionals supported with clinical expertise to meet national and regional health targets, and address whole-of-system care and integration.	Access to services improved. Quality of services improved.
	Cancer Care Coordination Model		Strengthened skill base from ACP training. Greater access to the consumer voice for service development and improvement.	Moving towards meeting patient expectations expressed in the Care Coordination Model. Improving access to and timeliness of information. Increased communication with cancer patients and their families/ whanau and/or carers.
	Conduct an annual Cancer Care Coordination codesign workshop to review and monitor better information around referrals and discharge.	June 2013		
	Develop the Cancer Consumer Community Network & Forum for Northland.	June 2012		
	Review the functionality and sustainability of Northland's regional and district clinical representation arrangements for	Dec 2012	Strengthened Northland clinical leadership across the	

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
	cancer and palliative care networks.		cancer streams. Improved leverage and support for regional and district projects for improvements in patient and clinical data management systems.	
Reducing the growth and burden of this chronic disease	Support the implementation of national Health Targets and NRHP targets for smoking (3.7 Better help for smokers to quit).			
Telehealth objectives	Develop process to provide follow-up oncology outpatient clinics at Kaitaia (see 3.14 Telehealth).		Increasing capacity so specialists are able to provide support and follow-up across the district.	Improved access to self management tools and support 24/7 with clinical supervision.
Improved access to palliative care services in Northland	Review and evaluate the effectiveness of the implementation of the Palliative Care Generalist Guidelines to identify further development required.	June 2013	Strengthened whole-of-system care. Status of the delivery of the guidelines assessed to identify further development.	Improved access to quality general palliative care services from primary care practices (including Whanau Ora) improving the level of support by palliative care specialists in patients care.
Informed patients and improved level of participation of patients and their whanau in decisions about their care	Continue to support the implementation of the Regional Advance Care Planning Project and implementation plan. Support the development of resources and tools specific for Maori and Pacific consumers. Develop the Northland project platform to strengthen and deliver ACP services across Northland. Support the Health Workforce Campaign. (See also 3.11 Advance care planning.)	June 2013	Health professionals across the continuum are able to assist patients participate in planning their future care, including end of life care. Improved techniques for tackling these challenging issues. Improved access to tools and techniques.	Patients able to articulate their beliefs, values and needs for their future care prior to them becoming unwell. Provide patients, families and whanau with opportunities to participate in the development of further tools and resources.

3.1.4 Respiratory diseases

National links	NRHP links	NHSP links
Health Target to provide advice and help to quit smoking.	A new priority under the Life and Years Priority Goal in 2012/13.	Headline actions for: • screening for LTCs • health literacy for LTCs • action plans for people with LTCs at high risk of hospital admission • clinical pathways for priority conditions (including LTCs)

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
Reducing the growth and burden of this chronic disease	Support the achievement of the national smoking Health Targets and NRHP targets (see 3.7 Better help for smokers to quit).		Strengthened integration of services and alignment of clinical and patient information between community and hospital services.	Improved access to respiratory related services. Improved access to support to quit smoking. Improved access to lung cancer services for patients with high suspicion of lung cancer.
	Appoint a clinical champion for respiratory-related conditions.	July 2012	Strengthened clinical leadership for the Northland Respiratory Network.	
	All Northland DHB respiratory-related service contracts will be reviewed to incorporate the requirement to contribute towards the national Health Targets for smoking. Align these contracts to the asthma and COPD national guidelines and include a mandatory requirement to provide ABC.	June 2013	Improved compliance at a service provision level to support continuous improvement in quality clinical services.	Increased access to support and help to quit smoking.
	Form the regional Respiratory Workstream. Develop the work programme and reporting protocols.	July 2012 Aug 2012	More integrated services and alignment of clinical systems and patient information between community and hospital services. Increased clinical support and linkages for health professionals in the community setting.	Improvement in clinical safety and quality of service.
	Implement Pulmonary Rehabilitation Programmes (with multidisciplinary focus) consistently in community settings across	June 2013	Strengthened community-based services available to	Improved access to health services and expertise.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
	Northland. Encourage multidisciplinary approach to pulmonary rehabilitation inpatient care in Whangarei. Extend multidisciplinary (outpatient based) physiotherapy pulmonary rehabilitation programmes from all district hospitals to various community settings.		patients. Community based health professionals are better supported with inpatient care to mobilise patients. Multidisciplinary evidence-based best practice approach to physical activity for respiratory-related conditions with a view in the future to extending this to all people living with LTCs. Community-based services address cost and travel barriers and encourage family participation.	Barriers of cost and travel addressed. Whanau engagement will build knowledge of health conditions and the impact of lifestyle choices. Individuals have peer support and are encouraged to bring their family/ whanau as support. Increased opportunities for building health knowledge and understanding of condition (health literacy). Ability for families to discuss lifestyle choices in a safe and secure environment. Families participate and consider changes to their lifestyle choices.
	Strengthen discharge practice with early support to prevent unnecessary readmissions. All COPD patient admissions to be given priority for pulmonary rehabilitation with Medical Outreach support and referred for a healthy home assessment. Target inequities by providing multidisciplinary team approach with cultural support in the community setting. *(See 3.8 Child and youth health for actions concerning children and youth with respiratory conditions or respiratory infections.)*	Dec 2012	Improved referral and access to community-based support services such as pulmonary rehabilitation and medical outreach at point of discharge.	Access to timely community support and follow-up post discharge.
	Increase the coverage of medical outreach services to 6 days a week, with a view to assessing the need for 7 days a week.	June 2013	Increased utilisation of the service. Reducing unplanned and avoidable readmissions.	Improved access to medical and nursing support, reducing hospital admissions. Improved health knowledge and understanding of condition and improved self

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
				management.
	Develop self-management support toolkit for respiratory-related conditions and service providers for Northland-wide use.	June 2013	Resources and tools available to support patients and develop self management. Support for health professionals to link with other support services.	Improved health information and building of knowledge to enable patients and their family/ whanau to develop health literacy, confidence to develop self-management strategies and increase their participation in health decisions.

3.2 Health of older people

National links	NRHP links	NHSP links
Priority in Minister's Letter of Expectations (integrated services; safe, independent living at home; dedicated stroke units; dementia). Quarterly reporting measure PP18.	Priority under 'Life and Years'. Delivering whole-of-system care including commencing reporting on interRAI clinical assessments (HBSS) and supporting HBSS agencies to achieve certification. Dementia workstream project. Workforce workstream	Headline actions for: • strengthen provision of home-based restorative services

Integrated structures and processes

The Health of Older People Strategy Group meets monthly. Its Chairperson is the GM Health of Older People and Support Services.

The membership is whole-of-sector and includes Specialist Health of Older People Services, Clinical Leadership, Psychiatric Services For Older People, Allied Health/ Support Services, Primary Care, Age Related Residential Care, Sector Advisor, Maori Health/ HBSS.

For Northland DHB, HOP services are defined as being for people who are under the care of a Geriatrician and assessed as being eligible for HOP Services by NASC.

The purposes of the Older People Strategy Group are to:

- determine the Northland DHB's health of older people work programme, taking into account local requirements and the Northern Regional Health Plan
- develop and lead NDHB's strategic planning for health of older people, adopting a whole-of-sector approach
- provide a work programme management function
- advise on funding decisions
- undertake the required service development activity, developing service integration and timely access to services across Northland
- maintain and report back on the work programme as required to NDHB committees, Executive Leadership Team, Senior Management Group and NDHB Health Planner.

3.2.1 Quality home and community support services for older people

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
Independence for those with impairments or disability support needs. Better, sooner, more convenient services.	Older people receiving long term HBSS will have a Comprehensive Clinical Assessment (using either the interRAI Contact Assessment or Home Care Assessment). Work with Northern Region DHBs to establish benchmarking of core quality measures, using the interRAI database. NDHB HOP Steering Group, consisting of representatives from NDHB and PHOs, will monitor and benchmark progress of quality measures and targets in the Annual Plan, NRHP and the Northland Health Services Plan.	50% of people receiving long term HBSS (1,300 of 2,600) have a Comprehensive Clinical Assessment by June 2013. 2,500 assessments per year. Quality measures to be	A more unified system because health professionals will be able to understand a common assessment language. Better services will be provided because benchmarking of support service quality will be	Independence will be promoted by quality home-based support services, reducing the need for hospitalisation and residential care. Older people will have more confidence in a system when it uses a consistent, internationally recognised

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
	Establish an approach for delivering and funding HBSS in the context of the pending National Service Specification and regional planning.	advised.	possible.	assessment and quality assurance tool.
	Monitor the impact of HOP initiatives to reduce unnecessary and avoidable hospital admissions for older people such as: • improved clinical assessment (see 3.9.1, 3.9.2) • reduction of injuries from falls and pressure injuries • increased specialist HOP (Gerontology Nurse Specialist and Geriatrician) involvement with ARRC (see 3.9.4) by Oct 2012 • ACP project (see 3.9.5): implement ACP and LCP in 2 ARRC facilities by December 2012 • identify baseline admission data for 75+ population and ongoing auditing methodology, by September 2012 *(see table at the end of* Clinical integration*)*.	2% reduction in unnecessary and avoidable hospital admissions from ARRC. Contribute to a 2% reduction in readmission rates for 75+ population *(see table at the end of* Clinical integration*)*.	Reduced load on hospital services.	Improved quality of life.
	Develop an Enablement Service for HOP, using NDHB's $120k share of the $3m allocated to HOP services nationally from pharmacy savings. The Enablement Service will receive referrals for home based support services and patients discharged from hospital, and undertake comprehensive assessments of them to identify health issues. Appropriate supports can then be put in place in the community to address these health issues (as distinct from HBSS which supports disability needs) thus enabling people to be maintained longer in the community.	Proposal for establishment of service to be developed by 31 July 2012.		

3.2.2 Comprehensive clinical assessment in residential care

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
Independence for those with impairments or disability support needs. Better, sooner, more convenient services. Older people	Support aged residential care facilities to implement Comprehensive Clinical Assessment in their facilities through contributing to the funding of the National interRAI project, and adopting the pathways established through regional and local planning. Increase engagement with ARRC facilities by specialist staff, as per 3.9.4.	20% of long term residents in five participating aged residential care facilities will have an interRAI clinical assessment by June 2013.	A more unified system because health professionals will be able to understand a common assessment language.	Older people will have more confidence in a system when it uses a consistent, internationally recognised assessment and quality assurance tool.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
requiring support or care receive services appropriate to their needs.				

3.2.3 Dementia pathway

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
Independence for those with impairments or disability support needs. Better, sooner, more convenient services. Impact: Older people requiring support or care receive services appropriate to their needs.	Invest Northland's share of the national $2.5m for the dementia pathway. Participate in dementia pathway activity carried out at the regional level. Establish a dementia pathway working group inclusive of primary care, community services, Alzheimers Association, by August 2012. Have an agreed Northland DHB pathway by February 2013. Continue to monitor the level of dementia community support, day care and respite services purchased and service utilisation to assess that there is an appropriate level of support for carers of people with dementia.	NDHB implementation plan for people living with dementia (arising from NRHP). Service utilisation and waiting lists for community support, dementia day services and respite care services.	A more unified and accessible system because health professionals, patients and their families will be more aware of available services that can help in their particular circumstances.	Independence will be promoted by people receiving appropriate services sooner, enabling them to stay at home longer.

3.2.4 Community specialist HOP teams

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
Independence for those with impairments or disability support needs. Better, sooner, more convenient services. Impact: Older people	Proactive use of DHB specialist Health of Older People Services (Geriatrician, Gerontology Nurse Specialists) to advise and train health professionals in primary care and aged residential care. Increase Gerontology Nurse Specialist input to 100% of ARRC facilities (currently at 10/24). Complete a survey of primary health care services to establish the support they require, by July 2012.	Increased number of hours of specialist HOP service consultations with heath professionals in primary care and aged residential care. Increased Specialist HOP FTES.	More skilled HOP workforce in primary care and ARRC.	People will receive better health and disability services through more skilled care by the existing workforce, resulting in an improved experience for patient and family.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
requiring support or care receive services appropriate to their needs.	Establish a new Gerontology Nurse Specialist position with responsibility for support and education in primary care, by Sep 2012. Increase Geriatrician service .	Contribution to meeting the 2% reduction in unnecessary and avoidable hospital admissions from ARRC mentioned under 3.2.1.		
Stroke	80% of acute stroke patients will be admitted to a stroke unit *(NRHP target)*. 6% of acute stroke patients will receive thrombolysis. Implement the acute TIA pathway. *(See also 3.1.1 Cardiovascular disease)*	NDHB optimises required capacity of 6 beds by June 2013 to achieve regional target. GAIHN pathway adapted by December 2012.	Strengthened patient pathways for stroke management Northland - wide. Application of best practice clinical guidelines for stroke management.	Improved health outcomes, patient safety and quality of life for patients and families across Northland.

3.3 Acute and unplanned care

3.3.1 Shorter stays in emergency departments (HT1)

National links	NRHP links	NHSP links
Health Target. Priority in Minister's Letter of Expectations of shorter waiting times. *MoH outcomes:* NZers living longer, healthier and more independent lives; people receive better health and disability services.	The Health Target is a strategic priority.	Performance measures for: • achieve national, regional and district waiting time targets • decrease in ED presentations that could have been managed in primary care • decrease in youth ED presentations • decrease in average ED length of stay • decrease in % of patients who return to ED within 48 hours

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
Reversal of acute conditions Better, sooner, more convenient services Confidence and trust in the health system	Develop a 6-bedded clinical area adjacent to ED. Continue to hold hospital coordination unit, patient flow meetings in both morning and afternoon (6% of waiting-time breaches in 2011 were due to blocks within hospital services). Hold ongoing daily breach meetings, with weekly analysis and follow-up by service managers. Radiology fast track for inpatients who can be discharged. Work closely with primary services on increasing the availability of urgent appointments in their practices. Conduct survey of ED patients over a three-week period to understand why patients choose to come to ED. Carry out project to implement integrated PHO and DHB patient records. Share data with general practices regarding ED presentation numbers, time of presentations, triage category etc. Implement Hospital 2 Home for cardiology and respiratory patients to address their high readmission rates; this is a new model for the management of this patient group, to be trialed over a six month period. Continue with rapid ward rounds and new electronic patient whiteboard now installed in both medical wards, which displays estimated date of departure. Revised and improved process for booking patient beds from ED	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within 6 hours. Over the next five years, reduce annual growth in ED attendances from the current 4.19% to 3% (about 400 presentations per year).	Improved patient safety. Improved patient outcomes. Decreased ED overcrowding. Decreased readmission rates. Improved working relationships with PHO and primary care. Greater ability of primary services to accommodate urgent appointments. Development of a different models of care for some youth. Improved hospital flow and reduced hospital bed block. Improved access to patient information. Patients to have easier access to same-day appointments.	Improved patient safety. Improved patient satisfaction. Improved patient outcomes. Decreased patient complaints.

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
	includes the use of an iPad and a process called 'book a bed ahead'. Develop and implement ED coordinator roles, who have key accountabilities for the patients ED length of stay. Implement strategies to reduce the high number of youth presentations to ED. Reduce unnecessary and avoidable hospital admissions of older people (3.2.1 Quality home and community support services for older people).			

3.3.2 Reducing growth in service demand

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
Reduced growth in bed days Reduced readmission rates for 75+	Gather baseline data on the numbers and patterns of hospital readmissions for ages 65+ and 75+.	Data to be gathered by 30 Sep 2012. Plan to be developed by 30 Nov 2012.	Reduced costs. Fewer adverse events. Reduced costs.	Improved quality of care.
	Manage growth in demand in NDHB hospitals, particularly in general medical, surgical (general and orthopaedic), mental health and pediatric services. Strengthen discharge planning and follow-up with an emphasis upon on older people and targeting Maori with long term conditions Establish global trigger tool baselines and develop an action plan for reducing rates of adverse events.	Unplanned admissions to reduce by 2,000 per year by 2017 Over the next five years, reduce annual growth in bed days from the current 5.32% to 2.82%.		
	Implement a post-discharge clinic for heart failure patients.	Reduce readmissions for this group by 25%.	Reduced costs.	Ability to remain at home.
	Enhance home and community support services for older people (detailed actions, targets and gains appear in 3.2.1 Quality home and community support services for older people).			

3.4 Primary care

National links	NRHP links	NHSP links
Priorities in Minister's Letter of Expectations of better, sooner, more convenient care, and integrating primary care with other parts of the health system.	A theme throughout the plan and the basis upon which the Northern Region will achieve better, sooner, more convenient services. Community pharmacy is a service priority.	Headline actions for: • locality plans for the four Northland localities in the NHSP • enhance screening for risk factors re LTCs • expand Primary Options Programme Northland • new models of integrated primary care *(with ten sub-actions)* • develop IFHCs by 2014

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
High quality, sustainable general practice service integrated with hospital services throughout Northland	ELT approval for Locality Plan teams to be formed and put in place. Support for development of locality plans obtained from PHOs and NGOs. Number and boundaries of localities are defined. Locality planning groups formed and project plan with milestones developed for each locality. Northland locality health needs analysis completed. Locality plans developed by Dec 2012.	Development of Locality Plans by Dec 2012.	Improved integration of services between primary / community and hospital services, particularly district hospitals. Engagement of stakeholders at a local level, mobilising community action and working with local Whanau Ora providers and NGOs. Consideration of health needs, equity of resource allocation and outcomes on a sub-district basis.	Localised, easier access to health services. Health services more responsive to local (subdistrict) need.
	Northland-wide primary care workforce census to be completed by primary care.	Complete census.	Information to develop a sustainable plan for primary care.	
	IFHC / network development IFHC development coordinator appointed and regular progress reviews between PHO and DHB established. *Main actions:* Develop individual plans for each demonstration site (see below for more detail). Review and scope other possible sites for IFHC development, focusing on the aim to reduce inequities between Maori and non-Maori, by June 2013. Develop plan for structures at PHO level to support IFHC	Development of integrated models of health care.	Improved efficiency and effectiveness in health service delivery, such as less duplication of lab tests.	Timely access to first-contact primary health services. Access to a coordinated range of health services relevant to need.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
	development (eg call centre), by Dec 2012 . Specific demonstration sites actions identified: 1 Develop Integrated Family Health Centre (IFHC) in the high needs community of Raumanga. a) Preferred site identified and engagement between PHO/DHB with Ministry of Education begun regarding possible transfer of land; decision expected by August 2012. b) Once site confirmed, modified pans for IFHC to be completed within 6 months. c) Scoping for PHO and DHB to identify funding possibilities, to be completed within 6 months of confirmation of site. 2 Develop a Whanau Ora Centre in Otangarei with Te Hau Awhiowhio o Otangarei Whanau Ora Collective. a) Community engagement complete and preferred site identified, by May 2012. d) Engagement between PHO and DHB with Ministry of Housing begun regarding possible transfer of land. b) Once site confirmed, modified pans for IFHC to be completed within 6 months. c) Scoping for PHO and DHB to identify funding possibilities, to be completed within 6 months of confirmation of site. 3 Integration within Dargaville IFHC to better integrate Maori health, primary health, DHB and NGO services on the one site: (a) Workshop between KCI, Te Ha Oranga and PHO/DHB stakeholders completed May 2012, and mandate confirmed for development of a IFHC at Dargaville which will build on the co-located services already present on site. (b) Plan to develop new service model for LTCs, in particular CVD and diabetes, by June 2013. (c) Options for telemedicine scoped by June 2013. (d) Integration of community pharmacy services by June 2013. (e) Implementation of Early Years hub including development			

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
	of web-based tool to reduce the risk of family of a child aged 0-6 missing out on services they need – implementation, by Dec 2012. 4 New model development in two large general practices (Bush Road and Primecare). a) Implement new model of funding to maximize opportunity to reduce population inequities including VLCA, by June 2013. b) Facilitate adoption of new business structure to provide a platform for new service model development, by June 2013. 5 Mid north (Kawakawa) IFHC model partnership with Ngati Hine Health Trust, Kawakawa GP practice and Moerewa Medical Services. a) Stakeholder group to be formed to scope project, by July 2012 6 Whanau ora hub development in the Far North to include health promotion, mobile nursing, GP services, home support, dental services. a) Project management resource identified, by June 2012 b) Project plan to be completed by Sept 2012. Train 5 General Practice Assistants *(Manaia PHO)*.			
	Develop proposal for a new quality and funding framework to align with identified priorities for primary care using Quality, SIA and Care Plus funding.	New funding framework devised June 2013	Targeted improvements taking account of capacity, capability and history. Implementation of continuous quality improvement framework . Support for development of multidisciplinary teamwork.	Improved access to primary care services. Systematic care provided and differentiated according to level of need.
	Manaia PHO Establish a train-the-trainers model to build capability and capacity of the primary care nurse workforce by establishing a Clinical Nurse Leaders Forum by end of 2012 *(Funded by Manaia PHO)*	Establish model.	Support for development of multidisciplinary teamwork. Improved efficiency and effectiveness in health service delivery.	Improved access to primary care services.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
	Develop standing orders framework and provide training for nurses across Northland. *(Funded by PHOs)* Develop a standardised orientation programme for practice nurses. *(Funded by PHOs)*	Establish by end of 2012. Establish by 2013.		
	Embed NZ Guidelines Group's diabetes pathway in general practice.	Development and implementation of clinical pathways across hospital and primary / community in diabetes.	Consistent health care delivered following national guidelines.	Improved diabetes care.
Prevention of illness and disease	Implement NDHB's Immunisation Action Plan (→ 3.4 HT4 Increased immunisation).			
Moving services to primary care	Explore the opportunity of an intersectoral youth space including drop-in health, social, employment and careers, education services.	District wide integrated services for adolescents across primary and secondary care.	Improved accuracy of assessment data (HEADSS framework) and utilisation of services. Reduced inappropriate utilisation of NDHB ED by young people and improved access to health services.	Improved access to relevant and appropriate adolescent friendly services.
	Continue skin cancer clinics in four GP practices. Estimated volume 160 patients, $50K identified.	Waiting times for intervention.	Hospital resources for other surgical procedures freed up.	Faster and more convenient access.
Reduction in preventable readmissions	Reduce unnecessary and avoidable hospital admissions of older people (3.3.2 Reducing growth in service demand, 3.9.1 Quality home and community support services for older people).			
	Expansion of sustainable Primary Options Programme Northland[8] (POPN) service is in development. Development group with clinical leaders from both primary and secondary are represented. Future actions include: A draft service model developed, by June 2012. Scoping audit at hospital and ED and GP practices to confirm possible volumes, by July 2012. Wider stakeholder communication about the new POPN	Scheme commences July 2012.	Number of hospital admissions reduced.	Patients avoid unnecessary hospital admissions and receive care closer to home.

[8] A scheme to enable primary care providers to provide treatment for people with selected acute conditions who would normally have been treated by secondary services.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
	service commences, by August 2012 Planning assumptions for new model: i) Target volumes minimum of 1,500 cases ii) Increase of funding to a maximum of $500K iii) All GP practices in Northland to utilise programme.			
Achieve the Health Target of waiting time in ED	Primary care and NDHB's ED services to work closely together to reduce demand on ED services (more detail is in (3.3.1 Shorter stays in EDs).	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within 6 hours.	Reduced number of ED attendances that could be dealt with by primary care.	Decreased barriers to access to primary care services. Shorter waiting times.
In partnership with its community pharmacies and other health providers, Northland DHB seeks to purchase community pharmacy services that contribute to improved, equitable health outcomes for its population. Community pharmacy services should be available that help patients and carers to manage their medications, and improve quality of life, including: • supporting patient adherence and informed choice • reducing waste • promotion of and participation in multi-disciplinary teams	*Warfarin* Community pharmacies within Northland already offer a district wide counseling service for patients on Warfarin and Dabigatran. Subject to the successful piloting of the Warfarin anti-coagulation point of care testing (POCT) programme, the final model will be rolled out in Northland. Initially it is expected that the service will be offered through those providers who indicate a willingness to take on the role. Given the recommendation that each participating pharmacy have 2-3 accredited pharmacists, in phase 1 this is likely to be limited to the larger providers, those in the larger population centres (Whangarei, Kaitaia, Kerikeri). Although rural need has been identified as a priority, rural pharmacies in Northland in the main have 1 or 2 pharmacists only. It is proposed that rural pharmacies be considered as phase 2 of any rollout of this programme.	Ongoing provision of funded counselling services. Phase 1 providers identified for rollout of POCT by March 2013. First POCT site operational no later than June 2013.	Ability to support the increasing number of patients being managed on warfarin. Improved management of patients on warfarin, with improved potential for early intervention within a primary care setting. Reduction in adverse events, and an associated reduction in hospital admissions.	Service provided closer to home. Shorter waiting times and faster turnaround. Stronger linkages with community pharmacy.
	E-prescribing Northland DHB has allocated a budget to meet the expected implementation of e-Prescribing during the second half of 2012/13. Rollout will align with the national implementation plan (yet to be advised).	E-prescribing implemented as per national implementation plan.	Improvements in the quality and safety of prescriptions. More efficient use of clinicians' and pharmacists' time. Improved patient experience of health services and increased opportunity to be more involved in managing their health conditions. Opportunities to improve patient adherence to medication regimes with	Reduced delays for dispensing prescriptions by reducing need for pharmacists to question illegible, ambiguous or erroneous prescription items. Improving patient safety by: • increasing the accuracy of prescriptions • avoiding transcription errors • providing fully legible prescriptions • catching potential drug

Outcome	Actions	Measures	Expected gains	
			For health services	**For patients/ clients**
			consequent improvement in patient outcomes and reduced costs of care. Opportunities to better manage pharmaceutical spend.	interactions or allergic reactions in advance. Frees up pharmacist time allowing patients to discuss medication problems, issues. Advice from pharmacists resulting in better patient outcomes.
	Regional Collaboration Northland DHB is committed to working in partnership with our regional colleagues. Activities include: • monthly regional information sharing meetings • DHB and community pharmacy representation in the regional pharmacy leaders meetings • sharing of ideas and alignment of service innovations where possible • a regional strategic direction for community pharmacy has been incorporated into the Northern Region Health Plan.	Ongoing meetings and information sharing.	Regional DHBs benefit from shared ideas and experiences. 'No surprises' environment. Consistent management of issues.	Consistent, quality services across the region.
	Safe Rx Northland DHB participates in the regional Safe Rx programme. This project aims to reduce harm from high risk medicines by informing primary care teams about them via the distribution of regular bulletins. The programme is currently in place with community pharmacy, and discussions are underway for implementation in primary care.	Safe Rx in place in primary care by the end of July 2012.	Better informed GPs and pharmacists. Reduced hospital admissions.	Reduced medicines-related incidents.
Zero fees for under 6s	Northland DHB has engaged with primary care to move towards an environment of zero fees for under 6s: All GP practices in Northland already have either VLCA status or free standard consultations for under 6s during normal business hours After-hours services are already free for enrolled patients in Hokianga, Whangaroa and the Bay of Islands areas Te Tai Tokerau and Manaia Health PHOs have indicated their support to move to a free after-hours environment for under 6s	Increase availability of free after-hours services for under 6s to be as near 100% as possible by 1 July 2012.	Improved utilisation of primary care services by young children, thus strengthening the ongoing relationship between patient and provider. Decreased utilisation of already stretched Emergency Department resources.	Improved access to primary health care services for all children aged under 6. Improved health outcomes for young children.

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
	The DHB has committed to fund GP practices at the current level of after hours copayment to support the move to free after-hours The Bay of Islands shared after-hours service has already committed to make casual visits free for under 6s from 1 July 2012 It is expected that all other GP practices that provide after-hours services will have a free after-hours service in place from 1 July 2012 After-hours services in Whangarei are provided by White Cross. There is ongoing discussion with White Cross, and a reimbursement scheme for eligible children is under discussion.			

3.5 Immunisation (HT4)

National links	NRHP links	NHSP links
Health Target. *MoH outcomes:* NZers living longer, healthier and more independent lives; good health and independence are protected and promoted.	The Health Target is a strategic priority. Northern Region DHBs continue to meet regularly, together with representatives from MoH, to ensure systems are developed that align with national goals and ensure cross-boundary provision of services. All regional DHBs participate in regular national teleconferences. Northland DHB is represented at national immunisation conference.	Performance measure for: • increase in on-time immunisation coverage

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
Prevention of illness and disease and better health and independence for children through reduced rates of vaccine preventable disease.	Implement NDHB Immunisation Action Plan in the following key areas. LMCs, GPs and Well Child/ Tamariki Ora providers will commit support for a Northland Immunisation Charter for Children. Trial a free 3rd-trimester GP appointment (B4 Birth Check) for mothers/ parents who have not enrolled with a GP. Continue to confirm GP details of all pregnant women when they book into a maternity facility. A whole-of-sector approach which makes it the responsibility of all health providers to check the immunisation status of a child whenever the child makes contact with their services, and where possible for them to offer an immunisation service. Planned activities include funding vaccination through Maori provider agreements, and ongoing education and inclusion of midwives. Ensure GPs are notified of all births within the first two weeks postnatally, to support the MoH's PHO and Provider Newborn Enrolment Policy of enabling 90% of newborns to be enrolled by 2 weeks postnatal with a GP, the NIR and a Well Child Provider. Address patient literacy and ensure consistency of messaging by engaging with LMCs and introducing a patient information	85% of eight month olds will be fully immunised[9] by July 2013: Maori 85% Total 85% Targets for future years: July 2014 90% Dec 2014 95%	A more unified and improved health and disability system. People receive better health and disability services. Health and disability system and services are trusted and can be used with confidence. Strengthened health workforce. Speeding up the implementation of the Primary Health Care Strategy. Children will be enrolled with, and visit their primary care provider on a regular basis. Managing immunisation events as much as possible within existing services should reduce overall cost.	Longer, healthier and more independent lives.

[9] That is, have had their primary course of immunisations, which occur at 6 weeks, 3 months and 5 months.

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
	package. Collect primary care data and monitor the provision of immunisation services at practice level to inform providers on performance and support under-performing practices. Enhance programmes that support the development of quality systems within primary care such as pre-calls, recalls, data capacity and capability. Continue to develop and implement the hospital-based vaccination programme, promoting immunisation as 'core business' within NDHB hospital services (outpatients, wards, Child Health Centre and ED). NIR will be the hub for all referrals to Outreach Immunisation Services and will coordinate the utilisation of other service providers in support of OIS for the delivery of catch-up immunisations. Enhance process to confirm "true declines". Review and align Outreach Immunisation Services (after geomapping) to improve coverage.			

3.6 Improved access to elective surgery (HT2)

National links	NRHP links	NHSP links
Health Target. Priority in Minister's Letter of Expectations of shorter waiting times. *MoH outcomes:* NZers living longer, healthier and more independent lives; people receive better health and disability services; the health and disability system and services are trusted and can be used with confidence.	High level objective under Triple aim 1, population health: 1.1 Achievement of outcome targets, eg measures relating to: 1.11 National Health Targets High level objectives under Triple aim 2, Patient Experience: 2.32 Improved access to elective services to restore or maintain peoples' functional independence	

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
Reversal of acute conditions Better, sooner, more convenient services	Use MoH's Elective Service Workforce Productivity funding to undertake two projects: The Productive Operating Theatre (TPOT): This will run over the next 18 months and look at the identification, planning and implementation of productivity and efficiency gains in theatres to assist NDHB in meeting its elective targets. Redesign of the Elective Orthopaedic Pathway. This is a whole-of-system approach to review and make improvements in the design and delivery of the orthopaedic service in Northland. It is expected this project will integrate with TPOT when the theatre phase of the project comes into scope. Improve theatre capacity by implementing the preferred option from NDHB's review and assessment of theatre capacity. This will involve entering into an agreement with the private facility in Northland to generate additional flex in theatre capacity. Continue to implement the Acute Care Reform Programme, an NDHB-funded initiative that focuses on improvements to the acute pathway in NDHB. The other two elective initiatives will interface with this programme in developing better operationalising of acute care reform in the DHB.	The [national] volume of elective surgery will be increased by at least 4,000 discharges per year. Elective surgical discharges: Base 4,821 Addit'l 1,613 Total 6,434	Better use of existing resources and funding to meet increases in demand of both acute and elective inpatient services. Increased theatre productivity.	Improved patient experience and waiting times. More discharges and costweights delivered to the population.
Waiting times	Northland DHB is committed to further increasing elective service outputs and to further reductions in waiting times including the achievement of a maximum five month waiting time by no later than 30 June 2013. Actions taken to support improvement include: • reviewing waiting list administrative systems and information provision by 30 September 2012			

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
	• establishment of a contract with a private provider to enable temporary increases in capacity in response to demand fluctuation by 31 July 2012 • establishment of an additional full day elective operating theatre session by 31 July 2012 • implementation of The Productive Operating Theatre (TPOT) quality improvement programme including achievement of the key milestones agreed with the Ministry of Health • implementation of the elective orthopaedic pathway redesign project including achievement of the key milestones agreed with the Ministry of Health • reviewing day surgery rates and day of surgery arrival rates and formulating an improvement plan by 30 September 2012 • production of a business case for a new CT scanner by 30 September 2012 to enable reductions in diagnostic waiting times. Northland DHB remains committed to prioritising patients for treatment using national tools and applying the assigned priority in booking processes.			

3.7 Better help for smokers to quit (HT5)

National links	NRHP links	NHSP links
Health Target. Priority in Minister's Letter of Expectations of better management of long term conditions. *MoH outcomes:* NZers living longer, healthier and more independent lives; good health and independence are protected and promoted; a more unified and improved health and disability system; people receive better health and disability services.	The Health Target is a strategic priority.	Headline actions for: • increased emphasis on reducing tobacco uptake and increasing cessation

Integrated structures and processes

Northland DHB Tobacco Target Steering Group

The purposes of the Northland DHB Tobacco Target Steering Group (TTSG) are to:

- provide leadership on the design, planning and provision of ABC Smoking Cessation support across all of Northland's hospitals and primary care general practice services.
- support and monitor Northland DHB hospitals and primary care tobacco target performance.
- provide advice and guidance to the Hospital Smokefree team and primary care providers delivering smoking cessation services in the community.

The TTSG is accountable to the Northland DHB Executive Leadership Team:

- the Executive Leadership Team (ELT) Sponsor provides progress reports on a monthly basis to ELT and the Senior Management Group
- the NDHB/ MoH Tobacco Lead ensures key stakeholders are kept informed by communicating relevant information about ABC Smoking Cessation to the Long Term Conditions Working Group, Cancer Control Steering Group, Public Health Services Advisory Group.
- the PHO representatives provide monthly reports to TTSG.

