Waitematā
District Health Board
Best Care for Everyone

2018/19–2020/21 Statement of Intent

Incorporating the 2018/19 Statement of Performance Expectations

Waitematā District Health Board

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

Mihimihi

E nga mana, e nga reo, e nga karangarangatanga tangata
E mihi atu nei kia koutou
Tena koutou, tena koutou, tena koutou katoa
Ki wa tatou tini mate, kua tangihia, kua mihia kua ea
Ratou, kia ratou, haere, haere, haere
Ko tatou enei nga kanohi ora kia tatou
Ko tenei te kaupapa, 'Oranga Tika', mo te iti me te rahi
Hei huarahi puta hei hapai tahi mo tatou katoa
Hei Oranga mo te Katoa
No reira tena koutou, tena koutou, tena koutou katoa

To the authority, and the voices, of all people within the communities
We send greetings to you all
We acknowledge the spirituality and wisdom of those who have crossed beyond the veil
We farewell them
We of today who continue the aspirations of yesterday to ensure a healthy tomorrow, greetings
This is the Annual Plan
Embarking on a journey through a pathway that requires your support to ensure success for all
Greetings, greetings, greetings

"Kaua e mahue tetahi atu ki waho
Te Tihi Oranga O Ngati Whatua"

The Waitematā District Health Board Statement of Intent, incorporating the Statement of Performance Expectations, is signed for and on behalf of:

Waitematā District Health Board

Professor Judy McGregor CNZM
Chair

Kylie Clegg
Deputy Chair

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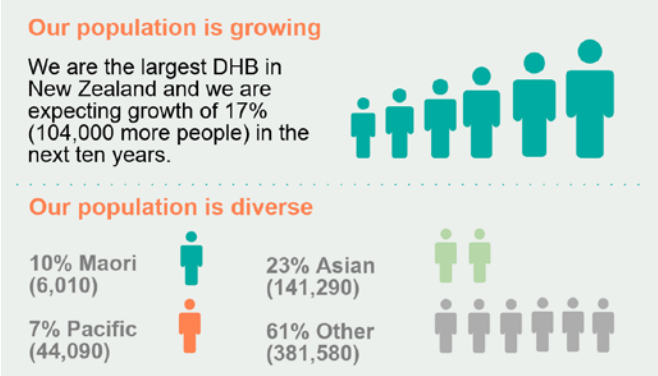
About Waitematā DHB

Who we are

Waitematā DHB is one of 20 DHBs established under the Health and Disability Act (2000). Waitematā DHB is the Government's funder and provider of health services to the estimated 630,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest DHB in the country, and are experiencing rapid population growth.



The age composition of Waitematā residents is similar to the national picture, with 19% aged less than 15 years, and 14% aged over 65.

Our population is diverse. 10% of Waitematā residents are Māori, 7% Pacific, and 23% are Asian. Our Asian population is proportionally our fastest growing population, and projected to increase to 27% of the total in the next ten years.

Waitematā's population is generally healthier than that of New Zealand as a whole. We have the highest life expectancy in New Zealand at 84.1 years, with an increase of 3.5 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (61%) and over a quarter of our adults are classified as obese (26%). Thirteen percent are current smokers (New Zealand Health Survey 2016/17).

Cancer is the most common cause of death (32%), and there are over 3,500 new cancer registrations in Waitematā every year. Cardiovascular disease (30%) and respiratory disease (10%) also account for a large proportion of deaths. Our 5-year survival rate for cancer is among the highest in New Zealand (68%) and our CVD and cancer mortality rates are also very low, a large proportion of all deaths in those aged under 75 are amenable through healthcare interventions (45% or 472 deaths in 2015).

The boundaries of Waitematā DHB extend to Wellsford in the north and as far south as the Auckland Harbour Bridge, incorporating Whangaparaoa in the east and the west coast beaches of Muriwai, Piha and Karekare. The North Shore and Henderson-Massey are densely populated suburban areas, while the large rural areas to the north and west have much sparser population.

We are a relatively affluent population, with a large proportion living in areas of low deprivation. One in twelve (8%) of our total population and 22% of Māori and Pacific people live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals experience poorer health outcomes than those in more affluent areas.

What we do

Waitematā DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. Around 7,100 people are employed by Waitematā DHB.

We have a budget of $1.799 billion in 2018/19.

We provide child disability, forensic psychiatric services, school dental services, and alcohol and drug services to the residents of the overall Auckland region on behalf of the other DHBs. Since 2013, the DHB has been the national provider of hyperbaric oxygen therapy services.

We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, and have contracts with approximately 600 other community providers.

We are making significant investments in state-of-the-art, modern facilities and services, with plans in place to continue developing our facilities to meet future demand.

The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

- Improve, promote, and protect the health of communities
- Reduce inequalities in health status
- Integrate health services, especially primary and hospital services
- Promote effective care or support of people needing personal health services or disability support.

DHBs act as 'planners', 'funders' and 'providers' of health services as well as owners of Crown assets. Our Planning, Funding and Outcomes Division is responsible for assessing its population's health need and determining the range of services to be purchased within the available funding constraints. Health needs assessment, along with input from key stakeholders, clinical leaders, service providers and the community, establishes the important areas of focus within our district. The identified needs are then balanced alongside national and regional priorities. These processes inform the Northern Region Health Plan, which sets the longer-term priorities for DHBs in the northern region, this Annual Plan and the metro-regional Māori Health Plan.

Māori Health Gain

Waitematā DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. We commit to the intent of Te Tiriti o Waitangi that established Iwi as equal partners alongside the Crown, with the Articles of Te Tiriti providing the strong foundation upon which our nation was built.

Within a health context, the four Articles of Te Tiriti provide a framework for developing a high performing and efficient health system that honours the beliefs and values of Māori patients, that is responsive to the needs and aspirations of Māori communities, and achieves equitable health outcomes for Māori and other high priority members of our communities.

Waitematā DHB will continue to co-develop and deliver a metro-regional Māori Health Plan. While we are proud of our achievements for our Māori population, the continuation of a Māori Health Plan enables us to remain focused in the pursuit of Māori health gain as well as greater and more meaningful collaboration and sharing of intelligence across DHBs in terms of Māori health.

Equity

While the Waitematā population overall has the longest life expectancy in New Zealand, Māori and Pacific people have life expectancies of 3.8 and 6.8 years, respectively, lower than the population as a whole.
Waitematā DHB is committed to helping all our residents achieve equitable health outcomes. Section 2 of the Annual Plan identifies specific activities designed to help reduce health equity gaps for Māori and other groups.

Waitematā DHB is also committed to improving health outcomes and achieving equity for disabled people. We are guided by the Vision of the New Zealand Disability Strategy 2016-2026:

New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.

With the launch of the New Zealand Disability Strategy, Waitematā and Auckland DHBs have started work on developing an Implementation Plan to achieve our goal of being fully inclusive and non-disabling.

The key challenges we are facing

Although the majority of our population enjoy very good health and the financial performance of our organisation has been strong, a number of challenges exist as a provider and funder of health services.

Growing and ageing population – the population will increase to approximately 734,000 over the next ten years, and the 65+ population will almost double over the next 20 years; combined with growth in demand, this will place considerable pressure on heavily utilised services and facilities, including primary and community health services (older people currently occupy around 45% of beds).

Prevention and management of long-term conditions – the most common causes of death are cancer (32%), cardiovascular disease (30%) and respiratory disease (10%); a large proportion of all deaths are amenable through healthcare interventions (16% or 490 deaths in 2014).

Health inequities – particular populations in our catchment continue to experience differences in health outcomes. This is most starkly illustrated by the gap in life expectancy of 5.6 years for Māori and 6.0 years for Pacific compared with other ethnicities.

Patient-centred care – patients, whānau and our community are at the centre of our health system. We want people to take greater control of their own health, be active partners in their own care and access relevant information when they need it.

One system – we need to ensure healthcare is seamless across the continuum and reduce disconnected and replicated services, as well as fragmentation of data and information between and across hospital, community and other services.

Financial sustainability – the financial challenge facing the broader health sector and Waitematā DHB is substantial; the current trajectory of cost growth is estimated to outweigh revenue growth by 2025. We need to make deliberate and focused strategic investment relevant to the specific needs of our population. This may require making some hard decisions about where we commit resource including reallocation of investment into services where we know we can achieve better outcomes.

Given the challenges we are facing we have identified three key areas of risk, and the focus needed to address these.

1. **Ensuring long-term sustainability through fiscal responsibility**

   To ensure we continue to live within our means we need to focus on:

   - Effective governance and strong clinical leadership
   - Connecting the health system and working as one system
   - Delivering the best evidence-based care to avoid wastage
   - Ensuring tight cost control to limit the rate of cost growth pressure.

2. **Changing population demographics**

   To cope with our growing and ageing population, we need to:

   - Engage patients, consumers and their families and the community in the development and design of health services and ensuring that our services are responsive to their needs
   - Assist people and their families to better manage their own health, supported by specialist services delivered in community settings as well as in hospitals
   - Increase our focus on proven preventative measures and earlier intervention.

3. **Meeting future health needs and the growing demand for health services**

   To deliver better outcomes and experience for our growing population, we must maintain momentum in key areas:

   - Focus on upstream interventions to improve the social and economic determinants of health, within and outside of the health system
   - Providing evidence-based management of long-term conditions
   - Working as a whole system to better meet people's needs, including working regionally and across Government and other services.
   - Quality improvement in all areas
   - Ongoing development of services, staff and infrastructure
   - Involving patients and family in their care.

National, regional and sub-regional strategic direction

National

Waitematā DHB operates collectively as part of a national health system. The overall direction and outcomes for the health sector are set by the Minister's expectations.

The New Zealand Health Strategy provides DHBs with a clear direction and road map to deliver more integrated health services. Waitematā DHB is committed to delivering on the Strategy's over-arching vision of 'All New Zealanders live well, stay well, get well'. Actions to deliver on the New Zealand Health Strategy are detailed in section 2 of our annual plan.

We actively work with other agencies to support at risk families and progress outcomes for children and young people, including the Ministry for Children, Oranga Tamariki. We will continue to work with New Zealand Health Partnerships Limited to progress initiatives.

