Disability Support Advisory Committee

Meeting

Thursday 18 March 2010

10:00am

Sir Douglas Robb Board Room
Level 7, Building 14
Greenlane Clinical Centre
Greenlane

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare

Disability Support Advisory Committee

For discussion with CPHAC

DSAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
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2.	
NOTING	
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2.	
KPIs	
RECOMMENDATIONS	
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RISKS	
RECOMMENDATIONS	
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NOTING	
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Disability Support Advisory Committee

For discussion with Board

DSAC Meeting Date:	
Feedback By:	
DAP	
RECOMMENDATIONS	
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KPIs	
RECOMMENDATIONS	
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RISKS	
RECOMMENDATIONS	
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NOTING	
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AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Disability Support Advisory Committee
Action Points

MEETING DETAILS	
Date and Time	

Agenda Item	Detail	Responsibility	Action

1

KARAKIA AND INTRODUCTIONS

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

2

ATTENDANCE AND APOLOGIES

3

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An "interest" can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction.
- Having a financial interest in another party to a transaction.
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it.
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction.
- Being otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority's reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.
Ensure the full nature of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legisaltion.govt.nz) and "Managing Conflicts of Interest – Guidance for Public Entities" (www.oag.govt.nz).

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Date: 10/03/2010

ADHB DSAC
INTERESTS REGISTER

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Jo AGNEW	1. Senior Lecturer Nursing Auckland University		Salary		4 February 2009
Susan BUCKLAND	1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board	Self-employed Professional Conduct Committee member Professional Conduct Committee member	Fees Hourly fee Hourly fee	Writer, editor and public relations services Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes Lay member of PCC to assess complaints and determine outcomes	7 August 2009
Bob TIZARD	1. Nil				27 February 2008
Peter DRUSKOVICH	1. Employee Taikura Trust				17 July 2008

Date: 10/03/2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Maria HULL-BROWN	1. Employee Mental Health Foundation 2. Member Age Concern NZ 3. Member Auckland City Council Disability Issues Advisory Group 4. Board member HOPE Foundation for Research on Ageing 5. Council Member Age Concern Auckland.				15 October 2009
Tunumafono Avaula FA'AMOE	1. Nil				24 June 2008
Dairne KIRTON	1. Nil				24 June 2008
Susan SHERRARD	1. Team Leader for CCS Disability Action 2. Trustee Ripple Trust				18 February 2010
Nanar TAN	1. Nil				16 July 2008

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CONFIRMATION OF MINUTES

- THURSDAY 18 FEBRUARY 2010

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Disability Support Advisory Committee
Minutes

MEETING DETAILS	
Date and Time	10:00am, Thursday, 18 February 2010
Venue	Sir Douglas Robb Boardroom Level 7, Building 14, Greenlane Clinical Centre, Epsom

2	**ATTENDANCE AND APOLOGIES**
	Board Members Jo Agnew (Chair) Peter Druskovich Marie Hull-Brown Susan Sherrard Rt Hon Bob Tizard Susan Buckland Dr Brian Fergus Dairne Kirton Nanar Tan **Management in Attendance** Dr Denis Jury - Chief Planning and Funding Officer Lisa Gestro - Planning and Funding Manager Janice Mueller - Director Allied Health Julie Helean – Manager, Planning & Service Development Ian Bell – Board Administrator **Apologies** The Chair declared the meeting open at 10:01am. An apology had been received from Garry Smith.
3	**CONFLICTS OF INTEREST**
	Susan Sherrard had advised the Board Administrator of her conflicts of interest being team leader for CCS Disability Action and Trustee of the Ripple Trust. There were no notifications of any conflicts of interest for items in the agenda.
4	**CONFIRMATION OF MINUTES 19 NOVEMBER 2009**
	Moved Bob Tizard; seconded Marie Hull-Brown *That the minutes of the Disability Support Advisory Committee meeting held on 19 November 2009 be a true and correct record.* Carried
5	**ACTION POINTS 19 NOVEMBER 2009**
	Chair The invitation to the Board Chair to attend a meeting was carried forward. **Staff Training** An email from the Viv Rawlings was tabled. The Committee requested that Viv attend the meeting in March rather than May. It was understood that Counties Manukau and Waitemata had a disability coordinator person employed.

6	**CHAIRMAN'S REPORT**
	The Chair advised that she had been in contact with Colleen Brown of Counties Manukau with a suggestion of a further regional meeting between three DSAC committees.
7	**CONSUMER COMPLAINTS SUMMARY REPORT**
	All complaints are categorised i.e. medication error, but there is no category disability. The Committee requested that there be a category of complaints by a disabled person or guardian. It was noted that there were advocates available and it might be helpful to remind staff to record verbal complaints. It was suggested that Funding and Planning record complaints in Risk Monitor Pro and that there be clarification of a complaints policy around disability. There were a number of means of complaints being from parents, primary care giver or paid caregiver and it was important that complaints be communicated and to be proactive in advocacy. It was suggested that Tony O'Connor be used to research communications. With under 65s the MoH was receptive to funding a support carer when the client was in hospital however there appeared to be no funding. The Committee asked that the development of funding, the interim funding pool and how ACC handles carers be researched.
8.1	**2010 - 2011 District Annual Plan and Statement of Intent**
	The process requiring DHBs to do an Annual Plan was outlined with that due on 12 March although funding available was only released just on Christmas which provided a tight timeline. The Plan, in addition to business as usual, showed initiatives and improvement programmes. Input had come from Maori Health, Pacific Health and CPHAC. Finances would be going to the Finance Committee on 2 March. Items related to disability, Maori and Pacific were spread through the document rather than grouped and covered what the ADHB wished to do or the Minister's initiatives. With Home Based Support Services this is a continuation from the current year introducing packages of care which were implemented on 1 July so this year there would be monitoring and debate on quality. Below the DAP were departmental work plans which should have more visibility for disabilities within the DAP. There was a need to measure performance and these needed to be specific and measurable. It was noted that the Board's policy concerning workforce was to reflect the population which should also apply to disability. It was noted that the document was streamlined and that to get detail other documents may need to be referred to. It was noted that ADHB do not have a Disability Strategy but there is a National Strategy which must be followed the reference being www.moh.govt.nz/moh.nsf/indexmh/hop/resources/publications/mohstrategies With bed blockages/Taikura a report on the flow, what the key issues were and the appropriate timeline to resolve then with what resources was requested with the issue being young people being placed in rest homes however they wanted access to funding and support to live on their own. It was noted that the services of the MoH were now under the National Health Board so may take time to resolve.
	EOI
	There were 3 EOI in the Auckland region with the Committee having an ability to influence them however it could not be said that they were competent business cases being light on financial details and engagement with clinical staff and the community. The Committee sought entrenchment of disability in the EOIs.

8.4	**The Eden Alternative Care Model in Aged Residential Care**
	Jill Woodward, CEO of the Elizabeth Knox Trust was in attendance and presented to the Committee. She had been with the Trust for 2 years with previous experience in hospice, Bay of Plenty Hospital and she stated that in aged care an approach to dying could be done better. Her presentation covered the accreditation and Edenising to provide a residence in a human habitat within a quality framework. There was a resident group with direct access to the Board, not through the CEO, and in redesigning new buildings a household concept was being used rather than corridors. There was strong involvement of the community through volunteers and relationships. The Chair thanked Jill for her presentation. Susan Sherrard left the meeting at 12:10pm.
8.2	**Group Special Education Report for Consultation**
	The discussion document was provided for information.
8.3	**Report of the Auditor General into the Monitoring of Rest Homes**
	The report was distributed and would be a point of discussion at the next meeting.
	NEXT MEETING
	The meeting closed at 12:18pm. The next meeting is scheduled for 10:00am, Thursday, 18 March 2010 Sir Douglas Robb Board Room Level 7, Building 14 Greenlane Clinical Centre Auckland

CONFIRMED

CHAIR: **DATE:**

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ACTION POINTS

- THURSDAY 18 FEBRUARY 2010

Disability Support Advisory Committee
Action Points from the Meeting held on Thursday 18 February 2010

Item	Detail	Designated	Action
Carried forward	Chair, Pat Snedden to be invited to next DSAC meeting in February 2010	Jo Agnew Ian Bell	
Carried forward	Training of staff on disabilities, identified staff with disabilities at March meeting	Vivienne Rawlings	
7	The Committee requested that there be a category of complaints by a disabled person or guardian. It was suggested that Funding and Planning record complaints in Risk Monitor Pro and that there be clarification of a complaints policy around disability.	Janice Mueller Andrew Keenan	
7	The Committee asked that the funding a support carer when the client was in hospital, the interim funding pool and how ACC handles carers be researched.	Lisa Gestro	
8.1	With bed blockages/Taikura a report on the flow, what the key issues were and the appropriate timeline to resolve then with what resources was requested with the issue being young people being placed in rest homes	Lisa Gestro	
8.3	The Report of the Auditor General into the Monitoring of Rest Homes to be discussed at the next meeting	Lisa Gestro	

6

CHAIRMAN'S REPORT

7

IMPROVEMENT ACTIVITIES

7.1 DAP Projects Report

Goal 1: Lift the health of people living in Auckland city

High Level Strategy	Objective	Strategies to achieve objectives
Reduce inequities in health status		
Maori	Increase access to services	1. Reduce Maori DNA rates. 2. Increase enrolment of Maori in PHOs 3. Rangatiratanga - Maori Health Equity Framework
Pacific	Build healthy communities	1. Healthy Village Action Zone (HVAZ) evaluation 2. Implement and monitor revised KPIs for HVAZ Parish Community Nurses 3. Healthy Village Action Zone leadership and coordination
Improve outcomes in priority areas		
Children & young people	Achieve agreed Ministry of Health immunisation targets (focus Maori & Pacific)	1. Increase PHO/primary care involvement in managing immunisation 2. Practice level reporting 3. Practice nurse NIR training 4. Maori immunisation initiative
	Improve oral health outcomes for children	1. Auckland DHB wide oral health promotion 2. Implement new service model
Older People	Streamline access to older people's services	1. Create a single point of entry to services 2. Develop clinical triage according to need (direct referral to community support) 3. Establish new Home Based Support Services 4. Increase packages of care available 5. Restorative care process implemented
Mental Health	Increase effectiveness across primary, secondary & tertiary services	1. Eating Disorder Services 2. Reconfigure Maori Mental Health Services 3. Reconfigure current level 3 & 4 residential rehab services 4. Implement share care project (PROGRESS+) Primary /secondary integration
Palliative Care	Implement revised service model to align with client need	1. Unbundle current resources 2. Restructure programs to achieve effective use of general and specialist services 3. Increase the input of primary care teams in palliative care services
Prevent & manage long term conditions	Strengthen community participation and action	1. Work with Healthy Village Action Zones initiative to spread lessons 2. Plan the approach to maximise community engagement 3. Achieve target for cardiovascular risk screening
	Support whanau and self resilience	1. Increase efficiency, capacity and options of self-management approaches
	Proactive planned coordinated care	1. Run a GP clinical network for long term conditions that develops planned care 2. Increase retinal screening capacity 3. Develop care pathways for people with long term conditions
	Intensive support for people with high needs	1. Pilot case management 2. Increase the percentage of people utilising cardiac rehabilitation 3. Develop workforce for Kaupapa Maori cardiac rehabilitation

Goal 2: Performance Improvement (Better, Sooner, More Convenient)

High Level Strategy	Objective	Strategies to achieve Objective
Improve the effectiveness & efficiency of Healthcare System		
Primary healthcare	Implementation of PHO-DHB primary healthcare plan	1. Implement approach to providing efficient & effective coordinated care in the neighbourhood
	Improve access to after hours primary care	1. Develop after-hours services including palliative and residential care
Improve Primary Secondary system efficiency -decrease total system cost	Improve information availability across system Improve access & efficiency of service delivery	1. e-referrals, health event summaries and electronic outpatient letters 2. Increase access to diagnostic tests in primary care 3. Transfer some services to primary/community
Improve hospital efficiency / throughput	Improve the performance of ED	1. Projects to improve performance against 6 hr benchmark (OPJ) 2. Increase the use of and capacity of primary options
	Improve the acute capacity management	1. OPJ Starship theatre project 2. Adult inpatient capacity step (beds and workforce)
	Improve Cardiac Surgery Throughput	1. OPJ Cardiac surgery project
Reduce waiting times for elective services	Increase elective services to National Intervention rates	1. Increase Greenlane capability to a full elective services centre (feasibility)
	Achieve Radiation Oncology intervention rates and reduce waiting times for both radiation & medical oncology	1. Improve service scheduling process & utilisation of day stay 2. Tumour specific model implementation 3. Optimising the patient journey projects
	Improve Outpatient Management for Surgical Patients while improving patient satisfaction	1. Patient centred scheduling and communication 2. Accurate waiting time information. Reduced Waiting time 3. Increased input from GP's
	Reduce unmet need for elective services	1. Establish a new elective services centre
Improve Leadership Capability	Clinical leadership model: implement, monitor and evaluate Improve senior leadership team performance	1 Leadership development, mentoring and engagement process 2 Integrated governance reporting implemented 3. Define baldrige roll out plan and complete base line
Improve clinical quality & professional governance	Implement sector wide clinical networks	1. Develop GP network (collaborative) with primary care
	Improve safety and quality of care	1. Implement NQIP Medication Safety, Infection Prevention & Control, Mortality Review, Incident Management 2. Increase the number of GP practices with Cornerstone accreditation
Strengthen the health workforces	Improve clinical staff retention Healthy workplace Develop response to Long Term Services Plan	1. Targeted recruitment ICU, Midwives, RMOs, OR staff 2. Define, train and implement new workforce roles 3. Review performance based incentive programs 4. Improve the ease of application and entry
Information management	Improve resilience and availability of core IT systems	1. Implement the resilience improvement plan
	Regional Strategic Plan	1. Regional Strategic Plan development in alignment with NZ HIS 2009
Planning	Improve Capacity Management	1. Implement dynamic planning process (right beds, staff, facilities)
	Long Term Services Planning	1. National 2. Regional 3. Local

Goal 3: Live Within Our Means (Improve Value for Money)

High Level Strategy	Objective	Strategies to achieve Objective
Manage Revenue	Ensure revenue received for services provided	1. IDF annual agreements ensure we are paid for what we do. 2. Participate in National pricing process
Improve Productivity	Reduce Administration Cost	1. Improve HR payroll processing and leave management 2. Reduce back office cost (regional shared services) 3. Manage administration of M&A FTE cap
	Improve Clinical Effectiveness	1. Improve clinical resource utilisation 2. Reduce variation in Clinical Practice
	Health Service Process Improvement	1. Implement improvement programs to reduce waste, improve flow and enhance the patient experience.
	Achieve procurement savings	1. Leverage national/regional procurement initiatives 2. Refine procurement strategy 3. Deliver direct treatment cost savings 4. Deliver indirect treatment cost savings 5. Monitor and collect rebates within contracts for supplies and services
Manage Cash	Optimise stock holding	1. Revisit replenishment parameters 2. Improve supply chain systems and processes
	Sustainable Cash Management Plan	1. Asset Management Plan alignment with the Long Term Services Plan 2. Improve prioritisation process for new capital 3. Long term financial modelling process is implemented

Goal Level Summary Report (Disability Support Advisory Committee)

DAP Projects

Total Projects: 5

DAP GOAL	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1) Lifting the Health of the people in Auckland City	4	4	1	1	1	0	1	0	4	0	0	4	0	0	4	0	0	0	0	0	0
2) Performance Improvement	1	1	1	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
3) Living within our Means	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	**5**	**5**	**2**	**1**	**1**	**0**	**1**	**0**	**5**	**0**	**0**	**5**	**0**	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**0**
Totals %	**100%**	**100%**	**40%**	**20%**	**20%**	**0%**	**20%**	**0%**	**100%**	**0%**	**0%**	**100%**	**0%**	**0%**	**100%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**

Review

No Review Comment has been made.

High Level Summary Report

Goal 1 Lift the Health of the people in Auckland City

DAP Projects

Total Projects: 4

DAP HLS	Number	Started	Current Phase					Cancelled	On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/Check	Act														
			Define	Measure	Analyse	Improve	Control		Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
1.1 Reduce inequalities in health status	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.2 Improve outcomes in priority areas	4	4	1	1	1	0	1	0	4	0	0	4	0	0	4	0	0	0	0	0	0
1.3 Prevent and manage long term conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	**4**	**4**	**1**	**1**	**1**	**0**	**1**	**0**	**4**	**0**	**0**	**4**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**
Totals %	**100%**	**100%**	**25%**	**25%**	**25%**	**0%**	**25%**	**0%**	**100%**	**0%**	**0%**	**100%**	**0%**	**0%**	**100%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**

Goal 1 Lift the Health of the people in Auckland City

Objectives

Objective	Objective Owner	Comment

Exceptions

There are no projects that have been marked as an exception

High Level Summary Report

Goal 2 Performance improvement

DAP Projects

Total Projects: 1

DAP HLS	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/Check	Act														
			Define	Measure	Analyse	Improve	Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Fully deliver	Partially deliver	Not deliver		Green	Orange	Red
2.1 Improve the effectiveness & efficiency of the healthcare system- primary care	1	1	1	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0
2.2 Improve the efficiency and effectiveness of the healthcare system– decrease total system cost- primary secondary interface	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve the efficiency and effectiveness of the healthcare system - hospital efficiency /throughput	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.4 Improve the efficiency and effectiveness of the healthcare system – reduce waiting times for elective services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.6 Improve leadership performance in clinical quality& professional governance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.7 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.8 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.9 Planning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals #	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
Totals %	**100%**	**100%**	**100%**	**0%**	**0%**	**0%**	**0%**	**0%**	**100%**	**0%**	**0%**	**100%**	**0%**	**0%**	**100%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**

Goal 2 Performance improvement

Objectives

Objective	Objective Owner	Comment

Exceptions

8

PAPERS

8.1 Update on the Revised Material in the 2010-11 District Annual Plan

8.2 Quality in Rest Homes – National Spot Audit Project

8.3 Management of Complaints

8.4 Access Audit

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DISABILITY SUPPORT ADVISORY COMMITTEE
Paper

Date	Thursday 18 March 2010
To	Disability Support Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denisj@adhb.govt.nz
Author	Lisa Gestro Ext 26097 lgestro@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	Update on the Revised Material in the 2010/11 DAP on Disability

1 Purpose

To present amendments to the Draft District Annual Plan on Disability following recommendations made at the last meeting

2 Recommendations

That the Committee

- **note** the proposed changes,
- **endorse** the revised document as appended

3 Background

The draft District Annual Plan was presented to the February DSAC meeting, and following discussion some key changes to clarify and strengthen the disability perspective were agreed.

4 Update

Following the last meeting changes were made to the draft DAP as agreed. The revised version was subsequently submitted to the Ministry of Health to comply with the 11 March deadline, and we will await feedback on the draft.

The final draft is appended for information.

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DISABILITY SUPPORT ADVISORY COMMITTEE
Paper

Date	Thursday 18 March 2010
To	Disability Support Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Greenlane Clinical Centre Phone: Ext 8071 Email: denisj@adhb.govt.nz
Author	Lisa Gestro, Planning and Funding Manager
Functional Group	Planning and Funding
Subject	Quality in Rest Homes - the Report on Effectiveness into arrangements to check the standard of services provided by rest homes - Office of the Auditor General and the national project for spot auditing of aged care facilities

1 Purpose

This paper serves to inform the committee of the recent activity in respect of quality within aged care, noting the link between the OAG report and the recent activity surrounding national spot audits

2 Recommendations

It is recommended that the Committee:

Note the findings of the report detailing various national activity relating to quality I aged care, and discuss any implications that this activity might have on the local provision of aged care

3 The Office of the Auditor general recently released a comprehensive report into the monitoring arrangements of Residential Care. The executive summary of the report is as follows:

There are about 34,000 people living in 715 certified rest homes throughout the country. Older people who live in rest homes are some of the most vulnerable in our society, so it is important to have effective arrangements for checking the quality and safety of rest home services. The effectiveness and efficiency of such arrangements was the focus of a performance audit by my staff.

By law, rest homes have to provide residents with care that meets the ***Health and Disability Services Standards*** (the Standards). To provide residential care services for older people, rest homes must be certified by the Director-General of Health and, to remain certified, rest homes must be audited to check whether they meet the many criteria set out in the Standards.

The Ministry of Health (the Ministry) is responsible for the auditing and certification of rest homes. In my view, since its introduction in October 2002, certification of rest homes has not provided adequate assurance that rest homes have met the criteria in the Standards, and the Ministry did not respond quickly enough to address weaknesses and risks in the arrangements that it has known about since 2004.

The Ministry is actively trying to address shortcomings in the effectiveness of auditing and certification arrangements. For example, it has a certification improvement project and wider work programme that have been well managed, and the project has so far met most of its milestones. Communication between all those involved in overseeing rest homes has improved. The Ministry

has also begun to manage risks more systematically.

However, more work remains to be done and it is still too early to tell whether the efforts to make the current arrangements work as intended will make a difference or whether certification is fundamentally unable to do what the legislation envisaged.

Auditing by designated auditing agencies has been inconsistent and sometimes of poor quality

Audits of rest homes can never eliminate the risk of poor care. Audits can only establish whether, at a particular point in time, rest homes have the systems and processes in place to minimise that risk.

The Ministry uses eight designated auditing agencies (DAAs) to carry out audits of rest homes.

The Ministry has known since 2004 that auditing by DAAs is inconsistent and sometimes of a poor quality. Notwithstanding its recent efforts, and evidence that DAAs are improving some aspects of their work, the Ministry did not respond to these problems quickly enough or with enough effect.

There are examples from 2008 and 2009 where DAAs have failed to find or report instances where rest homes have not met the criteria in the Standards. Serious failures in the care of residents have been identified later by other regulatory bodies. The frequency of these events may have been low, but they are significant because the failings are serious.

Progress reporting is a mechanism that is supposed to ensure that rest homes take action to fix problems identified by DAAs. Progress reporting is not always effective and is not leading to sustained improvements. Our file reviews showed that DAAs mostly rely on rest homes to report on their own progress and rarely make follow-up visits to verify that action has been taken. Some rest homes are repeatedly failing to meet the same or closely related criteria in the Standards, and some DAAs are behind in submitting progress reports to the Ministry.

Until its current programme of work, the Ministry's quality assurance of DAAs largely consisted of an evaluation of DAA audit reports (many of which were not properly completed). Except in times of crisis, the Ministry has given little feedback to DAAs on their performance, and it has never removed a DAA's designation despite evidence of sustained poor performance.

In my view, the Ministry must strengthen how it oversees the work of DAAs and how it deals with poor performance by DAAs. The Ministry's current programme of work has begun to address many of the weaknesses in auditing and certification. For example, the quality assurance system that the Ministry uses to oversee the work of DAAs has improved. There is now more stringent evaluation of DAA reports, closer scrutiny of DAAs known to be performing poorly, and the Ministry has begun to observe audits by DAAs. Communication between the Ministry and the aged care sector, including DHBs, has also improved. This work should have started sooner.

The Ministry has made efforts in the last two years to identify and address the problems with the current certification arrangements. Further, the need to improve the skill level and capacity of the HealthCERT team was recognised and restructuring began in 2008. A supporting information technology platform was put in place in 2008, enabling an accelerated work plan to continue throughout 2009.

Monitoring by district health boards

Rest homes are also monitored by DHBs. Most rest homes have a contract with their local DHB – the Age Related Residential Care Services Agreement (the age-related care contract). DHBs are required by law to monitor the delivery and performance of services by rest homes that they hold an age-related care contract with. Although the age-related care contract is the same throughout the country, individual DHBs interpret and monitor the contract differently. I encourage DHBs to achieve consistency in this matter.