Patu Puauahi Coalition

The Patu Puauahi Coalition is a network of smoking cessation practitioners that links contracted providers, community NGOs and other interagency groups.

The Coalition's key function is networking and sharing information and resources to build workforce capacity and capability, and to integrate the delivery of smoking cessation services across Northland. The Coalition aligns its activity with national smokefree media campaigns, health promotion and Smokefree Day.

Both the Tobacco Target Steering Group and the Patu Puauahi Coalition meet monthly.

3.7.1 Smokers in hospital

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
Healthy population Reversal of acute conditions Optimum quality of	*Support for patients* Takawaenga to continue to provide ABC for Maori patients with a particular focus on ED and Surgical Admission Unit.	Patients who smoke are seen by a health practitioner in public hospitals and are offered brief advice and support	Decreased preventable hospitalisations, especially respiratory illness, ischaemic heart disease, smoking-related cancers.	Increased quit attempts. Reduction in smoking rate across all ethnicities. Reduction in disparity

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
life for those with long term conditions Life expectancy gap between Maori and non-Maori continues to narrow (as per SFSP high level measure)	*Support for staff* Support for all staff will continue with free nicotine replacement therapy and ensuring more widespread compliance with the Smokefree Policy. All DHB staff who smoke will continue to be encouraged and supported to quit smoking. Review of Hospital Smokefree Team to ensure better utilisation of skills and support for programme. *Training and education* Increased training and education opportunities for staff to improve understanding of process, standing orders and NRT promotion. Smokefree champions will continue to be monitored to ensure that the training programme is effective in improving confidence and consistency around their role, particularly when facilitating ABC education for other staff. Promote ABC as part of standard regular observations such as temperature, pulse, respiration and blood pressure assessments. *Monitoring* Inpatient units provided with weekly reports and follow-up until target increases. Follow-up of units and specific staff to address where documented smokers have not been offered cessation advice. Senior clinicians and management updated monthly on ABC progress. Service ABC progress charts displayed on quality boards. Processes of documenting ABC support and coding to be reviewed to ensure consistency of approach and data monitoring. Targeted guidance and support for areas not achieving so that ABC becomes standard practice. *Smokefree environments* Planning for the Mental Health Inpatient Unit to become	to quit smoking: Maori 95% Total 95%	Reduced burden of long term conditions. Workforce that is responsive to needs of population. Increased level of education of staff related to ABC approaches. Business-as-usual approach to ABC practice imbedded within NDHB.	between Maori and non-Maori. Reduction in smoking related complications. Lives saved.

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
	smokefree by late 2012.			

3.7.2 Smokers in primary care

Outcome	Actions to achieve target	Target(s)	Expected gains	
			For health services	For patients/ clients
Healthy population Reversal of acute conditions Optimum quality of life for those with long term conditions Life expectancy gap between Maori and non-Maori continues to narrow (as per SFSP high level measure)	Support general practice to continue to implement NDHB-funded Enigma-designed database to record and monitor smoking status in primary care. Continue to fund 2,000 free cessation services/ quit attempts in general practice across Northland. Primary care continues to provide ABC activity with targeted free access to Maori, Pacific people, parents and pregnant women. Adopt a whole-of-system approach, providing leadership through NDHB Tobacco Target Steering Group. Support independent Lead Maternity Carer initiative to develop a pregnancy pathway supporting an increase in quit attempts for pregnant women. Support the achievement of the maternity smoking target by continuing to: • ensure all midwives are offered training to be quit card providers • offer midwives attendance at a NZ College of Midwives smoke change workshop • offer advice and help to all women during their pregnancy and during any admission to NDHB maternity services, including: ▪ asking about their smoking status ▪ offering appropriate nicotine replacement therapy ▪ offering the opportunity to discuss a smoking cessation plan. • enable midwives who are quit card providers to provide quit cards to the extended family, to improve the chances of successful smoking cessation (this was initiated through NDHB working with the midwifery council).	Patients who smoke are seen by a health practitioner in primary care, and are offered brief advice and support to quit smoking: Maori 90% Total 90% 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer being offered advice and support to quit.	Reduced burden of long term conditions on health services.	Lives saved. Reduced inequity in cancer deaths between Maori and non Maori. Vulnerable populations have access to supported quit attempts. Smokers are supported to make choices for healthy outcomes. Healthy pregnancies and babies.

3.8 Child and youth health

National links	NRHP links	NHSP links
Immunisation Health Target.	Child health is a new priority under the Life and Years Priority Goal in 2012/13.	Headline actions for: • increased focus on expectant mothers and young people • intersectoral initiatives such as Healthy Homes • enhance and expand school-based health services

Integrated structures and processes

Since 2009 Northland DHB has been actively engaging and coordinating planning with the wider child and youth sector both government and non government.

The Child and Youth Health and Disability Advisory Group

This multi-sectoral group was established to oversee and monitor the NDHB Child and Youth Strategy Implementation Plan 2007.

The group has representatives from NDHB Child Health Service management and clinical staff, NDHB Planning and Funding, PHO CEO, PHO Population Health Strategist, Plunket Area Manager, Ministry of Education, Ministry of Social Development, Maori Women's Welfare League, team managers from the disability sector, Youth Transitions Service Manager.

One of the key actions in 2011 for this group was to review the existing NDHB Child and Youth Health Strategy and commission the establishment of two workstreams, one for children and one for youth. Both groups were tasked with developing new and contemporary child and youth implementation plans for Northland DHB. In recognition of the importance of the interface with primary care, NDHB contracted with a GP who specialises in adolescent health to lead the Youth Workstream and the Population Health Strategist from Te Tai Tokerau PHO to lead the Child Workstream. The new Child Health Implementation Plan 2011-14 was signed off in July 2011. The Youth Health Implementation Plan is still awaiting sign-off but this is expected to be formalised by mid 2012. Both plans have been feeding into the development of the Northland Health Services Plan.

Immunisation Steering Group

This is a multi-sector group which includes representation from DHB staff, Public Health, NIR, PHOs, Outreach Immunisation Services, Plunket, Midwives, Maori providers and IMAC. There is strong clinical representation on the group to ensure ongoing service improvement. The focus of the group is to ensure the delivery of a quality immunisation services, on time. The CEO of the DHB is the current chair, highlighting the importance placed on immunisation services, and bringing clear leadership and direction to the group.

Child and Youth Mortality Review Group

The CYMRC for Northland DHB is a statutory committee accountable to the Health Quality and Safety Commission (HQSC). Its purpose is to review and report to the HQSC on deaths that are within the committee's scope, with a view to reducing these manner of deaths and to support the continuous quality improvement through the promotion of ongoing quality assurance programmes.

Current membership has representatives from Ministry of Education, Ministry of Social Development, NZ Police, Area Manager Child Youth and Family Services, Northern Area Manager Plunket, and NDHB management and clinical staff.

Before Schools Check Clinical Governance Group

This group provides guidance and advice about clinical governance issues to the B4SC Coordinator and ensures delivery of evidence-based clinical advice to ensure a consistent, high quality service is provided across the district.

Membership includes; B4 Check School Coordinator, other NDHB management and clinical staff, a nurse from general practice, PHOs, Maori health providers, education sector (Group Special Education and Early Childhood Centres), the rural sector, and a parent.

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
Progressive reduction in admission rates for rheumatic fever in children, especially Maori	Increase health literacy among parents. Increase awareness of the condition and how to manage sore throats among GPs. Continue with school-based throat swabbing programmes for children who live in high-risk areas who present with sore throats. These are provided by NGOs and NDHB in: • Te Kura o Otangarei • Whau Valley School • Te Kura Kaupapa o Te Rawhiti Roa • Manaia View School • Morningside Primary • Hora Hora School Continue with Healthy Housing programmes. Work towards implementing free after-hours services for all under 6s (addressed in detail at the end of 3.4 Primary care).	% decrease from 2011 rate	Reduced hospitalisations for rheumatic fever. Reduced demand on health services. Eventual eradication of rheumatic fever in the Northland population.	Healthier children. Reduced inequities for Maori. Improved mortality and morbidity for the Northland population, especially Maori.
Progressive reduction in SUDI rates in Northland	Continue to raise risks associated with SIDS through Well Child/Tamariki Ora providers and smoking cessation providers. Promote widely throughout Te Tai Tokerau the National SUDI Prevention Toolkit and the SUDI Health Promotion Kit post launch (March 2012)	Reduce SIDS notifications.	Reduced mortality from SUDI.	Reduced inequity for Maori. Improved life expectancy for babies.
Reduction in the number of young women who smoke during pregnancy, especially Maori	Increase smoking cessation support for lead maternity carers. Develop a coordinated cessation support programme for pregnant women, particularly Maori. Link community based cessation support to general practice. (3.7.2 Smokers in primary care, primary care contains further actions relating to smoking among pregnant women.)		Decline in the number of low birthweight babies born in Te Tai Tokerau. Decline in the number of premature births, especially among Maori. Reduced demand on SCBU. Improved child mortality rates.	Healthier babies born, especially to young Maori mothers.
All children are protected against preventable conditions, especially infectious diseases, gastroenteritis, skin	Support more education-based comprehensive care programmes in primary care. Develop more comprehensive, multidisciplinary, team based, collaborative and patient-centric programmes in primary care. Improve access to primary health care for youth through school	% Decrease in ASH rates	Reduction in demand for services. Less pressure on ED and inpatient services. Less pressure on child	Whanau/ families are more empowered to self-manage and take more responsibility for their own health and wellbeing.

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
and respiratory infections	based clinics. Immunisation (3.5 Immunisation). Vaccination status checked for all children <5 years who present to all health facilities. with opportunistic vaccinations offered at discharge where indicated.		health outpatient services.	
Timely and appropriate referred services for children	Utilise the E-prioritisation system to ensure all FSAs are triaged within MoH timeframes. Utilise Healthpoint to link with GPs concerning appropriate referrals and initial action plans.	Monitor waiting times for all disciplines monthly. Target children waiting for FSA >4 months. Internally review number of declined referrals.	Reduced pressures on Child Health Services. Reduction in number of declined referrals.	Families seen within timeframes. Families seen by appropriate clinician, reducing the need to refer on.
Reduced admissions to hospital	Work towards implementing free after-hours services for all under 6s (addressed in detail at the end of 3.4 Primary care). Continue with Healthy Housing programmes. Continue with school-based throat swabbing programmes for children who live in high-risk areas who present with sore throats. These are provided by NGOs and NDHB in: • Te Kura o Otangarei • Whau Valley School • Te Kura Kaupapa o Te Rawhiti Roa • Manaia View School • Morningside Primary • Hora Hora School	Reduced ASH rates for the 0-4 age group.	Reduced pressures on Child Health Services.	Healthier children.
Improved oral health in children and youth	Well child providers encourage enrolment with community oral health services. Improved youth access to free dental services throughout Northland.	Quarterly performance measures (PP10, PP11, PP12, PP13 in 8 Non-Health Target performance measures) for preschoolers, primary school students and adolescents.	Services are well coordinated to improve access to oral health care.	Children have healthier mouths. Children learn good oral health practices at an early age.
Whanau/ families are more empowered to better manage the impacts of mental illness within a	Training on child health and development issues has been arranged for clinicians in adult mental health services. Negotiations are currently underway with an NGO to provide support services to children of parents with mental illness and to	75% of clinicians in community adult mental health services to complete inservice training by July 2013.	Mental health services are able to offer an enhanced holistic model of care and support.	Improved access to mental health services. Whanau /families are more empowered to better manage the impacts of

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
Whanau Ora context	develop referral pathways for this cohort.	Referral pathway to community support developed by July 2012.		mental illness within a Whanau Ora context.
More stable and empowered youth	Increase proportion of referrals to Child and Adolescent Mental Health Service (CAMHS) with a strong behavioural component. CAMHS will actively promote the Incredible Years[10] programme to referrers (schools, GPs etc). Northland DHB will provide support to providers who offer the Incredible Years Programme. *(See also the action on a youth space in 3.4 Primary care.)*		Mental health services are better able to offer a range of therapeutic interventions that do not require psychopharmacology. Better differentiation between youth who suit behavioural programmes and those for whom psychotherapies would be more effective.	More stable and empowered whanau/ families. Young people retained in school system longer. Increased self esteem among young persons. Whanau/ families better able to self-manage.
Healthier young adults	Improve access to sexual health education in schools with accurate information being offered. Improved rates of condom use among youth in 2012/13 to protect from STIs. Improve access to contraception and contraceptive advice in the community, for example through local pharmacies and school based health services. Ensure services that deal with sexual health are youth friendly. Continue Public Health Nurse self-referral clinics in high schools including offering pregnancy tests, chlamydia screening and treatment, and condoms, and picking up on youth at risk of bullying and violence.	Annual decline in the number of young people diagnosed with sexually transmitted infections. Increase in number of referrals to community sexual health services. Increase in the number of youth accessing school based health services. Increase in number of youth accessing PHN clinics.	Reduced demand on clinical services. Improved ability of services that address sexual health to address sexual infections in our youth population. Fewer presentations to ED with STIs.	Reduction in the number of young people who have experienced sexually transmitted infections. Improved fertility.
Improve detection and increase referrals to CYFS and/or police for family violence and sexual abuse	NDHB assessment and intervention processes are aligned to *NZ Family Violence Intervention Guidelines: Child and Partner Abuse*. Increase referrals to CYFS of children and youth suspected of being abused. Improved awareness in primary care of screening for violence and the process of referrals to CYFS.	Numbers of children and youth who present to ED with non-accidental injury. Number of referrals from Ward 2, SCBU, Child Health Centre, ED and Maternity Services to	Earlier identification of at risk children and youth through appropriate screening. Earlier treatment and reduced demand on adult counselling and mental health services.	Safer, healthier children and youth.

[10] A national Ministry of Education-run programme, based on validated overseas models, for parents of children with challenging behaviours.

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
	A multidisciplinary approach combining health promotion about sexual abuse into schools, monitoring of sexual abuse cases and how many formal complaints are laid. Promotion of how rural communities can work better with Doctors for Sexual Abuse Care and police services in Northland.	CYFS. Number of youth observing and being subject to violence to reduce between the Youth'07 and planned Youth'12 health surveys. Number of children and youth experiencing sexual abuse to decline.		
Improved wellness and health throughout life	HEHA, Fruit in Schools programme, health promotion nutritional messages that are age-appropriate and use appropriate forms of media. Projects to target children and youth who are most at risk (high deprivation areas, low decile schools, personal history of asthma, family history of diabetes and CVD). Improved relationships with Sport Northland, local council bodies and iwi services about access to sports, kapa haka and facilities for physical activities. Monitoring of children and youth in primary care to identify early those children who are obese. Appropriately investigate and refer these children. Continued PHN school visits including personal health referrals and health education.	Improved uptake of eating 5+ fruit and vegetables per day. Improved access to physical activity. Reduction in number of children and youth in the overweight and obese categories. Number of school visits. Number of school referrals. School health education plan in place with every school.	Reduced burden on CVD and diabetes services. Reduction in ASH rates.	Improved health and nutrition for children and youth, particularly Maori.
Reduction in rates of alcohol and marijuana use in youth	Clear health promotion messages to reverse public opinion that marijuana is healthier than cigarettes. Improved regional access to drug and alcohol counselling services for youth. Local primary care providers equipped to identify drug and alcohol risk in their local community and to appropriately manage youth, or if required, refer them to support services. Local community projects about alcohol harm reduction, eg	Percentage of youth smoking marijuana currently is higher than cigarettes in Northland; target is to reverse this pattern. Binge drinking and drinking-while-driving	Reduced demand on adult drug and alcohol services. Reduced trauma and ED presentations around alcohol-related harm. Reduction in diagnoses of COPD and future health demand on services.	Improved knowledge about drug and alcohol effects by youth. Improved access to cessation support services.

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
	rugby referees talking about alcohol post sporting events, and the "Is it worth it" project.	rates are reduced.		
Families of children and young people with disabilities are more informed and are able to access information and support	Ensure and strengthen intersectoral collaboration. Develop disability toolkits for dissemination of information. Early identification of babies and young children with disabilities to ensure early response through recognised referral pathways. Recognise that families may require assistance to care for their child or young person through timely support and/or information. Review the recommendations from *The Health of Children and Young People with Chronic Conditions and Disabilities in Northland*[11]. Strengthen multidisciplinary approach combining NASC, NGO and NDHB teams to promote responsive family support. Continue to expand working relationships within the health and disability sectors by expanding levels of communication through cooperation and formal collaborative agreements. Shared responsibility within decision making.	100% of families receive timely and early support. 100% of families receive effective information. All interagency and liaison agreements are in place and working.	Services are well coordinated to improve disability support to families. Upskilled staff and improved knowledge base for workforce.	Families receive streamlined responses when and as they are needed. Families are supported to maintain resilience and sustain strong family units.
100% of young people with disabilities who transition from paediatric to adult health care receive continuity of health care	Working model is defined through collaborative communication at service delivery level. Systems are designed to ensure that all young people are followed up. Disability services are cognisant of the impacts and effects of high health and disability needs. Review the recommendations from *The Health of Children and Young People with Chronic Conditions and Disabilities in Northland*.[12] Review current and future individuals and families where self-determination is a goal.	Increased access to and continuation of managed and focused health care. Develop a pathway and working model for young people that identifies when and how to shift them from family-centered services to building their capacity to manage their own lives and needs.	Consistent practice and policy to meet needs of health practitioners. Fluidity of service delivery in all areas.	Consistent practice and policy to meet needs of families. Families and young people can identify and have clearer support which assists their forward thinking about adult life. Young people will have better ability to control and self-manage their own lives. The basic needs of individuals are considered in a holistic approach and practice principles.
Increased access to	Implement telehealth paediatric outpatient clinics at Kaitaia	2% increase in clients	Reduced medical travel time.	Reduce need for patients to

[11] Waikato DHB Youth Transition Standards of Care, quoted in Paediatric Society Report 2010 *Health of Children and Young People with Chronic Conditions and Disabilities in Northland.*
[12] Ibid.

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
services closer to home	Hospital.	seen via telehealth.		travel to Whangarei Hospital for specialist input.
Before School Checks	Continue to meet with Manaia PHO (lead contract holder for B4SC) to ensure there is clear understanding of any issues that might affect the programme.[13]	80%	Earlier detection of health problems.	Healthier children.

[13] NDHB is happy with the performance of Manaia PHO to date. We are reassured that the initiatives in place, as identified through the regular reporting process, identify and meet any issues that might otherwise prevent the 80% target being met. It is expected that this regular exchange of information will continue during 2012/13 to enable a rapid response to any as yet unidentified issues that may arise.

3.9 Child and youth mental health

National links	NRHP links	NHSP links
National priority in AP guidelines.	A key population under the mental health and addiction services priority.	

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
Access rates for child and youth mental health and addiction (MHA) services remain above 3%	Review skill mix to increase access to Child and Adolescent Psychiatrists. Colocate mental health/ AOD and youth health clinics in Kaitaia to increase access. Work with sector to enhance access to Gateway assessments, including referral to service as needed.	Access rates (see targets under measure PP6 in Module 8). Referrals from CYFS increase from 8% to 12% of referrals.	Increased ability to provide liaison to primary sector. Early intervention for clients. Integrated service delivery model.	Reduced waiting time to see child and adolescent psychiatrist. Access improved. One-stop accessible centre for youth.
Children and youth and their whanau are empowered to self-manage the impacts of mental illness and alcohol and other drug (AOD) issues	Review NGO contracts and increase investment in Child and Youth Mental Health and AOD community services (including school based) at 1 July 2012. Increased investment in child and youth mental health and addiction services by NGO providers from $875,577 to $1,912,146. Continue to build linkages with at-risk youth at schools.	Number of referrals of children and youth to school based mental health and addiction services. Proportion of referrals from schools increases from 15% to 17%.	Providing child and youth MHA services closer to home to improve access. Development of long term or enduring mental health and AOD issues for children and youth prevented. Fewer clients experiencing acute episodes. More effective and efficient targeting of resources.	Children and youth retained in education or employment longer. Children and youth and their whanau are better able to self-manage. Increased self-esteem among children and youth. Clients achieve greater stability in their conditions.
Improved wellness and health throughout life	NGO contract agreements from 1 July 2012 require providers of child and youth services to establish service line agreements with other key government departments: Education Services, Police, Youth Justice and Ministry of Social Development (CYFS).	Number of referrals from government services to community based mental health and addiction services.	Services are well coordinated to reduce duplication. Increased confidence and trust in services provided by NGO MHA providers. Appropriate referrals to mental health specialist services and reduced demand on these services.	Improved knowledge by children and youth and their whanau about mental health and the effects of alcohol and drugs.

3.10 Mental health

National links	NRHP links	NHSP links
Nation wide MHA Co-Existing Problems (CEP) Action Plan. Northern Region DHBs present regional CEP Action Plans to the Ministry. National KPI (Benchmarking Forums) project with the identification of at least one project to enhance service performance.	New priority under the Life and Years Priority Goal in 2012/13. Northern Region DHB generic contract clauses include Smoke Free Policy to be in place in NGO environments and provide smoking cessation support and advice to staff and services users.	Headline actions for: • strengthen the range of AOD interventions across the spectrum of services

Integrated structures and processes

DHBs and NGOs in the mental health and addictions sector are engaged in regional strategic planning and collaboration to improve outcomes for residents with mental health and addiction needs. This work aligns with the full range of national and regional mental health and addiction plans.

Northland staff regularly attend the Network North Coalition, Regional Funding Forums, monthly Clinical Director/ General Manager meetings, Eating Disorder Governance Group, Regional Youth Forensic Service, Regional Service Governance and Regional Service Planning meetings. Northland also has representation on working groups concerning the forensic pathway, services for clients with high and complex needs, addiction services, eating disorders, child and adolescent mental health and psychiatric services for older people.

The Northern Region Mental Health and Addiction Services team supports and coordinates a number of activities to assist with implementation of these plans, including the management and coordination of:

- the Network North Coalition, an array of sector groups and workstreams which span the full breadth of the mental health and addictions sector and provide sector advice, consultation and monitoring
- regional mental health and addictions planning and funding, including a range of activities to support regional service development, and associated business functions around agreements for regional provision, contract generation and management, quality improvement, and audit
- workforce planning and development
- Regional Service Coordination
- information systems, including the Auckland Regional Mental Health Information Technology project and the Programme for Integration of Mental Health Data in the Northern Region
- Key Performance Indicator Project, involving live testing across the country in nine DHBs and their partner NGOs.

Regional services planning and governance groups ensure that robust regional clinical and managerial planning and oversight is provided for regional services, and that issues pertaining to individual DHBs are also factored into provision.

The regional services work programme for 2010/11 will be informed by a service coverage document that has identified the priorities for activity. These will include:

- implementing the Northern Region Eating Disorders Services Plan 2008-2013 with recourse to the Northern Region Eating Disorders Services Governance Group (see subheading below)
- implementing changes to the delivery of alcohol and other drug services agreed to by NGOs
- ongoing implementation of the Strategic Review of DHB-provided community alcohol and drug services
- increasing the capacity of Regional Forensic Psychiatry Services through application of new mental health funds available from 2009
- establishing a new regional dementia advisory service through application of new mental health funds available from 2009
- implementing the regional child and adolescent mental health inpatient unit service delivery model reconfiguration
- developing a clinical network for services configured to provide for persons with high and complex needs
- the Regional Youth Forensic Service will increase contacts and establish an inpatient unit within the region, as well as establishing a hub-and-spoke model with dedicated staff in Northland and Counties Manukau to manage population demands and geographical issues.

Early Detection and Management Output Class

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
Mothers with strong attachment to babies	Referrals from GPs of women to attend postnatal cognitive behavioural therapy (CBT) programme *(NGO)*. Invest in the development of train-the-trainer for postnatal depression CBT programmes *(NGO)*. Establish workforce development capability with Lead Maternity Carers to enhance the detection of depression in pregnant women through routine screening.	Number of women attending postnatal CBT programmes. Referrals from Lead Maternity Carers to appropriate services to support women experiencing depression.	Earlier identification of at-risk mothers and babies through appropriate screening. Upskilled staff and improved knowledge base for workforce.	Women experiencing postnatal depression are supported to maintain strong attachment to their babies. Healthier children and mothers.
Enhanced service access for overall wellbeing and health and reduced health disparities	Trial strategies to increase Maori client participation in "Talking Therapies" as part of Primary Mental Health Packages of Care (Manaia Health PHO and Te Tai Tokerau PHO).	Increase number of POCs for Maori from 4.7% to 7%.	Improved access for Maori clients to POCs and improved service delivery.	Clients achieve greater stability in their conditions and health.
	GPs and PHOs screen for AOD issues within adult population of their practice and make appropriate service referrals.	Number of clients screened for AOD issues by GPs and PHOs and referred for treatment services.	Reduced demand on acute services. Early intervention will: • reduce developing long term and complex AOD conditions • reduce demand for intensive treatment services.	Clients achieve greater stability in their conditions and health.

Intensive Assessment and Treatment Output Class

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
Enhanced service access for overall wellbeing and health and reduced disparities for those accessing MHA	Clients of MHA services to be actively enrolled in GP and/or PHO practice to address physical health needs, that is, seeing their GP every 12 months. NGO contract agreements require clients' records of MHA Community Support Services to identify GP/ PHO and level of contact with provider from 1 July 2012. Clients address lifestyle behaviours that impact on severity and enduring nature of mental illness and/or addiction.	90% of client records with MHA services have GP details reported in JADE. 80% of clients of MHA Community Support Services are supported to see a GP every 12 months.	Reduced demand on acute services Enhanced integration of health and wellbeing of clients.	Clients achieve greater stability in their conditions and health. Improved physical health outcomes for clients. Increased self-management of health needs. Improved health status for clients.
	Increase access to AOD residential and community treatment	22% increase in NGO		

	programmes for adults provided by NGO providers from 1 July 2012.	AOD Residential Treatment Beds, going from 18 (now until 30 June 2012) to 22 beds (= 4 extra beds).		
Increased access to services closer to home	Provision of telehealth AOD clinics to Kaitaia and Kaikohe.	5% increase in AOD clients seen by Medical practitioner.	Reduce travel time of AOD medical staff.	Increased access to medical AOD input to Kaitaia and Kaikohe.
	Increased provision of AOD treatment programmes for adults provided by NGO providers within Northland from 1 July 2012.	4 FTE increase in NGO AOD Community Treatment Services.		

Rehabilitation and Support Output Class

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
All services responsive to co-existing problems (CEP) and working towards being CEP capable	All clients presenting to mental health services have alcohol and other drug (AOD) screening tool applied. All clients presenting to AOD services have MH screening tool (Mental Health Screening form 3 or Mini International Neuropsychiatric Interview) applied. Incorporate CEP responsiveness and capability into NGO contracts from 1 July 2012.	85% of clients presenting to mental health services have AOD screening tool applied within 3 months entry to service. 85% of clients presenting to AOD services have mental health screening applied within 3 months entry to service.	Mental health and AOD services are configured in such a way that supports service CEP capability.	Clients experience better service integration.
Reduction in number of people who are smoking and reduction in smoking-related diseases.	NGO mental health service contract agreements from 1 July 2012 will include smokefree policy. Increase smoking cessation support for clients of mental health services' community support services (see also 3.7.1 Smokers in hospital).	Number of clients of Community Support Work services provided smoking cessation support and advice.	Contribution to performance measures across the health spectrum.	Improved access to smoking cessation support and advice services.
Independence for those living with the experience of mental illness and/or addiction.	Hospital and community based services (including NGOs) to work together to identify strategies that would enhance social inclusion for clients within their local community. NGO mental health and addictions service contract agreements to include outcome measures from 1 July 2012 in line with results-based accountability framework.	Increase by 5% clients who strongly agree or agree that services support social and/or community inclusion.	Improved cost efficiencies and utilisation of resources	Recovery of people facilitated so they attain their full potential within their communities.

3.11 Advance care planning

National links	NRHP links	NHSP links
Emerging as a national issue in the feedback on AP V1.	One of two areas of focus under The Informed Patient, one of the three Priority Goals.	Headline actions for: • aligning ACP to NRHP

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
Independence for those with impairments or disability support needs. Better, sooner, more convenient services. Impact: Older people requiring support or care receive services appropriate to their needs.	21 NDHB and NGO staff will attend ACP training. Regional community awareness campaign. Programme infrastructure developed including material for continuous evaluation, production of communications material, provision of ongoing clinical supervision and support, website, measurement processes to record number of conversations, website effectiveness.	75% of patients and their whanau receive an ACP information brochure on admission to NDHB or ARRC. One level 3 and 20 level 2 ACP trainers trained by end of 2012/13.	Development of capacity and capability to improve health care to patients at the end of their lives.	Greater patient participation and improved health care through patients being better informed across the full health spectrum, and receiving the care they want or need at the end of their lives.

3.12 Maternity services

National links	NRHP links	NHSP links
Emerging into the national spotlight again in recent months.		Headline actions for: • increased focus on expectant mothers and young children

Outcome	Actions	Measures	Expected gains	
			For health services	For patients/ clients
High quality and safe maternity services	Quality initiatives: • 0.8 FTE position of Maternity Quality and Safety Standards Coordinator to be appointed • Maternity Services Clinical Governance Group has been formed, with the first meeting to be held in June 2012 • web-based information site is in development using Healthpoint • ongoing data collection and benchmarking against the MoH clinical indicators to commence	Group meetings. Website is up and running by Aug 2012 Data is collected and analysed.	Collaborative multidisciplinary approach to provide overview of quality and safety standards within the maternity service.	Improved communication. Seamless approach to care. Improved outcomes of a safe and healthy childbirth experience.
	Meeting the needs of those few women not booked with an LMC: • for those unbooked in pregnancy, birth or in the initial postnatal period, NDHB midwives will assist them to find an LMC, for primary care, or... • for the small minority who do not have an LMC or do not wish to have an LMC, NDHB midwives will provide primary care.	All mothers who wish to have an LMC for primary maternity care are assisted to find one if available	Ensuring all women have the opportunity to the provision of continuity of care with a known LMC to improve outcome. No woman is without midwifery care once identified to the maternity services, throughout pregnancy birth, and postpartum.	Partnership developed with the LMC to ensure continuity of care.
	Pregnancy and parenting education: • continue to offer parenting classes throughout Northland to all pregnant women and their partners, including evening and weekend classes, and classes for teenagers • continue to offer parent education throughout the childbirth continuum, including through the discharge process.	Classes and education sessions are held.	Women presenting to the service are well informed. Improved parenting skills, reducing admissions to the pediatrics service.	Improved knowledge and ability of mothers to make informed choices regarding their own and baby's care. Improved confidence in parenting skills and breastfeeding.

3.13 Maori health

3.13.1 Whanau Ora

National links	NRHP links	NHSP links
National priority in AP guidelines. Major Government policy plank.	One of two areas of focus under The Informed Patient, one of the three priority goals.	Headline target: life expectancy gap between Maori and non-Maori is reduced by 2 years by 2017. Headline actions for: • coaching support for people with LTCs based on WO framework • WO implementation and navigation through the WO Collectives *(see also links under 3.13.2)*

Northland DHB activity

In relation to Whanau Ora, Northland DHB will:

- provide assessment feedback on the Programmes of Action and Business Cases for Kaipara Whanau Ora Collective
- provide assessment feedback on the action research for Te Hau Awhiowhio o Otangarei
- maintain current investment of health services within the WO Collectives with opportunities to align services to NDHB health priorities
- implement regular forums with all WO Collectives to share reciprocal information on DHB environment and status of the Business Case and Action Research objectives
- utilise He Mangai Hauora mo Te Waka a Taonui as a forum for NDHB and Iwi to collectively respond and share information regarding WO
- post NGO VfM review of agreements, participate in discussions with community services providers led by MSD, who intend to establish integrated agreements with eligible service providers within two of the WO Collectives by June 2013
- review Maori-led contracts to increase linkages with other primary care providers.

Status of Whanau Ora Collectives

The four Northland Whanau Ora Collectives are at varying stages of development. Te Pu o Te Wheke, Te Hau Awhiowhio o Otangarei and Te Tai Tokerau Whanau Ora Collective have completed their business cases and these are supported by the WO Governance Group. Two of the collectives, Te Pu o Te Wheke and Te Tai Tokerau Whanau Ora Collective, have submitted action research proposals which have been assessed. Te Hau Awhiowhio o Otangarei still have to submit theirs. Kaipara Whanau Ora Collective, the fourth one, is at the stage of submitting their programme of action and business case.

While the Northland WO Collectives are still in the process of developing outcomes with whanau, there are identified specific clinical outcomes contained within their service delivery. These include:

- Whanau Ora assessments and case management
- continued progress in their Whanau Ora centres
- improved immunisation rates
- increased smoking cessation advice and support to high risk individuals
- increased CVD assessments for high risk individuals and the development of Diabetes Care Improvement Packages (3.6.2 Diabetes, second row of actions).

The integration of Whanau Ora systems into effective primary care and locality based healthcare planning in the Northland is seen as a continued priority for 2012/13.

Integrated agreements across funding agencies require more than one funder. Three community services providers have signalled their interest in establishing an integrated agreement, but so far only one of those providers has another funder who is ready to engage. By June 2013 Northland DHB intends to have two integrated contracts with results-based accountability reporting that will contribute to NDHB's outcomes and outputs, as described in the SOI framework (Graphic 23 in 5 Statement of Forecast Service Performance) and the NHSP (Appendix 2: Northland Health Services Plan).

Whanau Ora Collectives are included within Te Tai Tokerau Alliance for Health (ALT), which was formed in 2011. ALT has recently confirmed its role

as being to provide the governance structure for sector integration, strategic direction and the broad vision of integration. *(See also Clinical integration, subsection on intersectoral integration.)*

3.13.2 Maori health and Northland DHB

National links	NRHP links	NHSP links
Whanau Ora is a Governmental priority.	Appears as a focus throughout the plan. Whanau Ora is one of two areas of focus under The Informed Patient, one of the three priority goals.	Headline target: life expectancy gap between Maori and non-Maori is reduced by 2 years by 2017. Headline actions for: • screening for LTCs, esp for Maori • health literacy • discharge planning, follow-up clinics and other MoCs, esp for Maori • clinical pathways for priority conditions, esp to improve access for Maori • collaboration and info sharing with Maori providers to reduce DNAs • all NDHB-funded provider orgs will have policy on cultural competence

Northland DHB continues to regard improvements to Maori health and reductions to health inequities as inescapable parts of our core purpose. They are themes that underlie all our planning and service provision and are interwoven through all other priorities. The newly signed off Northland Health Services Plan has as one of its headline targets the reduction in the life expectancy gap between Maori and non-Maori by 2 years by 2017.