Regional

The Northern Region Health Plan (NRHP) was developed by the four Northern Region DHBs and primary care Alliance Partners, and provides an overall framework to meet the Government's objectives and the region's priorities each year.

The Northern Regional Alliance (NRA) oversees the NRHP. The NRA ensures regional alignment of plans and appropriate stakeholder representation and involvement, by having clinical network and workgroup memberships drawn as appropriate from each of our region's DHBs and with representation from across the primary-secondary continuum of care.

The overall direction and strategic intent of the NRHP is to achieve gains across the Triple Aim Framework, the New Zealand Health Strategy themes, and equity.

Sub-regional

Waitematā and Auckland DHBs have a bilateral agreement that joins governance and some activities to provide mutual benefit to the planning and delivery of enhanced, sustainable health services to over one million Aucklanders. The merger of a number of teams, including planning, funding and outcomes, has increased consistency of relationships across the two DHBs. There is also further collaboration across the three Metro Auckland DHBs, which allows for a more integrated and aligned approach to health services planning and delivery across Auckland.

Focus for the year

Work is underway on visibility and alignment of the equity planning, frameworks, work programmes and integration into current activity at Waitematā DHB. Alignment with the equity focus, especially for our Māori and Pacific populations, across metro Auckland, in the Long-Term Investment Plan (LTIP) and the Ministry of Health's *Achieving Health Equity* work programme, was also undertaken. The Ministry work programme is one of several joint Ministry and sector co-leadership and governance arrangements to advance the Government's priorities: Achieving Equity, Child Wellbeing, Mental Health and Primary Health Care. Dr Dale Bramley, CEO of Waitematā DHB, is the sector co-sponsor for the Achieving Equity work programme alongside Alison Thom, Māori Leadership at the Ministry of Health.

We expect our population to reach nearly 700,000 by 2025; this significant growth in our population and increased demand for clinical and community services provide both challenges and opportunities in the coming year.

The DHB will progress the following major developments over the next 12 months:

- construction of the $18.4 million, 15-bed medium secure Tanekaha Unit at the Mason Clinic
- completion and opening of a newly expanded Waitakere Hospital Radiology Department
- work with other Northern Region DHBs through the LTIP to guide medium- to long-term regional developments designed to improve health outcomes for everyone
- implement a Consumer Council to further bolster the DHB's commitment to a high quality, equitable and accessible health care service for the Waitematā community.

Supporting and developing our staff is a key focus for our organisation. Throughout July and August 2018, over 60 teams were visited by members of the executive and senior management team. The focus of the leadership visits was to show appreciation to our teams for the work they do and to discuss how we live our value 'with compassion'.

From feedback at these discussions, we are undertaking a series of initiatives to value and support people to thrive and make a difference at work as well as remove red tape from our corporate processes. We will continue to hold more forums throughout the year, where senior leaders meet with staff teams to listen and respond to the things that matter most to our people.

Key programmes and initiatives this year

The Waitematā Experience programme

The Waitematā Experience is a programme of activity to co-design and deliver an excellent experience for patients, whānau and staff. The programme aligns all the patient experience work occurring in the DHB allowing improved focus and a better use of resources.

Waitematā 2025

We have a 10-year plan to redesign and improve our physical environment so it is more comfortable for patients and their whānau, and will accommodate our increasing population.

Transforming Care

Transforming Care is a clinical leadership programme designed to build capability for care redesign and enhanced care management at Waitematā DHB. The programme was developed from the work led by Professor Richard Bohmer.

The Institute of Innovation and Improvement (i3)

Our new Institute will provide expertise to support clinical teams to design and implement new models of care and best practice processes. The Institute brings together expertise in costing analysis, data analysis, digital platforms, evaluation, innovation, leadership, patient and whānau experience, population health and quality improvement.

LeapFrog programme

The Leapfrog programme is focused on accelerating the DHB's strategic innovation projects. A series of new, Phase Two, projects will lead our transformation towards an integrated digital environment. We will continue to build on our Phase One projects including completing closed loop medication safety, extending our e-ordering and ePrescribing systems, providing mobile apps to staff, and applying innovative redesign in outpatient care and our future wards and clinics. In addition, we are developing a cloud strategy, implementing kiosks in our outpatient services and telehealth for remote consultations, developing our patient engagement system in hospital and beyond, and developing faster methods for clinician and patient identification.

Underpinned by LeapFrog, Waitematā DHB is recognised as a leader in the movement toward a more mobile, electronic health record. National comparisons, using an international measure of electronic adoption in hospitals, rank Waitematā in the top three DHBs.

Occupational Health and Safety

At Waitematā DHB, the health, safety and wellbeing of our people is a priority for our Board. Through our Safe Way of Working policies we, aim to increase our systematic approach to health and safety monitoring of our current performance, areas of improvement and learnings from each other.

This year we will implement our 3 year health and safety strategy with primary focus on staff wellbeing, workforce environment, hazard and risk management, governance and patient safety and experience. We are committed to working with our regional DHB partners so we can collectively improve our health and safety performance across the region.

Improving health outcomes for our population

Waitematā DHB's performance framework reflects the key national and local priorities that inform this Annual Plan, and demonstrate our commitment to an outcome-based approach to measuring performance.

We have identified two overall long-term population health outcome goals. These are:

- Maintain the highest life expectancy in New Zealand;
- Reduce the difference in health outcomes between ethnic groups.

The outcome measures are long-term indicators; therefore, the aim is for a measurable change in health status over time, rather than a fixed target.

System level measures (SLMs) and contributory measures that will support achievement of these overall goals were identified. We based the SLMs in our performance framework on those set by the Ministry of Health, which align with the five strategic themes of the New Zealand Health Strategy and other national strategic priorities.

SLMs provide an opportunity for DHBs to work with the primary, secondary and community care providers to improve health outcomes of their local populations.

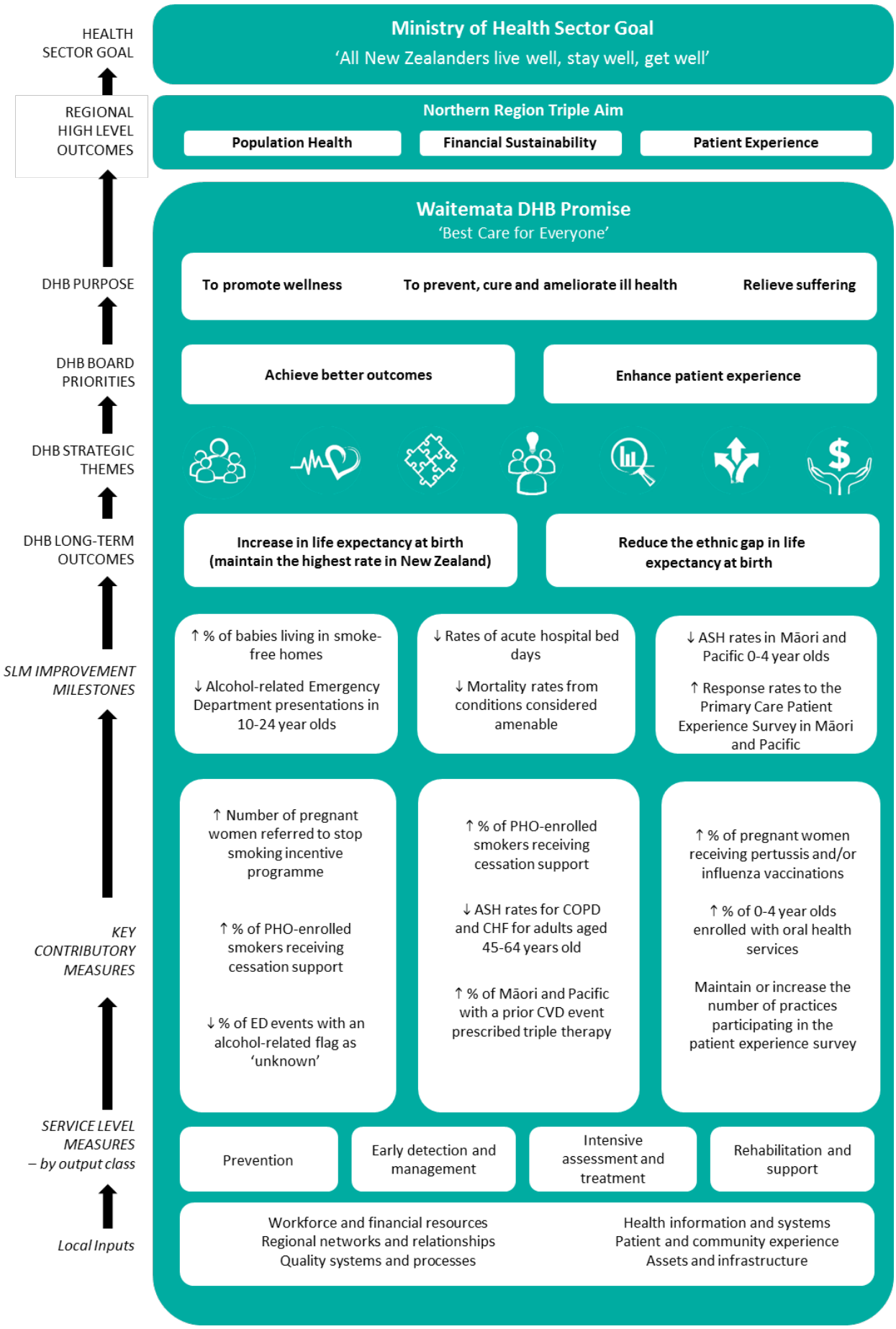
Contributory measures are essential to the achievement of SLMs and are front-line measurements of specific health processes or activities. The contributory measures included in our performance framework were selected from the set defined by our District Alliance and included in our SLM Improvement Plan.

Our SLMs and contributory measures are summarised below and presented in the intervention logic diagram on the next page. The diagram demonstrates how the services that we choose to fund or provide will contribute to the health of our population and result in the achievement of our longer-term outcomes and the expectations of Government. The Statement of Performance Expectations (Appendix B) details a set of service-level indicators that contribute to our overall performance framework. We will report progress against all these measures in our Annual Report.

