



**Auckland District Health Board**

# **District Annual Plan *2010 - 2011***

*22 June 2010*

## Status of this Document

Version 22 June: Final

### Approvals

Auckland DHB (Board)	3 March 2010 (draft for Ministry review)
Auckland DHB (CPHAC)	19 May 2010 (approved by Chair and CEO)
Minister of Health	22 September 2010

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

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

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## Office of Hon Tony Ryall

Minister of Health  
Minister of State Services

22 SEP 2010

Mr Pat Snedden  
Chair  
Auckland District Health Board  
PO Box 92-189  
Victoria St West  
AUCKLAND 1142

Received 24/9/10

Dear Mr Snedden

### Auckland District Health Board: 2010/11 District Annual Plan

This letter advises you that I have signed Auckland District Health Board's (DHB) 2010/11 District Annual Plan (DAP) for three years.

I appreciate the efforts your Board and management have put in over the past years to manage your DHB in a sustainable manner. More work lies ahead to achieve long lasting sustainability, while ensuring that New Zealanders get an improved delivery of services. The challenge for us all is to achieve this.

#### *Clinical and financial sustainability*

All DHBs must budget within their allocations and improve financial performance. I note your planned financial position which incorporates performance improvement actions and efficiencies in 2010/11. The DHB's actions to achieve efficiencies and control costs will be important in the current fiscal environment in 2010/11 and the out years. My approval of your DAP does not mean acceptance of your assumptions in out years.

The DHB's inter-district flow (IDF) planning assumptions for the 2010/11 period are in-line with the National Health Board's expectations. Please update the NHB on progress made towards resolving any unclarified issues.

#### *Health targets and priorities*

I appreciate the DHB's emphasis on the Government's health targets and priority areas, and on providing clear actions to drive continual improvement.

The Ministry of Health has advised that it considers there are heightened risks associated with your achievement of the agreed health targets for Shorter stays in Emergency Departments and Shorter waits for Cancer Treatment. I expect that your DHB remains focused on improving performance - including in these and other health target areas - and that it will work closely with the Ministry of Health, and in particular, the Health Target Champions, to deliver concrete actions to ensure good

progress is made. While ADHB has performed well in Elective Surgery, the 2010/11 plan is a significant increase and your close attention to lifting performance will be important.

#### *Mental Health Ring-Fence*

While I am not viewing your ring-fence spending as an impediment to the overall approval of your DAP, I expect the DHB to work with the Ministry during 2010/11 to ensure my expectations regarding the mental health ring-fence are met. This includes ensuring that the amount of funding not allocated in accordance with ring-fence expectations is tagged for allocation on mental health and addiction services in out years.

This should include the DHB working with the Ministry's Mental Health Group to determine the appropriate level of service delivery for the DHB's population; and in 2011/12 and out years allocating sufficient funding to support this. The NHB will ensure that this work is undertaken, as it forms part of my agreement to your 2010/11 DAP.

As part of this discussion, it will be important to work with the NHB to establish whether any proposed changes to mental health service models, including integrating primary and secondary mental health services, should be considered under the service change protocols outlined in the 2010/11 Operational Policy Framework (OPF).

#### *Policy Priorities*

New Zealanders want better access to a wider range of services closer to home. I expect your DHB to make substantial progress with implementing the Government's primary health care policy. Success in this area will require you to work increasingly closely and collaboratively with your Northern region colleagues. The DHB will need to keep the Ministry of Health and National Health Board well informed of its progress in this priority area, including through a quarterly report.

I note that your Board plans to work closely with other Northern DHBs, building on promising regional actions from 2009/10. I will be particularly interested to review your Regional Clinical Services Plan and to see how the Northern Region will collaborate in ways which improve the financial and clinical viability of specific services.

#### *DAP Approval*

The approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry of Health where any proposals may require my approval.

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

I wish you, your Board and management every success with the implementation of your 2010/11 DAP, and thank you for your contribution and efforts towards a unified health system.

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

Yours sincerely

Hon Tony Ryall  
Minister of Health

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 mihi 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

## Foreword

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 health care.

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 (expressions of interest) process. Our District Health Board will be a key partner in improving the quality of the frontline services being delivered to our population.

The Government's health strategy and the release of the Ministerial Review Group findings also impact on the Auckland District Health Board. 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**



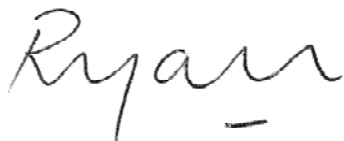
Pat Snedden  
**Chair**

Our Treaty of Waitangi partners  
**Te Runanga o Ngati Whatua**



R. Naida Glavish JP  
**Chair**

And signed on behalf of  
**The Crown**



Hon Tony Ryall  
**Minister of Health**

## Te Tiriti o Waitangi Statement

The DHB recognises and respects the Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o 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 Te Tiriti o 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 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.

### Whanau Ora

Auckland DHB works in partnership with Iwi to achieve a Whanau Ora approach to regional health services and whanau empowerment.

## Principles in action

<p><b>Partnership</b></p> <p>Te Runanga o Ngati Whatua as manawhenua, are partners with Auckland DHB</p>	<p>Memorandum of Understanding with Te Runanga o Ngati Whatua and its health arm. 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.</p>
<p><b>Participation</b></p> <p>Maori engagement in planning, development and delivery of health and disability services</p>	<p>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.</p> <p>There is engagement with Maori regarding the impact service and other changes may have on Maori communities and organisations.</p> <p>Assistance to further develop Maori providers in our district.</p>
<p><b>Protection</b></p> <p>Equity of participation, access and outcomes for all Maori. Equitable Maori health status. Safeguard Maori cultural concepts, values and practices</p>	<p>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.</p> <p>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.</p>

## Table of Contents

Foreword.....	v
Te Tiriti o Waitangi Statement .....	vii
Priorities for Health .....	1
Summary of developments proposed for 2010-11 .....	9
The Auckland DHB Health Care System.....	14
Activities that support the Auckland DHB health care system .....	15
Health promotion, prevention and protection .....	16
Community-based providers .....	17
Primary health care .....	18
The Auckland DHB provider (hospital and related services) .....	23
Priority and Developmental Work for 2010-11 .....	27
Goal 1: Lift the health of people living in Auckland city.....	27
Goal 2: Performance improvement: sooner, better, more convenient .....	30
Goal 3: Live within our means.....	35
National Performance Measures .....	36
Working Regionally.....	46
Risks and Mitigation .....	61
Managing the Funding.....	64
Population-based funding formula (PBF).....	64
Summarised price volume schedule .....	67
Services provided by non-government organisations .....	70
Financial Management .....	71
Appendix 1: Profile of the Population .....	74
Appendix 2: Leadership.....	75
Appendix 3: Consolidated Financial Tables .....	76
Appendix 4: Information Services Planning.....	83
Appendix 5. Statement of Significant Accounting Policies .....	85
Appendix 6: Price Volume Schedule .....	91
Appendix 7: Metro Auckland Primary Care Plan.....	98
Appendix 8. Additional data to support targets.....	108

## 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 (including the aim to reduce waiting times for treatment)
- 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

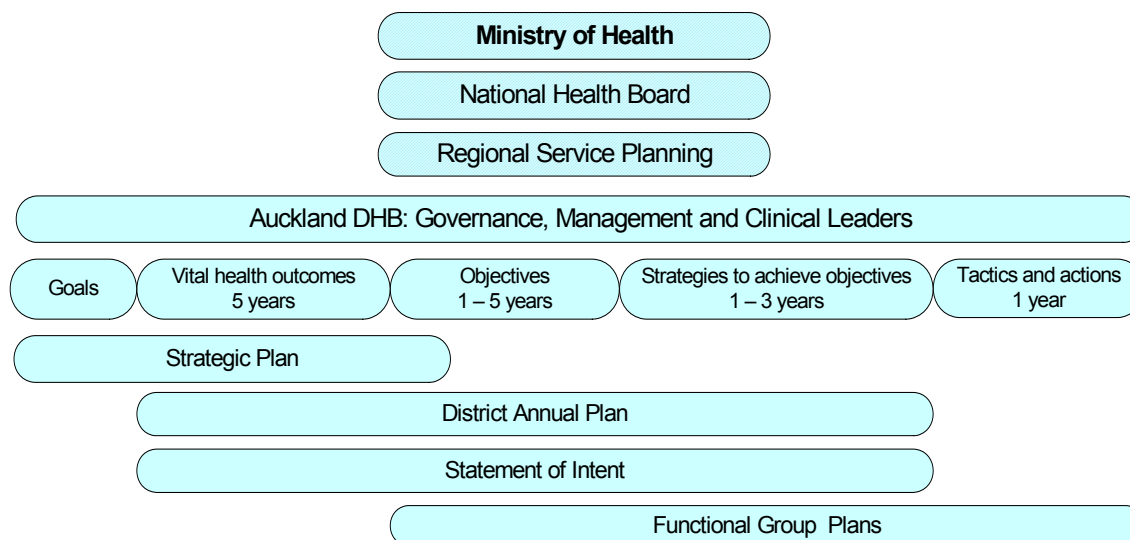
In 2010–2011 we will work closely with the National Health Board for future planning. We will do more planning across the Auckland region, especially around the development of clinical services.

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
- Health Care 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 health care 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 36)

### **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

*Progress against these critical targets is covered in more detail in the following section.*

*All projects to achieve the 6 national targets involve clinical leadership and clinical representation on the various steering groups*

### **Policy priorities**

Increased 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 (*which requires the provision of appropriate District Health Board information*)  
Improved mainstream effectiveness  
Shorter waiting times for chemotherapy treatment  
Improved health for people with severe mental illness through improved access  
Improved mental health services using relapse prevention planning  
DHBs report alcohol and drug service waiting times and waiting lists  
Deliver Te Kokiri: the Mental Health and Addiction Action Plan  
Improved oral health – Mean DMFT score at year 8  
More children caries free at 5 years of age  
Better use of DHB funded dental services by adolescent from Year 9 to 17 years  
Improved number of children enrolled in DHB funded dental services  
Family violence prevention

### **System Integration Dimension**

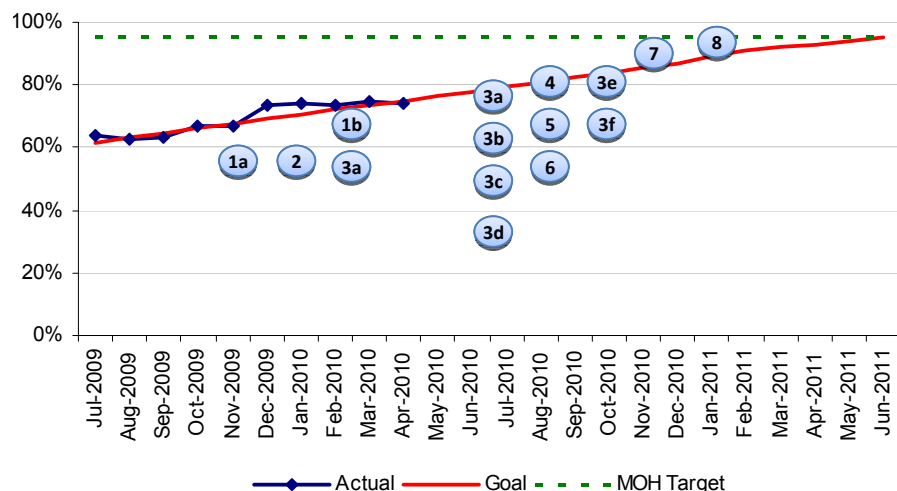
Reduced Ambulatory Sensitive Hospital Admissions  
Increased Regional Service Planning  
Confirmed Service Coverage  
Elective Services Standardised Intervention Rates (SIRs) met  
Increased funding for Māori health and disability initiatives  
DHB confirmation and exception reports – risk management  
Improved breast-feeding rates

### **Ownership Dimension**

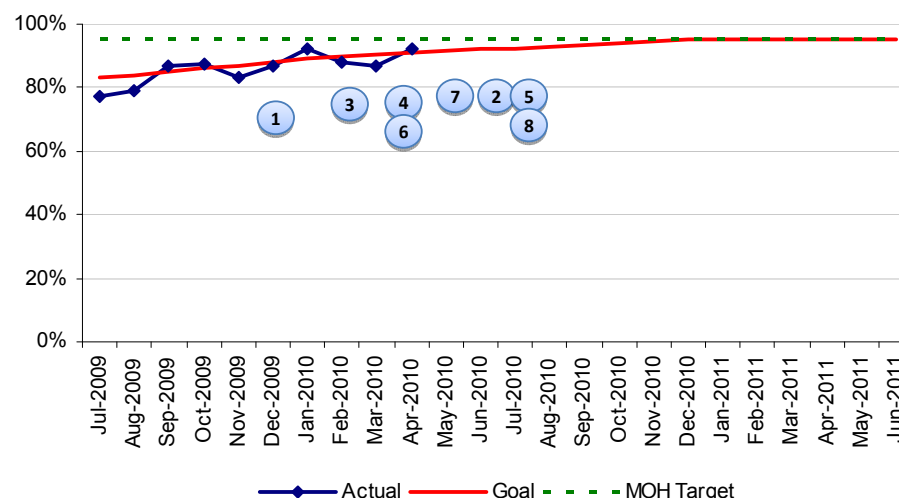
Low Staff Turnover  
Capital Expenditure managed to plan  
Shortened Elective and Arranged Inpatient Length of Stay  
Shortened Acute Inpatient Length of Stay  
Improved Theatre Productivity  
Increased Elective and Arranged Day Surgery (Daycases)  
Increased Elective and Arranged Day of Surgery Admission (DOSA)  
Reduced Acute Readmissions to Hospital  
Reduced Mortality  
Improved quality of data submitted to National Collections  
Output Delivery managed against plan  
Participation in the national patient satisfaction survey

## Auckland DHB progress against the six national target areas

**Patients admitted, discharged or transferred from Emergency Dept within 6 hours (adult acute patient flow). Actual versus target, July 2009 to June 2011**



**Patients admitted, discharged or transferred from Emergency Dept within 6 hours (child acute patient flow). Actual vs target, July 2009 to June 2011**



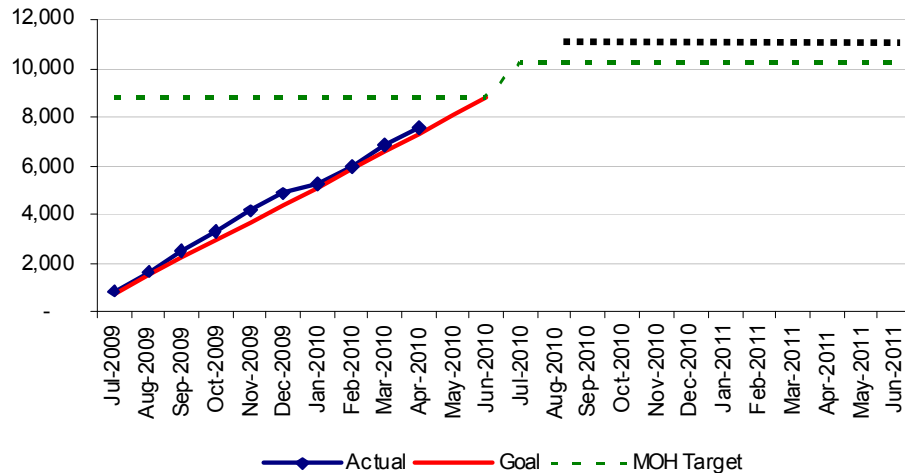
### Recent and current activities:

1. Additional beds opened in a) November 2009, and b) January 2010
2. Improved measurement systems to better identify clinical short stay patients
3. Reducing ward occupancy
  - a) Expediting patient discharges from wards by the introduction of daily 'rapid rounds' - completed in General Medicine wards - now being implemented into Orthopaedics and General Surgery
  - b) Increase the number of weekend discharges in General medicine and Orthopaedics
  - c) Improve the volume and accuracy of estimated discharge dates in General Medicine wards
  - d) Reduce short stay (<24 hr) admissions
  - e) Remove delays associated with NASC referrals
  - f) Remove delays associated with Taikura Trust patients
4. Bed management CMS system enhancements
5. Improved ED / Inpatient Team methods of communication
6. Increased Operational management
7. Improved scheduling of elective volumes
8. Phase 3 improvement initiatives focusing on occupancy and specialty service response time.

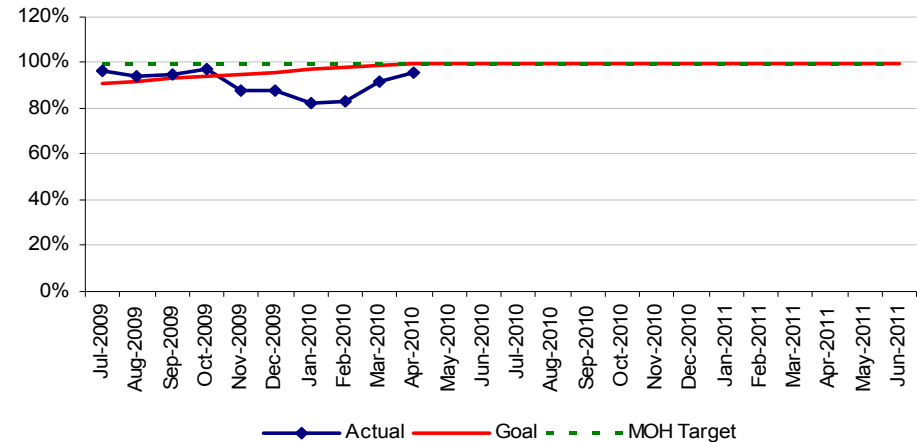
### Current activities:

1. Improved measurement systems to better identify clinical short stay patients
2. Improved bed management and patient transfer process
3. Expediting patient discharges from wards by improved application of estimated discharge dates
4. Development of weekly dashboard reporting for CED to better track performance
5. Workstream recently commenced to reduce short stay (<24 hr) admissions
6. Weekly communications of performance to ward level
7. Development underway of daily reviews to identify specific reasons for delays on a case-by-case basis and to communicate findings with relevant teams
8. Development of 'full hospital plan' to improve responsiveness when indicators of 'bed block' developing

**Improved access to elective surgery. Number of elective discharges for ADHB population. Actual versus Target to June 2011**



**Shorter waits for radiation therapy. % of patients commencing treatment within 6 weeks of FSA. And 4 weeks from Dec 2010. Actual vs Target, June 09 to Dec 10.**



\N.B. the dotted line is the adjusted target set on 17 August 2010

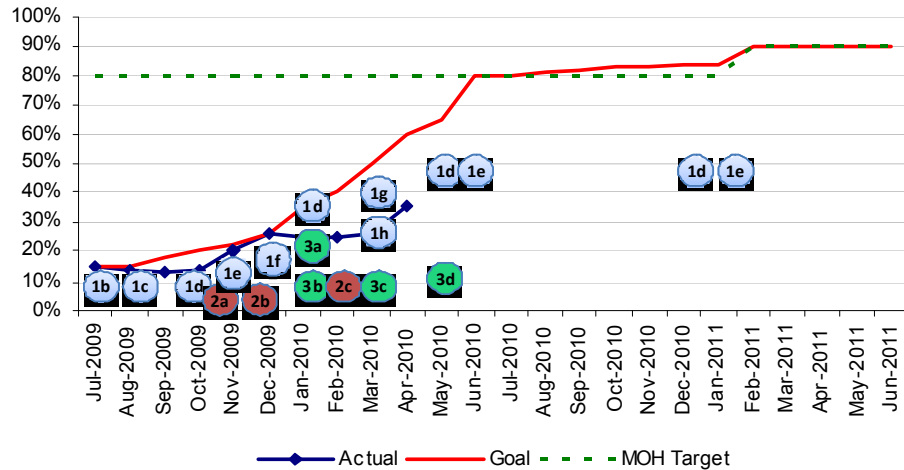
**Planned activities**

- Operationalisation of the Greenlane Surgical Unit
- Additional operating hours at Greenlane
- Increasing DOSA
- Operating Room productivity improvements
- Review booking / scheduling process
- Revise reports and information to better manage schedule
- Improve theatre capacity (refer to graph Reduce Cardiac Waiting List (pg 6 of this plan))
- Service level strategies to manage demand

**Current activities:**

- Weekly prioritisation meetings continue, with a focus on detailed scheduling to review and accommodate urgent referrals as well as manage fluctuations in demand.
- Development of a capacity modelling tool for future planning and management of workload based on acuity and demand (implement April 2010).
- Evening shifts have been extended until the end of May - this provides an additional 3 Linac treatment hours per day.
- Process analysing opportunities to improve the provision of radiation therapy treatment and services to meet MOH targets
- Outsourcing to Waikato Hospital - contingent on current wait time status, 9 patients have been treated at Waikato since mid Jan.
- Continue to prioritise the "flexible working hours" project to identify ways of increasing the treatment capacity within available FTE.
- Presentation of the business case for the replacement of MV5 to Regional Capital in March and ADHB Expenditure committee in April. On commissioning (Jan 2011) this will increase treatment capacity by approx 5 hours per day.
- Agreement with ARO to outsource a minimum of 50 Patients per annum to manage peaks in demand.