Compared to other DHBs, Northland is above average in our level of investment in Maori health. Northland DHB is committed to not allowing any disinvestment in Maori health, across services provided by both Maori NGOs and mainstream services. Without real increases in funding, it is more important than ever that DHBs examine services and contracts to ensure they are aligned with strategic priorities and provide the best value for money. This includes their contribution to improving Maori health and reducing inequities, and to "upstream" investment and intersectoral activities to prevent health problems developing.

The Maori Health Plan 2012/13 is produced separately to the Annual Plan. At its core is a set of performance measures for the health sector that address key needs among Maori at national, regional and local levels. These are based on the Health Targets and other quarterly indicators as well as additional indicators NDHB has added to reflect local needs (oral health, respiratory conditions, sudden infant deaths, rheumatic fever).

The foundation for the Maori Health Plan is the *Te Tai Tokerau Maori Health Strategic Plan 2008-2013*, developed jointly by Maori providers, PHOs and NDHB. It sets out a framework for improving Maori health that requires coordinated action by all public sector and territorial authority agencies in order to address not just health issues but economic prosperity, education and the environment.

NDHB's *Te Tai Tokerau Strategic Public Health Plan 2008-2011* also provides an important basis for Maori health gain. The plan was developed with engagement from public health funders and providers from across the health sector. It uses Te Pae Mahutonga as the planning framework to identify how public health can be strengthened and reoriented to maximise the potential of public health action to improve the health status of the people of Te Tai Tokerau.

Whanau Ora, a major Government policy, has the potential to contribute significant gain to Maori health. Progress to date in Northland and NDHB's activities are described in 3.13.1 Whanau Ora.

As well as the Maori-specific approaches described above, Maori health and reducing inequities are addressed throughout the Annual Plan. Module 3, which addresses NDHB's approaches to national priorities, addresses Maori needs wherever relevant throughout its issues, actions, targets and approaches to monitoring. Module 5, our Statement of Forecast Service Performance (the core of the Statement of Intent), places reducing inequities as one of our high level outcomes and targets for Maori are included in the indicators wherever possible.

Northland DHB's internal and external monitoring systems are being strengthened so that all indicators contain explicit mention of both Maori and non-Maori (at present, even among national indicators, separate reporting for Maori is not always required).

3.14 Telehealth

National links	NRHP links	NHSP links
	Listed under the proposed capital expenditure for information systems.	Headline actions for: • increasing support in community for lower dependency patients through Telecare • use telephone, email and video technology to provide advice to GPs re specialties with high referral rates

Outcome	Actions to achieve target	Measures	Expected gains	
			For health services	For patients/ clients
Increased access to services closer to home	Discussions with clinical heads of all specialties to explore telehealth options, with identification of another two initiatives for 2013/14.	2% increase in clients seen via telehealth.	Reduced medical travel time.	Reduce need for patients to travel to Whangarei Hospital for specialist input.
Increased clinical safety of helicopter transfers	Develop telehealth solution with ICU to enable them to monitor clients in district hospitals who require stabilisation and transfer to ICU. Implement telehealth solution initially in Kaitaia and Hokianga.	No change in status on arrival at ICU.	Increase specialist input into transfers of seriously ill patients. Reduction in unnecessary transfers and/ or incorrect status applied to transfer prior to departure. Increased support for medical officers working in district hospitals.	Improved management of seriously ill people through access to specialist advice.

Other actions concerning telehealth are to be found in 3.1.3 Cancer, 3.8 Child and youth health and 3.10 Mental health.

3.15 Workforce Strategy

National links	NRHP links	NHSP links
State Services Commission requirement of all Crown Entities. Quarterly reporting measure PP16.	Strategic priority under the Triple Aim. One of the four Enablers.	Workforce capacity and capability is one of the five Enablers, with eleven actions under it.

This section summarises NDHB's *Workforce Strategy 2012-2016*.

Outcome	Actions	Actions to be measured by	Expected gains	
			For health services	For patients/ clients
Culture	Scope up best practice models for staff engagement through HR practices to promote a supportive culture to retain staff.	Predominant issues in 2011 staff survey addressed. 2012 staff survey completed.	Higher retention rate of staff per annum.	Models of care are patient-centred.
	Develop Career Planning Framework through collaboration as a member of the Northern Region Training Hub (NoRTH).	Career planning framework completed.	A structured regional approach to career planning.	Retention of qualified staff to deliver continuity of patient care
	Integrate career planning as part of the performance appraisal process with staff.	Career plans in place for staff.	A structured approach to career planning with staff.	
	Development plans for all managers as part of the performance appraisal process.	Development plans in place for staff.	Retaining a motivated workforce.	Retention of qualified staff to deliver continuity of patient care.
	Implement compulsory cultural competency training for all staff.	Database shows numbers and percentage staff attending modules 1 and 2.	Culturally competent and safe staff practice when serving Maori patients.	Improved cultural competency in services delivered to Maori.
	Affirmative action in the recruitment and retention process of Maori and Pacific staff in professional and clinical roles.	Staff who are Maori and Pacific to increase by 1% per annum.	Improved responsiveness to reflect the high needs and demands of the population.	Improved cultural competency in services delivered to Maori.
	Work with Unions on setting goals to achieve service responsiveness Key personnel and Staff engagement groups continue to be active: • Bipartite Action Group & Forum • Local RMO Engagement Group • Association of Salaried Medical Specialist	Unions and HR department agreed goals Appropriate representation by staff and unions to the various forums to maintain positive working relationships		

Outcome	Actions	Actions to be measured by	Expected gains	
			For health services	For patients/ clients
	• Care Capacity Demand Management group. MECA forums – Labs, MRTs.			
Change leadership	Support the national Maori nursing leadership programme. Promote enrolment with Nga Manukura o Apopo.	Number of Northland nurse completions on Nga Manukura o Apopo course Q4 annually.	Greater demonstration of leadership from Maori in the health sector.	Provision of quality health care for those with the highest health needs.
	Develop internships for Nurse Practitioners in training.	Number of nurse practitioners in training and participating in intern programme.	Internships for training nurse practitioners provide the support to achieve registration in scope of practice.	Provision of quality health care for those with the highest health needs.
	Support and develop clinical leadership skills at all levels in the organisation.	Participation by clinicians in accredited leadership programmes.	Greater demonstration of leadership from clinicians in the health sector.	Provision of appropriate models of care to meet the needs of the community.
Capability	Collect data on the NGO sector by implementing a stocktake of their current health and disability workforce.	Stocktake to cover PHOs, Maori NGOs, ARRC providers and allied health providers.	Improved planning for supply and demand needs.	Services are delivered at the right time, in the right place, with the right people and skills.
	Ethnicity of the nursing workforce to reflect the population of Te Tai Tokerau: Stocktake of Maori and Pacific nursing workforce (as above). Leadership and management courses attended and completed by Maori and Pacific nurses. Develop strategy to increase Maori and Pacific nursing workforce. Support the aspirations of Maori nurses, eg Maori nursing capacity hui, mentoring groups. Work with Te Poutokomanawa (NDHB's Maori Directorate) to develop and deliver Maori workforce initiatives. Assist NorthTec to promote nursing as a career for Maori and Pacific students.	An increase the number of Maori and Pacific nurses completing PDRP and PG study (Q4 annually). Maori workforce initiatives identified and delivered (Q4 annually). Number of Maori and Pacific nurses in senior nursing positions (Q4 annually). Number of Maori and Pacific nurses in workforce increased by 10% by 2014 (Q2 2014).	Improved capability of the Maori nursing workforce.	Services to patients/ clients are delivered by a workforce that understands their cultural values.
	Promote Kia Ora Hauora Maori Health Careers Programme to influence, motivate and support Maori choice of, and entry into, a health career pathway.	Number of Programme Incubator students entering into a tertiary	Improved equity of Northland students entering into a health career pathway.	The future workforce will encompass professionals who understand cultural

Outcome	Actions	Actions to be measured by	Expected gains	
			For health services	For patients/ clients
		health career study pathway.		norms and values.
	Promote and encourage Maori to access Pihirau Hauora Maori scholarships and HWNZ non-regulated training funds.	Full disbursement of annual allocated scholarship and training funds.	Reduced barriers to accessing tertiary study for Maori student.	The future workforce will encompass professionals who understand cultural norms and values.
	Increase accessibility to learning and development throughout Northland. NoRTH forum utilised to oversee the development of the professions.	Increased engagement with the primary health sector and other training providers. Strong clinical oversight of medical, nursing and allied health professions	Shared resources to ensure consistency of training programmes where appropriate.	Improved patient care through transfer of knowledge.
Capacity	Support the implementation of self-management directed training within the primary sector regarding chronic conditions. Increase activity to build health literacy with patients who are at high risk of chronic conditions.	Results of the training.	More patients/ clients and their whanau can manage their chronic conditions. Reduction in secondary service acute presentation for chronic conditions.	Patients/ clients and their whanau are more informed and able to advocate and negotiate treatment for chronic conditions. Patients/ clients and their whanau improve relationships with their primary care providers to improve their own health and wellbeing. Patients/ clients and their whanau are more accepting of preventive care, medication compliance and health-seeking behaviour.
	Identify areas to improve utilisation of the current Human Resources Information System to enable better workforce reporting. Initiate a WF stocktake in primary health sector.	Delivery of appropriate workforce reports to facilitate decision making on workforce matters. Stocktake initiated, report completed and includes recruitment and retention, vulnerable and critical workforces, generic skills,	Better utilisation of the workforce to meet future demands.	A skilled and responsive workforce.

Outcome	Actions	Actions to be measured by	Expected gains	
			For health services	For patients/ clients
		workforce innovation.		
	Support the standardisation of PGY1 and 2 programmes by collaborating with metro DHBs in the Northern region to ensure that training programmes are standardised and aligned across the region to enable seamless transition across the region.	Training programmes are standardised. Transition across the region for medical is supported.		
	Nursing placements are negotiated and agreed to between PHOs and NDHB. Paediatric posts to support SMO in child health.	Nursing entry to practice placements into primary care. Paediatric post in place.		
	Pukawakawa fifth year medical students are organised and supported to participate in vocational training in GP practices. Ensure collegial support by GP for supervision in placements.	CMO responsible for verifying the medical council that continuing professional development is met.		

4 Stewardship

4.1 Monitoring of performance

The performance of Northland DHB is assessed on both financial and non-financial measures.

NDHB publishes annual forecasts of the coming year's finances in the Annual Plan and we report progress monthly to the National Health Board.

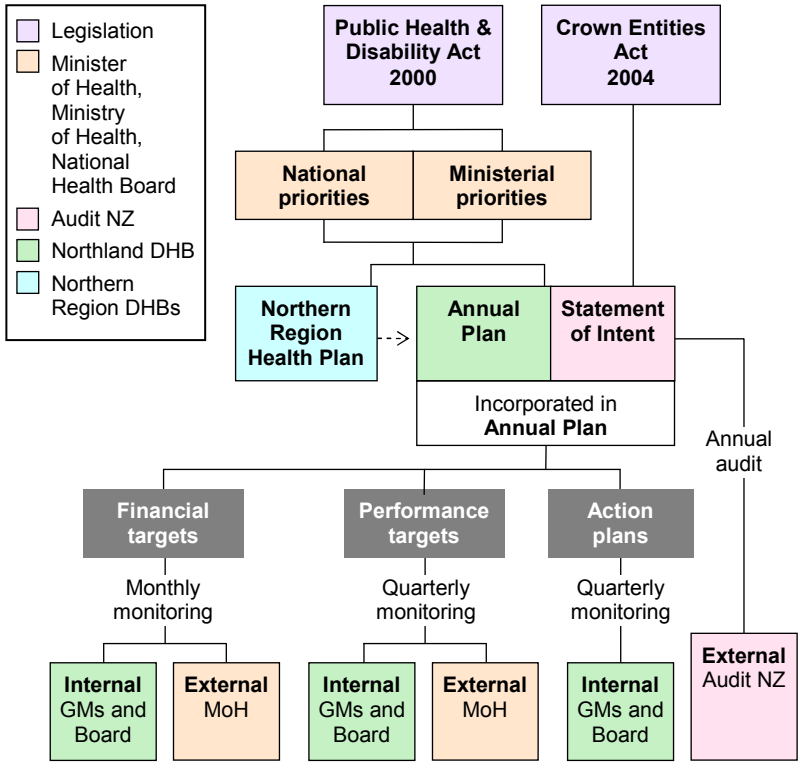
Non-financial performance is monitored quarterly. Health Target performance measures are covered in sections 3.2 to 3.6, while non-Health Target performance measures are in section 8.

In a wider sense, the elected Board of governors of NDHB is open to public scrutiny. Seven of the eleven members of the Northland DHB are elected at the three-yearly local body elections, with the remaining four appointed by the Minister of Health. The public are welcome to observe the meetings of the board and its statutory committees. Details of forthcoming monthly meetings are notified publicly in the local newspaper and available on our website, which also contains agendas and minutes of past meetings. Occasionally the Board or its committees have discussions from which they may decide to exclude the public; this is allowed for under the Public Health and Disability Act 200 under which DHBs operate.

As well as accountabilities within the health sector, Northland DHB is accountable to the Government through the Statement of Intent, whose monitoring is overseen by the Office of the Auditor General. DHBs reproduce the Statement of Forecast Service Performance section of the SOI (module 5 of the Annual Plan) in their Annual Reports.

Monitoring processes are summarised in Graphic 19.

Graphic 19 DHB planning and monitoring framework, national, regional and local



4.2 Provider arm services

4.2.1 Financial management systems

Northland DHB's Financial Management Systems give us the ability to set targets and monitor performance against these. Target setting occurs with advice from the Ministry of Health and includes financial budgets, numbers of employees and service delivery targets.

Performance against these targets is monitored on a monthly basis through Internal Performance Management Reports within each service, which are fed to the Executive Leadership Team. The reports are consolidated each month for NDHB's board of governance and its associated subcommittees. We also meet MoH's financial reporting requirements on a monthly basis.

NDHB continues to seek efficiencies in the way we operate, including participating in regional and national processes, for procurement, for example (7.3 Productivity initiatives). At least two-thirds of operating expenditure is on our workforce, and we continually reviewing patterns and levels of staffing to reduce costs.

The Financial Management System is, however, old and many processes are manual, especially procurement systems and processes. A significant advantage of having entered into the healthAlliance shared service has been the implementation of the Oracle Financial System. The system allows for a virtually paperless procurement process from requisition to payment, and ensures that frontline clinical staff can receive the necessary supplies at the right time at an optimum price with the minimum of administrative cost.

4.2.2 Information Services

NRHP: Strategic priority under the Triple Aim.

The regional shared service agency healthAlliance is now responsible for planning and delivery of information services. The rest of this section quotes the Northern Region Health Plan's section on information services. More detail is available in the NRHP itself.

Information systems are fundamental to the Northern Region's ability to deliver on the whole-of-system approach to health service delivery that is embedded throughout the NRHP. A key clinical driver in the plan is to improve the continuity of care for patients in our region across primary, secondary and tertiary care. This relies on consistent and reliable access to core clinical documents and facts for all clinicians involved in a patient's care.

5 priority areas from 2011/12

We are continuing to progress 5 priority areas identified in the 2011/12 plan:

1 Single Patient Administration System

The region will progressively move to a common patient administration system. This will be underpinned by standardised processes and improved data quality related to patient registration (NHI, demographics) and administration (referring, scheduling, booking, administration, transfer and discharge) of patients through our facilities. For primary care, improved access and contribution to National Health Index, demographics and visit information is required. Seamless integration with primary care patient management systems will be needed to support primary care access to the regional clinical workstation and the regional clinical data repository outlined below.

2 Single Clinical Workstation

This will provide a consistent user experience, improve clinical communication options and reduce the complexity of integration and audit functions. The four DHBs will progressively standardise on a Single Clinical Workstation, which in practice is a single version of Concerto. This activity will be supported by the national initiative to standardise the clinical workstation.

3 Regional Clinical Data Repository

To achieve the requirements of continuity of care, a regional clinical data repository is required. The most important step to be taken now is for Northland to join the use of the Regional TestSafe system. Northland clinicians must be able to both access and contribute to this regional clinical repository. An additional objective should be to improve primary care access and contribution to TestSafe.

4 Population Health Data Repository

This creates a single source of truth for regional population health information, potentially supported by a shared population health intelligence

team. This will improve collection, quality, availability and sharing of population health data across DHBs and PHOs.

5 Information Systems Infrastructure Resilience

To maintain current capability and support ongoing development, resilience of core IS infrastructure in all four DHBs must be reinforced.

The above "foundation projects" are critical to building a robust platform for ongoing regional information systems, and they will take a number of years to achieve. These programmes of work are the key focus for regional investment and activity. They should be 'protected' in local DHB capital and operational expenditure prioritisation processes.

Two new areas of focus for 2012/13

We have added two other priority areas this year to ensure our regional priorities remain aligned with national priorities.

6 Electronic solutions to support Safe Medication Management

This supports the national eMedicines programme of work, and for the Northern Region will encompass the roll-out of medicine reconciliation for secondary care and a pilot for hospital ePrescribing.

7 Shared Care Plan

Critical to the future new models of care is the ability to bring multidisciplinary teams across primary, community and secondary care together with the patient in a shared care planning environment. The investment in a truly patient-centred clinical management system is critical to promote ongoing investment in integrated care, devolution, acute demand management and empowerment of patients. Following a successful initial pilot, it is important to raise the regional profile of this initiative and to scale this concept to support key regional health improvement targets.

These areas of activity bring clinical teams together around the patient and develop the foundation required for ongoing investment in systems. The overall expanded plan supports clinical workflows and safety and decision-making across the sector.

Other regional and national IS priorities

Given the elapsed time before completion of these projects, some investment will also be possible and required in other regional projects. These underpin the delivery of key clinical priorities in the short to medium term. Other regional priorities that have been identified include:

- eReferrals phase 2
- eDischarges implemented to national standards
- eRostering
- continuation of regional network integration, single sign-on and single service desk as part of Shared Service programme of work
- shared financial management systems
- IS support for BSMC business case workstream.

Specific activities to support delivery of the NRHP work programme

Within these project workstreams some specific activities that will directly support delivery of the NRHP work programme include:

- implementation of Acute Predict to support consistent CVD and diabetes risk assessment across the region
- identify information system gaps in support of CVD and diabetes initiatives
- implement information systems to support the Access to Diagnostics initiative across the region
- TestSafe implemented in Northland
- piloting/rollout of Medications Management
- feasibility and scoping of systems to support Advance Care Planning.

We are well placed to proceed with IT initiatives

The Northern Region is well placed to proceed with these IT initiatives. We will evolve our regional clinical and business information governance arrangements and use the regional shared service agency (healthAlliance NZ Ltd) for delivery of IT services. It will be important that healthAlliance, under a centralised model of delivery, continues to maintain close links with its customers and high service satisfaction levels. This ensures that credibility with its DHB and community end-users is not compromised.

Detailed planning and prioritisation of existing and new district and regional projects in context of our NRHP priorities, continues as projects are initiated and implemented over time.

Further detail is provided in the *Northern Regional Information Strategy* for the period 2010 to 2020 (RIS10-20), and the *Northern Region Information Systems Implementation Plan* which sets the direction on information management, systems and services in the Northern Region. They align with

national, regional and district information strategies and are key enablers for primary, community and secondary care organisations to achieve their clinical and business objectives.

4.2.3 Human Resources

NRHP: Workforce is a strategic priority under the Triple Aim.

[This section deals with how Northland DHB manages its HR service. For NDHB's Workforce Strategy see 3.15 Workforce Strategy.]

NDHB recognises that improvements to achieve both our district and regional goals must be delivered by the right number and type of staff. Numerous staff training programmes help to continually improve capability and practice, and we are working with the other DHBs within NoRTH (Northern Regional Training Hub) to share, develop and nurture career pathways for various occupational groups; the focus is currently on Registered Medical Officers. Improving the patient experience and streamlining patient flows require new ways of thinking and working. Initiatives to achieve better patient flows are being addressed by quality processes within NDHB and by the various clinical governance groups.

Staffing numbers

Graphic 20 Northland DHB staffing summary

Category	No. staff	FTEs	
		Number	% of total
Medical senior	154	128	10.7
Medical junior	84	84	
Nursing	1,195	857	45.4
Midwifery	75	39	
Allied health	550	453	22.9
Non-clinical support	84	68	3.4
Management & admin	443	345	17.5
Total	2,585	1,973	100.0

In March 2012 Northland DHB employed 2,585 staff, representing 1,973 full-time equivalents (FTEs) (Graphic 20). Overall FTEs have remained stable since last year when the total was 1,978. Since then there has been a slight increase medical and nursing staff, offset by a slight fall in management and administrative staff due to some now working under healthAlliance, the regional shared services agency.

Northland DHB does not hold staffing information on the NGO providers with whom we hold contracts. Analysis of staff by number and skill mix is an important component in meeting demands on health services and improving patient care.

Monitoring, planning and negotiation

Human Resources reports are generated monthly for General Managers and discussed at the Senior Management Group. They include analyses of leave (annual, sick and other), attendance at conferences and courses, Continuing Medical Education days and expenditure, staff turnover by occupational group, and measures of productivity per FTE (hours worked compared with sick leave, annual leave etc). They also include important updates regarding the status of industrial wage negotiations for local, regional and nationally-based bargaining rounds.

Various forums exist for engagement of staff and unions. The Bipartite Action Group (BAG), attended by major CTU affiliated unions, meets quarterly for management and unions to discuss matters of common interest. This forum has been given a more formal structure as a result of agreements made with CTU unions as part of the National Terms of Settlement in 2010. A Joint Consultative Committee meeting with the Association of Salaried Medical Specialists is also held quarterly. The Joint Action Committee with the NZ Nursing Organisation established in 2008 has taken on a different form as a result of the formation of the BAG and the Care Capacity Demand Management programme (CCDM). CCDM Operations Group and Steering Group are representative of staff, union, and management which have specific workstreams working with the Safe Staffing Health Workplace Unit. A joint committee with the PSA has been operational for the last 24 months, its primary function being to ensure consistency of application of the process for career and salary progression as provided in the DHBs/PSA Allied, Public Health and Technical MECA. A Local Resident Doctor Engagement Group has been formed as an outcome of the recent interest-based bargaining settlement with the NZRDA to cement and support the relationship between NDHB and its Resident Medical Officers.

Human Resources engages with healthAlliance and the Northern Region DHBs to explore opportunities for regional collaboration. Areas include policy development, common key performance indicators and a strong employment relations reference group.

The Human Resources Department runs a series of training modules for clinical and non-clinical managers to ensure their skills are updated on both practical and theoretical bases.

Northland DHB has held staff satisfaction surveys in the past, but in 2007 we adopted the Health Roundtable template that is increasingly being used by other DHBs, so benchmarking will be possible in the future. Feedback from the staff satisfaction survey in 2009 has assisted the DHB with workforce planning and healthy workplace initiatives, particularly with regard to standards of acceptable behaviour. The next staff satisfaction survey will take place during the third quarter of 2012.

Matching staff numbers and skill mixes takes place at operational and strategic levels. In nursing, for example, TrendCare is used to compare service demands on wards with the staffing mix, so the two can be matched as closely as possible. Northland DHB is a pilot site for Care Capacity Demand Management and is working closely with the Safe Staffing and Health Workplaces Unit. Northland DHB also contributes information to the Health Workforce Information Programme run by DHBSS which seeks to analyse and project current and future workforce needs.

Good Employer requirements

Northland DHB adheres to the good employer requirements in S118 of the Crown Entities Act 2004, which cover:

- good and safe working conditions
- an equal employment opportunities programme
- the impartial selection of suitably qualified persons for appointment
- recognition within the workforce of the aspirations and needs of Maori, other ethnic or minority groups, women and people with disabilities
- training and skill enhancement of employees.

Workforce development

Services identify and support potential leaders in various occupational groups to develop both technical and managerial skills, ensuring succession planning is facilitated. This is key for NDHB to attract and retain skills to provide high quality, fit-for-purpose care and services to meet both the current and future needs of the community in line with Government expectations.

To attract and grow our workforce to meet service needs, training and development initiatives include the opportunity to participate in management, leadership and clinical programmes nationally and internationally. Staff satisfaction and retention is enhanced as training is development and aligned to organisational compliance requirements, service needs and staff's own professional development. Implementation of e-learning is enabling greater access to learning, communication, knowledge transfer and skill development, ensuring best practice is implemented.

Innovative models of care will be required to meet future needs. Services are actively working with staff locally, regionally and nationally to plan for future workforce requirements both in the provider arm and primary sector.

The Care Capacity Demand Management programme will utilise tested robust processes to assist Northland DHB to determine more accurately the base workforce requirement across services (initially nursing and midwifery) based on predicted and actual demand and comprehensive work analysis.

Another HWNZ initiative is the Advanced Trainee Scheme (ATS). The ATS is a HWNZ scholarship that assists advanced medical trainees to train or study overseas in a shortage specialty area, and on completion of training guarantees them a job in New Zealand (to which they are bonded). Northland DHB is hosting three trainees in psychiatry, orthopaedics and ENT.

Northland DHB provides retention incentives to support career pathways for dental therapists and midwives. NDHB continues to coordinate and allocate HWNZ funding for postgraduate study for nursing and midwifery and the non-regulated workforce. In addition NDHB pursues "Grow our Own" staffing initiatives by providing additional Maori scholarships for staff and a Pihirau Hauora Maori Scholarship for students who whakapapa to Te Tai Tokerau hapu and Iwi. There is also a training fund for the non-regulated Maori health and disability workforce to build their capability and capacity.

NDHB's relationships with Auckland University, Auckland University of Technology and NorthTec (Northland's polytechnic) continue to provide future opportunities for doctors, nurses, midwives and allied health professionals to join the organisation.

Regional training hubs

During 2011 Health Workforce New Zealand (HWNZ) will be working nationally to achieve a more strategic and integrated approach to career planning. A major focus of this work will be the development of and support for the regional postgraduate training hubs. Four regional training hubs – Northern, Midland, Central and South Island – have been set up.

In 2011 the Northern Region Training Hub (NoRTH) was established to play a key role in improving the support provided to post graduate medical, nursing and allied health trainees. This role builds on the administratively focused function that had previously been undertaken regionally for RMOs by ARRMOS. NoRTH will work closely with HWNZ, the NoRTH Board, tertiary education providers and DHBs through the Northern Region Clinical Leaders Forum to agree its workplan and align with wider workforce planning work being undertaken regionally and nationally. Priority is therefore being placed on:

- strengthening existing RMO clinical and managerial oversight to include active participation from medical, nursing and allied health professions and all four DHBs
- leading the delivery of key elements of workforce training and development for professional groups with an initial focus being on RMOs (particularly second-year house officers) and specialist nursing and allied health roles
- aligning recruitment, workforce planning and development to support delivery of new models of care and delivery of the Northern Region Health Plan
- strengthening systems and processes to support placement and workforce development activity.

Regionally, Northland has participated in a series of planning meetings around the Northern Regional Training Hub, which has resulted in the development of a project plan for a "Transitional Years" project. The key objective of this project will be to produce regionally consistent standards and education for the transitional years (PGY1 and PGY2) within the four Northern DHBs. Northland DHB will have two representatives on the project team. It is envisaged that other projects, focussed on other professional groups (nursing and allied health) will be developed in future.

The regional training hubs will initially focus on the training needs of postgraduate medical training and will progressively include other workforces.

The project plans are expected to be in place by March and will build on existing relationships and align with regional health sector planning. HWNZ expect the hubs to be underway from mid 2011.

4.2.4 Clinical leadership

NRHP: Priority area within the Workforce Enabler.

Involving clinicians in planning and management discussions and decisions is essential to improving services. NDHB's clinicians form an integral part of our management structures and processes and are intimately involved in regional planning processes (NDHB staff involved in the various regional processes and workstreams are listed in an appendix to the NRHP). Clinical governance groups being establishing by NDHB to improve systems and quality of care involve clinicians from both NDHB and the NGO sector.

Senior clinicians within the organisation are offered regular training in leadership and management skills to ensure that their contribution to organisation is maximised.

4.2.5 Quality and safety

NRHP: Integral part of the Patient Experience Triple Aim.
One of the five key drivers for change.

Quality and safety are integral to the way Northland DHB works. Our emphasis on quality and safety aligns with the aims of the National Health Board's Quality and Safety Commission and with the Regional Health Plan's First Do No Harm priority under the Patient Experience Triple Aim.

NDHB has an annually reviewed Quality and Safety Framework which lays out the programme, principles, processes, structures, roles and relationships that underpin quality and safety. We also produce quarterly quality reports for the Board's Hospital Advisory Committee, the Patient Safety Committee and the Service Management Group.

Specific quality and safety structures and processes in the Northland DHB Provider include:

- a Patient Safety Committee to oversee the quality and safety framework and monitor activities related to it

- other committees to monitor clinical risks and support quality assurance and improvement activities, including Drugs and Therapeutics, Laboratory and Transfusion, Infection Control, Quality Facilitators, and Morbidity and Mortality committees
- monitoring and management of adverse events and errors
- monitoring and management of complaints
- clinical audit and research projects
- benchmarking, especially in conjunction with Health Roundtable
- projects dealing with medicine reconciliation, effective communication, central venous line bundles, pressure ulcer prevention, falls prevention and stroke management bundles
- use of the Global Trigger Tool to measure patient harm for inpatient services.

An electronic risk register system allows all parts of the organisation to record and manage risk. The most serious risks are reviewed monthly with senior clinical staff to ensure they are mitigated to acceptable levels.

Risks to the organisation exist in:
- managing acute demand
- after-hours services in rural communities
- recruitment and retention of skilled staff
- the quality of the physical facilities of NDHB
- the quality of information systems within NDHB.

These risks are regularly reviewed to ensure appropriate mitigating actions are in plaice to address them.

Northland DHB's existing quality and safety efforts focussed on the primary health care sector include:
- GP liaison positions established by the DHB to provide links with the primary care sector and work on matters of mutual interest
- strong clinical governance within PHOs
- accreditation of GP practices and other community health care providers
- a governance group for the Primary Options initiative
- NGO membership of NDHB's governance structures for long term conditions and child and youth health.

During 2012 there will be ongoing implementation of a regional patient safety campaign, "First Do No Harm". This will reinforce many of the patient safety initiatives already underway in Northland and there will be an alignment between the regional and local programmes. It is envisaged that the regional programme will allow Northland to utilise regional training, toolkits, outcome measures and other resources to speed and strengthen implementation of and learning from patient safety initiatives. The regional campaign will be cross-sectoral and there will be a focus on engagement of primary care and the aged care sectors in quality and safety initiatives.

In addition, further direction from the National Health Board's Quality Improvement Commission can be expected to drive some specific programmes. This will include the implementation of a standard national medication chart for adult inpatient medical and surgical services.

4.2.6 Collaboration

Northland DHB is but one part of the public sector which itself is part of a wider social system, and people and patients flow in complex ways through a multitude of agencies and structures. The DHB is only one of many ways in which people's behaviour is influenced, so we must work in concert with other agencies. Our principal relationships are described in the following table.

Level	Nature of relationship
National	Ministry of Health provides advice about policy and related matters, and NDHB responds when consulted while policy is being considered. National Health Board funds and monitors DHBs, manages the annual funding and planning round, and oversees regional planning and national services.
Regional	NDHB engages with the three Auckland DHBs to develop the Northern Region Health Plan, which includes numerous workstreams on clinical services, information services etc. On an operational basis, NDHB provider clinicians refer patients to tertiary (more specialised) services in Auckland. NDHB has a firm relationship with the Northern DHB Support Agency (NDSA), jointly funded by the four Northern Region DHBs to provide some shared services, including mental health planning for the region. healthAlliance, the new shared services organisation for the Northern Region DHBs, provides 'back-office' functions such as payroll, procurement and information services.
Local	All of NDHB's services link in some way to Northland's NGOs, including general practices and PHOs, the community lab, Maori

	health providers, mental health providers and aged-care providers and others. A key focus at the moment is on smoothing the pathways for patients between primary care and hospital (secondary) services. The NDHB Funder holds 234 contracts with 178 non-government organisation providers of health services. It employs several portfolio managers to negotiate the contracts, monitor and support the providers. The Funder has been developing 'alliancing' arrangements with Northland's two PHOs over (3.4 Primary care) and the PHOs' Chief Executives are now included in Northland DHB's Executive Leadership Team meetings. The Funder involves health sector agencies in various planning and clinical governance groups.
Intersectoral	Northland DHB is a member of the Northland Intersectoral Forum, a collaboration of public sector and territorial local authority agencies from throughout Northland. NDHB's population health services works with territorial local authorities and a variety of government agencies on compliance with public health legislation, training of non-health sector staff in public health skills and knowledge, and control of communicable disease.

4.2.7 NDHB facilities

NRHP: Strategic priority under the Triple Aim.

Stage 1a of the Whangarei Hospital Redevelopment, the inpatient mental health unit, is complete. The unit opened in October 2011 and was occupied in November.

Work has progressed on stage 1b, the Whangarei kitchen relocation, with a preliminary concept design completed.

Business cases are being developed for the Whangarei Hospital intermediate stages, Maternity, Laboratory Chronic and Complex Care.

The business case for stage 2, Emergency Department / Acute Assessment Unit, will be completed in 2012/13.

4.2.8 Management of assets

We monitor the condition and performance of our assets and formulate priorities for physical works using project planning, life cycle analysis and asset management for prioritising asset maintenance. With shared services, greater emphasis will be placed on asset management planning from a regional perspective alongside the Auckland DHBs.

4.3 NGO services

Northland DHB holds 234 contracts with 178 non-government organisation (NGO) providers of health services. NDHB employs four Portfolio Managers to negotiate and monitor these contracts.

Procurement activities with NGOs are best described as a cyclical process of investment, monitoring and then either reinvestment or disinvestment.

Investment

We use a combination of tools available nationally to assist with specific investment decisions. Recently we have reviewed and updated our internal Prioritisation Policy (2.7 Key risks and opportunities). This policy will in future guide all investment activity, not just for NGOs, but across NDHB services as well.