Most (65%) DHBs do not consider certification to be reliable. Fourteen DHBs carry out their own auditing of rest homes (usually through their shared service agency), which largely duplicates the auditing carried out by DAAs. This diverts scarce resources from other monitoring work that could focus more on improving the quality of care in those rest homes where the risk to rest home residents is greatest.

Monitoring of rest homes by DHBs has not been well co-ordinated with the work of the Ministry. Occasionally, DHB auditors and DAA auditors have audited a rest home within days of each other, or on the same day. The results of the audits are often quite different.

Variable risk management

Certification relies on audits. Auditor independence is integral to the audit. We identified various threats to auditor independence inherent in the system. In our view, the Ministry could have responded more quickly to risks identified in the certification arrangements.

The Ministry now has a risk register, and has plans for managing several of the most significant risks, including:

- the risk of conflicts of interest;
- the risk that rest homes might select the cheapest or most lenient DAA;
- the risk that commercial pressures might influence an auditor's independence;
- the risk that DAAs might interpret and audit the Standards differently; and
- the risk that auditors might have inadequate skills and expertise.

Rest homes can choose which DAA will audit them, and most of the auditors who work for DAAs are freelance contractors. My staff found evidence of DAA auditors offering and providing rest homes with services in addition to auditing. Until 2009, the Ministry had not closely scrutinised the pricing and other business practices of DAAs. It now has limited knowledge of audit fees that different DAAs charge rest homes.

Certification audits are arranged well in advance, which means that the audit team may not see the rest home as it usually operates. The audit team (usually two people) is expected to check more than 200 criteria for a certification audit.

Some criteria will take longer than others to check. For example, DAAs check that the records kept are legible. DAAs also check that rest home residents are actively involved in the planning of each stage of service provision, which requires interviewing rest home residents and sometimes their families.

Most audits are carried out with only two days on site, which leaves DAAs little time to check each criterion thoroughly. A DAA could lose the rest home's business if the price for the audit were too high, which creates a commercial incentive to carry out audits quickly.

Ongoing effectiveness of certification

Rest home operators, DAAs, and DHBs agree that the introduction of the Standards and certification have raised standards in rest homes. However, there is evidence that the rate of improvement has slowed, and some rest homes consistently receive poor ratings for the same or closely related criteria. In addition, rest homes throughout the sector are often given poor ratings for some Standards - for example, the medicine management standard.

Overall findings

I am encouraged by the work the Ministry has done with DAAs and DHBs this year. However, it is too early to judge whether the changes being made will make the auditing, certification, and

monitoring of rest homes more effective and efficient.

My Office will do more work in 2011 to look at whether the changes the Ministry is now making have improved the effectiveness of the overall certification process. More fundamental changes to the design of the auditing, certification, and monitoring arrangements may yet be needed. I recommend that the Ministry consider whether other arrangements would be more effective and reliable.

I thank the staff of the Ministry, DAAs, DHBs and their shared service agencies, rest home providers, and the organisations that provide advocacy services for the elderly, for helping my staff with this performance audit.

Lyn Provost
Controller and Auditor-General

15 December 2009

4 **Recommendations of the Report**

Recommendations for the Ministry of Health

The first five recommendations for the Ministry are based on improving the existing certification arrangements. The sixth recommendation is significant, because we encourage the Ministry to reconsider the effectiveness of the existing certification arrangements.

We recommend that the Ministry of Health:

1. continue to strengthen how it oversees designated auditing agencies;
2. cancel the designation of audit agencies that continue to perform poorly;
3. continue to improve its use of auditing and certification information to identify common themes and trends in the rest home sector, and use that knowledge to identify how and where rest home residents are at greatest risk;
4. continue to improve how it manages risks in the certification arrangements, identifying the likelihood and severity of those risks and reviewing each year its risk management strategy;
5. begin to evaluate, by the end of 2010, the effectiveness of third-party accreditation and other work to strengthen the certification process, and share the results with district health boards, rest home operators, and organisations providing advocacy services for older people; and
6. reconsider the design of the certification arrangements by examining alternatives and evaluating whether the alternatives would be more effective and more reliable.

Recommendations for district health boards

We recommend that:

7. district health boards work together to ensure that they and their shared service agencies are interpreting the Age Related Residential Care Services Agreement consistently;
8. district health boards share information relevant to improving the safety and quality of services provided by rest homes quickly and freely with other agencies working in the rest home sector; and
9. once auditing by designated auditing agencies is effective and reliable, district health boards stop routine contract auditing and use their resources to work with those rest homes where improvements are needed most.

5	**Background** The spot audit (unannounced surveillance audit) pilot project is part of a broader work programme being undertaken by the Ministry and DHBs to improve the effectiveness and efficiency of aged residential care audits. The spot audit project included several components. It: • introduced an unannounced surveillance component to the audit process • integrated aspects of the DHB aged residential care (ARC) contract audit with the Ministry's certification surveillance audit • changed surveillance audit criteria and audit methodology requirements from prior surveillance audit requirements, and • piloted a new audit 'information gathering' tool. **Unannounced surveillance audit** Section 9 of the Health and Disability Services (Safety) Act 2001 requires all health care service providers to be certified and to provide services in accordance with all relevant service standards. All aged care residential service providers must be certified in accordance with the Act. HealthCERT, a division within the Regulation and Governance Directorate of the Ministry, oversee the certification process. Aged residential care providers must select an approved DAA to undertake regular audits against the relevant Health and Disability Services sector standards. This information then informs the Ministry about whether certification will be granted and when the next certification audit is required (between one and five years). The current audit regime includes an announced surveillance audit which is conducted by the approved DAA at a midpoint. A key component of the pilot project was the introduction of an unannounced "spot" audit. From 1 January 2010 all surveillance audits will be unannounced occurring three months either side of the previously due date. **Integration of audits** In addition to the certification and surveillance audits, the national aged residential care (ARC) services agreement provides a contractual framework between DHBs and individual aged residential care providers. DHBs have a statutory responsibility to monitor the delivery and performance of persons that the Board engages to provide aged residential care services. Many of the contract requirements are similar to the Health and Disability Services standards that must be met for Ministry of Health certification. The spot audit pilot project has involved integrating the Ministry's surveillance audit with aspects of the DHB aged residential care (ARC) contract audit. A decision by DHBs is expected in February 2010 as to whether the DHB quality audit framework will be integrated into full certification and surveillance audits. **Changed audit criteria and methodology** The criteria for the surveillance audit has been amended to further focus surveillance audits on key aspects of service delivery and risks that contribute to system and process failures. This took the previous minimum number of criteria for audits from 46 to 32 and no longer required all criteria within a standard to be audited. **Audit 'information gathering' tool** The spot audit pilot project has included a trial of a new audit 'information gathering' tool developed by the New Zealand Aged Care Association1 (NZACA). The NZACA established a project to develop the tool that included a working group comprising representatives from NZACA (two), providers (three), the Ministry (one), DHBs (one) and shared support agencies (one). A near final draft version of the tool was shared with DAAs for comment. As a result, there was further revision of the audit tool which resulted in a NZACA/MOH 'information gathering' tool for the pilot project.

	Project Update The spot audit pilot project combined amended surveillance audit requirements with corresponding ARC contract requirements that took the form of an unannounced audit. The evaluation was undertaken by Evalue Research, in collaboration with the Ministry of Health. The evaluation objectives were to assess whether the spot audit: • had a focus on day to day service delivery • aligned with international best practice for quality and management systems auditing, and • reduced the number of audits by combining the certification surveillance audit with the District Health Board (DHB) aged residential care (ARC) contract audit. The evaluation also examined the expected outcomes of the pilot, with a view to informing a national roll-out of unannounced surveillance audits. The findings are based on quantitative and qualitative data, including a comparison of baseline and spot audit data. In brief, the findings are as follows: • spot surveillance audits have a focus on day to day service delivery and are little more disruptive than an announced audit for service providers • overall there is a greater alignment with best practice for quality and management systems auditing. • it is possible to integrate contractual references within the certification system which will result in a reduction in the number of audits required within the aged residential care system. • DHBs participating in the pilot project had different views about the usefulness of the audit reporting they received to support contractual monitoring. • It is estimated that the overall impact on time for future spot audits is likely to be around 20 percent. • the audit 'information gathering' tool resulted in double-handling of data as auditors had to input information into the tool and then transfer it to the Ministry's reporting template. The evaluation concluded: • There is no question that the unannounced component has worked well and should continue. • The combination of a more realistic snapshot of aged residential care, along with changed surveillance audit criteria and audit methodology, has resulted in audits having an increased focus on service delivery. • Integrating aspects of the DHB aged residential care contract audit with the Ministry's certification surveillance audit is achievable However, it will require better communication between DAAs and DHB staff prior to audits, as well as clarification about roles and approaches for performance monitoring post an audit. It would be useful to provide further guidance to DAAs about the ARC contractual requirements as well as the level of engagement that DHBs require. • The information gathering audit tool did not represent good value in the spot audit process. A guidance document for auditors is likely to add more value without incurring additional costs to the audit process. This should be developed with specific input from DHBs, to ensure auditors collect data that supports their requirements. • Consideration of costs associated with the time required to undertake a spot audit will require further attention, cooperation and monitoring by all parties. Mechanisms need to be developed that keep the transaction costs to a minimum, while ensuring the focus remains on best practice auditing. • Further enhancements are required to the Ministry of Health's reporting template to allow for an abridged report to be generated.
	Next Steps DHB CEO's and GM's Planning and Funding are now in the process of confirming that the proposed integrated approach moving forward. The Ministry in conjunction with HOP managers will then develop an implementation approach that is acceptable to all parties – this will include considering any cost contributions from DHBs, and changes that were recommended from the evaluation process.

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DISABILITY SUPPORT ADVISORY COMMITTEE
Paper

Date	Thursday 18 March 2010
To	Disability Support Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denisj@adhb.govt.nz
Author	Lisa Gestro Ext 26097 lgestro@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	Management of Complaints

1 Purpose

To present follow up and further points of discussion and interest in relation to the management of complaints

2 Recommendations

That the Committee

- **review** the attached report
- **note** further work being undertaken,
- **note** the workshop scheduled for the 30th of March 2010
- **Agree** the recommendations below in respect of ongoing complaints reporting to the Committee

3 Background

At the end of 2009 the Disability Support Advisory Committee formally requested that there be a standing report submitted to the committee bi-monthly on the number of complaints received by the Provider from people with a disability, or which are in relation to disability.

An update was provided by the quality committee in February which highlighted the difficulty in capturing this type of information accurately, and in way that was meaningful to the organisation. Some of the concerns which were raised during the discussion of the report included:

- Who is defining the definition of a disability in terms of what is being captured
- If a disability is not reported as part of the complaint then this information is not captured
- This report only captures provider (hospital) related complaints and not community providers (rest homes, home based support etc)

4 Update

It was agreed that the Director of Allied Health would follow up these issues with the Quality

	Department and bring an update back to the next meeting. In addition it was agreed that investigations would be made into the recording of funder (community) complaints on Pro-Risk along side hospital complaints. It is recommended that a discussion be instigated at DSAC to formalize a way forward that captures in an appropriate way complaints raised across both provider and funder arm in respect of Disability or Disability related issues.
5	**Workshop** As well as updates on the above, it seemed pertinent to bring the upcoming Complaints Management workshop to the attention of the DSAC, which will undoubtedly touch on some of the issues that DSAC as been grappling with in respect of these issues. The agenda for the workshop is attached in appendix one, and consideration should be given to whether members of the committee may like to attend the workshop.

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DISABILITY SUPPORT ADVISORY COMMITEE
Paper

Date	18 March 2010
To	Disability Support Advisory Committee
From	Denis Jury, Chief Planning and Funding Officer Level 8, Building 13, Greenlane Clinical Centre Phone: 630 9943 ext 8071 Email: denisj@adhb.govt.nz
Author	Lisa Gestro Ext 26097 lgestro@adhb.govt.nz
Functional Group	Planning and Funding Functional Group
Subject	Update on Standing Agenda Item – Accessibility Audit

1 Purpose

The purpose of the paper is to:

- **Update** the committee on recent activity

2 Recommendations

That the Committee

- **Note** the update

3 Background

In 2007/08 the need for an audit to measure accessibility and service user experiences among the Disabled community became a priority for the ADHB. This objective was deferred a year due to competing priorities but was revisited following the launch of the Step Up Auckland report, which highlighted access as the single biggest issues for disabled people within Auckland City. Discussions began in mid 2009/10 with stakeholders and potential providers to agree the outcome that would be sought from the exercise, and to scope what such an audit might include.

4 Update

A small internal steering group was established in September last year, and a meeting took place with A1 Communications who agreed to facilitate the production of the initial report. Further expertise in Disability responsiveness and disability research have subsequently been added to the team, and a draft report has been compiled for the review of the ADHB and the DSAC Committee. A full update of the detail contained in the report will be provided to the committee at the meeting.

9

CONFIRM

9.1 Action Points for next DSAC Meeting

9.2 DSAC Feedback to CPHAC

9.3 DSAC Feedback to Board

Use Forms at beginning of Meeting Pack

10

GENERAL BUSINESS

11

APPENDICES

11.1 DAP

11.2 Workshop Agenda

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Auckland District Health Board

District Annual Plan *2010 - 2011*

1 March 2010
Copy for Board Review

Status of this Document

Working version

Approvals

Auckland DHB	
Ministry of Health	
Minister of Health	

Auckland DHB planning documents are available on the website www.adhb.govt.nz (under News and Publications)

- Statement of Intent
- District Strategic Plan 2006–10
- Population Health Needs Assessment

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Foreword

E nga mana, e nga reo, e nga karangarangatanga tangata
Ko te Toka Tu Mai O Tamaki Makaurau tenei
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 'Te Toka Tu Mai' 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
This is the message from the Auckland District Health Board
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 of the Auckland District Health Board
Embarking on a journey through a pathway that requires your support to ensure success for all
Greetings, greetings, greetings

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

This District Annual Plan summarises the priority challenges, opportunities and actions for the 2010–2011 year. We increase our attention this year on the Government's priorities for health: Better, Sooner, More Convenient Healthcare.

There is no doubt that the health sector has entered a new era where the annual funding increase is at a significantly reduced level. Regardless, we need to achieve a breakeven position for this financial year and subsequent ones. In this environment, we will achieve breakeven via productivity and efficiency gains, eliminate waste, and reduce variation using quality tools. While we will still fund and provide all the services required of a publicly funded health system, we will examine every health service to ask if that money would produce more health gain if allocated in another way.

We begin the year with a real orientation towards more integrated primary health care across the region. There are some exciting new ventures underway in primary care via the government's EOI process. Our DHB will be a key partner in improving the quality of the frontline services being delivered to our population.

The government health strategy and the release of the Ministerial Review Group findings also impact on the Auckland DHB. We must make the health sector changes required, and rapidly. These are step-changes as opposed to incremental changes, so we will proactively engage in both Regional and National initiatives, bringing the knowledge and expertise of Auckland DHB staff to deliver a better outcome. In October 2010 we have the local body elections with some possible changes to the Board and a review of our strategic direction.

Thank you for your commitment to health and the outcomes we plan to deliver in 2010–11.

Pat Snedden, Chair
Auckland District Health Board

Garry Smith, Chief Executive
Auckland District Health Board

This 2010–11 District Annual Plan
is signed for and on behalf of
Auckland District Health Board

Pat Snedden
Chair

Our Treaty of Waitangi partners
Te Runanga O Ngati Whatua

Naida Glavish JP
Chair

And signed on behalf of
The Crown

Hon Tony Ryall
Minister of Health

Treaty of Waitangi Statement

The DHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi encapsulates the fundamental relationship between the Crown and iwi. It provides the framework for Maori development, health and wellbeing. The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes to enable Maori to participate in, and contribute towards, strategies to improve Maori health outcomes. References to the Treaty of Waitangi in this document derive from, and should therefore be understood in this context.

As a Crown agent, the DHB will demonstrate how Treaty responsibilities are implemented through innovative strategies that apply the principles of Partnership, Participation and Protection. These principles are promoted by the Ministry of Health to provide direction to the health sector. Our commitment is therefore consistent with national Ministry of Health policy within *He Korowai Oranga – The Maori Health Strategy.*

Co-operative rangatiratanga and kawanatanga

The DHB and Te Runanga O Ngati Whatua (including its health agent Tihi Ora MaPO) hold a Memorandum of Understanding that outlines the principles, processes and protocols for working together at governance and operational levels.

In order to achieve rapid progress towards equitable Maori health outcomes, both parties recognise the value of co-operative rangatiratanga and kawanatanga as the means to achieve equitable Maori health outcomes.

Principles in action

Principle	Action
Partnership Te Runanga o Ngati Whatua as manawhenua, are partners with Auckland DHB	Memorandum of Understanding with Te Runanga o Ngati Whatua and its health agent Tihi Ora MaPO. Ngati Whatua, as Manawhenua partners with the DHB at governance and operational levels. This actively protects Maori interests in health planning and funding. Auckland DHB has a Maori Health Advisory Committee. There is consultation with Iwi Maori in planning health and disability services and regarding service and other changes.
Participation Maori engagement in planning, development and delivery of health and disability services	Responsible and responsive to Maori communities in our district and those who use our services. To develop and implement an innovative cross-DHB Maori health equity framework linked to co-operative rangatiratanga and kawanatanga. Active involvement of Manawhenua and Mataawaka communities at all levels. There is engagement with Maori regarding the impact service and other changes may have on Maori communities and organisations. Assistance to further develop Maori providers in our district.
Protection Equity of participation, access and outcomes for all Maori. Equitable Maori health status. Safeguard Maori cultural concepts, values and practices	Adhere to the Auckland DHB Tikanga Best Practice Policy to protect the rites/rights of Maori, respect the tikanga of manawhenua and practically contribute to providing services that are responsive to Maori needs and interests. Services will meet the rights/rites, needs, interests and aspirations of Maori. Commitment to the Maori Health Strategy, He Korowai Oranga and other national policy. Use the national Inequalities Framework, the health inequalities impact assessment tool and the national Prioritisation Framework prioritising whanau ora.

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Priorities for Health

Auckland DHB strategic priorities for health

Local health planning aligns with national health strategy.

The actions included in the Auckland DHB Annual Plan are determined by government's national health policy and our local Strategic Plan.

The overall vision for the Auckland DHB is:

Healthy Communities, Quality Healthcare, Hei Oranga Tika Mo Te Iti Me Te Rahi

Strategic priorities for the District Health Board reflect assessment of population health status, common problems and unmet needs:

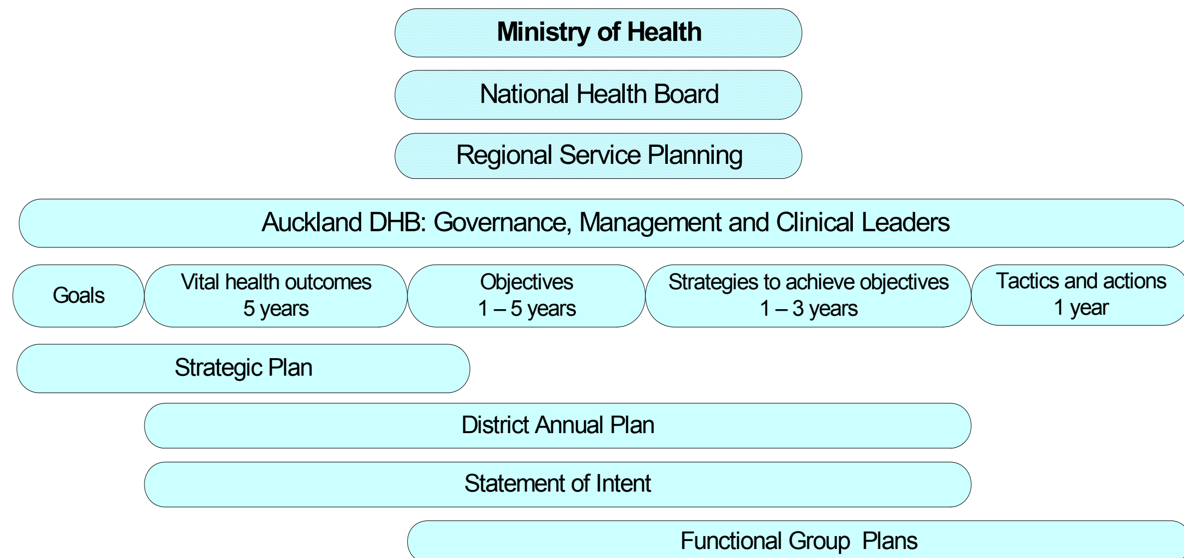
- reduce health inequities
- reduce cancer, diabetes and cardiovascular disease
- independence for disabled people and those who need support services
- better outcomes in child health
- better outcomes in mental health
- better outcomes for older people

In 2010–2011 we will work closely with the newly created National Health Board for future planning. We will do more planning across the Auckland region, especially around the development of clinical services. As a result, our District Strategic Plan will be reviewed in 2010.

This Annual Plan concentrates on activities during the 2010–11 year that are strategic priorities and which are over and above our business as usual.

Detailed work activities are covered in Five Functional Group Plans:

- Planning and Funding
- Clinical Quality and Professional Governance
- Healthcare System Improvement
- Operational Functional Group (Clinical Services)
- Corporate Services (Information Management and Technology Services, Human Resources, Finance and Corporate).