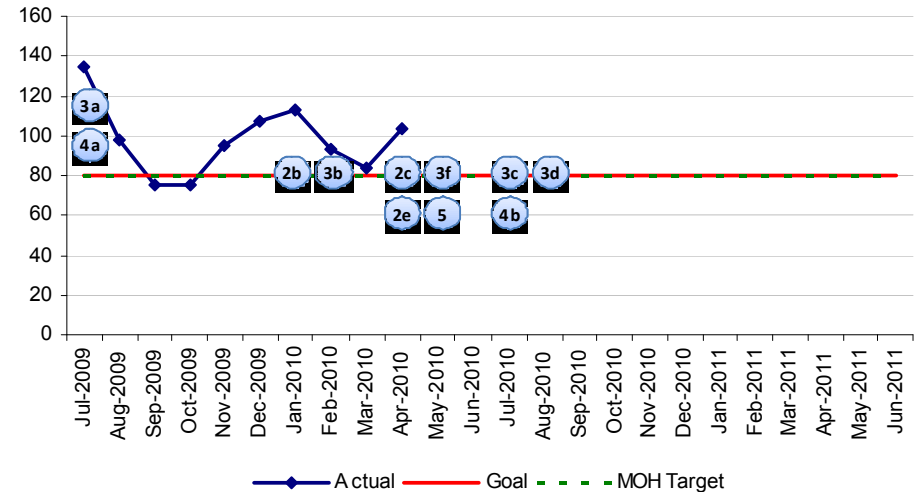
**Better help for smokers: % of hospitalised smokers provided advice and help to quit. Actual vs Target, June 2009 to June 2011**



**Recent and current activities:**

1. Training and coaching in The ABC of Smoking Cessation
  - a. Clinical coding team updated re ICD codes for smoking brief advice & support
  - b. Nurse training. 1500 nursing staff attended education sessions on ABC
  - c. 240 ADHB staff completed MoH National Smoking Cessation ABC on line
  - d. House Officer training on ABC and prescribing NRT at Quarterly orientations
  - e. Registrar orientation ABC training ongoing.
  - f. Standing Order training commenced
  - g. Staff coaching programme to support staff confidence in completing ABC
  - h. Implement strategy to improve medical staff buy in
2. Review of documentation & systems to support clinical staff do ABC & coding.
  - a. Standing Order for NRT rollout commenced.
  - b. Mental Health Tobacco Assessment live on HCC
  - c. Smoking Cessation ABC included in Electronic Discharge Summary
3. Monitoring, feedback & communication to improve performance
  - a. Monthly feedback to GMs, Service Managers and Charge nurses commenced
  - b. Ward Audits and feedback on documentation
  - c. Revised Communications plan to be implemented
  - d. World Smokefree and Ask About the Elephant Promotion 31 May

**Reduce cardiac waiting list. Actual versus Target, July 2009 to June 2011**

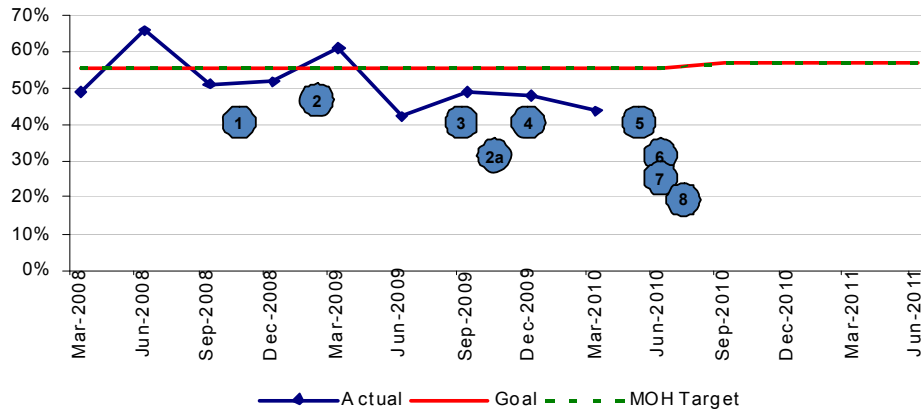


Although the target for 2010-11 is 80 (as agreed and based on the production plan / capacity available to manage this number) we will endeavour to get that to 60, as a buffer in case of any adverse impact. e.g. more referrals than anticipated or a critical member of staff is not available or strike action etc.

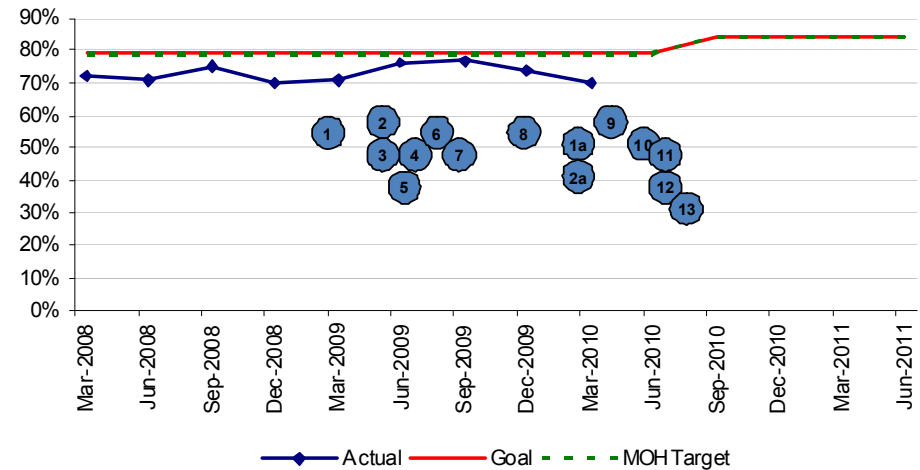
**Recent and current activities:**

1. Initial drive for an improvement to the waiting list
  - a) Successful recruitment campaign for CVICU nurses shortage
  - b) Outsource push to reduce the waiting list
2. Improve measurement and reporting
  - a) The development of improved operational measurement systems
  - b) The development of surgical clinical outcome reporting
  - c) Ongoing improvement of CTSU Throughput Meeting
3. Co-ordination & synchronisation between units to improve utilisation & throughput:
  - a) Daily bed management meeting
  - b) Development of online scheduling system
  - c) Development of ward load planning system
  - d) Development of the patient pathway management system
  - e) Capacity plan model developed for CVICU and Ward 42
  - f) Flex CVICU roster to optimise resource cover and reduce cancellations
4. Reduce patient related cancellations
  - a) Initiation of pre-admission process/clinic
  - b) Review & refine referral process to achieve 'full kit' patient information
5. Provide clinical leadership
  - a) Evaluate the position of 'Cardiac Clinical Leader'

**Diabetes Annual Checks  
Target vs Actual, March 2008 to June 2011**



**Get Checked patients with HBA 1c<8  
Actual vs Target, March 2008 to June 2011**



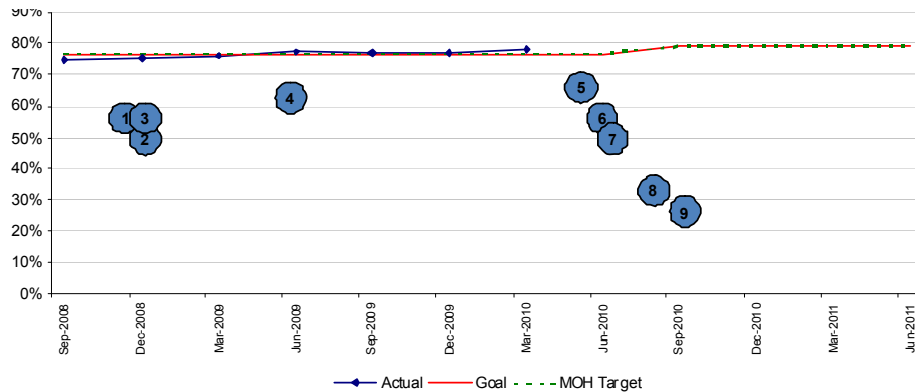
Recent and Current activities:

1. Increase awareness project with PHOs driving information share
2. Practise based data (results) feedback
  - a) Increase feedback options
3. Improved understanding of IT linkages in Practice systems
4. Auckland Diabetes Advisory Team- structured district plan of action
5. Routine reports to clinical advisory leadership meetings
6. Developing shared care pathway
7. Regional shared care pathway work
8. Develop regional shared target setting and service outcomes

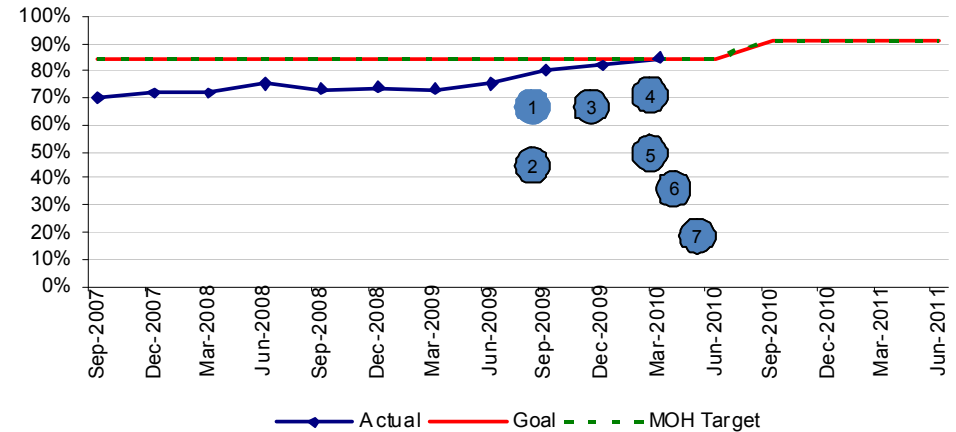
Recent and current activities:

1. Increase awareness project with PHOs driving information share
  - a) reinforce awareness
2. Practise based data (results) feedback via various mediums including Health point
  - a) increase feedback processes
3. Direct Secondary Service phone support for GPs
4. Increased community shared clinics with secondary care
5. Increased SE Asian Nurse Specialist access
6. Opportunity for self-management to include greater than 2 yr or less diagnosed people with diabetes
7. Improved culturally appropriate self management courses
8. Improved understanding of IT linkages in Practice systems (linking PPP)
9. Auckland Diabetes Advisory Team – structured agreed district plan of action
10. Redesign the supported self management to meet needs of population
11. Developing shared care pathway for Diabetes
12. Regional shared care pathway work including clinical workshop
13. Application for HRC funding to evaluate telephone support for LTC: Diabetes

**Cardiovascular risk screening  
Actual vs Target Sept 2008 to June 2011**



**Percentage of two year olds immunised  
Actual vs Target Sept 2007 to June 2011**



Recent and current activities:

1. Support the uptake of an electronic CVD tool
2. Training and information system support for electronic tool
3. IT help line for GPs for risk assessment tool
4. Increase the cumulative incentive payments for achieving both good assessment and good management together
5. Review and reshape incentives to link with PPP targets
6. Enhance links to Green Rx and maximise primary care uptake
7. Continue to work in various workplaces to enhance CVD risk assessment for men
8. Link in with research looking at ways to optimise Pacific males participation in health self management
9. Work regionally to have similar focus on incentive goals

Current activities:

- Practice level reporting available
- Primary care Immunisation Co-ordinators funded
- ADHB Immunisation Strategy approved
- Submission to Health Select Committee on actions to improve immunisation coverage
- Funding application made to Starship Foundation to fund social marketing programme
- Meeting of regional DHBs to agree regional immunisation target held
- Immunisation Governance Group exploring service delivery models to achieve maximum coverage

## Summary of developments proposed for 2010-11

### Financial pressures

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.

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### Contract review

All external contracts for discretionary health services, funded directly by Auckland DHB, will be subject to a review process in 2010-11. The review will investigate whether contracts are producing the best value for money (effectiveness, equity, efficiency and whānau 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.

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### 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 that submitted business cases to the Ministry of Health are:

- 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

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 region:

- 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

In line with the Minister's expectations re primary health care, the number of our PHOs in the Auckland DHB area may reduce from 5 to 4 in the 2010-11 year with further consolidation expected.

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**Work associated with service quality and efficiency**

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 quicker 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

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**Resident Medical Officers**

Although Resident Medical Officer shortages have reduced across the region, there are services where the problem is significant e.g. General Medicine, Psychiatry and Emergency Medicine. Strategies to improve retention and recruitment include reviewing the relevant rosters, service wide systems improvements to improve staff satisfaction, and improvements to the training and supervision of Resident Medical Officers.

Wider region-wide initiatives include improving allocation of rotations to ensure registration for post graduate year 1s, and to suit career pathways for post graduate year 2s and more senior Resident Medical Officers.

## **Regional work**

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 puts the focus of activity 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.

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## **Reducing inequities**

Auckland DHB retains a strategic focus on reducing existing inequalities in health status. Targeted activities are required to 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 DHB 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 Better, Sooner, 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.

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## **Changes as a result of the local body elections 2010**

Membership of the Board governing the Auckland DHB (and the Board's 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 election process with the remainder, and position of chair, appointed by the Minister of Health.

Changes to the Board and Advisory Committees 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.

**Auckland City Hospital Car Park Building**

In late 2009 the Auckland DHB Board approved the business case for a new Auckland City Hospital Car Park Building. This is the final component of the site master plan conceived under Auckland DHB's Health Services Delivery Plan designed to ease access to the Grafton site for patients and visitors. Resource consent has been obtained, building design has been finalised and tenders called for its construction. Subject to ministerial approval, Auckland DHB plans to commence this project in mid-2010.

The new Auckland City Hospital Car Park Building / Retail Commercial space is expected to cost approx \$18 million. It will provide 407 patient / visitor parks on six levels, immediately adjacent to the hospital main entrance. This will significantly improve public access and way-finding on the site. The current public parking is remote from the main entrance and this has led to problems for patients / visitors with respect to way-finding and travel distances on the site.

The project will also free up extra parking on the Auckland site for use by staff. A shortage of staff parks on the site means that Auckland DHB leases parks in Newmarket and shuttles staff to and from the hospital. This is inefficient and costly. Once the Auckland City Hospital Car Park Building is complete most of these staff will be able to park on the Grafton site and Auckland DHB will be able to eliminate the off-site parking costs.

The Auckland City Hospital Car Park Building will also have two levels of retail / commercial tenancies on the Park Road boundary of the site. This was required in order to obtain Resource Consent, but also contributes to a positive Net Present Value and enables Auckland DHB to make more effective use of its resources.

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**Incident management preparations in preparedness for the Rugby World Cup**

Police are the lead agency for the Rugby World Cup and are responsible for coordinating planning at national, regional and local levels. Planning is taking place internally and externally to health with the Manager, Emergency Management Service engaged to ensure good alignment of approach.

Auckland DHB planning will encompass a range of scenarios, including the implications that increased visitor volumes may have for primary care. A Steering Group has been formed to complete a multi-phased project, the first of which incorporates a review and redevelopment of existing plans. Secondly, exercises and evaluation of key planning components will identify gaps. Finally, the corrective measures and re-validation phase will address any deficiencies in planning prior to the start of the Rugby World Cup.

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**Improving Hospital Productivity, Quality and Patient Safety**

All district health boards have identified the need for improving hospital productivity and quality to meet the service delivery expectations and to address the financial challenges we face in tight fiscal times.

In 2009-10 we established a target for productivity improvement of 3%. This target needed to be achieved while improving the quality and safety of the services we provided. Approaches to accelerate our progress in this area include.

1. Elevating quality and productivity to the top of our agenda by implementing a performance reporting process to ensure visibility of results
2. Formal change projects using proven methods that engage staff to target both productivity and focus on the patient journey. This ensures quality and safety were also enhanced
3. Communication and engagement of staff to identify opportunities for improvement and implementing changes within their

**Improving Hospital Productivity, Quality and Patient Safety (cont)**

workplaces

4. Implementing the national quality improvement projects to reducing medication errors and hospital acquired infections while learning from our serious and sentinel events

The areas for improvement focussed on administration expenses, ward productivity and clinical variation/ waste reduction, reduced procurement spend and increased collective service planning. We have been successful in delivering the targeted improvement with our overall productivity improvement of 3% expected to be delivered while patients are experiencing shorter wait times and better service quality.

For 2010-11 a target of 4% productivity is built into our budget. This will be delivered via the actions described in section 2.1c of this Plan. We will take a broad approach to the areas of improvement by engaging our clinical and administration staff.

A summary of the approaches include:

- reducing variation and waste, e.g. Ward and Operating Room productivity, cancer waiting times, day of surgery admission rates, cardiac surgery throughput, and emergency department length of stay
- improving our focus on key quality and productivity KPIs
- enhancing our benchmarking and target setting processes
- working regionally and across the system on planning, procurement, and new service delivery approaches (primary care)
- working to improve the morale and wellbeing of our staff

Patient Safety and Performance Improvement is the “only game in town”.

Each service has a Clinical Director and Nurse Advisor role to provide clinical leadership and effective management of the area, including service development planning. Clinical Directors partner with the Service Managers and other clinical partners e.g. Nursing and Allied Health, to ensure plans are in place and followed through.

All service improvements use members of the leadership team in a sponsor role. General Managers and their clinical partners ensure that each service plan is linked to others; that there is cohesive development across similar areas of service provision; and that District Annual Plan and District Strategic Plan requirements are met.

## The Auckland DHB Health Care System

<b>A population health focus</b>	Lifting the health of people in Auckland city requires a broad view of health. A population health approach includes prevention, helping populations at risk, treatment and management of early-stage disease as well as a range of hospital and support services. Population health means intervening at the earliest possible stage of a health problem, especially those such as cardiovascular disease (CVD) and diabetes which can have long term and serious health impacts. We are especially concerned that children get the best start in life and are protected from adverse events such as communicable disease and domestic violence. Our Board is determined to see infant, child and family/whanau health improved in Auckland city. There is also attention to health inequities. Special and remedial actions are required for groups in our city via tools, like the Ministry of Health HEAT assessment, that ensure service innovation and change is of direct benefit to the groups living with the greatest disadvantage.
<b>A continuum of service</b>	People living in Auckland city have access to the full range of services along a continuum from prevention and health promotion, to specialist treatments and, when needed, hospice or palliative care. The challenge is to achieve better integration of these services. Health care providers receive the training and support needed to work across this continuum. We are also doing more to enhance patient feedback systems and to respond to suggestions made by advisory groups, consumer panels and via consultation.
<b>Primary health care</b>	Primary care services reach people close to their homes and in the settings that work best for them. Better, Sooner, More Convenient Primary Care is a priority of Government with significant changes underway re Primary Health Organisations (PHOs). Three primary care business cases have been developed which propose to integrate services for patients and which increase clinical leadership in health decision making. In future there will be more hospital-based clinical and management expertise supporting primary care and other community-based providers. Working with our PHO partners we continue our emphasis on Cornerstone quality accreditation and quality improvement. We are committed to working with the new national quality standards and our PHOs in the new environment. The new regional service developments in primary care also make a commitment to Whanau Ora, the Maori approach to health and wellbeing.
<b>Collaboration</b>	A continuum of care that meets patient needs should work across services. Integration is key. 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 are in partnership with community-based providers of care and other stakeholders. We address the wider determinants of health by working with local government, housing, employment, social development and education. 2010-11 will see the three DHBs in the greater Auckland area working more closely together. This will achieve a better use of resources available in the region. It also recognises that Aucklanders are mobile and use health services across the various city boundaries.
<b>Cost effective</b>	The focus on improving productivity and value for money continues. To breakeven we ensure that every dollar available to the DHB is well spent. Strong financial discipline ensures that resources are available to meet the expectations of our local population as well as the expectations of us as a Crown Entity. More attention will be paid to the contracts we hold with providers including our own hospital and related services. Through a contract review process we will assess if the funding can be better allocated or if there is some way to achieve health gain more effectively. The process will comply with the requirements of the Operational Policy Framework.

## Activities that support the Auckland DHB health care system

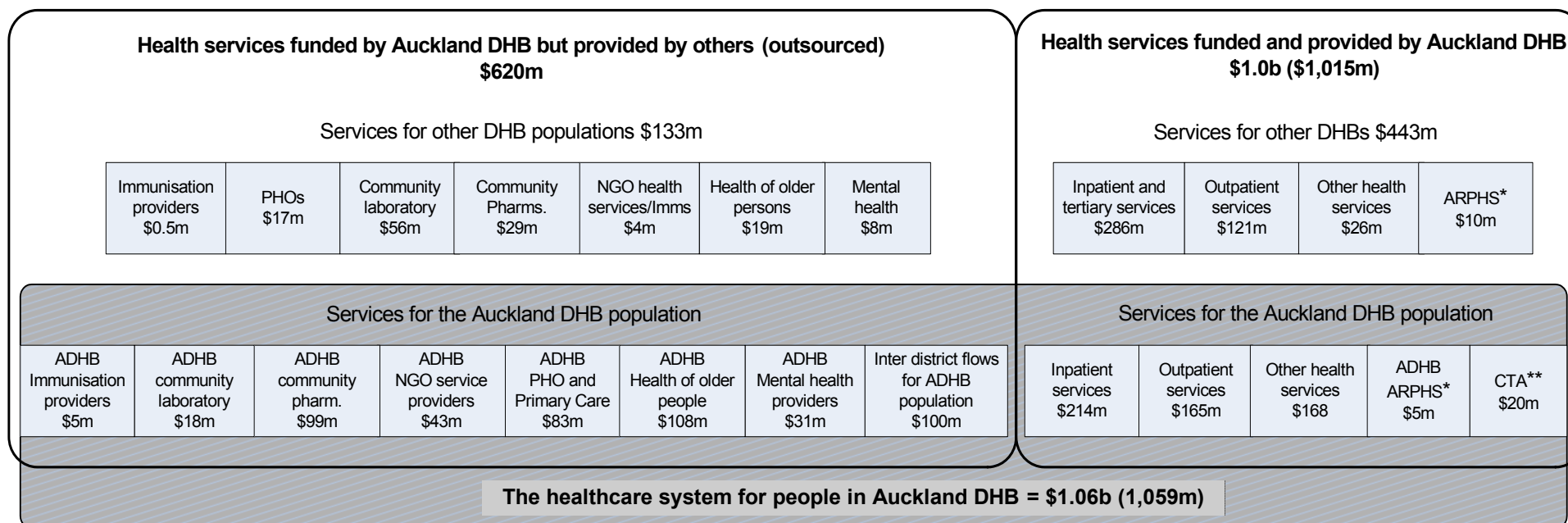
Auckland DHB's health care system includes a wide range of services from health promotion and prevention work through to the secondary and specialist services provided by our hospital. The total value of services is approximately 1 billion dollars for the Auckland DHB population.

Some funding for services comes directly from the Ministry of Health, e.g. public health services and from the Clinical Training Agency (to cover costs associated with junior medical training). Auckland DHB also provides services for other DHBs to the value of \$576 million.

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

The right component 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 shaded area 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.



\* ARPHS is the Auckland Regional Public Health Service; provided by ARPHS for the region

\*\* CTA is the Clinical Training Agency

## 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 is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB and Waitemata DHB 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.
- Population screening – the principle roles for Auckland Regional Public Health Service are:
  - provision of Public Health advice to District Health Boards on screening
  - provision of management and oversight of the National Immunisation Register (NIR) and the National Cervical Screening Programme (NCSP) Register

## 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. Some of the services listed below are covered by a regional contract and are for people living across the wider Auckland region. 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. Changes to primary care are underway in accord with Government requirements.

### *Summary of other services (non-hospital)*

<b>Type of provider</b>	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
<b>Total number of providers</b>	374
<b>Total value of services</b>	\$578,991,279
<b>Total number of beds in the community</b>	4,597

## Primary health care

Changes are forthcoming re primary health care via business cases submitted for Minister of Health approval. National and local objectives for Better, Sooner, More Convenient Primary Health Care will be achieved through implementation of the approved business cases. 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 2009-10 primary health care was delivered under five Primary Health Organisations serving people living in the Auckland region as per the breakdown below. AuckPAC will no longer exist as a result of the Alliance Health+ business case, and the Tongan Health Society will function within the consortium as an NGO. This means Auckland DHB will move from six PHOs to four by the end of the 2010 calendar year. Further consolidation is expected over the next financial year.

Primary health organisation (PHO)	% Maori	% Pacific	% Other	Total no. enrolled	% of total	No. full-time drs
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
<b>Total enrolled population: Auckland DHB</b>	<b>26,011</b>	<b>64,531</b>	<b>366,320</b>	<b>456,862</b>	<b>100%</b>	<b>417</b>
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%	
<b>Total % of Aucklanders enrolled in any PHO (regardless of the DHB that funds it)</b>	<b>73%</b>	<b>110%</b>	<b>90%</b>	<b>411,965</b>	<b>91%</b>	

## Priority focus for Primary Care

The following table outlines the focus for regional work associated with the development of primary care business cases. Auckland DHB will be a major partner in this work but all deliverables are the responsibility of the primary care initiatives approved by the Minister of Health. Auckland DHB is committed to working with the three Auckland Business Cases in their successful implementation.