Once investment decisions have been made, contract negotiations with NGOs are completed by the Portfolio Managers. These negotiations include decisions regarding price (though the Ministry of Health may direct price increases for particular services).

Monitoring

All contracts awarded are monitored in order to analyse service utilisation and to facilitate future planning. Monitoring requirements are written into each contract's service specifications when it is awarded. Nationwide service specifications, jointly agreed between the Ministry and DHBs and utilised by NDHB, cover the majority of our expenditure. Contract monitoring comprises a large percentage of each Portfolio Manager's workload because the majority of it is completed on a quarterly basis.

NGO contracts are also audited on a cyclical basis to ensure that services delivered are of the appropriate quality.

Reinvestment and disinvestment

At NDHB all contracts are reviewed as they approach their end date for alignment with national, regional and/or local priorities. Northland DHB recognises that the best outcomes for our population are achieved by directing money to services which align with the health priorities of NDHB. The new Prioritisation Policy will assist in this regard.

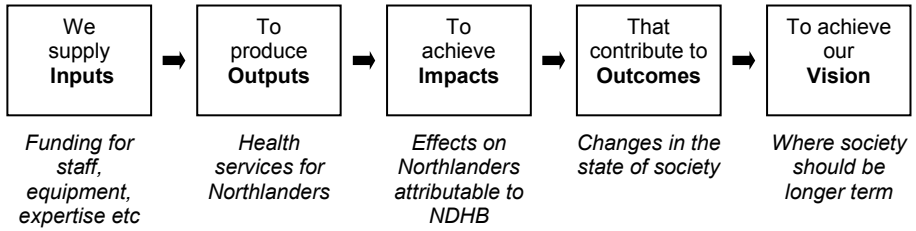
5 Statement of Forecast Service Performance

5.1 Intervention logic

5.1.1 Vision and High Level Outcomes

The core elements of Northland DHB's intervention logic are explained in Graphic 21.

Graphic 21 Northland DHB intervention logic



The highest levels are explained further in Graphic 22. To work towards our vision of creating a healthier Northland we will improve health status, improve equity, live within our means and build confidence and trust in the health system. These high level outcomes are consistent with the government's desire for the health sector to nurture citizens to live longer, healthier and more independent lives. As described in 2.5 Strategic alignment, they are also consistent with national direction from the Minister of Health and National Health Board, and with the Northern Region Health Plan.

The services Northland DHB funds and provides collectively contribute towards our high level outcomes.

Improved health status

This is achieved by encouraging healthier lifestyles, reducing risk factors such as smoking and weight gain, and promoting adoption of breastfeeding (services to achieve these are part of the Prevention Output Class, described further in the next section).

This includes primary care services that pick up on risk factors and identify symptoms of long term conditions such as diabetes, cardiovascular disease, addiction and depression as early as possible so they can be managed effectively (the Early Detection and Management Output Class). It also includes services that provide for early detection of depression and addictions.

Lifestyle control by people with long term conditions and active clinical management by health services is essential to minimise the effects of symptoms and delay disease progression as long as possible (achieved by both primary care services under the Early Detection and Management Output Class and hospital services under the Intensive Assessment and Treatment Output Class).

Managing the demands created by the increasing numbers of older people. This can be achieved by encouraging 'ageing in place' in the community and providing appropriate community supports for those with minor to moderate impairments and disabilities. If these work well, they will reduce and/or delay demands on residential care facilities (Intensive Assessment and Treatment Output Class; Rehabilitation and Support Output Class).

Managing long term conditions and the effects of an ageing population are key contributors to the Minister's aim of integrated services and better, sooner and more convenient services.

Improved equity

Reducing the gap in health status between Maori and non-Maori is a theme that runs through all the above activities. Generally, Maori experience higher rates of poor health, risky lifestyle behaviours, lower coverage by screening services, poorer access to primary care and hospital services, and they enter hospital services at a younger age. Reliable and comprehensive data by ethnicity from all services, providers and contracts is essential to monitor progress and improve service delivery. Improving cultural responsiveness is also necessary for services delivered to Maori.

Living within our means

DHBs that don't remain within budget face potential intervention from the Ministry of Health, so at a global level keeping the books balanced helps us retain control of our destiny. It is also a way of contributing to the government's aim of more effective and efficient public services.

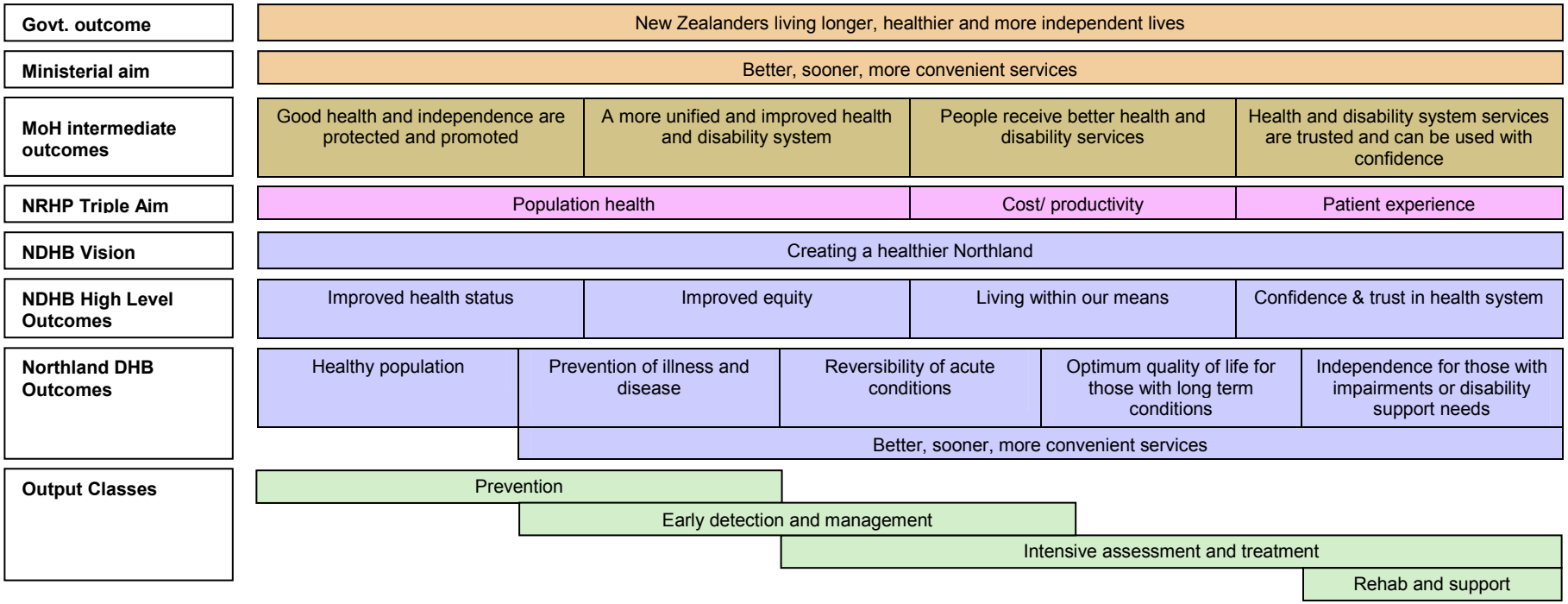
Living within our means is made easier if our population grows healthier and health services operate more effectively. We must also make continual improvements to productivity, enabling more services to be provided from the

health dollar. This is even more vital in the current constrained economic environment while demands from an expanding, aging and high needs population continue to grow.

Confidence and trust in the health system

Services should be available to people when and where they need them, and be trustworthy and of high quality; these are important contributors to the governmental aim of better, sooner and more convenient services. People also need complete and accurate information so that as service users they can make informed choices and their needs are managed better. Services, especially in hospitals, must be designed to minimise harmful consequences and side effects; "first do no harm" is one of the priorities of the Northern Regional Health Plan under the Triple Aim of Patient Experience. Effective clinical leadership is an essential contributor to this (4.2.4 Clinical leadership).

Graphic 22 Northland DHB's Intervention Logic with links to national priorities



5.1.2 Impacts, outputs and progress

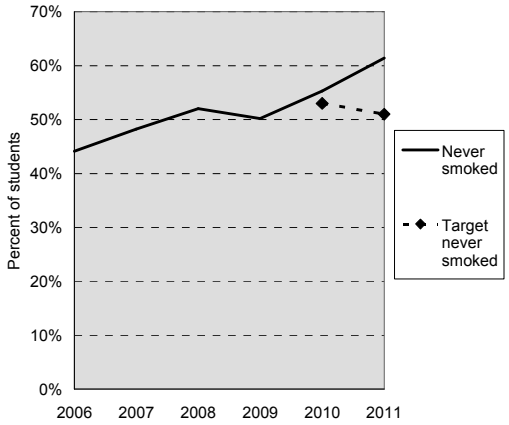
Having explained NDHB's intervention logic in relation to our High Level Outcomes in section 5.1.1, this section addresses Impacts and Outputs, the next steps down in the intervention logic hierarchy. Specifically, it describes why we have chosen this particular set of impacts, and how outputs – the services Northland DHB funds and provides – contribute to them. It also depicts trends over recent times to indicate the progress NDHB has been making.

It should also be possible to describe Northland DHB's progress by benchmarking against other DHBs, but, other than Health Targets and the Key Performance Indicator Framework for NZ Mental Health and Addiction Services, such data is not routinely available. Northland DHB is a member of the Health Roundtable in which member DHBs share information on performance and quality, but so far the tie-up between this data and the measures in the SOI is limited[14].

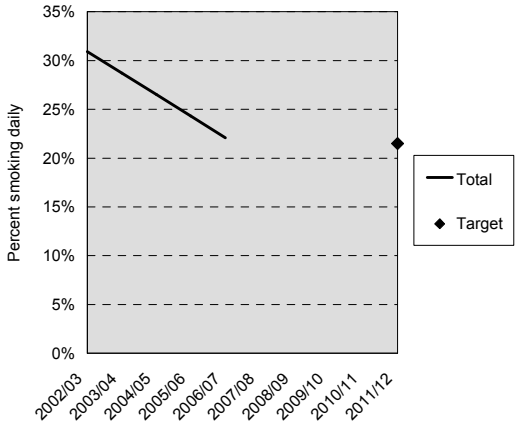
Impact	Impact measures	Rationale	Contribution made by Outputs
Tobacco: Lower prevalence of smoking-related conditions	Proportion of the Northland population who smoke daily. Proportion of Year 10 students who have never smoked. Proportion of smokers in primary care given advice and help to quit. Proportion of smokers admitted to hospital given advice and help to quit.	Smoking is one of the most significant lifestyle factors behind long term conditions. Smoking disproportionately affects Maori and other deprived populations. Smoking during pregnancy accounts for an estimated 20% of all pre-term births and 35% of low birthweight babies. Smoking rates are the focus of one of the six national Health Targets. Providing brief advice to smokers has been shown to increase the chance of smokers making a quit attempt. Brief advice works by triggering a quit attempt rather than by increasing the chances of success of a quit attempt. Research shows that it takes an average of 14 attempts before permanent non-smoking status is achieved, so the more quit attempts encouraged, the better. The chances of this quit attempt being successful are increased if nicotine replacement therapy or cessation support is also provided.	Services to reduce tobacco smoking focus on three key areas to reduce harm: • encouraging young people to never start (youth smoking rates continue to decline in Northland) • supporting adults who want to stop • supporting pregnant women who smoke because of the harm smoking does to the fetus.

[14] This refers to services in general, but mental health services do benchmark under the *Key performance indicator framework for New Zealand Mental Health and Addiction Services*.

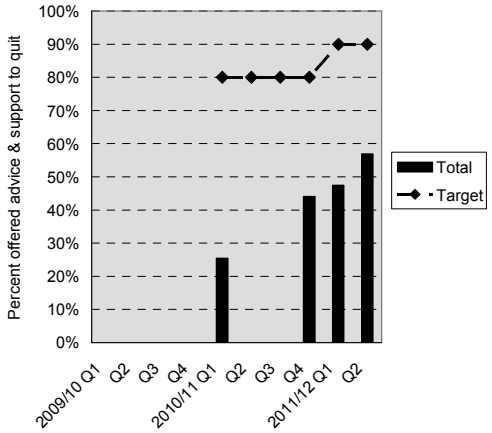
Northland Year 10 students who have never smoked[16]



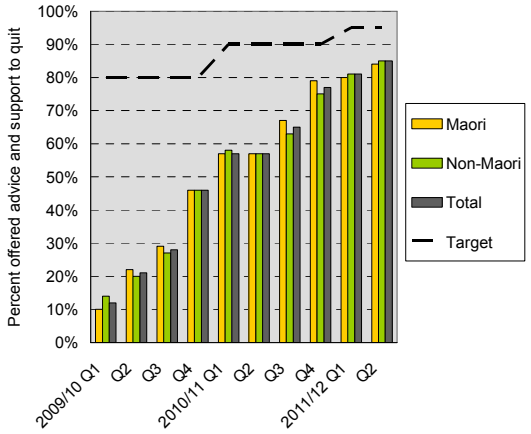
Northland population who smoke daily[15]



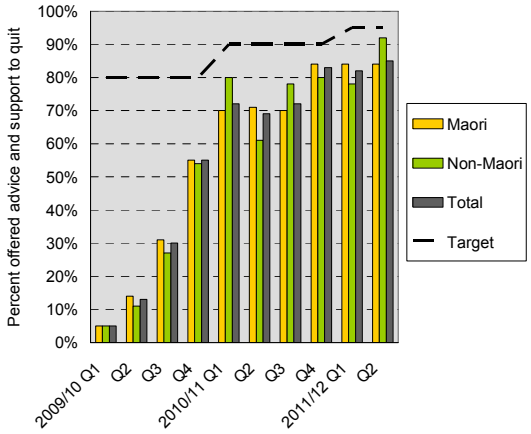
Smokers in primary care offered advice and support to quit[17]



Smokers in hospital offered advice and support to quit[18]



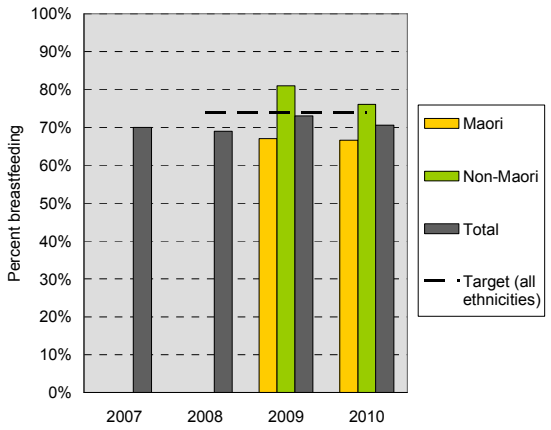
Smokers in maternity services offered advice and support to quit



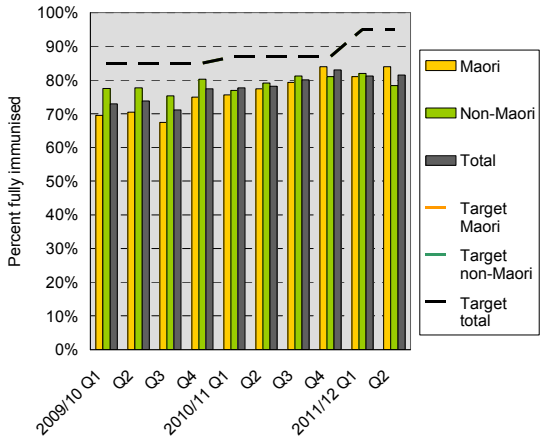
[15] Daily smokers is used rather than total smokers because the data source, the NZ Health Survey, did not report total smokers in 2002/03. Survey has been repeated in 2009/10, but data has not yet been released.
[16] 2010 results have not yet been released. NDHB target was introduced only in 2010/11.
[17] Reporting began only in 2010/11 Q1.
[18] Not reported by ethnicity until 2009/10 Q4.

Impact	Impact measures	Rationale	Contribution made by Outputs
Healthy children: Reduced likelihood of acquiring long term conditions later in life Lower incidence of communicable disease Healthier teeth and gums Safer children		Investing in the health of upcoming generations is an investment in the future health of Northlanders. A higher percentage of the child population is Maori, so improving child health will have a significant effect on improving the health of Maori.	NDHB has a Project Manager for child and youth health, who continues to support and develop the health sector to improve services.
	Mothers who breastfeed fully and exclusively at 6 weeks.	Higher rates of breastfeeding in infancy correlate with a lower chance later in life of developing health problems, including long term conditions. Breastfeeding rates are lower among Maori.	Mothers are provided with education and support to encourage them to breastfeed, whether they are supported by an NDHB midwife (hospital births) or an independent midwife (home and hospital births).
	% of eight-month-olds who are fully immunised.	Improved immunisation coverage leads directly to reduced rates of vaccine preventable (communicable) disease, and consequently better health and independence for children. This equates to longer and healthier lives. The changes required to reach the target immunisation coverage levels will lead to better health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. Immunisations (one of the six national Health Targets) are one of the most cost-effective ways of improving health.	NDHB works with primary care providers to continue to improve the rate and timeliness of full immunisation for two-year-olds.
	Referrals to CYFS of children suspected of being abused.	Every child has the right to live in a safe, nurturing environment free from abuse and neglect.	The Family Violence Service works to increase rates of identification and reporting throughout all NDHB's services but especially the Emergency Department, paediatric ward, the Special Care Baby Unit, the Child Health Centre and Maternity Services.
	Five-year-olds who are caries-free. Average number of decayed, missing or filled teeth in Year 8 students.	Oral health directly affects the state of health of the mouth, and the effects of tooth and gum disease can be lifelong. Significant rates of disease can also limit what children can eat, affect self-image and confidence, and create pain and discomfort. Northland has consistently had among the worst oral health statistics for children for many years.	A major restructure and expansion of NDHB's oral health services is now largely completed. It is increasing and improving treatment facilities and staffing numbers, and making significant improvements to service performance. This may mean however that oral health statistics will show a worsening in the short term as 'arrears" (previously unreached, higher need children) receive services, and better equipment detects more clinical problems than before. Northland remains unfluoridated after a brief foray into reticulated fluoridation in two Far North communities was abandoned in 2009. Northland will always struggle to reach the oral health status of DHBs with fluoridated water supplies.

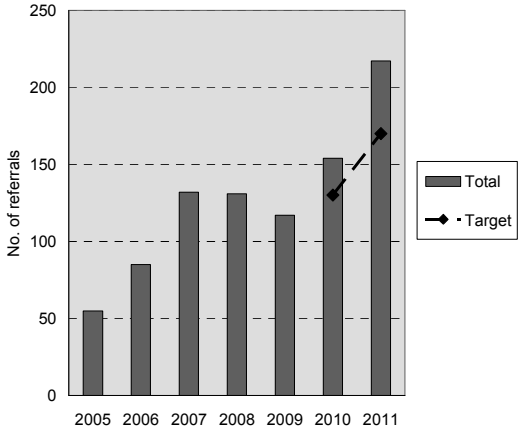
Mothers who breastfeed fully and exclusively at 6 weeks[20]



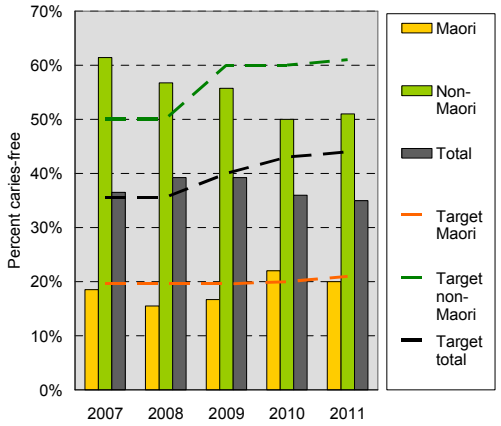
Children fully immunised by their second birthday[19]



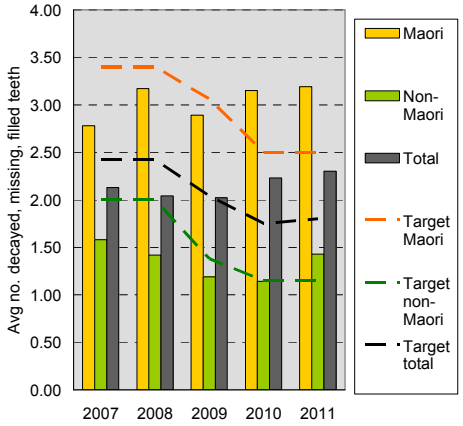
Number of referrals to CYFS by NDHB



Percent of 5-year-olds who are caries-free[21]



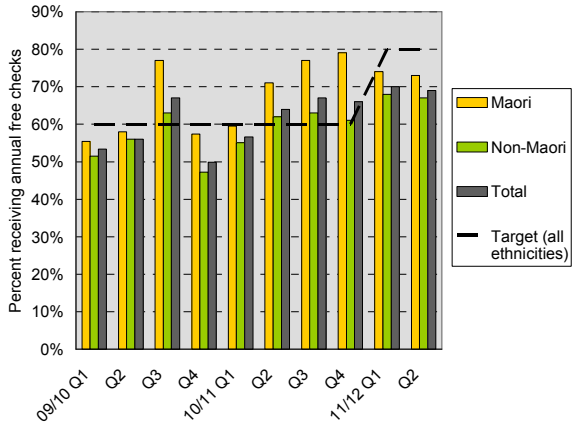
Average no. of DMF teeth in Year 8 students[22]



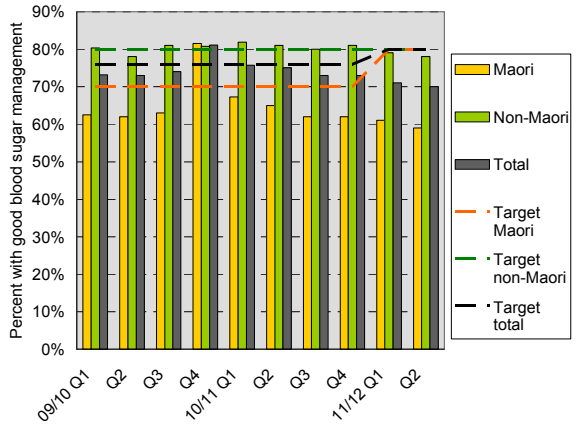
[19] Collected for the first time in 2009/10 Q1. Not reported by ethnicity until 2009/10 Q4.
[20] Indicator in 2007 was measured at 5 weeks. Reports by ethnicity not required before 2008/09.
[21] Data for 2010 will be reported in the Q3 reports (due in late April).
[22] Data for 2010 will be reported in the Q3 reports (due in late April).

Impact	Impact measures	Rationale	Contribution made by Outputs
Long term conditions: Amelioration of disease symptoms and/or delay in their onset	*Diabetes and CVD* Of those estimated to have diabetes, % who have had annual free checks. Of people with diabetes receiving annual free checks, % with good blood sugar management. Of people in eligible populations, those who have had a CVD risk assessment in the last 5 years.	Cancer, CVD and diabetes account for about three-quarters of deaths and are major causes of illness and restricted functioning. They are labelled as long term conditions (LTCs), because once diagnosed, people have them for the rest of their lives. Prevalence of LTCs increases with age, so action now is imperative in the face of the ageing population. Screening for diabetes and cardiovascular disease (CVD) is one of the six national Health Targets. More people need to receive checks earlier and the conditions they have should be managed appropriately and consistently. This will speed up the implementation of the Primary Health Care Strategy, be consistent with the Ministerial aim of better, sooner, more convenient services, and contribute to the governmental goal of New Zealanders living longer, healthier and more independent lives.	NDHB has a Programme Manager for LTCs and a Primary Care Development Manager who work with providers across the health sector to improve the detection and management of conditions. A three-pronged set of strategies is necessary: • preventing LTCs (see above under tobacco and breastfeeding) • screening to pick up conditions as early as possible (annual free checks for diabetes, risk assessments for cardiovascular disease, screening for breast and cervical cancer) • effectively managing conditions once they have developed through active partnerships between clinicians and patients.
	People diagnosed with cancer who receive radiation treatment within 4 weeks. People diagnosed with cancer who receive chemotherapy within 4 weeks. Breast cancer screening in eligible populations. Cervical cancer screening in eligible populations.	Cancer, CVD and diabetes account for about three-quarters of deaths and are major causes of illness and restricted functioning. They are labelled as long term conditions (LTCs) because once diagnosed, people have them for the rest of their lives. Prevalence of LTCs increases with age, so action now is imperative in the face of the aging population. Waiting times for both cancer radiation therapy and chemotherapy are one of the six national Health Targets.	For cancer, some of the biggest gains are to be made by ensuring early access to treatment to improve the chances of recovery or to alleviate symptoms. More timely access to radiation therapy and chemotherapy encourages public confidence and trust in the health system. It addresses the Ministerial priority of living within our means by ensuring resources are used effectively and efficiently. It also contributes to the governmental goal of New Zealanders living longer, healthier and more independent lives. Screening in the community to identify cancers as early as possible improves the chances of prevention or, if the condition already exists, recovery. The only two formal screening programmes that exist in New Zealand are for breast and cervical cancer.

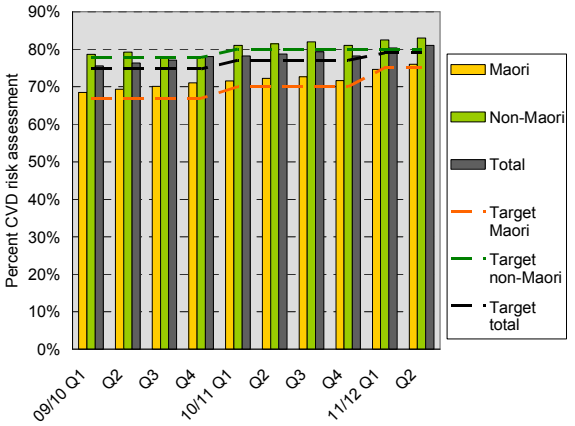
People estimated to have diabetes who have had annual free checks (AFCs)



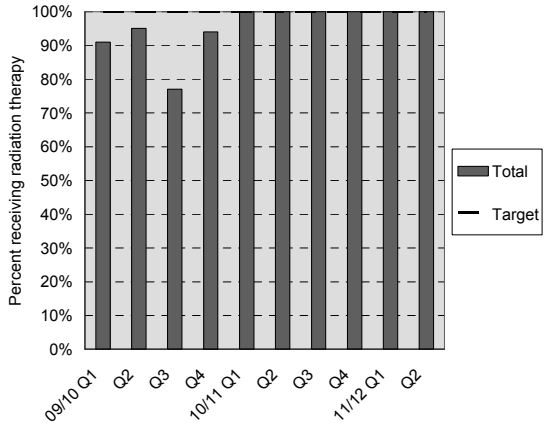
People with diabetes who have had AFCs who have good blood sugar management



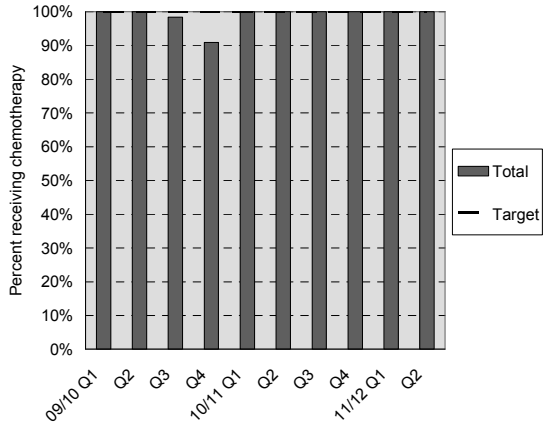
People in eligible populations[23] who have had a CVD risk assessment in the last 5 years



People diagnosed with cancer who receive radiation treatment within a specified period[24]

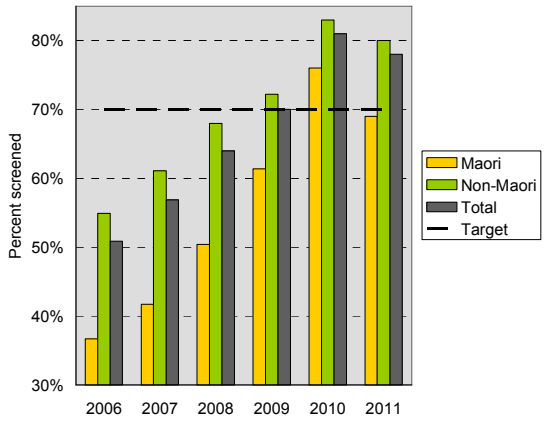


People diagnosed with cancer who receive chemotherapy within 6 weeks

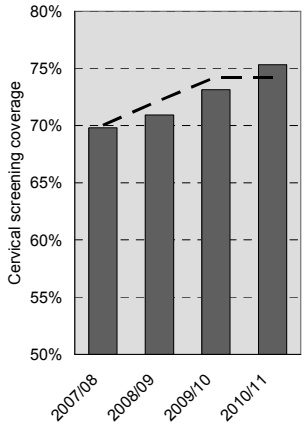


[23] Maori, Pacific, Indian: males aged 35-79, females aged 45-79. European & other: males aged 45-79, females aged 55-79.
[24] Six weeks until November 2010, four weeks from December 2010 onwards.

Breast cancer screening in eligible populations

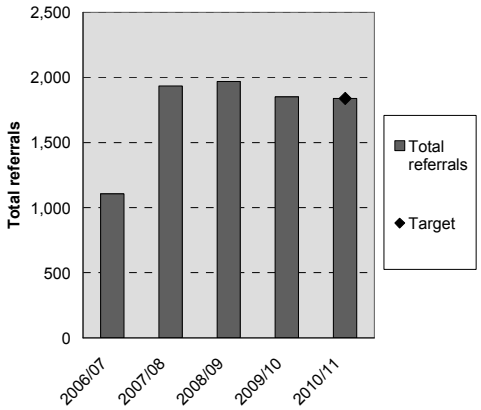


Cervical cancer screening in eligible populations

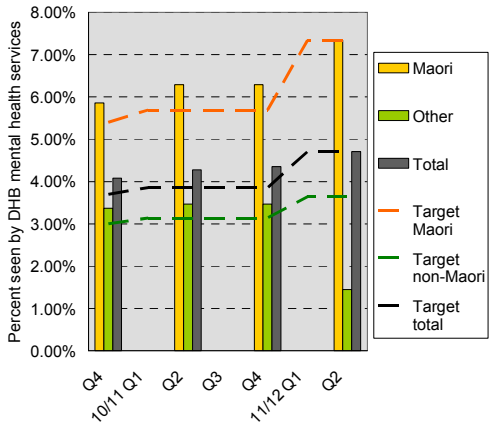


Impact	Impact measures	Rationale	Contribution made by Outputs
Mental disorders: Improved quality of life for both clients and their families Acute episodes are minimised, clients achieve greater stability in their condition	Number of referrals from GPs to Primary Mental Health Initiative Coordinators. Proportion of people with enduring mental illness aged 20-64 who are seen over a year.	Mental health has been a priority for the health sector since the Blueprint[25] was published in 1998. Severe disorders permanently affect 3% of the population. Mild to moderate disorders affect 20% of the population at any one time and 90% over a lifetime.	Severe mental disorders and addictions require support and treatment by the specialised clinical workforce employed by NDHB. Mild to moderate disorders can be dealt with largely by primary care services, with support from specialised clinical services if conditions become unstable. NDHB has implemented the Primary Mental Health Initiative since 2005, and continues to enhance the roles of specialised staff and support the primary care sector.

Number of referrals from GPs to Primary Mental Health Initiative Coordinators



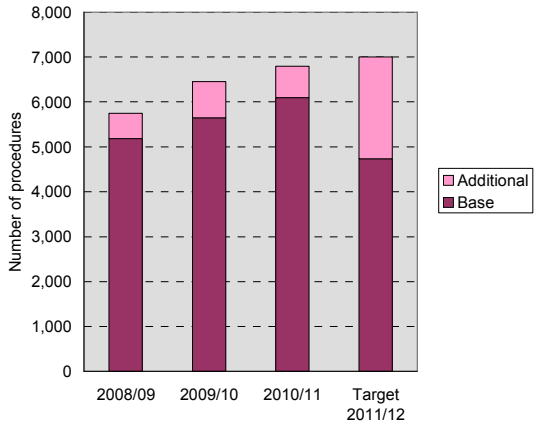
Proportion of people with enduring mental illness aged 20-64 who are seen over a year



[25] Mental Health Blueprint, the 1998 document that laid out proposed levels of services for the 3% of the population affected by severe mental disorders. Since then, funding and service provision have been gradually working towards achieving these levels.

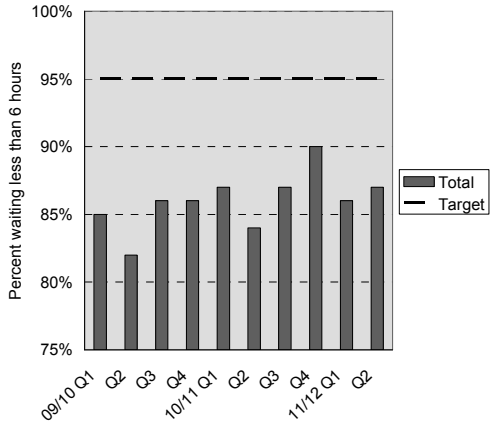
Impact	Impact measures	Rationale	Contribution made by Outputs
Elective surgery: Fewer debilitating conditions Delayed onset of long term conditions	Increase in the number of elective service discharges.	Elective surgery is an effective way of increasing people's functioning because it remedies or improves disabling conditions. Elective services are an important part of the health care system for the treatment, diagnosis and management of health problems. Increasing elective surgery by at least of 4,000 discharges nationally each year will result in better access to health and disability services for New Zealanders. Timely access to elective services is considered a measure of the effectiveness of the health system. Increasing delivery will improve access and reducing waiting times will increase public confidence that the health system will meet their needs. One of the six national Health Targets. An important contributor to the Minister's "better, sooner, more convenient" requirement.	About 80% of elective operations are provided by Whangarei Hospital, and most of the rest by tertiary service providers, mainly Auckland DHB. Between 2008/09 and 2010/11, when the Northland population increased by about 1.5%, the number of elective operations under the Health Target increased by 18%. Hospital services traditionally give the greatest priority to those with the most acute and urgent needs, so NDHB has been making a concerted effort to consciously direct resources towards elective surgery.