National priorities for health

Government wants Better, Sooner, More Convenient healthcare for all New Zealanders. DHBs are expected to concentrate on the following in 2010-11:

The Minister's Letter of Expectations

Improve service and reduce waiting times

- reduce excessive patient waiting times
- resources to support frontline services
- implement productivity and quality and safety improvements

Increase elective surgical volumes year on year

- both first specialist assessments and surgery
- move from reliance on spot purchasing from the private sector
- sustainable longer-term relationships to help grow elective surgery

Improve Emergency Department waiting times

- improve performance in line with the 6 hour length of stay target

Improve cancer treatment waiting times

- shorter interval between diagnosis and treatment, particularly radiation treatment

Primary Health Care Strategy

- provide a wider range of services in community settings
- services provided at no cost to patients
- consolidate PHOs where appropriate, acknowledging provider networks

Clinical Leadership

- strengthen clinical engagement from governance through the organisation

Regional Co-operation

- identify real gains/results from collaborating with neighbouring DHBs

More unified system

- meet national expectations re shared services
- make the most of collective procurement and back office rationalisation
- work on improvements from the MRG Report, such as quality and safety

Other government priorities for 2010-11

Use the primary care business case process to rationalise the number of PHOs in the Auckland DHB area

National measures of performance for the health sector

(These are covered in detail on page 23)

National targets

Shorter stays in emergency department

Improved access to elective surgery

Shorter waits for cancer treatment

Increased immunisation

Better help for smokers to quit:

Better diabetes and cardiovascular services

Policy priorities

Clinical leadership

Better, Sooner, More Convenient primary health care

Local Iwi/Māori engaged and participate in DHB decision-making, development of strategies and plans for Māori health gain

Improving mainstream effectiveness

Waiting times for chemotherapy treatment

Improving the health of people with severe mental illness through improved access

Improving mental health services using crisis prevention planning

DHBs report alcohol and drug service waiting times and waiting lists

Delivery of Te Kokiri: the Mental Health and Addiction Action Plan

Oral health – Mean DMFT score at year 8

Children caries free at 5 years of age

Use of DHB funded dental services by adolescent from Year 9 to 17 years

Improving the number of children enrolled in DHB funded dental services

Family violence prevention

System Integration Dimension

Ambulatory Sensitive Hospital Admissions

Regional Service Planning

Service Coverage

Elective Services Standardised Intervention Rates (SIRs)

Increase funding for Māori Health and disability initiatives

DHB confirmation and exception reports – risk management

Improving breast-feeding rates

Ownership Dimension

Staff Turnover

Capital Expenditure to Plan

Elective and Arranged Inpatient Length of Stay

Acute Inpatient Length of Stay

Theatre Productivity

Elective and Arranged Day Surgery

Elective and Arranged Day of Surgery Admission

Acute Readmissions to Hospital

Mortality

Data Submitted to National Collections

Output Delivery Against Plan

National patient satisfaction survey

Summary of Key Developments

Financial pressures (see page 54)	Our organisation must achieve a break even position within the allocated funding. At the same time there is significant pressure on costs and cost growth from increased service delivery requirements and the expectations of our labour market. Living within our means requires reprioritisation and reallocation of the resources available to us and also those within the region. Tools such as lean thinking help us find ways to reduce variation and avoid waste. 2010-11 sees more initiatives to avoid waste and improve productivity including clinical resource utilisation and practice change, reduced administrative costs and procurement savings. This includes maintaining management and administration FTE numbers below the Minister's December 2008 cap levels.
Contract review	All external contracts for discretionary health services, funded directly by Auckland DHB, will be subject to a review process in the 2010-11 year. The review will investigate whether the contracts are producing the best value for money (effectiveness, equity, efficiency and whanau ora). Providers will be kept up to date with this contract review process and any substantial service changes likely will be subject to consultation requirements and good contracting processes, for example, sufficient notice being given of any changes. As a result of funding pressures, there will be very little funding available for new initiatives. This annual plan includes only those areas of priority focus and activity that has funding approved. All other proposed developments that require funding above the base are on hold. Reduction in the Auckland Regional Public Health service funding for 2010–11 will mean reductions in the level of services that this public health service provides into the future. The service is finalising the scope of reductions and will reorganise its service delivery plan as efficiently as possible.
Changes in primary health care	The 5 Primary Health Organisations within the Auckland DHB boundary are likely to undergo large scale changes as a result of the Ministry of Health expressions of interest (EOI) process to deliver Better, Sooner, More Convenient Primary Care. Three primary care and DHB collaborations in the Auckland region are submitting business cases to the Ministry of Health. – Alliance Health+: A consortium of 3 Pacific PHOs in the Auckland region: – The Greater Auckland Integrated Health Network (GAIHN): A consortium of 312 general practice teams, 11 PHOs and the 3 Auckland region DHBs – National Māori PHO Coalition: This national coalition is progressing its proof of concept to enable the Whānau Ora strategy If successful, these initiatives will draw up a full implementation Blueprint for delivery by 30 June 2010. That process will include briefings and community engagement. The changes proposed that will impact in the DHB include: – Increased access to diagnostic testing for primary care – Some services transferred from hospital to primary/community settings – Improved access to after-hours primary care, including palliative and residential care – Reduced demand on acute (hospital) services by extending the preventative work done in the primary care setting (POAC) – Technology improvements like e-referrals, health event summaries and electronic outpatient letters to support primary health care

	practitioners – Changes to the management of long-term conditions
Work associated with service quality and efficiency (goal 2, page 15)	Alongside the re-configuration of primary health care sit a number of change projects within the hospital and related services: – Improving throughput and overall productivity e.g. cardiac surgery throughput will increase the number of bypass procedures per week – Completing 10 project work streams (including formalising the private public relationship and incentive schemes) – Getting more patients through the Emergency Department via projects aimed at adult and children's acute responses – Achieving better operating room productivity by using lean improvement programmes – Improving ward productivity by wards in Adults and Mental Health services using Releasing Time to Care – Raising day of surgery (DOSA) rates e.g. for elective Neurosurgery – Better Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding two operating rooms providing capacity for increasing volumes – Improve the patient experience while improving productivity by implementing service improvement projects in: –General medicine, Orthopaedics, Radiology, Paediatrics general surgery, General surgery, Ophthalmology – Reviewing pathways of care with a focus on improving health outcomes and reducing inequalities for Maori – Reducing Did not Attend rates (DNA) and failures to engage with treatment and follow up – Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology – Implementing lung and bowel tumour stream models – Increasing elective surgical discharges with the Greenlane Surgical Centre underway – Implementing regional clinical networks that provide leadership in cancer and cardiac services and that enable integration between hospital and primary care – Accelerating quality improvement with a focus on reducing avoidable variation and adverse events e.g. medication safety, infection, prevention and control, mortality review, incident management – Establishing a Consumer Council as another way to increase consumer engagement in quality improvement – Implement an Early Warning System for the physiologically unstable patients in all clinical areas – Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and other projects – Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System
Regional work (Page 33)	The northern regional DHBs are committed to implementing the Northern Regional Network, a plan to make sure that there is the best use of the resources available across the region. This collaboration means that the focus of activity is on population health gain, provides equitable access to health services and achieves some economies of scale in relation to transactional costs. Greater collaboration between the DHBs means that DHB boundaries do not impede patient care or efforts to achieve better health gain. This is especially important in the greater Auckland area where people move across boundaries for work and recreation and want to use health services at the time and place that suits them. This regional work will be expanded in 2010-11 with more back office functions being shared such as human resource management and other supporting functions including health service planning.

Reducing inequities	Auckland DHB retains a strategic focus on reducing existing inequalities in health status. Targeted activities are required make health status more equitable across population groups. In our city, the focus continues to be on Maori because of their indigenous status and high need. Other groups with high need include Pacific peoples and groups and neighbourhoods where health is compromised by economic deprivation, poor housing and barriers to accessing health services. Disabled people need supports that enable them to live with independence. They also expect the district health board to commit to the national Disability Strategy, working to change the poor social attitudes and behaviours that make for a disabling society. The DHB is supporting three business cases being progressed as part of the government requirement for sooner, better more convenient health care. We are working with our Treaty partners to get the right approach to achieve Maori health gain and to learn the iwi view of Whanau Ora. We will investigate those components that could be applied to a wider range of high needs groups, particularly Pacific people and people from refugee backgrounds where a holistic approach to health that includes the wider determinants is well understood. The Tamaki Transformation Project concentrates on Glenn Innes as an area of high need and is advancing some community based initiatives in collaboration with other government sectors. We are also pursuing our own mainstream work within the hospital. Every effort is made to keep patients engaged with the health system and follow-up for as long as they need it. Reducing DNA rates for Maori is a specific project. For people with diabetes, cancer, and heart problems, we are improving links between hospital and primary care so these patients get better management of long-term conditions in the community.
Changes as a result of the local body elections 2010	Membership of the Auckland District Health Board and its three statutory advisory committees is likely to change as a result of the 2010 local body elections. Seven members of the 11 member board are selected via the elections process with the remainder, and position of chair, appointed by the Minister of Health. Changes to the Board are likely to lead to a review of the Auckland DHB strategic plan and a closer concentration on regional issues. There is a requirement in the national measures of performance regarding Treaty of Waitangi training for Board members and this will be instigated in the 2010-11 financial year.

The Auckland DHB Health Care System

A population health focus	In order to function as a “real DHB” and lift the health of people in Auckland city we take a wide view of health. This focuses on population health and includes prevention, managing populations at risk, treatment and management of early stage disease, as well as a range of hospital and support services.
A whole continuum of services	People living in Auckland city have access to the full range of services from prevention and health promotion to specialist treatments and, when needed, hospice care. The challenge is to achieve better integration of these services. We have high level hospital care, specialty care, emergency and intensive care, greatly increased ability to deliver primary care, a range of community delivered services, home care, rehabilitation, a range of institutional, community and home-based care in both mental health and older people and palliative care. Health care providers receive continuing education and support so they can work across this continuum.
Primary health care	The approach relies on primary health care services, the delivery of health care programmes in various community settings and multi-disciplinary health care teams. Our clinical and management expertise supports primary care and community-based providers of care. We need to develop our expertise in working upstream so we can prevent problems early on. A primary health care has been completed which will guide future service developments
Collaboration	The success of the continuum of care in meeting patient needs rests in its ability to work across services. Integration is critical. The whole health care system depends on educational systems, the rapid introduction of improved therapies to improve the level of care over time, research and the support of information systems that tie the system together. We work in partnership with community-based providers of care and other stakeholders for overall performance of the system. We also try to address the wider determinants of health by working with other sectors such as local government, housing, employment, social development and education.
Cost effective	To be cost effective and to maximise the quality of health for our large population, the Auckland DHB health system must have ongoing access to the best health care practice, provide a continuum of care, and co-ordinate its use. Regional work is key to finding efficiencies in the system. We will do more work to make the best use of the resources across the wider Auckland region. There will be a focus in 2009-10 on improving productivity and value for money to ensure that every dollar available is well spent. Strong financial discipline will ensure that resources are available to meet the expectations of our local population as well as the expectations on us as a Crown Entity.

Activities that support the Auckland DHB health care system

Auckland DHB's health care system includes a wide range of services from health promotion and problem prevention work through to the secondary and specialist services provided by our hospital. The total value of services is approximately $1,054 million for the Auckland DHB population.

Some funding for services comes directly from the Ministry of Health, e.g. public health services. Auckland DHB also provides services for other DHBs to the value of $624 million.

The left component covers services provided to the Auckland population and to people from other DHBs that are contracted from various non government organisations (NGOs) and community providers (outsourced health services).

The right component of the figure shows the services that are provided by the Auckland DHB provider (hospital and related community services) for the Auckland population and to other DHBs.

The area in dotted lines at the bottom shows the range of services across the continuum of care that make up the package of services available for people living in Auckland.

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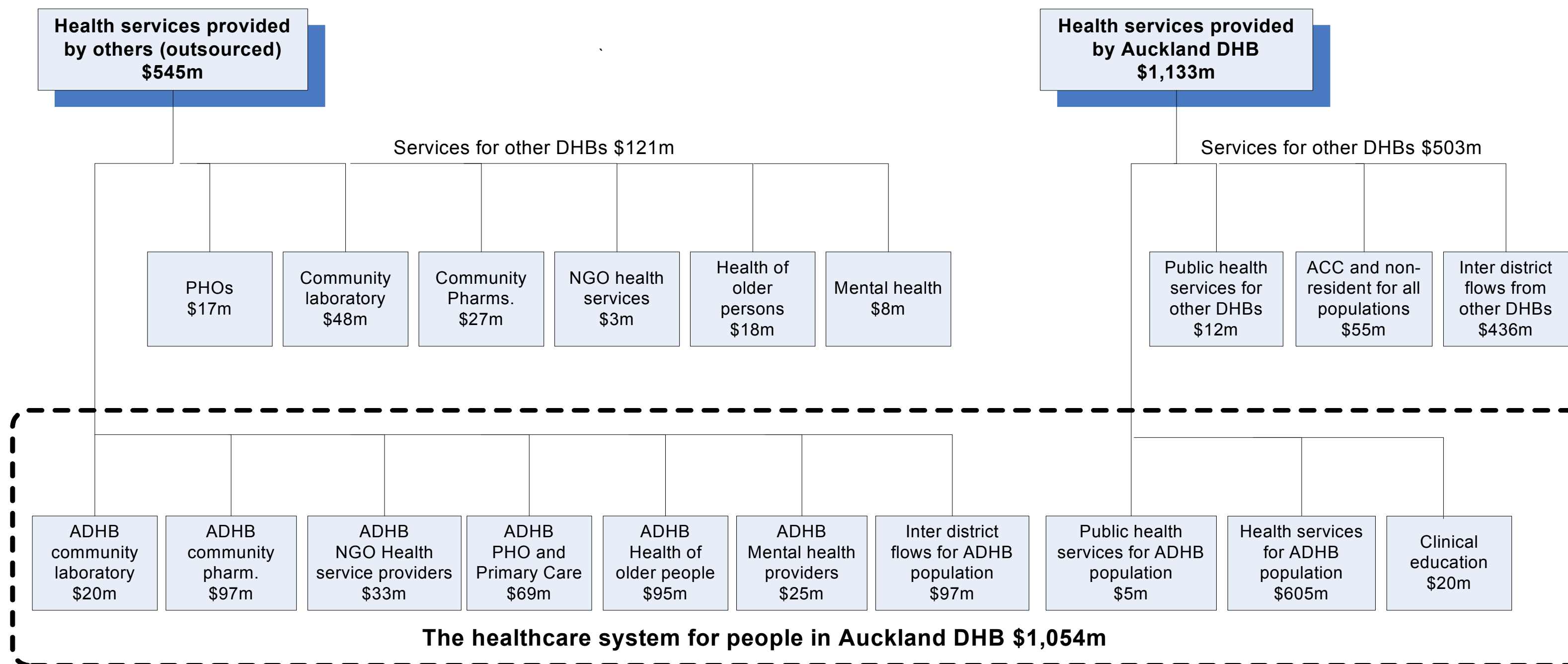


A continuum of service

The publicly-funded health care system available to people living in Auckland can be clustered into four main areas which cover the spectrum of activities from health promotion through to end of life support.

- Public Health Services (health promotion, prevention and protection)
- Primary and Community Services
- Hospital Services
- Support Services

Health promotion, prevention and protection

The Auckland Regional Public Health Service (ARPHS) is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB, Waitemata DHB areas under contract from the Ministry of Health. The service is responsible for improving population health outcomes and reducing inequalities. This work helps to reduce downstream demands on DHBs for personal health services.

The Auckland Regional Public Health Service delivers evidence and regulation based public health services which can be broadly grouped as follows:

- Notifiable and Communicable Disease Control – investigating the source of notifiable diseases and outbreaks and limiting the spread of infection. This is a mandatory function performed by the Auckland Regional Public Health Service across the region and will be delivered according to legislation and using evidence based protocols.
- Regulatory functions including:
  - physical environment regulatory functions, e.g., drinking water quality, biosecurity (exotic mosquito surveillance), hazardous substances, recreational water quality, lead poisoning, and all other public risks associated with environmental hazards
  - implementation of the International Health Regulations 2005
  - alcohol and tobacco regulatory functions and harm minimisation
  - emergency management – responding to local, national and international public health emergencies, e.g. the ‘keep it out, stamp it out’ response to the H1N1 novel influenza pandemic
  - health promotion targeted at discrete populations or sectors in the region to achieve overall improvements in health and reduced health inequalities.

Community-based providers

Auckland DHB contracts with a range of non government organisations (NGOs) to provide health and disability support services for people living in Auckland city. These services range from primary health services such as those provided via general practice through to supported accommodation for people with severe mental illness. The Auckland DHB also provides community services: Rehab Plus, community mental health services, community child health and disability services. A primary health care plan has been completed which will guide future service developments.

Summary of other services (non-hospital)

Type of provider	Community laboratory (includes Lab Plus) Dental Pharmacy Services for older people Maori health services Mental health services – alcohol and other drug services Pacific health services Primary health care Personal health services and inter district flows Women's and children's health services Miscellaneous services and national travel assistance
Total number of providers	350
Total value of services	$544,962,971
Total number of beds in the community	4,581

Primary health care

Changes are forthcoming re primary healthcare via business cases being developed for the Minister of Health. National and local objectives for better, sooner, more convenient primary health care will be achieved through the national expressions of interest process. Over 95% of the metro Auckland population is covered by one of three successful expressions of interest (EOI) in Auckland including:

Greater Auckland Integrated Health Network (GAIHN)	Covers over one million enrolled people across 11 PHOs within the greater Auckland region
Alliance Health+	A coalition of the three Pacific-led PHOs in Auckland across Counties Manukau DHB and Auckland DHB
National Māori PHO Coalition	A North Island consortium of PHOs with a focus on Whānau Ora

In the meantime primary health care is delivered under five Primary Health Organisations that serve people living in the Auckland region. The current breakdown of PHOs and their respective enrolment rates is detailed below.

Primary health organisation (PHO)	% Maori	% Pacific	% Other	Total number enrolled	% of total	Number of full-time doctors
Auckland PHO Limited	11%	9%	10%	46,896	10%	55
AuckPAC Health Trust Board	13%	24%	7%	43,478	10%	24
ProcCare Network Auckland Limited	53%	45%	75%	316,805	69%	284
Tongan Health Society Incorporated	0%	7%	0%	4,944	1%	6
Tamaki Healthcare Charitable Trust	23%	15%	8%	44,739	10%	48
Total enrolled population: Auckland DHB	**26,011**	**64,531**	**366,320**	**456,862**	**100%**	**417**
Auckland city residents enrolled with an ADHB PHOs	53%	77%	94%	344,025	76%	
Total non-Aucklanders enrolled with an Auckland DHB PHO	6,945	23,520	82,372	112,837	25%	
Auckland city residents enrolled with a 'non-ADHB' PHO	7,474	17,566	42,900	67,940		
Auckland city residents enrolled with a 'non-ADHB' PHO	28%	30%	13%	67,940	15%	
Total % of Aucklanders enrolled in any PHO (regardless of the DHB that funds it)	**73%**	**110%**	**90%**	**411,965**	**91%**	

The Auckland DHB provider (hospital and related services)

Auckland DHB provider arm includes Auckland City Hospital, the Greenlane Clinical Centre and a number of community-based services.

Auckland City Hospital	Acute adult medical, surgical and older people's health services Acute mental health services including the Child and Family Unit Child health services provided by Starship Children's Health Women's health and maternity services provided by National Women's Health
Greenlane Clinical Centre	Provides advanced outpatient, ambulatory services, and short-stay surgical care
Community-based services	Rehab Plus, older people's community based services, home health, community mental health services, community child health and disability services

Auckland DHB operates New Zealand's largest public hospital.

There are almost two million patient contacts each year.

Local hospital and outpatient services are provided for 446,000 Aucklanders.

The largest elective surgery delivery system in New Zealand with 30,000 elective procedures (approximately 50% of which are for other DHB populations).

There are approximately 10,000 staff or a little over 7,700 full-time equivalent positions (FTE).

Auckland DHB is the largest trainer of doctors in the country with approximately 1,477 medical staff of whom about 685 are in various stages of training.

The largest clinical research facility in New Zealand, engaging in work that attracts funding and participation here and overseas.

National Forensic Pathology Service (contract with Ministry of Justice).

National Newborn Screening Service (contract with National Screening Unit)

Over half the work done is for people who live outside Auckland city.

Auckland DHB is a specialist centre for the region and the rest of the country.

Provides tertiary services for the northern region (about 1.6 million people).

Some tertiary services (e.g., clinical genetics and paediatric oncology) are provided for people in the Northern, Midland and Central regions.

Specialist services for the whole of New Zealand include:

- organ transplant (heart, lung and liver)
- acute massive pulmonary embolism transferred for thrombarterectomy or extra corporeal membrane oxygenation (ECMO)
- acute respiratory distress syndrome in adults or children requiring ECMO
- acute major airway obstruction transferred for laser or stent placement
- massive haemoptysis transferred for surgery or bronchial arterial embolisation
- hepatic laceration requiring acute hepatic surgery
- paediatric Intensive Care Unit transfers
- paediatric cardiac services
- epilepsy surgery
- deep brain stimulation
- high-risk obstetrics.

Priority and Developmental Work for 201-11

Goal 1: Lift the health of people living in Auckland city

High level strategy	Objective	Strategies to achieve objectives
1.1 Reduce inequities in health status	1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	1.1.1.1 Work with the successful primary care business cases and Maori providers within these arrangements to: – develop Integrated Family Health Centres/Whanau Ora Centres – develop specific activities that achieve Whanau Ora – develop indicator measures for Whanau Ora – develop a Whanau Ora approach for all services devolved
		1.1.1.2 Implement the year one activities part of the cross DHB:MAPO Whanau Ora framework for 2010 - 2015
		1.1.1.3 Provide leadership in the development of Maori health workforce development
	1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	1.1.2.1 Integrate the Healthy Village Action Zone actions within the appropriate primary care business cases
		1.1.2.2 Participate in determining indicator measures for Pacific health gain in the three regional primary care business cases
		1.1.2.3 Host two Auckland DHB Pacific community leadership meetings to communicate the Auckland DHB Pacific Summit recommendations and the proposed plan
		1.1.2.4 Implement the Pacific best practice guidelines and training at ACH in at least 4 identified clinical areas (orthopaedic outpatient, child diabetes, renal and cardiology services) where there is high Pacific use and high DNA rates
		1.1.2.5 Complete the Healthy Village Action Zone evaluation
	1.1.3 Increase access to services for culturally and linguistically diverse populations	1.1.3.1 Cultural competency training focussed on culturally and linguistically diverse populations for all staff working in primary and secondary health services, with 50% of clinical staff completing at least two of the four on-line modules
		1.1.3.2 Increase the uptake of the Primary Health Interpreting Pilot so that 100% of the non-English speaking population using general practices in Auckland city has access to an interpreter when using General Practice services
	1.1.4 Support disabled people and improve their access	1.1.4.1 20% more clients over 65 are accepted into the Interim Funding Pool
		1.1.4.2 Audit report completed on accessibility: specifically physical access, culture,

High level strategy	Objective	Strategies to achieve objectives
	to healthcare and support services	employment and advocacy 1.1.4.3 KPIs developed for reporting disability issues and incidents to DSAC along with follow-up actions; for both provider audit and for Ministry of Health spot audit system
1.2 Improve outcomes in priority areas		
1.2a Children and young people	1.2a.1 Achieve immunisation targets	1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including: 1.2a.1.2 Working with EOI (primary care) respondents on actions to improve immunisation rates up to the 90% target by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised 1.2a.1.3 Working with other regional DHBs to achieve a regional immunisation target of 90% of all 2 year olds fully immunised
	1.2a.2 Improve the oral health of children	1.2a.2.1 Increase school dental clinics to six by June 2011 1.2a.2.2 Four new mobile clinics in total established by June 2011 1.2a.2.3 Reduce inequalities in the use of school dental services: – improving access by taking services to pre-schools – enhancing oral health education – increasing early enrolment with a focus on Maori and Pacific populations
1.2b Older people	1.2b.1 Home-based support services and restorative homecare initiatives	1.2b.1.1 Introduce the funding methodology for home-based services by July 2010 1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services
	1.2b.2 Quality improvement in residential care	1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations 1.2b.2.2 25% reduction in overall number of complaints from residential care
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	1.2c.1.1 90% of clients referred from Community Mental Health Centres back to general practice (where available or known) (ProGRESS+) 1.2c.1.2 Expand primary mental health, linking people to therapies such as online CBT, psycho-educational work, psycho-social interventions, employment support, talking therapies, and service navigators/coordinators to manage movement through the system 1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services