	Healthy start	Keeping children out of hospital	Youth are healthy, safe and supported	Preventing and detecting disease early	Using health resources effectively	Ensuring patient-centred care
System Level Measures	**Babies living in smokefree homes**	**Ambulatory sensitive hospitalisations**	**Youth Health (Alcohol and other drug related harm)✠**	**Amenable mortality**	**Acute hospital bed days**	**Patient experience**
2018/19 improvement milestone	**↑ % of babies living in smoke-free homes**	**↓ ASH rates for Māori and Pacific 0-4 year olds**	**↓ Alcohol-related Emergency Department presentations in 10 to 24 year olds**	**↓ Mortality rates from conditions considered amenable**	**↓ Rates of acute hospital bed days**	**↑ Response rates to Primary Care Patient Experience Survey (PES) in Māori and Pacific**
Key contributory measures	*↑ Pregnant women referred to stop smoking incentive programme* *↑ % of PHO-enrolled smokers receiving cessation support*	*↑ % pregnant women receiving pertussis and/or influenza vaccinations* *↑ % of 4 year olds enrolled with oral health services*	*↓ % of ED events with an alcohol-related flag as 'unknown' (data quality)*	*↑ % of PHO-enrolled smokers receiving cesstion support* *↑ % of Māori and Pacific with a prior CVD event prescribed triple therapy*	*↓ ASH rates for COPD and CHF for adults aged 45-64 years old* *↑ % of individuals with a prior CVD event prescribed triple therapy*	*Maintain or increase the number of practices participating in the patient experience survey*

✠ Note: The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing. Waitematā DHB has chosen to focus on the alcohol-related harm domain, starting with improvements in the identification and coding of alcohol-related ED events. Work is ongoing to improve chlamydia testing coverage under the sexual health domain.

Performance and intervention framework



Long-term outcomes

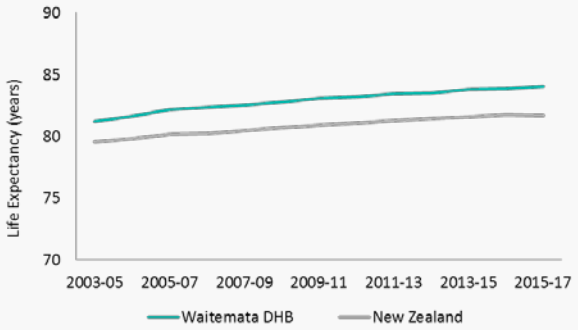
The long-term outcomes that we want to achieve are to increase life expectancy (measured by life expectancy at birth) and reduce ethnic inequalities (measured by the ethnic gap in life expectancy).

Highest life expectancy in New Zealand

Life expectancy at birth is recognised as a general measure of population health status. We have the highest life expectancy in the country at 84.1 years (2015–2017), which is 2.4 years higher than New Zealand as a whole. Half of this difference in life expectancy between New Zealand and Waitematā DHB is attributed to our lower mortality rates from cardiovascular disease and cancer. In Waitematā DHB, life expectancy has increased by 3.5 years since 2001, which is 0.8 years more than New Zealand.

Over the longer term, we aim to continue to have the highest life expectancy in the country and maintain a 2.7 year increase in life expectancy over the next decade.

Outcome measure – Life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

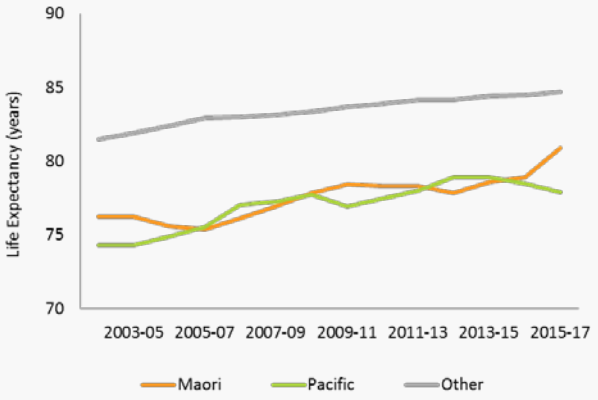
Reducing ethnic differences in health outcomes

Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 3.8 years for Māori and 6.8 years for Pacific (2015–2017). Life expectancy has increased in our Māori (5.2 years) and Pacific (3.3 years) populations since 2001 and the gap in life expectancy is gradually closing.

Mortality at a younger age from cardiovascular disease and cancers account for over half of the life expectancy gap in our Māori and Pacific populations.

We expect a reduction in the gap in life expectancy over the next decade, declining at the same or greater rate than that observed in the last ten years.

Outcome measure – Ethnic gap in life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. 'Other' ethnicity includes non-Māori/non-Pacific ethnicities.

Healthy start

Smoking during pregnancy and exposure to smoking in early childhood strongly influence pregnancy and early childhood health outcomes. The measure of the proportion of infants living in a smokefree household during the postnatal period correlates with maternal smoking in pregnancy. The rate of smoking in pregnancy, and worse pregnancy outcomes for mothers and babies, is higher among Māori and Pacific women and those living in areas of high deprivation.

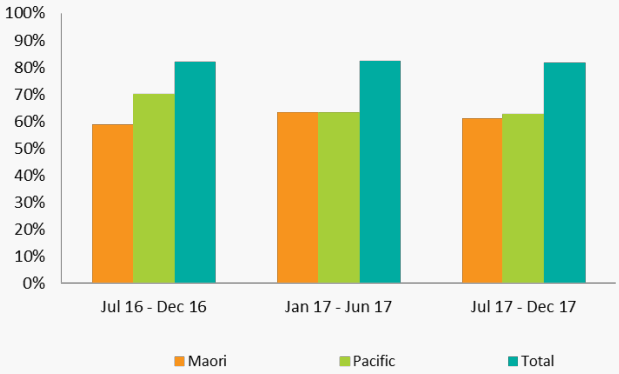
Increasing the proportion of babies who live in smokefree households at 6 weeks postnatal

Infants and young children are more exposed to second-hand smoke in homes than in other places. Second-hand smoke exposure is associated with preventable and harmful effects in children, and the effects of exposure are lifelong. Exposure has been identified as a significant contributor to health inequalities in children.

Utilising a supportive approach that maximises parents' instinct to do no harm to their children may motivate cessation, thereby reducing or eliminating adult contributions to children's exposure to second-hand smoke at home.

Annual improvement target: 2% increase
(baseline 82%, Jul-Dec 2017)

System level measure – Proportion of babies living in smokefree households at 6 weeks postnatal



Note: processes to improve data quality relating to this measure are ongoing. A new data standard will be established by the end of the year, thus current data should be interpreted with caution

Contributory measure – Referrals to maternal incentive programme

Cigarette smoking during pregnancy is an important modifiable risk factor for poor birth outcomes, including the risk of miscarriage, premature birth and low birth weight, as well as their children's risk of asthma and sudden unexplained death in infants (SUDI).

Pregnancy is a time when women are likely to be highly motivated to stop smoking themselves and to encourage their whānau to stop smoking. Evidence suggests that incentive-based smoking cessation programmes can be successful in reducing smoking rates during pregnancy and reducing the incidence of low birth weight babies.

Annual improvement target: 83 referrals per quarter (332 referrals FY)

(baseline = 65, 2017 calendar year)

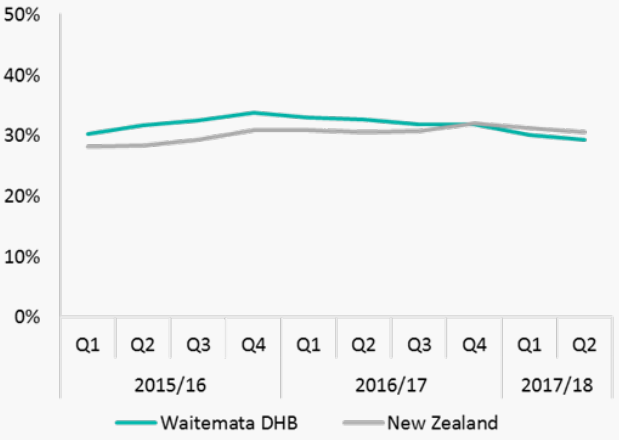
Smokers who live in the same household as babies and young children can often be reached through primary care.

Offering cessation support, NRT or referral to Stop Smoking Services is important to assist whānau members to become smoke-free. The use of other settings to identify and support smokers that live with young children will also be explored. A focus on activities to increase quit rates for Māori and Pacific is particularly important given the higher prevalence of smoking in these ethnic groups.

This contributory measure sits under this SLM and the Amenable Mortality SLM.

Annual improvement target: relative 10% increase
(baseline = 29.3%, Q2 2017/18)

Contributory measure – Proportion of PHO enrolled smokers receiving cessation support



Keeping children out of hospital

Ensuring that children have the best start to life is crucial to the health of the total population. Well integrated, high quality primary and community services can maintain good health, prevent health problems and improve health outcomes.

We seek to reduce admission rates to hospital for a set of conditions that are potentially avoidable through prevention or management in primary care (ambulatory sensitive hospitalisations – ASH). In children, these conditions are mainly respiratory illnesses, gastroenteritis, dental conditions, and cellulitis.

ASH rates are higher for Māori and Pacific children and addressing this inequity would significantly reduce potentially avoidable hospitalisation rates.

Reducing Ambulatory sensitive hospitalisation (ASH) rates for 0-4 year olds

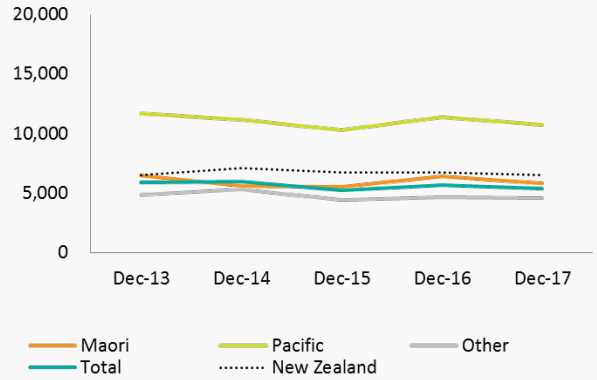
In the 12 months to December 2017, there were 2,154 admissions for 0–4 year olds that were potentially avoidable.