Number of additional elective procedures provided



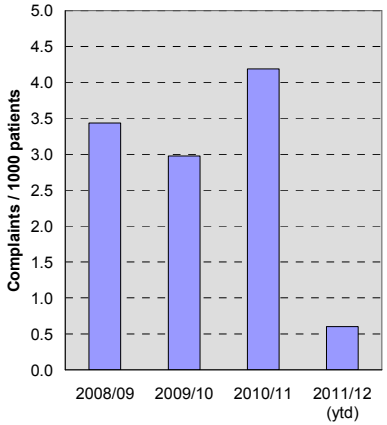
Impact	Impact measures	Rationale	Contribution made by Outputs
ED waiting times: More timely assessment, referral and treatment	Patients with an ED length of stay (time from presentation to admission, discharge or transfer) of less than 6 hours.	The purpose of emergency departments (EDs) is to provide urgent care, so by definition timeliness is important. Long times spent in waiting and receiving treatment in EDs are linked to overcrowding of the ED, compromised standards of privacy and dignity for patients, and poorer clinical outcomes (such as increased mortality and longer lengths of stay for people who are transferred into hospital as inpatients). Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services. It also addresses the Ministerial priority of living within our means by ensuring resources are used effectively and efficiently. One of the six national Health Targets.	Emergency services provided by EDs at Whangarei Hospital, NDHB's most specialised ED, as well as satellite services at the other three hospitals in Kaitaia, Kawakawa and Dargaville.

Patients with an ED length of stay of less than 6 hours

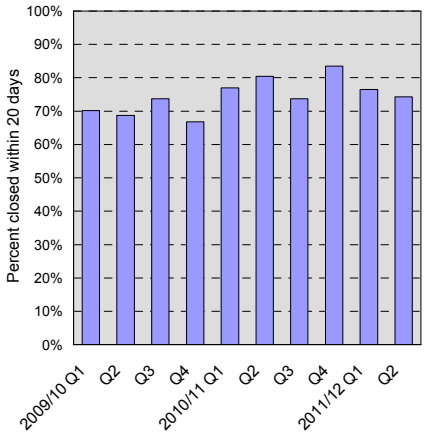


Impact	Impact measures	Rationale	Contribution made by Outputs
Quality and safety: More satisfied patients/ clients Fewer adverse clinical events	Number of complaints to NDHB per patient contact. Complaints to NDHB closed within 20 working days. HDC complaints that result in a finding of breach of the Code. Surgical site infections. Hand hygiene compliance.	Quality systems enhance the nature of care experienced by patients. They also reduce risks, cut down errors, smooth flows between services, improve staff morale and minimise resource wastage, so they are an important contributor to productivity and efficiency.	Space does not permit a full explanation here; Northland DHB's quality systems and the contribution they make are explained in more detail in 4.2.5 Quality and safety.

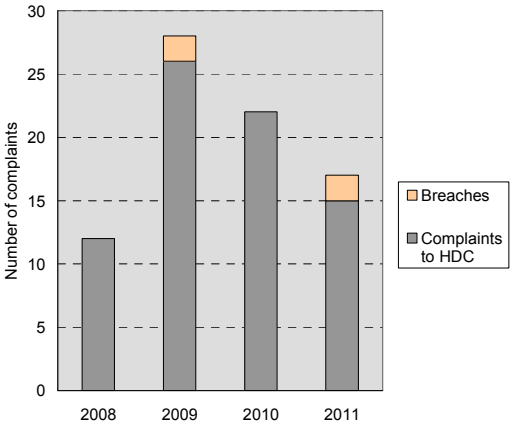
Number of complaints to NDHB per patient contact[26]



Complaints to NDHB closed within 20 working days

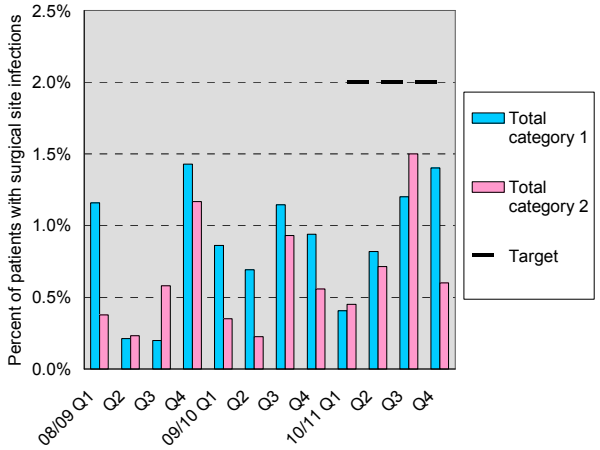


HDC complaints that result in a finding of breach of the Code

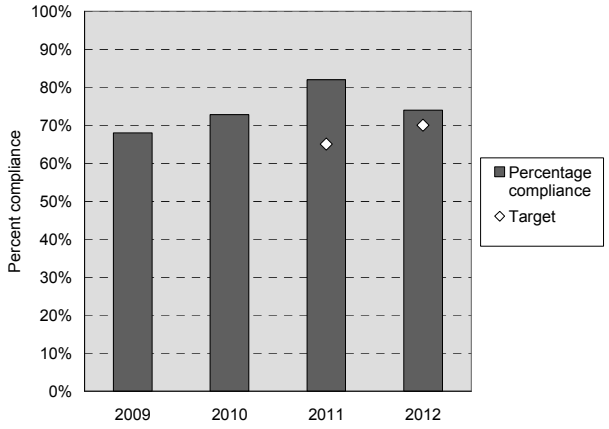


[26] Total patient / client contacts used for the 2011/12 calculation now includes visits by community services staffed by a range of health professionals. This means it is not directly comparable with the old hospital-only figure, but it is a fairer reflection of the total volume of services NDHB provides.

Surgical site infections[27]



Hand hygiene compliance[28]

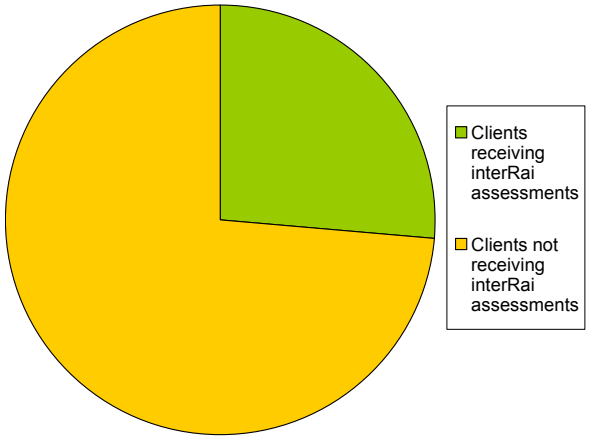


[27] Target was introduced only in 2010/11. Category 1 is "clean" surgery, typically elective surgery on a non-contaminated, non traumatic and non-inflamed site. Category 2 is "clean or contaminated" surgery in which there is a higher risk of acquiring infection because of the nature of the operation site (especially when it concerns the respiratory, gastro-intestinal or genito-urinary systems).

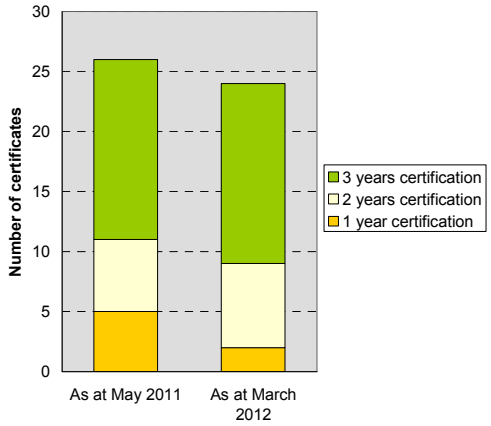
[28] Target did not exist until 2010/11.

Impact	Impact measures	Rationale	Contribution made by Outputs
Services for older people Older people requiring support or care receive services appropriate to their needs	Rising % of home based support services clients are assessed using the interRai tool.	The increasing number of older people, along with their higher level of acuity, is placing increasing pressure on budgets for home based support services and residential care. Home based support services are coming under growing pressure because there is an increasing number of older people receiving them (currently approximately 12% of Northland's over 65 population). This growth will be sustainable only if we allocate resources to those who really need them, as determined by appropriate assessment tools.	To improve the quality and consistency of needs assessments Northland DHB's Needs Assessment and Service Coordination service will implement the interRAI Minimum Data Set Home Care (MDS-HC) and Contact Assessment (CA).
	Decreasing percentage of high- and medium-risk corrective actions arising from certification.	The period of certification for aged residential care providers reflects their risk level – the fewer the number of risks identified during audits, the longer the period of certification. DHB aged care contract and MoH certification audit processes have been conducted through a single audit only since August 2010. DHBs concentrate on working with providers on corrective action plans to address any matters identified though the audits, monitoring progress against the agreed corrective action plans, and managing risks that may arise.	Certification reduces potential risks to residents by ensuring providers comply with the Health and Disability Services Standards.
	Number of respite care bed days utilised.	In January 2010 the Government committed funding targeted at dedicated residential respite beds for older people, which NDHB invested into four dedicated beds in the Far North. Monitoring to date has identified that the increase in actual bed day occupancy was less than expected. Reasons for this include the Far North's lower population numbers, and high turnover of clients on the managed respite programme. NDHB will review our respite care plan to show how we intend to fully utilise the funding and will provide specific target volumes. The current distribution of dedicated beds will be reviewed to reflect population need.	Respite care increases the level of planned access to 'time out' services for older people being cared for in the community. This improves the health and wellbeing of informal carers and enables older people to stay at home longer, thus delaying entry to long-term residential care.

Percentage of home based support services clients receiving interRai assessments[29]



Percentage of ARRC facilities by length of certification arising from the integrated audit process[30]



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[29] Northland DHB is currently rolling out interRAI Home Care and Contract Assessments across Northland as part of the national interRAI Implementation project. 2011/12 the first year for which reliable data exists for this measure.

[30] Essentially the same as 20111, since there is now one less provider and another now has only one certificate whereas before they needed two..

5.1.3 Output Classes

Nationwide, DHBs structure all their services into four Output Classes, each of which has several Suboutput Classes. A table at the start of section 5 (Graphic 22 Northland DHB's Intervention Logic with links to national priorities) indicates how these groups of services relate to different levels of health need. Section 1 (Graphic 13 Types of service by Output Class and type of provider) provides a more detailed description of types of service by Output Class and type of provider.

Prevention Output Class

Includes:

- health promotion to prevent illness
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases
- population health protection services (immunisation, screening etc)
- well child services.

Preventive services are publicly funded services that address health in the whole population or identifiable sub-populations. They are distinct from treatment services (the other three Output Classes) which address health and disability dysfunction.

Preventive services affect individual behaviours by addressing population-wide physical, social and political environments that influence health and wellbeing.

Early Detection and Management Output Class

Includes:

- primary health care
- oral health
- primary community care programmes
- pharmacy services
- community referred testing and diagnostics (laboratory services)
- primary mental health services.

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. They include general practice, community and Maori health services, pharmaceutical services, child and adolescent oral health services and primary mental health services.

These services are typically more generalist, usually available from multiple health providers and from a number of different locations within a DHB's district.

Intensive Assessment and Treatment Output Class

Includes:

- ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- inpatient services (both acute and elective) including diagnostic, therapeutic and rehabilitative services
- emergency department services including triage, diagnostic and therapeutic services
- secondary mental health services
- secondary maternity services
- assessment treatment and rehabilitation.

Intensive assessment and treatment services are publicly funded, and delivered by a range of secondary, tertiary and quaternary providers (defined in Graphic 13 Types of service by Output Class and type of provider). The bulk of them are located on or based at hospital sites and use specialist clinical expertise and equipment.

Rehabilitation and Support Output Class

Includes:

- needs assessment and service coordination (NASC)
- palliative care
- rehabilitation
- age related residential care beds
- home based support
- respite care
- day services
- life long disability services.

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC services.

5.1.4 Coverage of Sub-Output Classes

NDHB believes that the set of measures in sections 5.2 to 5.5 offer a fair representation of the breadth of services we fund and provide. They encompass all the Ministerial priorities and local priorities (Module 3) and the major health issues of the Northern Region Health Plan.

We have deliberately not tried to cover all 23 of the Sub-Output Classes. While together they represent the totality of funded and provided services, some merit more attention because they cover a more significant proportion of our services and resources, and they are affected more by current health needs and priorities (particularly long term conditions). We were also conscious of the need to keep the number of indicators to a manageable level.

5.1.5 Appropriateness of impact measures

Impact measures describe effects on the people we serve (patients, clients, populations in the community) while output measures describe the type and amount of service provided. For some impact measures we have been forced to use output measures as proxies, because current data systems do not provide proper impact data.

Three examples will help to illustrate the point.

> The impact of elective operations should be that patient functioning is improved. While this is assessed by surgeons during follow-up outpatient appointments, no hard data is collected, nor is there a tool to formally measure functioning.
>
> For immunisations, the impact measure should be the occurrence of communicable diseases in the community, but there is currently no comprehensive and accurate data on this. It would require an information system coordinated across all health services and providers (still some time away), but even that would not capture people who become ill and recover at home without ever making contact with a health service. Immunisation rates are therefore used as a proxy.
>
> For cancer treatments, a certain amount of time must elapse before clinicians can be reasonably certain the cancer will not recur. Five-year survival rates are typically used, and the proportion of people expected to survive varies according to the type of cancer. Obviously such 'proper' impact measures are inappropriate for a plan with a one (or at most three) year horizon.

This issue will be common to all DHBs, and solutions mostly lie in national or regional developments. Part of the solution may lie in including in the SFSP global impact measures for DHBs services, though there is as yet no universal agreement on what these should be.

Impact measures are labelled by type within the following tables. This year's SFSP has a total of 31, of which 6 describe quantity, 7 quality, 16 coverage and 2 timeliness.

5.1.6 Output measures

Some impact data actually measures outputs, so it hasn't been repeated in the outputs column.

The 2011 Audit NZ Management Report suggested the SOI would be improved by the inclusion of output targets. This has not been addressed as this is not how NDHB normally operates and the benefits of using this approach are unclear.

5.1.7 Improvements to measures

NDHB needs to do more work on defining our high level outcome measures. We have begun to address this under the Northland Health Services Plan, whose outcomes framework includes high level measures for life expectancy, unplanned hospital admissions, patient recommendations on services provided. These have now been included in the SFSP, though we have not yet set performance measures for all of them.

Benchmarking against other DHBs has also not been addressed. As noted in the introduction to 5.1.2, benchmarking data is not easy to come by. Neither have we addressed the Audit NZ suggestion of international comparisons because this is fraught with issues around comparability of data from different health systems. If this is to be addressed at all, a national level approach would make the most sense.

5.2 Output Class: Prevention

OUTPUTS				IMPACTS							OUTCOMES
We will undertake these activities	**And ensure these outputs are delivered**	**Belonging to Suboutput Class**	**Output measures**	**To lead to these impacts**	**Impact measures**						**To achieve this outcome**
					Description	**Categories**	**Baseline**	**Target**			
								2012/13	**2013/14**	**2014/15**	
Increase number of schools participating in Action on Smoking and Health Year 10 survey Target schools with high Maori enrolments Implement smokefree school project plan and pilot smokefree schools toolkit Implement brief intervention training and quit support Regulatory enforcement on tobacco sales to minors	Health promotion programmes in schools through Smokefree/ Auahi Kore	Health promotion and education	Number of health smoking promotion programmes in schools: 30 (2011 CY). Total students advised about stopping smoking: 400 (2011 CY).	*Tobacco:* lower prevalence of smoking-related conditions.	Proportion of Year 10 students who have never smoked. *[COVERAGE]*	Total population	61.4% (2011 ASH Y10 survey)	65%	70%	75%	Healthy population
Identify populations with lower rates of breastfeeding Support midwives to encourage breastfeeding	Midwifery services by independent practitioners and hospital midwives Support by lactation consultants.	Health promotion and education	Support provided to mothers to breastfeed. Hospital annual births 2,060 2011 CY. Lactation consultant patient contacts 2011 (6 mth extrapolation) 2,552 first contact, 2,250 follow up.	*Healthy children:* reduced likelihood of acquiring long term conditions later in life.	Northland mothers who breastfeed fully and exclusively at 6 weeks. *[COVERAGE]*	Maori Total	68% 72% (2010/11 Plunket data)	78% 78%	79% 79%	80% 80%	Healthy population

OUTPUTS				IMPACTS						OUTCOMES
We will undertake these activities	**And ensure these outputs are delivered**	**Belonging to Suboutput Class**	**Output measures**	**To lead to these impacts**	**Impact measures**					**To achieve this outcome**
					Description	**Categories**	**Baseline**	**Target**		
								2012/13	**2013/14**	**2014/15**	
Coordinate the activities of immunisation providers through the Immunisation Steering Group Actively support providers via the Regional NIR Coordinator	Primary care services performing immunisations.	Immunis-ations	1,758 children immunised before 8 months, 2011 CY[31].	*Healthy children:* lower incidence of communicable disease.[32]	% of eight-month-olds who are fully immunised. *[COVERAGE]*	Maori Total	N/a (see footnote 30)	85% 85%	90% 90%	95% 95%	Healthy population
Cancer groups and pathways	Cancer risk assessments in primary care. Screening for breast and cervical cancers.	Community referred testing and diagnostics	Breast cancer screening in eligible populations. 10,155 Northland women screened 2010/11, including 2,018 Maori, 8,047 non-Maori.	*Cancer:* if curable, increased likelihood of survival; if incurable, reduced severity of symptoms.	Breast cancer screening in eligible populations.[33] *[COVERAGE]*	Maori Total	73.6% 75.4% (2009/10-2010/11)	[34]70% 70%	70% 70%	70% 70%	Prevention of illness and disease Optimum quality of life for those with long term conditions
			Cervical cancer screening in eligible populations (= IM). 30,425 eligible women screened June 2008-June 2011.		Cervical cancer screening in eligible populations. *[COVERAGE]*	Total	75.3% (women smeared June 2008 - June 2011)[35]	80%	80%	80%	

[31] No data available on the new 8-month target because it applies only from Jul 2012, while all reporting up until June 2012 will be in relation to the old 2-year-old target.
[32] A better impact measure would be the incidence of communicable disease in the population, but this data is not readily available.
[33] The targets apply over two years, since that is the frequency with which women in the target age group should be screened. The achievement for targets may be variable yearly but meet the 2 year target of 70% set by the National Screening Unit.
[34] NDHB's target has been set at 70% because that is the national target set by the National Screening Unit, though we try to aim slightly higher than that to improve our chances of achieving it.
[35] Data covers three years because this is the recommended frequency for cervical cancer screening.

5.3 Output Class: Early Detection and Management

OUTPUTS				IMPACTS						OUTCOMES
We will undertake these activities	**And ensure these outputs are delivered**	**Belonging to Suboutput Class**	**Output measures**	**To lead to these impacts**	**Impact measures**					**To achieve this outcome**
					Description	**Categories**	**Baseline**	**Target**		
								2012/13	**2013/14**	**2014/15**	
Implement the Tupeka Kore (Smokefree) Plan ↑ funding for smoking cessation programmes, including Advice, Brief intervention, Cessation (ABC). Support Quit Card providers	Advice and help offered to smokers in primary care to quit.	Primary health care	75,354 smokers recorded in primary care. 23,601 current smoker recorded. 3,960 offered brief advice. 1,545 offered cessation support. 698 quit providers (individuals) registered as at March 2012.	*Tobacco:* lower prevalence of smoking-related conditions.	Proportion of the Northland population who smoke daily. *[COVERAGE]*	Maori	47.8 (2006/07 NZ Health Survey)	46.8%	45.8%	44.8%	Prevention of illness and disease
					Proportion of smokers in primary care provided with advice and help to quit.[36] *[COVERAGE]*	Total population	57.0% (PHO Perf. Programme Q2 2011/12)	95%	95%	95%	
Expand oral health services throughout Northland using the "hub and spoke" model of service delivery Target services to areas and populations with high needs Provide health promotion services to encourage good oral health	Oral health assessment and treatment.	Oral health	Enrolled in DHB-funded oral health services: 6,440 preschool, 17,123 primary school children, 8,341 adolescents.	*Healthy children:* healthier teeth and gums.	Five-year-olds who are caries-free. *[QUANTITY]*	Maori Total	20% 35% (2011 CY)	55% 55%	57% 57%	59% 59%	Prevention of illness and disease
					Average number of decayed, missing or filled teeth among Year 8 students. *[QUANTITY]*	Maori Total	3.19% 2.30% (2011 CY)	1.12 1.12	1.10 1.10	1.08 1.08	
Oversee the Local Diabetes Team contract to plan and coordinate services Establish a Northland-wide Clinical Governance framework	Risk assessments in primary care (annual free checks, blood tests, risk profiles). Laboratory tests.	Primary health care Community referred testing and diagnostics	4,989 diabetes annual reviews performed in primary care Apr 2010-Mar2011. 3,637 diabetics with good blood sugar management Apr		Of those estimated to have diabetes, % who have had annual free checks. *[COVERAGE]*	Maori Total	73% 69% (2011/12 Q2)	80% 80%	82% 82%	84% 84%	Optimum quality of life for those with long term conditions
					Of people with diabetes receiving annual free checks,	Maori Total	59% 70% (2011/12	80% 80%	82% 82%	84% 84%	

[36] A better impact measure would be the proportion of smokers trying to quit, but this was not included when the Health Target was set up. The output measure is being used as a proxy in the interim.

OUTPUTS				IMPACTS						OUTCOMES
We will undertake these activities	**And ensure these outputs are delivered**	**Belonging to Suboutput Class**	**Output measures**	**To lead to these impacts**	**Impact measures**					**To achieve this outcome**
					Description	**Categories**	**Baseline**	**Target**		
								2012/13	**2013/14**	**2014/15**
			2010-Mar2011. 6,419 CVD risk assessments performed in primary care.		% with good blood sugar management. *[COVERAGE]*		Q2)			
					Of people in eligible populations, those who have had a CVD risk assessment in the last 5 years.[37] *[COVERAGE]*	Maori: Total	53% 54% (2011/12 Q3)	70% 70%	90% 90%	90% 90%
Fund PHOs to provide services for people with mild to moderate mental disorders	Care provided in a primary care setting for people with mild to moderate disorders whose condition is stable.	Primary health care	Number of referrals from GPs to Primary Mental Health Initiative Coordinators: 2008/09 1,968 2009/10 1,852 2010/11 [38]1,838	*Mental disorders:* improved quality of life for both clients and their families; acute episodes are minimised, clients achieve greater stability in their condition.	Number of referrals from GPs to Primary Mental Health Initiative Coordinators.[39] *[QUANTITY]*	Total	1,838 2010/11	1,838	1,838	1,838	Reversal of acute conditions

[37] Up until Q2 2011/12, performance on CVD risk assessments was calculated using a proxy measure (certain lab tests for heart conditions). From Q3 2011/12, the measure was changed so that it recorded actual risk assessments completed, so the performance percentages above will not compare with those in former SOIs.

[38] The number dropped from 2009/10 because a clearer referral process used by GPs enabled the service to target people in higher need, whose care naturally needed more time and resources.

[39] Used as a proxy impact measure in lieu of readily available data on the state of health of people with mild to moderate mental conditions who attend primary health care. No increases are planned in the number of people treated because the funding is now capped.

5.4 Output Class: Intensive Assessment and Treatment

OUTPUTS				IMPACTS						OUTCOMES
We will undertake these activities	**And ensure these outputs are delivered**	**Belonging to Suboutput Class**	**Output measures**	**To lead to these impacts**	**Impact measures**					**To achieve this outcome**
					Description	**Categories**	**Baseline**	**Target**		
								2012/13	**2013/14**	**2014/15**	
Services to support smokers in hospital Targeted smoking cessation services for pregnant women	Advice and help given to smokers in hospital to quit.	Acute services	6,115 smokers admitted to NDHB hospitals 2010/11. 4,815 offered advice and help to quit.	*Tobacco:* lower prevalence of smoking-related conditions.	Proportion of the population who smoke daily. *[COVERAGE]*	Maori	47.8 (2006/07 NZ Health Survey)	46.8%	45.8%	44.8%	Healthy population Prevention of illness and disease
					Percent of smokers admitted to hospital given advice and help to quit.[40] *[COVERAGE]*	Maori Total	84% 84% (2011/12 Q2)	95% 95%	95% 95%	95% 95%	
Provide a Child Protection Service Maintain close links with CYFS and Police	Identification of at-risk children through appropriate screening	Acute services	217 referrals to CYFS of children suspected of being abused (=IM) in 2011 CY.	*Healthy children:* safer children	Referrals to CYFS of children suspected of being abused.[41] *[QUANTITY]*	Total population	217 (CY 2011)	225	235	245	Prevention of illness and disease
Provide emergency department, inpatient and outpatient services for people with acute needs Fund Auckland DHB for those who need tertiary care Maintain and improve links with primary care and palliative care	Provision of adult cancer therapies	Acute services	284 radiation therapy treatments for new Northland patients in Auckland Hospital 2010/11.	*Cancer:* if curable, increased likelihood of survival; if incurable, reduced severity of symptoms.[42]	People diagnosed with cancer who receive radiation treatment within 4 weeks. *[TIMELINESS]*	Maori Total	100% 100% (2011/12 Q2)	100% 100%	100% 100%	100% 100%	Optimum quality of life for those with long term conditions
			Chemotherapy treatments for Northland patients in 2010/11: 673 Auckland Hospital, 1,731 Whangarei Hospital.		People diagnosed with cancer who receive chemotherapy within 4 weeks. *[TIMELINESS]*	Maori Total	100% 100% (2011/12 Q2)	100% 100%	100% 100%	100% 100%	
Provide community mental health services Ensure people with	Specialised clinical support by NDHB community mental health services.	Mental health	Number of contacts by community mental health services with people who have	*Mental disorders:* improved quality of life for both clients and their families;	Proportion of people with enduring mental illness aged 20-64	Maori Total	7.34% 4.71% (2011/12 Q2)	7.34% 4.71%	7.34% 4.71%	7.34% 4.71%	Independence for those with impairments or disability

[40] A better impact measure would be the proportion of smokers trying to quit, but this was not included when the Health Target was set up. The output measure is being used as a proxy in the interim.
[41] This repeats the output measure because referral to CYFS is the extent of the impact health services can have on suspected victims of abuse.
[42] A better impact measure would be: for breast cancer, cervical cancer and major cancers: new cases, survival rates and deaths. Data systems are not yet set up to generate this information promptly enough for timely monitoring, so the output measures are being used as proxies in the interim.

OUTPUTS				IMPACTS						OUTCOMES
We will undertake these activities	**And ensure these outputs are delivered**	**Belonging to Suboutput Class**	**Output measures**	**To lead to these impacts**	**Impact measures**					**To achieve this outcome**
					Description	**Categories**	**Baseline**	**Target**		
								2012/13	**2013/14**	**2014/15**	
enduring mental conditions have appropriate support in the community Provide inpatient care when people experience acute phases	Admission to hospital for those whose condition is unstable.		enduring mental illness[43]: Direct 85,000 Care coord'n 42,000 (2011/12 extrap. from 9 months data)	acute episodes are minimised, clients achieve greater stability in their condition.	who are seen over a year. *[COVERAGE]*						support needs Optimum quality of life for those with long term conditions
Provide elective surgical services Fund Auckland DHB for those who need tertiary care	Elective surgical procedures.	Elective services	Number of elective procedures (no standard number or pattern because it is negotiated each year with MoH).	*Elective surgery:* fewer debilitating conditions; delayed onset of long term conditions.	Increase in the number of elective services discharges *[QUANTITY]*	Base Additional Total	4,734 2,264 6,998 (2011/12 forecast)	4,821 1,613 6,434	4,888 1,635 [44]6,523	4,955 1,658 6,613	Reversal of acute conditions Better, sooner, more convenient services
Provide emergency department services in all four NDHB hospitals	Assessments, treatments and referrals performed in EDs.	Acute services	Emergency department attendances: 2009/10 40,072 2010/11 40,956 (10 months extrapolated)	*ED waiting times:* more timely assessment, referral and treatment.	Patients with an ED length of stay (time from presentation to admission, discharge or transfer) of less than 6 hours. *[QUALITY]*	Total	87% 2011/12 Q2	95%	95%	95%	Reversal of acute conditions Optimum quality of life for those with long term conditions Better, sooner, more convenient services
Operate the Quality Resource Unit	Leadership advice and monitoring by the Chief Medical Advisor and Quality Resource Unit	Acute services Elective services	Total inpt + daypt + outpt events: 2010/11 [45]502,250	*Quality and safety:* more satisfied patients.	Number of complaints to NDHB per patient event *[QUALITY]*	Total population	0.15%	0.2%	0.2%	0.2%	Confidence and trust in the health system Better, sooner, more convenient
					Complaints to NDHB closed within 20 working days	Total population	75%	80%	85%	90%	

[43] Direct = directly with client and/or whanau; care coordination = on behalf of client, with another agency.
[44] These targets assume past patterns of increase will continue, but are estimates only because actual targets are set by MoH each year according to their methodology and assumptions.
[45] This figure is higher than in previous years because it now includes visits by community services staffed by a range of health professionals.

OUTPUTS				IMPACTS						OUTCOMES
We will undertake these activities	**And ensure these outputs are delivered**	**Belonging to Suboutput Class**	**Output measures**	**To lead to these impacts**	**Impact measures**					**To achieve this outcome**
					Description	**Categories**	**Baseline**	**Target**		
								2012/13	**2013/14**	**2014/15**	
					[QUALITY]						services
			15 complaints to HDC 2011 CY.		HDC complaints that result in a finding of breach of the Code. *[QUALITY]*	Total population	0.8% (CY 2011)	0.8%	0.8%	0.8%	Living within our means
			Total operations: 2009/10 9,379 2010/11 9,964	Fewer adverse clinical events	Surgical site infections. *[QUALITY]*	Total	<2%	[46]<2%	<2%	<2%	
			2,553 events observed 2011 CY.		Hand hygiene compliance. *[QUALITY]*	Total	60%	70%	75%	78%	

[46] Less than 2% is recognised as the "gold standard" for this indicator. NDHB's rate has been consistently under this for some time.

5.5 Output Class: Rehabilitation and Support

OUTPUTS				IMPACTS						OUTCOMES
We will undertake these activities	**And ensure these outputs are delivered**	**Belonging to Suboutput Class**	**Output measures**	**To lead to these impacts**	**Impact measures**					**To achieve this outcome**
					Description	**Categories**	**Baseline**	**Target**		
								2011/12	**2012/13**	**2013/14**	
Comprehensive clinical assessment, for older people receiving long term home based support services (HBSS) using the interRAI Home Care and Contact Assessment.	Home based support services provided by NGOs.	NDHB's NASC[47] (Needs Assessment and Service Coordination) service.	Completed interRAI assessments.	Quality assessment and HBSS services lead to a reduction in the need for hospitalisation and residential care.	95% of long-term HBSS clients entitled to an interRAI assessment will receive one. *[COVERAGE]*	interRAI Home Care and Contact Assessment	16% (438 assess-ments out of 2,720 clients as at Dec 2011)	95%	95%	95%	Independence for those with impairments or disability support needs Optimum quality of life for those with long term conditions
Fund providers of residential care and home based support services (HBSS).	HBSS provided by NGOs. Residential care provided by NGOs.	NDHB's Needs assessment and service coordination service.	Hours funded for HBSS: 197,324 (38%) home maintenance, 315,234 (62%) personal cares (2011/12 forecast)[48].	Support for older people: older people requiring support or care receive services appropriate to their needs.	Rising % of home based support services provided to older people who have higher support needs. *[COVERAGE]*	Household mngt Personal care (hours paid)	38% 62%	36% 64%	34% 66%	32% 68%	
Certification of age-related residential care (ARRC) facilities under Health and Disability Sector Standards.	Work with providers on corrective action plans resulting from audits and provide input from Gerontology Nurse Specialists (GNS) to improve quality.	Age related residential care beds.	Results and Corrective Action Plans from ARRC integrated certific-ation audits. 15/24 ARRC providers with 3-year certification (Dec 2011) 100% GNS input into ARRC services 24/24.		Decreasing percentage of high and medium risk corrective actions arising from certification. *[QUALITY]*	Percentage of ARRC services with 3 year certification	63% as at Dec 2011	70%	79%	88%	
Contracting of respite care beds.	Respite care services	Respite care.	Number of respite care bed days occupied 3,600 in 2010/11 (extrap. from 6 months data).		Number of respite care bed days utilised *[COVERAGE]*	Respite care bed days occupied	4,183	4,183[49]	4,200	4,300	

[47] For a definition, see Graphic 13, note (e).
[48] Actual outputs for 2010/11 (inc Hokianga Health) = 219,249 hours (40%) HM and 324, 984 (60%) PC. 09/10 actual = 44% HM, 56% PC.
[49] Targets are conservative because no extra funding is currently available.

5.6 SFSP summary information

This section contains the summary financial tables which divide NDHB's services into Output Classes, and a table summarising in one place all the measurement information from throughout the Statement of Forecast Service Performance.