High level strategy	Objective	Strategies to achieve objectives
		are embedded in existing secondary care mental health structures 1.2c.1.4 Complete the reconfiguration of levels 3 and 4 residential rehabilitation; i.e. to contract for support hours that provide flexibility for consumers to get the level of service required, including residential support where needed 1.2c.1.5 Review and reconfigure the continuum of services to focus on recovery and social inclusion using best practice and evidence based approaches
1.2d Long term conditions	1.2d.1 Strengthen community participation and action	1.2d.1.1 Ensure locality networks, and any integrated family health centres established under the primary care business cases, use community participation and action to determine health services for heart failure, cardiac rehabilitation and stroke
	1.2d.2 Integration of services across primary and secondary care	1.2d.2.1 Pilot working across specialist and generalist services (i.e. across primary care and hospital) for a better patient experience in 2 approved areas : CVD and cardiac programme 1.2d.2.2 Work towards seamless shared care plans and advanced care planning to maximise patient health outcomes
	1.2d.3 Primary care takes a greater role in managing long term conditions	1.2d.3.1 Work with the integrated primary health care networks to: – help primary care take a greater role in managing long term conditions, especially mental health, diabetes, cardiovascular disease and COPD – increase access to diagnostics within primary care 1.2d.3.2 Better diabetes and cardiovascular services, with increased percent of: – the eligible adult population having their CVD risk assessed – people with diabetes attending free annual checks – people with diabetes having satisfactory or better diabetes management
	1.2d.4 Support whanau and self resilience	1.2d.4.1 Increase information available to individuals and their whanau 1.2d.4.2 Provide a range of options that will enhance self-management and resilience 1.2d.4.3 Pilot coaching services to support people with long term conditions in line with evidence base 1.2d.4.4 Increase Maori health outcomes in the Long Term Condition management strategy: cardiac rehabilitation, diabetes detection, diabetes annual check, diabetes follow up and management and retinal screening 1.2d.4.5 Increase Pacific health outcomes in the Long Term Conditions management strategy: cardiac rehabilitation; diabetes detection; diabetes annual check; diabetes follow up and management; and retinal screening

More detail on some of these performance measures is included on page 26

Goal 2: Performance improvement: sooner, better, more convenient

High level strategy	Objective	Strategies to achieve objectives
2.1 Efficient and effective health care system		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Work with the newly established networks to implement the primary health care business cases i.e. the priorities in year one agreed objectives
2.1b Improve primary–secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement e-referrals, health event summaries and electronic outpatient letters (including support for regional primary care business case responses)
		2.1b.1.2 Increase access to diagnostic testing for primary care as per the timetable of the primary care business cases
		2.1b.1.3 Transfer services to primary/community (devolution) as per the timetable of the primary care business cases
		2.1b.1.4 Improve access to after hours primary care, including palliative and residential care with 15% increase in palliative clients accessing primary care
	2.1b.2 Reduce acute demand	2.1b.2.1 Work with the primary care business case to increase the use of primary options for acute care (POAC) by 8%
2.1c Improve quality of hospital care while improving productivity	2.1c.1 Improve service throughput and productivity	2.1c.1.1 Improve cardiac surgery throughput from an average of 16 to 21 bypass procedures per week. Complete implementation of the 10 project work streams (including formalising the private, public relationship and incentive schemes)
		2.1c.1.2 Eliminate unnecessary follow ups to reduce follow ups by 10%
		2.1c.1.3 Improve performance against the Emergency Department six-hour measure from 76% to 95% by implementing project solutions in the adult and children's acute flow projects
		2.1c.1.4 Improve level 8 operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes
		2.1c.1.5 Improve ward productivity by 3% by an increase in number of wards in Adults and Mental Health services using Releasing Time to Care from 6 to 24
		2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery

High level strategy	Objective	Strategies to achieve objectives
		2.1c.1.7 20% reduction in unnecessary bed days due to improved discharge processes for under 65's 2.1c.1.8 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding two operating rooms providing capacity for increasing volumes; construction planned to commence early 2011
2.1c Improve quality of hospital care while improving productivity (cont)	2.1c.2 Improve ward productivity by implementing releasing time to care	2.1c.2.1 Improve the patient experience while improving productivity by implementing service improvement projects in: – General medicine – Orthopaedics – Radiology – Paediatrics general surgery – General surgery – Ophthalmology
	2.1c.3 Improve mainstream effectiveness	2.1c.3.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches 2.1c.3.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori 2.1c.3.3 Reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rates by 5%) 2.1c.3.4 60% of discharge letters to Pacific people include another primary health care provider
	2.1c.4 Improve crisis prevention planning in mental health	2.1c.4.1 Greater than 90 percent of long term clients have up-to-date relapse plans
	2.1c.5 Hospitalised smokers given assistance to stop smoking	2.1c.5.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2010 2.1c.5.2 450 pregnant women enrolled into smoking cessation programme per annum
	2.1c.6 Reduce waiting times for oncology	2.1c.6.1 Where required, radiation therapy will commence within four weeks of referral by December 2010 2.1c.6.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology 2.1c.6.3 Implement lung and bowel tumour stream models by June 2011

High level strategy	Objective	Strategies to achieve objectives
	2.1c.7 Increase elective surgical discharges to 9,572	2.1c.7.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway – Implement new model of care and workforce roles in the Greenlane Surgical Centre – Maintain past elective surgery improvement by including primary care in the referral pathways and patient management – Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
2.2 Improve leadership capability	2.2.1 Strengthen Clinical Leadership model	2.2.1.1 Refine, implement and monitor integrated governance model
	2.2.2 Improve Senior Leadership Team Performance	2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement 2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care 2.2.2.3 Monitor and report against "In Good Hands" implementation
2.3 Improve Clinical Quality & Professional Governance	2.3.1 Implement regional clinical networks	2.3.1.1 Provide leadership in cancer and cardiac clinical networks 2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care
	2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events	2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management 2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas 2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and other projects 2.3.2.4 Implement Senior Leadership Team 'Walk-around' safety programme i.e growth and training in clinical leadership 2.3.2.5 Establish Consumer Council to increase consumer engagement in quality improvement 2.3.2.6 Evaluation against Health Excellence Framework 2.3.2.7 Continue roll out of Cornerstone accreditation across primary care 2.3.2.8 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System

High level strategy	Objective	Strategies to achieve objectives
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity
2.4 Strengthen the health workforce	2.4.1 Ensure workforce capability is matched to service delivery current and future	2.4.1.1 Targeted recruitment of ‘hard to staff’ clinical roles/ workforces
		2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme
		2.4.1.3 Increase the percentage of Maori in the workforce via the Tamaki project, with increases from xx to xxx
		2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme
		2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%
	2.4.2 Healthy workplaces	2.4.2.1 Staff engagement survey conducted and strategies to promote positive workplace culture implemented
		2.4.2.2 Review models of care for the opportunities for redesign/ innovative engagement of our workforce inclusive of primary care
2.5 Information management	2.5.1 Improve the resilience and availability of core IT systems	2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time
		2.5.1.2 KPI reporting for end-to-end application performance in place
		2.5.1.3 IMTS user satisfaction increases by >10% against previous year
		2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month
		2.5.1.5 Tier 1 system availability increases to >99.95%
	2.5.2 Improve corporate records and knowledge management	2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance
		2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)
		2.5.2.3 Ministry of Health data quality targets met
		2.5.2.4 Implement a shared care planning platform between primary and secondary care (including support for regional primary care EOI responses)
2.6 Planning	2.6.1 Long term planning and change management	2.6.1.1 Complete the updated District Strategic Plan to Ministry of Health requirements and deadlines
		2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030:

High level strategy	Objective	Strategies to achieve objectives
		– description of future models of care across the continuum of care – plan the shape, size, setting, and location for future services and inter district flow patients – provide the strategic context for major future developments and business cases – develop workforce response to current and long term service plans via regional and the national workforce planning – increase the focus on regional planning and collaboration with the regional primary care business cases 2.6.1.3 Any potential service and/or finding changes arising from implementation of the National Health Board are identified and responded to

Goal 3: Live within our means

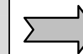
High level strategy	Objective	Strategies to achieve objectives
3.1 Break-even position maintained		
3.1a Manage revenue	3.1a.1 Ensure revenue received for services provided	3.1a.1.1 Reconfigure renal services in response to Waitemata DHB repatriation and mange any associated risks 3.1a.1.2 Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations 3.1a.1.3 Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster 3.1a.1.4 Manage service reconfigurations financial impacts within Vote Health parameters
3.1b Cost management	3.1b.1 Improve processes	3.1b.1.3 Align systems (national and regional) where shared services across the region or the country results in greater administration efficiency • Human resource management • Financial management information system
	3.1b.2 Manage labour resources	3.1b.2.1 Manage the FTE cap for management and administration staff 3.1b.2.2 Improve HR payroll processing and leave management 3.1b.2.3 Manage industrial relations (MECA) negotiations against financial and sustainability risk
	3.1b.3 Enhance asset and supply chain management	3.1b.3.1 Asset Management Plan alignment with the Long Term Services Plan 3.1b.3.2 Leverage national /regional procurement initiatives 3.1b.3.3 Progress procurement strategy (national and regional) and supply chain processes
3.2 Sustainable balance sheet		
3.2a Manage cash	3.2a.1 Sustainable cash management	3.2a.1.2 Cash/Financing Plan aligns with Asset Management and Long Term Services Plans

Savings Related Activity

Auckland DHB contributes to national health goals, notably to get the best out of the sector funding available. Auckland DHB will improve the efficiency, effectiveness and alignment with the government's priorities of the funding we administer, through innovation and cost effective delivery of services. Savings will be achieved through performance improvement actions, which will be monitored monthly. We contribute information on expected and actual performance against the indicators to the Ministry of Health, especially those regarding price, quantity and standards, so results can be measured across the sector.

Ministry of Health performance improvement actions

Short term impact across Vote Health	Stronger funding framework to drive improvements across Vote Health Improved purchasing and prioritisation identified by rolling in-depth spending reviews, including options for funding devolution that optimise purchasing power Stronger accountability with monitoring and enforcement based on support plans, streamlined reporting and rapid intervention when performance issues arise
Short term impact across DHBs	Improved hospital productivity and quality – focus on hospital wards, theatre utilisation, increasing day surgery and emergency departments Primary Care Implementation Plan – strengthen focus on chronic disease management and reducing avoidable hospitalisation Working with the sector to improve purchasing – including: smarter contracting, collective procurement and shared back-office services Contain rate of employment cost growth Maximum use of settings to enforce plans and deliver improved value against price, quantity and standards
Medium term impact across sector	Support sector to achieve all government health targets on time New models of care, focus on innovative use of workforce Service planning to define national and regional services Accelerated quality improvements including reductions and then elimination of avoidable variations and adverse events



These actions form the basis for the specific Auckland DHB actions below

Auckland DHB performance improvement actions

Objectives	Actions	Deliverables – timing By June 2011	Savings impact – measure
Improved hospital productivity and quality – focus on hospital wards, theatre utilisation, increasing day surgery and emergency departments	Improve performance against the Emergency Department six-hour measure from 76% to 95% by implementing project solutions in the adult and children's acute flow projects (2.1c.1.3) Improve ward productivity by 3 % by an increase in number of wards in Adults and Mental Health services using Releasing Time to Care from 6 to 24 (2.1c.1.5) Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery (2.1c.1.6) Improve the patient experience while improving productivity by implementing service improvement projects (Concord programme) (2.1c.2.1) The Plan re the development of Greenlane for full elective services on target with commissioning underway (2.1c.7.1) Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and other projects (2.3.2.3) Manage service reconfigurations financial impacts within Vote Health parameters (3.1a.1.4)	Increase in hospital productivity measures	Breakeven is achieved in accord with phased plan Manage costs within budget Direct treatment cost savings achieved Indirect savings achieved Greenlane theatres commissioned in accord to plan Improve acute operating room productivity with reduced waiting time for acute surgery
Primary Care Implementation Plan – strengthen focus on chronic disease management and reducing avoidable hospitalisation	Work with the newly established networks to implement the primary health care business cases i.e. the priorities in year one agreed objectives (2.1a.1.1) Work with the primary care business case to increase the use of primary options for acute care (POAC) by 8% (2.1b.2.1) Support the development of clinical networks to enable integration between hospital and primary care (2.3.1.2)	Programmes in place aimed at: • reducing avoidable hospital admissions • integrating family health care • devolving some secondary services to primary care	Nil for 2010–11 year, as establishment year
Working with the sector to improve purchasing – including:	Align systems (national and regional) where shared services across the region or the country results in greater	Reduce procurement expenditure, savings achieved	Procurement costs within budget

Objectives	Actions	Deliverables – timing By June 2011	Savings impact – measure
smarter contracting, collective procurement and shared back-office services	efficiency – Human resource management – Financial management information system (3.1b.1.3) Achieve procurement savings by leveraging national / regional procurement initiatives (3.1b.3.2) Progress supply chain processes (3.1b.3.3)		
Contain rate of employment cost growth	Review models of care and opportunities for workforce redesign and innovative use of the workforce inclusive of primary care (2.4.2.2) Participate in regional Long Term Health Service Plan and the national workforce planning process for the sector (2.6.1.2) Manage industrial relations (MECA) negotiations against financial and sustainability risk (3.1b.2.3) Manage the FTE cap for management and administration staff (3.1b.2.1) Improve HR payroll processing and leave management (3.1b.2.2)	Achieve FTE targets	Employment costs within budget
Maximum use of settings to implement plans and deliver improved value against price, quantity and standards	Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations (3.1a.1.2) Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster (3.1a.1.3) Manage service reconfigurations financial impacts within Vote Health parameters (3.1a.1.4)	Plans in place to guide future allocation of resources	

National Performance Measures

The following table covers all the indicators of performance that the government expects from district health boards. The first six are national health targets. Auckland DHB provides regular reports to the Ministry of Health on our progress against these targets. The suite of indicators below show our activity in areas of usual business and therefore go well beyond targets already covered for work in the 2010-11 year that is new or developmental work.

Health target	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
Shorter stays in emergency departments	95 percent of patients will be admitted, discharged, or transferred from an emergency department within six hours	95%
Improved access to elective surgery	The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1,400 per year)	Meet elective discharge volumes 9,572
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010	100% of people requiring radiation therapy will commence within four weeks by December 2010 100% of patients meet radiation oncology and chemotherapy waiting times
Increased immunisation	90 percent of two year olds are fully immunised by July 2011 and 95 percent by July 2012	90% of two year olds immunised 85% immunisation coverage rate for two-year-old Maori tamariki 90% old immunisation coverage rate for two-year-old Pacific children
Better help for smokers to quit	90 percent of hospitalised smokers will be provided with advice and help to quit by July 2011; and 95 percent by July 2012 80 percent of patients attending primary care will be provided with advice and help to quit by July 2011; 90 percent by July 2012; and 95 percent by July 2013	90% hospitalised smokers 80% of patients attending primary care
Better diabetes and cardiovascular services	Increased percent of the eligible adult population will have had their CVD risk assessed in the last five years	Achieve 100% of targets set for CVD risk assessment 5% increase in the management of >15% absolute cardiovascular

Health target	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
		risk Increase cardiovascular disease risk assessment by PHOs for eligible people by at a minimum of 5% for total group to 82% total, with emphasis to increase Maori and Pacific assessments to at a minimum of 76% and 78% respectively Increase by 5% the number of Pacific and Maori people accessing and enrolling in cardiac rehabilitation
	Increased percent of people with diabetes will attend free annual checks	Achieve 100% of target for free annual diabetic get checks Increase the diabetes detection by 5% for total group from 55% to 60% and at a minimum from 50% to 55% for Maori and Pacific Increase the number of people receiving annual free diabetes check by 2% for total group
	Increased percent of people with diabetes will have satisfactory or better diabetes management	Achieve 100% of target for diabetes management Increase good diabetes management (HbA1c <8%) for total group by 5%, from 79% to 84% Increased referral to and participation in diabetes self-management courses by 5% total group 5% increase in the number of Maori accessing and completing kaupapa diabetes self management courses Increase retinal screening rate by 5% for people with diabetes for total group from 75% to 80%
Implementation of Better, Sooner, More Convenient primary health care	DHBs involved in the development of business cases with successful Expression of Interest providers are required to report on progress of the implementation of those changes as agreed to in their District Annual Plan	Progress on implementing business case changes will be reported once a year as part of the quarter four report
Local iwi/Maori engagement and participation in DHB decision-making, develop strategies and plans for	Report demonstrating seven key aspects how local iwi/Maori engagement and participation in DHB decision-making, development of strategies and	100% of PHOs have Maori Health Plans agreed to by the DHB 100% of DHB members have undertaken Treaty of Waitangi training

<table>
<tr><th>Health target</th><th>Ministry of Health indicator of performance</th><th>The Auckland DHB target for 2010–11</th></tr>
<tr><td>Maori health gain</td><td>plans for Maori health gain</td><td></td></tr>
<tr><td>Improving mainstream effectiveness</td><td>Report providing information on the activities undertaken to improve mainstream effectiveness ensuring clinical safety and effectiveness for Maori</td><td>Six-monthly reports describing the reviews of pathways of care undertaken that focus on improving health outcomes and reducing health inequalities for Maori
Show examples of actions taken to address issues identified</td></tr>
<tr><td>Waiting times for chemotherapy treatment</td><td>Report providing wait times data including an exceptions report where wait times exceed six weeks</td><td>100% achievement to target</td></tr>
<tr><td>Improving the health status of people with severe mental illness through improved access</td><td>The average number of people in Auckland DHB, seen per year (rolling every three months) for:
• child and youth aged 0–19, for Maori, Other, and in total
• adults aged 20–64, for Maori, Other, and in total
• older people aged 65+, for Maori, Other, and in total</td><td>Six-month reports confirming access targets as below
<table>
<tr><th></th><th>Other</th><th>Maori</th><th>Total</th></tr>
<tr><td>Children and young people: under 19</td><td>1.94%</td><td>3.44%</td><td>2.12%</td></tr>
<tr><td>Adult: 20–64 years</td><td>2.93%</td><td>8.18%</td><td>3.30%</td></tr>
<tr><td>Older people: 65 and over</td><td>3.49%</td><td>2.99%</td><td>3.48%</td></tr>
<tr><td colspan="3">Actual extra number of clients</td><td></td></tr>
</table></td></tr>
<tr><td>Improving mental health services using crisis prevention planning</td><td>Report on crisis prevention planning
• number of adults and older people (by Maori, Pacific and total) with enduring serious mental illness who have been in treatment for two years or more since the first contact with any mental health
• number of children and young people (by Maori, Pacific and total) who have been in secondary care treatment for one or more years
• number and percentage of long-term clients with up to date crisis prevention/resiliency plans</td><td>At least 90 percent of long-term clients have up-to-date relapse prevention plans by July 2011
<table>
<tr><th></th><th>Maori</th><th>Pacific</th><th>Other</th><th>Total</th></tr>
<tr><td>20 years and over</td><td>90%</td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Children and youth</td><td>90%</td><td>90%</td><td>90%</td><td>90%</td></tr>
<tr><td>Total</td><td>90%</td><td>90%</td><td>90%</td><td>90%</td></tr>
</table></td></tr>
<tr><td>DHBs report alcohol and drug service waiting times and waiting lists</td><td>Narrative report on:
• name and location of service(s) with the longest waiting time and waiting list
• explain variances of more than 10% in waiting</td><td>Work with Waitemata DHB to get baseline information (NGO and provider arm services) for:
• inpatient medical detoxification
• social/residential detoxification</td></tr>
</table>

<table>
<tr><th>Health target</th><th>Ministry of Health indicator of performance</th><th>The Auckland DHB target for 2010–11</th></tr>
<tr><td></td><td>times or waiting lists
explain/identify targets that the DHB may have for reducing waiting times and or waiting lists
Waiting times reported by Maori and Other ethnicities</td><td>specialist prescribing
structured counselling
day programmes
residential programmes
Broken down by ethnicity</td></tr>
<tr><td>Delivery of Te Kokiri: the Mental Health and Addiction Action Plan</td><td>Summary report on progress made towards Implementation of Te Kokiri: the Mental Health and Addiction Action Plan</td><td>Annual report on progress (in the third quarter)</td></tr>
<tr><td>Oral health – mean DMFT score at Year 8</td><td>Report providing oral health DMFT data
Total number of permanent teeth of year eight children, decayed, missing (due to caries), or filled and the total number of caries free children at the commencement of dental care, at the last dental examination, before the child leaves the DHB Community Oral Health Service (by ethnicity breakdown)</td><td>Average DMFT Year 8
<table>
<tr><th></th><th>At 31 December 2009</th><th>Target</th></tr>
<tr><td>NZ Maori</td><td>1.21</td><td>1.15</td></tr>
<tr><td>Pacific</td><td>1.69</td><td>1.60</td></tr>
<tr><td>Other</td><td>0.65</td><td>0.60</td></tr>
<tr><td>Total</td><td>0.96</td><td>0.90</td></tr>
</table></td></tr>
<tr><td>Children caries free at five years of age</td><td>Report providing oral health caries free data
Total number of caries free children and the number of primary teeth decayed, missing (due to caries), or filled at the first examination after the child has turned five years, but before their sixth birthday
Data by Maori, Pacific and Other</td><td>% caries free at five years
<table>
<tr><th></th><th>At 31 December 2009</th><th>Target</th></tr>
<tr><td>NZ Maori</td><td>45.60</td><td>48</td></tr>
<tr><td>Pacific</td><td>36.20</td><td>37</td></tr>
<tr><td>Other</td><td>71.50</td><td>73</td></tr>
<tr><td>Total</td><td>61</td><td>62</td></tr>
</table></td></tr>
<tr><td>Utilisation of DHB funded dental services by adolescent from Year 9 up to and including age 17 years</td><td>85% of adolescents use dental services (from Year 9 up to 17 years)
90 percent of 13 to 17 years olds use dental services each year by 2015
Ethnicity breakdown by Maori, Pacific and Other</td><td>68% of adolescents use dental services by 2011 (from 64.3% actual data 2009)
Reduced inequalities for Maori and for Pacific compared to ‘Others’</td></tr>
<tr><td>Improving the number of</td><td>50% of 0-2year olds enrolled with DHB funded dental</td><td>35% of 0-2 years olds enrolled with DHB funded dental services</td></tr>
</table>

Health target	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
children enrolled in DHB funded dental services	services under age five years 85% of 3-4 year olds enrolled with DHB funded dental services under age five years Ethnicity breakdown by Maori, Pacific and Other	65% of 3-4 year olds enrolled with DHB funded dental services Annual report in quarter three
Reduction in Family Violence	Report confirming audit score targets are met Data provided to DHB by the Auckland University of Technology (AUT) Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit	Overall audit scores of 70/100 for child and partner abuse components of the Violence Intervention Programme Annual as part of quarter four report
Ambulatory Sensible Hospital Admissions	Commentary on 12 month ASH data, specifically progress against the national rate. Information about how health inequalities are being addressed with respect to this health target, particularly for Pacific and Māori 45-64 year olds	Auckland DHB to remain below the national average for ASH rates Reduction in inequalities between Māori and Pacific people aged 0 - 74 years and Other New Zealanders aged 0-74 years.
Regional Service Planning	Collaborate with neighbouring DHBs to develop a Regional Service Plan (RSP). Ensure the plan development addresses: – services that are currently vulnerable, or that can be expected to become so during the period of the plan because of workforce shortages, demand growth and/or funding issues – services related to significant capital investment proposals expected in the next 3 years – service configuration changes that will contribute to financial viability	Report on the progress of the Regional Service Plan
Service Coverage	Service coverage expectations are met Resolution of service coverage gaps by reporting an appropriate resolution plan and adequate progress made against it	Meet all service coverage expectations Report on any areas where there are exceptions to service coverage, and not approved as long term exceptions, and any other gaps in service coverage
Elective Services Standardised Intervention Rates (SIRs)	Standardised Intervention Rates reported. For elective surgical services and a range of elective procedures. • For publicly funded casemix included elective	Meet the Standardised Intervention Rates as a measure of Auckland DHB delivery of services to the Auckland population • Target intervention rate of at least 292 per 10,000 of population