The overall rate of admissions (5,426 per 100,000) has declined over the past five years. Rates in the Pacific population (10,756) are twice as high as other ethnicities.

Our aim is to reduce rates by 3% and reduce the equity gap for our Māori and Pacific children.

Annual improvement target: 3% reduction
(baseline = 5,426 per 100,000 population, Dec 2017)

System level measure – Ambulatory sensitive hospital admissions per 100,000 in those aged 0–4 years



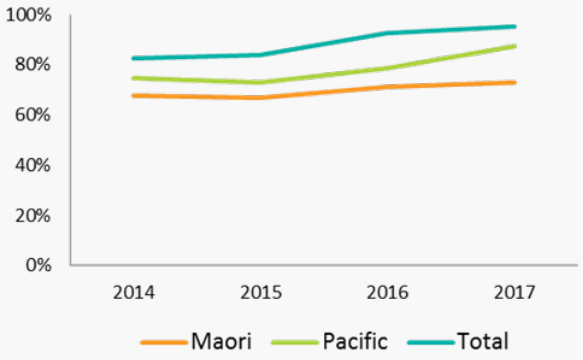
Hospitalisations due to dental conditions in the 0-4 age group make up about 10% of ASH admissions (209 events in the 12 months to Dec 2017), and are increasing.

Improving accessibility of oral health programmes will reduce the prevalence and severity of early childhood dental decay, and reduce the numbers requiring hospital admission for serious dental problems.

At the end of December 2017, 95% of all pre-schoolers were enrolled with oral health services, although this figure was much lower for Māori (73%).

Annual improvement target: 95% of children aged 0-4 enrolled with oral health services

Contributory measure – Proportion of Preschool children (0-4 years) enrolled with oral health services

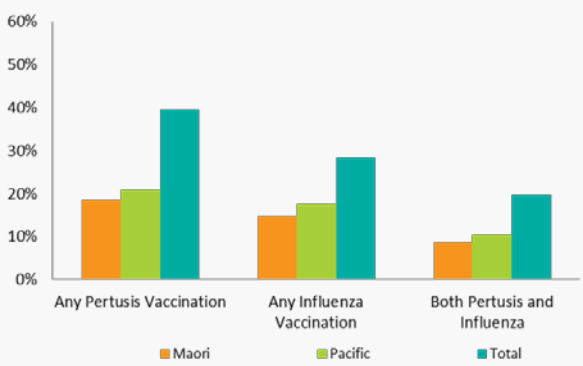


Respiratory conditions are the largest contributor to ASH rates in Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants, and can lead to further respiratory complications. Both are vaccine preventable and vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

Pregnant women are recommended to have both vaccinations every pregnancy. For babies born in 2017, only 20% of mothers had received both vaccinations during pregnancy, with rates much lower for Māori and Pacific.

Annual improvement target: 50% coverage for influenza and pertussis vaccination in pregnancy across all ethnicities.

Contributory measure – proportion of pregnant women receiving pertussis and/or influenza vaccinations in pregnancy



Note: Graph shows vaccination coverage in the 12 months to December 2017

Youth are healthy, safe and supported

Promoting healthy behaviours during adolescence and taking steps to better protect young people from health risks are critical in preventing health problems and poor life outcomes in adulthood. Most New Zealand youth successfully transition to adulthood but some do not, mainly due to an interplay of individual, family and community circumstances, or risk factors.

The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing: Youth experience of health system; Sexual and reproductive health; Mental health; Alcohol and drugs; and Access to preventative services. Waitematā DHB has chosen to focus on the impact of alcohol at both an individual and health system level.

Alcohol and drugs – Alcohol-related emergency department (ED) presentations in 10 to 24 year olds

Alcohol is deemed the most commonly used recreational drug in New Zealand. Alcohol contributes to violence, self-harm, injuries and many medical conditions, and is responsible for over 1,000 deaths and 12,000 years of life lost each year in New Zealand.*

Identifying and monitoring alcohol-related ED presentations enables DHBs to better understand the contribution of excessive alcohol consumption to ED presentations for young people. It is a starting point to encourage DHBs to move toward more extensive screening, brief intervention and referrals (including to primary care and community care).

Annual improvement target: Establish Baseline

Processes are ongoing to ensure that alcohol involvement in ED presentations is captured accurately and consistently. This process will continue throughout the year.

Systems have only recently been established to enable alcohol-related ED presentations to be coded.

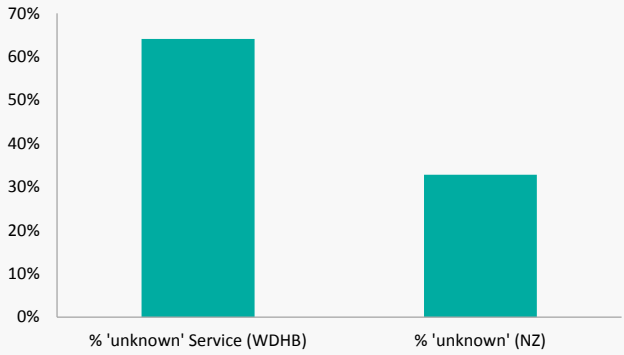
The mandatory question is: 'Is alcohol associated with this event?' Possible answers are: Yes, No, Unknown and Secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved).

In the 12 months to March 2018, more than 60% of admissions to Waitematā DHB's emergency departments had 'unknown' recorded as the answer to this question.

Significant quality improvement work has begun to ensure consistent and accurate collection of this information. This year we will continue the focus on improving the accuracy and reliability of alcohol-related data collection in our EDs.

Annual improvement target: Reduce ED events with an 'unknown' alcohol-related field to less than 10%

Contributory measure – Proportion of ED events with an alcohol-related flag as 'unknown'



* Connor J, Kydd R, Rehm J, Shield K. Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Wellington: Health Promotion Agency; July 2013.

Prevention and early detection

Amenable mortality is a measure of the effectiveness of healthcare-based prevention programmes, early detection of illnesses, effective management of long-term conditions and equitable access to health care. It measures the number of deaths that could be avoided through effective health interventions at an individual or population level. Amenable mortality rates are higher in Māori and Pacific people. Rates have reduced over time, but less quickly for Pacific populations.

Reducing rates of amenable mortality

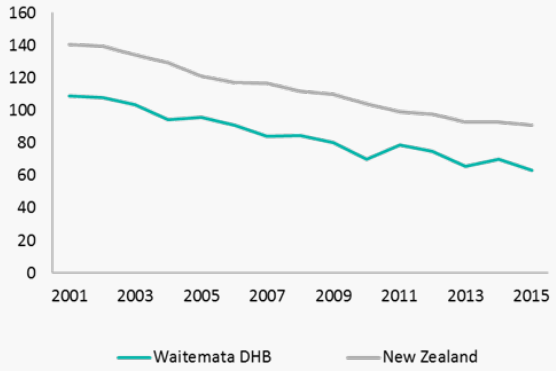
Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.

In 2015, we estimate that 472 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were potentially amenable. The rate of amenable mortality has steadily decreased over the past decade and is currently 63.2 per 100,000 population.

We aim to continue this rate of reduction in amenable mortality.

Improvement target: 6% reduction by 2020
(baseline = 65.6 deaths per 100,000 population, 2013)

System level measure – Mortality from conditions considered amenable, rate per 100,000 population

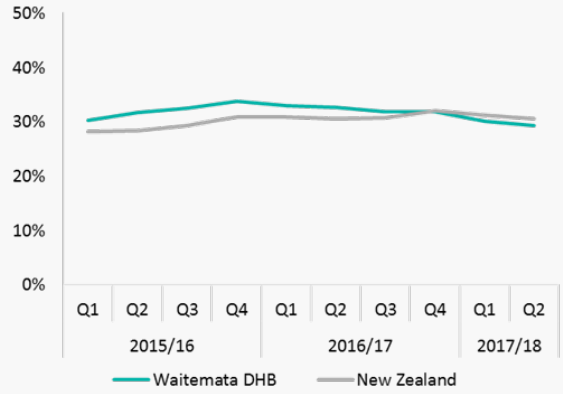


Life-long smoking is associated with a decade of life lost for an individual. Quitting smoking before the age of 40 years, and preferably much earlier, will reduce about 90% of the years of life lost from continued smoking.*

Providing smokers with brief advice to quit increases their chances of making a quit attempt. The likelihood of that quit attempt being successful is increased if behavioural support, such as a referral to 'quit smoking' services, and/or pharmacological smoking cessation aids are provided.

Annual improvement target: relative 10% increase
(baseline = 29.3%, Q2 2017/18)

Contributory measure – Proportion of PHO enrolled smokers receiving cessation support



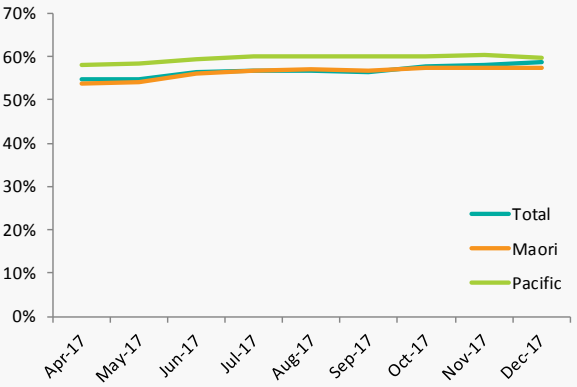
New Zealand guidelines recommend that, where appropriate, people who experience a heart attack or stroke should be treated with a combination of medications known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta-blocker and a statin).

We intend to make sure that our patients who have had a CVD event are receiving the best possible care.

Currently, 59% of the Metro Auckland Māori and Pacific population who have had a CVD event are prescribed triple therapy medication.

Annual improvement target: relative 5% increase
(baseline = 59%, December 2017)

Contributory measure – Proportion of Māori and Pacific with a prior CVD event prescribed triple therapy (Metro Auckland)



Note: data not currently available by DHB of domicile, to be addressed in 2018/19

*Prabhat Jha, M.D et al. (2013). 21st-Century Hazards of Smoking and Benefits of Cessation in the United States. *N Engl J Med*, 368:341-350.

Using health resources effectively

Acute hospital bed days per capita is a measure of the use of acute services in secondary care. This could be improved by effective management in primary care, optimising patient flow within the hospital, discharge planning, community support services and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary and secondary care and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. The rate of acute bed day use is higher for Māori and Pacific people.