Statement of Financial Performance - By Output Class

	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	2012-13 Budget Total
DHB Provider Revenue	222,647	27,348	11,122	11,468	272,585
Less Revenue Offsets	- 5,449				- 5,449
DHB Funder Revenue	72,043	104,932	9,698	52,537	239,210
DHB Governance & Administration	3,597				3,597
					-
Total SOI Revenue	292,838	132,280	20,820	64,005	509,943
Personnel Costs					
Medical Labour	45,725	2,311	696	0	48,732
Nursing Labour	54,547	5,870	1,215	3,734	65,366
Allied Health Labour	16,912	7,597	2,342	2,922	29,773
Non Clinical Support Labour	180	3	1	-	184
Management and Admin Labour	6,223	1,321	933	366	8,843
	-	-	-	-	
Non-Personnel Operating Costs	-	-	-	-	
Outsourced Clinical Services	4,243	218	61	381	4,903
Oth Clinical Supp	28,164	1,254	500	1,711	31,629
Implants	4,407	-	-	-	4,407
Pharmaceuticals	3,774	155	6	205	4,140
Infrastructure and Non Clinical	21,349	3,200	435	1,233	26,217
Allocated Pharmaceuticals	1,018	33	2	59	1,112
Corporate Departments	19,321	3,587	1,220	1,519	25,647
Cost of Capital	5,693	719	216	373	7,000
CTA Recoveries	- 2,020	- 60	- 18	- 24	- 2,122
Patient Support	4,421	134	8	55	4,618
Service Based Departments	7,344	1,536	552	545	9,976
Sterile Supplies	234	5	1	30	269
Provider Payments					
Personal Health	58,483	103,336	3,997	659	166,474
Mental Health	13,527	799	-	65	14,391
Disability Support Services	0	-	9	51,618	51,627
Public Health	71	-	813	1	884
Maori Health	-	798	4,880	194	5,872
Total SOI Operating Expenditure	293,616	132,814	17,869	65,644	509,943
Surplus (Deficit)	-778	-534	2,951	-1,639	0

Graphic 23 Summary of Northland DHB's Statement of Service Performance

Vision	Creating a healthier Northland								
High Level Outcomes	Improved health status		Improved equity		Living within our means		Confidence and trust in the health system		
High Level Measures	Life expectancy gap between Maori and non-Maori ↓ by 2 years	↓ gaps between: (a) Maori and non-Maori (b) Northland and NZ	↓ mortality rate (age-standardised)	↓ infant mortality	Unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017		>95% of patients report they would recommend the service provided		
Outcomes	Healthy population	Prevention of illness and disease	Reversal of acute conditions	Optimum quality of life for those with long term conditions	Independence for those with impairments or disability support needs		Better, sooner, more convenient services		
Impacts	**Tobacco** Lower prevalence of smoking-related conditions	**Healthy children** Reduced likelihood of acquiring long term conditions later in life Lower incidence of communicable disease Healthier teeth and gums Safer children	**Long term conditions** Amelioration of disease symptoms and/or delay in their onset	**Cancer** If curable, increased likelihood of survival If incurable, reduced severity of symptoms	**Mental disorders** Improved quality of life for both clients and their families Acute episodes are minimised, clients achieve greater stability in their condition	**Elective surgery** Fewer debilitating conditions Delayed onset of long term conditions	**ED waiting times** More timely assessment, referral and treatment	**Quality and safety** More satisfied patients Fewer adverse clinical events	**Support for older people** Older people requiring support or care receive services appropriate to their needs.
Impact Measures	% of the population who smoke daily % of Year 10 students who have never smoked % of smokers in primary care given advice and help to quit % of smokers admitted to hospital given advice and help to quit	Full and exclusive breastfeeding at 6 weeks % of 8-month-olds who are fully immunised 5yo who are caries-free Average number of decayed, missing or filled teeth in Y8 students Referrals to CYFS of children suspected of being abused	% people with diabetes with annual reviews... ...of them, % with good blood sugar management Eligible people receiving CVD risk assessment in the last 5 years % ↑ in specialist diabetes referrals	Breast cancer, cervical cancer screening in eligible populations People diagnosed with cancer who receive radiation treatment and chemotherapy within 4 weeks	Referrals from GPs to Primary Mental Health Initiative Coordinators % of people with enduring mental illness aged 20-64 who are seen over a year	↑ in elective service discharges	Patients with ED length of stay of less than 6 hours	Complaints to NDHB per patient contact Complaints to NDHB closed within 20 working days HDC complaints that result in a finding of breach of the Code Surgical site infections Hand hygiene compliance	% HBSS clients assessed using interRai tool % of high and medium risk corrective actions arising from certification Respite care bed days utilised
Output Classes	Prevention		Early detection and management		Intensive assessment and treatment			Rehabilitation and support	
Outputs	Health promotion programmes in schools through Smokefree/ Auahi Kore Advice and help for smokers in primary care to quit Advice and help for smokers in hospital to quit	Midwifery services Support by lactation consultants Primary care services performing immunisations Oral health assessment and treatment Identifying at-risk children through screening	Risk assessments in primary care (diabetes annual reviews, blood tests, risk profiles) Laboratory tests	Cancer risk assessments in primary care Screening for breast and cervical cancers Provision of cancer therapies	Primary care for people with mild to moderate disorders whose condition is stable Specialised clinical support by NDHB community mental health services Admission to hospital for those whose condition is unstable	Elective surgical procedures	Assessments, treatments and referrals performed in EDs	Leadership, advice and monitoring by the Chief Medical Advisor and Quality Resource Unit	Home based support services Residential care Work with providers on corrective action plans resulting from audit Respite care services
Output Measures	Health promotion programmes in schools Students advised about stopping smoking Advice and help offered to smokers in primary care Quit Card Providers. Advice and help offered to smokers in hospital	Support provided to mothers to breastfeed Lactation consultant contacts Immunisations completed by eight months Oral health treatments for 5yo and Y8 students Referrals to CYFS of children suspected of being abused	Risk assessments performed on people with diabetes and/or CVD Lab tests on people with diabetes Specialist diabetes referrals	Breast cancer screening in eligible populations Cervical cancer screening in eligible populations Radiation treatments Chemotherapy treatments	Referrals from GPs to Primary Mental Health Initiative Coordinators Contacts by community mental health workers with people who have enduring mental illness	Additional elective procedures	Emergency department attendances	Measures of the quality and safety of services	Assessments by NASC service Certification audits Respite care bed days utilised

Key: Green = prevention OC, orange = early detection & management OC, blue = intensive assessment & treatment OC, pink = rehab & support OC. Underlines = main measures. Yellow highlights = Health Targets.

6 Service configuration

6.1 Service coverage

The Service Coverage Schedule (1.2 Health sector context) specifies the services a DHB must ensure are provided. This section deals with any significant exceptions that might be sought. Northland DHB seeks no such exceptions.

6.2 Service issues

Northland DHB has no emerging service issues other than what is already covered under 6.3 or described within the context of the Northern Region Health Plan.

6.3 Service change

This is a list of "significant" service changes possible in the next year. It does not include possible changes emerging from the Northland Health Services Plan because the plan is still under development and specific proposals and changes are yet to emerge and be agreed upon.

Northland DHB will follow the Service Change Protocols in the Operational Policy Framework. We will notify the National Health Board of any service changes resulting from planned service reviews or that may arise during 2011/12.

Title	Description	Rationale	Timing	Risk	
				Description	Lo/med/hi
Pharmacy services	Proposal to look at an alternative way of funding community pharmacy services and enhanced services for people with long term conditions assessed as needing additional support. Current pharmaceutical dispensing costs are financially unsustainable with 5-7% year-on-year	National initiative to improve community pharmacy services. National commitment to review pharmacy services as part of current national agreement. Aims are to: • contain dispensing costs • improve health outcomes for people with long term conditions • reduce health inequities • support better, sooner, more convenient care.	From 1 July		

Title	Description	Rationale	Timing	Risk	
				Description	Lo/med/hi
	increases. Current workforce poorly integrated with primary care. Little motivation in funding arrangements to focus on health outcomes and management of long term conditions.				
Service reviews	Service reviews will be conducted across all hospital services and NGO contracts to which Northland DHB is a party.	As notified in the Northland Health Service Plan (NHSP), NDHB will: "Undertake value for money reviews of all [that is, both NGO and hospital] NDHB-procured services." Once the review is completed, NDHB will notify the National Health Board of the results. Discussion will clarify those that are considered to meet the "significant service change" criteria, thus triggering the service change protocol as laid out in MoH's Operational Policy Framework.	Ongoing from May 2012 after the NHSP was signed off.	Negative criticism from providers and public if significant changes are proposed. To be mitigated by: • being transparent about the process and the tools and criteria used • emphasising the need for fairness of resource distribution and expectation of performance across all services • emphasising the need for obtaining the best value for money from the health dollar.	Depends on results of review

7 Financial performance

National links	NRHP links	NHSP links
Ministerial and Ministry requirement to remain within budget.	'Living within our means' is part of the mission. Cost / productivity is one of the Triple Aims.	Outcome goal is to live within available funding.

7.1 Managing the funding

Northland DHB has consistently maintained a balanced budget. This has met the requirements of the Minister and has allowed the DHB some flexibility in allocating resources to new needs and services. In the current climate of financial constraints and capped funding in real terms, keeping the books in the black is even more important.

Northland DHB's Financial Management Systems give us the ability to set targets and monitor performance against these. Target setting occurs with advice from the Ministry of Health and includes financial budgets, numbers of employees and service delivery targets.

Performance against these targets is monitored on a monthly basis. This starts with Internal Performance Management Reporting within each service which feeds into the Executive Leadership Team. The reports are consolidated each month for the board of governance and its associated subcommittees. We also meet MoH reporting requirements on a monthly basis.

NDHB continues to seek efficiencies in the way we operate, including participating in regional and national processes. At least three-quarters of operating expenditure is on our workforce, and we continually reviewing patterns and levels of staffing to reduce costs.

NDHB is committed to Health Benefits Limited but the current indicative investment cost and returns represent significant losses and are therefore unacceptable As a result we are unable to include any financial information or benefits at this stage.

Northland DHB received a total increase of $13.8m in the December 2011 Funding Envelope. This population based funding increase is a contribution to both our cost and population growth pressures. The 2012/13 contribution to cost pressure is $6.7m (1.49%) and the contribution to demographic growth is $7.1m.

7.2 The three-year forecasts

NDHB will achieve a break-even performance for each of the three years detailed in the financial template.

The 2012/13 result has been arrived at after taking into account all the currently known cost increases we forecast to occur. Included are the additional increased capital costs of the new Mental Health Inpatient Unit (opened in October 2011), and new Information Systems (costs include additional depreciation and the loss of interest income as cash resources diminish). Wage increases after the expiry of current employment agreements have been budgeted at 2%. Total new operational savings are expected to be $2.6m in 2011/12.

The outer years have been reported as break-even, although the increased depreciation and operating costs and loss of interest income resulting from continuing investment in building development and information technology, coupled with an advice from the Ministry of Health that future funding increases will be no more in actual terms than that received this year, has meant that savings assumptions have needed to be included in those results.

The level of savings assumed for these out-years is approximately $2.5m in 2013/14 and a further $3.0m in 2014/15. It will be achieved from savings of the regional shared service organisation (healthAlliance) as well as savings realised from the investments themselves.

The 2013/14and 2014/15 projections have been based on the following assumptions:

- core revenue increases will continue at their current dollar value, approximately $13.8m per annum; any reduction in this increase will increase the savings targets

- other revenue will increase at 1.49% (the current Contribution to Cost Pressures funding level) with the exception of interest income which will decline as capital expenditure increases
- staff costs will rise by 4% per annum
- outsourced services will rise by 4% per annum
- clinical supplies will rise by 4% per annum
- infrastructure and non-clinical supplies will rise by 4% per annum
- payments to NGO providers will rise by 2% per annum.

7.3 Productivity initiatives

Our major productivity initiatives are as follows:

Initiative	Estimated savings 2012/13
Regional Shared Services: Commenced 1 March 2011; full savings will be realised over 3 years	$784k
Human resources: Continue to hold vacant positions	$1,500k
Motor vehicles: Replace old fleet with a mixture of leased and purchased new vehicles to reduce repairs and fuel costs; improve fleet vehicle usage to reduce fuel and maintenance costs	$300k
Total	$2,584k

7.4 Full time equivalent (FTE) staff management

Emphasis has been placed on controlling FTE numbers. Increases arise from the substitution of locum costs with employed FTE positions, specifically - funded new positions (oral health for example) and clinical positions driven by increased patient demand.

Management and administrative FTEs have been held, despite increases in activity and new services. FTE level remains well below the FTE cap.

7.5 Capital plan

The financial templates include the capital plan for the DHB. Baseline capital, funded via depreciation, is the common description of the plan which funds the replacement of existing assets.

Strategic capital is funded from the DHB's cash resources, Crown equity and Crown debt. Northland DHB's strategic capital intentions signalled in the Annual Plan represent ambitions to renew our building stock on the Whangarei and Kawakawa campuses, and to upgrade our essential clinical information systems.

7.6 Assets

Assets were last valued on 30 June 2009 and will be re-valued as at 30 June 2012. No forecast of this revaluation has been made in the financial templates.

7.7 Disposal of land

If Northland DHB decides to dispose of any land transferred to or vested in the DHB, we will do so under the Health Sector Transfers Act 1993. Northland DHB has no plans at present to dispose of any land.

7.9 Financial statements

Statement of Comprehensive Income

$000s

	2010-11 Audited Actuals	2011-12 Forecast	2012-13 Budget	2013-14 Budget	2014-15 Budget
DHB Provider Revenue	257,455	265,376	272,585	279,230	286,038
DHB Funder Revenue	220,450	228,771	231,356	237,140	243,068
DHB Governance & Administration	4,018	3,597	3,597	3,687	3,779
Inter District Flow Revenue	8,139	7,500	7,854	8,050	8,252
Total Revenue	490,063	505,243	515,392	528,107	541,137
DHB Provider Operating Expenditure	241,112	247,599	253,105	259,281	265,611
DHB Non Provider Funded Services	159,333	169,171	170,378	174,638	179,003
DHB Governance & Administration	3,990	3,578	3,576	3,666	3,757
Inter District Flow Expense	65,087	67,100	68,833	70,553	72,317
Total Operating Expenditure	469,522	487,448	495,891	508,138	520,689
Earnings before Interest, Depreciation, Abnormals & Capital Charge	20,540	17,795	19,501	19,968	20,448
Less					
Interest on Term Debt	3,095	1,457	1,600	1,638	1,678
Depreciation	11,565	11,034	12,141	12,432	12,730
Revaluation					
Earnings before Abnormals & Capital Charge	5,880	5,304	5,760	5,898	6,040
Profit/(Loss) on Sale of Assets	-	-	-	-	-
Net Operating Surplus (Deficit)	5,880	5,304	5,760	5,898	6,040
Capital Charge	5,210	5,304	5,760	5,898	6,040
Surplus (Deficit)	**670**	**1**	**(0)**	**(0)**	**0**
Revaluation of Fixed Assets	(680)	-	-	-	-
Comprehensive Income	**(10)**	**1**	**(0)**	**(0)**	**0**

Statement of Movements in Equity

$000s

	2010-11 Audited Actuals	2011-12 Forecast	2012-13 Budget	2013-14 Budget	2014-15 Budget
Equity at the beginning of the period	64,343	66,370	67,897	67,897	67,897
Surplus/Deficit for the period	670	1	(0)	(0)	0
Total Recognised Revenues and Expenses	65,013	66,371	67,897	67,897	67,897
Other Movements					
Revaluation of Fixed Assets	(680)	-	-	-	-
Other	488	-	-	-	-
Equity introduced (Repaid)	1,550	1,527	-	-	-
Equity at end of Period	**66,371**	**67,898**	**67,897**	**67,897**	**67,897**

Statement of Financial Position

$000s

	2010-11 Audited Actuals	2011-12 Forecast	2012-13 Budget	2013-14 Budget	2014-15 Budget
Equity					
Crown Equity	36,873	38,425	38,425	38,425	38,425
Retained Earnings	2,655	4,161	4,161	4,160	4,161
Subsidiaries & unrestricted trusts	300	315	315	315	315
Revaluation Reserve	24,991	24,971	24,972	24,972	24,972
Capital Injections	1,551	25	25	25	25
Total Equity	66,370	67,897	67,898	67,897	67,897
Represented by:					
Assets					
Current Assets	51,480	37,436	27,170	19,730	19,730
Non-Current Assets	133,923	133,367	144,446	151,886	153,049
Total Assets	185,403	170,803	171,617	171,616	172,779
Liabilities					
Current Liabilities	86,363	70,197	71,010	71,010	71,010
Non-Current Liabilities	32,670	32,709	32,709	32,709	33,871
Total Liabilities	119,033	102,906	103,720	103,720	104,882
Net Assets	**66,370**	**67,897**	**67,897**	**67,897**	**67,897**

Statement of Cash Flows

$000s

	2010-11 Audited Actuals	2011-12 Forecast	2012-13 Budget	2013-14 Budget	2014-15 Budget
Cash Flows from Operating Activities					
Operating Income	478,728	504,361	511,512	525,046	538,014
Operating Expenditure	471,454	502,606	499,725	514,048	526,752
Net Cash from Operating Activities	7,273	1,755	11,787	10,998	11,262
Cash Flows from Investing Activities					
Interest receipts 3rd Party	4,169	3,673	3,000	3,072	3,146
Sale of Fixed Assets	51	-	-	-	-
Purchase of Fixed Assets	(20,435)	(16,328)	(23,453)	(35,300)	(30,400)
Increase/Decrease in Investments and Restricted & Trust Funds Assets	3,960	5,060	-	20,353	17,670
Net Cash from Investing Activities	(12,255)	(7,596)	(20,453)	(11,875)	(9,584)
Cash Flows from Financing Activities					
Equity injections (repayments)	1,550	1,527	-	-	-
Borrowings	(76)	(5,537)	-	-	-
Interest Paid	(1,544)	(1,457)	(1,600)	(1,638)	(1,678)
Repaid debts	-	-	-	-	-
Other Non-Current Liability Movement	-	-	-	-	-
Net Cash from Financing Activities	(70)	(5,467)	(1,600)	(1,638)	(1,678)
Net Increase/(Decrease) in Cash held	(5,051)	(11,308)	(10,266)	(2,515)	(0)
Add opening cash balance	29,141	24,090	12,781	2,515	(0)
Closing Cash Balance	24,090	12,781	2,515	(0)	(1)

Note: *Cash balance includes short term investments which are considered cash or cash equivalents*

Consolidated Statement of Financial Performance ($000s)	2010-11 Audited Actuals	2011-12 Forecast	2012-13 Budget	2013-14 Budget	2014-15 Budget
MOH Devolved Funding	456,925	472,094	485,481	497,618	510,058
MOH Non-Devolved Contracts (provider arm side contracts)	11,533	11,477	10,668	10,828	10,991
Other Government (not MoH or other DHBs)	4,016	3,473	3,627	3,682	3,737
Patient / Consumer sourced	462	559	573	582	590
Total Other Income	7,311	8,809	5,648	5,784	5,922
IDFs	8,139	7,500	7,854	8,050	8,252
InterProvider Revenue (Other DHBs)	1,676	1,333	1,540	1,563	1,587
Total Consolidated Revenue	490,062	505,243	515,392	528,107	541,137
Personnel Costs	166,521	170,697	180,811	185,338	189,977
Outsourced Services	14,305	13,129	15,489	15,681	15,874
Clinical Supplies	40,303	43,279	40,949	42,014	43,107
Infrastructure & Non-Clinical Supplies	23,974	24,072	19,431	19,925	20,433
Finance Costs	8,305	6,761	7,360	7,537	7,718
Depreciation	11,565	11,034	12,141	12,432	12,730
Personal Health	154,351	165,068	166,096	170,248	174,504
Mental Health	14,922	14,745	14,392	14,752	15,120
Disability Support Services	47,592	49,125	51,934	53,232	54,563
Public Health	1,592	1,462	917	940	963
Maori Health	5,963	5,871	5,872	6,019	6,169
Total Operating Expenditure	489,392	505,243	515,392	528,118	541,159
Surplus (Deficit)	**670**	**0**	**(0)**	**(11)**	**(22)**

Key Financial Analysis and Banking Covenants

	2010-11 Audited Actuals	2011-12 Forecast	2012-13 Budget	2013-14 Budget	2014-15 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	119,033	102,906	103,720	103,720	104,882
Debt	24,650	24,650	23,650	23,650	23,650
Owners Funds	66,370	67,897	67,897	67,897	67,897
Total Assets	185,403	170,803	171,617	171,616	172,779
Owners Funds to Total Assets	35.8%	39.8%	39.6%	39.6%	39.3%
Interest Expense	3,095	4,269	1,600	1,638	1,678
Depreciation Expense	11,565	11,034	12,141	12,432	12,730
Surplus/(Deficit)	670	1	- 0	- 0	0
Interest Cover	4.95	3.58	8.59	8.59	8.59
Debt/Debt + Equity Ratio	27%	27%	26%	26%	26%
Banking Covenants					
Debt/Debt + Equity Ratio	27.1%	26.6%	25.8%	25.8%	25.8%
Interest Cover	5.0	3.6	8.6	8.6	8.6
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

8 Non-Health Target performance measures

The principal performance measures by which performance of DHBs is measured are the national Health Targets, dealt with in Module 3. This section describes the other centrally-driven performance measures by which DHB performance is gauged quarterly, and the targets set by Northland DHB.

Many of these measures and targets are used in 5 Statement of Forecast Service Performance.

Indicator	Target for 2012/13
PP1 Clinical leadership	
The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and DHB engagement with it across their region. This will include a summary of the following – how the DHB is: • contributing to regional clinical leadership through networks • investing in the development of clinical leaders • involving the wider health sector (Including primary and community care) in clinical inputs • demonstrating clinical influence in service planning • investing in professional development • influencing clinical input at board level and all levels throughout the DHB – including across disciplines. What are the mechanisms for providing input?	Qualitative report only. *National target: n/a.*
PP2 Implementation of better, sooner, more convenient primary health care	

The DHB provides a qualitative report as follows:
1 *[This refers to DHBs with BSMC Alliances, which is not relevant to NDHB.]*
2 All DHBs are required to report progress against the deliverables in their jointly agreed approach to meeting the following expected measures:
• description of how all necessary clinicians and managers (primary-community and secondary) will be involved ongoing in the process of development, delivery and review
• activities to integrate community pharmacy
• activities to expand and integrate nursing services
• evidence of health needs analysis of population by localities
• identification of targeted areas/ patient groups for improved outcomes as a result of enhanced primary and community service delivery (with a focus on managing long term conditions such as CVD and diabetes) including identification of and achievement against:
  • targets for the number of people that are expected to be appropriately managed in a primary-community setting instead of secondary care
  • targets for growth reduction in ED attendance, acute inpatient admissions and bed days
  • a target for the prevention of readmissions for the 75+ population (and any other target populations)
  • new service activity in quantified patient terms
• identification of and activities (with timeline) to ensure infrastructure and revenue streams appropriate to support the identified change in activities and service delivery model
• progress against the above infrastructure and revenue stream milestones
• identification of and progress against the activities to ensure free after-hours services to children under six years of age.
 	
Additional reporting required for Q4. Each DHB must provide a report with the following information:
• each PHO's working capital requirements
• each PHO's total cash balance and total income in advance at the end of the financial year
	Qualitative report only.
	National target: n/a.

<table>
<tr><th>Indicator</th><th>Target for 2012/13</th></tr>
<tr><td>• the PHOs that the DHB has required to provide forecast expenditure plans for both cash balances and income in advance, including quarterly targets for reductions in cash balances to the agreed level
• a copy of the relevant PHO's forecast expenditure plans.</td><td></td></tr>
<tr><td colspan="2">PP6 Improving the health status of people with severe mental illness (rates of access to DHB mental health services)</td></tr>
<tr><td>The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months).</td><td><table><tr><th></th><th>Maori</th><th>Total</th></tr><tr><td>Ages 0-19</td><td>4.06%</td><td>3.90%</td></tr><tr><td>Ages 20-64</td><td>7.34%</td><td>4.71%</td></tr><tr><td>Ages 65+</td><td>1.61%</td><td>1.61%</td></tr></table>Targets are negotiated by each DHB, not set nationally.</td></tr>
<tr><td colspan="2">PP7 Improving mental health services using relapse prevention planning</td></tr>
<tr><td>1 The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment (at least one provider arm contact every three months for two years or more) for two years or more since the first contact with any mental health service. The subset of AOD-only clients will be reported for 20 years plus.</td><td>Number to be reported.
National target: n/a.</td></tr>
<tr><td>2 The number of children and youth who have been in secondary care treatment (at least one provider arm contact every three months for one year or more) for one or more years, who have a treatment plan.</td><td>Number to be reported.
National target: n/a.</td></tr>
<tr><td>3 The number and percentage of long-term clients with up to date relapse prevention/ treatment plans (NMHSS criteria 16.4 or HDSS [2008] 1.3.5.4 and 1.3.5.1 [in the case of child and youth]).</td><td><table><tr><th></th><th>Maori</th><th>Total</th></tr><tr><td>Ages 0-19</td><td>97%</td><td>97%</td></tr><tr><td>Ages 20-64</td><td>97%</td><td>97%</td></tr></table>National target for all above categories: 95%.</td></tr>
<tr><td>4 Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.</td><td>Qualitative report only.
National target: n/a.</td></tr>
<tr><td colspan="2">PP8 Shorter waits for non-urgent mental health and addiction services</td></tr>
<tr><td>Rolling annual waiting time data will be provided by MoH, sourced from PRIMHD.

A narrative is required to:
• identify what processes have been put in place to reduce waiting times
• explain variances of more than 10% waiting times target</td><td>Mental health services, NDHB only:<table><tr><th>% seen within</th><th>0-19</th><th>20-64</th><th>65+</th><th>All ages</th></tr><tr><td>3 wks:</td><td></td><td></td><td></td><td></td></tr><tr><td>Yr 1</td><td>60%</td><td>60%</td><td>70%</td><td>62%</td></tr><tr><td>Yr 2</td><td>70%</td><td>70%</td><td>75%</td><td>71%</td></tr><tr><td>Yr 3</td><td>80%</td><td>80%</td><td>80%</td><td>80%</td></tr><tr><td>8 wks:</td><td></td><td></td><td></td><td></td></tr><tr><td>Yr 1</td><td>70%</td><td>70%</td><td>80%</td><td>72%</td></tr><tr><td>Yr 2</td><td>80%</td><td>80%</td><td>90%</td><td>82%</td></tr><tr><td>Yr 3</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr></table>AOD services, NDHB plus NGOs:<table><tr><th>% seen within</th><th>0-19</th><th>20-64</th><th>65+</th><th>All ages</th></tr><tr><td>3 wks:</td><td></td><td></td><td></td><td></td></tr><tr><td>Yr 1</td><td>50%</td><td>50%</td><td>70%</td><td>55%</td></tr><tr><td>Yr 2</td><td>65%</td><td>65%</td><td>75%</td><td>67%</td></tr><tr><td>Yr 3</td><td>80%</td><td>80%</td><td>80%</td><td>80%</td></tr><tr><td>8 wks:</td><td></td><td></td><td></td><td></td></tr><tr><td>Yr 1</td><td>70%</td><td>70%</td><td>70%</td><td>70%</td></tr><tr><td>Yr 2</td><td>80%</td><td>80%</td><td>80%</td><td>80%</td></tr><tr><td>Yr 3</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr></table></td></tr>
<tr><td colspan="2">PP10 Oral health, DMFT score at Year 8</td></tr>
<tr><td>Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the percentage number of:

1 Permanent teeth of children in school Year 8 (12 & 13-year olds) that are:
decayed (D)
missing due to caries (M)
filled (F)

2 Children who are caries-free (decay-free).</td><td><table><tr><th>Non-fluoridated</th><th>Maori</th><th>Total</th></tr><tr><td>DMFT year 1</td><td>1.12</td><td>1.12</td></tr><tr><td>DMFT year 2</td><td>1.12</td><td>1.12</td></tr></table>Targets are negotiated by each DHB, not set nationally. In Northland, all targets are for non-fluoridated areas.</td></tr>
<tr><td colspan="2">PP11 Oral health, children caries-free at age 5</td></tr>
</table>

Indicator	Target for 2012/13
At the first examination after the child has turned five years, but before their sixth birthday, the total number of: 1 Children who are caries-free (decay-free) 2 Primary teeth of children that are: decayed (D) missing due to caries (M) filled (F).	*Non-fluoridated* / Maori / Total Caries-free year 1: 55% / 55% Caries-free year 2: 58% / 58% *Targets are negotiated by each DHB, not set nationally. In Northland, all targets are for non-fluoridated areas.*
PP12 Utilisation of DHB-funded dental services by adolescents *(transitional measure, not included in performance dashboard reports)*	
In the year to which the reporting relates, the total number of adolescents accessing DHB-funded adolescent oral health services, defined as: 1 The unique count of adolescent patients' completions and non-completions under the Combined Dental Agreement 2 The unique count of additional adolescent examinations with other DHB-funded dental services (eg DHB community oral health services, Maori oral health providers and other contracted oral health providers). To reduce duplication of effort, at the end of each quarter in the year to which the reporting relates, MoH will organise a data extract from Sector Services for all DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs' use in determining part 1 of the numerator.	**Total** Year 1: 65% Year 2: 75% *National target: 85%*
PP13 Improving the number of children enrolled in DHB-funded oral health services	
1 In the year to which the reporting relates, the total number of children under five years of age, (aged 0 to 4 years of age inclusive), who are enrolled with DHB-funded oral health services (DHB's community oral health service and other DHB-contracted oral health providers such as Maori oral health providers).	Year 1: 70% of the 0-4 population. Year 2: 75% of the 0-4 population. *National target: n/a.*
2 In the year to which the reporting relates: (a) the number of preschool children and primary school children, in total and for each school decile, who have not been examined according to their planned recall period in DHB-funded dental services (DHB's community oral health service and other DHB-contracted oral health providers such as Maori oral health providers)	Year 1: 15% of the enrolled population Year 2: 15% of the enrolled population
(b) the greatest length of time children have been waiting for their scheduled examination, and the number of children that have been waiting for that period.	*No target.*
PP16 Workforce – career planning	
DHB provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff, provide: (a) the number receiving HWNZ funding; (b) the number with a career plan: • medical staff • nursing • allied technical • Maori health • Pacific • pharmacy • clinical rehabilitation • other.	**No. receiving HWNZ funding** / **No. with career plan** Medical Nursing Allied technical Maori health Pacific Pharmacy Clinical rehabilitation Other *National target: n/a.*
PP18 Improving community support to maintain the independence of older people	
Numerator: The number of people aged 65 and older who have received long-term home support services in the last 3 months who have had a comprehensive clinical assessment and a completed care plan. *Denominator:* The number of people aged 65 and older who have received long-term home support services in the last three months.	All clients currently receiving long-term home based support services to have a Comprehensive Clinical Assessment in 2012/13: 50% New clients receiving long-term home based support services to have a Comprehensive Clinical Assessment in 2012/13: 100% All clients receiving long-term home based support services to have a Comprehensive Clinical Assessment in 2014/15: 95%

<table>
<tr><th>Indicator</th><th>Target for 2012/13</th></tr>
<tr><td></td><td>National target: 95%</td></tr>
<tr><td colspan="2">PP20 Improved management for long term conditions (CVD, diabetes, stroke)</td></tr>
<tr><td>1(a) cardiovascular disease

DHBs supply a quarterly narrative report that comments on data supplied by MoH, and DHB performance in relation to the number of people diagnosed with ischemic heart disease and on lipid lowering medications, with a view to establishing a formal performance baseline for application in 2013/14.</td><td>Qualitative report only.

National target: n/a.</td></tr>
<tr><td>1(b) stroke services

DHBs are to provide a quarterly narrative report on stroke services delivered including plans and actions to improve services.</td><td>Qualitative report only.

National target: n/a.</td></tr>
<tr><td>1(c) Maintain or improve access to Diabetes Annual Reviews:

Numerator: count of enrolled people in the PHO with a record of a Diabetes Annual Review during the reporting period.

Denominator: the number of enrolled people in the PHO who would be expected to have diagnosed diabetes, using the Diabetes Prevalence Estimate Data.

Source: PHO Performance Programme Indicators Definitions 1 July 2011 version 5.3 Sept 11.</td><td><table><tr><th></th><th>Maori</th><th>Total</th></tr><tr><td>Patients</td><td>80%</td><td>80%</td></tr></table></td></tr>
<tr><td>2(a) Progress in delivery of diabetes care improvements

Provide a quarterly progress report on delivery of actions and volumes agreed for each improvement area identified in the Annual Plan.</td><td>Qualitative report only.

National target: n/a.</td></tr>
<tr><td>2(b) Local Diabetes Team

Provide the annual report from the Local Diabetes Team to MoH as outlined in the Service Specification for Specialist Medical and Surgical Services, Diabetes Service, Local Diabetes Team Service.</td><td>Qualitative report only.
National target: n/a.</td></tr>
<tr><td>2(c) Diabetes management:

Numerator: the number of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64mmol/mol at their free annual check during the reporting period (data source DHB).

Denominator: the number of unique individuals with type I or type II diabetes on a diabetes register whose date of their free annual check is during the reporting period (data source DHB). [Note that this is the numerator from the Diabetes Free Annual Check indicator.]</td><td><table><tr><th></th><th>Maori</th><th>Total</th></tr><tr><td>Patients</td><td>80%</td><td>80%</td></tr></table>
Targets are negotiated by each DHB, not set nationally.</td></tr>
<tr><td colspan="2">PP21 Ensure Immunisation coverage for two year olds</td></tr>
<tr><td>Each quarter, DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan.

MoH will provide summary data for the quarter on the nationwide service framework library web site NSFL homepage: http://www.nsfl.health.govt.nz/.</td><td><table><tr><th></th><th>Maori</th><th>Total</th></tr><tr><td>2-year-olds</td><td>95%</td><td>95%</td></tr></table></td></tr>
<tr><td colspan="2">SI1 Ambulatory sensitive (avoidable) hospital admissions</td></tr>
<tr><td>Each DHB is expected to provide a commentary on their latest 12 month ASH data available via the nationwide service library. This commentary may include additional district level data not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions.