### Specific deliverables for each service area of primary healthcare (business case)

Service Area	Key Result Area	Key Performance Indicator	Implemented by
<b>Access to Diagnostics</b>	Software development	ProExtra Demand Management tool and web based triage tools complete and ready for installation	30 June 2010
	Regional acceptability and feasibility	Regional impact assessment complete	31 July 2010
	Software implementation	Installation and training complete for all 100 Auckland DHB practices	31 Dec 2010
	Community access	Community providers contracted for direct GP referrals	31 Dec 2010
	Software implementation	Installation and training complete for all Waitemata DHB and Counties Manukau DHB practices	31 Dec 2011
<b>Access to minor surgery/skin lesions</b>	Minor surgery within primary care	100% increase in publically funded minor skin lesion procedures in primary care over 2008-09 volumes	30 Sept 2011
<b>Clinical Pathways</b>	Phase 1 : Clinical Pathway: Dyspepsia Commence Re-Implementation of Pathway for Gastroenterology:	Reduction in all Secondary care FSAs for Dyspepsia for all those participating in programme Reduction in unnecessary Gastroscopies in Secondary Care by up to 30% for referrers participating in programme Reduction in time to wait for a Gastroscopy in secondary care to clinically appropriate timeframe	30 June 2010  with 30% implementation by 30 June 2010
	Regional Clinical Pathways working group across the care continuum	Establish with Terms of Reference and Scope to include regional process to be undertaken to solve the problem	31 May 2010
	Phase 2 : Areas for regional Clinical Pathways	A minimum of five prioritised, selected and agreed across GAIHN Clinical Pathway development completed for each of five areas Key performance indicators developed Processes implemented and tested Commencement of minimum of five Clinical Pathways	30 June 2010 31 March 2011 30 April 2011 15 June 2011 30 June 2011
<b>Pharmaceuticals</b>	Resource Management - Pharmaceuticals	Reduction of \$1.5m actual verses budgeted pharmaceutical expenditure (including drug cost and dispensing fees) for the Pilot Programme GPs in 2010-2011	30 June 2011

Service Area	Key Result Area	Key Performance Indicator	Implemented by
	Quality use of medicines	Conduct medication reviews within a sample of residential care facilities Evaluate the impact of the medication reviews	30 Sept 2010 March 2011
<b>Acute Demand/POAC</b>	Reducing Acute Demand through POAC	50% increase in budgeted POAC volumes (i.e. over 5,000 additional referrals)	30 June 2011
<b>After Hours/Extended Hours</b>	After Hours Network Phase One	Development of a regional after hours plan A minimum of 10 operational clinics until 10pm across region Increased availability of regional triage and disposition Availability of essential medicines Measurable reduction in inappropriate presentations to emergency departments across the region within 12 months	1 July 2010
<b>Pharmaceuticals</b>	Resource Management - Pharmaceuticals	Reduction of \$1.5million actual versus budgeted pharmaceutical expenditure (including drug cost and dispensing fees) for the Pilot Programme GPs in the 2010 - 2011 financial year	30 June 2011
<b>Maori Services Devolution</b>	Phase One Devolve all non core Maori specific services currently provided by DHBs to Iwi / Community	Potential devolution of delivery of the following services, in accordance with current contract deliverables: <ul style="list-style-type: none"> <li>- Well Child services in community</li> <li>- Parenting programmes in community setting</li> <li>- Healthy Lifestyle planning in community setting</li> <li>- CAYADS- Drug and Alcohol services, in community setting</li> </ul>	30 June 2011
	Phase Two- Review of DHB services that have high Maori service utilisation, or services of high priority for Maori that are under-utilised	Identification of services for devolution Development of a regional devolution template Literature review to identify evidenced for Indigenous community service models Assessment of Provider capacity Development of service devolution implementation plan, to include change management strategy, and risk management contingencies Key stakeholder engagement process Sign off for Iwi / MOU	31 Dec 2010  Board Recommendation February 2011
	Phase Three Implementation of service review recommendations for service devolution across three DHBs	Contract negotiations- DHB / Ministry of Health Implementation of service devolution	30 June 2012

## Enhancing PHO approaches to the management of long term conditions

Service Area	Key Performance Indicator	Implemented by
<b>Cardiovascular disease</b>	<p>Work with all PHOs to ensure that their CVD risk assessment tool enables accurate data collection</p> <p>Actively utilise and report annually on the care planning for individuals screened whom have either diabetes or a risk assessment &gt;15%</p> <p>Review incentives programme for practices to promote good practise. Incentives programme for implementation in the 2011-2012 year agreed</p> <p>Implement and evaluate two cardiac rehabilitation programmes delivered in the community</p> <p>Review trend in utilisation of stroke unit quarterly for incremental increases of care being delivered in the dedicated unit</p> <p>Review and monitor the direct GP referrals to the TIA team for rapid assessment and decreased progression to acute stroke outcomes</p>	<p>Dec 2010</p> <p>Dec 2010</p> <p>Six monthly</p> <p>Six monthly</p>
<p><b>Regional Health Targets for CVD risk assessment</b></p> <p>(agreed as part of the business case)</p>	<p>80% of the total eligible population will have a CVD risk assessment undertaken within the previous 5 years</p> <p>Link outcomes to PHO Performance Programme (PPP) scheme to maximise incentives</p> <p>Work with the ministry of health to ensure the denominators for health targets and PHO Performance Programme are the same so that the same data set is being used for all reporting regardless of the interval</p>	<p>Dec 2011</p> <p>July 2011</p>
<b>Diabetes</b>	<p>Initiate a raising awareness process with all PHOs to reinforce the DGC (Diabetes Get Checked) annual check for their diabetes population. All practises contacted routinely use existing communication networks to keep Diabetes Get Checked high on practice awareness with notices reported quarterly</p> <p>Updates of progress towards targets reported quarterly at Local Diabetes Team meetings</p> <p>Review existing supported self-management processes, including Kaupapa and other high needs groups, and implement new approach</p> <p>Implement community retinal screening service</p> <p>Review of self-management opportunities to include the introduction of refresher updates for</p>	<p>September 2010</p> <p>Bi-monthly</p> <p>August 2010</p> <p>Jan 2011</p> <p>Progress reported Dec 2010</p>

Service Area	Key Performance Indicator	Implemented by
	<p>people with diabetes diagnosed greater than 2 years ago</p> <p>Review and strengthen links to wider lifestyle activities such as green prescription to support effective self management</p>	
<p><b>Regional Health Targets</b> (agreed as part of the business case)</p> <p><b>Diabetes Detection</b> Improve diabetes detection across the region for total population to 55%</p> <p><b>Diabetes Management</b> Improve good diabetes management across the region to 70%</p>	<p>Establish regional collaborative clinical networks to promote awareness and increase the uptake of annual diabetes get checked</p> <p>Establish methodology for setting PHO and practice targets that lead to DHB targets being met. PHOs commit to reaching targets by working with their practices</p> <p>Establish regular reporting at DHB, PHO, and practice level with sharing of DHB/PHO level information at 3 Better, Sooner, More Convenient Consortia CVD/Diabetes clinical network meetings</p> <p>Review regional diabetes contract differences (as part of the Long Term Conditions review) and develop a strategy for appropriate collaborative approaches to regional contracting including incentives</p> <p>Regional diabetes care pathway developed and agreed</p> <p>Promote strategies for greater identification and proactive care for those patients with HbA1c&gt;8</p> <p>Diabetes Care pathway implemented including agreed quality improvement framework</p> <p>Regional agreement on core competencies for diabetes self management courses</p> <p>Collaborative approaches to workforce development for self-management skill development</p> <p>Examine opportunity for regional governance based on local diabetes teams</p>	<p>July 2010</p> <p>Sept 2010</p> <p>Sept 2010</p> <p>July 2010</p> <p>Dec 2010</p> <p>Dec 2011</p> <p>Dec 2010</p> <p>Dec 2010</p> <p>July 2011</p>
<p><b>Better help in primary care for smokers to quit</b></p>	<p>Maintain contracts for smokefree coordinators in Primary Care to facilitate systems and processes to assist in reaching the target and training of primary care workforce in ABC</p> <p>Joint communication plan developed with secondary care</p> <p>Primary care representatives continue to be represented on Auckland DHB Tobacco Control Steering Group</p> <p>Review clinical leadership in primary care and develop closer links with clinical leadership in secondary care through workshop</p>	<p>by Sept 2010</p> <p>by Sept 2010</p>

## 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.

<b>Auckland City Hospital</b>	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
<b>Greenlane Clinical Centre</b>	Provides advanced outpatient, ambulatory services, and short-stay surgical care
<b>Community-based services</b>	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 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 focus for the Provider (hospital and related services)

Area of focus	Process underway	Specific initiatives 2010-11
<p><b>Shorter Stays In Emergency Departments</b></p>	<p>Auckland DHB has a delivery plan for decreasing patient time in our Emergency Departments. This will be an area of considerable focus for 2010-11</p> <p>The project is titled 'the acute patient flow project' to ensure it maintains a whole of systems view. The project structure will remain in place for the 2010-11 year with two streams of work; one for Children's Services with the other for Adult Services.</p> <p>The General Manager Operations is overall sponsor for both with the General Manager Children's and General Manager Adult, sponsor of the respective programmes.</p> <p>The approach is a whole of systems with the improvements required divided into the 3,2,1 areas. As part of this each steering group includes the clinical lead and representatives from each part of the system. These are primary care, Emergency Departments, inpatient services as well as daily operations.</p> <p>The two streams have identified the different areas of work required and have commenced work with the analysis of the impact on how and when this will achieve the target.</p> <p>The areas of work differ between to two services depending on the constraints identified in the define stage of the programme. These include pre hospital, capacity, systems and process changes, work flow within each of the 3,2,1 components, access to supporting services, patient journey, bed management, discharge practices.</p>	<p>Improved measurement systems to better identify clinical short stay patients in emergency departments</p> <p>Improved staffing and processes within our emergency department (ED)</p> <p>Reducing ward occupancy through:</p> <ul style="list-style-type: none"> <li>• expediting patient discharges from wards by the introduction of daily 'rapid rounds'</li> <li>• increase the number of weekend discharges</li> <li>• improve the volume and accuracy of estimated discharge dates in wards to improve planning and communication for patients and families</li> <li>• reduce short stay (&lt;24 hr) admissions</li> <li>• improved bed management planning and communication</li> <li>• improved ED / inpatient team methods of communication</li> </ul> <p>Develop the Greenlane Surgical Unit</p> <p>Work on improving the discharge planning process is well underway, with several wards implementing the concept of 'Rapid Rounds' to facilitate improved communication and planning between specialities.</p> <p>Staged introduction of a Releasing Time to Care programme led by ward nursing teams – with the goal of reviewing ward systems and processes to greatly increase the time that nurses have available to spend directly with patients and their families</p>
<p><b>Improved access to elective surgery</b></p>	<p>A process improvement approach commenced prior to 2010-11 that will incorporate all initiatives under one umbrella. This will be sponsored by the CEO and led by the General Manager Operations with a Clinical Lead.</p>	<p>Increasing capacity through a number of projects</p> <ul style="list-style-type: none"> <li>• Acute patient flow project</li> <li>• Releasing time to care</li> <li>• Increase of weekend discharges</li> <li>• Opening of the Greenlane Surgical Unit. As part of the</li> </ul>

Area of focus	Process underway	Specific initiatives 2010-11
		<p>Greenlane Surgical Unit project the patient flow is being redesigned to shorten the process. The target of 60:60 (Sixty days maximum for FSA and 60 day maximum for surgery is designed for Greenlane Surgical Unit. The next stage involves expanding this to other services.</p> <ul style="list-style-type: none"> <li>• Implement an adaptive capacity (production planning) tool by service</li> </ul> <p>Increase DOSA rates</p> <p>Implement the Productive Operating Room within one Operating Room suite</p> <p>(see appendix 8)</p>
<p><b>Cancer Treatment:</b> <b>Reduce waiting times for access to cancer services</b></p>	<p>Develop a <b>Strategic Plan for the Sustainable delivery of Radiation Oncology for the Northern Region to 2019</b>.</p> <p>This is a 10 year plan developed jointly by the region to deliver the appropriate level of services to the Northern region population. The plan incorporates the capacity requirements and a strategy to deliver the optimal configuration of public and private radiation therapy services for the future.</p> <p><b>A regional communication strategy</b> which provides stakeholders with detailed information about waiting times and ongoing service improvement initiatives.</p> <p><b>Radiation Oncology operational capacity modelling.</b> A tool to enable capacity forecasting based on referrals by triage category is currently in development. This will enable the service to flex proactively to meet Radiation Therapy waiting time targets. This may include outsourcing to the private sector.</p> <p><b>Project “Operation 28 days”.</b> This project ensures the service identifies and addresses any barriers to patient flow. The goal of the project is to improve the capacity of the service and meet the current 6 week target and the 4 week target from December 2010.</p> <p><b>Flexible Workforce project.</b> This project is focused on working</p>	<p>Radiation Therapy Strategic Plan signed off by northern region CEOs in 2010. Implementation of new technology commencing 2010</p> <p>MV5 Linear Accelerator operational by January 2011</p> <p>Regional stakeholders involved in collaborative work with weekly updates</p> <p>Model to be operational by June 2010</p> <p>Lean six sigma project to review use of treatment capacity</p> <p>Operational plan in place by August 2010</p> <p>Project commenced May 2010</p>

Area of focus	Process underway	Specific initiatives 2010-11
	<p>with key stakeholders and union partners with the aim of recruiting and retaining a flexible workforce for the future.</p> <p><b>Project Timely Referral to FSA.</b> This project is focused on reducing the overall time from receipt of referrals to the Regional Oncology service to First Specialist Assessment Clinic.</p>	<p>Project commenced in April 2010</p> <p>Operational plan in place by September 2010</p>
<p><b>Better help for hospitalised smokers to quit</b></p>	<p>Implement an electronic/dashboard system that enables services to monitor their progress toward meeting the 90% target</p> <p>ABC Training Plan reviewed and updated by August 2010 and strategies implemented, including actions to train Kai Atawhai , Kai Manaaki and Kaiawhina on the ABC of smoking cessation and Quit Card provision</p> <p>ABC smoking cessation training handed over to Nurse Educators and included in their core accountabilities</p>	<p>December 2010</p> <p>March 2011</p> <p>February 2011</p>

## Priority and Developmental Work for 2010-11

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

High level strategy	Objective	Strategies to achieve objectives
<b>1.1 Reduce inequities in health status</b>	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: <ul style="list-style-type: none"> <li>– develop Integrated Family Health Centres/Whanau Ora Centres</li> <li>– develop specific activities that achieve Whanau Ora</li> <li>– develop indicator measures for Whanau Ora</li> <li>– develop a Whanau Ora approach for all services devolved</li> </ul>
		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 Auckland City Hospital 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 health care and support services	1.1.4.3 employment and advocacy 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
<b>1.2 Improve outcomes in priority areas</b>		
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 Work with EOI (primary care) respondents on actions to improve immunisation rates to the 91% for Auckland DHB by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised 1.2a.1.3 Work with other regional DHBs and our primary care partners 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 Continued development of the secondary to primary care shift to achieve target of 90% of mental health clients (achieved through extension of ProGRESS+) 1.2c.1.2 Expand primary mental health; implementation of online therapies, appointment of primary care employment support worker, appointment of CSW in primary care to provide psycho-education and psycho-social interventions; and service navigators/coordinators to manage movement through the system

High level strategy	Objective	Strategies to achieve objectives
		<p>1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures</p> <p>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</p> <p>1.2c.1.5 Review and reconfigure the continuum of mental health services to focus on recovery and social inclusion using best practice and evidence based approaches</p>
1.2d Long term conditions	1.2d.1 Strengthen community participation and action	1.2d.1.1 Ensure community participation at a locality level to input into the changes occurring in primary health care as part of the metro Auckland approach to long term conditions
	1.2d.2 Integration of services across primary and secondary care	1.2d.2.1 Work with our primary care partners to develop care pathways across primary-secondary care for at least two common long term conditions (including diabetes)
		1.2d.2.2 Increase the number of GPs using electronic referral systems to at least 10%
	1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions	1.2d.3.1 Meet existing target re number of the eligible adult population having their CVD risk assessed
1.2d 3.2 At least 2 cardiac rehabilitation courses are run in the community		
1.2d 3.3 At least 10% of retinal screening to be undertaken in the community		
1.2d.4 Support whanau and self resilience	1.2d.4.1 Pilot coaching services to support people with long term conditions in line with evidence base	
	1.2d.4.2 Work with our primary care partners to improve outcomes for Maori, Pacific people and other high need groups through a range of strategies that involve families and communities	
1.2e Palliative care	1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	<p>1.2e.1.1 Service redesign for palliative care agreed, and which aligns the specialist and generalist workforce</p> <p>1.2e.1.2 Liverpool Care Pathway trial is evaluated with phase 2 undertaken according to the outcome</p> <p>1.2e.1.3 Review of equipment services so that equipment provision becomes aligned and streamlined by June 2011</p> <p>1.2e.1.4 ProCare palliative care pilot rolled out and evaluated with 2 other PHOs beginning the programme</p>

More detail on some of these performance measures is included on page 36

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

High level strategy	Objective	Strategies to achieve objectives
<b>2.1 Efficient and effective health care system</b>		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Develop a comprehensive metro Auckland primary care plan in collaboration with DHBs and primary care
2.1b Improve primary–secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement regional e-referrals, health event summaries and electronic outpatient letters
		2.1b.1.2 Increase access to diagnostic radiology for primary care by providing community assessment for up to 4,500 procedures and improving access for 16,000 patients
		2.1b.1.3 Shift minor surgery activity into the community, increasing more convenient primary care based treatments for skin cancer across the metro region from 513 to 1200 per year
		2.1b.1.4 Implement a formalised network across Auckland, proving local access to urgent care that will be integrated with general practice services
		2.1b.1.5 Improve access to primary care for palliative care clients by 15%
		2.1b.1.6 Implement a clinically led “proof of concept” process to more effectively manage the community pharmaceutical budget by facilitating appropriate prescribing and safe use of medicines. Target savings of \$1.5m
	2.1b.2 Reduce acute demand	2.1b.2.1 Increase by 50% across the metro Auckland region the number of Primary Options for Acute Care (POAC) referrals (target of 12,500 patients managed in a community setting)
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 17 to 20 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 up rate by 10%
		2.1c.1.3 Improve performance against the Emergency Department six-hour measure

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		<p>from 76% to 95% by implementing project solutions in the adult and children's acute flow projects</p> <p>2.1c.1.4 Improve adult operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes (UK NHS Productive Operating Theatre Programme)*</p> <p>2.1c.1.5 Improve ward productivity by 3% by increasing the number of wards in Adults and Mental Health services using Releasing Time to Care from 6 to 24</p> <p>2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery</p> <p>2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011</p> <p>2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in:</p> <ul style="list-style-type: none"> <li>- General medicine</li> <li>- Orthopaedics</li> <li>- Radiology</li> <li>- Paediatrics general surgery</li> <li>- General surgery</li> <li>- Ophthalmology</li> </ul>
	2.1c.2 Improve mainstream effectiveness	<p>2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches</p> <p>2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori</p> <p>2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11)</p> <p>2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider</p>
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011 2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum
		2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010 2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology 2.1c.5.3 Implement lung and bowel tumour stream models by June 2011
	2.1c.4 Hospitalised smokers given assistance to stop smoking	2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway <ul style="list-style-type: none"> <li>– Implement new model of care and workforce roles in the Greenlane Surgical Centre</li> <li>– Maintain past elective surgery improvement by including primary care in the referral pathways and patient management</li> <li>– Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time</li> </ul>
<b>2.2 Improve leadership capability</b>	2.1c.5 Reduce waiting times for oncology	2.2.1.1 Refine, implement and monitor integrated governance model 2.2.1.2 Monitor and report against “In Good Hands” implementation
	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
<b>2.3 Improve Clinical Quality and Professional Governance</b>	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 discharge process 2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s

High level strategy	Objective	Strategies to achieve objectives
		<p>2.3.2.5 Implement Senior Leadership Team 'Walk-around' safety programme i.e. growth and training in clinical leadership</p> <p>2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement</p> <p>2.3.2.7 Evaluation against Health Excellence Framework</p> <p>2.3.2.8 Continue roll out of Cornerstone accreditation across primary care</p> <p>2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System</p>
	2.3.3 Improve research quality	2.3.3.1 Research strategy developed and approved by Board with annual report on activity
<b>2.4 Strengthen the health workforce</b>	2.4.1 Ensure workforce capability is matched to service delivery current and future	<p>2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces</p> <p>2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme</p> <p>2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015)</p> <p>2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme</p> <p>2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%</p>
<b>2.5 Information management</b>	2.5.1 Improve the resilience and availability of core IT systems	<p>2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time</p> <p>2.5.1.2 KPI reporting for end-to-end application performance in place</p> <p>2.5.1.3 IMTS user satisfaction increases by &gt;10% against previous year</p> <p>2.5.1.4 Number of unplanned system outages reduced from &gt;20 to &lt;5 per month</p> <p>2.5.1.5 Tier 1 system availability increases to &gt;99.95%</p>
	2.5.2 Improve corporate records and knowledge management	<p>2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance</p> <p>2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)</p>
	2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met
<b>2.6 Planning</b>	2.6.1 Long term planning and	2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines

High level strategy	Objective	Strategies to achieve objectives
2.6 Planning (cont)	change management	<p>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:</p> <ul style="list-style-type: none"> <li>- description of future models of care across the continuum of care</li> <li>- plan the shape, size, setting, and location for future services and inter district flow patients</li> <li>- provide the strategic context for major future developments and business cases</li> <li>- develop workforce response to current and long term service plans via regional and the national workforce planning</li> <li>- increase the focus on regional planning and collaboration with the regional primary care business cases</li> </ul> <p>2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to</p>

\* Refer to appendix 8

### Goal 3: Live within our means

High level strategy	Objective	Strategies to achieve objectives
<b>3.1 Break-even position maintained</b>		
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 manage 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 The impacts of any service reconfigurations are managed 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
	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) and assess draft proposals against outcomes and against financial and sustainability risks
	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
<b>3.2 Sustainable balance sheet</b>		
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

## 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 shows our activity in areas of usual business. These go well beyond the targets already covered for 2010-11 activity that is new or developmental.