Reducing acute hospital bed days

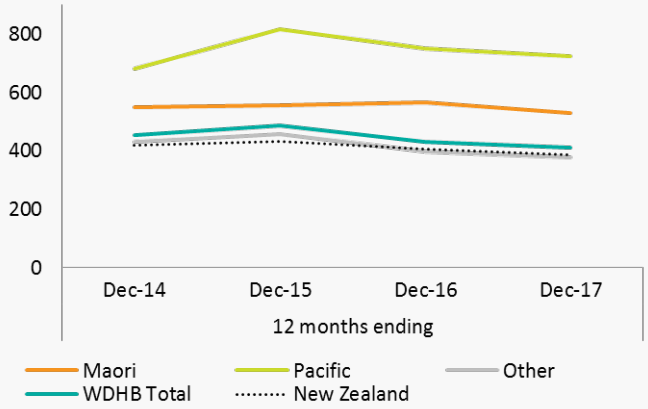
Acute admissions account for approximately one half of all hospital admissions in New Zealand. Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressure on DHB staff and facilities.

Our standardised rate of acute bed days has declined slightly since 2014 (453 per 1,000 population to 410 per 1,000 population) and remains slightly higher than the national rate.

We plan to target populations most likely to be admitted or readmitted to hospital, and focus on prevention and treatment of conditions that contribute the most to acute hospital bed days.

Annual improvement target: 3% reduction
(baseline = 409.9 per 1,000 population, Dec 2017)

System level measure – Waitematā DHB acute hospital bed days per 1,000 population



Note: Age standardised rate

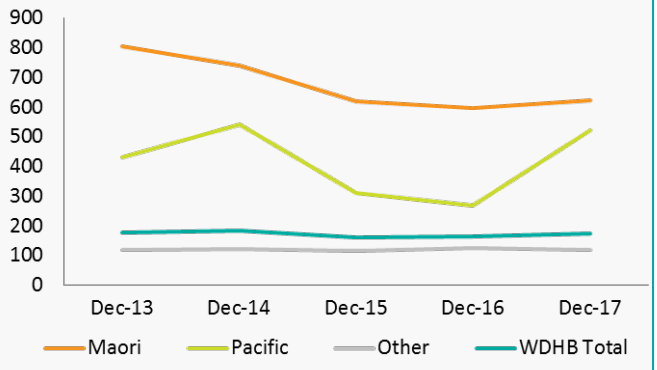
Congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) are long-term debilitating conditions that are responsible for a significant number of acute hospitalisations and overall bed days.

Both conditions can often be well managed with intensive treatment and follow-up in primary care along with patient and family education, potentially preventing the need for hospitalisation. Should hospitalisation be required, often those receiving effective management in primary care have a shorter length of stay and lower risk of readmission.

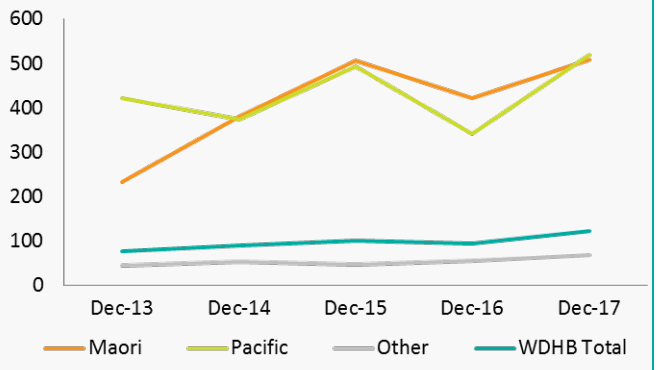
Annual improvement target: 2% reduction
(baseline COPD = 173 per 100,000 population, CHF = 123 per 100,000 population Dec 2017)

Contributory measure – ASH rates for COPD and CHF for adults aged 45-64 years old

Chronic Obstructive Pulmonary Disease



Congestive Heart Failure



Person-centred care

Patient experience is a good indicator of the quality of health services. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care. Patient experience is positively associated with adherence to recommended medication and treatments, engagement in preventive care (such as screening services and immunisations) and ability to use the health resources available effectively, as well as overall health outcomes. This measure provides new information about how people experience health care and how integrated their care is, and may highlight areas where a greater focus is needed.

Enhancing patient experience of care

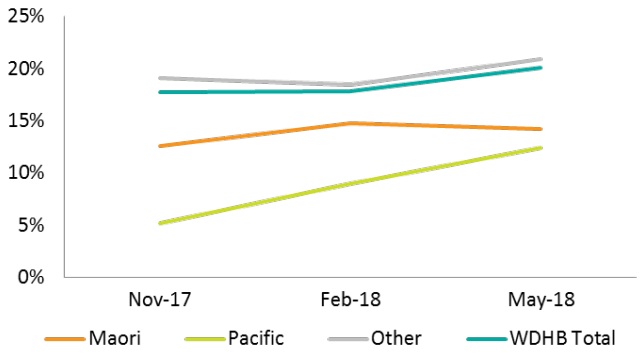
The primary care patient experience survey was developed by HQSC to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety.

There is a regional focus on improving response rates to the primary care survey to ensure that the perspective of all patients can be captured and the findings from the survey can be generalised to the patient population, particularly in Māori and Pacific patients.

As at May 2018, only 12-14% of Māori and Pacific patients invited to complete surveys had participated, compared with 21% for other ethnicities.

Annual improvement target: increase response rate for completed surveys by absolute 2% for Māori and Pacific (baseline 12.6% Māori, 5.2% Pacific, November 2017)

System level measure – Response rates to the Primary Care Patient Experience Survey



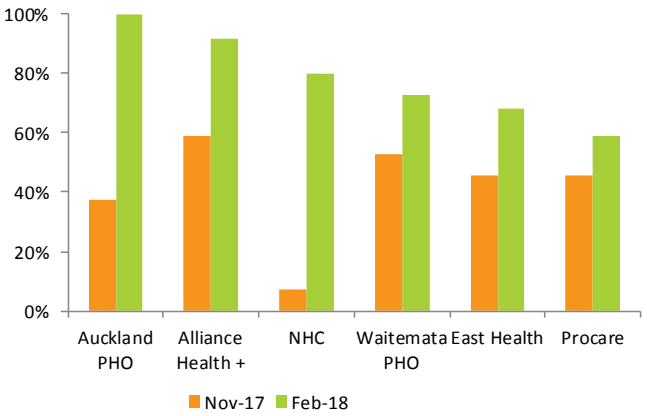
The Primary Care Patient Experience Survey (PES) was implemented in practices during 2017/18. Before reporting on patient experience scores, we want to ensure participation in the PES at a PHO and practice level.

Participation by practices in the PES requires a great deal of developmental work by PHOs including infrastructure, practice engagement, capacity building, and patient communication.

As at February 2018, 69% of all practices were participating in the survey, an increase from 43% in November 2017.

Annual improvement target: Maintain or increase participation (from June 2018 baseline)

Contributory measure – Maintain or increase the number of practices participating in the patient experience survey*



*Metro Auckland data

STATEMENT OF PERFORMANCE EXPECTATIONS

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for the 2018/19 year.

Performance measurement framework

Our focus for 2018/19 is on delivering the key targets identified in our performance framework, which will ultimately result in better health for our population, measured by our two long term outcomes:

- An increase in life expectancy
- A reduction in the ethnic gap in life expectancy

Measures within this SPE represent the outputs/activities we deliver to meet our goals and objectives in Section 2 and our Statement of Intent, and also provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators. The national System Level Measures are not included in our SPE as these are high level population health goals and not necessarily appropriate as direct measures of annual service performance. We are reporting the SLM contributory measures in our SPE as these measures contribute to the achievement of the SLMs and are measurements of specific health processes or activity.

Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures will be reported in the DHB's Annual Report, and audited at year end by the DHB's auditors, AuditNZ.

Targets and achievements

Targets and comparative baseline data for each of the output measures are included in the following sections. When assessing achievement against each measure we use a grading system to rate performance. This helps to identify those measures where performance was very close to target versus those where under-performance was more significant. The criteria used to allocate these grades are as follows.

Criteria		Rating	
On target or better		Achieved	
95–99.9%	0.1–5% away from target	Substantially achieved	
90–94.9%	5.1–10% away from target*	Not achieved, but progress made	
<90%	>10% away from target**	Not achieved	

*and improvement on previous year
** or 5.1–10% away from target and no improvement on previous year

Key to output tables

Symbol	Definition
Ω	Measure is demand driven – not appropriate to set target
↓	A decreased number indicates improved performance
↑	An increased number indicates improved performance
↔	Maintain current performance
Q	Measure of quality
V	Measure of volume
T	Measure of timeliness
C	Measure of coverage

Output class 1: Prevention Services

Preventative services protect and promote health in the whole population or identifiable sub-populations by targeting changes to physical and social environments that engage and support individuals to make healthier choices. Prevention services include: health promotion to prevent illness and reduce unequal outcomes; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services, such as immunisation and screening services. By supporting people to make healthy choices and maintain good health, effective prevention services can have a significant impact on health outcomes.