Each DHB should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Maori 45-64 year olds</td><td><table><tr><th>Age group</th><th>Ethnicity</th><th>Rate</th></tr><tr><td>0-74</td><td>Maori</td><td>116</td></tr><tr><td></td><td>Total</td><td>116</td></tr><tr><td>0-4</td><td>Maori</td><td>116</td></tr><tr><td></td><td>Total</td><td>116</td></tr><tr><td>45-64</td><td>Maori</td><td>106</td></tr><tr><td></td><td>Total</td><td>106</td></tr></table>
Targets are negotiated by each DHB, not set nationally.</td></tr>
<tr><td colspan="2">SI2 Regional service planning</td></tr>
<tr><td>A single progress report on behalf of the region</td><td>Qualitative report only.</td></tr>
</table>

Indicator	Target for 2012/13
agreed by all DHBs within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan. For each action the progress report will identify: • the nominated lead DHB/ person/ position responsible for ensuring the action is delivered • whether actions and milestones are on track to be met or have been met • performance against agreed performance measures and targets • financial performance against budget associated with the action. If actions/ milestones/ performance measures/ financial performance are not tracking to plan, a resolution plan must be provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan.	*National target: n/a.*
SI3 Ensuring delivery of service coverage	
Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the AP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: • analysis of explanatory indicators • media reporting • risk reporting • formal audit outcomes • complaints mechanisms • sector intelligence.	Qualitative report only. *National target: n/a.*
SI4 Elective services standardised intervention rates	
Major joint replacement and cataract procedures Exception report: for any procedure where the standardised intervention rate in the 2011/12 financial year is significantly below the target level, produce a report demonstrating: 1 what analysis the DHB has done to review the appropriateness of its rate 2 *either:* (a) whether the DHB considers the	Major joint replacements: 21 per 10,000 *National target: 21.0 per 10,000* Cataract procedures: 27 per 10,000 *National target: 27.0 per 10,000*

Indicator	Target for 2012/13
rate to be appropriate for its population *or:* (b) a description of the reasons for its relative under-delivery of that procedure. 3 The actions being undertaken in 2012/13 that will ensure the target rate is achieved. (Data sourced from National Minimum Dataset.)	
Cardiac procedures Exception report: for any procedure or service where the standardised intervention rate in the quarter is significantly below the target level, produce a report demonstrating: 1 what analysis the DHB has done to review the appropriateness of its rate 2 *either:* (a) whether the DHB considers the rate to be appropriate for its population *or:* (b) a description of the reasons for its relative under-delivery of that procedure 3 the actions being undertaken in 2012/13 that will ensure the target rate is achieved.	Cardiac procedures: 138 *National target: 6.5 per 10,000* *NDHB target: 6.5 per 10,000* Percutaneous revascularization: 253 *National target: 11.9 per 10,000* *NDHB target: 11.9 per 10,000* Coronary angiography: 686 *National target: 32.3 per 10,000* *NDHB target: 32.3 per 10,000*
SI5 Delivery of Whanau Ora	
The DHB provides a qualitative report identifying progress within the year that shows the DHB's active engagement with existing and emerging Whanau Ora Provider Collectives steps towards improving service delivery within these providers, and supporting the building of mature providers. This will include a summary of how the DHB is: • contributing to the strategic change for Whanau Ora in the district • contributing information about Whanau Ora within the district at appropriate forums, including nationally. • investing in Whanau Ora Provider Collectives through deliberate activities • involving the DHB's governors and management in the Whanau Ora activity in the district • demonstrating meaningful activity moving towards improved service delivery and building mature providers.	Qualitative report only

Indicator	Target for 2012/13
SI7 Improving breastfeeding rates	
DHBs are expected to set DHB-specific breastfeeding targets with a focus on Maori, Pacific and the total population respectively (see reducing inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the national indicator. DHBs will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Maori and Pacific communities. The Ministry will provide breastfeeding data sourced from Plunket, and DHBs must provide data from non-Plunket well-child providers. DHBs are to report providing the local data from non-Plunket well-child providers.	<table><tr><th>Age</th><th>Maori</th><th>Total</th></tr><tr><td>6 weeks</td><td>78%</td><td>78%</td></tr><tr><td>3 months</td><td>65%</td><td>65%</td></tr><tr><td>6 months</td><td>28%</td><td>28%</td></tr></table> *Targets are negotiated by each DHB, not set nationally.*
OS3 Inpatient length of stay*	
Exception report: for any procedure or service where the standardised intervention rate in the quarter is significantly below the target level, produce a report demonstrating: 1 what analysis the DHB has done to review the appropriateness of its rate 2 *either:* (a) whether the DHB considers the rate to be appropriate for its population *or:* (b) a description of the reasons for its relative under-delivery of that procedure 3 the actions being undertaken in 2012/13 that will ensure the target rate is achieved. (Data sourced from National Minimum Dataset.)	3.70 days *DHBs are to state their year-end target. The Ministry will assume that 25% of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.*
OS5 Theatre utilisation	
Each quarter, the DHB is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility. • actual theatre utilisation • resourced theatre minutes • actual minutes used as a percentage of resourced utilisation. The expectation is that DHBs will supply information on the quarterly template. Baseline performance should be identified as part of the establishment of the target. The goal for 2011/12 will be one of the following: • for DHBs whose overall utilisation is less than 85%, a target that is a substantial incremental step towards achieving the 85% target is recommended • for DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended.	86% *National target: 85%*
OS6 Elective and arranged day surgery	
Exception report: the standardised day surgery rate is the ratio of the 'actual' to 'expected' day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The DHBs 'actual' day surgery rate, and the nationwide day surgery rate, are both defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients), divided by the total number of surgical discharges in the 12 months to the end of the quarter (for elective and arranged surgical patients). The 'expected' day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG represents for the DHB, and summing the result across all DRGs. (Data sourced from National Minimum Dataset.)	*59.6% standardised*
OS7 Elective and arranged day-of-surgery (DOSA) admissions	
The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a percentage. Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being	At least 93% *Suggested targets:* *DHB result below 95%: 95%* *DHB result >95%: maintain current levels.*

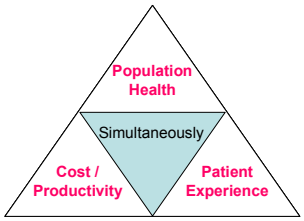
Indicator	Target for 2012/13
taken to gain improvements. (Data sourced from National Minimum Dataset.)	
OS8 Acute readmissions to hospital	
The standardised acute readmission rate is the ratio of the 'actual' to 'expected' acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage. The DHB's 'actual' acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The 'expected' acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the DHB. Readmissions are aggregated by DHB of service. Where an acute readmission occurs within a different DHB to that of the previous inpatient discharge (ie, the first admission), and the previous discharge DHB of Service is consistent with the previous discharge Agency Code, the readmission will be allocated against the DHB of the initial inpatient discharge. Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. (Data sourced from National Minimum Dataset.)	TBC by 31 July with MoH *DHBs are to state their year-end target. The Ministry will assume that 25% of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.*
OS10 Improving the quality of data provided to National Collection Systems	
1 National Health Index (NHI) duplications *Numerator:* Number of NHI duplicates that require merging by Data Management per DHB per quarter. The numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter. *Denominator:* Total number of NHI records	National and NDHB target: >3%, ≤6%
created per DHB per quarter (excluding pre-allocated NHIs and newborns).	
2 Ethnicity set to 'not stated' or 'response unidentifiable' in the NHI *Numerator:* Total number of NHI records created with ethnicity of 'not stated' or 'response unidentifiable' per DHB per quarter. *Denominator:* Total number of NHI records created per DHB per quarter.	National and NDHB target: >0.5%, ≤2%
3 Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS) *Numerator:* Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB. *Denominator:* Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB.	National and NDHB target: ≥55%, < 65%
4 Timeliness of NMDS data *Numerator:* Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge. *Denominator:* Total number of publicly funded NMDS events in the NMDS per DHB per quarter.	National and NDHB target: >2%, ≤5%
5 NNPAC emergency department admitted events have a matched NMDS event *Numerator:* Total number of NNPAC emergency department admitted events that have a matching NMDS event. *Denominator:* Total number of NNPAC emergency department admitted events.	National and NDHB target: ≥97%, <99.5%
6 PRIMHD File Success Rate *Numerator:* Number of PRIMHD records successfully submitted by the DHB in the quarter. *Denominator:* Total number of PRIMHD records submitted by the DHB in the quarter.	National and NDHB target: ≥98%, <99.5%

Indicator	Target for 2012/13
OP1 Output Delivery Against Plan	
1 Hospital production Each DHB is required to submit completed Production Plans as part of the Annual Plan round. From these Production Plans, MoH will calculate planned outputs for the following groups of personal health services. • casemix included medical services • casemix included surgical services • casemix included maternity services • non-casemix medical services • non-casemix surgical services • ED non-admitted events.	National and NDHB target: output delivery within 3% of plan.
2 delivery of personal health services and mental health services For Mental Health Services provided by the DHB's provider arm, the DHB must complete the Mental Health Volumes Reporting template. This will be provided by the Ministry, and included with the main quarterly reporting template.	National and NDHB target: output delivery within 5% of plan.
DV1: Improving cancer treatment	
Detailed information will be provided in the MoH's data definitions for the faster cancer treatment indicators. Please refer to this document for information on the definitions, data collection and exceptions. The information will be available on the NSFL by March 2012.	National and NDHB target: data is provided to establish baseline.
DV2: Improving waiting times for diagnostic services	
Elective coronary angiogram to be reported to the National Booking Reporting System (NBRS) in accordance with NBRS data dictionary reporting requirements. CT, MRI and colonoscopy reporting templates to be submitted to the National Health Board within 20 days of the end of the previous month. The reporting template will be located on the NSFL website with other Performance Measure documents.	*Data is provided to establish baseline.*

Appendix 1: Northern Region Health Plan overarching framework

Our Mission

To improve health outcomes and reduce disparities by delivering better sooner more convenient services. We will do this in a way that meets future demand whilst living within our means



Our Region's Strategic Challenges

Inequalities in health status and health outcomes linked to ethnicity and socioeconomic deprivation.

Demand for health care services, and particularly acute care, is predicted to exceed the level of health care resources.

The cost of providing publicly funded health services is growing at an unsustainable rate, influenced by demand pressures, new technologies and labour costs.

Delivery of care is fragmented between primary and secondary services and is based around an episodic model of care which does not work well for people with long term and complex conditions.

There are substantial human and financial costs to our community associated with failures in health and disability services.

Strategic goals	Population Health			Patient experience				Cost and productivity
	Lift health outcomes of Northern Region	Life and years (longer, healthier, more independent lives)	Reduce health inequalities	Better services	First do no harm	Informed choice	Performance improvement	Ensure capacity to meet demand while living within our means
Areas of focus and high level objectives	The Northern Region has seven areas of focus within a 'Life and years' programme of work: • diabetes • cancer • child health • outcomes for older people • respiratory disease • mental health and addiction For each of these areas of focus the intent is to improve health outcomes by ensuring regional equity of access to care, improved treatment, times, appropriate screening mechanisms and delivery of whole of system care. High level objectives are to minimise impacts from disease or condition. For the identified areas of focus this will be evidenced by: 1.1 Achievement of Outcome Targets, eg measures relating to: 1.11 national Health Targets 1.12 time: treatment timeframe 1.13 demand: acute presentations, bed-day reductions 1.14 identification of target population: eg risk assessment rates, target rates for clinical assessments, management plan initiation etc 1.15 condition progression 1.16 incidence of rates of significant events of interest 1.2 Integration of care across primary and secondary services 1.3 Improved communication and collaborative approaches between health and other social agencies 1.4 Regionally consistent response and methodology for care delivery: 1.41 development and regional implementation of clinical care guidelines/ pathways 1.42 development and regional implementation of regionally consistent supporting processes 1.5 Improvements in KPIs: 1.51 measures reflecting the safety and quality of care 1.52 improvements in measuring capacity 1.6 Development and support of workforce to meet demand: 1.61 capability 1.62 capacity 1.63 change leadership 1.64 culture 1.7 Alignment of capacity and demand			We will raise the patient experience across all services and ensure: 2.1 Improved safety and quality with a particular focus on: • falls causing harm • pressure injuries • CLAB • medications safety • transfers of care This will be achieved by: 2.11 achievement of Outcome Targets; incidence or rates of significant events of interest 2.12 implement regionally consistent definitions and baseline data to support KPIs 2.13 improve the region's use of the Global Trigger Tool 2.14 improve transfer of care 2.15 establish regional 'toolkit' repository 2.2 Informed patient choice to achieve greater patient participation and to ensure patients get appropriate care that best suits their context. The Northern Region's initial focus: Advance Care Planning. 2.21 consistent Advance Care Planning: pilot, promote, consolidate 2.3 Appropriate health and disability services are able to be accessed in a timely manner when needed 2.31 rapid access for patients with acute needs 2.32 improve access to elective service to restore/ maintain peoples' functional independence 2.33 maintain/ reduce target waiting times for patients accessing the hospital system				The Northern Region will consider cost and productivity issues in all work undertaken. This will include ensuring that: 3.1 Regional resources are used effectively and services delivered efficiently with minimal wastage 3.2 Capacity and demand are aligned: 3.3 Infrastructure and assets are managed to ensure safe, efficient, effective and affordable services, evident by: 3.31 regional collaboration on capital planning 3.31 delivering major infrastructure developments on time within budget 3.4 Regional radiology services a improve by focus on access to, and timeliness of radiology diagnostics 3.5 We work in partnership to effectively influence health and wellbeing outcomes, evident by: 3.6 We invest in information systems and technology in priority areas: 3.61 common patient administration system 3.62 single clinical workstation 3.63 regional clinical data repository 3.64 population health data repository 3.65 IS infrastructure 3.66 safe medication management 3.67 shared care plan

Three measurement categories to measure progress:

Process – steps that will be completed by a particular date

Foundations – building blocks that need to be in place

Outcomes – achievements and benefits

Appendix 2: Northland Health Services Plan

The importance of the NHSP and how it was assembled is described in 2.3 Northland Health Services Plan. This section includes extracts which highlight key outcomes and the road ahead.

Executive summary – overview

Over the next 20 years, the health needs of the Northland population will increase as a result of population growth and ageing, and increasing prevalence of long term conditions (LTCs). Furthermore, health inequities between Maori and Non-Maori may worsen, given the prevalence and impact of LTCs, associated risk factors such as obesity, relative differences in socio-economic status, and the impact of poor local economy performance (Northland has the lowest GDP of any region in New Zealand).

Northland primary health, community and hospital services today are under demand pressure. The forecast future escalation in demand will mean services will need considerably increased capacity, but this cannot simply be 'more of the same' if population outcomes are to improve, and inequities are to reduce. The need for change is compounded by medium-long term forecasts of supply-side constraints in operational and capital funding, and availability of workforce. Some Northland facilities are already at or approaching maximum capacity.

Together these factors point to the unsustainability of the Northland health system in its current form. 'Future-proofing' requires different resource allocation patterns, and adoption of new ways of working that improve access, make better use of the available workforce, and improve service performance. New and enhanced facilities and improved use of technologies are also required.

The Northland Health Services Plan (HSP) describes these future challenges, and the responses that will lay the foundation for long-term clinical and financial sustainability. The HSP has been developed in conjunction with key clinical and managerial leaders from across the Northland health system, together with input from wider stakeholder groups. It builds on existing Northland DHB plans, and learnings from other systems - locally and regionally in New Zealand, and internationally.

The HSP has a 20-year horizon, with a particular focus on the early actions that anticipate the intensifying pressures on the Northland health system, and reduce the risk of crisis-driven, reactive responses.

An HSP Outcomes Framework has been developed using the Triple Aim methodology: achieving improvements in population health, patient experience, and cost / productivity simultaneously. Six 2017 Headline Targets have been identified and a range of Headline Actions developed to contribute to achieving these Targets. The Targets are challenging but feasible. They demonstrate the commitment of Northland health sector leaders to making real improvements in the health and care experience of all Northlanders. Importantly they also demonstrate the strong commitment of these leaders to address longstanding health inequities between Northland Maori and Non-Maori.

Outcomes Framework

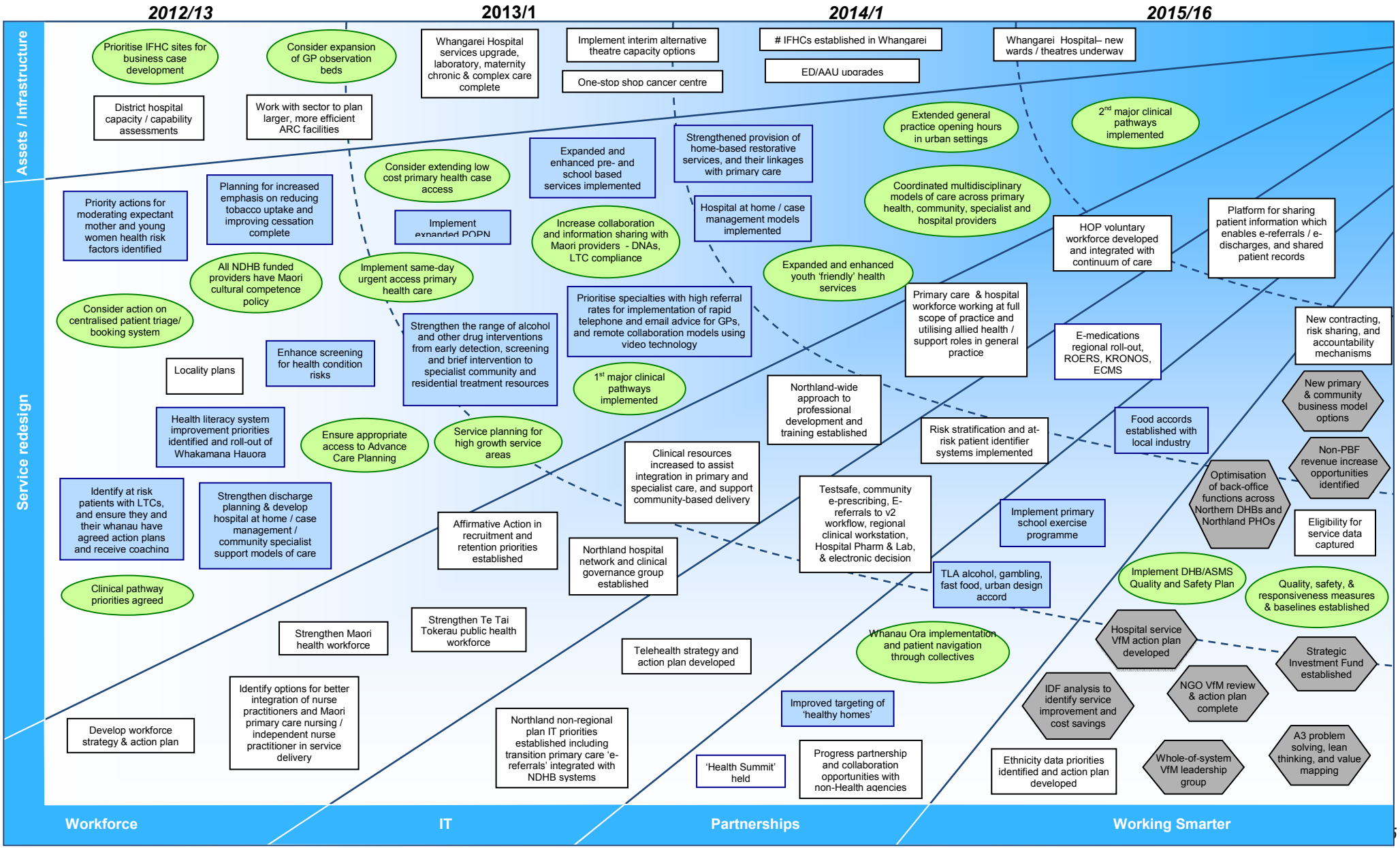
The following table describes the Outcomes Framework in full at its highest four levels. The three Outcome Areas match those of the Northern Region Health Plan. Each of them has a full set of Headline Actions and Performance Measures which are too detailed to reproduce here. All are supported by Enablers (workforce capability and capacity, information systems and technology, assets and infrastructure, partnerships and community development, working smarter), each of which has its own set of actions.

Outcome Areas	Population Health	Patient Experience	Cost and Productivity
Outcome Goals	Improving the health of Northlanders and reducing	Patients and whanau experiencing clinically and culturally safe, good quality,	The Northland health system living within available funding by improving productivity and

	health inequities		effective, efficient and timely care		prioritising resources to their most cost effective uses	
2017 Headline Targets	Life expectancy gap between Maori and non-Maori is reduced by 2 years	Unplanned hospital admissions for Northlanders are reduced by 2,000 annually by 2017	Every Northlander with urgent health needs has same day access to primary care	>95% of patients report they would recommend the service provided	Value for money savings of $5m achieved against projected cost increases every year	Northland hospital labour productivity benchmarks in top 5 of DHBs
Objectives	Increasing the number of Northlanders who are health literate and living healthy lifestyles, with a particular focus on improving Maori health outcomes. Increasing the availability of and access to services in primary and community settings, particularly urgent, intermediary ('step down') and restorative services. Improving primary care access to specialist advice to support community-based care.		Ensuring patients and their whanau are supported throughout their care pathways with early interventions to address health needs and risks, and links with social services. Providing patients and whanau with access to more personalised health services, including active involvement in their own care planning. Ensuring Northland health organisations operate with cultural competence.		'Working smarter' to reduce duplication and waste. Ensuring service investment and provider performance demonstrates value for money. Strategic investment in new models of care, service innovations and capacity development.	

The Road Map on the next page locates the Headline Actions according to which Enabler they apply to, and divides them according to the year in which they are planned to occur.

This indicative implementation Roadmap has been developed for key initiatives proposed in the NHSP. Given the constrained funding environment that the Northland health system is operating in, review of this Roadmap will be needed to prioritise initiatives and agree implementation timeframes throughout the planning period.
Key: BLUE Rectangles (Population Health), GREEN Ovals (Patient Experience), GREY Hexagons (Cost/Productivity), and WHITE Rectangles (Enablers).



Appendix 3: Diabetes Care Improvement Package

Purpose of this document

This document outlines the proposal for the use of the Diabetes Get Checked funding to be utilised for the Diabetes Care Improvement Package (DCIP). The proposal has been developed jointly between NDHB and the two PHOs. This version five document supersedes earlier draft versions and takes account of the comments received from a wide variety of stakeholder groups including:

- Meetings with primary health care staff around the district
- PHO clinical governance groups
- Long-term conditions clinical governance group
- Maori health provider organisations
- Diabetes NZ
- Alliance Leadership Team (meeting due 11th May)
- MoH.

This proposal focuses on the single disease diabetes and the new DCIP because this is the immediate task requirement. However this proposal is part of a wider integrated approach within a broad-based long term conditions strategy which encompasses a whole of system view (hospital, primary, preventative, self management).

Background

The diabetes annual free check (AFC) or "Get Checked" programme currently supports a free annual check for those diagnosed with diabetes.

From 1 July 2012, the *Get Checked* programme will be replaced with the *Diabetes Care Improvement Package (DCIP) i.e*. DHBs will use the funding currently allocated to the *Get Checked* programme to provide the *Diabetes Care Improvement Package*, planned in consultation with primary care.

There is to be no national consistent model for the proposed improvement packages, and DHBs have the flexibility to negotiate with their providers (especially primary care) as to what form these packages should take. DHBs are expected to use the funding currently allocated to the *Get Checked* programme to provide the *Diabetes Care Improvement Package.*

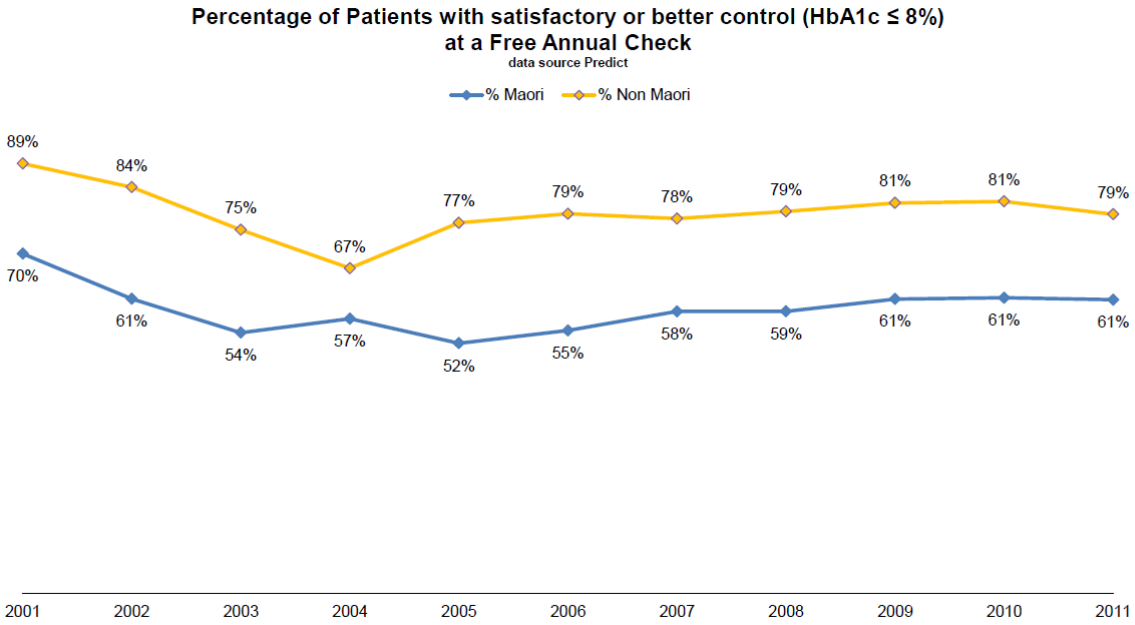
It should be noted that although the diabetes check is no longer free after 30 June 2012, it is expected as part of the DCIP that all patients with diabetes should continue to have their annual diabetes check, as part of evidence based good diabetes management.

Current Situation in Northland

Northland currently has 7,837 known patients with diabetes registered with GP Practices within our two Northland PHOs. The Northland diabetes prevalence is forecast to increase by 72% from 2009 to 2026; in part by ageing and ethnicity trends, but also in part by the developing obesity epidemic. Much of this increased demand will manifest itself as additional workload for primary health care and community services. It is seen as a priority that the capacity and capability within primary health care is developed to deal with this predicted increase in demand. It is believed the disease burden could be reduced through better systematic identification and management of patients with diabetes.

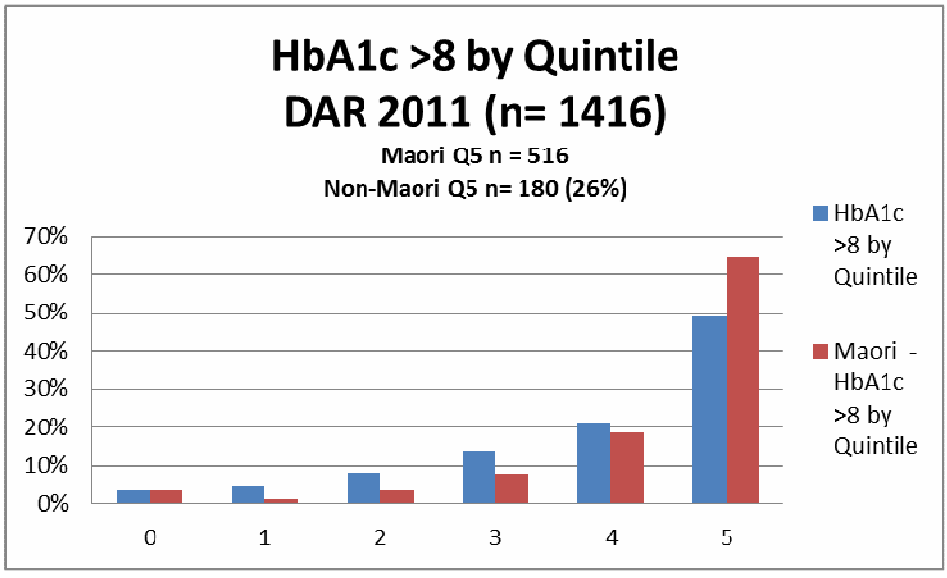
The PREDICT template provides a consistent format for recording findings from a CVD assessment and diabetes check (which includes a foot check and the recording of when a patient last attended retinal screening). The Northern Region Diabetes Guidelines recommend that patients have an annual check. The information extracted from the PREDICT system provides a comprehensive database on Northland's identified diabetes population managed by primary care. This information is available by GP Practice and PHO and the reports are provided to the PHO clinical governance groups and NDHB.

In the past few years whilst Northland has achieved or been close to the national target of 80% of known patients with diabetes attending Diabetes Annual Free Checks it should be noted it has not always achieved this for Maori with our last quarterly report indicating only 59% for Maori[50]. We have also not done so well on the HbA1c <64mmol/mol management. This is the case particularly for our Maori population. The graph below shows our progress in managing HbA1C levels as a district since 2001.



Currently the percentage of Maori with HbA1Cs under 64mmol/mol is 61% and non-Maori at 79%.

A similar disparity is reflected in our Quintile 5 population when compared to other quintiles. Of those patients with less than optimal glycaemic control 49% have a quintile 5 address. The bulk (75%) of those are Maori but 26% or n=180 are non-Maori.



We are also aware there is variation in KPI indicators relating to the management of diabetes by GP Practice. The two indicators that are reported on; i) percentage of Diabetes Annual Review (DAR) and ii) good glycaemic control show a wide variation in performance between GP Practices within Northland[51]. Much of the focus of this proposal is about reducing the variability in these process outcomes and ensuring

[50] Quarter 2 Jan 2012 MOH Quarterly Reports

[51] It should be noted that the number of patients with Diabetes per practice also varies significantly with twelve practices having under 100 and three practices with over 500 identified patients with diabetes.

Northland continues with its existing robust data reporting system (PREDICT/DrInfo) and feedback to GP Practices.

	Range between practices across Northland (Te Tai Tokerau and Manaia PHOs)
DAR	13%-89%
Good Glycaemic control	36%-88%

The proposal should not be seen in isolation from the other developments/initiatives' taking place or planned for diabetes services and other long-term conditions including CVD. Many of these are targeted at assisting GP Practices develop capacity and capability to follow best practice guidelines and evidence based practice and will assist in the delivery of the Diabetes Care Improvement Package. These include:

- Ongoing support of nurses delivering care to patients with diabetes
- Implementation of clinical nurse champions in each GP Practice (Manaia PHO)
- Implementation of population health nurse champions in each GP Practice (Te Tai Tokerau PHO)
- Roll-out of train-the-trainer conversation maps for patient education across the district
- KPI reporting by GP Practice to PHO clinical governance groups and individual GP Practices
- Survey of nursing staff (primary/community/secondary) on clinical skills and knowledge in the management of diabetes to aid workforce development planning
- Increase in the number of 2-day training courses for primary care nurses provided by the Diabetes Centre to include provision in mid and far north localities
- Development of nutritional/obesity strategy across the district
- Development of a podiatry service strategy across the district
- Continued development of Long term conditions strategy
- Continuation and expansion of self management programme roll-out for LTCs Stanford model "Whakamana Hauora"
- Review patient diabetes education sessions and resources, including stocktake and evaluation
- Whanau Ora CVD / Diabetes Demonstration Sites will implement early intervention and self management programmes to assess and manage the conditions
- Build business case to further develop electronic patient management tools (Electronic Care Planning for Chronic Disease)
- Mentoring project/Quality Improvement Teams (QITs).

Feedback from clinical staff involved in delivery of diabetes services

A summary of the 'bottom-line' requirements identified at the three locality meetings held around the district in February 2012 to elicit clinical staff feedback as to what should be contained in the Diabetes Care Improvement Packages is provided below.

Issue	Whg	KK	Kaitaia
Practice specific interventions	X	X	
Quality Improvement Teams		X	
Keep database (Predict) and use the audit tools	X	X	X
Education of nurses	X	X	X
Nurses delivering service	X	X	X
Connect with Care Plus	X		
Education of patients /lifestyle/health literacy	X	X	X
Not to be used to fund podiatry or retinal	X		X
Free at the point of access should remain	X		
Money must continue to flow		X	
No more fragmentation – need co-ord		X	
Every provider has to meet the same standard		X	
Keep money in primary health			X
Use to reduce HbA1c			X
Dietary advice tools – supermarket tours	X	X	X
Work collaboratively – share resources between practices			X

At the meetings there was a recognition that each GP Practice organised its diabetes services differently and therefore whatever was developed for the DCIP it must be flexible and designed to take account of this variability.

One element which was considered essential by all three groups was to maintain the use of the PREDICT template so that the comprehensive database developed for Northland's patients with diabetes managed by primary health care could be maintained.

Improved dietary/nutrition support and lifestyle advice was another theme which was identified by many in the meetings as was the need for primary care nurses to provide more of the services to patients with diabetes.

Two of the groups requested that the funding should not be used to fund additional podiatry and retinal screening, not because these items were not considered important but because it was felt they should be funded from other sources.

Details of proposal

The change stipulated by the recent MoH directive introducing the DCIP merely removes the 'free' or 'subsidised' element of the annual diabetes check. Responsibility for the provision of primary-led diabetes services remains with the GP Practice. Completion of an annual diabetes check is part of evidence based good practice guidelines and it is expected GP Practices will continue to adhere to those guidelines in their management of patients with diabetes. This includes a foot check and the recording of the completion of retinal screening. It is also expected that the PREDICT template will continue to be completed for all patients attending an annual check.

Both of these are pre-conditions to any GP Practice receiving DCIP funding.

There is also an expectation all Northland GP Practices will participate in this DCIP scheme.

The principles embedded within this proposal are for positive action to:

- Redress the current inequitable outcomes for Maori patients with diabetes within Northland
- Support and strengthen a continuous quality improvement culture within primary health care
- Support GP Practices to plan for and audit their outcomes for their enrolled population
- Continue to develop capacity and capability of the workforce for diabetes in primary health services
- Strengthen multi-disciplinary working and in particular to support a nurse-led delivery model of diabetes services (as appropriate). This includes the current provision of Maori health providers nurse based services
- Every GP Practice is different and organises its diabetes services differently.

Any plans for change should be supported by robust quality improvement methods and practice. In line with other DCIP proposals being developed within the Northern Region[52] Practice centred collaborative methodology where clinical and quality improvement expertise combine to support GP Practices to collectively work together to improve service provision is a fundamental component of this proposal.

Funding constraints demand that services be targeted towards meeting the needs of those most in need. The focus for the DCIP will therefore be on High Needs Patients (identified as Maori, Pacific or from Quintile 5 as this is where it is believed is Northlands greatest need[53].

It is believed the current system with a monetary amount paid for each Diabetes Annual Free Check (on top of the capitation funding formulae) is transactional in nature and maintains the fee-for-service culture in primary care. The introduction of the DCIP provides the opportunity to move away from this approach and to further develop the planned proactive care that is fundamental to the long term condition management that forms a population health approach within each GP Practice. Participation in the DCIP is not negotiable and is expected across both PHOs.

[52] Counties Manukau DHB Replacement of Get Checked and Revised CVD Risk Assessment Target Discussion document for consultation. March 2012.

[53] Northland does not normally report data broken down by Pacific ethnicity because the numbers are relatively small and mean that individuals are potentially identifiable at the GP Practice level data.