National performance measures	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	A volume increase nationally for elective surgery has been set at 8,300 discharges for the 2010-11 year. The Ministry of Health requires Auckland DHB to deliver 1,724 of these 8,300 discharges	Meet elective discharge volumes, end of year target: 11,149
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	91% of two year olds immunised (to meet regional target) 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% of eligible hospitalised smokers  80% of eligible patients attending primary care



National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
Better diabetes and cardiovascular services		<p>Increased referral to and participation in diabetes self-management courses by 5% total group</p> <p>5% increase in the number of Maori accessing and completing kaupapa diabetes self management courses</p> <p>Increase retinal screening rate by 2% for people with diabetes for total group from 75% to 77%</p>
Clinical leadership	Undertake and report on a self assessment of the work it has undertaken to improve clinical leadership	Progress on the four measures identified to assess clinical leadership
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 Maori health gain	Report demonstrating seven key aspects how local iwi/Maori engagement and participation in DHB decision-making, development of strategies and plans for Maori health gain	<p>Develop 4 panui per annum to disseminate to Iwi/Maori communities profiling health issues, services and issues important to Maori health</p> <p>Hold 2 DHB and Te Runanga o Ngati Whatua board to board hui per annum</p> <p>Undertake consultation to inform the development of a new Auckland DHB Maori health plan</p> <p>100% of PHOs have Maori Health Plans agreed to by the DHB</p> <p>100% of DHB members have undertaken Treaty of Waitangi training</p> <p>Participation in the Regional Inter-Sectoral Whanau Ora collaborative, contributing a health perspective</p> <p>Develop an integrated and comprehensive Whanau Ora outcomes framework</p> <p>Using the current workforce to address Whanau Ora and identify workforce opportunities to achieve Whanau Ora</p>

National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11																				
Improving mainstream effectiveness	Report providing information on the activities undertaken to improve mainstream effectiveness ensuring clinical safety and effectiveness for Maori	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																				
Waiting times for chemotherapy treatment	Report providing wait times data including an exceptions report where wait times exceed six weeks	100% achievement to target																				
Improving the health status of people with severe mental illness through improved access	The average number of people in Auckland DHB, seen per year (rolling every three months) for: <ul style="list-style-type: none"> <li>child and youth aged 0–19, for Maori, Other, and in total</li> <li>adults aged 20–64, for Maori, Other, and in total</li> <li>older people aged 65+, for Maori, Other, and in total</li> </ul>	Six-month reports confirming access targets as below <table border="1" data-bbox="1294 568 2022 842"> <thead> <tr> <th></th> <th>Other</th> <th>Maori</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Children &amp; 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 +</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>909</td> </tr> </tbody> </table>		Other	Maori	Total	Children & young people: under 19	1.94%	3.44%	2.12%	Adult: 20–64 years	2.93%	8.18%	3.30%	Older people: 65 +	3.49%	2.99%	3.48%	Actual extra number of clients			909
	Other	Maori	Total																			
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Improving mental health services using relapse prevention planning	Report on relapse prevention planning <ul style="list-style-type: none"> <li>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</li> <li>number of children and young people (by Maori, Pacific and total) who have been in secondary care treatment for one or more years</li> <li>number and percentage of long-term clients with up to date relapse prevention/resiliency plans</li> </ul>	At least 95 percent of long-term clients have up-to-date relapse prevention plans by July 2011 <table border="1" data-bbox="1294 951 2022 1142"> <thead> <tr> <th></th> <th>Maori</th> <th>Pacific</th> <th>Other</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>20 years and over</td> <td>95%</td> <td>95%</td> <td>95%</td> <td>95%</td> </tr> <tr> <td>Children &amp; youth</td> <td>95%</td> <td>95%</td> <td>95%</td> <td>95%</td> </tr> <tr> <td>Total</td> <td>95%</td> <td>95%</td> <td>95%</td> <td>95%</td> </tr> </tbody> </table>		Maori	Pacific	Other	Total	20 years and over	95%	95%	95%	95%	Children & youth	95%	95%	95%	95%	Total	95%	95%	95%	95%
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Total	95%	95%	95%	95%																		
DHBs report alcohol and drug service waiting times and waiting lists	Narrative report on: <ul style="list-style-type: none"> <li>name and location of service(s) with the longest waiting time and waiting list</li> <li>explain variances of more than 10% in waiting times or</li> </ul>	Work with Waitemata DHB to get baseline information (NGO and provider arm services) for: <ul style="list-style-type: none"> <li>inpatient medical detoxification</li> <li>social/residential detoxification</li> </ul>																				

National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11															
	waiting lists <ul style="list-style-type: none"> <li>explain/identify targets that the DHB may have for reducing waiting times and or waiting lists</li> </ul> Waiting times reported by Maori and Other ethnicities	<ul style="list-style-type: none"> <li>specialist prescribing</li> <li>structured counselling</li> <li>day programmes</li> <li>residential programmes</li> </ul> Broken down by ethnicity															
Delivery of Te Kokiri: the Mental Health and Addiction Action Plan	Summary report on progress made towards Implementation of Te Kokiri: the Mental Health and Addiction Action Plan	Annual report on progress (in the third quarter)															
Oral health – mean DMFT score at Year 8	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)	Average DMFT Year 8 <table border="1" data-bbox="1294 651 1960 884"> <thead> <tr> <th></th> <th>At 31 December 2009</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>NZ Maori</td> <td>1.21</td> <td>1.00</td> </tr> <tr> <td>Pacific</td> <td>1.69</td> <td>1.15</td> </tr> <tr> <td>Other</td> <td>0.65</td> <td>0.55</td> </tr> <tr> <td>Total</td> <td>0.96</td> <td>0.73</td> </tr> </tbody> </table>		At 31 December 2009	Target	NZ Maori	1.21	1.00	Pacific	1.69	1.15	Other	0.65	0.55	Total	0.96	0.73
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Children caries free at five years of age	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	% caries free at five years <table border="1" data-bbox="1294 960 1960 1193"> <thead> <tr> <th></th> <th>At 31 December 2009</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>NZ Maori</td> <td>45.60%</td> <td>50%</td> </tr> <tr> <td>Pacific</td> <td>36.20%</td> <td>38%</td> </tr> <tr> <td>Other</td> <td>71.50%</td> <td>80%</td> </tr> <tr> <td>Total</td> <td>61%</td> <td>66%</td> </tr> </tbody> </table>		At 31 December 2009	Target	NZ Maori	45.60%	50%	Pacific	36.20%	38%	Other	71.50%	80%	Total	61%	66%
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Utilisation of DHB funded dental services by adolescent from Year 9 up to and including age 17 years	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	68% of adolescents use dental services by 2011 (from 64.3% actual data 2009) Reduced inequalities for Maori and for Pacific compared to 'Others'															

National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
Improving the number of children enrolled in DHB funded dental services	<p>50% of 0-2-year olds enrolled with DHB funded dental services under age five years</p> <p>85% of 3-4 year olds enrolled with DHB funded dental services under age five years</p> <p>Ethnicity breakdown by Maori, Pacific and Other</p>	<p>50% of 0-2 years olds enrolled with DHB funded dental services</p> <p>85% of 3-4 year olds enrolled with DHB funded dental services</p> <p>63% of 0-4 year olds enrolled</p> <p>Improve the status of arrears to &lt;10%</p> <p>Annual report in quarter three</p>
Reduction in Family Violence	<p>Report confirming audit score targets are met</p> <p>Data provided to DHB by the Auckland University of Technology (AUT) Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit</p>	<p>Overall audit scores of 170/200 for child and partner abuse components of the Violence Intervention Programme</p> <p>Annual as part of quarter four report</p>
Ambulatory Sensitive Hospital Admissions	<p>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</p>	<p>Auckland DHB to remain below the national average for ASH rates</p> <p>Reduction in inequalities between Māori and Pacific people aged 0 -74 years and Other New Zealanders aged 0-74 years</p> <p>ASH Maori age group 45-64 is the only age group significantly above the national average and requires action. The rate for this group is 132.4.</p> <p>Target for Maori is 122</p> <p>Target for Pacific is 105</p>
Regional Service Planning	<p>Collaborate with neighbouring DHBs to develop a Regional Service Plan (RSP). Ensure the plan development addresses:</p> <ul style="list-style-type: none"> <li>- 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</li> <li>- services related to significant capital investment proposals expected in the next 3 years</li> <li>- service configuration changes that will contribute to financial viability</li> </ul>	<p>Report on the progress of the Regional Service Plan</p>

National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
Service Coverage	<p>Service coverage expectations are met</p> <p>Resolution of service coverage gaps by appropriate resolution plan and adequate progress made against it</p>	<p>Meet all service coverage expectations</p> <p>Report on any areas where there are exceptions to service coverage not approved as long term exceptions, and any other gaps in service coverage</p>
Elective Services Standardised Intervention Rates (SIR)	<p>Standardised Intervention Rates reported. For elective surgical services and a range of elective procedures.</p> <ul style="list-style-type: none"> <li>• For publicly funded casemix included elective discharges in a surgical DRG, a target intervention rate of at least 260 per 10,000 of population will be achieved.</li> <li>• For major joint replacement procedures, a target intervention rate of 18 per 10,000 of population will be achieved, comprised of: <ul style="list-style-type: none"> <li>– 9 per 10,000 of population for hip replacement</li> <li>– 9 per 10,000 of population for knee replacement</li> </ul> </li> <li>• For cataract procedures, a target intervention rate of 27.0 per 10,000 of population will be achieved.</li> <li>• For cardiac procedures a target intervention rate of at least 5.9 per 10,000 of population will be achieved <ul style="list-style-type: none"> <li>– Cardiac surgery is coronary artery bypass graft (CABG), valve replacement or repair, and CABG plus valve replacement or repair, for people 15 and over</li> <li>– The current national intervention rate for percutaneous revascularization is 10.8 per 10,000</li> </ul> </li> </ul>	<p>Meet the Standardised Intervention Rates as a measure of Auckland DHB delivery of services to the Auckland population</p> <ul style="list-style-type: none"> <li>• at least 270 per 10,000 of population for casemix included elective discharges in a surgical DRG</li> <li>• 18 per 10,000 of population for major joint replacement procedures</li> <li>• 27.0 per 10,000 of population for cataract procedures</li> <li>• at least 6.23 per 10,000 of population for cardiac procedures</li> </ul>
Increase funding for Māori Health and disability initiatives	<p>Report actual expenditure on Māori Health Providers by General Ledger (GL) code</p> <p>Report actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit (PU)</p> <p>DHB predicted expenditure for Māori health in the DHB 2009-10 Annual Plan compared to actual expenditure, with explanation of variances</p>	<p>Complete the data and technical analysis required to build a picture of Maori expenditure across the Auckland DHB health system</p> <p>Report on progress</p>

National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11			
DHB confirmation and exception reports – risk management	<p>Formal risk management and reporting system to manage DHB risks and report them to its Board</p> <p>The system meets current Australia / New Zealand Standard requirements relating to risk management</p> <p>Report how frequently the DHB submits its formal risk report updates to its Board (or a Board approved sub-committee)</p>	Monthly Board risk reporting			
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		6 weeks	3 months	6 months
Staff Turnover	<p>Information of exits compared to total headcounts according to the 5 main professional groups within the provider arm:</p> <ul style="list-style-type: none"> <li>– medical personnel</li> <li>– nursing personnel</li> <li>– allied health personnel</li> <li>– management and administration</li> <li>– support personnel</li> </ul>	Quarterly reports submitted with all specified breakdowns			
Capital Expenditure to Plan	<p>DHB expenditure plans for capital reflect the management of expenditure, and make appropriate capital investment decisions</p> <p>Match expenditure to plan with consideration given to appropriate investment decisions. Financial information is provided through monthly financial templates</p>	Submission of the financial plans and templates related to Annual Plan requirements			
Elective and Arranged Inpatient Length of Stay	Reduce the average length of stay (ALOS) for elective and arranged inpatients	4.15 bed days			

National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
Acute Inpatient Length of Stay	<p>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</p> <p>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</p>	<p>4.15 days</p> <p>moving progressively to 4.05 in 2011-12 and to 3.92 in 2012-13</p> <p>Auckland DHB ALOS exceeds the national target for a number of reasons. Auckland City Hospital is a receiving hospital for cases from outside the Auckland DHB catchment across a wide range of specialities, inclusive of acute and elective cases. The transferred cases are invariably of higher complexity and contribute to longer length of stay, for example:</p> <ul style="list-style-type: none"> <li>- Approximately 50% of the ADHB provider arm patients are from outside the ADHB catchment</li> <li>- Starship Children’s Health provides a wide range of sub speciality services nationally, and in some units this referred work contributes up to 70% of the throughput</li> <li>- Oncology biopsies and renal transplant donors</li> <li>- Complex obstetric cases</li> </ul> <p>Refer also to page 23 for a list of specialist services provided for the whole of New Zealand</p> <p>Auckland DHB is committed to reducing its ALOS but the wide range of high end complex service provision equates to slower progress in reaching the national ALOS target</p>
Theatre Productivity	<p>Reduction in the number of theatre sessions that start late, finish early, or are cancelled</p> <p>Data for each theatre:</p> <ul style="list-style-type: none"> <li>- scheduled theatre sessions in the quarter</li> <li>- cancelled theatre sessions in the quarter</li> <li>- theatre sessions that start late (&amp; do not finish early)</li> <li>- theatre sessions that finish early (&amp; started on time)</li> <li>- theatre sessions that start late and finish early</li> </ul>	<p>Discharge elective WIES going through theatre has been 88 per working day. The goal for 2010-11 is to increase this by 6% to 93</p> <p>Cardiac: By increasing the number of by-pass cases from 17 to 20 per week. Achieved by maintaining the cancellation rate at 12% which is a reduction from current levels of 31%.</p>
Elective and Arranged Day Surgery	Increase the proportion of elective and arranged surgery undertaken on a daycase basis	60% standardised

National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2010–11
	<p>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</p> <p>The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise</p>	
Elective and Arranged Day of Surgery Admission	<p>90 percent of its elective and arranged surgery on a day of surgery admission (DOSA) basis</p> <p>The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise</p>	<p>65 percent of elective and arranged surgery on a day of surgery admission (DOSA) basis (This target will be progressively increased in the out years to achieve 90% by 2011)</p> <p>Achieve targets for acute volume for Auckland residents</p>
Acute Readmissions to Hospital	The DHB is expected maintain 28 day unplanned acute readmission rates at the current rate or lower	10.40%
Mortality (in-hospital patient deaths)	Each DHB is expected to maintain its 30 day mortality rate at the same level, or reduce it, over the year	<p>Maintain a 30 day mortality rate at the same level i.e. 1.39</p> <p>Being the number of in-hospital patient deaths within 30 days of admission, as a proportion of all patient discharges, including daycases</p>
Data Submitted to National Collections	Each DHB will improve the quality of data provided to national collections against specified targets	<p>NHI Duplications: 3% or less</p> <p>Ethnicity Not Stated in the NHI: 4% or less</p> <p>Standard vs. Specific Descriptor: 35% or more</p> <p>National Minimum Data Set timeliness: target is 5% or less</p>
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	<p>Acutes delivered to 100% of contract</p> <p>Electives delivered to 100% of contract</p>
National Patient Satisfaction Survey	Patient satisfaction survey or similar tool	Continue using the national survey tool

## 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.

The following section outlines work in the region. It provides details re the intended deliverables; their associated targets, funding allocations and timelines.

### Changes via national projects

<p><b>National work</b></p>	<p>Advance the five national initiatives:</p> <ul style="list-style-type: none"> <li>• National Services Location: a national service implementation plan by end of June 2011 in conjunction with the National Health Board</li> <li>• High Cost Treatments: aim for consistency in the menu of high cost treatments, linked with advanced care plans. A national service implementation plan by end of June 2011 in conjunction with the National Health Board</li> <li>• Health Procurement: deliver \$30 million savings in 2010-11, Health Procurement to provide detail of current plans, potential and range of potential savings being sought. Auckland DHB will assess our share of the total, based on expenditure and timing of contract renewal</li> <li>• Shared Services: deliver a shared services change programme that offers best value to DHBs over the next three years. And includes a risk management plan given the importance of shared services as an enabler for DHB delivery of services</li> <li>• Low Evidence Activities and Treatments: achieve a single list of low-evidence activities and treatments, including better targeting of pharmaceuticals schedule. A national service implementation plan by end of June 2011 in conjunction with the Ministry of Health and the National Health Board</li> </ul> <p>Implement the donation after cardiac death as a project to be rolled out across the country</p> <p>Leading a national programme for the Ministry of Health on Maori nursing and midwifery workforce development</p>
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## Changes proposed via regional services, projects and initiatives

	Regional work	2010-2011 deliverables						
<p><b>Implement Better, Sooner, More Convenient primary health care (business cases)</b></p>	<p>The focus for 2010-11 is to implement the objectives of Better, Sooner, More Convenient primary health care. This means more personalised primary care where services are provided closer to the home. Downstream this will help Aucklanders to be healthier and it should also reduce the demand on public hospitals.</p> <p>Government is supporting the development of integrated family health centres. These will be more convenient for patients, 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.</p> <p>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.</p> <p>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:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">Greater Auckland Integrated Health Network (GAIHN)</td> <td style="padding: 5px;">Covers over one million enrolled people across 11 PHOs within the greater Auckland region</td> </tr> <tr> <td style="padding: 5px;">Alliance Health+</td> <td style="padding: 5px;">A coalition of the three Pacific-led PHOs in Auckland across Counties Manukau DHB and Auckland DHB</td> </tr> <tr> <td style="padding: 5px;">National Māori PHO Coalition</td> <td style="padding: 5px;">A north island consortium of PHOs with a focus on Whānau Ora</td> </tr> </table> <p>There is a common objective to have a locality or neighbourhood approach to:</p> <ul style="list-style-type: none"> <li>- improve local access to services</li> <li>- co-ordinate and integrate services</li> <li>- drive quality improvement</li> <li>- be responsive to community needs</li> <li>- shift some secondary services to local settings</li> <li>- models and structures that are of sufficient scale and capacity to drive change</li> <li>- meet the Minister's goal of reducing the number of PHOs</li> </ul>	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	<p>DHBs are working with the 3 primary care consortiums to agree plans. Likely areas of actions are:</p> <p>New packages of care for mama, pepi and tamariki to support Whānau Ora</p> <p>Clinical pathways across primary and secondary care</p> <p>Integrated family health centres and whanau ora centres</p> <p>Locality networks and approaches</p> <p>More efficient/effective management and commissioning across PHOs and the 3 DHBs</p> <p><b>Key work streams</b></p> <p>More minor surgery in the community</p> <p>Direct access to diagnostics</p> <p>Primary/secondary clinical pathways</p> <p>Consistent use of POAC</p> <p>Co-ordinated approach to affordable after hours</p> <p>Pharmaceuticals – releasing funds for the frontline and improved quality</p> <p>Devolution of services for Maori</p>
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							

	<b>Regional work</b>	<b>2010-2011 deliverables</b>
	<p>Some PHOs have already made progress through amalgamations. Each DHB is canvassing the views of stakeholders on the best approach to meet these goals</p> <p>The DHBs will continue to work closely with the three consortiums over 2010-11 to implement their business cases including their plans to develop:</p> <ul style="list-style-type: none"> <li>- new packages of care for mama, pepi, and tamariki to support whanau ora</li> <li>- clinical pathways across primary and secondary care</li> <li>- integrated family health centres and whanau ora centres</li> <li>- locality networks and approaches</li> <li>- a more efficient and effective management and commissioning layer across PHOs and three DHBs</li> </ul> <p>Refer appendix 7 for more detail</p>	<p>Increasing Maori provider capability</p> <p>Regional Health Targets</p> <p>It is likely there will be at least a 20% reduction in the number of PHOs across metro-Auckland by 31 December 2010</p> <p>Regionally agreed approach by 30 June 2010</p> <p>More formal plan with associated policies ready for implementation by December 2010</p>
<b>The Northern Region Network Strategy</b>	<p>The proposed scale of regional activity needs to be supported by a more effective regional framework than currently exists</p> <p>The DHBs have agreed an overall Northern Region Network (NRN) framework and will work with the Ministry of Health, National Health Board and Shared Services Establishment Board to ensure appropriate alignment</p> <p>During 2010-11 the DHBs will implement the recommendations outlined in the Northern Region Network Strategy</p> <p>Detailed implementation planning is underway around clinical services and business services with early work to establish key activities in 2010-11:</p> <p><b>Clinical Services activity:</b></p> <ul style="list-style-type: none"> <li>• Review, align and clarify roles and mandates of the Northern Cancer Network, ROOG and the Regional Oncology Service</li> <li>• Establish 3 new networks <ul style="list-style-type: none"> <li>- Cardiac/Heart disease</li> <li>- Radiology</li> <li>- Regional Elective Services Network</li> </ul> </li> <li>• Strengthen the governance and management of 3-4 key regional services</li> <li>• Agree the direction for Public Health Services and School Dental services</li> <li>• Strengthen clinical leadership capability across the region and to leverage clinical</li> </ul>	<p><b>Clinical Networks</b></p> <p>Strengthening the governance/management of regional services</p> <p>Better sooner more convenient primary care</p> <p>Clinical leadership</p> <p>Innovation and research</p>

	<b>Regional work</b>	<b>2010-2011 deliverables</b>
	<p>leadership across clinical disciplines with small and vulnerable FTE</p> <ul style="list-style-type: none"> <li>• Share systems and information to support innovation and research at a regional level that will be of benefit to all DHBs</li> <li>• Review planning support activities undertaken at a DHB level and regionally, agree how to undertake this work</li> </ul> <p><b>Business Services activity:</b></p> <ul style="list-style-type: none"> <li>• Plans to align functions across the region <ul style="list-style-type: none"> <li>– Information Services</li> <li>– Finance</li> <li>– Business Solutions</li> <li>– Procurement and Supply Chain</li> <li>– Payroll</li> <li>– Internal Audit</li> <li>– ARRMOS</li> </ul> </li> <li>• Initiatives in the following areas as the first of 3 planned wave of implementation: <ul style="list-style-type: none"> <li>– IS Strategy and Planning for core systems</li> <li>– Procurement for non clinical items</li> <li>– Financial, Procurement and Supply Chain financial software systems</li> <li>– Transactional reporting (Finance)</li> <li>– IS Project delivery and IS Service delivery</li> <li>– Internal Audit</li> <li>– ARRMOS</li> </ul> </li> </ul>	<p><b>Planning support</b></p> <p>IS Strategy and Planning for core services</p> <p>Procurement for non clinical items</p> <p>Financial, procurement and supply chain software systems</p> <p>Transactional reporting (finance)</p> <p>IS Project delivery and IS service delivery</p>
<b>Northern Region Clinical Service Planning</b>	<p>The Northern DHBs have undertaken the foundation work required to develop a long term Regional Clinical Service Plan. This includes:</p> <ul style="list-style-type: none"> <li>• Work undertaken in each DHB around clinical service planning and patient pathway redesign and quality improvement</li> <li>• Detailed reviews of individual services that have been undertaken regionally</li> <li>• Initial assessment of services which are vulnerable across the region (will be updated on completion of the Regional Clinical Services Plan)</li> <li>• Two phases of regional work re long term regional service planning: <ul style="list-style-type: none"> <li>– Phase 1 completed, developed a joint statement of demand and supply of health services with agreed regional picture of current and future inpatient bed requirements, current bed and theatre capacity and population forecasts</li> </ul> </li> </ul>	<p>Regional Clinical Services Plan completed, Oct 2010</p> <p>Monitoring of progress against RCSP implementation plan (further milestones will be specified on completion of the Regional Clinical Services Plan in Quarter 2)</p> <p>Establish new clinical networks:</p> <ul style="list-style-type: none"> <li>• Cardiac/Heart</li> </ul>