Health target	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
	discharges in a surgical DRG, a target intervention rate of at least 292 per 10,000 of population will be achieved. • For major joint replacement procedures, a target intervention rate of 21.0 per 10,000 of population will be achieved, comprised of: – 10.5 per 10,000 of population for hip replacement – 10.5 per 10,000 of population for knee replacement • For cataract procedures, a target intervention rate of 27.0 per 10,000 of population will be achieved. • For cardiac procedures a target intervention rate of at least 6.23 per 10,000 of population will be achieved – Cardiac surgery is coronary artery bypass graft (CABG), valve replacement or repair, and CABG plus valve replacement or repair, for people 15 and over – The current national intervention rate for percutaneous revascularization is 10.8 per 10,000 • Where the standardised intervention rate is significantly below the target level, report: – analysis reviewing the appropriateness of the rate, and – whether the DHB considers the rate to be appropriate for its population, or – describe the reasons for the under-delivery of that procedure; and – actions to ensure the target rate is achieved	for casemix included elective discharges in a surgical DRG • Target intervention rate of 21.0 per 10,000 of population for major joint replacement procedures • Target intervention rate of 27.0 per 10,000 of population for cataract procedures • Target intervention rate of at least 6.23 per 10,000 of population for cardiac procedures
Increase funding for Māori Health and disability initiatives	Report actual expenditure on Māori Health Providers by General Ledger (GL) code. Report actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit (PU). Provide a table that reflects the DHB predicted expenditure for Māori health in the DHB 2009-10	Complete the data and technical analysis required to build a picture of Maori expenditure across the Auckland DHB health system Report on progress

Health target	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
	Annual Plan compared to actual expenditure, with explanation of variances.	
DHB confirmation and exception reports – risk management	Formal risk management and reporting system to manage DHB risks and report them to its Board The system meets current Australia / New Zealand Standard requirements relating to risk management Report how frequently the DHB submits its formal risk report updates to its Board (or a Board approved sub-committee)	Formal risk management and reporting system
Improving breast-feeding rates	Increase the proportion of infants exclusively and fully breastfed at six weeks to 74% or greater; at three months to 57% or greater; and at six months to 27% percent or greater	74% of infants exclusively and fully breastfed at six weeks 57% of infants exclusively and fully breastfed at three months 27% of infants exclusively and fully breastfed at six months 58% of Maori babies are exclusively or fully breastfed at six weeks 58% of Pacific babies are exclusively or fully breastfed at six weeks
Staff Turnover	Information of exits compared to total headcounts according to the 5 main professional groups within the provider arm: – medical personnel – nursing personnel – allied health personnel – management and administration – support personnel	Quarterly reports submitted with all specified breakdowns
Capital Expenditure to Plan	DHB expenditure plans for capital reflect the need to manage expenditure, and make appropriate capital investment decisions. DHBs should attempt to match expenditure to plan, with consideration given to appropriate investment decisions. Financial information is provided through monthly financial templates.	Submission of the financial plans and templates related to DAP requirements Plans in place to meet any issues that cause the expenditure to be out of line with plan

Health target	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
	No additional financial reporting by DHBs is required beyond routine reporting provided in the financial templates.	
Acute Inpatient Length of Stay	DHBs are supplied with target ranges. DHBs can go outside suggested target ranges where they can demonstrate this is in the interests of wider objectives DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	
Theatre Productivity	Reduction in the number of theatre sessions that start late, finish early, or are cancelled	Data elements submitted for each theatre: – number of scheduled theatre sessions in the quarter (may be zero if the theatre is not in use) – number of cancelled theatre sessions in the quarter – number theatre sessions that start late (and do not finish early) – number of theatre sessions that finish early (and started on time) – number of theatre sessions that start late and finish early.
Elective and Arranged Day Surgery	Increase the proportion of elective and arranged surgery undertaken on a daycase basis DHBs will be supplied with suggested target ranges. DHBs can go outside target ranges where they can demonstrate this is in the interests of wider objectives The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise	End of year target is 9,572
Elective and Arranged Day of Surgery Admission	90 percent of its elective and arranged surgery on a day of surgery admission (DOSA) basis The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	90 percent of its elective and arranged surgery on a day of surgery admission (DOSA) basis Achieve targets for acute volume for Auckland residents
Acute Readmissions to	The DHB is expected maintain 28 day unplanned	Maintain 28 day unplanned acute readmission rates at the current

Health target	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
Hospital	acute readmission rates at the current rate or lower	rate or lower
Mortality	Each DHB is expected to maintain its 30 day mortality rate at the same level, or reduce it, over the year	Maintain a 30 day mortality rate at the same level
Data Submitted to National Collections	Each DHB will improve the quality of data provided to national collections against specified targets	NHI Duplications: 3% or less Ethnicity Not Stated in the NHI: 4% or less Standard vs. Specific Descriptor: 35% or more National Minimum Data Set timeliness: target is 5% or less
Output Delivery Against Plan	Each DHB is expected to deliver hospital outputs to a level in line with planned outputs stated at the year's beginning	Acute WIES delivered to 100% of contract Hospital outputs delivered in line with planned outputs
National patient satisfaction survey	Patient satisfaction survey or similar tool.	Improve on previous year's survey results

Working Regionally

Working nationally and regionally with other DHBs maximises health gain for people living in the region and allows for the best use of the resources available.

Most importantly, regional work addresses the challenges the northern region is facing re high population growth, ageing and disease trends, and also around workforce shortages and ensuring the sustainability of the region's services.

Changes via national projects

National work	Advance the five national quality improvement projects (Auckland DHB to lead the project on hospital infection prevention and control) National services underway to evaluate new technologies Implement the donation after cardiac death as a project to be rolled out across the country Leading a national programme for the Ministry of Health on Maori nursing and midwifery workforce development

Changes proposed via regional services, projects and initiatives

	Regional work
Implement Better, Sooner, More Convenient primary health care (EOI business cases)	Primary health care is strategically important to DHBs. Auckland DHB is working with neighbouring DHBs to strengthen primary healthcare so that the region can deliver better health outcomes and reduce inequalities at lower cost. The focus for 2010-11 is to implement the objectives of Better, Sooner, More Convenient primary health care. This is focused on more personalise primary care where services are provided closer to the home. Downstream, this will make Aucklanders healthier and reduce the demand on public hospitals. The Government has highlighted the need for large scale transformational improvements in the configuration of services and models of care for primary health care. This includes the establishment of Integrated Family Health Centres which will bring together a number of different services, including some previously only available in hospital settings. Auckland DHB, along with our neighbouring DHBs, has been active in the development of three business cases, all aimed at integrating primary health care. These are still in development. When complete they will identify: • planned actions to support the business case development and ongoing implementation of the business cases • major deliverable milestones including timings • how the DHB will measure whether the actions are delivering Better, Sooner, More Convenient primary health care. Government is supporting the development of integrated family health centres. These will be more convenient for patients,

<table>
<tr><th></th><th>Regional work</th></tr>
<tr><td></td><td>offering: extended opening hours and walk-in clinics; a greater role for nurses (e.g. nurse clinics); delivering a broader range of services; and consolidation of services across general practice and PHOs.

A common objective is to reduce inequalities and have a neighbourhood or locality dimension to primary and community services. This is to improve co-ordination and navigation for patients, drive quality improvement, increase services connection with communities, and shift some secondary services to these localities for more convenience.

These national and local objectives will be achieved through the national expressions of interest process. Over 95% of the metro Auckland population is covered by one of three successful expressions of interest (EOI) in Auckland including:

<table>
<tr><td>Greater Auckland Integrated Health Network (GAIHN)</td><td>Covers over one million enrolled people across 11 PHOs within the greater Auckland region</td></tr>
<tr><td>Alliance Health+</td><td>A coalition of the three Pacific-led PHOs in Auckland across Counties Manukau DHB and Auckland DHB</td></tr>
<tr><td>National Māori PHO Coalition</td><td>A north island consortium of PHOs with a focus on Whānau Ora</td></tr>
</table>

DHBs will work with each of these three consortiums over 2010-11 to implement their business cases. Proposed deliverables for 2010-11 include:
• new packages of care for mama, pepi and tamariki to support Whānau Ora (by 31 December 2010)
• clinical pathways across primary and secondary care
• integrated family health centres and whānau ora centres
• a new approach to community radiology (by 30 June 2011)
• a regionally consistent approach to Primary Options for Acute Care (by 30 June 2011)
• one integrated family health centre or whānau ora centre in each metro Auckland DHB (by 30 June 2011)
• an acute chest pain management pathway (by 30 June 2011)
• locality networks and approaches
• a more efficient and effective management and commissioning layer across PHOs and the three DHBs

Progress on implementing the business case changes will be reported once a year as part of the quarter four report</td></tr>
<tr><td>The Northern Region Network Strategy</td><td>The proposed scale of regional activity needs to be supported by a more effective regional framework than currently exists. Accordingly, the DHBs have committed to progressively implementing the Northern Regional Network (NRN) which will support each DHB to make the most effective use of their health resources to ensure they are able to:
• Achieve the greatest possible health gain for the population of the region</td></tr>
</table>

	Regional work
	• Provide equitable and appropriate access to DHB provided and funded health services • Reduce transactional costs and leverage scale where there is benefit from doing so • Maintain strong influence and control over crucial aspects of the Northern DHBs' responsibilities • Be confident that they have a robust forum for the long term planning of health services for their regionally unique demographics – both now and into the future. The DHBs have agreed an overall framework and will work with the Ministry of Health, National Health Board and Shared Services Establishment Board to ensure appropriate alignment. During 2010-11 the DHBs will progressively work to implement the recommendations outlined in the NRN Strategy.
Northern Region Clinical Service Planning	Over the recent past, the Northern DHBs have undertaken the foundation work required to develop a long term Regional Clinical Service Plan. This includes: • Work undertaken in each DHB around clinical service planning and patient pathway redesign and quality improvement • Detailed reviews of individual services that have been undertaken regionally • An initial assessment of services which are vulnerable across the region (this work will be updated on completion of the Regional Clinical Services Plan) • Two phases of work that have been undertaken regionally in respect to long term regional service planning: – Phase 1 which focused on developing a joint statement of demand and supply of health services and generated an agreed regional picture of current and future inpatient bed requirements, current bed and theatre capacity and population forecasts – Phase 2 with the over riding objective being to develop a focused plan that will further shape the strategic direction for service planning in the region, identify the changes needed to meet the new health targets and support the 2009 and subsequent business cases for capital expenditure. Rather than trying to develop a comprehensive plan for all services, Phase 2 focused around 5 key work streams, clinical networks and regional services, urgent and acute care, planned and elective care, health of older people and radiology. This work will now be leveraged to develop the first Regional Clinical Service Plan by October 2010. The Ministry is seeking plants that will describe the future configuration of services across the region that will best ensure clinical viability and financial affordability from a regional perspective, and to inform resource allocation and service provision decisions at the regional and district level.
Cancer services	**Northern Cancer Network** The Northern Cancer Network (NCN) will assist northern DHBs to address the national cancer priorities. Through regional collaboration the Network and DHBs will work to achieve consistent diagnosis and treatment timeframe targets for lung and bowel cancer. Tumour streams and multidisciplinary meetings will be the main mechanism through which to achieve these improvements in 2010–11. Objectives and targets are agreed for the Northern region and documented in the specific cancer targets for Auckland DHB:

	Regional work	
	Increase throughput and productivity in alignment with tumour-stream goals	
	Priority focus	**Objectives**
	Improve cancer treatment waiting times especially for radiation treatment	Work collaboratively to ensure there is sufficient sustainable capacity to meet and maintain the 2014-2015 target intervention rate i.e. 46% Improve the functioning of multidisciplinary team meetings and increase the number of patients presented to multidisciplinary team meetings as a means to increase the referral rate for treatment Standardise the model of care for cancer care coordination within the Northern Region Support the Regional Cancer service and Northern Cancer Network to monitor and review waiting times and ensure service efficiency and quality improvement Collectively monitor and respond to triggers for initiating the next public capacity step according to the Regional Radiotherapy Strategy Participate in ongoing Cancer Network activity
	Lung cancer	Support the regional lung cancer tumour stream to achieve the following targets. Time from: • GP referral to first specialist assessment: < 2 weeks: increase from 43% to 50% across region • first specialist assessment (FSA) to decision to treat: 80% of patients within 4 weeks • decision to treat to surgery: < 2 weeks: increase from 36% to 50% • decision to treat to Medical FSA (chemotherapy) within 2 weeks : increase from 7% to 50% • decision to treat to radonc FSA (radiation oncology) within 2 weeks: 36%-50% • 100% of those requiring radiation therapy will commence within four weeks of referral by December 2010
	Bowel cancer	Work with the Northern Cancer Network and the bowel cancer tumour stream to identify targets as for lung cancer by August 2010 Redesign patient pathways to reduce waiting times for bowel cancer patients Introduce a regional colorectal MDM form (regional electronic form)

<table>
<tr><th></th><th colspan="2">Regional work</th></tr>
<tr><td></td><td></td><td>Develop and implement a regional prioritisation criteria for colonoscopies
Improve data capture to support service improvements that increase access to colonoscopies</td></tr>
<tr><td></td><td>Chemotherapy</td><td>Improve reporting of performance measures for chemotherapy wait times
Support the Cancer Network and Regional Cancer Service to capture and report chemotherapy wait times</td></tr>
<tr><td></td><td>Improve outcomes for vulnerable groups</td><td>Work with the northern Cancer Network to identify and implement referral pathways from DHB cancer services back to community support services for Maori to improve care management</td></tr>
<tr><td>Elective Services</td><td colspan="2">In 2009 work was undertaken regionally to determine the best regional response to meet the Minister’s objectives for Elective Services Units and improved access to elective services, recognising the wider DHB objectives in terms of sustainable delivery of clinical services in a financially constrained environment. Based on this work Northern Region has developed a proposal which encompasses:
• The establishment of the Regional Elective Services Network (RESN) which will support; the development and design of regional referral pathways, workforce development and training, service delivery models, and intervention and demand analysis.
• Progressively moving to equitable intervention rates across the region, underpinned by a streamlined model of care with distributed Elective Services Units playing a key role in the delivery. The elective workstream will increasingly be separated from the acute workstream, with the exception being the most complex cases. The implications for each DHB are:
– Northland DHB will adopt a range of local strategies to ensure delivery of elective volumes but will not establish a dedicate Elective Services Unit as there is not sufficient scale
– Auckland DHB will extend the Greenlane Short Stay Unit into the Greenlane Surgical Centre which will include 4 additional theatres, 25-30 inpatient beds, a new endoscopy suite and an extended Clinical Sterile Services Department. This development will be staged with the first phase completed in April 2010 and all phases completed by April 2011
– Waitemata DHB will develop a dedicated purpose built elective facility on the North Shore Hospital campus that will comprise 4 theatres, 4 outpatient clinics and 40 additional inpatient beds. This development will be completed in December 2010 and could be open for the first patients in February 2012
– Counties Manukau DHB will expand the current Manukau Surgical Centre by 4 theatres, and extend the CSSD and bring a blood bank on site to support the additional theatres. Indicative timing for this extension is 2014-15
The Elective Services Units will undertake a mix of additional electives, repatriated publicly funded volumes currently being undertaken in private facilities and volumes that are decanted from the main acute/elective theatres to the Elective Services Unit. In all cases (apart from acute eyes) the Elective Services Units will be dedicated to elective service delivery.</td></tr>
</table>

	Regional work
Mental health (includes Eating Disorder Service and Forensics)	Implementation of the Northern Region Eating Disorders Services Plan 2008-2013, covering the Northern and Midland regions. The key elements of this plan include: • Services for People Aged 15 Years and Under will be provided by Starship Hospital, involving the establishment of 5 specialist beds • Services for People Aged over 15 Years which it is intended will be provided from a residential treatment facility with the clinical services provided by the existing Regional Eating Disorders Service. The final configuration for this service will be dependent on receipt of an acceptable response to RFP. In addition, new funding will be available to supplement Regional Eating Disorders Services, and the establishment of FTE within DHBs to increase local capacity. Auckland DHB is also involved in other regional work underway: • Regional strategy for forensic services including mapping the service user journey, clinical governance, clinical pathways, benchmarking etc • Participation in Regional review of Alcohol and Drug services
Regional Nutrition and Food Service	The Auckland Metropolitan DHBs are currently planning to establish a regional nutrition and food service. This regional project will help the Auckland DHBs produce patient meals in the future at an acceptable price. The project is also investigating the quality of meal service delivery to the bedside could be improved, and if the DHBs should own or contract out some parts, all parts or none of the food production facility ownership, food production, distribution and patient delivery functions. A business case is being developed (not yet approved) that intends to achieve several outputs: • Economies of scale in food production thus reducing cost • Reduced duplication and complexity of kitchen based operations • Reduced footprint requirements for hospital based kitchens • Use of new technology that will increase operational efficiencies and be more environmentally friendly • Improved patient menu choice resulting in enhanced patient outcomes and reduced wastage • Reduced food wastage through more efficient menu ordering processes on the ward level • Potential to centralise Meals on Wheels • Nutritional assessments facilitated by robust regional IT system will improve patient outcomes through better nutrition and may result in reduced length of stay and complications • The potential to scale food production up for other DHBs Completion date for the business case is 31 July 2010. If the business case is approved, the timeframe for any change is June 2012
Auckland Regional	Auckland Regional Public Health Service (ARPHS) provides public health services for the people within the three district health

	Regional work
Public Health Service (ARPHS)	boards in the Auckland region. ARPHS aims to keep people well through preventing disease, prolonging life and promoting health. Public health services improve the health of the region's population and reduce demands on DHBs and other health providers for personal health services (in both the short and long term). Reductions in the Auckland Regional Public Health Service funding for 2010–11 will mean reductions in the level of service provided into the future. The service will finalise the scope of reductions by July 2010 and will reorganise its service delivery plan as efficiently as possible. The Auckland Regional Public Health Service focuses on those public health services that are most effectively and efficiently undertaken at the regional level. Many of these provide legal and mandatory functions on behalf of the Ministry of Health. A regional approach is necessary for many public health areas of work such as contact tracing and limiting the spread of communicable disease outbreaks within and across DHB boundaries. The 2010–11 focus will be on: • consolidating inter-agency regional emergency planning. This will maintain and update emergency and response plans, particularly in the area of pandemic planning. This will better protect the region from future public health emergencies • working with other sectors, such as local and central government, to ensure that decisions outside the health sector consider health and health inequalities consequences • working with the inaugural Auckland Council to try and influence the development of strategies, policies and operational practices. The aim is to help the new Council understand (and act on) its considerable ability to influence health outcomes • health promotion targeted at discrete populations or sectors in the region to achieve overall improvements in health and reduced health inequalities • ensuring programme development achieves all the possible opportunities to reduce health and social inequalities for Maori and Pacific communities • programmes aimed at reducing alcohol and tobacco use, including the Auckland DHB/Waitemata DHB Pacific smoking cessation programme • continue responding to public health risks arising from environmental hazards.
Community laboratories	The three Auckland Region DHBs will work collaboratively on the management of the community laboratory service to ensure a quality service is provided that meets expectations. This will consist of ongoing monitoring and management of the contracts that are in place with Labtests and Diagnostic Medlab. A strategic review of the future provision of histopathology services will also be undertaken that encompasses both community and hospital laboratory services.
Community pharmacy	The four northern DHBs continue to work together on community pharmacy in three key areas: Relationship development — Auckland DHB has its own community pharmacy advisory group who discuss local initiatives and opportunities. A regional advisory group will be continued and opportunities developed to enable

<table>
<tr><th></th><th colspan="2">Regional work</th></tr>
<tr><td rowspan="3"></td><td></td><td>the individual advisory groups to come together to explore common opportunities. The regional advisory group will also support the regional DHBs with advice on contract review and e-prescribing</td></tr>
<tr><td>Contract review</td><td>The four northern region DHBs will continue to provide support and input in to the national contract review. The current agreement with community pharmacies has an expiry date of 31 August 2011. The national review will inform options for agreement options from1 September 2011</td></tr>
<tr><td>e-prescribing</td><td>e-prescribing allows prescriptions to be sent electronically to the dispensing pharmacy from the prescriber. e-prescribing reduces the administration burden; it improves safety; and it improves the information available on pharmaceutical use

The four northern region DHBs will undertake an initial scoping of the potential to develop and implement an e-prescribing model for the region that can then be picked up by other DHBs/regions. After the initial scoping, a decision will be made as to progressing the development and implementation or not</td></tr>
<tr><td>Regional Workforce and Human Resource</td><td colspan="2">In 2010-2011 the four DHBs in the Northern Region will collaborate around employment relations; recruitment; workforce development; special projects; HR infrastructure and systems development; and shared services including the Auckland Regional Resident Medical Officers Service (ARRMOS).

The Northern Region DHBs Human Resource Management Strategy (2009-2013) guides future work, aligns with the Regional Information Services Strategy, and aims to enhance the recruitment and retention of our workforce whilst effectively managing the associated costs.

Existing objectives will be extended in 2010-11: in depth regional reporting on a range of established recruitment KPIs, collaboration to negotiate regional external partnership agreements, and greater collaboration with DHB workforce development activity.

National strategy around Employment Relations is a priority for 2010-11. Relationships, consultative and communication mechanisms are in place to manage Employment Relations processes along with the inherent and potential risks of industrial negotiations, including management of settlement costs.

Several projects align with ER priorities. The SMO Job sizing project will complete an agreed Service Size for each speciality, job sizing each SMO (1,400 in the region) to that Service Size, aligning remuneration to the MECA and implementing regional remuneration relativity strategies across like specialities. Data is 0.captured into a SMO Information system which informs payroll and has associated service, DHB and regional reporting functionality.</td></tr>
</table>

	Regional work
	Auckland Regional RMO Services Ltd (ARRMOS) Auckland Regional RMO Services Ltd (ARRMOS) provides recruitment, allocation, rostering, daily operations, workforce development and general administration support to the three DHBs who between them employ 1,080 RMOs (40% of the national workforce). RMOs access training regionally and are allocated into appropriate training runs under the direction of professional College aligned Vocational Training Committees. The national focus for 2010-11 is to work closely with the CTAB, DHBNZ etc on developing a model for nationally consistent RMO administration in line with the recommendations of the 2009 RMO Commission report. Regionally the organisation will focus on achieving the KPIs outlined in its three strategic plans: i.e reducing vacancy rates from 10% to 5% by 2013, increasing RMO retention rates by improving run evaluation results (a measure of workforce satisfaction) to a minimum score of 4/5 from the current 3.5/5. DHBs are committed to restoring the balance between supply of medical graduates with demand for training positions by holding RMO FTE growth to zero and then increasing RMO positions in close alignment with growth in medical student placements from 2014. Additional demand for delivery of medical services will be diverted into growth of alternative workforces. **Regional pilot of the Physician Assistant Role** The four Northern Region DHBs and the University of Auckland Faculty of Medical and Health Sciences are undertaking a pilot of the USA, trained, medical model Physician Assistant role. The first stage will involve a pilot of two Physician Assistants in surgery (including elective surgery) at Counties Manukau DHB, for 12 months commencing mid 2010. Once the pilot is underway, the DHBs will consider further pilots in other specialities and at other DHBs. The Physician Assistant role is not a doctor or nurse substitution, but complements other members of the health care team. The first pilot will determine whether Physician Assistant have a role to play in the future of surgery in NZ (with a particular emphasis on elective surgery). **Workforce Development plans** Recruitment, education and workforce plans are being aligned across the region. Regional approaches to new models of care and workforce redesign are included in long term sector planning. This includes a regional approach to new roles in Operating rooms and elective surgical services. Schools-based programmes across the region aim to recruit and retain more Maori and Pacific young people in tertiary studies in health related courses and ongoing employment within our sector. Better health outcomes are a desired result of more Maori and Pacific being in education and in good jobs earning a higher income. Regional workforce activity aligns with national workforce development plans such as DHBNZ Future Workforce. The four District Health Boards will plan and implement national priorities in health related to workforce in ways which maximise patient outcomes and health worker engagement.