It is proposed that a quality team from each PHO will support each GP Practice to develop a specific diabetes action plan for that individual practice for the following 12 months. Practice plans where performance has been consistently below expectation will identify the systems, processes and/or workforce competency issues that contribute to lack of achievement and will include involvement of the PHO quality teams as relevant. The receipt of any funding by the GP Practice will be dependant on the production of an agreed action plan. The plan will include the following:

- Identification and focus on each GP practice's *high needs patients with diabetes* and development of a plan to improve the management of these patients. This may include the GP Practice using the DCIP funding to purchase more nursing time, send nurses on CNE, re-align kaiawhina services- community health worker time etc. from local NGOs as part of Whanau Ora. It may also include actions like developing new service models with the mobile nurses provided by Maori NGOs and small GP Practices sharing resources with other GP Practices that are geographically close.
- Improvement in performance on specified KPIs over a 12 month period. The targets will be negotiated with each GP Practice and will use as a starting point their current performance. The KPIs will be finalised by NDOW as part of its clinical governance role but they are likely to include the following process outcomes:
  - % of patients with HbA1C below 64[54]
  - % patients with diabetes with BP <130/803
  - % patients with diabetes with CVD risk is >15% over 5 years on statins
  - % patients with TC <4.0 and LDL <2.03
  - % smokers
  - % on ace inhibitors etc.
- Evidence for the outcomes of lifestyle interventions, dietary advice, exercise is somewhat weak. It is therefore proposed that the HbA1C be used as the main indicator for the success or otherwise of these lifestyle interventions.
- Adherence to recommended clinical guidelines in relation to diabetes care (note this includes an annual check which includes a foot check). There will be an expectation that the number of checks will increase in line with the increasing number of diabetes's patients enrolled with each GP Practice;
- Completion of the PREDICT template for all checks completed on patients with diabetes;
- Evidence of the use of systematic processes in place for audit and recall of patients with diabetes.

This approach recognises the principle of 'proportional universality' whereby it is recognised there are certain 'givens' e.g. adherence to clinical guidelines, completion of the PREDICT template etc. but that there needs to be extra focus where it is most needed, namely on high needs patients with diabetes.

A copy of a sample GP Practice plan is attached as appendix 1. In recognition of the need for positive action to redress the current inequitable outcomes for Maori patients with diabetes within Northland the GP Practice plan identifies separate targets for Maori and it is expected that higher targets for improvement will be set for these indicators (as relevant).

The PHOs will be responsible for the operational aspects of the DCIP scheme including:
- The payment schedule to GP Practices – this is expected to be monthly
- Agreeing the GP Practice Plans including the targets (working within the parameters set by NDOW)
- Regular monitoring of progress with each GP Practice and their individualised plan
- Provide Quality Improvement Team support to each practice
- Provide quarterly reports to NDOW
- Ensure consistency is applied between the two PHOs in the operation of the scheme.

Te Tai Tokerau PHO (the lead PHO) will provide a quarterly report to NDHB for contract monitoring purposes.

DCIP Programme Goals

The following have been identified as overall programme goals:

[54] NZ Guidelines Group: Management of Type 2 Diabetes

1 There will be a reduction in disparity between Maori and non-Maori patients in the management of their diabetes throughout Northland

   Measured by: a) difference in the HbA1Cs between Maori and non-Maori reducing

   b) number of Maori seen in primary care as part of their diabetes management increases

2 All GP Practices will develop a GP Practice specific plan for their patients with diabetes

   Measured by: a) signed GP Practice individualised plans by October 2012

3 All GP Practices will continue to use the PREDICT population health system to monitor adherence to evidence based guidelines on the management of Diabetes.

   Measured by: a) production of quarterly reports on progress using PREDICT data

4 Development and implementation of quality improvement methodology implementation in primary care

   Measured by: a) QIT teams established and working with GP Practices,

   b) Diabetes Nurse Champions in GP Practices developed (Manaia PHO),

   c) Population Health Champions developed (TTT PHO),

   d) roll-out of train-the-trainer for Conversation Maps

5 There will be evidence of improved alignment and shared care between general practice an Maori provider mobile nursing teams where available with formal case management processes established.

Governance of DCIP Scheme

Northland is part of the Northern Region Diabetes Clinical Network and will continue to use the expertise and advice made available to it through this group. Reports on progress of the DCIP will be made to the clinical network. Further, the clinical lead of the regional network has been invited to become a member of NDOW.

There will be a two-tier governance structure which builds upon the pre-existing clinical governance structure for diabetes in primary health care. At an operational management level the two individual PHO clinical governance groups will monitor progress and advise actions with each GP Practice.

At a Northland wide level the Northland Diabetes Operational Workstream (which incorporates the Local Diabetes Team - LDT) will have the overview of progress. Its role will be to:

- Identify broad principles for the operation of the DCIP
- Set clinical target parameters
- Review quarterly progress of each GP Practice (anonymised)
- Review the operation of the DCIP scheme after 12 months

Quarterly progress reports and sources of monitoring data

Northland has 100% coverage for Dr Info and the PREDICT database system within primary care. The PREDICT system holds detailed information on approximately 5,000 patients with diabetes who have had a diabetes annual review. This leaves approximately 2,500-3,000 patients with diabetes who are enrolled with a GP Practice but have never had an annual diabetes review and are not on the PREDICT database. The intention is that the monitoring of progress with the DCIP will include reviewing information on ALL known patients with diabetes. A copy of a sample quarterly report covering ALL known diabetes patients is provided overleaf. Unfortunately it is not possible to break down these indicators by Maori, Non-Maori at this point of time as this report is generated by Dr Info.

A second report providing the more detailed information on diabetes patients that have attended an annual review and are therefore on the PREDICT database will provide information on the progress to achieve the individual GP Practice Plan. This report will provide information by Maori and non-Maori.

Diabetes Care Improvement Quarterly Reporting											
	Patients with Diabetes	Current with DAR (15mths)		"Good" BP control		"Good" lipid control		"Good" Glycaemic Control		Not prescribed Asprin	
	n=	n=	%	n=	%	n=	%	n=	%	n=	%
	95	76	80%	88	93%	66	69%	77	81%	43	45%
	540	459	85%	510	94%	399	74%	373	69%	133	25%
	105	87	83%	101	96%	74	70%	68	65%	35	33%
	433	323	75%	106	24%	361	83%	156	36%	236	55%
	94	82	87%	89	95%	75	80%	55	59%	30	32%
	374	125	33%	296	79%	218	58%	249	67%	160	43%
	302	185	61%	272	90%	198	66%	228	75%	126	42%
	185	131	71%	162	88%	129	70%	144	78%	84	45%
	147	112	76%	138	94%	108	73%	89	61%	52	35%
	73	52	71%	66	90%	51	70%	60	82%	27	37%
	62	47	76%	58	94%	42	68%	50	81%	22	35%
	542	368	68%	508	94%	396	73%	416	77%	184	34%
	246	218	89%	235	96%	163	66%	182	74%	117	48%
	51	39	76%	50	98%	36	71%	39	76%	13	25%
	173	139	80%	164	95%	114	66%	113	65%	79	46%
TTTPHO Totals	**3422**	**2443**	**71%**	**2843**	**83%**	**2430**	**71%**	**2299**	**67%**	**1341**	**39%**
	188	140	74%	170	90%	120	64%	148	79%	86	46%
	533	393	74%	471	88%	374	70%	419	79%	181	34%
	363	235	65%	334	92%	265	73%	299	82%	114	31%
	591	432	73%	535	91%	426	72%	431	73%	243	41%
	57	37	65%	44	77%	35	61%	40	70%	24	42%
	79	68	86%	76	96%	58	73%	66	84%	32	41%
	55	42	76%	52	95%	40	73%	42	76%	20	36%
	24	3	13%	13	54%	10	42%	21	88%	14	58%
	341	185	54%	320	94%	229	67%	255	75%	164	48%
	302	228	75%	265	88%	207	69%	207	69%	139	46%
	337	261	77%	306	91%	244	72%	276	82%	80	24%
	85	67	79%	79	93%	57	67%	50	59%	26	31%
	140	104	74%	117	84%	91	65%	105	75%	75	54%
	272	203	75%	261	96%	196	72%	178	65%	154	57%
	128	94	73%	111	87%	85	66%	91	71%	77	60%
	158	132	84%	150	95%	100	63%	100	63%	84	53%
	74	66	89%	73	99%	51	69%	39	53%	21	28%
	156	131	84%	146	94%	116	74%	123	79%	71	46%
	88	70	80%	79	90%	65	74%	66	75%	17	19%
	106	38	36%	101	95%	62	58%	78	74%	47	44%
	171	108	63%	134	78%	125	73%	136	80%	79	46%
	167	85	51%	156	93%	113	68%	123	74%	48	29%
Manaia PHO Totals	**4415**	**3122**	**71%**	**3993**	**90%**	**3069**	**70%**	**3293**	**75%**	**1796**	**41%**
data source Dr Info Mar 12	**Targets**		**80%**		**80%**		**80%**		**80%**		

The MoH requires quarterly reporting on progress with the DCIP from the NDHB.

Implementation of programme

It is proposed that a two staged approach is taken covering years 2012/13 and 2013/14.

The first year of implementation will focus on changing the model of care within GP Practices from a fee-for-service approach to one of a more focused population health approach. The second stage will focus on developing an alliancing approach between our Maori NGOs, GP Practices, PHOs and the District Health Board, along with making sure we have integrated IT systems across the different organisations capturing all the diabetes data.

For the 2013/14 (2nd year of the DCIP) we will review the total diabetes spend including the DCIP funding principles to see how these might best support building those strong relationships/alliancing and integrating the diabetes activity across GP Practice and Maori health providers.

Evaluation of programme

As this is the first year of operation it is vital that we evaluate the scheme. Discussions are currently underway with the Northern Region Diabetes Clinical Network with a view to them evaluating the four different Northern region DHB's DCIP plans.

The budget and administration of the scheme

A budget has been estimated for 1 July 2012 to 30 June 2013 based on current prevalence and target rates for the Diabetes Annual Free Checks of **$370,664**.

For the first year of operation it is proposed that as a minimum the overall amount of money paid to the GP Practices will be the same as 2011/12 payments for the diabetes Annual Free Checks (i.e. approx. $290K) and the remaining funding will be paid to each PHO to support the administration and implementation of the scheme, and assist in the provision of the support to the GP Practices including the formation of the Quality Improvement Teams.

The total amount of money identified to be paid to all the GP Practices for fulfilment of their plans is to be based on the following principles for the financial year 2012/13:

- There will be a minimum payment to every GP Practice when signed-up to a Practice Plan ie a minimum "floor" payment of: 1 day of nurse time per month (this rate will be consistent throughout Northland)
- No practice receives less than 90% of the funding they received last year through the Diabetes free annual check programme. **T**his principle is intended to smooth the way in the transition from the old DAR programme to the new DCIP programme
- A component of the payment will be based on the GP Practices diabetes register (50%)
- A component of the payment will form a 'High Needs Adjuster' to take account of the number of high needs/poor glycaemic controlled patients with diabetes registered with each GP Practice (50%).

The individual GP Practice Plan will form the basis for the reporting template and assist with identifying specific coaching, training and mentoring needs for each GP Practice.

A monthly payment schedule to GPs (utilising the DAR monies) will be developed and agreed by the two PHOs.

If progress is not achieved according to the individualised GP Practice Plan consideration will be given to modifying the payment provided to the relevant GP Practice. This will follow significant support, coaching and mentoring or other appropriate action to improve practice.

NDHB will contract with the lead PHO for the provision of the DCIP. This proposal document will form an addendum to the contract.

GP Practices will be encouraged to provide diabetes review and management services free to the service user. Many patients with diabetes meet the current Care Plus criteria and this could be the mechanism to provide a free consultation.

Timeline for Implementation of DCIP by July 2012

The Diabetes Care Implementation Package comes in to operation 1st July 2012. The timetable is extremely tight to achieve implementation by 1st July 2012.

Pre implementation of the programme a pragmatic approach is being proposed where a number of actions will occur simultaneously to fit in with various meeting schedules. In particular this means that once NDOW has received comments back from key stakeholders the proposal will be taken to the various groups (LTC CG, ALT) in May. It also means that if a timescale does not fit with existing meeting schedules (e.g. PHO clinical governance committees, comments may need to be provided electronically).

The DHB and PHOs will need to develop a detailed implementation plan and communications strategy to key stakeholders including consumers prior to the start of the DCIP scheme.

Whilst it is anticipated the development individual GP Practice Plans will occur before the 1st July deadline it is accepted that not all plans may be agreed by the 1st July start date. The intention though is for all GP practice plans to be completed by August so as to not disrupt the payment schedule to GP practices significantly.

Detailed timetable provided below.

Proposed timetable

Action	Mar	Apr	May	June	July	Aug
NDOW sends draft proposal to key stakeholders for comment/endorsement						
Summary of draft proposal sent to MoH as part of Annual Plan for Information						
Summary of draft proposal sent to Regional Clinical Diabetes Network for Information						
Receipt of comments from key stakeholders: • PHO Clinical Governance Groups • Maori Health Providers • NZ Diabetes • Attendees at the three locality meetings • Relevant NDHB GMs • Secondary Care Diabetes SMO						
Lead PHO Identified						
Development of PHO Implementation Plan						
NDHB – Lead PHO Contract Specification developed						
Paper goes to LTC CGG at its May Meeting (first week of May(						
Paper goes to ALT Meeting (11th May)						
Proposal to NDHB CFO for approval Mid May						
PHOs start implementation Plan						
PHOs finalise GP Practice Plans						

Kathryn de Luc
Primary Care Development Manager
Northland DHB, May 2012

DCIP Appendix One

Diabetes Care Improvement Plan for xxx Practice

All baseline data is taken from 2011 Diabetes Annual Reviews

Treatment Targets	Actual Performance 2011	Indicator	Agreed improvement by June 2013
	543	Patients have Diabetes coded in your PMS	
Actions			
Dr Info audit is used to identify • patients with pre-diabetes requiring monitoring for early diagnosis of diabetes			
90%	422(78%)	Patients received Annual Review in 2011	80%
90%	292 (60%)	Maori Patients received Annual Review in 2011	70%
Actions			
• patients without or overdue are offered an annual review (Dr Info audit) • review of recall systems with recommendations for improvement implemented • liaise with Maori organisations to improve uptake • monitor rate of reviews by month			
80%	289(68%)	Patients with "good" glycaemic control (<65mmol/mol)	73%
80%	183(63%)	Maori Patients with "good" glycaemic control(<65mmol/mol)	73%
-	89(21%)	Patients are on insulin	-
Actions			
• identify patients with poor glycaemic control and review treatment plan with prescriber • support patients with poor control to access shopping tours and conversation maps • ensure every patient has a care plan and provide extra support to those with poor control • review initiation of insulin with recommendations for improvement implemented			
80%	268(91%)	Patients whose CVD risk is >15% over 5 years are prescribed an antihypertensive	Maintain
80%	186(91%)	Maori Patients whose CVD risk is >15% over 5 years are prescribed an antihypertensive	Maintain
80%	332(79%)	Patients whose CVD risk is >15% over 5 years are prescribed a statin or lipid lowering drug	80%
80%	233(80%)	Maori Patients whose CVD risk is >15% over 5 years are prescribed a statin or lipid lowering drug	Maintain
80%	307(73%)	Patients whose CVD risk is >15% over 5 years are prescribed a platelet thinning or anti-coagulant	77%
80%	209(72%)	Maori Patients whose CVD risk is >15% over 5 years are prescribed a platelet thinning or anti-coagulant	77%
80%		Patients with BP <130/80	Maintain
80%		Maori Patients with BP <130/80	Maintain
		Patient with total cholesterol <4.0 and LDL <2.0	
		Maori Patient with total cholesterol <4.0 and LDL <2.0	
-	214(51%)	Patients with micro albuminuria or overt nephropathy	-
-	162(55%)	Maori Patients with micro albuminuria or overt nephropathy	-
80%	189(88%)	Patients with renal disease on an ACE/ARB[3]	Maintain
80%	142(87%)	Maori Patients with renal disease on an ACE/ARB[3]	Maintain
Actions			
• continue to monitor and support best practice prescribing • review DrInfo audits to identify patients and review treatment plans with prescriber			

A quarterly report is required from each GP Practice on progress with target and a brief narrative report with comments on progress with other actions such as liaison with Maori providers etc.

…… (signature) **……(signature)**
GP Practice Principal **PHO CEO**

Appendix 4: Statement of Accounting Policies

The Financial Statements included in this plan have been prepared using the following Accounting Policies. These policies are also used by the Northland District Health Board to prepare its Annual Report which is audited by Audit New Zealand. There have been no changes to the Accounting policies during the periods reported upon.

Reporting entity

Northland District Health Board (NDHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. NDHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. NDHB is a reporting entity for the purposes of the NZ Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Crown Entities Act 2004 and the Public Finance Act 1989.

NDHB is a public benefit entity (PBE), as defined under NZIAS 1.

The consolidated financial statements of NDHB and group for the year ended 30 June 2010 comprise NDHB and its joint venture subsidiary the Kaipara Total Health Care Joint Venture (54% owned).

NDHB's activities involve funding and delivering health and disability services in a variety of ways to the community.

Statement of compliance

The consolidated financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS) as appropriate for public benefit entities, and other applicable Financial Reporting Standards as appropriate for public benefit entities.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

Basis of preparation

The financial statements will be presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on historical cost basis except for land and buildings that are stated at their revalued amounts.

The accounting policies as set out below have been applied consistently to all periods presented in these consolidated financial statements.

The preparation of financial statements in conformity with NZIFRS requires management to make judgments, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions will be based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgments about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates will be recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

There have been no changes in accounting policies during the financial year.

The Board and group have adopted the following revisions to accounting standards during the financial year, which have only had a presentational or disclosure effect:

NZ IAS 1 Presentation of Financial Statements (Revised 2007) replaces NZ IAS 1 Presentation of Financial Statements (Issued 2004). The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with owners. The Board and group have decided to prepare a single statement of comprehensive income for the year ended 30 June 2010 under the revised standard. Financial statement information for the year ended 30 June 2009 has been restated

accordingly. Those items of other comprehensive income presented in the statement of comprehensive income were previously recognised directly in the statement of changes in equity.

Amendments to NZ IFRS 7 Financial Instruments: Disclosures. The amendments introduce a three-level fair value disclosure hierarchy that distinguishes fair value measurements by the significance of valuation inputs used. A maturity analysis of financial assets is also required to be prepared if this information is necessary to enable users of the financial statements to evaluate the nature and extent of liquidity risk. The transitional provisions of the amendment do not require disclosure of comparative information in the first year of application.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted, and are relevant to NDHB include:

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NA IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. NDHB has not yet assessed the effect of the new standard and expects it will not be early adopted.

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by NDHB. Control exists when NDHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

The consolidated financial statements include the parent (Northland District Health Board) and its subsidiary. The subsidiary is accounted for using the purchase method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis. All significant inter-entity transactions are eliminated on consolidation.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

Investment in subsidiaries are carried at cost in NDHB's own "parent entity" financials statements.

Budget Figures

The budget figures are those approved by the health board in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by NDHB for the preparation of these financial statements.

Foreign currency transactions

Transactions in foreign currency are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign

currencies that are at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings
- plant and equipment
- vehicles
- work in progress.

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and accumulated impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer every three years. The net revaluation results are credited or debited to other comprehensive income and is accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that offsets a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive income.

Accumulated depreciation at revaluation date is eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount.

Property that is being constructed or developed for future use as investment property is classified as property, plant and equipment and stated at cost until construction or development is complete, at which time it is reclassified as investment property.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, Plant and Equipment Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Northland Health Limited (a hospital and health service company) vested in Northland District Health Board on 1 January 2001. Accordingly, assets were transferred to NDHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus or deficit is calculated as the difference between the net sales price and the carrying amount of the asset. The gain or loss is recognised in the reported net surplus of deficit in the period in which the transaction occurs. Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to retained earnings.

Additions to property, plant and equipment

The cost of an item of property, plant and equipment is recognised as an asset if, and only if, it is probable that future economic benefits or service potential associated with the item will flow to NDHB and the cost of the item can be measured reliably.

In most instances, an item of property, plant and equipment is recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Leased assets

Leases where NDHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of

finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

The property held under finance leases and leased out under operating lease is classified as investment property and stated at fair value. Property held under operating leases that would otherwise meet the definition of investment property may be classified as investment property on a property-by-property basis.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to NDHB. All other costs are recognised in the statement of comprehensive income as an expense as incurred.

Depreciation

Depreciation is provided using the straight line method on all property plant and equipment other than land, and recognised in the surplus or deficit.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are:

Class of asset	Estimated life	Depreciation rate
Buildings		
Structure	1 to 65 years	1.5% - 100%
Services	1 to 25 years	4% - 100%
Fit out	1 to 10 years	10% - 100%
Plant and Equipment	1 to 10 years	10% - 100%
Motor Vehicles	5 years	20%

The residual value of assets is reassessed annually to determine if there is any indication of impairment.

Work in progress is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Borrowing costs

For each property, plant and equipment asset project, borrowing costs are recognised as an expense in the period which they are incurred.

Intangible assets

Intangible assets that are acquired by NDHB are stated at cost less accumulated amortisation and impairment losses.

Costs that are directly associated with the development of software for internal use, are recognised as an intangible asset. Direct costs can include the software development employee costs and an appropriate portion of relevant overheads.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is provided in the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use.

Class of asset	Estimated life	Amortisation rate
Software	2 to 3 years	33% - 55%

Impairment of property, plant and equipment and intangible assets

Intangible assets that have an indefinite useful life, or not yet available for use, are not subject to amortisation and are tested annually for impairment. Assets that have a finite useful life are reviewed for indicators of impairment at each balance date. When there is an indicator of impairment the asset's recoverable amount is estimated. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable

amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the entity would, if deprived of the asset, replace its remaining future economic benefits or service potential.

The value in use for cash-generating assets and cash generating units is the present value of expected future cash flows.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus of deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Financial Instruments

Non-derivative financial instruments

Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Financial instruments are initially recognised at fair value plus transaction costs unless they are carried at fair value through surplus or deficit in which case the transaction costs are recognised in the surplus or deficit.

Financial instruments are derecognised when the rights to received cash flows have expired of have been transferred and NDHB have transferred substantially all the risks and rewards of ownership.

Financial assets are classified into the following categories for the purposes of measurement:

- fair value through surplus or deficit
- loans and receivables
- fair value through other comprehensive income.

Classification of the financial asset depends on the purpose for which the instruments were acquired.

Financial assets at fair value through surplus or deficit

Financial assets at fair value through surplus or deficit include financial assets held for trading. A financial asset is classified in this category if acquired principally for the purpose of selling in the short-term or is part of a portfolio that are managed together and for which there is evidence of short-term profit-taking.

Financial assets acquired principally for the purpose of selling in the short-term or part of a portfolio classified as held for trading are classified as a current asset.

After initial recognition financial assets in this category are measured at their fair values with gains or losses on remeasurement recognised in the surplus or deficit.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the balance date, which are included in non-current assets. NDHB's loans and receivables comprise cash and cash equivalents, trade and other receivables, term deposits, Trust / Special Fund assets and related party loans.

After initial recognition they are measured at amortised cost using the effective interest method less any provision for impairment. Gains and losses when the asset is impaired or derecognised are recognised in the surplus or deficit.

The effective interest rate method is a method of calculating the amortised cost of a financial instrument and of allocating interest over the relevant period. The effective interest rate is the rate that exactly discounts future cash receipts or payments through the expected life of the financial instrument, or where

appropriate, a shorter period to the net carrying amount of the financial instrument.

Financial assets at fair value through other comprehensive income

Financial assets at fair value through other comprehensive income are those that are designated as fair value through other comprehensive income or are not classified in any of the other categories above. They are included in non-current assets unless management intends to dispose of the investment within 12 months of the balance date.

NDHB's Bond investments that it intends to hold long-term but which may be realised before maturity are held in this category.

After initial recognition these investments are measured at their fair value, with gains and losses recognised in other comprehensive income except for impairment losses, which are recognised in the surplus or deficit.

On derecognition the cumulative gain or loss previously recognised in other comprehensive income is re classified from equity to the surplus or deficit.

Cash and cash equivalents

Cash and cash equivalents comprise cash balances and call deposits with maturity of no more than three months from the date of acquisition.

Accounting for finance income and expense is explained in a separate note

Interest-bearing loans and borrowings

Subsequent to initial recognition, other non-derivative financial instruments such as Interest bearing loans and borrowings, are measured at amortised cost using the effective interest method, less any impairment losses.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Trade and other payables

Trade and other payables are initially measured at fair value and subsequently stated at amortised cost using the effective interest rate method.

Impairment

At each balance sheet date NDHB assesses whether there is any objective evidence that a financial asset or group of financial assets is impaired. Any impairment losses are recognised in the surplus or deficit.

Loans and other receivables

Impairment of a loan or a receivable is established when there is objective evidence that NDHB will not be able to collect amounts due according to the original terms. Significant financial difficulties of the debtor/issuer, probability that the debtor/issuer will enter into bankruptcy, and default in payments are considered indicators that the asset is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted using the original effective interest rate. For debtors and other receivables, the carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account. Overdue receivables that have been renegotiated are reclassified as current (i.e. not past due). For other financial assets, impairment losses are recognised directly against the instruments carrying amount.

Financial assets at fair value through other comprehensive income

For equity investments, a significant or prolonged decline in the fair value of the investment below its cost is considered objective evidence of impairment. For debt investments, significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered objective indicators that the asset is impaired.

If impairment evidence exists for investments at fair value through other comprehensive income, the cumulative loss (measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in the surplus or deficit) recognised in other comprehensive income is reclassified from equity to the surplus or deficit.

Equity instrument impairment losses recognised in the surplus or deficit are not reversed through the surplus or deficit.

If in a subsequent period the fair value of a debt instrument increases and the increase can be objectively related to an event occurring after the impairment loss was recognised, the impairment loss is reversed in the surplus or deficit.

Inventories

Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cost is determined on a first in first out basis.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

Interest bearing borrowings

Interest bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plan

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Long service leave, sabbatical leave and retirement gratuities

NDHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated on an actuarial basis and involves the projection, on a year by year basis, of the entitlements, based on accrued service. These benefits are estimated in respect of their incidence according to assumed rates of death, disablement, resignation and retirement and the in respect of those events according to assumed rates of salary progression. A value is placed on the resulting liabilities by discounting the projected entitlements back to the valuation date using a suitable discount rate.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount NDHB expects to pay. These are recognised in the surplus or deficit when they accrue to employees. NDHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Sick leave

NDHB recognises a liability for sick leave to the extent that compensated absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent the NDHB anticipates it will be used by staff to cover those future absences.

Provisions

A provision is recognised at fair value when NDHB has a present legal or constructive obligation as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and that a reliable estimate can be made. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability. The movement in provisions are recognised in the surplus or deficit.

Revenue relating to service contracts

NDHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or NDHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Income tax

NDHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Goods and services tax

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities is classified as an operating cash flow in the statement of cashflows.

Commitments and contingencies are disclosed exclusive of GST.

Revenue

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year. It is measured at fair value of consideration received or receivable.

Goods sold and services rendered

Revenue from goods sold is recognised when NDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and NDHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to NDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by NDHB.

Rental income

Rental income is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Interest

Interest Income is recognised using the effective interest method.

Expenses

Operating lease payments

An operating lease is a lease whose term is short compared to the useful life of the asset or piece of equipment.

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method.

Equity

Equity is the community's interest in Northland District Health Board and is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into a number of components.

The components of equity are Retained Earnings, Revaluation Reserve (consisting of Land and Buildings), Trust/Special Funds and fair value through other comprehensive income reserves. Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund

component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Insurance Contracts

The future cost of ACC claims liabilities is revalued annually based on the latest actuarial information. Movements of the liability are reflected in the surplus or deficit. Financial assets backing the liability are designated at fair value through surplus and deficit.

Contingent liabilities

Contingent liabilities are recorded in the Statement of Contingent Liabilities at the point at which the contingency is evident. Contingent liabilities are disclosed if the possibility that they will crystallise is not remote.

Cost of Service (Statement of Service Performance)

The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of NDHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

NDHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost allocation policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Criteria for direct and indirect costs

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

Appendix 5: Glossary

Term	Definition or explanation
ABC	a service for helping smokers to quit which consists of Ask, Brief intervention, Cessation
ACP	Advance Care Planning, forward planning for end-of-life care for people with terminal conditions.
ACS	acute coronary syndrome
ALT	Alliance Leadership Team (see Clinical Integration section that introduces Module 3)
ANZACS	Australia and New Zealand Acute Coronary Syndrome registry
AOD	alcohol and other drugs
AP	Annual Plan
ARRC	age related residential care (defined further in Graphic 13)
ARRMOS	Auckland Regional Resident Medical Officer Services
ASH	ambulatory sensitive hospitalisations, a subset of avoidable hospitalisations (sometimes also Action on Smoking and Health)
ATS	Advanced Trainee Scheme (explained in 4.2.3)
B4SC	Before School Checks
BAG	Bipartite Action Group (explained in 4.2.3)
BOI	Bay of Islands
BSMC	Better, sooner, more convenient
CAMHS	Child and Adolescent Mental Health Service
CBT	cognitive behavioural therapy
CCDM	Care Capacity Demand Management programme
CEP	co-existing problems (in mental health and addictions)
CLAB	central line acquired bacteraemia, easily treatable infection occurring in patients with AIDS
COPD	chronic obstructive pulmonary [lung] disease
CT	computerised tomography [a type of scanner]
CTU	Council of Trade Unions
CVD	cardiovascular disease
CY	calendar year (as opposed to FY)
CYFS	Child Youth and Family Service, part of the Ministry of Social Development
DCIP	Diabetes Care Improvement Package
DHBSS	DHB Shared Services, a national agency that helps DHBs on employment issues, contracts and performance improvement
DNA	did not attend, a health service term for people who do not show up for booked appointments
DOSA	day-of-surgery admission
DRG	Diagnostic Related Group, defined in a footnote to Graphic 7
DSAC	Doctors for Sexual Abuse Care
ED	Emergency Department
ELT	Executive Leadership Team (of NDHB)
ENT	ear, nose and throat
FSA	first specialist appointment, the first appointment a patient has with a specialist after referral by their GP
FTE	full time equivalent (= 40 hours per week of work time)
FY	financial year (for DHBs, 1 July to 30 June)
GDP	Gross Domestic Product
GM	General Manager
GP	General Practitioner
GTT	Global Trigger Tool, which monitors adverse events in hospitals
HbA1C	a measurement of the amount of sugar in the blood
HBL	Health Benefits Limited, established in 2010 to reduce costs and deliver savings in administrative, support and procurement services for the health sector.
HBSS	home based support services (for older people)
HDSS	Health and Disability Support Services
HDC	Health and Disability Commission

Term	Definition or explanation
HEHA	Healthy Eating, Healthy Action
HOP	Health of Older People
HQSC	Health Quality and Safety Commission, a national organisation established under amendments to the Public Health and Disability Act in 2010
HWNZ	Health Workforce New Zealand
ICU	Intensive Care Unit
IDF	Inter District Flows, payment by one DHB for (usually tertiary) services provided to its population by another DHB
IFHC	Integrated Family Health Centre
interRAI	collaborative network of researchers in over 30 countries committed to improving health care for persons who are elderly, frail, or disabled. Our goal is to promote evidence-based clinical practice and policy
ICT	information and communications technology
IM	impact measure
IS	information systems
IT	information technology
JADE	A computer software product (and the company that makes it)
KPI	key performance indicator
LoE	(Minister's) Letter of Expectations, explained further in .....
LMC	Lead Maternity Carer
LTC	long term condition, which includes CVD, diabetes, cancer and respiratory diseases
MECA	multi-employer collective agreement
MHA	mental health and addictions
MoC	model of care
MoH	Ministry of Health
MRI	Magnetic Resonance Imaging [a type of scanner]
MSD	Ministry of Social Development
NASC	Needs Assessment and Service Coordination (see Graphic 13)

Term	Definition or explanation
NBRS	National Booking Reporting System, which provides summary statistics for Elective Services Performance Indicator reports
NDHB	Northland District Health Board
NDOW	Northland Diabetes Operational Workgroup
NDSA	Northern [region] DHB Support Agency
NGO	non-governmental organisation (in health, usually used to refer to all organisations in the health sector outside a DHB)
NHB	National Health Board
NHI	National Health Index, the system which applies a unique identifying code to each person who receives health services
NHSP	Northland Health Services Plan, explained in section 2.3 and Appendix 2
NIF	Northland Intersectoral Forum, a group of government agencies and local bodies
NIR	National Immunisation Register
NMDS	National Minimum Data Set, a national collection of public and private hospital discharge information
NMHSS	National Mental Health Service Specification
NNPAC	National Non-Admitted Patient Collection, data on outpatient and ED patients
NoRTH	Northern Region Training Hub
NRHP	Northern Region Health Plan
NRT	nicotine replacement therapy
NSFL	National Service Framework Library, which contains guidelines and criteria for services and data
NZRDA	NZ Resident Doctors Association
OAG	Office of the Auditor General
OC	Output Class
OIS	Outreach Immunisation Service(s)
PAS	Patient Administration System
PBFF	Population Based Funding Formula, used by MoH to allocated funding to DHBs on the basis of their population, with weightings for

Term	Definition or explanation
	certain population characteristics
PCI	percutaneous coronary intervention, any of several techniques for managing heart vessel blockages with catheters
PDRP	Professional Development and Recognition Programme, designed to recognise and reward nurses and midwives for their level of practice and contribution to nursing and midwifery
PHD Act	Public Health and Disability Act
PHO	Primary Health Organisation
POPN	Primary Options Programme Northland
POC	package of care
PRIMHD	Programme for the Integration of Mental Health Data (MoH's single national mental health and addiction information database)
PSA	Public Service Association
RMO	Resident Medical Officer
SAU	Surgical Admission Unit
SCBU	Special Care Baby Unit (= neonatal intensive care)
SFSP	Statement of Forecast Service Performance, Module 5 of the Annual Plan and part of the SOI
SOI	Statement of Intent
STEMI	ST-segment elevation myocardial infarction, a type of heart attack
ST segment elevation	*see above*
STI	sexually transmitted infection
SUDI	sudden unexpected death in infancy (sometimes also used to mean sudden unexplained death in infancy)
TIA	trans ischaemic attack, a warning sign of a potential stroke
TPOT	The Productive Operating Theatre, an MoH-sponsored programme
Triple Aim	The highest level of purpose in the NRHP (see Appendix 1)
TTSG	(NDHB) Tobacco Target Steering Group
TTT PHO	Te Tai Tokerau Primary Health Organisation
VfM	value for money

Term	Definition or explanation
VLCA	Very Low Cost Access, a payment that supports PHOs and practices that have forgone revenue from patient fees in order to deliver on Very Low Cost Access to primary health care and reduce health inequities.
WO	Whanau Ora
WOC	Whanau Ora Collective