	Regional work	2010-2011 deliverables		
<b>Northern Region Clinical Service Planning</b>	<ul style="list-style-type: none"> <li>Phase 2 objective, to shape the strategic direction for service planning in the region, identify the changes needed to meet the health targets, and support the 2009 and subsequent business cases for capital expenditure. Phase 2 focuses on 5 work streams, clinical networks and regional services, urgent and acute care, planned and elective care, health of older people and radiology.</li> </ul> <p>The Regional Clinical Service Plan will describe the future configuration of services across the region. It will ensure clinical viability and financial affordability from a regional perspective, and will inform resource allocation and service provision decisions at the regional and district level.</p>	<ul style="list-style-type: none"> <li>Regional Elective Services</li> <li>Radiology</li> </ul>		
<b>Cancer services</b>	<p><b>Northern Cancer Network</b></p> <p>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.</p> <p>Objectives and targets are agreed for the Northern region and documented in the specific cancer targets for Auckland DHB:</p> <p>Increase throughput and productivity in alignment with tumour-stream goals</p> <table border="1"> <tr> <td>Improve cancer treatment waiting times especially for radiation treatment</td> <td> <p>100% of those requiring radiation therapy will commence within four weeks of referral by December 2010</p> <p>Work collaboratively to ensure there is sufficient sustainable capacity to meet and maintain the 2014-2015 target intervention rate i.e. 46%</p> <p>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</p> <p>Standardise the model of care for cancer care coordination within the Northern Region</p> <p>Support the Regional Cancer service and Northern Cancer Network to monitor and review waiting times and ensure service efficiency and quality improvement</p> <p>Collectively monitor and respond to triggers for initiating the next public capacity step according to the Regional Radiotherapy Strategy</p> <p>Participate in ongoing Cancer Network activity</p> </td> </tr> </table>	Improve cancer treatment waiting times especially for radiation treatment	<p>100% of those requiring radiation therapy will commence within four weeks of referral by December 2010</p> <p>Work collaboratively to ensure there is sufficient sustainable capacity to meet and maintain the 2014-2015 target intervention rate i.e. 46%</p> <p>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</p> <p>Standardise the model of care for cancer care coordination within the Northern Region</p> <p>Support the Regional Cancer service and Northern Cancer Network to monitor and review waiting times and ensure service efficiency and quality improvement</p> <p>Collectively monitor and respond to triggers for initiating the next public capacity step according to the Regional Radiotherapy Strategy</p> <p>Participate in ongoing Cancer Network activity</p>	<p><b>Radiotherapy</b></p> <p>Meet 6 week waiting time target</p> <p>Meet 4 week waiting time target</p>
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	Regional work	2010-2011 deliverables
<b>Cancer services</b>	<p>Lung cancer</p> <p>Support the regional lung cancer tumour stream to achieve the following targets. Time from:</p> <ul style="list-style-type: none"> <li>• GP referral to first specialist assessment: &lt; 2 weeks: increase from 43% to 50% across region</li> <li>• first specialist assessment (FSA) to decision to treat: 80% of patients within 4 weeks</li> <li>• decision to treat to surgery: &lt; 2 weeks: increase from 36% to 50%</li> <li>• decision to treat to Medical FSA (chemotherapy) within 2 weeks: increase from 7% to 50%</li> <li>• decision to treat to radonc FSA (radiation oncology) within 2 weeks: 36%-50%</li> <li>• 100% of those requiring radiation therapy will commence within four weeks of referral by December 2010</li> </ul>	<p><b>Lung:</b></p> <p>Increase from 43 per cent to 50 per cent the patients discussed in Thoracic Multidisciplinary Meeting (TMDM) within 28 days of referral</p> <p>Increase from 30 per cent to 50 per cent the Patients that have thoracic surgery within 14 days of the Thoracic Multidisciplinary Meeting</p> <p>Increase from 36 per cent to 50 per cent the patients that have First Specialist Assessment (FSA) Medical Oncology within 14 days of the Thoracic Multidisciplinary Meeting</p> <p>Increase from 7 per cent to 50 per cent the patients that have FSA Radiation Oncology within 14 days of the Thoracic Multidisciplinary Meeting</p> <p><b>Bowel:</b></p> <p>Baseline performance against regional timeliness standards will be established</p> <p>Regional prioritisation criteria established for colonoscopies</p>
	<p>Bowel cancer</p> <p>Work with the Northern Cancer Network and the bowel cancer tumour stream to identify targets as for lung cancer by August 2010</p> <p>Redesign patient pathways to reduce waiting times for bowel cancer patients</p> <p>Introduce a regional colorectal MDM form (regional electronic form)</p> <p>Develop and implement a regional prioritisation criteria for colonoscopies</p> <p>Improve data capture to support service improvements that increase access to colonoscopies</p> <p>100% of those requiring radiation therapy will commence within four weeks of referral by December 2010</p>	
	<p>Chemotherapy</p> <p>Improve reporting of performance measures for chemotherapy wait times</p> <p>Support the Cancer Network and Regional Cancer Service to capture and report chemotherapy wait times</p>	
	<p>Improve outcomes for vulnerable groups</p> <p>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</p>	
<b>Elective Services</b>	<p>Regional work meets the Minister's objectives for Elective Services Units and for improved access to elective services. This achieves DHB objectives re the sustainable delivery of clinical services in a financially constrained environment</p> <p>The Northern Region proposal encompasses:</p>	<p>Establish Regional Elective Services Network</p> <p>Greenlane Clinical Services Centre completed. First phase completed</p>

	<b>Regional work</b>	<b>2010-2011 deliverables</b>								
<b>Elective Services</b>	<ul style="list-style-type: none"> <li>Establish the Regional Elective Services Network to support; the development and design of regional referral pathways, workforce development and training, service delivery models, and intervention and demand analysis</li> <li>Move to equitable intervention rates across the region, using a streamlined model of care with distributed Elective Services Units. Elective work will increasingly be separated from acute; the exception being the most complex cases</li> </ul> <p>The implications for each DHB are:</p> <table border="1"> <tr> <td>Northland DHB</td> <td>local strategies to ensure delivery of elective volumes. No dedicated Elective Services Unit due to insufficient scale</td> </tr> <tr> <td>Auckland DHB</td> <td>extend the Greenlane Short Stay Unit into the Greenlane Surgical Centre: 4 additional theatres, 25-30 inpatient beds, a new endoscopy suite and an extended Clinical Sterile Services Department</td> </tr> <tr> <td>Waitemata DHB</td> <td>dedicated purpose-built elective facility on the North Shore Hospital campus: 4 theatres, 4 outpatient clinics and 40 additional inpatient beds</td> </tr> <tr> <td>Counties Manukau DHB</td> <td>expand the current Manukau Surgical Centre by 4 theatres, extend the CSSD, and bring a blood bank on site to support the additional theatres</td> </tr> </table> <p>Elective Services Units will undertake a mix of additional electives, repatriated publicly funded volumes currently being undertaken in private facilities, and volumes decanted from the main acute/elective theatres to the Elective Services Unit</p> <p>In all cases (apart from acute eyes) the Elective Services Units will be dedicated to elective service delivery</p>	Northland DHB	local strategies to ensure delivery of elective volumes. No dedicated Elective Services Unit due to insufficient scale	Auckland DHB	extend the Greenlane Short Stay Unit into the Greenlane Surgical Centre: 4 additional theatres, 25-30 inpatient beds, a new endoscopy suite and an extended Clinical Sterile Services Department	Waitemata DHB	dedicated purpose-built elective facility on the North Shore Hospital campus: 4 theatres, 4 outpatient clinics and 40 additional inpatient beds	Counties Manukau DHB	expand the current Manukau Surgical Centre by 4 theatres, extend the CSSD, and bring a blood bank on site to support the additional theatres	<p>in April 2010 and all phases completed by April 2011</p> <p>Waitemata DHB completes detailed planning for a dedicated Elective Services Unit facility on the North Shore site. Completed in December 2011 and could be open for the first patients in February 2012</p> <p>Counties Manukau DHB expansion. Indicative timing is 2014-15</p>
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<b>Cardiology</b>	<p>The Regional Cardiology Group has representatives from the four northern DHBs. The group enables continuing collegiality, collaboration and provides a forum for ongoing dialogue in order to achieve equity of access and care and best possible outcome for all patients in the Northern region</p> <p>The Group has sponsored the development of two business cases, Drug Eluding Stents (DES) and Implantable Cardiac Defibrillators (ICD), which was funded by the national committee NSTR. The Group will review the outcome of these business cases when considering further regional service provision and development upon the completion of the business cases in 2010</p> <p>The Regional Cardiology Group is also focused on completing a strategic plan for the sustainable provision of cardiology services for the northern region</p> <p>The regional cardiology strategic plan recommends the development of a cardiology clinical</p>	<p>Review the outcomes of the two business cases, Drug Eluding Stents (DES) and Implantable Cardiac Defibrillators (ICD)</p> <p>Complete a strategic plan for the sustainable provision of cardiology services for the northern region</p> <p>Develop a cardiology clinical network to support the plan</p>								

	<b>Regional work</b>	<b>2010-2011 deliverables</b>
<b>Cardiology</b>	<p>network that will provide the strength to work through the initiatives and strategies proposed in the strategic plan</p> <p>The intent of the strategic plan is to provide guidance and a direction for the DHBs to work towards. This is being cognisant that most services will always be delivered locally, however there is significant similarity around some of the current issues in regards to service delivery and setting priorities in regards to service development</p>	
<b>Mental health (includes Eating Disorder Service and Forensics)</b>	<p>Implementation of the Northern Region Eating Disorders Services Plan 2008-2013, covering the Northern and Midland regions.</p> <p>The key elements of this plan include:</p> <ul style="list-style-type: none"> <li>• Services for People Aged 15 Years and Under will be provided by Starship Hospital, involving the establishment of 5 specialist beds</li> <li>• 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</li> </ul> <p>Auckland DHB is also involved in other regional work underway:</p> <ul style="list-style-type: none"> <li>• Regional strategy for forensic services including mapping the service user journey, clinical governance, clinical pathways, benchmarking etc</li> <li>• Participation in Regional review of Alcohol and Drug services</li> </ul>	<p>Dedicated service for people aged 15 years and under will be provided by Starship Children's Health Service, involving the establishment of 5 specialist beds</p> <p>Residential treatment service (potentially 8 beds for Northern DHBs and 1 for Midland region) for people aged over 15 years. The final configuration for this service will be dependent on receipt of an acceptable response to RFP.</p> <p>FTE appointed within DHBs to supplement Regional Eating Disorders Services and increase local capacity</p> <p>Establish additional regional forensic services</p> <ul style="list-style-type: none"> <li>• court liaison services (1.0 FTE)</li> <li>• forensic community team (1.0FTE)</li> <li>• forensic prison mental health team (5.0FTE)</li> </ul>
<b>Northern Region Oral Health – Regional Services/Networks</b>	<p>To improve the oral health of children and adolescents and reduce inequalities, using a needs-based approach, and efficient resource use and distribution. This requires effective, timely communication with children, parents, providers and other organisations</p>	<p><b>Enrolment targets:</b></p> <ul style="list-style-type: none"> <li>• 0-2 years- 50%</li> <li>• 3-4 years- 85%</li> </ul>

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<b>Northern Region Oral Health – Regional Services/Networks</b>	<p>Priorities for 2010-11</p> <ul style="list-style-type: none"> <li>Implement the Oral Health Business Case</li> <li>Improve oral health status for children and adolescents, and increase enrolment of 0-4 year olds</li> <li>Improve the status of arrears (Ministry of Health expectation is &lt;10%)</li> <li>Reports have greater consistency and robustness</li> <li>Establish Community Based Workers to target preschool population</li> <li>Reduce the volumes of arrears and increase service use by adolescents</li> <li>Understand the distribution of dental disease among population groups and use data to improve preventive services (e.g. fissure sealants), preschool dental services (five-year health outcomes), assign risk status and appropriate recalls</li> <li>Track pre-school enrolments/examinations; communicating with primary care providers and DHBs</li> <li>Improve scheduling and appointments to decrease arrears</li> </ul> <p>Health targets</p>	<ul style="list-style-type: none"> <li>5-12 years- 95%</li> <li>13-17 years- 85%</li> <li>Adolescent oral health:</li> <li>85% (Year 8) transfer and utilisation rate</li> <li>Arrears target is &lt;10%</li> <li>DNA rate for oral health &lt; 10%</li> <li>Ratio of Dental Assistants to Dental Therapists 0.8:1</li> </ul> <p><b>Regional deliverables:</b></p> <p>Community based workers appointed to target preschool population in Auckland Regional Dental Service (ARDS)</p> <p>Reduced numbers of arrears and increased ARDS utilisation by adolescents</p> <p>Complete implementation of oral health business cases</p>																																																													
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<b>Regional Nutrition and Food Service</b>	<p>Auckland Metropolitan DHBs plan to establish a regional nutrition and food service. This will help DHBs produce patient meals in the future at an acceptable price. The project is investigating how the quality of meal service delivery to the bedside could be improved. It will also consider 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.</p> <p>A business case is being developed that aims for:</p> <ul style="list-style-type: none"> <li>• economies of scale in food production thus reducing cost</li> <li>• reduced duplication and complexity of kitchen based operations</li> <li>• reduced footprint requirements for hospital based kitchens</li> <li>• use of new technology to increase operational efficiencies and be more environmentally friendly</li> <li>• improved patient menu choice resulting in enhanced patient outcomes and reduced wastage</li> <li>• reduced food wastage through more efficient menu ordering processes on the ward level</li> <li>• potential to centralise Meals on Wheels</li> <li>• nutritional assessments facilitated by regional IT system to improve patient outcomes through better nutrition</li> <li>• the potential to scale food production up for other DHBs</li> </ul>	<p>Completion date for the business case is 31 July 2010</p> <p>If the business case is approved, the timeframe for change is June 2012</p>
<b>Auckland Regional Public Health Service (ARPHS)</b>	<p>Auckland Regional Public Health Service (ARPHS) provides public health services for people within the three district health 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)</p> <p>Reductions in the Auckland Regional Public Health Service funding for 2010–11 mean reductions in the level of service provided into the future. The service will reorganise its service delivery plan as efficiently as possible</p> <p>The focus is on those public health services that are most effectively and efficiently undertaken at the regional level. A regional approach is necessary for areas such as contact tracing and limiting the spread of communicable disease outbreaks within and across DHB boundaries. Many of these are legal and mandatory functions provided on behalf of the Ministry of Health</p> <p>The 2010–11 focus is:</p>	<p>Consolidate inter-agency regional emergency planning</p> <p>Progressively increase the number of primary care practices with robust Emergency Care Plans</p> <p>Lead targeted health promotion campaigns targeted at discrete population to achieve improvements in health and reduce health disparities</p>

	<b>Regional work</b>	<b>2010-2011 deliverables</b>
<b>Auckland Regional Public Health Service (ARPHS)</b>	<ul style="list-style-type: none"> <li>consolidate inter-agency regional emergency planning. 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</li> <li>work with other sectors, such as local and central government, to ensure that decisions outside the health sector consider health and health inequalities consequences</li> <li>work with the inaugural Auckland Super City 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</li> <li>target health promotion at discrete populations or sectors in the region to achieve overall improvements in health and reduced health inequalities</li> <li>ensure programme development achieves all the possible opportunities to reduce health and social inequalities for Maori and Pacific communities</li> <li>programmes aimed at reducing alcohol and tobacco use, including the Auckland DHB/Waitemata DHB Pacific smoking cessation programme</li> <li>respond to public health risks arising from environmental hazards</li> </ul>	
<b>Auckland Regional Settlement Strategy Migrant Health Activity</b>	<p>The Auckland Regional Settlement Strategy Migrant Health Plan is a region-wide approach to improving the health of Asian, refugee and migrant populations. Culturally and linguistically diverse groups have disparities in health status, barriers to health care and disability services, and under-use the services available</p> <p>The Auckland Regional Settlement Strategy Health Workstream Steering Group prioritises three areas of implementation:</p> <ul style="list-style-type: none"> <li>resourcing disability service and support needs for refugees and migrants</li> <li>providing sustainable health interpreting services to primary health</li> <li>providing cultural diversity training programmes for the primary and secondary health and disability workforce</li> </ul> <p>Primary Health Interpreting Services will be incorporated into the delivery of any integrated family health centres, and other primary health projects. Interpreting services beyond those already underway e.g. pharmacies and community-based retinal screening, are being considered subject to the funding available</p> <p>Cultural competency training for the primary and secondary health and disability workforce is offered to staff in the three Auckland region District Health Boards with e-learning modules available 2010</p>	<p>Report on outcomes of agreed service level agreements for the three projects:</p> <p>Child Disability Support Services for Asian, Migrant and Refugee</p> <p>An evaluation of primary health interpreting services pilot, December 2011</p> <p>Cultural Competency Training</p> <p>Auckland Region Middle Eastern/Latin American/ African (MELAA) Health Needs Assessment</p>

	<b>Regional work</b>	<b>2010-2011 deliverables</b>						
<b>Auckland Regional Settlement Strategy Migrant Health Activity</b>	<p>An evaluation of the Cross Cultural Training Course programmes on health practitioner cultural competency knowledge, skills, attitudes and behaviours will be completed by November 2011</p> <p>The culturally competent Child Disability Service and rehabilitation model being developed in the Auckland region will also be evaluated in 2010</p> <p>The Auckland region South Asian Physical Activity and Nutrition Promotion Service raises awareness that South Asian groups are at increased risk of CVD and diabetes. Culturally appropriate nutrition messages will be promoted to these communities</p> <p>Auckland DHB is undertaking an Auckland Region Middle Eastern/Latin American/ African (MELAA) Health Needs Assessment, including demography and health status</p>							
<b>Community laboratories</b>	<p>The three Auckland Region DHBs will collaborate to manage 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</p> <p>A strategic review of the future provision of histopathology services will be undertaken that encompasses both community and hospital laboratory services</p>	<p>Manage community laboratory service to ensure a quality service is provided that meets expectations</p> <p>Accreditation of LTA</p> <p>Complete histopathology review</p>						
<b>Community pharmacy</b>	<p>The northern DHBs continue to work together on community pharmacy in three key areas:</p> <table border="0"> <tr> <td style="vertical-align: top;">Relationship development</td> <td>Auckland DHB has a community pharmacy advisory group. A regional advisory group will continue with opportunities for individual groups to explore common issues. The regional advisory group will support the regional DHBs with advice on contract review and e-prescribing</td> </tr> <tr> <td style="vertical-align: top;">Contract review</td> <td>The 4 northern region DHBs will continue to provide support and input to the national contract review. The current agreement with community pharmacies expires 31 August 2011. The national review will inform options for agreement options from 1 September 2011</td> </tr> <tr> <td style="vertical-align: top;">e-prescribing</td> <td> <p>e-prescribing allows prescriptions to be sent electronically to the dispensing pharmacy from the prescriber. This reduces the administration burden; improves safety; and improves information available on pharmaceutical use</p> <p>The northern region DHBs will scope the potential to develop and implement an e-prescribing model for the region that can then be picked up by other DHBs/regions. A decision will be made following scoping whether to progress the development and implementation or not</p> </td> </tr> </table>	Relationship development	Auckland DHB has a community pharmacy advisory group. A regional advisory group will continue with opportunities for individual groups to explore common issues. The regional advisory group will support the regional DHBs with advice on contract review and e-prescribing	Contract review	The 4 northern region DHBs will continue to provide support and input to the national contract review. The current agreement with community pharmacies expires 31 August 2011. The national review will inform options for agreement options from 1 September 2011	e-prescribing	<p>e-prescribing allows prescriptions to be sent electronically to the dispensing pharmacy from the prescriber. This reduces the administration burden; improves safety; and improves information available on pharmaceutical use</p> <p>The northern region DHBs will scope the potential to develop and implement an e-prescribing model for the region that can then be picked up by other DHBs/regions. A decision will be made following scoping whether to progress the development and implementation or not</p>	<p>New agreement for community pharmacy completed</p>
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e-prescribing	<p>e-prescribing allows prescriptions to be sent electronically to the dispensing pharmacy from the prescriber. This reduces the administration burden; improves safety; and improves information available on pharmaceutical use</p> <p>The northern region DHBs will scope the potential to develop and implement an e-prescribing model for the region that can then be picked up by other DHBs/regions. A decision will be made following scoping whether to progress the development and implementation or not</p>							

	Regional work	2010-2011 deliverables						
<b>Regional Workforce and Human Resource</b>	<p>The Northern Region DHBs Human Resource Management Systems Strategy 2009-2013 aligns with the RIS 10-20. This may be reviewed depending on the national direction set re the scope of this strategy</p> <p>The Northern DHBs will continue to work together on in-depth regional reporting on established recruitment KPIs and will collaborate around the negotiation of regional external partnership agreements (which have resulted in substantive cost savings)</p> <p>National strategy in the area of Employment Relations will determine regional ER activity. Relationship, consultative and communication mechanisms are in place to manage these processes. Inherent and potential risks of industrial negotiations will be managed including the management of settlement costs</p> <p>Key projects in 2010-11</p> <table border="1"> <tr> <td>SMO Job sizing project</td> <td>Develop an agreed Service Size for each speciality, job sizing each SMO (1400 in the region) to that Service Size Align remuneration to the MECA and implementing regional remuneration relativity strategies across like specialities</td> </tr> <tr> <td>Auckland Regional RMO Services Ltd (ARRMOS)</td> <td>Work with CTAB, DHBNZ etc on a model for nationally consistent RMO administration in line with recommendations of the 2009 RMO Commission report</td> </tr> <tr> <td>Physician Assistant Pilot.</td> <td>The 4 Northern Region DHBs and the University of Auckland Faculty of Medical and Health Sciences are undertaking a pilot of the USA trained, medical model of the Physician Assistant (PA) role  Stage one involves a pilot of two PAs in surgery (including elective surgery) at CMDHB for a period of 12 months, commencing mid 2010  DHBs will then consider to further pilots in other specialities and at other DHBs</td> </tr> </table> <p>Work is ongoing to get recruitment, education and workforce plans regionally aligned. School-based programmes are key to preparing more Maori and Pacific young people for tertiary studies in health related courses, and ongoing employment within our sector</p> <p>Better health outcomes are a desired result of more Maori and Pacific being in education and in good jobs earning a higher income</p>	SMO Job sizing project	Develop an agreed Service Size for each speciality, job sizing each SMO (1400 in the region) to that Service Size Align remuneration to the MECA and implementing regional remuneration relativity strategies across like specialities	Auckland Regional RMO Services Ltd (ARRMOS)	Work with CTAB, DHBNZ etc on a model for nationally consistent RMO administration in line with recommendations of the 2009 RMO Commission report	Physician Assistant Pilot.	The 4 Northern Region DHBs and the University of Auckland Faculty of Medical and Health Sciences are undertaking a pilot of the USA trained, medical model of the Physician Assistant (PA) role  Stage one involves a pilot of two PAs in surgery (including elective surgery) at CMDHB for a period of 12 months, commencing mid 2010  DHBs will then consider to further pilots in other specialities and at other DHBs	<p>Progressive implementation of the Regional Human Resource Management Systems Strategy</p> <p>Progress SMO job sizing work to align remuneration to MECA and implement regional remuneration strategies across like specialties</p> <p>Nationally consistent RMO administration processes aligned with RMO Commission Report in place</p> <p>Initiate the Physician Assistant pilot (2 FTEs)</p>
SMO Job sizing project	Develop an agreed Service Size for each speciality, job sizing each SMO (1400 in the region) to that Service Size Align remuneration to the MECA and implementing regional remuneration relativity strategies across like specialities							
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Physician Assistant Pilot.	The 4 Northern Region DHBs and the University of Auckland Faculty of Medical and Health Sciences are undertaking a pilot of the USA trained, medical model of the Physician Assistant (PA) role  Stage one involves a pilot of two PAs in surgery (including elective surgery) at CMDHB for a period of 12 months, commencing mid 2010  DHBs will then consider to further pilots in other specialities and at other DHBs							
<b>Information systems (including RISP)</b>	<p>The Northern DHBs are committed to the Information Strategy for 2010 to 2020. This supports new models of care and underpins the development of a person-centred model to achieve better, sooner, more convenient health care. The strategy was developed with the Ministry of Health and aligns with the Health Information Strategy for NZ (2005) and the</p>	<p>Shared Care Planning – In partnership with PHOs and GPs, DHBs will implement pilot projects which are clinically led and enable</p>						

	Regional work	2010-2011 deliverables						
<b>Information systems (including RISP)</b>	<p>priorities set out by the new National IT Board</p> <p>In 2010-2011 the Northern Region will establish a regional governance structure to implement the strategy. DHBs will undertake smaller initiatives to start the strategy, as well as progress and complete some significant regional projects already underway</p> <p>Regional Information Systems projects will improve the integration of primary and secondary care services. Patients benefit through improved continuity and safety of the health services</p> <p>Priority deliverables for 2010-2011 include:</p> <table border="1" data-bbox="488 539 1579 922"> <tr> <td data-bbox="488 539 683 608">Shared Care Planning</td> <td data-bbox="683 539 1579 608">With PHOs and GPs, DHBs will implement pilot projects which are clinically led and enable the use of shared care plans between providers</td> </tr> <tr> <td data-bbox="488 608 683 762">Electronic Referrals</td> <td data-bbox="683 608 1579 762">Implement a regional electronic Referrals solution between primary and secondary care providers (eReferrals phase 1)  Plan for enhancements that allow faster turnaround and improved responses to referrals (eReferrals phase 2 &amp; 3)</td> </tr> <tr> <td data-bbox="488 762 683 922">Enhance the regionally shared clinical data repository</td> <td data-bbox="683 762 1579 922">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> <p>This supports the outcomes of the national and regional primary care initiatives including the establishment of integrated family health centres</p> <p>Efficiency will improve through opportunities re joint procurement of IT equipment and services, regional hosting of information systems and implementation of shared IT services</p> <p>For some improvements, one individual DHB will take the lead:</p> <p>Auckland DHB: Management of Scanned Clinical Records and Electronic Medical Record for regional Oncology Service</p> <p>Waitemata DHB: Electronic rostering of staff and Enterprise content management</p> <p>Counties Manukau DHB: Medicine Reconciliation and Electronic Discharge Summary improvements</p> <p>DHB Information Systems teams will manage existing information and infrastructure systems and services, including the continuous improvement of quality and efficiency of IT service management processes</p>	Shared Care Planning	With PHOs and GPs, DHBs will implement pilot projects which are clinically led and enable the use of shared care plans between providers	Electronic Referrals	Implement a regional electronic Referrals solution between primary and secondary care providers (eReferrals phase 1)  Plan for enhancements that allow faster turnaround and improved responses to referrals (eReferrals phase 2 & 3)	Enhance the regionally shared clinical data repository	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)	<p>the use of shared care plans between providers</p> <p>Phase 1 of Regional electronic referrals solution between primary and secondary care providers implemented</p> <p>Regionally shared clinical data repository expanded to include pharmaceutical dispensing information between Pharmacies, GPs and DHBs, sharing of outpatient letters between DHBs and GPs and sharing of various additional diagnostic test results between DHBs and GPs</p> <p>Phase 2 on Mental Health electronic patient record system</p>
Shared Care Planning	With PHOs and GPs, DHBs will implement pilot projects which are clinically led and enable the use of shared care plans between providers							
Electronic Referrals	Implement a regional electronic Referrals solution between primary and secondary care providers (eReferrals phase 1)  Plan for enhancements that allow faster turnaround and improved responses to referrals (eReferrals phase 2 & 3)							
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	<b>Regional work</b>	<b>2010-2011 deliverables</b>
<b>Procurement</b>	<p>Northern DHBs will work with the newly established Shared Services Establishment Board (SSEB) so that procurement meets DHB needs. Collaborative procurement work will be improved via:</p> <ul style="list-style-type: none"> <li>• joint procurement clinical governance arrangements</li> <li>• a joint procurement plan</li> <li>• work to align systems and processes</li> <li>• reduced duplication of effort</li> </ul>	<p>Establish joint procurement clinical governance arrangements</p> <p>Develop a joint procurement plan</p> <p>Progressive alignment of systems and processes with reduced duplication of effort</p> <p>Initiatives aimed at reducing costs</p>
<b>Work with Waitemata DHB</b>	<p>Auckland DHB is working with Waitemata DHB to:</p> <ul style="list-style-type: none"> <li>• develop the required capacity to support the repatriation of agreed renal services</li> <li>• develop a long term services plan which defines service delivery by Auckland DHB to the Waitemata DHB population</li> <li>• review progress to date and decide on the future service configuration of ophthalmology and regional pain services as a component of the above plan</li> </ul>	By June 2013
<b>Regional Asset and Capital Planning</b>	<p>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. There are strong competing demands for Health Capital Budget funding which will put at risk a number of strategic investment proposals.</p> <p>There is scope to improve asset management both locally and regionally in 2010-11:</p> <ul style="list-style-type: none"> <li>• Align with the Regional Clinical Services Plan (when completed Oct 2010)</li> <li>• Improve information about the asset base</li> <li>• Improve the capital budgeting process</li> <li>• Strengthen links between service planning and asset management planning, including affordability analysis</li> <li>• Develop a transparent decision making framework for use in challenging investment requests, and to help the region make the tough decisions that are likely to be required in the medium term</li> </ul> <p>At a regional level the focus will be on the latter two areas outlined above.</p>	Regional Asset Management Plan 2011-12 that is aligned with Regional Clinical Service Plan

## 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
There is significant growth in the Health of Older People area, driven by legislated entitlement to care (and home based support services if the distribution of service level is of a higher acuity than planned). We have funding for this, budgeted on past history, but nevertheless potential for over budget expenditure exists	Confirmed implementation of the new Home Based Support Services framework which matches payment to complexity  Introduction of InterRai system to support consistent assessment processes  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 Population Based Funding and is associated with emerging health needs. Also Population Based Funding does not recognise the specific disease burden, and other population skews in the Auckland DHB population	Continued discussions with the Ministry of health regarding population skews and also new ethnicity related health needs
Acute demand greater than predicted	Management focus on unit cost reduction and patient pathway development (primary care business cases)
Development of Long Term Conditions management programmes are being impacted by the ongoing development and speed of the primary care business cases	Close involvement in primary care business case development and respective implementation plans  Work closely with other DHBs in the region
The prevalence forecasted for Diabetes and CVD has increased from 21,000 (2009) to 25,000 (2010). This level of increased volume makes it difficult for the district to not only absorb these increases but increase the target to be achieved. The target for Pacific diabetes detection is however slightly decreased from 58% (2009-10) to 55%. However, the actual number increases and this may prove difficult to achieve given the increasing prevalence	By maintaining our 2009-2010 targets for most groups still equates to an increase of 3,033 free diabetes annual checks, and an increase of 2,430 individuals with and HbA1c <8%  Discussions with the Local Diabetes Advisory Team and other colleagues concluded that with the prevalence increase, maintaining our current targets with a slight decrease for Pacific would be appropriate and achievable

## 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)	<p>Implement regional and local prioritisation process to ensure agreed programme of work can be delivered with existing resources</p> <p>Maximise opportunity for regional and national collaboration to share resources and outputs</p>
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	<p>Targeted recruitment plans</p> <p>Understanding the drivers of turnover for these groups and implementing appropriate interventions</p> <p>Targeted retention strategies</p> <p>The regional cancer service will continue to work proactively to increase placements in cancer specialities via national training programmes as well as international recruitment. Strategies to retain specialist staff will also remain a key focus the service</p>
<p>The elective target set for Auckland DHB is a significant challenge. The target represents 21% of the increase nationally</p> <p>This rate of increased delivery will become increasingly difficult given the population based funding anomalies that are apparent within the Auckland DHB population. These include having an aged care service that significantly exceeds the population revenue Auckland DHB receives for that population. While nationally Auckland DHB has the lowest elective</p>	<p>Adopting this target underscores Auckland DHB's commitment to increasing its elective surgical rates for its population</p> <p>Auckland DHB expects to work with the Ministry of Health during the 2010-11 year to address these and other Population Based Funding imbalances to support the government's electives services strategy and to ensure fair access for the Auckland DHB population</p>

Issues and risks	Mitigation strategies
intervention rates we had the 4 <sup>th</sup> highest increase in elective surgery delivery over 4 years 2005-06 to 2008-09. This clearly shows Auckland DHB commitment to increasing access for its population	
<p>Cancer wait times:</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. An inability to roster extended hours for radiation therapy and/or outsource treatment leading up to December 2010, and</li> <li>2. The delay in replacement of the MV5 linear accelerator (scheduled to be commissioned in Jan 2011)</li> </ol> <p>These two factors will place additional pressure on waiting time targets</p>	<ol style="list-style-type: none"> <li>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 January 2011 to manage peaks in demand</li> <li>2. Close project management of time lines for replacement plan. Slippage reported immediately to enable strategies for mitigating waiting delays to be implemented</li> </ol>
<p>The organisation is undergoing a vast number of changes, some of which required considerable culture change to support. The overall programme of change is ambitious and will require activities over the longer term</p> <p>The changes signalled in this plan are year 2 of our process improvement plan</p>	<p>We have change management staff with expertise who are facilitating the changes needed and continue to mentor staff through this process</p>

### 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

### Population-based funding formula (PBF)

The Ministry of Health uses a Population Based Formula (PBF) to distribute funding to each of the 21 District Health Boards classification

Funding is allocated on a proportionate basis relative to the national population and specific socio-economic factors and deprivation. Each district's population is 'adjusted' for gender, ethnicity and social-deprivation status and age

While Auckland's district population is growing to nearly half a million people, our rate of increase is lower than neighbouring DHBs. This means a lowered share of national PBF funding for Auckland DHB relative to others

The overall socio-economic status of the Auckland population, relative to the national population, is viewed as 'less worse off' based on socio-economic factors and deprivation classification

Auckland district does however have other emerging ethnic populations with high health needs that are yet to be recognised in the funding formula, e.g. South Indian for diabetes/cardiovascular and African communities for maternity/reproductive health

Auckland DHB is expected to restrain cost growth, reduce waste and improve productivity over 2010-11

The Minister of Health expects:

- Auckland DHB will continue to maintain its provision of 'core services' (in line with the national Quality Policy Framework, National Service Coverage and Service Schedules)
- Auckland DHB must also 'demonstrate' health services growth that is in line with demographic trends
- Per capita expenditure on community pharmaceuticals will be maintained at the current level
- 'First contact patient care' should be adequate to meet population growth and demographic demand
- Savings will need to be achieved from PHO management fees and others
- Oncology services are a national priority; and there will be increased pressure to reduce further wait times for treatment and follow ups

Because Auckland DHB revenue is fixed, our cost structures need to be less or equal to the budget cost target. There is a real fiscal risk to Auckland DHB if we deliver services beyond those we can afford

Auckland DHB key funding allocation principles are:

- Acutes and electives service will be separately monitored, with little scope of 'transferring monies' across the service types to offset overproduction in one or the other
- Acute emergency and urgent services funding for 2010-11 will be set by annualising the 2009-10 YTD production and adding an averaged growth factor of 0.85% per month (to cover over the year, the projected population growth of 1.53%). The impact of this increased service provision means compromises in the

This includes work for other DHBs, which has not been contracted for, or where there is no 'wash-up agreement

funding and development of new and innovative service programmes

- Community pharmacy is based on national agreement between CEOs and PHARMAC; which has forecasted population growth and higher utilization due to greater primary care access and screening programmes
- A 2% increase in First Contact funding will be applied in 2010-2011 as part of the primary health care funding
- Community laboratory budget reflects the regional contracts
- Services such as Health of Older People that received a heavy reduction in the current year's budget have a compensatory step up in funding. This is also the case for PHO funding where a 'catch up' is proposed
- The majority of NGO contracts are demand driven (often driven by primary on-referrals) and these need to be funded to the forecast demographic demand levels
- Auckland DHB will apply a price increase in the Aged Residential Care Contract. The increase includes 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 unannounced spot audits being implemented from 1 January 2010 there may be a cost increase to providers for such audits due to increased time taken to conduct the audits

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.

Further work will be undertaken to agree the size of the Auckland DHB mental health ring-fence figure. This work is expected to be completed by December 2010.

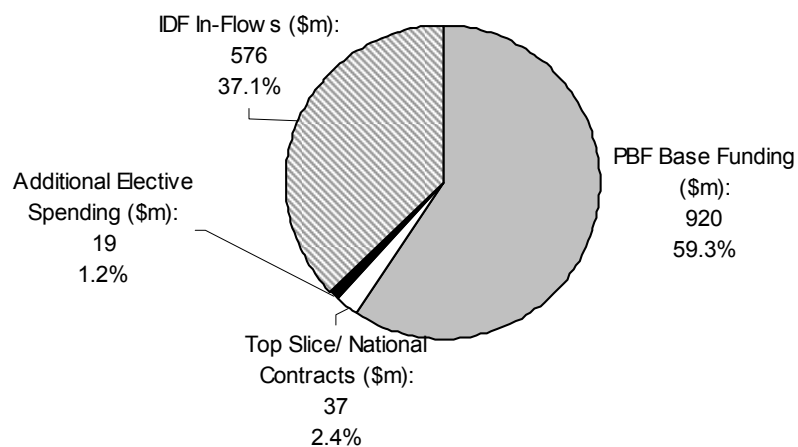
## Funding received

### 2010–11 Ministry of Health and IDF\* funding compared to 2009–10

	2009–10 Forecast \$m	2010–11 Plan \$m	% change
Population-based funding (PBF)	930.8	956.4	2.8%
Additional sector capability initiatives	12.1	10.3	(14.9)%
Additional elective spending	18.6	22	18.3%
Other side contracts	60.1	66.9	11.3%
Inter District Flows	558.7	574.7	2.9%
<b>Total</b>	<b>1,580.3</b>	<b>1,630.3</b>	<b>3.2%</b>

\* IDF = inter district flows, people who come into the ADHB area for treatment

## Breakdown of Auckland DHB funding received



## The district-wide allocation of funding

	Services for Auckland Population, \$m			
	By Auckland DHB provider	Provided by other DHBs & funded by ADHB	ADHB community/NGO providers	Total \$ by Auckland DHB
Hospital personal health services	\$316	\$51	-	\$367
Additional electives	\$18	\$3	\$6	\$27
Pharmaceuticals	\$82	\$10	\$89	\$181
Laboratory services	\$27	\$1	\$19	\$47
PHOs and related services e.g. GMSS		\$11	\$72	\$83
Mental health services	\$92	\$18	\$33	\$125
Health of Older People, Aged Residential Care, and Home Based Support Services	\$35	\$8	\$101	\$144
Public Health (regional)	\$15	-	\$2	\$17
Radiology services	\$33	-	\$1	\$34
Other hospital-based services				-
Other community-based services	-	\$2	\$8	\$10
Other-miscellaneous	\$5		\$1	\$6
<b>Total</b>	<b>\$623m</b>	<b>\$104m</b>	<b>\$332m</b>	<b>\$1,041m</b>

## Capital expenditure projects for 2010-11

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 Auckland City Hospital site starting in 2010-11  \$11 million 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 Auckland DHB 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
Starship Theatres Upgrade	A \$15 million project to upgrade the theatres in Starship with \$7m budgeted for build commencement in 2010-11

Financing for the above projects in the 2010-11 year is to be provided from Auckland cashflows and existing debt facilities.

## 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
<b>Adult Emergency Department</b>	Emergency Medicine	2,702		712	
<b>Ambulatory Health Services</b>	Dermatology	89	30	54	17
	Endocrinology	74		95	
	Immunology	192		275	
	Oral Health	18	304	46	806
	Rheumatology	76		4	
<b>Cancer and Blood services</b>	Haematology	842		1,490	

Portfolio	Sub speciality	Cost weighted discharge			
		For Auckland population		For other populations	
		Acute	Elective	Acute	Elective
	Oncology	869		1,875	
<b>Cardiac Services</b>	Cardiology	2,707	817	2,866	1,423
	Cardiothoracic	1,460	986	4,209	4,118
	Vascular Surgery	954	439	1,409	995
<b>General Medicine</b>	General Medicine	9,608		322	
	Infectious Diseases	193		61	
<b>General Surgery, Trauma, Gastro, Respiratory</b>	Gastroenterology	510		109	
	General Surgery	5,023	3,188	1,802	807
	Liver Resections	-	-	-	-
	Respiratory Medicine	1,487		1,080	
<b>Paediatric Medical and Community services</b>	General Paediatrics	1,232		2,120	
	Paediatric Emergency department	1,227		1,035	
	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		
<b>Ophthalmology</b>	Ophthalmology	334	997	738	1,589
<b>Orthopaedics Adult</b>	Orthopaedics	5,183	3,375	710	249
<b>Paediatric Cardiac and ICU's</b>	Adult Congenital Heart	31	62	1	55
	Newborn Services	2,672		1,811	
	Paediatric Cardiac	479	334	1,555	2,156
<b>Surgical and Community Services</b>	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
<b>Transplant, Renal, Urology, ORL, Neurology</b>	Neurology	900	-	635	-
	Neurosurgery	999	413	2,449	1,230

Portfolio	Sub speciality	Cost weighted discharge			
		For Auckland population		For other populations	
		Acute	Elective	Acute	Elective
	ORL	464	774	773	768
	Renal Medicine	1,126		995	
	Renal Transplant	181		613	
	Urology	629	761	1,186	735
<b>Women's Health</b>	Gynaecology	1,216	1,361	224	597
	Obstetrics	5,616		2,458	
<b>Grand Total</b>		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 criteria to determine how the Future Funding Track (FFT) is applied to specified Health of Older Persons and Personal Health Agreements. The process covers service agreements excluded from nationally or regionally negotiated price increases. The criteria help 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 (Lab Tests Auckland Ltd and Diagnostic Med Lab Ltd)	2	\$73,755,000*	
Dental	69	\$4,195,800	
Health of older persons services – residential care	66 (total facilities 80)	\$96,233,844	4,222 contracted beds (at September 2009)
Health of older persons services (inter district flows)		\$9,079,716	
Health of older persons services – non-residential care	16	\$5,259,324	
Home-based support	5	\$18,500,004	
Maori health services	2	\$1,471,726	
Mental health services	31	\$24,767,982.7	195 contracted beds (among other services purchased)
Mental health (inter district flows)		\$17,661,624	
Mental health services – alcohol and other drug services	6	\$9,119,433.3	180 contracted beds (among other services purchased)
Pacific health services	3	\$2,089,479.01	
Primary care organisation (PCO)	1	\$1,690,191.76	
Personal health services (includes Lifting the Health of Aucklanders, miscellaneous services and national travel assistance)	23	\$22,907,054	
Personal health services (inter district flows)		\$73,726,320	
Pharmacy	122 (total facilities 123)	\$112,932,116**	
Pharmacy (wholesalers)	4	\$4,600,000**	
Primary health care organisation (PHOs)	5 (as at 1 March 2010)	\$94,001,664	
Women's and children's health services	19	\$7,000,000	
		<b>\$578,991,279</b>	<b>4,597 total beds in the community</b>

\* This figure represents the total value of the spend against this service inclusive of inter district flows

\*\* These figures equate to the combined Pharmacy budget and represent the total value of the spend against this service inclusive of inter district flows

## 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
- Board policy is to revalue land and buildings to fair value, as determined by a registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every 3 years. The latest revaluation was completed on 30 June 2009. We do not anticipate a revaluation of property assets during the District Annual Plan planning horizon. A +/- 5% change in the valuation of land and buildings would result in a change in asset values of \$40m, and impact on the Statement of Financial Performance by approximately \$4.0m per annum.

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.

### Efficiency Related Activity

Auckland DHB contributes to the national health goal of getting the best out of the funding available. We 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.

Efficiencies 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.

<b>Auckland DHB actions</b>	<b>efficiencies</b>
Achieve financial security	\$1.3m
Improve productivity and quality	\$11.4m
Enhance regional cooperation.	\$3.3m

## Statement of financial performance

<b>STATEMENT OF FINANCIAL PERFORMANCE</b>	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<b>REVENUE</b>					
<b>Base Funding</b>					
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
<b>Side Contracts with Ministry of Health</b>					
Additional Electives	19,176	18,611	20,358	20,358	20,358
Sector Capability & Innovation	-	12,122	10,253	10,253	10,253
Other Side Contracts	60,417	60,037	66,863	66,863	66,863
	79,593	90,770	97,474	97,474	97,474
<b>Other Revenue</b>					
Other Patient Care	35,755	33,584	32,951	33,643	34,316
External	99,427	86,437	82,091	83,933	85,593
	135,182	120,022	115,043	117,576	119,909
<b>TOTAL REVENUE</b>	<b>1,638,253</b>	<b>1,700,299</b>	<b>1,743,618</b>	<b>1,795,344</b>	<b>1,848,493</b>
<b>OPERATING COSTS</b>					
Employee Costs	686,971	720,008	734,414	758,319	783,696
Treatment Costs	254,627	257,152	249,067	254,298	259,384
Funder Payments	521,457	550,560	573,934	590,848	608,269
Property & Equipment Maintenance	51,098	49,809	50,839	51,890	52,928
Administration	20,382	18,444	24,225	24,734	25,228
<b>TOTAL OPERATING COSTS</b>	<b>1,534,536</b>	<b>1,595,973</b>	<b>1,632,480</b>	<b>1,680,089</b>	<b>1,729,505</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>103,717</b>	<b>104,326</b>	<b>111,138</b>	<b>115,256</b>	<b>118,989</b>
<b>NON OPERATING COSTS</b>					
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	36,617	36,650	36,500
<b>TOTAL NON OPERATING COSTS</b>	<b>103,392</b>	<b>104,114</b>	<b>111,081</b>	<b>115,196</b>	<b>118,928</b>
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>	<b>325</b>	<b>212</b>	<b>58</b>	<b>60</b>	<b>61</b>

## 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

72% of non-Maori die over the age of 75 years of age compared to 16% for Maori

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

Maori have higher Years of Lost Life (YLL) rates than non-Maori

### Pacific

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

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.

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

### Asian, migrants and refugees

Asian people make up 25% 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 3-4e 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.

*Multiple data sources, primarily the Ministry of Health, Health Survey and 2010 updates*

## Appendix 2: Leadership

### Organisational values

Integrity	Respect	Innovation	Effectiveness
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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.
Dr Margaret Wilsher	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, Procure Network Auckland PHO
Kay Hyman	General Manager – Clinical Services
Margaret Dotchin	General Manager – Clinical Services and Nurse Director, Adult Health Services
Dr Margaret Wilsher	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 Estimate \$'000	2012-13 Estimate \$'000
<b>REVENUE</b>					
<b>Base Funding</b>					
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
<b>Side Contracts with Ministry of Health</b>					
Additional Electives	19,176	18,611	20,358	20,358	20,358
Sector Capability & Innovation	-	12,122	10,253	10,253	10,253
Other Side Contracts	60,417	60,037	66,863	66,863	66,863
	79,593	90,770	97,474	97,474	97,474
<b>Other Revenue</b>					
Other Patient Care	35,755	33,584	32,951	33,643	34,316
External	99,427	86,437	82,091	83,933	85,593
	135,182	120,022	115,043	117,576	119,909
<b>TOTAL REVENUE</b>	<b>1,638,253</b>	<b>1,700,299</b>	<b>1,743,618</b>	<b>1,795,344</b>	<b>1,848,493</b>
<b>OPERATING COSTS</b>					
Employee Costs	686,971	720,008	734,414	758,319	783,696
Treatment Costs	254,627	257,152	249,067	254,298	259,384
Funder Payments	521,457	550,560	573,934	590,848	608,269
Property & Equipment Maintenance	51,098	49,809	50,839	51,890	52,928
Administration	20,382	18,444	24,225	24,734	25,228
<b>TOTAL OPERATING COSTS</b>	<b>1,534,536</b>	<b>1,595,973</b>	<b>1,632,480</b>	<b>1,680,089</b>	<b>1,729,505</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>103,717</b>	<b>104,326</b>	<b>111,138</b>	<b>115,256</b>	<b>118,989</b>
<b>NON OPERATING COSTS</b>					
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	36,617	36,650	36,500
<b>TOTAL NON OPERATING COSTS</b>	<b>103,392</b>	<b>104,114</b>	<b>111,081</b>	<b>115,196</b>	<b>118,928</b>
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>	<b>325</b>	<b>212</b>	<b>58</b>	<b>60</b>	<b>61</b>

**Table 2: Statement of comprehensive income**

STATEMENT OF COMPREHENSIVE INCOME	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>	325	212	58	60	61
<b>OTHER COMPREHENSIVE INCOME</b>					
Gains/Losses on Property Revaluations	( 35,739)	-	-	-	-
<b>TOTAL COMPREHENSIVE INCOME</b>	<b>( 35,414)</b>	<b>212</b>	<b>58</b>	<b>60</b>	<b>61</b>

**Table 3: Cost of service statement**

COST OF SERVICE STATEMENT	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<b>Governance &amp; Funding Administration</b>					
Revenue	3,245	6,628	4,892	5,029	5,170
Expenses	( 11,815)	( 12,077)	( 5,789)	( 6,024)	( 6,262)
<b>Net Surplus/(Deficit) - Governance &amp; Funding Administration</b>	<b>( 8,570)</b>	<b>( 5,449)</b>	<b>( 897)</b>	<b>( 995)</b>	<b>( 1,092)</b>
<b>Provider</b>					
Revenue	1,076,717	1,137,922	1,162,210	1,192,841	1,224,062
Expenses	( 1,102,462)	( 1,135,465)	( 1,162,154)	( 1,193,838)	( 1,230,819)
<b>Net Surplus/(Deficit) - Provider</b>	<b>( 25,745)</b>	<b>2,457</b>	<b>56</b>	<b>( 997)</b>	<b>( 6,757)</b>
<b>Funder</b>					
Revenue	1,463,505	1,536,164	1,585,022	1,634,218	1,685,034
Expenses	( 1,428,865)	( 1,532,960)	( 1,584,123)	( 1,632,166)	( 1,677,124)
<b>Net Surplus/(Deficit) - Funder</b>	<b>34,640</b>	<b>3,204</b>	<b>899</b>	<b>2,052</b>	<b>7,910</b>
<b>Elimination</b>					
Revenue	( 905,214)	( 980,415)	( 1,008,506)	( 1,036,744)	( 1,065,773)
Expenses	905,214	980,415	1,008,506	1,036,744	1,065,773
<b>Net Surplus/(Deficit) - Elimination</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>Total</b>					
Revenue	1,638,253	1,700,299	1,743,618	1,795,344	1,848,493
Expenses	( 1,637,928)	( 1,700,087)	( 1,743,560)	( 1,795,284)	( 1,848,432)
<b>TOTAL SURPLUS/(DEFICIT) FOR THE YEAR</b>	<b>325</b>	<b>212</b>	<b>58</b>	<b>60</b>	<b>61</b>

**Table 4: Statement of changes in equity**

STATEMENT OF CHANGES IN EQUITY	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<b>Balance as at 1 July</b>	549,131	478,717	482,144	486,260	489,462
Total Comprehensive Income	(35,414)	212	58	60	61
Capital Contributions from the Crown	-	3,215	4,058	3,143	-
Capital Repayments to the Crown	(35,000)	-	-	-	-
<b>Balance as at 30 June</b>	<b>478,717</b>	<b>482,144</b>	<b>486,260</b>	<b>489,462</b>	<b>489,523</b>

**Table 5: Statement of financial position**

STATEMENT OF FINANCIAL POSITION	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<b>ASSETS</b>					
<b>CURRENT ASSETS</b>					
Cash, Bank Balances & Investment bonds	35,287	30,030	13,293	11,695	16,074
Financing Cash Deposit	-	10,500	21,000	31,500	42,000
Restricted Trust Funds	11,780	11,508	11,508	11,508	11,508
Receivables and Prepayments	63,416	63,719	58,435	59,419	60,518
Inventories	11,717	11,717	12,106	12,445	12,794
	122,200	127,474	116,342	126,567	142,893
<b>NON CURRENT ASSETS</b>					
Restricted Trust Funds	8,000	8,000	8,000	8,000	8,000
Property, Plant and Equipment	888,803	896,986	915,566	915,041	909,056
Intangible Assets	12,766	19,970	24,607	25,992	26,425
Derivatives in Gain	8,227	5,052	4,399	3,463	2,440
Investment in Associates	386	386	386	386	386
	918,182	930,394	952,958	952,881	946,307
<b>TOTAL ASSETS</b>	<b>1,040,382</b>	<b>1,057,868</b>	<b>1,069,300</b>	<b>1,079,449</b>	<b>1,089,200</b>
<b>LIABILITIES</b>					
<b>CURRENT LIABILITIES</b>					
Trade and Other Payables	133,129	134,652	137,189	139,145	141,785
Employee Benefits	118,013	121,568	124,900	127,773	131,350
Borrowings	18,375	85,564	25,836	27,642	30,218
Funds held in Trust	1,038	1,054	1,126	1,198	1,270
Derivatives in Loss	1,273	(0)	-	-	-
	271,827	342,837	289,051	295,757	304,623
<b>NON - CURRENT LIABILITIES</b>					
Employee Benefits	20,673	20,673	20,880	20,880	21,464
Borrowings	269,167	212,213	273,109	273,349	273,589
	289,840	232,886	293,989	294,229	295,053
<b>TOTAL LIABILITIES</b>	<b>561,666</b>	<b>575,723</b>	<b>583,040</b>	<b>589,986</b>	<b>599,676</b>
<b>EQUITY</b>					
Public Equity	566,090	569,304	573,362	576,505	576,505
Accumulated Deficit	(477,657)	(477,444)	(477,386)	(477,327)	(477,266)
Revaluation Reserve	381,277	381,277	381,277	381,277	381,277
Trust/Special Funds	9,007	9,007	9,007	9,007	9,007
<b>TOTAL EQUITY</b>	<b>478,716</b>	<b>482,144</b>	<b>486,260</b>	<b>489,462</b>	<b>489,523</b>
<b>NET ASSETS</b>	<b>1,040,383</b>	<b>1,057,867</b>	<b>1,069,300</b>	<b>1,079,449</b>	<b>1,089,200</b>

**Table 6: Statement of cash flows**

STATEMENT OF CASH FLOWS	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<b><u>CASH FLOWS FROM OPERATING ACTIVITIES</u></b>					
<b>Cash was provided from</b>					
Provision of Health Services	1,592,646	1,700,738	1,744,507	1,790,113	1,842,618
Repayment of Major Debtors by the Crown	36,957	-	-	-	-
Interest Received	11,356	5,217	4,436	4,793	5,411
	1,640,959	1,705,955	1,748,944	1,794,906	1,848,028
<b>Cash was applied to</b>					
Employee Costs	(657,814)	(716,453)	(730,875)	(755,446)	(779,533)
Other Operating Costs	(917,172)	(911,339)	(931,907)	(956,412)	(979,628)
Interest Paid	(21,065)	(21,458)	(19,910)	(17,360)	(16,060)
	(1,596,051)	(1,649,251)	(1,682,693)	(1,729,218)	(1,775,222)
<b>Net Cash Flow from Operating Activities</b>	<b>44,908</b>	<b>56,704</b>	<b>66,251</b>	<b>65,687</b>	<b>72,807</b>
<b><u>INVESTING ACTIVITIES</u></b>					
<b>Cash was provided from</b>					
Proceeds from Sale of Fixed Assets	83	22	(16)	-	-
Decrease/(Increase) in Restricted Trust & Financing Funds	(1,042)	(10,212)	(10,428)	(10,428)	(10,428)
	(959)	(10,190)	(10,444)	(10,428)	(10,428)
<b>Cash was applied to</b>					
Purchase of Fixed Assets and Intangibles	(42,344)	(65,063)	(77,527)	(60,000)	(58,000)
<b>Net cash (Outflow) from Investing Activities</b>	<b>(43,303)</b>	<b>(75,253)</b>	<b>(87,971)</b>	<b>(70,428)</b>	<b>(68,428)</b>
<b><u>FINANCING ACTIVITIES</u></b>					
Proceeds from Capital Raised/(Repaid)	(35,000)	3,215	4,058	3,143	-
Proceeds from Loans Raised	0	20,575	11,425	10,500	10,500
Loans Repaid	(10,500)	(10,500)	(10,500)	(10,500)	(10,500)
<b>Net cash (Outflow) from Financing Activities</b>	<b>(45,500)</b>	<b>13,290</b>	<b>4,983</b>	<b>3,143</b>	<b>-</b>
<b>OPENING BANK BALANCE</b>	<b>79,181</b>	<b>35,287</b>	<b>30,028</b>	<b>13,291</b>	<b>11,693</b>
<b>NET CASH INFLOW/(OUTFLOW)</b>	<b>(43,895)</b>	<b>(5,259)</b>	<b>(16,737)</b>	<b>(1,598)</b>	<b>4,379</b>
<b>CLOSING BANK BALANCE</b>	<b>35,287</b>	<b>30,028</b>	<b>13,291</b>	<b>11,693</b>	<b>16,072</b>

**Table 6 (cont): Statement of cash flows**

<b>RECONCILIATION OF OPERATING DEFICIT WITH CASH FLOWS FROM OPERATING ACTIVITIES</b>	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<b>Total Surplus/(Deficit) for the Year</b>	325	212	58	60	61
<b>Non - Cash Items</b>					
Depreciation and Impairment Losses	42,811	48,182	54,310	59,140	63,552
(Gains)/Losses on Financial Instruments	(5,228)	1,902	653	936	1,023
Amortisation of Borrowing Costs	239	172	173	336	240
	37,822	50,256	55,136	60,413	64,815
<b>Items Classified as Investing Activities</b>					
Gain on Sale of Property Plant and Equipment	339	1,472	16	-	-
<b>Movements in Working Capital</b>					
(Increase)/Decrease in Receivables	14,180	(303)	5,284	(984)	(1,098)
(Increase)/Decrease in Inventories	(955)	0	(389)	(339)	(348)
Increase/(Decrease) in Payables	(6,803)	5,067	6,146	6,538	9,378
	6,422	4,764	11,041	5,215	7,931
<b>Net Cash Flow from Operating Activities</b>	44,908	56,704	66,251	65,687	72,807

**Table 7: Balance sheet equity ratio**

<b>BALANCE SHEET EQUITY RATIO</b>	2008-09 Actual \$'000	2009-10 Forecast \$'000	2010-11 Plan \$'000	2011-12 Estimate \$'000	2012-13 Estimate \$'000
<b>Equity Position</b>					
Crown Equity	(468,671)	(472,084)	(476,127)	(479,258)	(479,247)
Trust Equity	(10,045)	(10,061)	(10,133)	(10,205)	(10,277)
Total Equity	(478,716)	(482,144)	(486,260)	(489,462)	(489,523)
<b>Total Debt</b>	-	-	-	-	-
Bank					
Bonds	(120,000)	(120,000)	(50,000)	(50,000)	(50,000)
Crown Funding Authority	(163,500)	(173,200)	(244,500)	(244,500)	(244,500)
	(283,500)	(293,200)	(294,500)	(294,500)	(294,500)
Total Debt	(283,500)	(293,200)	(294,500)	(294,500)	(294,500)
Total Debt + Equity	(762,216)	(775,344)	(780,760)	(783,962)	(784,023)
<b>Equity Ratio - to be less than 65%</b>	37.2%	37.8%	37.7%	37.6%	37.6%
	4,041	4,577	4,445	6,491	9,307

Key lenders and applicable covenants	
Key lenders	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	
<b>Bonds</b>	\$120 million: \$70 million to mature 2010* \$50 million to mature 2015 * Commitment by Crown Health Funding Agency to fund
<b>Crown Health Funding Agency</b>	\$184.5 million * increasing to \$254.5 million when bonds repaid
<b>Commonwealth Bank of Australia</b>	\$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 led 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
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](http://www.adhb.govt.nz/publications).

<b>Reporting entity</b>	<p>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.</p> <p>Auckland DHB is a public benefit entity (PBE), as defined under NZ IAS 1.</p> <p>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.</p>	
<b>Statement of compliance</b>	<p>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).</p>	
<b>Basis of preparation</b>	<p>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.</p> <p>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.</p>	
<b>Basis for consolidation</b>	<b>Subsidiaries</b>	<p>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.</p>
	<b>Associates</b>	<p>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).</p> <p>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.</p> <p>Northern DHB Support Agency Limited with Counties-Manukau and Waitemata DHB exists to provide a shared</p>

		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.
<b>Transactions eliminated on consolidation</b>	All inter-entity transactions are eliminated on consolidation.	
<b>Foreign currency</b>	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.	
<b>Budget figures</b>	The budget figures are those approved by the Board in its District Annual Plan and included in the Statement of Intent tabled in Parliament.	
<b>Equity</b>	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.	
<b>Property, plant and equipment (PPE)</b>	The major classes of property, plant and equipment are as follows: <ul style="list-style-type: none"> <li>- Freehold land</li> <li>- Freehold buildings and fitouts</li> <li>- Plant, equipment and vehicles</li> <li>- Leased assets</li> <li>- Work in progress</li> </ul>	
	<b>Owned assets</b>	<p>Except for land and buildings, items of PPE are stated at cost, less accumulated depreciation and impairment losses.</p> <p>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.</p> <p>Additions to PPE between valuations are recorded at cost.</p>
	<b>Disposal of property, plant and equipment</b>	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.
	<b>Leased assets</b>	<p>Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases.</p> <p>Operating lease payments are recorded as an expense in the Statement of Financial Performance on a straight-line basis over the lease term.</p>

	<b>Subsequent costs</b>	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.							
	<b>Depreciation</b>	<p>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:</p> <table border="1"> <thead> <tr> <th>Asset class</th> <th>Useful lives</th> </tr> </thead> <tbody> <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> </tbody> </table> <p>The residual value, useful life and depreciation method of assets is reassessed annually.</p> <p>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.</p>	Asset class	Useful lives	Freehold buildings and fitouts	1–89 years	Plant, equipment and vehicles	2–20 years	Lease assets
Asset class	Useful lives								
Freehold buildings and fitouts	1–89 years								
Plant, equipment and vehicles	2–20 years								
Lease assets	4–8 years								
<b>Intangible assets</b>	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.								
<b>Interest-bearing loans and borrowings</b>	<p>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.</p> <p>Crown Health Financing Agency borrowings are recorded at nominal or “face” value.</p>								
<b>Derivative financial instruments</b>	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.								
<b>Trade and other receivables</b>	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.								
<b>Inventories</b>	<p>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.</p> <p>Inventories held for distribution are stated at the lower of cost and current replacement cost.</p>								
<b>Cash and cash equivalents</b>	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.								

<b>Properties held for sale</b>	Properties held for sale are measured at the lower of carrying amount or fair value less costs to sell.	
<b>Impairment</b>	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.	
<b>Financial instruments</b>	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.	
<b>Employee benefits</b>	<b>Defined Contribution Plan (DCP)</b>	Obligations for contributions to DCPs are recognised as an expense in the Statement of Financial Performance as incurred.
	<b>Retiring Gratuities and Long Service Leave</b>	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.
	<b>Annual leave, sick leave, continuing medical education leave and expenses</b>	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.
<b>Provisions</b>	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.	
<b>Revenue</b>	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.	

	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.	
<b>Expenses</b>	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.	
<b>Income tax</b>	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.	
<b>Goods and services tax (GST)</b>	All amounts are shown exclusive of GST, except for receivables and payables that are stated inclusive of GST.	
<b>Borrowing costs</b>	Borrowing costs are recognised as an expense when incurred.	
<b>Cost allocation</b>	Auckland DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below:	
	<b>Cost allocation policy</b>	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.
	<b>Criteria for direct and indirect costs</b>	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.
	<b>Cost drivers for allocation of indirect costs</b>	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.

### 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.

## Examples of the co-operative agreements or arrangements

The following are some examples of the co-operative agreements or arrangements that the 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

Hospital specialist service	Unit of Measure	For Auckland resident population		For other populations	
		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
Cardiothoracic	Written plan of care	320	\$ 45,919	102	\$ 11,246
	Attendance	181	\$ 70,913	548	\$ 213,567
Child Health & Disability	Cost weighted discharge	2,446	\$ 10,789,307	8,327	\$ 36,723,407
	Programme	203,000	\$ 209,325	-	\$ -
Clinical Infectious Diseases	Service	1	\$ 1,752,126	-	\$ -
	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

Hospital specialist service	Unit of Measure	For Auckland resident population		For other populations	
		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		For other populations	
		2010-11 proposed Volumes	2010-11 proposed \$	2010-11 proposed Volumes	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	-	\$ -

Hospital specialist service	Unit of Measure	For Auckland resident population		For other populations	
		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
	Completed 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

Hospital specialist service	Unit of Measure	For Auckland resident population		For other populations	
		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		For other populations	
		2010-11 proposed Volumes	2010-11 proposed \$	2010-11 proposed Volumes	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		For other populations	
		2010-11 proposed Volumes	2010-11 proposed \$	2010-11 proposed Volumes	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

## Appendix 7: Metro Auckland Primary Care Plan

### Metro Auckland Plan to implement “Better, Sooner More Convenient”

The metro Auckland health partners are committed to clinical led implementation of this plan for **Better, Sooner, More Convenient** (BSMC) care.

They are also committed to building the capability and capacity of primary and community based services to address the significant challenges to the health system now and into the future. The three BSMC business case consortiums including the three metro-Auckland DHBs, primary, community and hauora providers are committed to delivering the necessary outcomes through key focused initiatives, strong clinical leadership, investment of resources and a regional approach.

The **Better, Sooner More Convenient** policy provides opportunities for clinicians, primary care organisations, providers and DHBs to integrate a system that truly puts patients first, increases the capacity and access of quality community based clinical services and manages our shared, scarce resources effectively.

In the first year of this plan (2010/11) the following immediate improvements will be made to the region’s services to address fragmentation, inconsistency and inefficiencies in some crucial core services.

- ✓ **Direct access to radiology.** There will be better and sooner access to radiology. An additional 4,500 procedures will be provided and GPs will be able to directly refer 16,000 patients so speeding up the process of obtaining this service.
- ✓ **More Minor Surgery in the community.** There will be a 130% increase in treatments for skin cancer from 513 to 1,200 with surgery being offered in more convenient primary care settings by primary care clinicians.
- ✓ **Reduced impact on hospitals (POAC).** There will be a 50% increase in the number of Primary Options for Acute Care (POAC) referrals meaning that in total over 12,500 people’s acute care will be safely managed in the community. This will include broadening the scope of referrals from DHB emergency departments and ambulances. The resultant decrease in ED attendances is expected to be at least 5,000.
- ✓ **Co-ordinated metro Auckland approach to affordable after hours.** Across Auckland there will be a formalised network of at least 10 clinics across Auckland providing local, affordable access to urgent care until 10pm. This will integrate with the patient’s usual GP to ensure continuity.
- ✓ **Primary secondary clinical pathways.** We will develop clinical pathways to ensure care is delivered in the right place by the right clinician with greater involvement and integration with primary care. Five pathways will be developed which will result in 10% being done in primary care and 10-20% of outpatient appointments being freed up in those areas for other patients.
- ✓ **Pharmaceuticals: Releasing funds for the front line and improving quality.** We will invest in a clinically led process to more effectively manage our community pharmaceutical budget. This will involve doctors, nurses and clinical pharmacists and \$1.5 million real savings by appropriate prescribing and safer use of medicines, particularly primary care and residential care.
- ✓ **Increasing Māori provider capability.** The DHBs and the Ministry of Health will devolve direct funding of over \$600K to Iwi and Māori providers by December 2010. This will put the control of these services nearer to the communities they service whilst supporting the implementation of the Whānau Ora programme.
- ✓ **Regional Health Targets.** We will accelerate progress to meet the national Health Targets by shifting from DHB specific targets to regional targets across all the business cases. We agree to stretch our regional targets for immunisation (90%), diabetes, CVD risk assessment (80%) and smoking to substantially improve our combined performance so also address key areas of inequality in our system.

These are described further in this document with more detailed information available on request.

## Supporting the activity and getting ready for 2011/12

Over the next year we will continue to build on the work already done to develop a comprehensive, integrated and more responsive approach to address the intent of Better Sooner More Convenient for Aucklanders.

During 2010/11 we will achieve this by:

- Subject to due diligence and with full Board support incrementally **implement the alliance approach** with our business case partners
- **Establishing local health networks** across Auckland
- Developing a comprehensive **metro-Auckland Primary Care Plan** across all three DHBs and all three business cases
- Development of a **metro-Auckland approach to long term conditions**
- Build on the after hours planning to make additional progress in acute demand management
- Develop the necessary alliances and structures to **deliver seamless care between provider arm community services and general practice (including district nursing)** through consultation with the relevant staff and unions. Commitment to **developing an integrated multidisciplinary wound care pathway** across the region and testing it within a number of practices across 2010/11. Would also look to **collocate at least two wound care clinics into the community** which we would look to be based at an IFHC, community health hub or Whānau Ora centre.
- We will do further clinically led design and development work across all three BSMC business cases in relation to Local Health Networks, Integrated Family Health Centres, Community Health Hubs, Whānau Ora Centres and enhanced general practice. Subject to council planning and resource consent processes **we expect to have one to two centres across the region by 30 June 2011.**

## What is our objective?

### 1. Better Access to Diagnostics - Radiology

To provide metro Auckland GPs with:

1. Direct access to key radiological investigations – X-ray, Ultrasound, CT and MRI
2. Regionally agreed clinical triage criteria to support decision making about radiology referrals
3. Virtual budgets to help manage demand

## How?

Building on a successful pilot in ADHB:

- Regional clinical triage criteria and decision support within GP PMS systems
- Virtual budgets through a demand management tool integrated into GP PMS systems

### 2. Minor Surgery – Skin Lesions

Increase the volumes for minor skin surgery in primary care thereby improving access for Aucklanders and skin cancer outcomes.

- The establishment of a consistent DHB approach through a regional clinical governance group by 30 June 2010
- Contracts in place with credentialed GPs by 30 September 2010
- Consistent processes across all three DHBs for referral to credentialed GPs by 1 October 2010

<p><b>Why?</b></p>	<p><b>1. Better Access to Diagnostics - Radiology</b></p> <ul style="list-style-type: none"> <li>- Contracts with private and public radiology participating in the scheme</li> <li>- Training for all general practice teams</li> <li>- Phase I – Roll out to at least 100 practices within ADHB (80%) by 31 December 2010</li> <li>- Phase II – Through local clinical engagement and support, roll out to up to another 100 practices in Greater Auckland between 1 January and 30 June 2011</li> </ul> <p>- To improve the patient journey to speed up their diagnosis and treatment. Currently, the system does not support GPs and their patients to access key radiological tests where needed. Patients face long waits and convoluted referral pathways to access tests.</p> <p>- Sustainability - efficient and targeted use of resources and skills to free up capacity for other front line services</p> <p>- To improve the quality of referrals and appropriate investigations</p>	<p><b>2. Minor Surgery – Skin Lesions</b></p> <ul style="list-style-type: none"> <li>- Evaluation and review by 30 June 2011</li> </ul> <p>A proportion of minor skin surgery could be performed safely in the community setting.</p> <p>Currently waiting times for minor skin lesion procedures performed in the hospital are too long with potentially dangerous delays to diagnosis.</p> <p>Access across Auckland is highly variable across the three DHBs. Patients are inconvenienced by unnecessary visits to hospital.</p>
<p><b>Why will it be good for patients?</b></p>	<p>Better, sooner, more convenient access to community radiology across Auckland. Patients will access more diagnostics closer to home, experience fewer steps in accessing care with reduced wait times. This will be evidenced by:</p> <ol style="list-style-type: none"> <li>1. An additional 4,500 community diagnostic procedures in 2010/11</li> <li>2. 16,000 patients accessing radiology sooner via direct referral from general practice in 2010/11 with the potential to increase to 40,000 in 2011/12</li> <li>3. 750 First Specialist Assessments released and/or no longer required due to more efficient processes</li> <li>4. DNA rates to reduce by 50% for referrals from participating practices</li> <li>5. Inappropriate or rejected referrals from participating practices to reduce by 80%</li> </ol>	<ul style="list-style-type: none"> <li>- Improved access to DHB funded skin cancer surgery</li> <li>- Shorter waiting times and earlier treatment for patients requiring minor skin lesion surgery leading to improved outcomes</li> <li>- Surgery performed closer to where patients live</li> <li>- Access to a new community based minor surgery service in ADHB</li> </ul> <p>Evidenced by:</p> <ul style="list-style-type: none"> <li>- 1,200 community based skin lesion procedures over 2010/11. This is a 100% increase from 2008/09</li> <li>- Reductions in wait times</li> </ul>
<p><b>Why will it be good for</b></p>	<ul style="list-style-type: none"> <li>- More timely results</li> <li>- Reduced acute admissions and emergency presentations</li> </ul>	<ul style="list-style-type: none"> <li>- Regionally consistent approach to publicly funded minor surgery</li> <li>- Secondary care surgeons freed up to perform more specialist</li> </ul>

	<b>1. Better Access to Diagnostics - Radiology</b>	<b>2. Minor Surgery – Skin Lesions</b>
<b>providers?</b>	<ul style="list-style-type: none"> <li>- Patients arriving at outpatient appointments with investigations complete.</li> <li>- Better primary/secondary collaboration and integration of care</li> <li>- Maximises the use of scarce workforce and reduces DNAs</li> </ul>	<ul style="list-style-type: none"> <li>- elective surgery whilst utilising the capability within primary care</li> <li>- Clarity of referral and care pathways for skin cancer</li> <li>- Less need to monitor in primary care while waiting for surgery</li> <li>- Appropriate treatment is provided in the most cost effective setting</li> </ul>
<b>Funded through</b>	Existing provider arm radiology resources and an additional investment of over \$900k across metro Auckland between July 2010 and June 2011.	Investment of an additional \$137,400 per annum, which is a 134% increase on 2009/10.
<b>What is our objective?</b>	<p><b>3. Clinical Pathways</b></p> <p>We are going to implement regionally agreed Clinical Pathways for specific conditions to improve patient experience and provider efficiency across primary and secondary care.</p>	<p><b>4. Acute Demand/POAC</b></p> <p>To increase the capacity of managing them sooner and in more convenient, safe and effective community based settings. dramatically reduce the number of avoidable Emergency Department presentations and subsequent hospital admissions by</p>
<b>How?</b>	<p>We are going to commence a regional re-implementation of a gastroenterology pathway for dyspepsia immediately with a roll out to 30% of providers by 30 June 2011 and the remaining providers by 30 June 2012.</p> <p>We will select, develop and test of a minimum of five additional clinical pathways across primary and secondary care rolling out by 1 July 2011.</p> <p>This will build and link to the Auckland Regional e-Referrals Project involving both primary and secondary clinicians across the metro Auckland DHBs.</p> <p>Within this initiative referral criteria for 24 specific conditions have been developed which provides a robust base to further design full clinical pathways. One example of this is the work already completed for skin lesion referrals.</p>	<p>To meet the above objectives we will deliberately expand the use of POAC over 2010/11 through:</p> <ol style="list-style-type: none"> <li>1. Increased promotion of the POAC programme to GPs and Accident &amp; Medical clinics</li> <li>2. Developing, implementing and enabling clinical care pathways for the most common diagnoses referred to emergency departments, but manageable in primary care</li> <li>3. Enabling, educating and encouraging hospital emergency departments to refer appropriately to primary care through the POAC service</li> <li>4. Introduce POAC to Ambulance Services to either treat patients on site or to transport suitably triaged patients to primary care settings for further treatment rather than to hospital emergency departments</li> <li>5. Work with residential care and rest home facilities to ensure early intervention and onsite treatment of residents to avoid unnecessary attendance and admission to hospitals</li> <li>6. Specifically target practices with large Māori populations and those with high rates of admission for Māori to ensure that POAC contributes to reducing inequalities</li> </ol>

<b>Why?</b>	<p><b>3. Clinical Pathways</b></p> <p>Inefficiencies and poor co-ordination between primary and secondary care occur at multiple points in the patient journey leading to unnecessary delays, inconvenience and potentially harm for patients, and unnecessary appointments and frustration for clinicians.</p>	<p><b>4. Acute Demand/POAC</b></p> <p>Attendances at emergency departments across Auckland have been steadily increasing and are a large threat to future viability. Continued growth at the current rate is considered unsustainable from both financial and health workforce perspectives. In addition, patients often prefer to be managed at home and not face long waits or admission to hospital.</p>
<b>Why will it be good for patients?</b>	<p><b>Sooner:</b> Shorter waiting time for those who genuinely need a secondary care intervention  <b>Better:</b> Regionally consistent care regardless of address  <b>More Convenient:</b> A reduction in follow up visits for patients being undertaken in the community closer to where they live or work</p> <p>As evidenced by:</p> <ul style="list-style-type: none"> <li>- 30% reduction in first specialist assessments for dyspepsia across the Auckland metro by 30 June 2011</li> <li>- Completed implementation of a minimum of five additional clinical pathways across the Auckland metro supported by the e-referral process by 30 June 2012 with a corresponding: <ul style="list-style-type: none"> <li>o 10% reduction in FSA in secondary care</li> <li>o 20% reduction in Follow Up visits</li> <li>o 10% shift of visits into Primary Care</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Over 15,000 referrals to the POAC scheme that should result in more than 12,750 patients being safely and successfully managed in the community thus creating reduced demand on hospital Emergency Departments</li> <li>- More convenient care for those 12,750 patients and their whānau who avoid the disruption of a visit to hospital</li> <li>- Increased utilization by Māori to a rate equivalent to their population share reducing their need for presentation to hospital</li> </ul>
<b>Why will it be good for providers?</b>	<ul style="list-style-type: none"> <li>- Primary care GPs better equipped to manage patients not reaching referral threshold for a particular condition</li> <li>- Sustainability - will release first specialist assessment time for more complex cases and accommodate population growth</li> </ul>	<ul style="list-style-type: none"> <li>- More satisfying for practitioners to be supported to manage people safely in the community and being resourced to do the right thing clinically</li> <li>- Regionally consistent approach for patients and providers so less confusion which has been an issue in the past</li> <li>- Front line clinicians in Emergency Departments face less demand and can also use POAC as a resource for early discharge ensuring secondary resources are available for the more acutely unwell</li> <li>- Avoided attendances and admissions will assist with delivery of the national health target for Emergency Departments</li> </ul> <p>Measured by 5,000 additional POAC referrals over 2010/11. 85% of these will</p>

	3. Clinical Pathways	4. Acute Demand/POAC
<b>Funded through</b>	Existing resources and/or provisions already made elsewhere e.g. e-referrals	avoid needing to go to hospital because of this care. New funding of up to \$1,237,500 will be invested across metro Auckland. The financial return on investment is expected to be \$1.16 for every dollar spent in year one, increasing to \$1.22 in future years.
<b>What is our objective?</b>	<p><b>5. After Hours</b></p> <p>Provide our shared populations in Auckland with access to more affordable, more equitable, and urgent after hours care across a variety of localities in the region while still promoting the patient's medical home.</p>	<p><b>6. Pharmaceuticals</b></p> <p>To have a clinically led process to effectively manage the pharmaceutical budget to release funds for frontline services while improving medicines safety for patients and improved prescribing quality for providers.</p>
<b>How and when?</b>	<p>Phase 1: A clinically led process with an initial focus on establishing a core network of services till 10pm.</p> <p>Phase 2: A subsequent focus on a comprehensive network including overnight, ambulance and emergency services.</p> <p>Phase 1: By July 1<sup>st</sup> 2010</p> <ul style="list-style-type: none"> <li>- Development of a metro-Auckland after hours plan</li> <li>- A minimum of 10 operational clinics until 10pm across region</li> <li>- Increased availability of regional triage and disposition</li> <li>- Affordable copayments consistently available for high needs groups</li> <li>- Availability of essential medicines</li> <li>- Linkages from the Medical Home to IFHCs, Community Health Hubs and Whānau Ora Centres</li> </ul>	<p>In 2010 - 2011 we will operate phase one of a clinically led pharmaceutical budget management programme in ADHB &amp; CMDHB with three large and diverse PHOs (East Health Trust, ProCare Network Auckland and ProCare Network Manukau). This will focus on:</p> <ul style="list-style-type: none"> <li>- Detailed analysis of prescribing trends</li> <li>- Development of quality programmes and messages based around the following themes: <ul style="list-style-type: none"> <li>o Reducing unnecessary poly-pharmacy</li> <li>o Reducing wastage through prescribing appropriate quantities of medicines</li> <li>o Addressing and reducing unexplained inter-provider variability in prescribing patterns</li> </ul> </li> <li>- Implementation of the above programmes using: <ul style="list-style-type: none"> <li>o Clinical pharmacist led academic detailing</li> <li>o Prescriber small group education sessions with doctors and nurses</li> <li>o Prescriber feedback reports</li> <li>o Prescribing guideline development</li> </ul> </li> </ul> <p>Within Waitemata there will be a particular focus on safe use of medicines within aged residential care facilities.</p>
<b>Why?</b>	There is no single regional after hours strategy. Funding challenges combined with varying capacity of workforce across the metro has meant that access for patients to services to meet	In primary care there is currently no systematic approach to examining and improving the quality of prescribing of pharmaceuticals amongst front line clinicians, particularly general practitioners and those within

	<p><b>5. After Hours</b></p> <p>urgent care needs outside of regular hours is not as easy as it should be.</p> <p>For providers trying to meet after hours needs and sustain regular services has been a significant challenge and led to a wide variety of provision in after hours.</p> <p>The result is inconsistency across the metro with varied, uncoordinated services with generally unaffordable co-payments for much of the population.</p> <p>A key negative consequence has been the number of inappropriate presentations to Emergency Departments throughout the region.</p>
<p><b>Why will it be good for patients?</b></p>	<p><b>6. Pharmaceuticals</b></p> <p>aged residential care.</p> <p>Poor use of pharmaceuticals (including both under and over-use) by both prescribers and patients contribute to a substantial number of avoidable adverse events including up to 10% of avoidable hospitalisations.</p> <ul style="list-style-type: none"> <li>- Improved medicines safety through reduced poly-pharmacy</li> <li>- Simpler medication regimens especially for patients with multiple long term conditions</li> <li>- Less risk of harm and adverse events</li> </ul>
<p><b>Why will it be good for providers?</b></p>	<p>Being able to access a health care professional outside of regular hours for acute need will be much less problematic than before. As members of a collective organisation they will have readily available information on the network, operating hours, localities and costs.</p> <p>Reduced co payments will enable high needs groups to access more readily. They will be sure of their medical home and sure of how to access care outside of this whenever there is urgent need.</p> <ul style="list-style-type: none"> <li>- A clinically led process to improving prescribing quality</li> <li>- Clinical influence over where pharmaceutical savings are 'reinvested'</li> <li>- Some reduced hospital utilisation from medication related events</li> <li>- Reduced pressure on pharmaceutical budgets</li> </ul> <p>At least \$1.5million of pharmaceutical expenditure being released for front line services in the 2010 / 2011 financial year.</p> <p>A decrease in admissions to secondary care due to medicine related adverse events.</p>
<p><b>Funded through</b></p>	<p>A sustainable, fair and workable model for after hours across the region.</p> <p>Measured by A measurable reduction in inappropriate presentations to emergency departments across the region within 12 months. In addition, a suite of measures will be developed by 1 July 2010 to reflect the impact of all acute demand initiatives (including the after hours and POAC initiatives).</p> <p>For both phases - Re-use of the current \$5.0m and further invest approximately \$450,000 in 2010/11. Current DHB/MoH funding</p> <p>An investment of \$850,000 across all three DHBs in the 2010 / 2011 year.</p>

## 5. After Hours

needs to be ongoing as well as new ways of funding services that must be ongoing/ developed for sustainability of the network.

## 7. Māori Service Development

1. Enhancing capacity of Iwi and Māori led providers to deliver Whānau Ora services, to high needs communities
2. To establish and implement the Whānau Ora system for Auckland
3. Devolution of services from DHBs and the Ministry of Health to support Whānau Ora development

### What is our objective?

### How?

- Implementation of a three year strategy to identify key services currently provided in metro-Auckland DHBs, that could be provided in the community setting
  - Involvement of the MoH, DHBs, Iwi, the National Māori PHO Coalition and Māori led providers
1. Year 1 – Identification and transition of all non - core Kaupapa Māori services, to Iwi / Kaupapa Māori led providers in the community
  2. Year 2 – Review of DHB services to identify high Māori utilisation of services as well as those services that are high priority areas and are under utilised by Māori
  3. Year 3 – Implement the review recommendations across the three Auckland DHBs

### Why?

1. We need to develop a whānau ora system that is a whole of systems approach, which needs to include
  - a. Co-ordinated planning service delivery
  - b. development of outcome measures
  - c. Work force development
  - d. Whānau ora assessment framework
  - e. High performing provider organisations
2. These are the components of a system that will assist in reducing inequalities and improving Māori health status
3. Current systems include varying degrees of these components

## 6. Pharmaceuticals

## 8. Health Targets

To achieve the National Health Targets for Auckland.

We will shift from DHB specific targets to regional targets with clinically led regional collaboration and co-ordination for 2010/11. This will include:

- Explicit joint ownership of performance against target with each BSMC Primary Care Business Group and their providers
- Establishment of a clinically led regional immunisation co-ordination and governance group
- Greater sharing of information regionally and with feedback to providers
- Ongoing review of outreach immunisation service delivery models and contracts
- Service development with the National Māori Coalition, specifically with their Mama, Pepi and Tamariki programme
- Regional planning on confirmation of the primary care smoking cessation target

These indicators reflect large areas of inequality, particularly amongst Māori and Pacific populations who have higher rates of smoking, experience much higher rates of CVD/Diabetes, and have lower immunisation rates.

## 7. Māori Service Development

and provider organisations having varying capacity and capability to deliver to high need families

### Why will it be good for patients?

- More consistent access and care with fewer steps in the process and planned co-ordinated pathways of care that are measureable
- Workforce development will improve performance of Māori providers thus improving service to patients.
- More care provided closer to home.

### Why will it be good for providers?

- Capacity and capability to improve responsiveness to communities of need
- More appropriate use of resources
- Service devolution will assist the ability of providers to measure patient outcomes which will lead to better targeting of resources
- Better primary/secondary collaboration and integration of care

Measured by

Devolution of \$600k of services (largely health promotion and public health) from metro-Auckland DHBs and the Ministry of Health to Iwi and Māori providers by 30th December 2010<sup>1</sup>. This will put the control of these services closer to the communities they serve whilst supporting the implementation of the Whānau Ora approach.

### Funded through

Existing resources

## 8. Health Targets

Improved health status for all Aucklanders through:

- At least 4,500 additional diabetes checks in 2010/11
- At least 1,400 additional 2 year olds fully immunised in 2010/11
- A greater number of patients being given smoking cessation advice in primary care

- A shared clinically led regional service with both clear standards and guidelines on diabetes and CVD that are utilised by all in metro Auckland
- It will be easier to achieve high rates of coverage which is supported by service delivery
- Collaborative efforts of DHBs and primary care to meet the agreed regional targets

Measured by

A commitment to meet the following regional Health Targets.

Target	Current 2009/10 metro-Auckland Performance	Indicative 2010/11 Metro-Auckland Target
Immunisations	85%	90%
Diabetes Detection	49%	55%
Diabetes Management	70%	70%
CVD Risk Assessment	79%	80%
Smoking Cessation	To be confirmed once primary care indicator and timing has been confirmed.	

Multiple funding streams and performance incentives already included within DAP baselines.

<sup>1</sup> Subject to approval of contract transfers by the Ministry of Health

## PHO configuration

Across metro-Auckland there is a common objective to have a locality or neighbourhood approach (ref: GAIHN, NMPC and AH+ Business Plans as well as the Waitemata DHB, Auckland DHB and Counties Manukau DHB Primary Care Plans). This is to improve local access to services, co-ordination and integration, drive quality improvement, be responsive to community needs and shift some secondary services to local settings.

The metro-Auckland DHBs will be looking to support models and structures that:

1. support the locality/neighbourhood approach to be responsive to community needs
2. are of sufficient scale and capacity to drive change, and
3. meet the Minister's goal of reducing the number of PHOs

Some PHOs have already made progress through amalgamations (e.g. Te Kupenga O Houturoa and The People's Centre Trust) and proposed amalgamations (e.g. the incorporation of three PHOs in the Alliance Health+). There are other PHO mergers also in progress although at this stage none within the Waitemata DHB. It is likely there will be at least a 20 percent reduction in the number of PHOs across metro-Auckland by 31 December 2010.

Each DHB is canvassing the views of various stakeholders on the best approach to meet these goals over May and June 2010 and will have a regionally agreed approach for review by the Ministry by 30 June 2010. The approach will be developed into a more formal plan with associated policies (e.g. cross boundary PHO policies and contracting) in consultation with key stakeholders over July to October with implementation by December 2010.

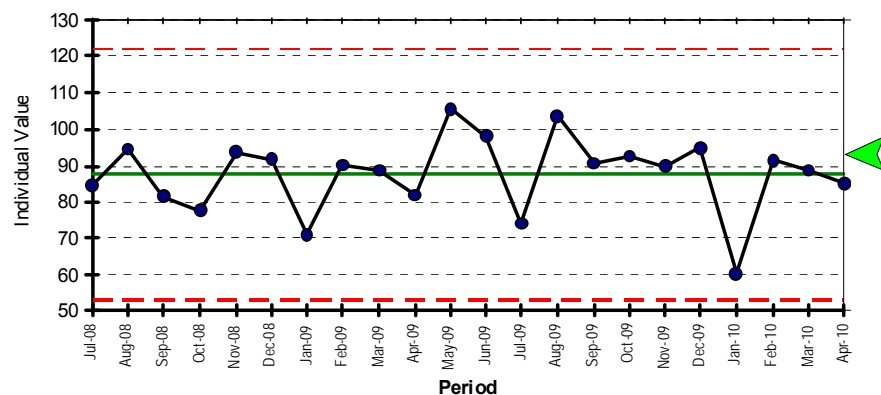
## Appendix 8. Additional data to support targets

### Data relating to 2.1c.1.4: Operating Room Productivity

#### Elective Throughput

Discharge elective WIES going through theatre has been a fairly constant 88 per working day for the past two financial years. The goal for 2010-11 is to increase this by 6% to 93.

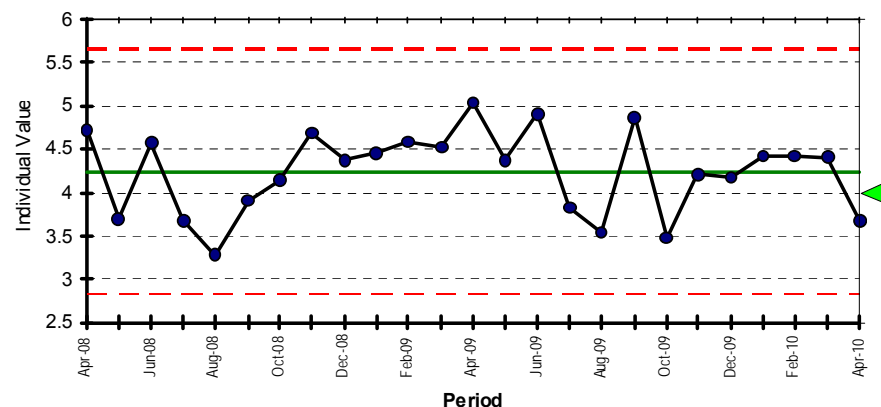
#### In house elective WIES per day through theatre



#### Wait Times

Reduce the median acute time to theatre by 6% from 4.25 to 4.00.

#### Median acute time to theatre (decimal hours) – all suites



The UK NHS Productive Operating Theatre Programme is a lean improvement programme that realises benefits through process changes that:

- improves patient experiences and outcomes (e.g. reduce waiting and pain, avoid hypothermia)
- improves team working and communication (e.g. reduce errors, improve reliability and safety, enhance job satisfaction)
- increases efficiency (e.g. improve start times, reduce turnaround times, avoid over-runs, increase touch time)
- makes savings on consumables and through stock reductions.