Outputs measured by	Notes	Baseline 2016/17	Target 2018/19
Health promotion			
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months	C	90%	90%
% of PHO-enrolled patients who smoke and received cessation support	Q	29.3%	32.2%
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking	C	87%	90%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	65[1]	332
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Q	100%	95%
Number of clients engaged with Green Prescriptions	V	3,756[2]	5,400
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy		40%[3]	50%
Influenza vaccination coverage for children aged 0-4 years who are hospitalised for respiratory illness - Māori - Pacific - Total		 10%[4] 7%[4] 12%[4]	15%
Increased immunisation - % of eight months olds will have their primary course of immunisation on time (total population) - % of eight months olds will have their primary course of immunisation on time (Māori)	C	 92% 86%	 95%
Rate of HPV immunisation coverage (2004 birth cohort)	C	60%	75%
Population-based screening			
% of women aged 50-69 years having a breast cancer screen in the last 2 years	C	66%	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	74%	80%
% of 15-24 year olds tested for chlamydia	C	12%[4]	15%
Bowel Cancer Screening			
% of people aged 60-74 years invited to participate who returned a correctly completed kit[5] - Māori - Pacific - Other	Q	New indicators	60%
% of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 45 working days	T	97%	95%
Children			
% of 4 year olds receiving a B4 School Check	C	94%	90%
Auckland Regional Public Health Service[6]			
Number of tobacco retailer compliance checks conducted	V	321	300
Number of license applications and renewals (on, off club and special) received and are risk assessed	V	3,870	Ω
% of tuberculosis (TB) and latent TB infection cases who have started treatment and have a recorded start date for treatment	Q	96%	90%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	New indicator	85%

[1] Data for 12 months to Dec-17
[2] Data for 2017/18
[3] CY2017 births
[4] Data as at Dec 2017
[5] Patients invited during 2018 and 2019, i.e. round 4 (this differs from previous screening rounds, which involved patients aged 50-74 years old).
[6] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various settings, including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. Access to these services ensures that those at risk, or with disease onset, are recognised early and their condition is appropriately managed. Early detection and management services also enable patients to maintain their functional independence with less invasive intervention.

Outputs measured by	Notes	Baseline 2016/17	Target 2018/19
Primary health care			
Rate of primary care enrolment (Māori)	C	92%	90%
Number of referrals to Primary Options for Acute Care (POAC)	V	10,727	10,811
POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions		2.4%[7]	3%
% of the eligible Māori population who have had their CVD risk assessed in the last five years	C	87%	90%
% of Māori patients with prior CVD who are prescribed triple therapy	Q	56.5%[8]	59.4%
% of Pacific patients with prior CVD who are prescribed triple therapy	Q	62.7%[8]	65.8%
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds: - Māori - Pacific - Chronic obstructive pulmonary disease (COPD) - Congestive heart failure (CHF)		 7,460 10,850 173 123	 7,311 10,633 170 121
% of PHO enrolled population who have login access to a portal	C	17%[9]	20%
% of practices participating in Primary Care Patient Experience survey		43%[10]	≥ Jun 2018 result
Primary Care Patient Experience Survey response rate - Māori - Pacific		 12.6%[11] 5.2%[11]	 14.6% 7.2%
Pharmacy			
Number of prescription items subsidised	V	7,310,184	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	37,424	Ω
Number of community laboratory tests	V	3,902,938	Ω
Oral health			
% of preschool children enrolled in DHB-funded oral health services	C	95.5%[12]	95%
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 - 2018 - 2019	Q	 0.61[12]	 0.61 0.61
% of children caries free at five years of age - 2018 - 2019	Q	 67%[12]	 67% 67%

[7] 12 months to Sep-17, assumes all POAC is ASH, excluding musculoskeletal and DVT.
[8] Jan 2018 data.
[9] 12 months to Dec-17, Metro Auckland total
[10] 12 months to Nov-17, Metro Auckland total
[11] 12 months to Nov-17, based on DHB of practice
[12] CY2017

Output class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by specialist providers in facilities that co-locate clinical expertise and specialised equipment, such as a hospital or surgery centre. These services include ambulatory, ED and inpatient services (acute and elective streams), such as diagnostic, therapeutic and rehabilitative services. Effective and prompt resolution of medical and surgical emergencies and treatment of significant conditions reduces mortality, restores functional independence and improves health-related quality of life, thereby improving population health.

Outputs measured by	Notes	Baseline 2016/17	Target 2018/19
Acute services			
Number of ED attendances	V	121,352	Ω
% of ED patients discharged, admitted or transferred within six hours of arrival	T	97%	95%
% of ED admissions in 10-24 year olds where alcohol-related ED presentation status is 'Unknown'	Q	New indicator	<10%
% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	T	90%	90%
% of potentially eligible stroke patients thrombolysed	C	7.7%	10%
% of ACS inpatients receiving coronary angiography within 3 days	T	72%	70%
Maternity			
Number of births in Waitematā DHB hospitals	V	7,045	Ω
Elective (inpatient/outpatient)			
Number of elective surgical discharges (PP45)	V	23,998	22,073
Surgical intervention rate[13]	C		
- Major joints		28.0	21
- Cataracts		39.7	27
- Cardiac		6.1	6.5
- PCR		16.5	12.5
- Angiogram		41.7	34.7
% of people receiving urgent diagnostic colonoscopy in 14 days	T	92%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days		78%	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	0%	0%
% of accepted community referrals receiving their scan within 6 weeks	T		
- CT		98%[14]	95%
- MRI		98%	90%
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	86%	80%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.10	<0.11[15]
% of falls risk patients who received an individualised care plan	Q	96%	90%
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions	Q	0.06	<8.4[16]
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision	Q	95%	100%
% of hip and knee procedures given right antibiotic in right dose	Q	96%	95%
Surgical site infections per 100 hip and knee operations	Q	1.61	<0.93[17]
Mental Health			
% of population who access Mental Health services:	C		
- Age 0–19 years		3.7%	3.49%
- Age 20–64 years		3.6%	3.43%
- Age 65+ years		2.00%	2.01%
% of 0-19 year old clients seen within 3 weeks:	T		
- Mental Health		71%	80%
- Addictions		89%	80%
% of 0-19 year old clients seen within 8 weeks:			
- Mental Health		95%	95%
- Addictions		98%	95%

[13] Data for year ending March 2016
[14] Jun-17 result
[15] Jan12-Jun17 national median
[16] Sep14-Jun17 national median
[17] Sep15-Nov17 national median

Output class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination provided by the Needs Assessment and Service Coordination (NASC) Service for a range of services, including palliative care, home-based support, and residential care services. Rehabilitation and support services are provided by the DHB and non-DHB sector, e.g. residential care providers, hospice and community groups. Effective support services restore function and help people to live at home for longer, therefore improving quality of life and reducing the burden of institutional care costs.

Outputs measured by	Notes	Baseline 2016/17	Target 2018/19
Home-based support			
Proportion of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI)	Q	98%	95%
Palliative care			
Proportion of hospice patient deaths that occur at home	Q	32.5%	↑
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	4.5%	5%
Residential care			
ARC bed days	V	915,023	Ω

Financial Performance Summary

Statement of Comprehensive Income	2016/17 Audited Actual $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Revenue						
MoH	1,506,695	1,595,378	1,669,254	1,702,367	1,736,275	1,770,239
IDFs & Inter DHB Provider	85,259	86,543	89,409	91,187	93,008	94,822
Other government	10,042	11,024	10,787	11,001	11,220	11,443
Other	25,117	31,752	29,522	30,607	31,183	31,767
Total revenue	**1,627,113**	**1,724,697**	**1,798,972**	**1,835,162**	**1,871,686**	**1,908,271**
Expenditure						
Personnel	604,008	641,786	660,266	671,129	677,913	691,790
Outsourced	76,281	74,166	78,056	79,044	79,734	81,389
Clinical Supplies	118,245	123,940	126,343	127,794	129,102	131,804
Infrastructure and Non-Clinical	41,856	54,541	43,222	28,310	38,341	39,195
Payments to Non-DHB Providers	727,334	778,862	829,731	861,045	878,129	894,991
Interest	6,532	0	0	0	0	0
Depreciation and Amortisation	28,006	29,508	31,407	31,493	32,120	32,755
Capital charge	21,560	36,679	36,947	36,347	36,347	36,347
Total Expenditure	**1,623,822**	**1,739,482**	**1,805,972**	**1,835,162**	**1,871,686**	**1,908,271**
Other comprehensive income	3,291	(14,785)	(7,000)	0	0	0
Revaluation of land and building	(378)	0	0	0	0	0
Total Comprehensive Income/(Deficit)	**2,913**	**(14,785)**	**(7,000)**	**0**	**0**	**0**

Four-year plan

Prospective summary of revenues and expenses by output class	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Early detection				
Total revenue	557,716	568,002	579,387	590,666
Total expenditure	558,074	566,829	575,038	586,232
Net surplus/(deficit)	**(358)**	**1,173**	**4,349**	**4,434**
Rehabilitation and support				
Total revenue	**219,115**	223,156	227,629	232,060
Total expenditure	**218,808**	222,241	225,459	229,848
Net surplus/(deficit)	**307**	**916**	**2,170**	**2,212**
Prevention				
Total revenue	**28,988**	29,523	30,115	30,701
Total expenditure	**29,149**	29,607	30,035	30,620
Net surplus/(deficit)	**(161)**	**(84)**	**79**	**81**
Intensive assessment and treatment				
Total revenue	984,923	1,003,088	1,023,193	1,043,111
Total expenditure	991,711	1,005,092	1,029,792	1,049,839
Net surplus/(deficit)	**(6,788)**	**(2,004)**	**(6,599)**	**(6,727)**
Consolidated surplus/(deficit)	**(7,000)**	**0**	**0**	**0**

The methodology used to create the above information is being reviewed during the 2018/19 financial year, in conjunction with Audit New Zealand, and external professional accounting advisors.

FINANCIAL PERFORMANCE

Financial management overview

In the year to 30 June 2018, the DHB reported a deficit of $14.8m against a breakeven budget. This result reflects a breakeven operating performance, impaired by provisioning for the possible effects of the Holidays Act, and the effects on leave balances revaluation following the settlement on the NZNO wage dispute.

Within each Arm of the DHB (principally Funder and Provider), different financial results were achieved, providing a partial offset. The Provider reported a deficit against budget of $37.4m, offset by surpluses in the Funder and Governance Divisions totalling $22.6m. This situation, of deficits in Provider divisions offset by Funder surpluses, is not uncommon in the DHB sector.

The Board recognises that these offsetting results are unacceptable and are not sustainable. Continued adverse variances in the Provider Arm of the DHB necessarily limit the options available to the Board to invest in new services and initiatives, both in the Hospital sector and in Primary Care.

During the 2017/18 financial year, the Board made a number of significant investments, including a major organisational change management programme to improve maturity in the management of project, programmes and portfolios across the whole organisation.

Planning commenced on a number of major facility programmes to redevelop the two hospital sites and associated infrastructure. The first of these programmes is the Elective Capacity and Inpatient Beds that will see additional theatre, inpatient wards and endoscopy capacity on the North Shore Campus.

For the 2018/19 financial year, the DHB is forecasting a $7.0m deficit budget, which reflects a deficit of $21.7 in the Provider, offset by a $17.7m surplus in the Funder.

The deficit within the Provider assumes that a $13.3m savings plan will be achieved, and there is a risk to meeting this plan. The budgeted result in the Funder also contains risk with regards to IDF payments, NGO demand-driven expenditure, Pay Equity and In Between Travel.

Oversight of progress against the savings plans was strengthened by the creation of a Financial Sustainability Portfolio Governance Group (FSPGG). This group consists of three Board members (including Chair and Deputy Chair), senior financial executives, and the CFO of Auckland DHB.

The FSPGG will oversee the portfolio of Board approved savings initiatives, and report progress back to the Board.

The Board will approve any significant savings projects and plans, especially those that are high risk. The CEO and CMO have the Board's delegation to halt any project they believe might affect quality or patient outcome.

At an operational level, the savings plan is monitored by the Operational Financial Sustainability Group, chaired by the Director of Hospital Operations.

The Executive Leadership Team receives a weekly report on progress against the plan.

During the 2017/18 financial year, the DHB delivered savings of $26m, of which $8.8m were one off and will not repeat in subsequent years. The annualised value of sustainable savings achieved was approximately $19m.

Improving the financial performance of the Provider Arm is being delivered via a series of strategic initiatives as well as opportunistic short-term strategies. The strategic initiatives are developed with senior management and clinicians, with a high degree of focus on improving patient care as well as improving financial performance. The Board will not compromise patient care and safety in its endeavours to improve financial performance.

The financial challenges facing the DHB are considerable, and as noted above, the current performance of the Provider Arm is not sustainable.

The challenges we face include:

- Continuing clinical wage settlement and contractual increases well above funding levels
- Reliance in the past of one-off windfalls or non-repeatable benefits, and surpluses generated within the Funder
- High population growth driving service demand with a lagging funding stream

- Critical restraint in regional IT infrastructure
- 'Hump funding' to transition/transform the organisation
- Investment in facilities to replace those not fit for purpose, and to accommodate growth.

Key assumptions for financial projections

Revenue Growth

Revenue has been based on the Ministry of Health advice received in June 2018.

For the out-years, we have assumed that the funding increase will be 2.0%. Other revenue is based on contractual arrangements in place and reasonable and risk assessed estimates for other income.

Expenditure Growth

Expenditure growth of $86.8m above 2017/18 actual expenditure is planned for the DHB. This is driven by: demographic growth-related cost pressure on the services we provide; demographic growth impact on demand-driven third party contracts; clinical staff volume growth to meet service growth requirements; costs for staff employment contract agreements and step increases; costs for national initiatives including increases in the NGO sector for pay equity; cost of capital for new facility developments (interest, depreciation and capital charge – cost of capital on the revaluation of land and buildings at 30 June 2018); and inflationary pressure on clinical and non-clinical supplies and service contracts. Key expenditure assumptions include:

- Impact on personnel costs of all settled employment agreements, automatic step increases and new FTEs, estimated provisions for expired employment contracts and of employment agreements expiring during the planning period
- Clinical supplies cost growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. Costs also reflect the impact of volume growth in services provided by us and are mitigated by the impact of procurement cost savings initiatives.
- That staff cost (MECA) increases will be at 2%, with any shortfall over the settlement of the nurses' current employment negotiation funded from additional MoH revenue.
- The effects of the asset revaluation as at 30 June 2018 have not been incorporated into this plan.

Forecast Financial Statements

The Board of Waitematā DHB is responsible for the issue of the forecast financial statements, including the appropriateness of the assumptions underlying the forecast financial statements.

The forecast financial statements have been prepared to comply with the requirements of Section 139 of the Crown Entities Act. The forecast financial statements may not be appropriate for use for any other purpose. It is not intended for the forecast financial statements to be updated within the next 12 months.

In line with requirements of Section 139(2) of the Crown Entities Act 2004, we provide both the financial statements of Waitematā DHB and its subsidiaries (together referred to as 'Group') and Waitematā DHB's interest in associates and jointly controlled entities.

The Waitematā DHB group consists of the parent, Waitematā District Health Board and Three Harbours Health Foundation (controlled by Waitematā District Health Board). Joint ventures are with healthAlliance N.Z. Limited and Awhina Waitakere Health Campus. The associate companies are Northern Regional Alliance Limited formerly called Northern DHB Support Agency Limited (NDSA) and South Kaipara Medical Centre Limited.

The tables below provide a summary of the financial statements for the audited result for 2016/17, year-end preliminary results for 2017/18 and plans for years 2018/19 to 2021/22. The financial statements have been prepared on the basis of the Key Assumptions for Financial Forecasts and the significant accounting policies summarised in the Statement of Accounting Policies. The actual financial results achieved for the period covered are likely to vary from the forecast/plan financial results presented. Such variations may be material.

Forecast Statement of comprehensive income – parent

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Government and Crown Agency Revenue	1,516,737	1,606,402	1,680,041	1,713,368	1,747,495	1,781,682
Patient Sourced and Other Income	24,776	31,752	29,522	30,607	31,183	31,767
IDFs and Inter DHB Provider Income	85,259	86,543	89,409	91,187	93,008	94,822
Total Funding	**1,626,772**	**1,724,697**	**1,798,972**	**1,835,162**	**1,871,686**	**1,908,271**
Personnel Costs	604,008	641,786	660,266	671,129	677,913	691,790
Outsourced Costs	76,388	74,166	78,056	79,044	79,734	81,389
Clinical Supplies Costs	118,245	123,940	126,343	127,794	129,102	131,804
Infrastructure and Non-Clinical supplies Costs	98,987	120,728	111,576	96,150	106,808	108,297
Payments to Other Providers	727,227	778,862	829,731	861,045	878,129	894,991
Total Expenditure	**1,624,855**	**1,739,482**	**1,805,972**	**1,835,162**	**1,871,686**	**1,908,271**
Net Surplus/(Deficit)	**1,917**	**(14,785)**	**(7,000)**	**0**	**0**	**0**
Other Comprehensive Income	**0**					
Gains/(Losses) on Property Revaluations	(378)	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**1,539**	**(14,785)**	**(7,000)**	**0**	**0**	**0**

Historically, we have performed well financially, with surpluses generated in the past five years. The business transformation programme implemented in 2010/11 and continued in subsequent years contributed significantly to the achievement of surpluses in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

However, the rate of recent population growth, the ageing of the population the DHB serves, the state of our ageing infrastructure and facilities, and requirements for the development of services, facilities and Information Systems to provide high quality, safe and effective care has increased the financial pressures on the DHB, and the financial challenges are the greatest they have been for several years. As a result, the DHB is now forecasting a deficit in 2018/19 and returning to breakeven in the 2019/20 financial year.

Forecast Statement of comprehensive income – group

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Government and Crown Agency Revenue	1,516,737	1,606,402	1,680,041	1,713,368	1,747,495	1,781,682
Patient Sourced and Other Income	25,117	31,752	29,522	30,607	31,183	31,767
IDFs and Inter DHB Provider Income	85,259	86,543	89,409	91,187	93,008	94,822
Total Funding	**1,627,113**	**1,724,697**	**1,798,972**	**1,835,162**	**1,871,686**	**1,908,271**
Personnel Costs	604,008	641,786	660,266	671,129	677,913	691,790
Outsourced Costs	76,281	74,166	78,056	79,044	79,734	81,389
Clinical Supplies Costs	118,245	123,940	126,343	127,794	129,102	131,804
Infrastructure and Non-Clinical supplies Costs	97,954	120,728	111,576	96,150	106,808	108,297
Payments to Other Providers	727,334	778,862	829,731	861,045	878,129	894,991
Total Expenditure	**1,623,822**	**1,739,482**	**1,805,972**	**1,835,162**	**1,871,686**	**1,908,271**
Net Surplus/(Deficit)	**3,291**	**(14,785)**	**(7,000)**	**0**	**0**	**0**
Other Comprehensive Income	**0**					
Gains/(Losses) on Property Revaluations	(378)	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**2,913**	**(14,785)**	**(7,000)**	**0**	**0**	**0**

Forecast Statement of comprehensive income – governance & funding administration

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Revenue	12,878	14,040	15,431	15,737	16,051	16,363
Expenditure						
Personnel	10,166	10,609	13,511	13,773	14,039	14,307
Outsourced services	7,387	6,742	8,545	8,714	8,886	9,058
Clinical supplies	0	0	1	1	1	1
Infrastructure & non clinical supplies	(5,707)	(5,452)	(6,626)	(6,751)	(6,875)	(7,003)
Total Expenditure	**11,846**	**11,899**	**15,431**	**15,737**	**16,051**	**16,363**
Surplus/(Deficit)	**1,032**	**2,141**	**0**	**0**	**0**	**0**

Forecast Statement of comprehensive income – provider

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Income						
MoH via Funder	786,617	840,616	869,244	886,628	904,360	922,356
MoH Direct	38,569	22,106	23,688	24,158	24,638	25,125
Other	40,679	48,563	46,178	47,594	48,508	49,436
Total Income	**865,865**	**911,285**	**939,110**	**958,380**	**977,506**	**996,917**
Expenditure						
Personnel	593,842	631,177	646,755	657,356	663,874	677,483
Outsourced services	68,894	67,424	69,511	70,330	70,848	72,331
Clinical supplies	118,245	123,940	126,342	127,793	129,101	131,803
Infrastructure & non clinical supplies	103,661	126,180	118,202	102,901	113,683	115,300
Total expenditure	**884,642**	**948,721**	**960,810**	**958,380**	**977,506**	**996,917**
Surplus/(Deficit)	**(18,777)**	**(37,436)**	**(21,700)**	**0**	**0**	**0**

Forecast Statement of comprehensive income – funder

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Income						
Revenue	1,547,612	1,653,963	1,729,046	1,763,349	1,798,478	1,833,647
Expenditure						
Personal Health	1,123,687	1,175,884	1,229,465	1,268,846	1,294,118	1,319,477
Mental Health	208,297	219,302	230,495	235,071	239,757	244,421
DSS	167,762	211,183	226,042	230,530	235,128	239,704
Public Health	11,124	9,998	9,681	9,869	10,063	10,256
Māori Health	3,081	3,111	3,292	3,357	3,423	3,489
Governance	12,625	13,975	15,371	15,676	15,989	16,300
Total Expenditure	**1,526,576**	**1,633,453**	**1,714,346**	**1,763,349**	**1,798,478**	**1,833,647**
Surplus/(Deficit)	**21,036**	**20,510**	**14,700**	**0**	**0**	**0**

Forecast capital costs

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Depreciation	28,006	29,508	31,407	32,032	32,669	33,315
Interest Costs	6,532	0	0	0	0	0
Capital Charge	21,560	36,679	36,947	36,347	36,347	36,347
Capital Costs	**56,098**	**66,187**	**68,354**	**68,379**	**69,016**	**69,662**

Capital costs are expected to increase with additional capital investments. The increase in depreciation charge is mainly due to our accelerated facilities programme and continued investment in facilities and equipment. The capital charge has increased as a result of revaluation of the underground infrastructure and revaluation of land and buildings; however, this will be funded by specific new revenue from the Ministry of Health.

Waitematā DHB is required to revalue its land and building assets in accordance with the New Zealand Equivalent to International Accounting Standard 16 Land and Buildings, Plant and Equipment (NZIAS 16) every three to five years. The three-year cycle for detailed revaluation exercises for Waitematā DHB was last prepared on 30 June 2015. A full revaluation on land and buildings has been carried out for the financial year ending 30 June 2018 but the effect of this revaluation has not yet been included in these financial plans. However, revaluations will increase Capital Charge.

Forecast statement of cashflows – parent

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Cashflow from operating activities						
MoH and other Government/Crown	1,592,374	1,686,859	1,761,753	1,804,555	1,840,503	1,876,504
Other Income	28,560	28,477	33,940	30,607	31,183	31,767
Interest received	4,166	2,076	1,803	1,583	1,583	1,583
Payments for Personnel	(608,107)	(624,385)	(658,527)	(668,629)	(677,913)	(691,790)
Payments for Supplies	(984,172)	(1,017,136)	(1,088,701)	(1,098,693)	(1,125,306)	(1,147,379)
Capital Charge Paid	(21,762)	(36,679)	(36,948)	(36,347)	(36,347)	(36,347)
GST Input Tax	749	1,523	(639)	0	0	0
Interest payments	(8,349)	0	0	0	0	0
Net cashflow from operating activities	**3,459**	**40,735**	**12,681**	**33,076**	**33,703**	**34,338**
Cashflow from investing activities						
Sale of Fixed Assets	0	0	0	0	0	0
Capital Expenditure (-ve)	(63,717)	(24,878)	(34,533)	(25,119)	(34,422)	(35,455)
Acquisition of investments	24,440	(2,952)	0	0	0	0
Net cashflow from investing activities	**(39,277)**	**(27,830)**	**(34,533)**	**(25,119)**	**(34,422)**	**(35,455)**
Net cash movements	**(35,818)**	**12,905**	**(21,852)**	**7,957**	**(719)**	**(1,117)**
Cash and cash equivalents at the start of the year	53,631	17,813	30,718	8,866	16,823	16,104
Cash and cash equivalents at the end of the year	**17,813**	**30,718**	**8,866**	**16,823**	**16,104**	**14,987**

On 15 February 2017, all of the DHB's Crown debt, $276.7M, was converted to Crown equity.

Forecast statement of cashflows – group

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Cashflow from operating activities						
MoH and other Government/Crown	1,592,375	1,686,859	1,761,753	1,804,555	1,840,503	1,876,504
Other Income	28,326	28,477	33,940	30,607	31,183	31,767
Interest received	4,166	2,076	1,803	1,583	1,583	1,583
Payments for Personnel	(608,107)	(624,385)	(658,527)	(668,129)	(677,913)	(691,790)
Payments for Supplies	(984,173)	(1,017,136)	(1,088,701)	(1,098,193)	(1,125,306)	(1,147,379)
Capital Charge Paid	(21,762)	(36,679)	(36,948)	(36,347)	(36,347)	(36,347)
GST Input Tax	749	1,523	(639)	0	0	0
Interest payments	(8,349)	0	0	0	0	0
Net cashflow from operating activities	**3,225**	**40,735**	**12,681**	**33,076**	**33,703**	**34,338**
Cashflow from investing activities						
Sale of Fixed Assets	**0**	0	0	0	0	0
Capital Expenditure (-ve)	(63,717)	(24,878)	(34,533)	(25,119)	(34,422)	(35,455)
Acquisition of investments	24,440	(2,952)	0	0	0	0
Net cashflow from investing activities	**(39,277)**	**(27,830)**	**(34,533)**	**(25,119)**	**(34,422)**	**(35,455)**
Net cash movements	**(36,052)**	**12,905**	**(21,852)**	**7,957**	**(719)**	**(1,117)**
Cash and cash equivalents at the start of the year	55,682	19,630	32,535	10,683	18,640	17,921
Cash and cash equivalents at the end of the year	**19,630**	**32,535**	**10,683**	**18,640**	**17,921**	**16,804**

Forecast statement of financial position – parent

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Current Assets	85,856	97,914	79,519	91,276	93,807	95,890
Non-current assets	784,389	787,647	789,155	784,023	786,612	789,199
Total assets	**870,245**	**885,561**	**868,674**	**875,299**	**880,419**	**885,089**
Current Liabilities	218,353	241,205	231,288	237,213	241,633	245,553
Non-current liabilities	37,677	33,446	33,476	34,176	34,876	35,626
Total liabilities	**256,030**	**274,651**	**264,764**	**271,389**	**276,509**	**281,179**
Net assets	**614,215**	**610,910**	**603,910**	**603,910**	**603,910**	**603,910**
Total equity	**614,215**	**610,910**	**603,910**	**603,910**	**603,910**	**603,910**

Forecast statement of financial position – group

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Current Assets	89,484	97,914	79,519	91,276	93,807	95,890
Non-current assets	792,313	787,647	789,155	784,023	786,612	789,199
Total assets	**881,797**	**885,561**	**868,674**	**875,299**	**880,419**	**885,089**
Current Liabilities	218,424	241,205	231,288	237,213	241,633	245,553
Non-current liabilities	37,677	33,446	33,476	34,176	34,876	35,626
Total liabilities	**256,101**	**274,651**	**264,674**	**271,389**	**276,509**	**281,179**
Net assets	**625,696**	**610,910**	**603,910**	**603,910**	**603,910**	**603,910**
Total equity	**625,696**	**610,910**	**603,910**	**603,910**	**603,910**	**603,910**

Disposal of land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, Waitematā DHB will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. Waitematā DHB will comply with the relevant protection mechanism that addresses the Crown's obligations under Te Tiriti o Waitangi and any processes related to the Crown's good governance obligations in relation to Māori sites of significance.

Statement of movement in equity – parent

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Balance at 1 July	**612,676**	**614,215**	**599,428**	**592,428**	**592,428**	**592,428**
Comprehensive Income/(Expense)						
Surplus/(deficit) for the year	1,917	(14,785)	(7,000)	0	0	0
Other Comprehensive income	(378)	(2)	0	0	0	0
Total Comprehensive Income	**1,539**	(14,787)	**(7,000)**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown *	0	0	0	0	0	0
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**614,215**	**599,428**	**592,428**	**592,428**	**592,428**	**592,428**

*Conversion of Crown loans to equity on 15 February 2017.

Statement of movement in equity – group

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Balance at 1 July	**622,783**	**625,696**	**610,911**	**603,911**	**603,911**	**603,911**
Comprehensive Income/(Expense)						
Surplus/(deficit) for the year	3,291	(14,785)	(7,000)	0	0	0
Other Comprehensive income	(378)	0	0	0	0	0
Total Comprehensive Income	**2,913**	**(14,785)**	**(7,000)**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown	0	0	0	0	0	0
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**625,696**	**610,911**	**603,911**	**603,911**	**603,911**	**603,911**

Additional information

Capital expenditure

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Funding Sources:						
Free cashflow from depreciation	28,006	29,508	31,407	32,032	32,669	33,315
External Funding	0	0	0	0	0	0
Inflow from sale of fixed asset	0	0	0	0	0	0
Cash reserves	58,973	310	(15,060)	(28,186)	(31,898)	(34,288)
Total Funding	86,979	29,818	16,347	3,846	771	(973)
Baseline Capital Expenditure						
Land	0	0	0	0	0	0
Buildings and Plant	(22,646)	(9,841)	(11,533)	(1,165)	(11,500)	(11,845)
Clinical Equipment	(8,880)	(7,592)	(13,227)	(13,624)	(14,033)	(14,454)
Other Equipment	(427)	(458)	(4,105)	(4,228)	(4,355)	(4,485)
Information Technology	(5,499)	(2,758)	(400)	(412)	(424)	(437)
Intangible Assets (Software)	(1,622)	(122)	(2,844)	(2,929)	(3,017)	(3,108)
Motor Vehicles	0	0	0	0	0	0
Total Baseline Capital Expenditure	**(39,074)**	**(20,771)**	**(32,109)**	**(22,358)**	**(33,329)**	**(34,329)**
Strategic Investments						
Land	0	0	0	0	0	0
Buildings and Plant	(24,643)	(4,107)	(2,424)	(2,761)	(1,093)	(1,126)
Clinical Equipment	0	0	0	0	0	0
Other Equipment	0	0	0	0	0	0
Information Technology	0	0	0	0	0	0
Intangible Assets (Software)	0	0	0	0	0	0
Motor Vehicles	0	0	0	0	0	0
Total Strategic Capital Expenditure	**(24,643)**	**(4,107)**	**(2,424)**	**(2,761)**	**(1,093)**	**(1,126)**
Total Capital Payments	**(63,717)**	**(24,878)**	**(34,533)**	**(25,119)**	**(34,422)**	**(35,455)**

Banking facilities

Shared commercial banking services

Waitematā DHB is in the shared commercial banking arrangements with various other DHBs, the Bank of New Zealand ('BNZ') and New Zealand Health Partnerships Limited. The BNZ provide banking services to the sector, managed by New Zealand Health Partnerships Limited. DHBs are no longer required to maintain separate standby facilities for working capital.