<table>
<tr><th></th><th>Regional work</th></tr>
<tr><td>Information systems (including RISP)</td><td>
The Northern DHBs are committed to the Information Strategy for 2010 to 2020. The strategy supports the transformation to new models of care and underpins the development of a person-centred model to achieve better, sooner, more convenient healthcare. The strategy was developed in collaboration with the Ministry of Health and aligns with the national direction set by the Health Information Strategy for NZ (2005) and priorities set out by the new National IT Board.
In 2010-2011 the Northern Region DHBs will establish a regional governance structure to implement the strategy. DHBs will also undertake smaller initiatives to start the strategy, as well as progress and complete some significant regional projects that are already underway.
The focus of regional Information Systems projects is to improve the integration of primary and secondary care services. This benefits patients through improving continuity and safety of the health services they receive. Priority deliverables for 2010-2011 include:
<table>
<tr><td>Shared Care Planning</td><td>In partnership with PHOs and GPs, DHBs will implement pilot projects which are clinically lead and enable the use of shared care plans between providers</td></tr>
<tr><td>Electronic Referrals</td><td>Implement a regional electronic Referrals solution between primary and secondary care providers (eReferrals phase 1). Also begin the plan for enhancements that allow faster turnaround and improved responses to referrals (eReferrals phase 2 and 3)</td></tr>
<tr><td>Enhance the regionally shared clinical data repository</td><td>DHBs will expand the use and content of the regional clinical data repository for sharing of pharmaceutical dispensing information between Pharmacies, GPs and DHBs (TestSafe Pharmacy project); sharing of outpatient letters between DHBs and GPs (Regional Clinical Documents project); and sharing of various additional diagnostic test results between DHBs and GPs (Regional Éclair Enhancement projects)</td></tr>
</table>
These initiatives support the outcomes of the national and regional primary care initiatives, including the establishment of integrated family health centres.
The DHBs will look for opportunities to improve efficiency through joint procurement of IT equipment and services, regional hosting of information systems and implementation of shared IT services as appropriate. Projects in this area include the implementation and (phased) roll-out of:

enhancements to regional Repository (TestSafe) and Mental Health systems (ARMHIT phase 2)
regional tender process for the 4 DHB’s telecommunications service requirements
nationally hosted InterRai older peoples health assessment system
regionally hosted Endoscopy solution
regionally hosted Radiology Information System solution
regionally hosted Picture Archiving and Communication system (Radiology PACS)

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<tr><th></th><th>Regional work</th></tr>
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- implementation and partial roll-out of a regionally hosted Finance Information Management System

In addition to the above regional initiatives there are a number significant DHB specific information systems and process improvements where an individual DHB will lead the way ahead of the other DHBs in the region.

<table>
<tr><td>Auckland DHB</td><td>Management of Scanned Clinical Records
Electronic Medical Record for regional Oncology Service</td></tr>
<tr><td>Waitemata DHB</td><td>Electronic rostering of staff
Enterprise content management</td></tr>
<tr><td>Counties Manukau DHB</td><td>Medicine Reconciliation and Electronic Discharge Summary improvements</td></tr>
</table>

In addition, DHB Information Systems teams will concentrate on the management of a wide range of existing information and infrastructure systems and services, including the continuous improvement of quality and efficiency of IT service management processes.
</td></tr>
<tr><td>Procurement</td><td>

The Northern DHBs will work closely with the newly established Shared Services Establishment Board (SSEB) so that procurement meets the DHB's needs. In support of this work, the Northern DHBs will improve their collaborative procurement work in 2010-11 through a number of initiatives, including:

- joint procurement clinical governance arrangements
- a joint procurement plan
- work to align systems and processes
- reduced duplication of effort
</td></tr>
<tr><td>Work with Waitemata DHB</td><td>

Auckland DHB is working with Waitemata DHB to:

- develop the required capacity to support the repatriation of agreed renal services by June 2013
- develop a long term services plan which defines service delivery by Auckland DHB to the Waitemata DHB population
- prioritise a review of progress to date and make a decision on the future service configuration of opthalmology and regional pain services as a component of the above plan
</td></tr>
<tr><td>Regional Asset and Capital Planning</td><td>

The first Northern Region Asset Management Plan was developed in 2009 in line with Ministry timelines. The region is unlikely to be able to afford the investments proposed in this plan and that there will increasingly be strong competing demands for Health Capital Budget funding which will put at risk a number of strategic investment proposals.

There is scope to improve asset management both locally and regionally. In 2010-11 it is envisaged that this will occur at a number of levels:
</td></tr>
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	Regional work
	• Improving information about the asset base • Improving the capital budgeting process • Strengthening the linkages between service planning and asset management planning, including affordability analysis • Developing a transparent decision making framework for use in challenging investment requests and to help the region to make some of the tough decisions that are likely to be required in the medium term The DHBs have signalled specific improvement initiatives in their individual plans. At a regional level the focus will be on the latter two areas outlined above.

Risks and Mitigation

The following material relates to any risks related to the implementation of this annual plan. It does not cover the risks we are exposed to in the normal management of District Health Board business. A full register of risks exists and is constantly updated.

Goal 1: Lift the health of people living in Auckland city

Auckland DHB is responsible for planning and funding the majority of health services provided for its resident population as well as a number of regional and national services. Critical or major issues and risks impacting on achievement of this goal include the following.

Issues and risks	Mitigation strategies
Potential for budget over run with home based support services packages of care model if distribution of service level in of a higher acuity than planned	Close monitoring and working closely with the providers
Population Based Funding imbalances don't recognise funding requirements for our population i.e. the growth in population is higher than forecast in PBF and is associated with new emerging health needs	Ministry of Health discussions on new ethnicity health needs (eg, diabetes in south Asians)
Acute demand greater than predicted	Management focus on unit cost reduction and patient pathway development (primary care/EOI)

Goal 2: Improve performance

Critical or major issues and risks impacting on achievement of this goal include the following.

Issues and risks	Mitigation strategies
Ability to adequately resource information system initiatives (demand> supply)	Implement regional and local prioritisation process to ensure agreed programme of work can be delivered with existing resources Maximise opportunity for regional and national collaboration to share resources and outputs
Support resources (information systems, procurement, HR, etc) drop in productivity during distraction by move to increased collaboration and shared services	Where appropriate develop appropriate change management plans and monitor key DHB deliverables closely during change process
One or more of the three business cases (EOIs) for the development of more integrated primary health care in the region may not be successful	Should any of the business cases not be successful, the DHB will continue to work with stakeholders to deliver on the objectives of Better, Sooner, More Convenient and the local emphasis on a locality approach and reducing inequalities. Actions are covered in each of the respective DHB's primary care plans/discussion documents
Workforce shortages in some areas linked to health improvement priorities, e.g. for radiation therapists, physicists, radiation oncologists, operating room staff and midwives	
Cancer wait times: By July 2010 we must treat all patients within 6 weeks; this reduces to 4 weeks from December 2010. There is a risk that cancer radiation therapy wait times are not met due to: 1. An inability to roster extended hours for radiation therapy and/or outsource treatment leading up to December 2010, and 2, The delay in replacement of the MV5 linear accelerator (scheduled to be commissioned in Jan 2011) These two factors will place additional pressure on waiting time targets.	1 Daily management of forecast capacity to enable proactive management of treatment rosters and requirements to outsource. Additional extended hours shifts may be required following Jan 2011 to manage peaks in demand. 2. Close project management of time lines for replacement plan. Slippage reported immediately to enable strategies for mitigating waiting delays to be implemented.

Goal 3: Live within our means

Auckland DHB continues with its objective of maintaining a break-even financial result. Critical and major issues and risks impacting on achievement of this goal include the following.

Issues and risks	Mitigation strategies
Budgets are based on assumptions and predictions of future activity. Accordingly there is the inherent risk that future events are not in accordance with these predictions	Processes for monitoring variations are established so that actions can be identified to address any variation. Close monitoring of volumes.
We expect to achieve a break even position within the allocated funding and to manage the various environmental factors that impact on budget	This will require reprioritisation and reallocation of resources and a number of significant initiatives in areas such as clinical resource utilisation and practice changes, productivity improvements, reduced administrative costs and procurement savings

Managing the Funding

Funding allocation across the health system

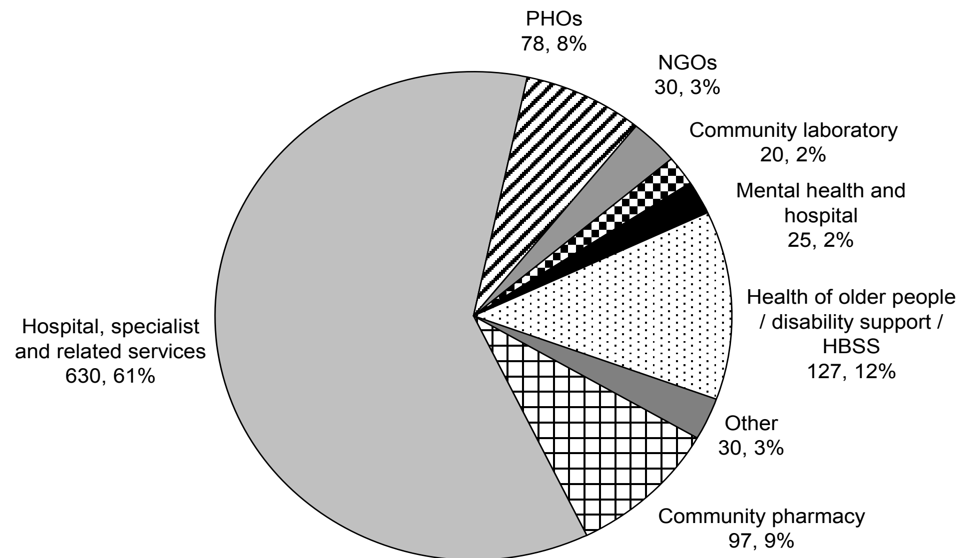
2010–11 funding compared to 2009–10

	2009–10 $ million	2010–11 $ million	% change
Population-based funding (PBF)	929.2	956.4	2.9%
Additional sector capability initiatives	12.1	12.1	0.0%
Additional elective spending	18.6	18.7	0.5%
Inter District Flows	554.3	576.0	3.9%
Other	10.7	10.7	0.0%
Total	**1,524.9**	**1,573.9**	**3.2%**

The district-wide allocation of funding (non-IDF)

Funding allocation for the Auckland DHB population	Proportion of the funding	
	Auckland DHB provider ($ m)	Non-Auckland DHB provider ($ m)
Personal health Additional electives Pharmaceuticals Laboratory services Primary health organisations and related GP services, e.g., GMS and PNS Mental health Health of older people/residential care & home support Other: • public health • clinical education		
Total		

Funding allocation across health services for the Auckland DHB population



Breakdown of funding across the Auckland DHB health care system

To be updated

A review of all contracts is underway to ensure that the funding available to the Auckland DHB is allocated to best effect. This prioritisation work will cover the provider arm and contracts with providers outside the Auckland DHB owned services. NGOs will be expected to operate on the revenue as per existing funding arrangements with Auckland DHB funder

Funded new initiatives

Project/service	2010–11	Source of funds
Respite care Easier access to respite services with dedicated respite care beds so older people can stay at home for longer and to protect the wellbeing of carers	$5 million	Government funding committed in 2009–10
Postnatal stays To ensure mothers have the choice to stay at birthing facilities longer so they can establish breastfeeding and the confidence to return home	$11 million	Government funding committed in 2009–10

Note: Figures may not include inter district flows.

Auckland DHB will apply a 1.73% increase to price in the Aged Residential Care Contract. The 1.73% increase to price will include any cost implications (if any) on providers from changes to the new audit regime and any funding implications that may arise out of the A21 Review for 2010/11.

With the implementation of unannounced spot audits from 1 January 2010 the pilot evaluation report indicates there may be a cost increase to providers for such audits due to increased time taken to conduct the audits. Any increased cost to providers that may accrue from the changes to the audit regime is included in the increase to prices that the DHB will pass through to aged residential care for 2010/11.

Capital expenditure

For the three years covered by this plan the following significant capital expenditure projects are planned.

Projects for 20100-11

Greenlane Clinic Centre elective surgical facility	Commenced work on stage one of a multistage development
Car park at Auckland City Hospital	Pending Ministerial approval, we propose to build the new car park building at the ACH site starting in 2010-11 $11million included in the 2010-11 capital plan (unapproved)
Building 10 exit and site development	Building 10 is a two storey, early 1900s structure on the Greenlane site. The building covers a key future development area on the Greenlane site. The Building 10 Exit Plan is releasing this area for the development of future clinical facilities. Ministry of Health bed modelling for ADHB indicates such facilities

	may be required within the next five to ten years. In combination with the gradual exit of occupants, sections of the building will be demolished.
Major project self-funded	

Summarised price volume schedule

Contracted case weight outputs from Auckland DHB hospital and specialist services 2010–2011

Portfolio	Sub speciality	Cost weighted discharge			
		For Auckland population		For other populations	
		Acute	Elective	Acute	Elective
Adult Emergency Department	Emergency Medicine	2,702		712	
Ambulatory Health Services	Dermatology	89	30	54	17
	Endocrinology	74		95	
	Immunology	192		275	
	Oral Health	18	304	46	806
	Rheumatology	76		4	
Cancer and Blood services	Haematology	842		1,490	
	Oncology	869		1,875	
Cardiac Services	Cardiology	2,707	817	2,866	1,423
	Cardiothoracic	1,460	986	4,209	4,118
	Vascular Surgery	954	439	1,409	995
General Medicine	General Medicine	9,608		322	
	Infectious Diseases	193		61	
General Surgery, Trauma, Gastro, Respiratory	Gastroenterology	510		109	
	General Surgery	5,023	3,188	1,802	807
	Liver Resections	-	-	-	-
	Respiratory Medicine	1,487		1,080	
Paediatric Medical &	General Paediatrics	1,232		2,120	
	Paediatric Emergency department	1,227		1,035	

Portfolio	Sub speciality	Cost weighted discharge			
		For Auckland population		For other populations	
		Acute	Elective	Acute	Elective
Community services	Paediatric Endocrinology	43		140	
	Paediatric Gastroenterology	312		484	
	Paediatric Haem/Onc	391		1,768	
	Paediatric Immunology	17		88	
	Paediatric Infectious Diseases	23		75	
	Paediatric Neurology	68		329	
	Paediatric Renal Medicine	104		311	
	Paediatric Respiratory Medicine	151		959	
	Paediatric Rheumatology	22		44	
Ophthalmology	Ophthalmology	334	997	738	1,589
Orthopaedics Adult	Orthopaedics	5,183	3,375	710	249
Paediatric Cardiac & ICU's	Adult Congenital Heart	31	62	1	55
	Newborn Services	2,672		1,811	
	Paediatric Cardiac	479	334	1,555	2,156
Surgical & Community services	Paediatric Neurosurgery	97	54	883	281
	Paediatric ORL	130	482	323	484
	Paediatric Orthopaedics	779	344	1,404	1,249
	Paediatric Pain Service	-		1	
	Paediatric Surgery	435	235	1,651	825
Transplant, Renal, Urology, ORL, Neurology	Neurology	900	-	635	-
	Neurosurgery	999	413	2,449	1,230
	ORL	464	774	773	768
	Renal Medicine	1,126		995	
	Renal Transplant	181		613	
	Urology	629	761	1,186	735
Women's Health	Gynaecology	1,216	1,361	224	597
	Obstetrics	5,616		2,458	
Grand Total		51,663	14,955	42,171	18,384

Note: The full Price Volume Schedule is included in the appendix.

Services provided by non-government organisations

Auckland DHB has a set of criteria to determine how the Future Funding Track (FFT) is applied to specified Health of Older Persons and Personal Health Agreements. The process covers those service agreements excluded from nationally or regionally negotiated price increases. The criteria aim to achieve consistency between the prices of similar services at a local, regional and national level – based on affordability.

Summarised list of other services (non-hospital)

The type of provider	Number of providers	Total value of services	Number of beds (if applicable)
Community laboratory (includes Lab Plus)	To be updated		
Dental			
Health of older persons services – residential care			
Health of older persons services (inter district flows)			
Health of older persons services – non-residential care			
Home-based support			
Maori health services			
Mental health services			
Mental health (inter district flows)			
Mental health services – alcohol and other drug services			
Pacific health services			
Primary care organisation (PCO)			
Personal health services (includes Lifting the Health of Aucklanders, miscellaneous services and national travel assistance)			
Personal health services (inter district flows)			
Pharmacy			
Pharmacy (wholesalers)			
Primary healthcare organisation (PHOs)			
Women's and children's health services			

Financial Management

The Minister's Letter of Expectations requires the organisation to achieve a break even position within the allocated funding. This requires reprioritisation and reallocation of resources and investment in tools such as lean thinking in order to enable new ways of working, reduce variation and ensure avoidance of waste.

The significant pressure on costs and cost growth, arising from increased service delivery requirements and the expectations of the labour market, means our drive to identify and implement new ways of working throughout the organisation is an imperative. This District Annual Plan incorporates a number of initiatives to avoid waste and improve productivity, including clinical resource utilisation and practice change, reduced administrative costs and procurement savings. This includes maintaining management and administration FTE numbers below the Minister's December 2008 cap levels, with the processes and rules for managing below this cap now well established.

Key assumptions within the financial plans include:

- There is significantly reduced interest income compared with earlier years due to lower interest rates. This reflects the impacts of the world economic crisis which has also increased uncertainty in terms of there being a new world paradigm in which established historical practices and expectations may no longer apply
- The world economic recession has also increased uncertainty and risk regarding the future levels of donation income that will be received and the collection of payments from non-residents
- Inflation is generally assumed at 2.3 percent. The potential future impact of the forex rate movements is also inherently uncertain in a small economy such as New Zealand operating in a global environment. A one percent inflationary movement in the cost of goods and services equates to approximately $8 million at Auckland DHB
- Employee terms and conditions are subject to negotiation and interpretation. The impact of employee wage rate settlements have been estimated for inclusion in the financial plans, including agreed MECA settlements through to their expiry date and step increases within the MECA documents. There is an uncertain impact arising from job sizing which will need to be absorbed within the overall budget. A one percent variation in employee costs equates to approximately $7 million at Auckland DHB
- There is uncertainty in property market values, particularly since the new world economic environment. Accordingly it is assumed that there will be no change in the revaluation reserve. It is assumed that funding arrangements in relation to depreciation and capital charges arising from the revaluation reserve will not change.

As advised in the Crown Funding letter, the future funding track is assumed to grow at the same level as 2010-11 year to 2012-13.

As assumptions are made due to there being uncertain or unknown future events, they inherently represent a risk in that actual events may vary from the assumption. Similarly, actions which require a change from current processes and activities inherently represent a risk due to the need for a change in established practices and behaviours.

Statement of financial performance

STATEMENT OF FINANCIAL PERFORMANCE	2008-09 Actual $'000	2009-10 Forecast $'000	2010-11 Plan $'000	2011-12 Esimate $'000	2012-13 Esimate $'000
REVENUE					
Base Funding					
Population Based	899,155	930,832	956,414	983,194	1,010,723
Inter District Flows	524,323	558,675	574,688	597,100	620,387
	1,423,479	1,489,507	1,531,102	1,580,294	1,631,111
Side Contracts with Ministry of Health					
Additional Electives	19,176	18,611	18,797	19,474	20,175
Sector Capability & Innovation	-	12,122	12,622	13,077	13,548
Other Side Contracts	60,417	60,037	65,189	67,535	69,967
	79,593	90,770	96,608	100,086	103,689
Other Revenue					
Other Patient Care	35,755	33,584	32,951	33,643	34,316
External	99,427	86,437	82,091	84,662	87,077
	135,182	120,022	115,043	118,305	121,393
TOTAL REVENUE	**1,638,253**	**1,700,299**	**1,742,753**	**1,798,686**	**1,856,193**
OPERATING COSTS					
Employee Costs	686,971	720,008	734,604	757,719	784,732
Treatment Costs	254,627	257,152	247,204	256,974	264,756
Funder Payments	521,457	550,560	574,997	591,941	609,392
Property & Equipment Maintenance	51,098	49,809	50,839	51,890	52,928
Administration	20,382	18,444	24,160	24,667	25,161
TOTAL OPERATING COSTS	1,534,536	1,595,973	1,631,804	1,683,192	1,736,970
OPERATING SURPLUS/(DEFICIT)	103,717	104,326	110,948	115,494	119,224
NON OPERATING COSTS					
Depreciation	42,810	48,182	54,310	59,140	63,552
Interest	20,904	20,346	20,154	19,406	18,876
Capital Charge	39,678	35,586	36,426	36,900	36,700
TOTAL NON OPERATING COSTS	103,392	104,114	110,890	115,446	119,128
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	**325**	**212**	**58**	**48**	**96**

Appendix 1: Profile of the Population

Poverty

The biggest contributor to low life expectancy is poverty which is also affected by ethnicity and gender.

In self-assessed health status, there is a direct relationship between age, gender, ethnicity and income for all ethnic groups, except Pacific.

People who are poor, Pacific and those in age groups 14–24 and over 65 years score their health the lowest.

49% of Maori and 64% of Pacific people live in the most deprived areas of Auckland city compared to 25% of the 'Others'. Most Indians and Asians live in the Avondale-Roskill Ward – 46% and 33% of their populations respectively. The 'Other' populations are fairly evenly distributed across all Auckland wards.

The most populated areas in Auckland City are Tamaki-Maungakiekie and Avondale-Roskill Wards – 25% and 20% of Auckland's population respectively. Most Maori and Pacific people live in the Tamaki-Maungakiekie Ward – 39% and 46% of their populations respectively.

Many of our children (41% of all 0–4 year olds) live in the most deprived areas of the city.

Maori and Pacific

72% of non-Maori and non-Pacific people die over the age of 75 years of age compared to 16% for Maori and to 32% for Pacific people.

Maori in Auckland are more likely (compared to New Zealand and to local non-Maori) to smoke tobacco and marijuana, to be obese and to drink alcohol in a hazardous manner.

Pacific people are far more likely (compared to NZ Pacific and to local non-Pacific) to be obese, smoke tobacco, and have a poor diet.

Maori and Pacific ethnic groups have higher Years of Lost Life (YLL) rates than non-Maori, non-Pacific.

Source: Multiple data sources, primarily the Ministry of Health 2006–07 Health Survey.

Asian

Asian people make up 23% of Auckland's population. 36% of Asians are South Asian and about 80% of this group are Indian.

Auckland is one of the highest non-English, non-Maori speaking areas with over 100 different languages spoken.

About 13% of our population need some kind of assistant or interpreting when they attend health services.

Asians have good health compared to 'Others'. There are lower risks for Asians for all the indicators of health except for regular exercise and vegetables consumption.

For South Asian and particularly for Indian people, while there is a lower mortality rate from cardiovascular disease, they have the highest rate of hospitalisation for myocardial infarction and angina. They are the highest users for angioplasty and CABG operations.

Disability

About one in five Aucklanders live with impairment; the most common being loss of functioning related to mobility, agility and hearing. The rate of disability increases as people age.

Poorly informed social attitudes remain the most common barrier for disabled people.

Gender

Men die younger than women by at least nine years (although the rates are improving for both genders).

Men have poorer health than women: they smoke more tobacco and marijuana, have higher cholesterol, are more likely to be overweight and to have a poor diet.

Men are more likely to drink alcohol in a hazardous manner

Men however, exercise more often than women..

Men assess their health as better than women except in the general health perceptions scores. In this area men assess their health as poorer than women.

Appendix 2: Leadership

Organisational values

Integrity	Respect	Innovation	Effectiveness

Kia u ki te tika me te pono

Board members

Pat Snedden (Chair)
Jo Agnew
Susan Buckland
Harry Burkhardt (Deputy Chair)
Chris Chambers
Rob Cooper
Brian Fergus
Ian Scott
Bob Tizard
Seiuli Juliet Walker
Ian Ward

Senior leadership team

Garry Smith	Chief Executive
Ann Yates	Midwifery Leader
Hilda Faasalele	General Manager – Pacific Health
Barbara Stevens	CEO, Auckland PHO
Cath Byrne (acting)	Nurse Leader – Women & Child Health
Brent Wiseman	Chief Financial Officer
Dr Celia Palmer	Clinical Leader Planning & Funding
Dr Clive Bensemann	Director Mental Health Services.
David Sage	Chief Medical Officer
Dr Denis Jury	Chief Planning and Funding Officer
David Sage (acting)	Director – Women's Health

Senior leadership team (continued)

Fionnagh Dougan	General Manager – Clinical Services
Dr Glennis Mafi	Clinical Leader, Tongan Health
Greg Balla	Director Performance and Innovation
Dr Guy Naden	Clinical Leader, Auckpac PHO
Mr Ian Civil	Director of Surgery
Janice Mueller	Director of Allied Health, Scientific and Technical
Johan Vendrig	Chief Information Officer
Juliet Middleton	CEO, Procare Network Auckland PHO
Kay Hyman	General Manager – Clinical Services
Margaret Dotchin	General Manager – Clinical Services and Nurse Director, Adult Health Services
Dr Margaret Wilsher	Deputy Chief Medical Officer and Medical Director Adult Health
Matire Harwood	Clinical Leader, PHO
Naida Glavish	Chief Advisor Tikanga and General Manager Maori Health
Dr Neil Hefford	Clinical Leader, PHO
Ngaire Buchanan	General Manager – Operations
Paul Lavulo	CEO, Tongan Health PHO
Dr Richard Aickin	Director of Child Health
Dr Rick Franklin	Clinical Leader – Ambulatory
Dr Russell Smart	Clinical Leader, Auckland PHO
Taima Campbell	Executive Director of Nursing
Tereki Stewart	CEO, Tamaki PHO
Dr Vanessa Beavis	Director – ADHB Operating Rooms and Anaesthesia
Vivienne Rawlings	General Manager Human Resources
Winston Timaloa	CEO, Auckpac PHO

Appendix 3: Consolidated Financial Tables

Table 1: Statement of financial performance

STATEMENT OF FINANCIAL PERFORMANCE	2008-09 Actual $'000	2009-10 Forecast $'000	2010-11 Plan $'000	2011-12 Esimate $'000	2012-13 Esimate $'000
REVENUE					
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Capital Charge	39,678	35,586	36,426	36,900	36,700
TOTAL NON OPERATING COSTS	103,392	104,114	110,890	115,446	119,128
TOTAL SURPLUS/(DEFICIT) FOR THE YEAR	**325**	**212**	**58**	**48**	**96**

Table 2: Statement of performance by output class

TBA

Table 3: Statement of financial position

STATEMENT OF FINANCIAL POSITION	2008-09 Actual $'000	2009-10 Forecast $'000	2010-11 Plan $'000	2011-12 Esimate $'000	2012-13 Esimate $'000
ASSETS					
CURRENT ASSETS					
Cash, Bank Balances & Investment bonds	35,287	31,258	21,418	34,048	30,021
Restricted Trust Funds	11,780	22,008	32,508	43,008	53,508
Receivables and Prepayments	63,416	63,719	52,104	53,405	54,689
Inventories	11,717	11,717	12,203	12,545	12,896
Property Intended for Resale	-	-	-	-	-
	122,200	128,702	118,233	143,006	151,114
NON CURRENT ASSETS					
Restricted Trust Funds	8,000	8,000	8,000	8,000	8,000
Property, Plant and Equipment	888,677	896,986	915,566	915,041	909,056
Intangible Assets	12,892	19,970	24,607	25,992	26,425
Derivatives in Gain	6,954	5,052	4,399	3,463	2,440
Investment in Associates	386	386	386	386	386
	916,909	930,394	952,958	952,881	946,307
TOTAL ASSETS	1,039,109	1,059,096	1,071,191	1,095,887	1,097,421
LIABILITIES					
CURRENT LIABILITIES					
Bank Overdraft	-	-	-	-	-
Trade and Other Payables	123,907	124,639	127,111	109,222	132,474
Employee Benefits	128,026	128,026	129,086	166,362	141,075
Borrowings	18,375	90,347	30,619	32,425	35,001
Funds held in Trust	1,038	1,054	1,126	1,198	1,270
Derivatives in Loss	-	(0)	-	-	-
	271,345	344,065	287,941	309,206	309,820
NON - CURRENT LIABILITIES					
Employee Benefits	20,673	20,673	20,880	20,880	21,464
Borrowings	268,375	212,213	273,109	273,349	273,589
	289,048	232,886	293,989	294,229	295,053
TOTAL LIABILITIES	560,392	576,951	581,930	603,435	604,873
EQUITY					
General Funds					
Opening Balance	132,114	97,439	100,867	107,983	111,175
Net Surplus/(Deficit)	325	213	58	48	96
Capital Contributions	(35,000)	3,215	7,058	3,143	-
Capital Withdrawals	-	-	-	-	-
Closing Balance	97,439	100,867	107,983	111,175	111,270
Revaluation Reserve					
Opening Balance	381,278	381,278	381,278	381,278	381,278
Movement in Revaluation Reserve					
- Land	-	-	-	-	-
- Buildings and Plant	-	-	-	-	-
Total Movement in Revaluation Reserve	-	-	-	-	-
Closing Balance	381,278	381,278	381,278	381,278	381,278
TOTAL EQUITY	478,717	482,145	489,261	492,452	492,548
NET ASSETS	1,039,110	1,059,096	1,071,191	1,095,887	1,097,421

Table 4: Statement of cash flows

TBA

Table 5: Balance sheet equity ratio

BALANCE SHEET EQUITY RATIO	2008-09 Actual $'000	2009-10 Forecast $'000	2010-11 Plan $'000	2011-12 Esimate $'000	2012-13 Esimate $'000
Equity Position					
Crown Equity	(468,672)	(472,085)	(479,128)	(482,248)	(482,271)
Trust Equity	(10,045)	(10,061)	(10,133)	(10,205)	(10,277)
Total Equity	(478,717)	(482,145)	(489,261)	(492,452)	(492,548)
	-	-	-	-	-
Total Debt					
Bank	-	-	-	-	-
Bonds	(120,000)	(50,000)	(50,000)	(50,000)	(50,000)
Crown Funding Authority	(163,500)	(173,200)	(244,500)	(244,500)	(244,500)
	(283,500)	(223,200)	(294,500)	(294,500)	(294,500)
Total Debt	(283,500)	(223,200)	(294,500)	(294,500)	(294,500)
Total Debt + Equity	(762,217)	(705,345)	(783,761)	(786,952)	(787,048)
Equity Ratio - to be less than 65%	**37.2%**	**31.6%**	**37.6%**	**37.4%**	**37.4%**

Key lenders and applicable covenants	
Key tenders	**Covenants to all lenders**
Commercial Bank of Australia Crown Health Financing Agency Bonds on issue	Cashflow from operations greater than zero Debt to debt + equity less than 65%

Key lenders and arrangements	
Bonds	$120 million: $70 million to mature 2010* $50 million to mature 2015 * Commitment by Crown Health Funding Agency to fund
Crown Health Funding Agency	$184.5 million * increasing to $254.5 million when bonds repaid
Commonwealth Bank of Australia	$65 million working capital facility

Appendix 4: Information Services Planning

A: District Annual Plan level projects

Note 1: projects in stage 0, 1 or 2 remain subject to budget and/or business case approval.
Note 2: projects that have a * after the name are in the 2009-2010 District Annual Plan but are likely to require some activity in 2010-2011 to complete.

Name	Description	Priority (MoH score)	Type	HISNZ Action Zone	Scope	Finish	est. capital budget FY10/11 ('000s)	Total Cost (ADHB portion) ('000s)
Clinical Alerts	Upgrade alerts functionality to ensure information can be shared regionally and nationally - improve data quality through improvement of processes	1	Upgrade		Region	tbd	$250	tbd
Document & Content Management	Establish core capability in document management and content management to support improved access to information and to improve compliance with public records act	1	New		Region	tbd	$250	tbd
Shared Care Planning	Establishment of a shared care planning environment to support a variety of clinically lead share care planning initiatives in the region; supports Integrated Family Health Centre concept	1	New	7	Region	Jun-2011	$250	tbd
E-Referrals Phase 1*	Implementation of a system to support submission of electronic referrals from GPs to DHBs in the Auckland Region	Approved	New	8	Region	Dec-2010	$ -	$460
Regional Clinical Documents*	Sharing of health event summaries between DHBs and GPs; phase 1 focuses on outpatient letters	1	New	6	Region	Aug-2010	$ -	$200
E-Referrals Phase 2	Extend phase 1 deliverable (GP to DHB e-referral) with electronic triage and feedback process including redesign of internal DHB referral and triage processes	2	Upgrade	8	Region	tbd	$250	$250
TestSafe Pharmacy*	Extension of existing TestSafe repository with Community Pharmacy Dispensing Records	Approved	New	4	Region	May-2010	$ -	$263
IT Resilience Phase 2*	Improvement of resilience of ADHB IT infrastructure - load balancing, application monitoring + design for phase 3	Approved	Replacement		Local	Mar-2010		$800
IT Resilience Phase 3*	Implementation of new server consolidation, virtualisation and storage platform (centered around Grafton site)	Approved	Replacement		Local	Sep-2010	$317	$2,627
ASPIRE*	Solution for the electronic distribution of all transcription service output to all (internal and external) recipients.; phase 1 focus on outpatient letters and radiology reports to GPs and patients	Approved	New	6	Local	Sep-2010	$200	$640
IT Resilience Phase 4	Extend resiliency to dual site redundancy (Greenlane) and extend use of platform	2	Replace		Local	tbd	$1,860	$3,720

B: Functional Group Plan level projects

Note 1: projects in stage 0, 1 or 2 remain subject to budget and/or business case approval.
Note 2: projects that have a * after the name are in the 2009-2010 District Annual Plan but are likely to require some activity in 2010-2011 to complete.

Name	Description	Priority (MoH score)	Type	Scope	Finish	Capital budget 2010/11 ('000s)	Total Cost (ADHB portion) ('000s)
PACS upgrade	Upgrade hardware and software to ensure these can be supported ; regional alignment of platforms, potentially develop regional redundancy/ DR options	1	Upgrade	Region	tbd	$570	$570
Rostering	Upgrade existing licenses; extend use of system and align with WDHB implementation	2	Upgrade	Region	tbd	$900	tbd
Cervical Screening and Colposcopy database	Solution to meet legislative/MOH reporting requirements, will reduce clerical FTE and process inefficiencies within the colp service, will allow more accurate clinical assessment and annotation to occur due to systems clinical and pathology interface-service is currently running substandard service	2	New	TBD	tbd	$100	$100
Voice recognition in transcription service	Phase 2 following CRIS replacement project so high priority in 2011-12 as it is expected to deliver significant productivity gains	2	Replace	TBD	tbd	$ -	$300
PIMS Theatre upgrade	Standard upgrade to ensure software stays current	2	Upgrade	Local	tbd	$250	$250
ARMHIT Auckland Regional Mental Health IT (phase 2)	Extend regional mental health system with integration across primary, secondary and community care settings	2	Upgrade	Region	tbd	$ -	$150
Upgrade and consolidation of Financial MIS	Upgrade of Oracle FMIS to version 12 + regional alignment of processes + regional hosting by healthAlliance	2	Upgrade	Region	Dec-2011	$600	$600
CRIS IDM Upgrade/ replacement	Replacement of current scanning solution aimed at providing better roadmap for the system including features for process improvement in clinical records and transcription (voice recognition)	1	Replace	Local	Dec-2011	$1,000	$1,500
Desktops	Maintenance of the ADHB PC fleet based on 5 to 6 year useful life of PCs - upgrades also driven by need to keep virus software protection current.	1	Replace	Local	ongoing	$1,500	ongoing
IT infrastructure	Maintain core infrastructure based on 4 - 7 year useful life of various components	1	Replace	Local	ongoing	$700	ongoing
Licenses	placeholder for critical software upgrades and true-ups (Microsoft) as changes to infrastructure and PC fleet occur.	1	Replace	Local	ongoing	$300	ongoing
Cancer and Blood Service Medical Record	Implementation of electronic record and clinic scheduling solution for medical and possibly radiotherapy. Necessary to address clinical risk around poor availability of clinical data and to enable improvement of waiting times by more effective scheduling and use of resources.	2	New	Region	tbd	$ 600	$1,000
Community Retinal Screening	Replace information systems to support the Regional alignment and integration of retinal screening services	1	Replace	Region	tbd	tbd	tbd
Paed Cytotoxic Forms*	Redevelop the Paediatric Cytotoxic web forms to address clinical safety issues	Approved	Upgrade	Local	Dec-2009	$ -	$67

Name	Description	Priority (MoH score)	Type	Scope	Finish	Capital budget 2010/11 ('000s)	Total Cost (ADHB portion) ('000s)
Interpreters Database*	Replace the existing Access DB used to support the ADHB Interpreters Service, with a system that can support the requirements of ADHB and the Primary Health sector	Approved	Replace	Local	Jun-2010	$ -	$80
InterRai implementation*	Implement one or more of the InterRAI assessment tools in OPH as part of wider OPH programme of work. To include Contact Assessment and Home Care	Approved	New	Nation	tbd	$ -	$294
Radiology Order Entry Results Sign-off phase 2*	Solution for electronic ordering, sign-off, escalation and reconciliation of radiology procedures and results. Phase 2 is roll-out to all ADHB services	1	New	Local	Jul-2010	$ -	$150

Appendix 5. Statement of Significant Accounting Policies

The following is a summarised description of the accounting policies used in the preparation of this District Annual Plan. A full description of accounting policies used by Auckland DHB for financial reporting, budgeting and forecasting can be found in the 2009 Annual Report on the website at www.adhb.govt.nz/publications.

<table>
<tr><td>Reporting entity</td><td colspan="2">The reporting entity is the Auckland District Health Board (ADHB) which was created by the New Zealand Public Health and Disability Act 2000. Auckland DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, and the Public Finance Act 1989 and the Crown Entities Act 2004.
Auckland DHB is a public benefit entity (PBE), as defined under NZ IAS 1.
Auckland DHB's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions, e.g., laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district.</td></tr>
<tr><td>Statement of compliance</td><td colspan="2">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 (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for Public Benefit Entities (PBE).</td></tr>
<tr><td>Basis of preparation</td><td colspan="2">The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following asset and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swaps), financial instruments and land and buildings.
The preparation of financial statements in conformity with NZ IFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are 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 judgements about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.</td></tr>
<tr><td rowspan="2">Basis for consolidation</td><td>Subsidiaries</td><td>Subsidiaries are entities controlled by Auckland DHB. Control exists when Auckland DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. Auckland DHB is the main beneficiary of the Auckland District Health Board Charitable Trust.</td></tr>
<tr><td>Associates</td><td>Associates are those entities in which Auckland DHB has the power to exert significant influence, but not control, over the financial and operating policies. Auckland DHB holds shareholdings in the following associates: Auckland Regional RMO Services Limited (previously The Northern Clinical Training Network Limited) (33% owned) and Northern DHB Support Agency Limited (33% owned).
Auckland Regional RMO Services Limited is a joint venture company with Counties-Manukau and Waitemata DHBs, which exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland regional DHBs.
Northern DHB Support Agency Limited with Counties-Manukau and Waitemata DHB exists to provide a shared</td></tr>
</table>

		services agency to the three Auckland regional DHB boards in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.
Transactions eliminated on consolidation	All inter-entity transactions are eliminated on consolidation.	
Foreign currency	Both the functional and presentation currency of Auckland DHB and Group is in NZD. Transactions in foreign currencies are translated at the exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at balance date are translated to NZD at the rate ruling at that date.	
Budget figures	The budget figures are those approved by the Board in its District Annual Plan and included in the Statement of Intent tabled in Parliament.	
Equity	Equity comprises contributions from the Crown, accumulated surpluses/deficits and reserves. Crown contributions are recognised at the amount received, accumulated surpluses/deficits in accordance with the financial results using generally accepted accounting principles, and reserves from changes in the value of land and buildings.	
Property, plant and equipment (PPE)	The major classes of property, plant and equipment are as follows: • Freehold land • Freehold buildings and fitouts • Plant, equipment and vehicles • Leased assets • Work in progress	
	Owned assets	Except for land and buildings, items of PPE are stated at cost, less accumulated depreciation and impairment losses. Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. The latest revaluation was done on 30 June 2009. Additions to PPE between valuations are recorded at cost.
	Disposal of property, plant and equipment	Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the Statement of Financial Performance is calculated as the difference between the net sales price and the carrying amount of the asset.
	Leased assets	Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. Operating lease payments are recorded as an expense in the Statement of Financial Performance on a straight-

<table>
<tr><td rowspan="3"></td><td></td><td>line basis over the lease term.</td></tr>
<tr><td>Subsequent costs</td><td>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 future economic benefit embodied within the item will flow to Auckland DHB. All other costs are recognised in the Statement of Financial Performance as an expense as incurred.</td></tr>
<tr><td>Depreciation</td><td>Depreciation is charged to the Statement of Financial Performance using the straight line method. Land is not depreciated. Depreciation is set at rates that write off the cost or fair value of the assets, less their estimated residual values, over their useful lives, as follows:
<table>
<tr><th>Asset class</th><th>Useful lives</th></tr>
<tr><td>Freehold buildings and fitouts</td><td>1–89 years</td></tr>
<tr><td>Plant, equipment and vehicles</td><td>2–20 years</td></tr>
<tr><td>Lease assets</td><td>4–8 years</td></tr>
</table>
The residual value, useful life and depreciation method of assets is reassessed annually.
Work in progress is not depreciated. The total cost of a project is transferred to property, plant and equipment on its completion and then depreciated.</td></tr>
<tr><td>Intangible assets</td><td colspan="2">Computer software not an integral part of the related hardware is treated as an intangible asset. Such intangible assets are acquired separately and are capitalised at cost less accumulated amortisation and impairment losses.</td></tr>
<tr><td>Interest-bearing loans and borrowings</td><td colspan="2">Interest-bearing capital bonds are measured at amortised cost using the effective interest method. Amortised cost is calculated by taking into account any issue costs, and any discount or premium on settlement.
Crown Health Financing Agency borrowings are recorded at nominal or “face” value.</td></tr>
<tr><td>Derivative financial instruments</td><td colspan="2">Auckland DHB uses foreign exchange and interest rate swap contracts to manage its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities. Such derivatives are accounted for as trading instruments, and are stated at fair value.</td></tr>
<tr><td>Trade and other receivables</td><td colspan="2">Trade and other receivables are recognised and carried at original invoice amount less impairment. Bad debts are written off during the period in which they are identified.</td></tr>
<tr><td>Inventories</td><td colspan="2">All items are valued at the lower of cost, determined on a first-in first-out basis, and net realisable value. A provision for slow moving or obsolete stock is made.
Inventories held for distribution are stated at the lower of cost and current replacement cost.</td></tr>
<tr><td>Cash and cash equivalents</td><td colspan="2">Cash and cash equivalents comprise cash and call deposits with an original maturity of less than three months. Bank overdrafts that are repayable on demand and form an integral part of Auckland DHB’s cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows.</td></tr>
</table>

Properties held for sale	Properties held for sale are measured at the lower of carrying amount or fair value less costs to sell.	
Impairment	The carrying amounts of Auckland assets are reviewed at balance date to determine whether there is any indication of impairment. Impairment losses are recognised in the Statement of Financial Performance.	
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.	
Employee benefits	**Defined Contribution Plan (DCP)**	Obligations for contributions to DCPs are recognised as an expense in the Statement of Financial Performance as incurred.
	Retiring Gratuities and Long Service Leave	Auckland DHB's net obligation in respect of Retiring Gratuities and Long Service Leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods calculated on an actuarial basis.
	Annual leave, sick leave, continuing medical education leave and expenses	Annual leave is a short-term obligation and is calculated on an actual basis at the amount Auckland DHB expects to pay when staff take leave or resign. Sick leave is a short-term obligation which represents the estimated future cost of sick leave attributable to the entitlement not used at balance date calculated as the amount expected to be paid. Continuing medical education leave and expenses are calculated based on a discounted valuation of the estimated three years non-vesting entitlement under the current collective agreement with senior medical officers based on current leave patterns.
Provisions	A provision is recognised when Auckland DHB has a present obligation (legal or constructive) as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and a reliable estimate can be made. If the time-value of money is material the obligation is discounted to its present value. Restructuring: a provision for restructuring is recognised when Auckland DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly.	
Revenue	The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is received monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year. Revenue from services provided is recognised to the proportion that the transaction is complete, when it is probable that the payment associated with the transaction will flow to Auckland DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Auckland DHB. Auckland DHB is required to recognise and expend all monies appropriated within certain contracts, e.g., the mental health ring-fence on mental health services, during the year in which it was appropriated. Should this not be done such revenue, with the agreement of the funder, is included in Payables and Accruals in the Statement of Financial Position until the time this obligation is discharged.	

<table>
<tr><td></td><td colspan="2">Trust and special fund donations received are treated as revenue on receipt, in the Statement of Financial Performance. These funds are administered by the Auckland District Health Board Charitable Trust.
Interest income is recognised using the effective interest method.</td></tr>
<tr><td>Expenses</td><td colspan="2">Payments made under operating leases are recognised in the Statement of Financial Performance on a straight-line basis over the term of the lease.
Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases.</td></tr>
<tr><td>Income tax</td><td colspan="2">Auckland DHB 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.</td></tr>
<tr><td>Goods and services tax (GST)</td><td colspan="2">All amounts are shown exclusive of GST, except for receivables and payables that are stated inclusive of GST.</td></tr>
<tr><td>Borrowing costs</td><td colspan="2">Borrowing costs are recognised as an expense when incurred.</td></tr>
<tr><td rowspan="4">Cost allocation</td><td colspan="2">Auckland DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below:</td></tr>
<tr><td>Cost allocation policy</td><td>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.</td></tr>
<tr><td>Criteria for direct and indirect costs</td><td>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.</td></tr>
<tr><td>Cost drivers for allocation of indirect costs</td><td>The cost of internal services not directly charged to outputs is held in central overhead pools, for example, the cost of building accommodation. The exceptions to this are ring-fenced services Mental Health and Public Health where an allocation of overheads is made, and some services that sell to third parties, for example LabPlus.</td></tr>
</table>

Statement re service agreements

For the purposes of section 25 of the New Zealand Public Health and Disability Act, Auckland DHB notes that it is permitted by this annual plan to enter into service agreements, on terms and conditions it considers appropriate for the particular services contracted for in that service agreement , where such a service agreement is implicitly or expressly required to achieve the strategic objectives and outcomes outlined in this annual plan or to deliver the services Auckland DHB is required by statute or contract with the Crown or any other party to deliver.

Schedule of arrangements

Under section 24 of the New Zealand Public Health and Disability Act, Auckland DHB is permitted to enter into co-operative agreements or arrangements with any person in order to assist in meeting its objectives or to enhance health or disability outcomes for people or to enhance efficiencies in the health sector where that agreement or arrangement is authorised by its annual plan.

Below are some examples of the co-operative agreements or arrangements Auckland DHB is authorised by this plan to enter into in the future. Auckland DHB may also enter into any other co-operative agreements or arrangements which, in the opinion of its Chief Executive, will assist in meeting its objectives, or will enhance health or disability outcomes for people, or enhance efficiencies in the health sector.

Auckland DHB has co-operative arrangements in place to achieve the following objectives	Meet public health objectives for the region Improve public health outcomes for Maori across the region Advance healthy housing development strategy Work regionally and nationally with other DHBs, DHBNZ, tertiary education institutions and the Crown in respect health education and work force development Work regionally and nationally with other DHBs and DHBNZ in relation to procurement Achieve regional collaboration in the recruitment of staff Maintain the multi-agency centre, Puawaitahi, where various agencies case-manage specialist investigation and treatment for abused children Allow staff of other entities to access Auckland DHB facilities for research, training or to work with Auckland DHB staff Undertake initiatives with tertiary education institutions to promote public health, research, evidence-based practice and clinical effectiveness Clinical trial agreements, via the ADHB Charitable Trust to develop better treatment options and quality measures Enable Auckland DHB to assist ACC in the treatment of injuries and provision of care Occupation licences to allow early childhood education and care services on Auckland DHB sites for children of Auckland DHB staff Occupation licences to provide premises for organisations who assist Auckland DHB in meeting its objectives or to enhance health or disability outcomes for people, for example Starship Foundation and Ronald McDonald House Assist with the treatment of inmates in the care of the Department of Corrections Support community health initiatives Implement a regional Drinking Water Incident Co operation Plan Co ordinate with other sectors in Strengthening Families, the joint sector project to improve case management for children and families with high need

Appendix 6: Price Volume Schedule

2010–2011 contracted outputs from Auckland DHB hospital and specialist services

		For Auckland resident population		For other populations	
Hospital specialist service	Unit of Measure	2010-11 proposed Volumes	2010-11 proposed $	2010-11 proposed Volumes	2010-11 proposed $
A Plus Links	Assessments	1,326	$ 2,024,627	-	$ -
	Attendance	8,267	$ 854,147	22	$ 1,588
	Bed day	26,368	$ 17,276,289	539	$ 371,926
	Client	1,935	$ 1,769,098	-	$ -
	Clients	648	$ 1,062,017	-	$ -
	Contact	83,426	$ 8,407,831	-	$ -
	Hour	8,964	$ 204,359	-	$ -
	Programme	187,268	$ 193,103	-	$ -
	Visit	3,261	$ 554,581	-	$ -
Adult Congenital Heart	Attendance	154	$ 51,564	254	$ 83,794
	Cost weighted discharge	93	$ 408,532	56	$ 248,399
Audiology	Adjuster	85,260	$ 96,071	-	$ -
	Service	87,906	$ 93,003	-	$ -
	Test	4,230	$ 730,332	3,317	$ 572,623
Cardiology	Assessment	-	-	46	$ 365,355
	Attendance	7,200	$ 2,399,793	1,274	$ 444,673
	Client	1,335	$ 286,752	-	$ -
	Cost weighted discharge	3,525	$ 15,545,575	4,290	$ 18,919,347
	Implant only	2	$ 23,553	6	$ 72,613
	Locally Defined	286,883	$ 295,822	-	$ -
	Programme	399,419	$ 492,869	61,850	$ 2,370,673
	Test	3,007	$ 809,454	947	$ 255,662
	Written plan of care	320	$ 45,919	102	$ 11,246
Cardiothoracic	Attendance	181	$ 70,913	548	$ 213,567
	Cost weighted discharge	2,446	$ 10,789,307	8,327	$ 36,723,407
Child Health & Disability	Programme	203,000	$ 209,325	-	$ -
	Service	1	$ 1,752,126	-	$ -
Clinical Infectious Diseases	Test	292	$ 161,979	1,061	$ 588,352
Critical Care	Service	123,690	$ 130,863	-	$ -
Dermatology	Attendance	5,415	$ 1,173,162	583	$ 131,727
	Cost weighted discharge	119	$ 525,138	71	$ 312,681
	Programme	-	-	1	$ 8,720
	Treatment	2,585	$ 729,790	1,173	$ 127,577

		For Auckland resident population		For other populations	
Hospital specialist service	Unit of Measure	2010-11 proposed Volumes	2010-11 proposed $	2010-11 proposed Volumes	2010-11 proposed $
Diabetes	Attendance	7,222	$ 1,506,618	246	$ 71,561
	Client	3,376	$ 850,091	281	$ 70,792
	Contact	2,746	$ 335,086	37	$ 4,903
	Item Dispensed	(0)	($0)	2	$ 8,281
	Procedure	6,462	$ 597,418	487	$ 45,007
	Written plan of care	220	$ 36,868	-	$ -
Donor Coord	Programme	-	-	2	$ 1,264,363
Elective Services	ADHB Defined	213,992	$ 226,401	-	$ -
	Service	311,339	$ 329,395	-	$ -
Emergency Medicine	Attendance	10,925	$ 3,607,326	3,687	$ 1,217,334
	Cost weighted discharge	2,702	$ 11,916,391	712	$ 3,141,141
Endocrinology	Attendance	2,900	$ 980,816	2,090	$ 638,263
	Cost weighted discharge	74	$ 325,298	95	$ 417,948
	Test	2,148	$ 362,826	474	$ 80,075
Fertility Plus	Attendance	130	$ 27,912	215	$ 46,231
	Bed day	5	$ 4,953	19	$ 18,649
	Client	38	$ 97,581	52	$ 137,372
	Prescription	29,097	$ 29,600	80,477	$ 81,869
	Procedure	312	$ 875,411	658	$ 1,844,961
	Service	31	$ 4,247	1	$ 96
Gastroenterology	Attendance	7,460	$ 4,858,939	826	$ 675,908
	Cost weighted discharge	510	$ 2,249,092	109	$ 479,989
	Procedure	43	$ 37,954	20	$ 17,779
	Test	52	$ 27,728	20	$ 10,604
General Medicine	Attendance	1,643	$ 454,846	41	$ 12,019
	Cost weighted discharge	9,608	$ 42,377,070	322	$ 1,420,942
General Paediatrics	Attendance	11,686	$ 3,830,877	466	$ 143,395
	Cost weighted discharge	1,232	$ 5,432,962	2,120	$ 9,351,503
	Programme	1,530	$ 188,015	40	$ 4,863
General Surgery	Attendance	11,986	$ 3,936,895	2,806	$ 864,845
	Contact	586	$ 59,636	337	$ 32,425
	Cost weighted discharge	8,211	$ 36,214,777	2,609	$ 11,508,253
	Implant only	15	$ 181,052	-	$ -
	Written plan of care	30	$ 5,027	4	$ 678
Genetics	Attendance	461	$ 384,791	1,042	$ 870,908
	Clinical FTE	-	-	390	$ 567,351
Gynaecology	Attendance	9,864	$ 3,213,885	3,684	$ 1,337,840
	Cost weighted discharge	2,576	$ 11,363,002	821	$ 3,620,243
	Procedure	2,183	$ 1,896,528	4,181	$ 4,085,399

Hospital specialist service	Unit of Measure	For Auckland resident population: 2010-11 proposed Volumes	For Auckland resident population: 2010-11 proposed $	For other populations: 2010-11 proposed Volumes	For other populations: 2010-11 proposed $
	Written plan of care	135	$ 13,826	4	$ 403
Haematology	Attendance	11,396	$ 4,784,040	7,703	$ 3,274,359
	Cost weighted discharge	842	$ 3,713,539	1,490	$ 6,570,555
	Premium	108,351	$ 110,225	568,633	$ 578,470
	Programme	1	$ 18,726	6	$ 94,230
	Written plan of care	104	$ 18,720	11	$ 1,980
Imaging	Attendance	35	$ 60,374	126	$ 219,812
	Relative Value Unit	34,889	$ 2,281,485	11,464	$ 749,628
Immunology	Attendance	1,222	$ 504,785	2,163	$ 878,974
	Cost weighted discharge	192	$ 844,953	275	$ 1,214,204
	Patients	5	$ 179,934	10	$ 358,807
Infectious Diseases	Attendance	1,563	$ 540,443	823	$ 271,898
	Cost weighted discharge	193	$ 851,406	61	$ 269,800
	Service	116,544	$ 118,560	358,469	$ 364,670
Labs	Service	4,401,200	$ 4,477,341	9,797,024	$ 9,966,513
Liver Transplants	Assessment	-	-	77	$ 663,107
	Attendance	230	$ 72,373	254	$ 79,684
	Procedure	-	-	48	$ 9,302,554
	Programme	79,175	$ 81,642	1	$ 91,977
Maori Health Corp	Service	530,442	$ 864,921	1,869	$ 169,114
Metabolic Service	Programme	58,423	$ 59,434	567,246	$ 577,059
Needs Assessment, Service Coordination	Assessment	8,766	$ 1,702,245	-	$ -
	Hour	5,550	$ 765,876	-	$ -
	Service	1	$ 241,349	-	$ -
Neurology	Attendance	2,720	$ 1,302,992	5,588	$ 2,707,389
	Cost weighted discharge	900	$ 3,967,404	635	$ 2,798,955
	Procedure	8	$ 353,673	2	$ 87,560
	Programme	334,950	$ 334,950	-	$ -
	Test	217	$ 95,943	1,469	$ 650,886
	Written plan of care	449	$ 75,212	932	$ 156,196
Neurosurgery	Attendance	795	$ 317,161	2,209	$ 883,391
	Cost weighted discharge	1,412	$ 6,229,611	3,678	$ 16,223,051
	Written plan of care	-	-	4	$ 3,224
Newborn Services	Attendance	788	$ 559,411	974	$ 690,868
	Cost weighted discharge	2,672	$ 11,783,653	1,811	$ 7,985,014
	Service	316,124	$ 334,456	294,078	$ 318,661
Nutrition	Contact	6,238	$ 717,332	7,714	$ 886,987
Obstetrics	ADHB Defined	0	$ 40,825	-	$ -

		For Auckland resident population		For other populations	
Hospital specialist service	Unit of Measure	2010-11 proposed Volumes	2010-11 proposed $	2010-11 proposed Volumes	2010-11 proposed $
	Attendance	11,099	$ 4,368,925	7,278	$ 2,784,841
	Client	329	$ 82,809	277	$ 69,639
	Contact	21,359	$ 3,068,678	4,529	$ 650,752
	Cost weighted discharge	5,616	$ 24,767,950	2,458	$ 10,841,327
Oncology	Attendance	26,425	$ 11,468,850	74,399	$ 32,380,125
	Cost weighted discharge	869	$ 3,832,619	1,875	$ 8,267,287
	Programme	3,510,440	$ 3,526,317	7,867,440	$ 7,878,691
Ophthalmology	Attendance	19,127	$ 3,390,051	30,643	$ 5,498,008
	Contact	1,313	$ 253,137	2,104	$ 405,471
	Cost weighted discharge	1,331	$ 5,868,647	2,328	$ 10,265,509
	Procedure	1,705	$ 382,991	2,586	$ 569,698
	Written plan of care	-	-		
Oral Health	Attendance	4,227	$ 980,710	11,001	$ 2,525,637
	Competed treatment	3,862	$ 575,622	9,682	$ 1,443,137
	Cost weighted discharge	322	$ 1,418,576	852	$ 3,756,790
	Fitting of a Prosthetic eye	20	$ 26,764	70	$ 95,418
ORL	Attendance	7,281	$ 1,813,323	2,675	$ 687,056
	Contact	1,050	$ 165,165	1,495	$ 235,277
	Cost weighted discharge	1,238	$ 5,458,716	1,541	$ 6,794,395
	Treatment	471	$ 162,243	1,439	$ 495,488
	Written plan of care	47	$ 7,848	2	$ 332
Orthopaedics	Attendance	14,034	$ 3,236,609	1,611	$ 365,075
	Cost weighted discharge	8,558	$ 37,743,308	958	$ 4,227,247
	Service	81,158	$ 85,865	-	$ -
Orthotics	Service	140,465	$ 142,895	53,579	$ 54,505
Pacific Health Corp	Service	380,569	$ 420,910	-	$ -
Paediatric Allied Health	Attendance	521	$ 37,662	1,141	$ 82,506
	Contact	261	$ 37,250	632	$ 90,884
Paediatric Cardiac	Attendance	862	$ 631,119	1,789	$ 1,300,427
	Cost weighted discharge	813	$ 3,586,621	3,711	$ 16,366,687
Paediatric Dermatology	Attendance	500	$ 113,049	427	$ 98,883
Paediatric Emergency department	Attendance	9,677	$ 3,194,987	7,867	$ 2,597,493
	Cost weighted discharge	1,227	$ 5,412,677	1,035	$ 4,563,670
Paediatric Endocrinology	Attendance	1,005	$ 365,285	2,582	$ 931,800
	Client	119	$ 29,972	394	$ 99,256
	Cost weighted discharge	43	$ 189,266	140	$ 618,050
	Item Dispensed	8	$ 28,321	8	$ 25,424
Paediatric Family	Service	62,245	$ 63,322	181,842	$ 184,988

		For Auckland resident population		For other populations	
Hospital specialist service	Unit of Measure	2010-11 proposed Volumes	2010-11 proposed $	2010-11 proposed Volumes	2010-11 proposed $
Information Service					
Paediatric Family Options	Service	80,947	$ 82,348	263,872	$ 268,437
Paediatric Gastroenterology	Attendance	233	$ 84,501	669	$ 234,649
	Cost weighted discharge	312	$ 1,376,734	484	$ 2,135,617
Paediatric Haem/Onc	Attendance	1,816	$ 717,643	7,505	$ 2,832,631
	Cost weighted discharge	391	$ 1,723,351	1,768	$ 7,797,269
	Premium	132,160	$ 134,446	926,231	$ 942,255
	Programme	63,638	$ 88,717	331,494	$ 482,909
Paediatric Home Health Care	Service	433,591	$ 441,092	193,902	$ 197,257
Paediatric Immunology	Attendance	390	$ 166,930	455	$ 186,998
	Cost weighted discharge	17	$ 76,991	88	$ 387,110
	Patients	1	$ 35,350	2	$ 71,761
Paediatric Infectious Diseases	Attendance	187	$ 74,523	383	$ 149,933
	Cost weighted discharge	23	$ 99,366	75	$ 328,584
Paediatric Intensive Care Unit	Service	-	-	4,522	$ 4,900
Paediatric Neurology	Attendance	1,924	$ 712,046	1,945	$ 691,424
	Cost weighted discharge	68	$ 299,090	329	$ 1,452,616
Paediatric Neurosurgery	Attendance	117	$ 48,399	524	$ 217,061
	Cost weighted discharge	151	$ 665,067	1,164	$ 5,133,231
Paediatric ORL	Attendance	4,147	$ 1,013,152	1,674	$ 400,105
	Cost weighted discharge	612	$ 2,697,774	807	$ 3,559,713
Paediatric Orthopaedics	Assessment	12	$ 33,781	59	$ 170,067
	Attendance	3,896	$ 940,575	5,455	$ 1,268,733
	Cost weighted discharge	1,122	$ 4,948,921	2,653	$ 11,702,662
Paediatric Pain Service	Attendance	105	$ 46,888	214	$ 97,422
	Cost weighted discharge	-	-	1	$ 6,179
Paediatric Palliative Care	Attendance	718	$ 838,841	1,127	$ 1,316,765
Paediatric Renal Medicine	Attendance	353	$ 113,390	787	$ 226,505
	Cost weighted discharge	104	$ 460,413	311	$ 1,372,169
	New client	-	-	3	$ 8,468
	Patient Months	18	$ 35,594	136	$ 275,390
Paediatric Respiratory Medicine	Attendance	343	$ 224,200	1,128	$ 793,918
	Client	14	$ 6,671	111	$ 54,409
	Cost weighted discharge	151	$ 666,114	959	$ 4,229,997

Hospital specialist service	Unit of Measure	For Auckland resident population: 2010-11 proposed Volumes	For Auckland resident population: 2010-11 proposed $	For other populations: 2010-11 proposed Volumes	For other populations: 2010-11 proposed $
	Test	33	$ 7,777	36	$ 8,484
Paediatric Rheumatology	Attendance	160	$ 49,738	493	$ 158,382
	Cost weighted discharge	22	$ 95,305	44	$ 191,904
	Programme	-	-	1	$ 509,155
Paediatric Surgery	Attendance	1,203	$ 296,114	3,171	$ 809,510
	Cost weighted discharge	670	$ 2,955,526	2,476	$ 10,918,501
Palliative Care	Programme	437,140	$ 450,762	-	$ -
Physiotherapy	Attendance	7,235	$ 523,033	488	$ 35,251
Rehab Plus	Attendance	687	$ 123,880	-	$ -
	Day Attendance	115	$ 23,738	-	$ -
	Service	8,000	$ 5,388,118	-	$ -
	Visit	3,537	$ 654,230	-	$ -
Renal Medicine	Attendance	30,621	$ 10,448,008	19,672	$ 6,658,788
	Cost weighted discharge	1,126	$ 4,965,207	995	$ 4,388,649
	New client	49	$ 268,516	33	$ 255,087
	Patient Months	1,171	$ 2,511,168	932	$ 2,049,111
	Service	219,656	$ 223,456	-	$ -
	Written plan of care	86	$ 14,388	24	$ 3,983
Renal Research	Service	2,482	$ 2,525	23,859	$ 24,272
Renal Transplant	ADHB Defined	-	-	1	$ 2,955,496
	Attendance	120	$ 16,616	150	$ 20,770
	Cost weighted discharge	181	$ 796,834	613	$ 2,705,632
Respiratory Medicine	Assessment	-	-	37	$ 290,623
	Attendance	8,181	$ 2,919,899	4,801	$ 2,530,078
	Client	1,383	$ 1,009,515	1,770	$ 1,286,200
	Cost weighted discharge	1,487	$ 6,558,233	1,080	$ 4,762,017
	Premium	49,045	$ 49,893	176,523	$ 179,576
	Procedures	52	$ 13,489	104	$ 27,221
	Programme	-	-	11	$ 2,148,303
	Service	-	-	3	$ 51,357
	Test	402	$ 94,735	362	$ 85,249
Rheumatology	Attendance	3,098	$ 1,074,392	109	$ 33,933
	Cost weighted discharge	76	$ 337,138	4	$ 16,962
Sexual Health	Contact	8,640	$ 1,582,485	13,166	$ 2,422,704
	Premium	550,926	$ 560,457	865,348	$ 880,318
	Service	181,505	$ 181,505	367,540	$ 367,540
Social Work	Contact	1,126	$ 164,898	3,254	$ 476,596
Specialist Mental Health Service	Client	1	$ 502,051	-	$ -

Hospital specialist service	Unit of Measure	For Auckland resident population: 2010-11 proposed Volumes	For Auckland resident population: 2010-11 proposed $	For other populations: 2010-11 proposed Volumes	For other populations: 2010-11 proposed $
The Auckland Regional Pain Service	Attendance	1,130	$ 347,496	1,404	$ 494,555
	Client	45	$ 135,069	30	$ 88,872
Urology	Attendance	4,111	$ 1,320,211	1,031	$ 406,063
	Cost weighted discharge	1,390	$ 6,129,418	1,921	$ 8,471,656
	Procedure	131	$ 247,832	176	$ 465,144
	Written plan of care	304	$ 51,013	215	$ 36,036
Vascular Surgery	Attendance	1,906	$ 726,032	2,454	$ 934,697
	Cost weighted discharge	1,393	$ 6,144,646	2,404	$ 10,603,483
Well Child	Client	286,412	$ 303,022	-	$ -
	Contact	1,756	$ 247,466	-	$ -
	Programme	124,845	$ 132,085	-	$ -
	Service	230,214	$ 3,803,431	-	$ -
	Test	482,744	$ 543,954	-	$ -
Whakaruruhau	Service	408,277	$ 415,340	967,152	$ 983,883
Women's & Children's Health Management	Adjuster	131,829	$ 139,474	-	$ -
Women's & Children's Social Work	Contact	823	$ 120,601	1,220	$ 178,671
Women's & Children's Therapy	Attendance	2,012	$ 145,428	736	$ 53,185

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TUESDAY, 30 March 2010

Time		Session	Presenter
9:55 am	Welcome and opening of workshop **Andrew Keenan, Quality Manager ADHB**		
10:00 am		Introductions and expectations of the Day **Rae Lamb, Deputy Commissioner Complaints Resolution**	
10:10 am		Resolving complaints What works well, what doesn't? What are the challenges? Question and Answer session	**All DHBs (5 – 10 Minute presentation)**
11:15 am		Title What works well from consumers' point of view	**Tony Daly** National Education, Training & Resource Manager
11:30 pm		Morning Tea	
11:45 am		Title Description	**Elizabeth Finn** HDC Education Manager
12:15 pm		"You be the Commissioner"	**Rae Lamb** Deputy Commissioner
1:00 pm		Lunch Break	
2:00 pm		Nuts and Bolts Dealing with complaints as the funder rather than provider When are meetings helpful? Learning from complaints management	 **Lisa Gestro** Planning & Funding Manager, ADHB **Amy Stone** Consumer Liaison Coordinator, ADHB **Jocelyn Peach** Director of Nursing & Midwifery, WDHB
3:00 pm		Afternoon Tea	
3:15 pm		Trouble shooting Case study from each DHB. What is the optimal way of handling complaints? Working with repeat complainers/difficult behavior.	**All DHBs** **(Please bring one complaint to share during this session).**
4:15 pm		Wrapping up Reflections on day. Going forward – what next?	**Rae Lamb** Deputy Commissioner
4:30 pm	Workshop	Conclusion	

Disability Support Advisory Committee
Agenda

MEETING DETAILS	
Time and Date	Thursday, 18 March 2010 10:00 a.m. – 12:00 p.m.
Venue	Sir Douglas Robb Board Room, Level 7, Bldg 14, Greenlane
Members	Jo Agnew (Chair), Susan Buckland, Peter Druskovich, Tunumafono Ava Fa'amoe, Dr Brian Fergus, Marie Hull-Brown, Dairae Kirton, Nanar Tan, Rt Hon Bob Tizard
Apologies	
In Attendance	Dr Denis Jury, Lisa Gestro, Janice Mueller, Ian Bell.

	Item	Page No
1	**Karakia and Introductions**	**001**
2	**Attendance and Apologies**	**005**
3	**Conflicts of Interest**	**007**
4	**Confirmation of Minutes** - Thursday 18 February 2010	**013**
5	**Action Points** - Thursday 18 February 2010	**019**
6	**Chairman's Report**	**023**
7	**Improvement Activities** 7.1 DAP Projects Report	**025**
8	**Papers** 8.1 Update on the Revised Material in the 2010-11 District Annual Plan 8.2 Quality in Rest Homes – National Spot Audit Project 8.3 Management of Complaints 8.4 Access Audit	**035**
9	**Confirm** 9.1 Action Points for next DSAC Meeting 9.2 DSAC Feedback to CPHAC 93 DSAC Feedback to Board	**057**
10	**General Business**	**059**
11	**Appendices** 11.1 Appendix 1 - DAP 11.2 Appendix 2 – Workshop Agenda	**061**

NEXT MEETING	
	Date and Time: Thursday 20 May 2010 10:00 a.m. – 12:00 p.m. **Venue:** Sir Douglas Robb Board Room, Level 7, Bldg 14, Greenlane

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare