



District Annual Plan

For The Year Ending 30 June 2003

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Glossary of terms

Abbreviation	Full description
ACC	Accident Compensation Commission
ADHB	Auckland District Health Board
ADT	Admission Discharge and Transfer
ALOS	Average Length of Stay
BSC	Balanced Score Card
CBU	Clinical Business Units
CEC	Collective Employment Contract
CEO	Chief Executive Officer
CFA	Crown Funding Agreement
CFU	Children and Family Unit
CMDHB	Counties Manukau District Health Board
COO	Chief Operating Officer
CPHAC	Community and Public Health Advisory Committee
CSS	Clinical Support Services
CTA	Clinical Training Agency
CYFS	Child Youth and Family Service
DEAS	Disability Empowerment and Advocacy Service
DHB	District Health Board
DHBNZ	District Health Boards of New Zealand
DID	Disability Issues Directorate
DiSAC	Disability Services Advisory Committee
DNA	Did Not Attend
DSS	Disability Support Services
FTE	Full Time Equivalent
GM	General Manager
GP	General Practitioner
HAC	Hospital Advisory Committee
HBO	Health Benefits Organisation
HFA	Health Funding Authority
HP	HealthPAC
HR	Human Resources
IANZ	International Accreditation New Zealand
ICU	Intensive Care Unit
IDF	Inter District Flow
IPA	Independent Practitioners' Association
ISLA	Internal Service Level Agreement
KPI	Key Performance Indicators
LMC	Lead Maternity Care
MAC	Multi-Agency Centre
MAPO	Maori Purchasing Organisation
MHINC	Mental Health Information National Collection
Minister	Minister of Health
MOH	Ministry of Health
MUD's	Matched Unrelated Donor Transplants

Abbreviation	Full description
MWS	Medical Warning System
NASC	Needs Assessment Service Co-ordination
NDSA	Northern District Support Agency
NGO	Non Government Organisations
NHI	National Health Index
NMDS	National Minimum Data Set
NZHIS	New Zealand Health Information Service
NZHS	New Zealand Health Strategy
NZPHD Act	New Zealand Public Health and Disability Act
OPF	Operational Policy Framework
ORL	Otorolngology
OSH	Occupational Health and Safety
PACS	Picture Archiving and Communication System
PBFF	Population Based Funding Formula
PCO	Primary Care Organisation
PHARMAC	Pharmaceutical Management Agency
PHCS	Primary Health Care Strategy
PHO	Primary Health Organisation
PICU	Paediatric Intensive Care Unit
RAC	Recruitment and Administration Centre
RFP	Request For Proposal
RMO	Registered Medical Officers
SLA	Service Level Agreement
SMO	Senior Medical Officers
SREA	Sub Regional Equity of Access
PSFP	Projected Statement of Financial Performance
WDHB	Waitemata District Health Board
WMP	Workforce Management Plan

1 Executive Summary

1.1 Background

This District Annual Plan (the Plan) has been prepared in accordance with the requirements of the Public Finance Act 1989 and the New Zealand Public Health and Disability Act 2000 (NZPHD Act). It addresses the requirements of current policy settings and reporting requirements advised by the Ministry of Health (MOH). The activities of the Auckland District Health board (ADHB) are guided by the objectives set out in the New Zealand Public Health and Disabilities (NZPHD) Act, the New Zealand Health Strategy, the draft New Zealand Disability Strategy and the Minister of Health's expectations. The plan acknowledges the importance of relationships that support the principles of partnership, participation and protection embodied in the Treaty of Waitangi.

1.2 Overview

The Plan reflects operational intentions that are consistent with the District Strategic Plan for the Auckland District Health Board 2002–2007. The Plan demonstrates to the local population and the Minister of Health how the Auckland DHB will achieve the Government's priorities for health within the funding available over the next three years. The Government's priorities are outlined in the New Zealand Health Strategy and the New Zealand Disability Strategy; both of which provide the framework for future health service development.

There were approximately 367,737 people living in the Auckland DHB area in 2001. This represented approximately 9.8 percent of the total New Zealand population. It is expected that there will be about 492,340 people living in the district by 2021, an increase of 124,603 people (34 percent) over a 20-year period. Significant demographic shifts are expected to occur over this period, with changes to the ethnic composition and age structure of the resident population. Growing numbers and changes in the population structure are a challenge to future health service planning.

The Auckland DHB vision of 'Healthy Communities, Quality Healthcare' reflects a focus on the health of our population. This focus includes working with other agencies, organisations, iwi and community leaders to achieve our goals. We want the best possible health and independence for the district and region that can be achieved within our available resources.

The needs of our population have been identified in the Population Health Needs Assessment undertaken by the ADHB in 2001. This work utilised demographic data, epidemiology and community input to draw a profile of the local population and priority health needs and identified the following:

- Cardiovascular disease and cancer are the leading causes of death
- Diabetes is predicted to increase markedly over the next 10 years, especially among Maori and Pacific peoples

Four key goals are woven through each area in this Plan. These translate into priorities for the future based on:

- The need to live within the finances available and reduce the level of deficit.
- Government policy: The NZ Health Strategy and NZ Disability Strategy
- National strategies to assist various services, e.g. the National Mental Health Strategy; Reproductive and Sexual Health Strategy, Older People and Positive Aging Strategies
- The outcome of the 2001 Auckland DHB health needs assessment including community engagement work
- Joint work with the other DHBs in the region

There is also more we can do to address our Treaty of Waitangi obligations and ensure Maori in our district experience good health. This will be assisted by the Memorandum of Understanding the ADHB has with Te Runanga o Ngati Whatua. This document outlines a number of partnership principles, processes for engagement and protocols. These protocols have been implemented across the organisation at Board, funding and service planning and provider levels.

There is also a need to reduce inequalities in the health status of Pacific and new migrant populations in the district. People on low incomes have poorer health status and this is associated with the inequalities in health for Maori, Pacific people and new migrants, particularly those people from refugee backgrounds.

In looking ahead, we have taken into account the realities of our current situation. Our hospital and related services have a significant deficit and a huge building and change programme in place. We commit to working hard for our local communities and endeavouring to provide better services within the constrained budget by improving the way we do things rather than spending more money.

1.3 Key Goals and Focus for Future Action

1.3.1 Get control of our finances

We lost over \$66 million in the year to 30 June 2002 and we need to do things very differently to stop these losses.

1.3.2 Make the Change Programme happen

We need to speed up the move to standardise, consolidate and integrate our services to improve patient care and capture the required operational efficiencies of \$40 million per annum by the completion of the programme. This will require collaboration across all health services to streamline care and to secure more cost-effective health gain. The Change Programme has been established to manage this process and has completed its organisation design

phase and is proceeding with five projects designed to transform systems and processes and a full analysis of its work is set out in this plan.

1.3.3 Finish the Building Programme

The Building Programme is managing the construction of the new buildings on the Grafton and Greenlane sites. This provides the platform to enable the gains from the Change Programme to work to maximum effect by the opening date for the new Grafton facilities in October 2003. There is high level of collaboration with the Change Programme to ensure that essential changes in systems and processes are achieved before the migration to the new facilities take place.

The new Auckland City Hospital will offer acute medical and surgical inpatient services. It will be nine levels high (five levels lower than the existing Auckland Hospital building) and have an opening capacity for 752 beds. ADHB has already opened a new laboratory and mortuary (LabPlus), and a new carpark building (Helipad Carpark) on the Grafton site. Construction of a new acute mental health unit (to replace the Conolly Unit) is underway north of the existing Auckland Hospital building and will be completed in January 2003. The ADHB Greenlane site will be transformed into the Greenlane Clinical Centre with completion of the new buildings in September 2003 and refurbishment of existing buildings by October 2004.

1.3.4 Lift the health performance of Aucklanders

The commentary on the nature and scope of activities above has already provided an indication of the challenges that are being managed for this goal. These challenges include:

- Reflecting our Treaty of Waitangi responsibilities within the framework of the NZPHD Act by establishing and maintaining strong relationships that inform funding decisions through a better understanding of the health needs of Maori
- Focusing on population health through analysis of needs and the further development of processes to inform funding decisions
- Reducing inequalities through analysis of needs and the use of priority setting criteria to inform funding decisions
- Managing continuums of care through initiatives that improve information flows between providers and assist the provision of care by primary care providers thereby reducing the level of acute admission to hospitals
- Strengthening the primary care sector by prioritising funding for new initiatives, improving information and collaborating with other government agencies and groups to enable issues to be addressed at a more holistic level
- Developing a network of Primary Health Organisations (PHO) to assist the processes of integrating care and managing costs
- Improving quality and safety of services by maintaining and improving quality and risk management systems and engaging with other DHBs on key issues such as the management of inter district flows

This Plan identifies the work that will be undertaken to improve the health of performance of Aucklanders.

1.4 Get Control of Our Finances

Implementing the direction outlined in this Plan is dependent on available funding and careful cost management. As noted above the ADHB is under extreme financial pressure and had a deficit for the 2001-02 financial year of \$66 million and initially planned a budgeted deficit for the 2002-03 financial year of over \$86 million.

This level of deficit was unacceptable and the ADHB has developed strategies to reduce the budgeted deficit level for 2002-03 down to \$63.5 million (the last \$2.5 million of this loss reflects MOH support for increased costs arising from wage settlements). The MOH has also agreed to address the adverse impact of the site-specific adjuster by supporting an increased in the permitted deficit levels to cover the \$15m negative impact on the ADHB in the 2002-03 year. Continued support for the site specific adjuster will also be required in the outer years in order to address deficit levels that result from increased interest, depreciation and capital charges as a result of the building programme and the MOH has this matter under review.

The ADHB is working to manage the potential for a deficit in the funder arm of approximately \$7 million that is included in the \$63.5 million above. This position will be closely managed through the year in close dialogue with MOH. The projected deficit reflects high cost levels anticipated for referred services such as laboratories and pharmaceuticals.

The table set out on the next page contains the forecast information and the financial section to this plan provides more detailed information to assist your understanding of the figures.

AUCKLAND DISTRICT HEALTH BOARD	2001-02	2002-03	2003-04	2004-05
Consolidated Projected Statement of Financial Performance - illustrated version	Actual \$000	Budget \$000	Forecast \$000	Forecast \$000
Ministry of Health - Base Contract				
Provider & Governance	526,646	544,893	569,523	590,160
Funder	187,217	218,217	219,348	224,114
Risk Pool	15,914	0	0	0
	729,777	763,110	788,871	814,274
Ministry of Health - Other Contracts	41,759	46,617	47,549	48,976
	771,536	809,727	836,420	863,250
External Revenue	66,314	64,046	65,327	67,287
Total Revenue	837,850	873,773	901,747	930,537
Operating Costs				
Provider Cost Base	659,631	678,839	691,682	726,609
% Increase in Provider Cost Base		3%	2%	5%
Change Programme Savings	0	-10,000	-9,902	-24,376
Provider	659,631	668,839	681,780	702,233
% Increase in Provider Cost Base (Net of Change Programme savings)		2%	2%	3%
Funder	203,131	225,185	226,348	231,114
Total Operating Costs	862,762	894,024	908,128	933,347
Operating Surplus/(Deficit)	-24,912	-20,251	-6,381	-2,810
Provider & Governance	-24,912	-13,283	619	4,190
Funder	0	-6,968	-7,000	-7,000
Operating Surplus/(Deficit)	-24,912	-20,251	-6,381	-2,810
Additional savings to be achieved	0	10,000	0	0
	-24,912	-10,251	-6,381	-2,810
Depreciation	-27,337	-30,408	-45,600	-53,500
Interest	-4,242	-6,035	-19,428	-27,352
Capital Charge	-9,569	-14,306	-19,793	-22,293
Total Depreciation, Interest, Capital Charge	-41,148	-50,749	-84,821	-103,145
Total Surplus/(Deficit)	-66,060	-61,000	-91,202	-105,955

Of special note are the following factors:

- Higher costs for wage settlements of up to \$2.5 million are covered by an agreement with the Crown to allow the approved total deficit to escalate to \$63.5 million
- Change Programme savings are important in assisting the organisation in managing within its cost increase targets of 2%, 2% and 3% over the three-year period of the plan
- The table illustrates the additional savings target of \$10 million to be achieved in order to reach a \$61 million deficit target for 2002-03 (\$63.5 million including the wage settlement figure). Strategies have been developed to achieve this target including improvements in ACC claiming, realised benefits on sale of surplus property properties and investments and further operational savings
- There is a potential deficit in the funder arm should funding prove insufficient to meet costs. The funder arm is engaged in a number of local

and regional initiatives aimed at controlling expenditure. These focus on improving both referrer and provider management tools and incentives.

- The site specific adjuster issue noted above is reflected in the anticipated Crown support for the deficit level budgeted for the 2002-03 year. The MOH will also consider this matter further as part of the work to implement population based funding in 2003-04

In seeking to manage the deficit level the Board has not authorised any service disinvestments. To manage any future consideration of disinvestment the ADHB has developed processes that recognise the principles presented to the MOH in the Prioritisation Framework Report submitted in May 2002. This would address disinvestment from non-clinical services before clinical services.

The deficit and the building programme create significant equity requirements. A review of future equity requirements has been undertaken to confirm the equity required to finance the operational deficit, baseline capital plan for equipment and information systems, building programme and enable the ADHB to at all times remain within its banking covenants. These requirements are reflected in this plan.

Even with the range of issues the ADHB is managing the organisation remains mindful of the need to protect and invest in the primary care and other key priorities whilst addressing the issues and change processes facing our secondary and tertiary hospital services.

1.5 Summary of objectives for population groups

The following commentary outlines the strategic intent of the ADHB and is directly aligned with the District Strategic Plan. The strategies and initiatives required to progressively achieve these objectives are set out in Section 4.4 of the plan.

1.5.1 Maori Health

The ADHB is continuing to grow relationships that support the principles of partnership, participation and protection embodied in the Treaty of Waitangi. This requires the development of the Maori health provider network and the development of workforce capabilities. This plan includes a wide range of initiatives that address these objectives.

1.5.2 Pacific Health

There is a need to reduce health disparities between Pacific people and non-Pacific peoples through development of appropriate policy and initiatives. Much of this work requires intersectoral collaboration as well as actions to improve access to preventative and primary care services. These in turn are dependent on developing partnerships with Pacific providers, communities, faith-based organisations and other agencies.

Evidence-based approaches will be used to create improved outcomes for Pacific populations. Education and support for Pacific providers will support this approach through workforce development and development of increased cultural competency for all providers.

1.5.3 New Migrants Health

Improving the health status of new migrants requires a focus on health promotion, prevention and early intervention using approaches that are culturally acceptable, accessible and appropriate. This will be achieved through a focus on managing continuums of care and ensuring that migrants are able to access essential services.

Migrants often have high or complex needs and workforce development, education, research, monitoring and evaluation initiatives are required to address these needs and support achievement of the overall health objectives.

1.5.4 Children and Younger People's Health

The objective is to improve the health status of children and young people by having a greater focus on health promotion, prevention and early intervention. To achieve this objective the ADHB will work to ensure that all services are accessible, acceptable and appropriate for children, young people and families/whanau.

There is also a focus on continuous improvement in co-ordination and access to health services for those children or young people with high or complex needs or who are vulnerable. This includes continuing recognition of the importance of developing good monitoring and evaluation processes and a focus on workforce development, research and education.

1.5.5 Adult Health

The ADHB will continue to work on improving the health status of women and men through a focus on health promotion, prevention and early intervention. Equitable and timely access will be sought for quality, safe, and appropriate services regardless of the patient's ethnicity, age and locality.

There is an emphasis on managing the co-ordination and access to health services for those women and men with high or complex needs, or who are vulnerable. This includes having a gendered and holistic approach in data collection, planning, delivery, workforce development, research, monitoring and evaluation of services.

1.5.6 Older People's Health

The ADHB will work to fund and provide excellent health services for rapidly growing population of older people. This will in some circumstances require attention to any areas of discrimination or ageism within health and the

community. Issues will be managed by involving consumers, families, whanau and caregivers in service planning, monitoring and evaluation.

It is important that older people have good access to information about services and the ASDHB will work to develop consumer-centred models of care for older people across all service sectors

There is a need to reduce the gap between longevity for Maori and Pacific peoples and other New Zealand populations and to improve mental health services for older people through implementation of the regional strategy for older people. This requires early identification of conditions via better training for professionals and regional information sharing processes. Culturally appropriate and effective support for families, whanau and caregivers will assist this process of improvement.

For 2002-03 the ADHB is also completing work in preparation for the devolution of disability support services funding for older persons that is currently planned for 1 July 2003.

1.6 Summary of objectives for service areas

1.6.1 Primary Health Care

The long-term development path for primary health care includes the use of the population needs assessment findings to assist regional work programmes and the implementation of the national primary care strategy. The review of the cost-effectiveness of services and management of acute demand are critical component of this work in order to ensure that adequate funding is available for the planned improvements.

The management of integration processes anticipates better coordination between providers and requires continued improvements in the quality and safety of primary care services. There is also a need to improve access to primary care services for priority populations and to develop the primary care workforce. The development of PHOs is part of this work and will increase linkages between providers and improve the management of patient care and control over costs. This will assist in the longer term processes for chronic and disease management.

Sustainable funding for primary care will come through management of growth in fees for service expenditure and management of demand for acute services. The management of demand for referred services such as pharmaceuticals and laboratories is also a critical factor and will involve the use of risk sharing/budget holding processes and improved linkages with Primary Care Organisations (PCO) and PHOs.

To be successful in these aims it is important that communities and individuals take greater responsibility for their own wellbeing.

1.6.2 Secondary and Tertiary Care

The ADHB is committed to managing a realistic and sustainable secondary and tertiary strategy to ensure quality specialist services are available to support the health needs of the Auckland region. This means:

- Preparing for the introduction of population based funding (PBF)
- Developing and implementing processes for the management of inter district flows (IDF)
- Developing agreed prioritisation processes for decision making
- Agreement of service changes with other DHBs to address sub regional equity of access (SREA)
- Management of significant projects such as the Change and Building Programmes
- Representation on national groups working on improvements to services.
- Collection/analysis of data (health needs and demographic information) for planning.
- Research on acute demand and on patient flow between districts and regions.
- Systems that improve quality, accreditation and credentialing.
- Strategies that improve retention of the workforce and ensure cultural competence.

1.6.3 Mental Health

Mental health initiatives are designed to improve access to services and equity in access overall. There is a continued focus on improving service quality and ensuring good integration between linked services.

Increased stakeholder participation in planning and service development will be targeted including development of mental health networks. This will assist the process of improving the information required to guide funding decisions.

1.6.4 Public Health

The ADHB will work with the MOH to implement the NZ Health Strategy objectives including better knowledge and information for decision making and community participation in planning. This will include working with the MOH on health goals and objectives in the primary care setting to gain better evidence-based solutions and working with personal health providers to increase knowledge and further develop a skilled workforce.

1.6.5 Disability Support Services

The ADHB has established a Disability Advisory Committee (DiSAC) and is developing strategies and systems to manage the devolution of Support Services funding for older people to Auckland DHB in 2003. This includes a stocktake and analysis of needs.

The ADHB will work to ensure services are fully accessible by people with disabilities and will involve people with disabilities in education and training for service providers and in planning and monitoring the delivery of health services for people with disabilities.

1.7 Workforce

The ADHB has developed integrated Human Resources (HR) vision, strategic intent and goals to support the achievement of ADHB's business and healthcare service objectives. These aim to ensure that ADHB staff are:

- Flexible
- Patient - focused
- Capable
- Accountable
- Performance-driven
- Team-oriented

This plan includes a comprehensive range of initiatives to develop the full potential of the ADHB workforce. The table below summarises the key linkages between these initiatives and the ADHB's four key goals:

Goal area	Linkage	Comment
Business performance	<ul style="list-style-type: none"> • Recruitment & Admin. Centre • Performance Management • Employee Relations • Remuneration • People Development 	More efficient processes will save costs and improve business effectiveness. Managers are provided with the tools and resources to effectively lead and manage.
Change Programme	<ul style="list-style-type: none"> • Workforce Management Plan • Change Implementation • Recruitment & Admin. Centre • Employee Relations • Remuneration 	HR strategies and services will enable implementation of the new organisation structure.
Building Programme	<ul style="list-style-type: none"> • Change Implementation • Performance Management • People Development 	Manage successful migration to new building through effective change implementation, robust performance management, staff training and OSH planning.
13 Health Strategies	<ul style="list-style-type: none"> • Workforce Management Plan • People Development • Recruitment & Admin. Centre 	HR strategies and services ensure ADHB has required staff numbers and skills to deliver on health strategies. Address Maori & Pacific workforce development and specific skill shortages.

1.8 Summary of action points.

We are committed to delivering health services to the people we serve within the funding available. We must gain control of our current financial crisis and reduce the deficit to manage this effectively.

The ADHB will maximise efficiency in the secondary and tertiary sector as part of the Change Programme. This review will create develop new ways of operating and then assist each clinical business unit with its transition process. This will cover areas such as:

- Increasing utilisation of theatres
- Reducing the average length of stay for patients
- Increasing the number of same day treatments
- Reducing the number of inpatients
- Accessing clinical information across the two sites using process such as real time patient records and digital dictation

Developing good collaborative processes across the DHB will be pivotal to securing more cost effective health gain.

A key element of our work programme is the planning for the migration of staff, equipment and patients to the new facilities when they are built:

July and August 2002 - complete concept design and prioritise work. Design detail at the process level put in place the project structure

September and October 2002 - complete detailed designs for each HBO

November and December 2002 - design pilots for systems and processes

January to March 2003 - begin, track and modify pilots and start roll out of new systems such as the theatre system, concerto framework, discharge summaries, and digital dictation

March to June 2003 - complete roll out of systems and begin post implementation phase of embedding new processes and systems. Gain approval for a second stage of work

July to September 2003 - facilitate migration of services into new Greenlane facilities and begin data gathering and conceptual design for second stage

October and November 2003 - facilitate migration into the new Auckland City Hospital

December 03 and January 2004 - continue detail design and building new processes and systems

At the same time as managing these difficult processes we will not lose site of our role as a DHB. We will continue to focus on protecting and investing in the

primary sector, specifically through health promotion, protection and preventative services. The benefits of this approach will be realised in the long term, not the immediate future.

The NZ Health Strategy 13 priority objectives will determine our actions in the next five years, with greatest emphasis on the prevention of diabetes. We will also be encouraging integration between the primary, secondary and tertiary services and identifying areas where primary services can be made more efficient. This will involve reallocating resources from low priority areas to high priority areas within primary health, and shifting resources from the secondary, tertiary and national tertiary sector into the primary services.

The ADHB will also take a wider geographic focus in recognising that more than 50 percent of its hospital services are provided to people outside the Auckland DHB area. Any reduction in the level of ADHB services would create problems for other DHBs and affect the people from other areas who use Auckland DHB services. The ADHB will work with other DHBs to manage the flow of patients between areas, agree service changes required under the sub regional equity of access programme and work to resolve the issues that exist with current pricing structures.

We will take a lead in managing these initiatives as well as engaging in public consultation to help determine the priority health areas and processes for funding decisions. We will consult if significant service changes are proposed following the formal adoption of the Strategic Plan.

Signed for and on behalf of the
AUCKLAND DISTRICT HEALTH BOARD

Wayne Brown
Chairman

2 Introduction

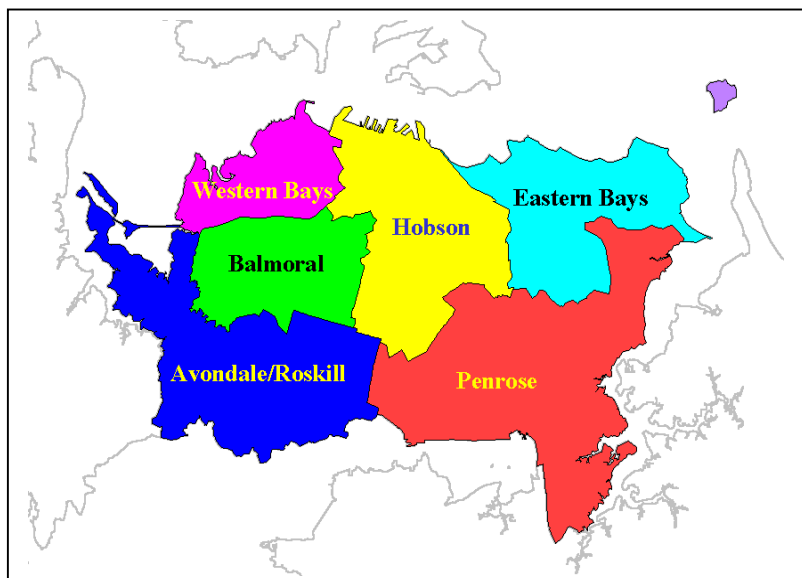
This Plan has been developed in accordance with the requirements of the NZ Public Health and Disability Act (NZPHD) 2000 (Section 39). The Annual Plan is the accountability document between ADHB and the Minister of Health and informs the public about the operational activities planned for the twelve-month period ending 30 June 2003. The structure and format of this plan are consistent with guidelines issued by the MOH.

Preparation of the Annual Plan of the ADHB has been guided by the objectives set out in the ADHB District Strategic Plan, the New Zealand Health Strategy, the NZPHD, the Draft Disability Strategy, and the Minister of Health's expectations and the Government's policy priorities.

2.1 Population characteristics

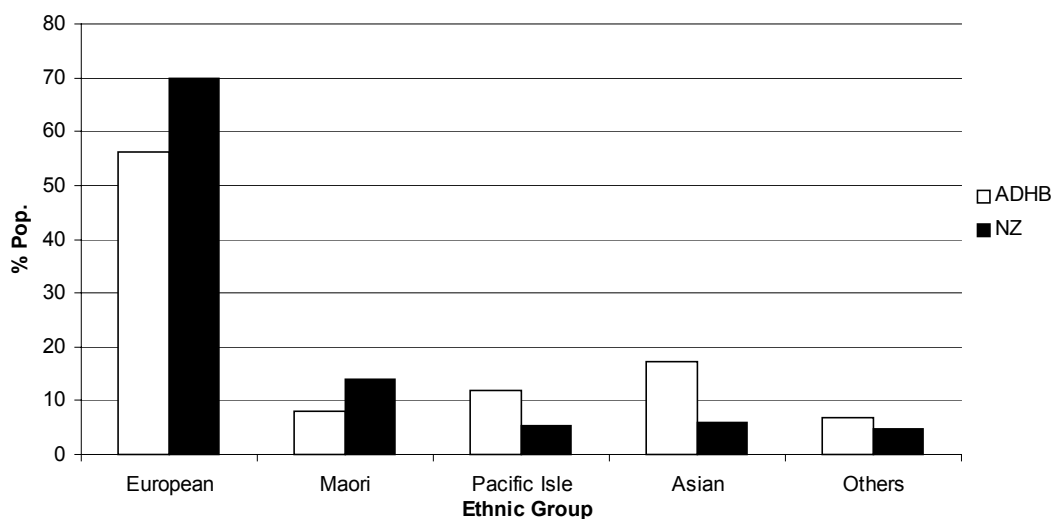
2.1.1 Geographic area

The ADHB has the third largest DHB population resident within its geographic. This population comprises a number of diverse communities, unique to the ADHB. The boundaries for the ADHB are identical to the boundaries for Auckland City. The ADHB health district spans several community board areas and Wards and includes the Hauraki Gulf Islands.

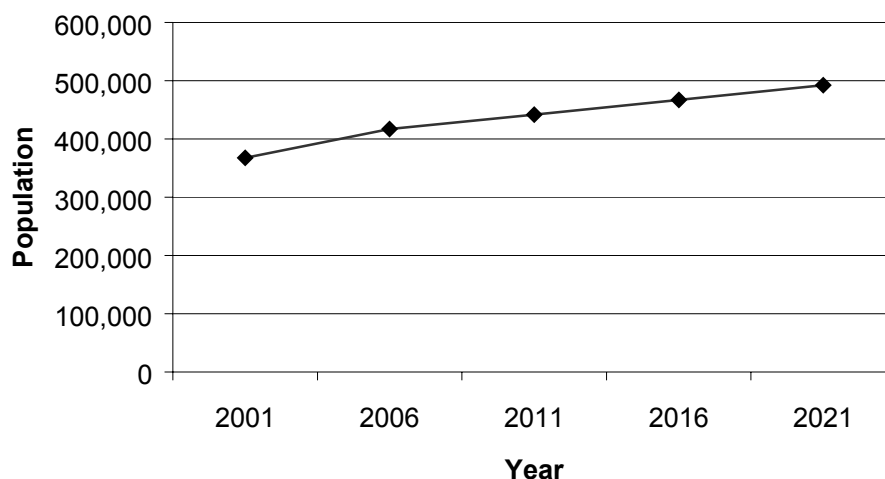


2.1.2 Growth, Age and Ethnicity

There were approximately 367,734 people living in the Auckland DHB health district in 2001. There were approximately 7.9% Maori, 11.9% Pacific people and 17.2% Asian people. Approximately 19.7% of the population were children (0-14yrs), 15.3% were aged between 15-24 years and 10.3% of the population were aged 65 years or more. Approximately one third of the ADHB population live in highly deprived (NZDEP96, deciles 8-10) areas.

NZ and Auckland DHB populations by Ethnic Group (%), 2001.

The population structure and trends over time have important implications for future service demand and service planning. The population is expected to grow by 26 percent between 2001 and 2021. The population is expected to age over time, with an increase in the proportion of the population aged over 65 years and a reduction in the proportion of children (0-14yrs) in the population over this period. Population growth is expected to be very high in the areas of Penrose, Meadowbank, Auckland Central, Walmsley (the Stoddard Road area of Sandringham and Avondale) and Waiheke Island between 2001 and 2021.

Population growth in the Auckland DHB area 2001–2021

In addition, the ethnic composition of the population is expected to change over time, with a greater proportion of Asian and Pacific peoples and a reduction in the proportion of Maori in the ADHB population. The ADHB will need to exercise flexibility in planning in order to meet the future health needs of the changing population.

Older people comprise an increasing proportion of the population including Maori and Pacific Island peoples although their increase is small.

ADHB	European #	Maori #	Pacific Island #	Asian #	Others #	Total #
65-74	13,449	660	1,458	1,869	1,431	18,867
75-84	11,352	222	570	573	963	13,680
85+	4,686	63	102	153	378	5,382
Total 65+	29,487	945	2,130	2,595	2,772	37,929

Changes since 1996 census	ADHB Change #	ADHB %	NZ %
65-74	-1,977	-9.5	-0.2
75-84	-225	-1.6	13.1
85+	708	15.1	26.4
Total 65+	-1,494	-3.8	6.6

2.1.3 Health Status

Because of the complex nature of measuring health and well-being, a range of different health measures are presented to provide insights into the overall health status of people in the community. The information presented includes both mortality rates and morbidity in the community, derived from public hospital discharges, census data and survey data.

Whilst the emphasis is on comparing health status indicators between people who reside in the Auckland Central District and the total New Zealand population, age group and ethnic group sub-populations are provided where appropriate and where information is available.

2.1.4 Mortality

Information on mortality (deaths) in New Zealand is available from the death certification registry. Mortality data is accurate in New Zealand and reasonably comprehensive and includes information on the date of an individual's death, cause of death, date of birth, occupation, residence, gender and ethnicity.

All-Cause Mortality

The table below presents standardised all-cause mortality rates, by ethnicity, for people living in the Auckland Central District, 1996-98. The standardised rates presented are summary health status measures expressed as rates per 100,000 population.

Standardised all-cause mortality (100,000 pop.) Auckland and New Zealand, 1996-98.

	Auckland	New Zealand
Pacific Islander	1040.8	1041.0
Maori	995.5	1155.4
Other	678.5	692.0

Data source: NZHIS: 1 Standardised to NZ pop.

Maori and Pacific Island all-cause mortality rates are high in comparison to the rates for other ethnicities in both the ADHB area and the total New Zealand population. The other grouping in this context includes Europeans and Asians. Whilst the highest mortality rates are among Pacific Island peoples, the rate for Pacific Islanders residing in the ADHB zone is similar to the total New Zealand rate. This would indicate that the health status for Pacific Islanders residing in the ADHB area is similar to that of Pacific peoples residing elsewhere in New Zealand.

The all-cause mortality rate among Maori residing in the ADHB zone, however, is substantially less than the rate for all New Zealand Maori. This indicates that although health status among Maori is not as high as health status enjoyed by other ethnicities in Auckland, Maori in the ADHB community have higher health status than their counterparts elsewhere in the country.

Cancer and ischaemic heart disease is the leading causes of death for all ethnic groups in the ADHB population. There are however, significant variations in other leading causes of deaths between ethnic groups. For instance, injury and poisoning, perinatal conditions and diabetes featured more strongly in Maori and Pacific peoples than among "Other" ethnic groups.

Perinatal Mortality

Mortality rates in infancy are commonly used as indicators of health in a population. Their popularity as summary measures of health is based upon the assumption that they are particularly sensitive to differences in socio-economic status and healthcare interventions.

Perinatal rates are presented for both the ADHB population and the total New Zealand population in the table below. This mortality indicator is derived using the total number of infants that die within the first seven days following birth and is expressed as a rate per 1,000 live births. The table on the next page shows that Maori suffer higher rates of perinatal mortality than non-Maori do. However, this disparity appears to be much more pronounced among Maori residing in the ADHB area.

Perinatal mortality (rates per 1,000 live births) for Auckland and New Zealand, 1996-98.

	Auckland	New Zealand
Maori	10.9	7.7
Non - Maori	6.8	7.0

Data source: NZHIS

Life Expectancy At Birth

Life expectancy at birth is also commonly used as an indicator of population health status. It is defined as the average number of years a newborn is expected to live, if current mortality rates were to continue.

The table below shows life expectancy estimates at birth for residents of the Auckland Central District and the total New Zealand population. As can be seen, females have a greater life expectancy than males in both populations

and female life expectancy is very similar between both groups. In comparison, males in the national population are expected to live, on average, slightly longer than males residing in the ADHB area.

Life Expectancy at birth: Auckland and New Zealand populations.

	Auckland	New Zealand
Male	73.9	74.3
Female	79.8	79.6

Data sources: Walker R (2001) Population profile in ADHB Region. ADHB, Auckland. www.stats.govt.nz

2.1.5 Morbidity

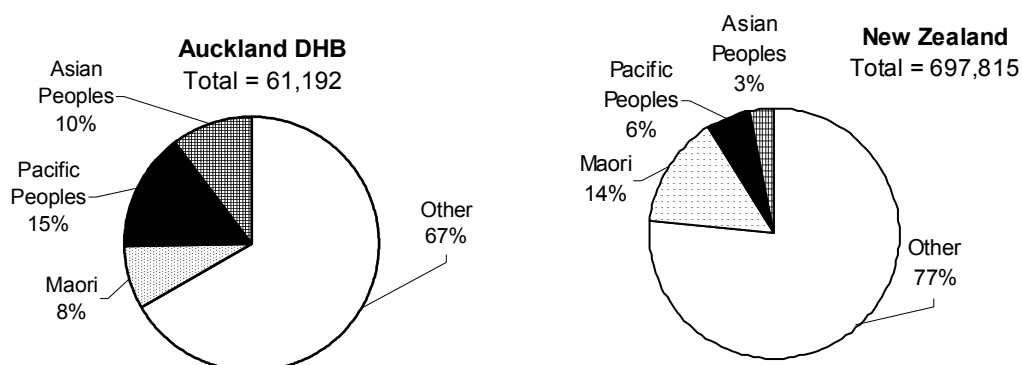
Information on morbidity, or illness, is often used in conjunction with death data (mortality information) in assessing population health status. In this section, information about people who are first admitted and then discharged from public hospitals is used as a measure of morbidity (this type of information can also be used to inform about access by the community to health services and health service utilisation). These hospitalisations are officially recorded and presented here as public hospital discharges.

Estimates of the prevalence of illness and injury are also presented in this section. These estimates have been obtained from survey data and provide information about health and well being in the Auckland community that is complimentary to the more traditional measures of population health status.

Public Hospital Discharges

The chart below presents public hospital discharges for residents of the ADHB zone and the total New Zealand population, by ethnic group. As can be seen, the majority of discharges for both the ADHB and New Zealand populations occurred among other ethnicities in 1999-00. This is not surprising as this category includes the majority of the population.

% Public Hospital Discharges, by Ethnicity, for ADHB and New Zealand populations, 1999-00.



Data source: Walker R (2001) Demographic Profile of Population in ADHB Region. ADHB, Auckland.

There are some marked differences in ethnic discharge proportions between the ADHB and New Zealand populations, especially among the Maori, Pacific and Asian peoples. To a large extent these disparities are due to the difference in ethnic composition of the populations of interest. For instance, a

greater proportion of the ADHB population identifies as Pacific peoples (12%), compared to the New Zealand population (5.6%). Thus, Pacific peoples comprised a greater proportion of all ADHB public hospital discharges (15%) in 1999-00, compared to the proportion for all New Zealand (6%).

Public hospital discharges (rates per 100,000 pop.) for specific diseases for ADHB and New Zealand populations, 1996-98.

Disease	ADHB	New Zealand DHBs (median rate)
Alcohol related	52.3	71.5
Diabetes	73.6	89.6
Injury	1726.4	1785.9
Ischaemic heart disease	583.7	778
Stroke	259.2	261.3
Cancer	943.8	1172
Suicide attempt	73.8	77.4

Data source: Hill P, Walker R, Lane L (2001) *Preliminary Review of the Demographic Characteristics and Health Status of People in Central Auckland*. ADHB, Auckland.

The table above illustrates public hospital discharge rates for ADHB residents, compared to rates for the New Zealand population. As can be seen, The rates for the ADHB population are relatively low in comparison to the median rates for all New Zealand DHBs.

Prevalence of Illness and Injury

Information on the prevalence of illness and injury in the population has been obtained for two separate time periods. The data were collected in a general population health survey that measured the prevalence of illness and injury in the population retrospectively over a 12 month and one month period.

The table below shows the percentage of the population experiencing illness or injury during these two time periods, for the four Northern-most DHBs in 1996-97.

Prevalence (% pop.) of illness/injury in the last month and last 12 months by DHB, 1996-97.

	% suffering illness/injury in last month	% suffering illness/injury in last 12 months
Northland DHB	47.3	73.7
Waitemata DHB (North Shore pop)	36.2	62.6
Waitemata DHB (West Auckland Pop)	40.3	69.5
ADHB	31.4	73.2
Counties-Manukau DHB	36.6	68.1

Data source: Parr A, Whittaker R, Jackson G (1998) *The Northern Region Health Survey 1996-97*. HFA, Auckland.

The results show that over the month preceding the survey, the lowest rates of illness and injury in the Northern New Zealand DHB populations were observed in the ADHB population. However, over the twelve-month period preceding interview, 73.2% of the ADHB population recalled at least one episode of illness or injury. This rate was second only to the rate observed in the Northland population.

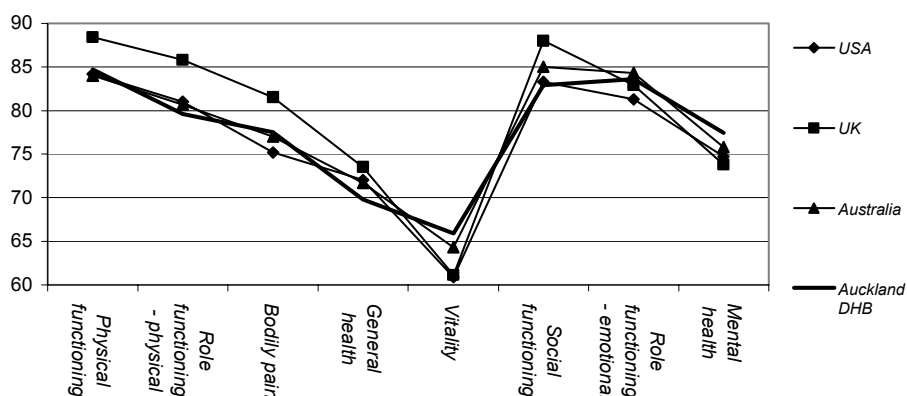
2.1.6 Self-Perceived Health Status

Many population health status measures are derived from routinely collected health service information. A more direct source of information on health status that can also be used as an indicator of health in a population is obtained by asking people themselves how they perceive their health and well being.

Self-perceived assessments of health status provide important insights into how different individuals and groups of individuals both value and rate their existing quality of life. More direct methods of health status measurement are increasingly being utilised in larger population assessments of health status.

The Medical Outcomes Short-form 36 (SF-36) questionnaire was used to measure self-perceived health status in the adult ADHB population in 1996-97. The graph below presents average scores for eight separate aspects of health and well being for people residing in the ADHB zone. These self-perceived scores are compared to scores from the USA, UK and Australia.

Average SF-36 Scores for ADHB, UK, USA and Australia.



Data source: Parr A, Whittaker R, Jackson G (1998) *The Northern Region Health Survey 1996-97*. HFA, Auckland.

The graph shows that average SF-36 scores for the ADHB are similar to those from the UK, USA and Australia. The average 'general health' and 'vitality' scores are consistently low between populations and the 'physical functioning' and 'social functioning' scores are consistently high. ADHB residents scored lower on 'role functioning-physical', 'general health' and 'social functioning', whilst scoring highest in the areas of 'vitality' and 'mental health'.

2.2 Health needs and key issues

The ADHB has completed a health needs assessment and the results and initial assessment of priorities are discussed in section 4.2.1. The ADHB Health Needs Assessment including Maori health profile is complete. The ADHB is completing a Maori Health Needs Assessment that is due for completion in October 2002.

The profiling of the population will continue to be updated as the 2001 census data is further analysed. We are aware that we need better systems to measure the health of our communities. This will involve working with other agencies to measure and analyse both positive and negative indicators of health, to monitor trends in health status over time, and most importantly, to ensure that this informs our decisions.

2.3 Treaty of Waitangi

2.3.1 Commitment and application

The ADHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of Waitangi is the fundamental relationship between the Crown and Iwi and as such, provides the framework for Maori development, health and wellbeing.

The NZ Public Health and Disability Act 2000 requires a DHB to establish and maintain processes to enable Maori to participate in and contribute towards strategies for Maori Health improvement. This is in order to recognise and respect the principles of the Treaty of Waitangi with a view to improving health outcomes for Maori. General references to the Treaty of Waitangi in this document derive from and should therefore be understood in this context.

As a Crown Agency the ADHB will demonstrate how Treaty responsibilities are managed within the health sector by our commitment to the principles of Partnership, Participation and Protection. These principles have been outlined by the Ministry of Health in order to provide direction specific to the health sector. Similarly, some of the processes that we have established are in the form of Partnership agreements and relationships with local Iwi. These relationships and agreements support the overarching and ongoing Crown relationships with Maori that have been established by the Treaty.

Each principle contains a significant provision that relates to health and these are incorporated in all aspects of this plan. Our commitment is consistent with the Ministry of Health, He Korowai Oranga - Maori Health Strategy and the Memorandum of Understanding we hold with Te Runanga o Ngati Whatua and its operational arm Tihi Ora MAPO. This Memorandum of Understanding outlines key principles, processes and protocols for working together at both governance and operational levels.

Alongside our relationship with Ngati Whatua as manawhenua is our responsibility to the Maori communities in our district and those who use our

services. ADHB works together with iwi, hapu, whanau and Maori communities to develop strategies for Maori health gain and appropriate health and disability services.

Partnership

Working in accordance with our Memorandum of Understanding with Te Runanga o Ngati Whatua to ensure that Ngati Whatua, as manawhenua, are partners with the ADHB at the governance level. This health partnership ensures that we actively protect Maori interests in our health planning and funding activities.

With regard to public funding and provision of health and disability services, this requires meaningful consultation with Maori and involvement in the planning of health and disability services

ADHB as an agent of the Crown is required to meaningfully engage with Maori as regards to the impact service changes may have on Maori communities and organisations.

Participation

Involving Maori at all levels of the sector in planning, development and delivery of health and disability services.

ADHB will recognise this by actively involving manawhenua and mataawaka communities in defining health needs, and involving them in the implementation and provision of health services which will improve health and disability services and health outcomes for Maori. Once again this commits our organisation to ongoing engagement with Maori.

Protection

The ADHB will aim to ensure that Maori enjoy the same level of health as non-Maori and will safeguard Maori cultural concepts, values and practices. This includes the right of equity between Maori and other New Zealanders to health services and the expectation that these services will meet the rights/rites, needs, interests and aspirations of Maori.

ADHB recognises the need for equity of participation, access and outcomes for all Maori and that there is still some way to go to achieve these goals.

ADHB acknowledges the need to preserve and protect the rites of Maori including te reo, carvings, waiata, tukutuku and karakia according to tikanga of manawhenua and other Maori living in our district.

2.3.2 Maori Health Service

He Kamaka Oranga (Maori Health) within the ADHB will ensure it is responsible for all aspects of policy development, planning and funding, provider management, quality, clinical leadership and Tikanga Maori. It also provides assistance in managing Treaty of Waitangi risks as a result of its monitoring and evaluation processes.

Maori Health will seek to consolidate current Maori health initiatives within the secondary and tertiary sector of the ADHB on a business as usual basis while driving initiatives in primary health care, public health, integration and co-ordination and intersectoral strategies including Maori population health strategies.

2.4 Environment

2.4.1 Government expectations

The operational emphasis of the DHBs is to:

- have a population focus addressing disparities in health & disability status
- Shift emphasis towards promotion of health, prevention of ill health and disability and early intervention
- Foster collaboration and co-operation between local providers, with services focused more on users needs rather than providers
- Involve and engage with the community and other key stakeholders, and promote outreach programmes and local community initiatives.

DHBs operate in an open and democratic manner with:

- A majority of Board members being publicly elected
- Meetings of the Board and its principal committees held in public.

DHBs are required to establish and maintain processes to involve Maori in strategies for Maori health improvement.

DHBs' District Strategic Plans are expected to demonstrate how funding changes are being managed to better reflect the needs of their population. This process includes addressing the government's key priorities as set out in the NZ Health and Disability Strategies.

2.4.2 Health and Disability Sector characteristics

The health and disability sector continues to be characterised by a growing gap between what is possible and what can be provided within existing resources. The ADHB is committed to the difficult task of reducing its deficit as part of this plan with a view to developing long-term financial viability.

The Consumer

- Consumers have expectations of quality, efficiency, value and accountability.
- The culture of the health system is shifting to respond better to consumer needs.
- Patients will become more aware of the need for self-management.
- The numbers of older people will rise as life expectancy increases and chronic disease prevalence will continue to grow significantly.

- Access to the Internet will decrease the information gap between provider and consumer.

The Funding Context

- It is expected that DHBs will move to funding based on population, commencing 2003-04. This will require a different approach to managing inter district flows with the agreement of contracts for services between each DHB
- Funding for the current year is based on a three year funding package computed using incremental increases on provider contracts managed by the funder arm of the ADHB. Funding is not related to the population in the Auckland central district.
- There is an expectation of cost management within predetermined boundaries for the three-year period of the funding package. For the ADHB this comprises maximum cost increases of 2% for the 2002-03 and 2003-04 years and 3% for the 2004-05 year
- Private health expenditure is rising significantly as well as private insurance.

Health Policy Environment

- The Crown sets minimum access criteria, quality standards, and the range of publicly funded services (Service Coverage Requirements).
- There is a commitment to meet the National Blueprint for mental health services over the medium term.
- DHBs are expected to manage within the fully implemented national booked waiting times policy.
- There will be significant movement to equitable thresholds for access to elective surgery across the country.
- There is a requirement to apply consistent national funding and pricing frameworks based upon a common costing methodology.

Health Trends

- The range and prevalence of disease continues to change. In New Zealand there is an increasing incidence of mental illness, diabetes, some cancers, age-related illnesses and some infectious diseases.
- There is continuing pressure on secondary and tertiary services with growth in acute medical admissions and increasing complexity and co-morbidity.
- Utilisation and expenditure for diagnostic services, pharmaceuticals, and continuing care for the elderly continue to increase.

Service Providers

- Services will become increasingly complex and efficient for a given level of care.
- Pressures to increase the ambulatory components of care will continue.
- Integrated provider networks will be a trend with an increasing variety of inter-linkages between facilities and providers.
- There continues to be an emphasis on fostering and further developing culturally appropriate services.

- Non-governmental organisations will continue to grow to respond to niche needs.

Technology

- Advanced technologies will blur the distinction between different care settings.
- New techniques such as minimally invasive surgery are resulting in shorter hospital stays and less disruption for families for some conditions.
- Greater cooperation and openness in the health sector will govern integrated and sophisticated health information systems, and increase localised autonomy.
- Development of new pharmaceuticals, mobility equipment and computer-based communication technology is making it possible to provide people with more independence.
- New e-business models will place major pressure on existing systems and processes.
- Genomics and biotechnology will increase the opportunities for gene therapy and prevention of genetic disease over the next decade.
- The casemix funding models do not allow flexibility to manage the introduction of new technology to improve patient care such as improved implants for surgical procedures
- New technology may not result in reduced costs for the health sector but can provide significant benefits when viewed in a wider context such as earlier return to work of a donor who undergoes laparoscopic surgery

Workforce

- There will be increasing globalisation of the workforce particularly professional workforce.
- Shortages are expected in a number of areas such as senior medical officers, junior medical staff, nurses, midwives and technical staff.
- There is an ongoing focus on developing Maori workforce and Maori providers.
- There are increasing demands for additional support and training to enable foreign trained staff and those trained solely in tertiary institutions to function safely.
- Multiple career changes within the workforce will be more common.
- Recent changes to the employment relations legislation will require consideration to ensure compliance

Research and Training

- There is a need to continually address workforce development needs in order to contribute to improved health service delivery and patient outcomes

2.4.3 Regional issues

There are a wide range of common issues and significant mobility of population that occurs across and between the three Auckland DHBs. It has been agreed that the greater Auckland DHBs comprising Counties Manukau, Waitemata and Auckland will work collaboratively together. Common issues can be better represented as a region and there is a need for a robust forum for resolving inter-district issues that affect particular DHBs. In working together the DHBs have agreed to:

- Use funder resources as efficiently as possible
- Ensure appropriate Maori and Pacific Island input to these decisions
- Maintain service coverage across the region
- Confirm lead DHB business rules and protocols
- Establish effective regional governance to further this where it serves our common interests

A governance structure is being developed to manage this collaborative process and the three DHBs are developing a set of principles based on:

- Working together for common greater Auckland interests
- Resolving significant disagreement
- Ensuring that the Auckland population is not disadvantaged in funding or service provision.
- The DHB most affected by an issue having the lead role in formulating the region's response to the issue

The range of issues identified for the Greater Auckland region are identified below and actions are being developed to address each of these areas:

- **Population Based Funding** - addressing the three areas of revenue levels, implementation and the role of lead DHBs. Seven issues have been identified with respect to revenue:
 - ✓ Historic undercounting due to census projections being lower for Auckland than actual population figures or estimates
 - ✓ The demographic growth adjuster ignores negative population growth and dilutes the impact of growth by 50%
 - ✓ Mental health funding is below that of the Central and Southern regions by almost 30%
 - ✓ Disability funding is believed to be below equitable entitlement by \$30m
 - ✓ Post-enumeration surveys reveal that parts of the region have disproportionate undercounting from people who don't fill in the census
 - ✓ Waitakere is excluded from the national diseconomies adjuster pool
 - ✓ The quantum of the tertiary adjuster pool does not adequately compensate tertiary providers
- **PHO development** - implementation of the government strategy for PHO acknowledging the inter district connections between providers
- **Prioritisation** - agreeing business rules for prioritisation where more than one district is affected or common issues need to be addressed

- **Site Adjuster for Cost of Capital, Interest and Depreciation** - the current funding for the sector for interest, cost of capital and depreciation is allocated to DHBs through the price mechanism in a one line adjuster. The system leads to windfall gains and windfall losses depending on the financial position of each DHB
- **The process for managing Inter District Flows** - A working group to develop inter district processes that linking with national level initiatives
- **Regional provider configuration/SREA** - since 1996 the three Auckland DHBs have been planning on the basis of the delivery of secondary services locally and regional services by one provider
- **ACC revenue** - up to \$40m of the money has been transferred from Vote Health to Vote ACC for health related activity but does not flow to DHBs due to ACC buying services from the private sector in preference
- **Community Pharmaceutical Growth** - growth is strong in parts of Auckland, particularly Waitemata and there is wastage from non-compliance.
- **Community Laboratory Growth** - regional growth is high compared to funding path. There is a large collection infrastructure in Auckland and close commercial relationships between laboratory providers and prescribers
- **Non-resident bad debts** - cost for region estimated at \$8-10 million
- **National Contribution of Auckland DHBs** - Many services have complexities that are not recognized by casemix or other pricing systems.
- **Impact of private medicine** - the large private sector market in Auckland drives up laboratory and initial pharmaceutical costs.
- **Shared Services** - IT convergence already adopted as an agreed strategy
- **Implementation of PHO strategy** - Distribution of funding may unfairly disadvantage Auckland because of the 3 out of 21 phenomenon rather than a population based funding approach.

The ADHB is committed to this collaborative programme of work with the other DHBs.

3 Strategic direction

3.1 Vision and values

3.1.1 Vision

Healthy Communities, Quality Healthcare

3.1.2 Purpose

The purpose of the ADHB is to achieve the best possible health and independence possible within available resources for our diverse communities, through a focus on assessing and meeting needs, in collaboration with others.

The ADHB is here to:

- Promote, improve and protect the health of our people and communities and promote the inclusion and participation in society, and independence of, people with disabilities
- Ensure the provision of safe, effective, innovative and comprehensive health and disability support services, including community, public, primary, secondary, tertiary, and quaternary health services
- Uphold the Treaty of Waitangi by working in partnership with Ngati Whatua to ensure the protection and participation of Maori at all levels
- Address inequalities, reduce barriers to access and ensure Maori, Pacific people, Asian and other disadvantaged groups have specific solutions for their particular needs
- Undertake and support research, training and education, in conjunction with the Auckland University Faculty of Medicine and Health Sciences
- Assess needs, prioritise and allocate resources to best match assessed population needs
- Provide leadership of change within the sector
- Work collaboratively and co-operatively within and across the sector
- Develop our workforce so it is able and willing to meet population needs and make valuable contributions to achieving our vision
- Engage our communities

3.1.3 Principles

The ADHB endorses the principles outlined in the New Zealand Health Strategy. The following principles and values will guide the decisions and actions of the ADHB.

- Honouring the special relationship between Maori and the Crown under the Treaty of Waitangi
- Good health and wellbeing for all New Zealanders throughout their lives
- An improvement in health status of those currently disadvantaged

- Collaborative health promotion and disease and injury prevention by all sectors
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
- A high-performing system in which people have confidence
- Active involvement of consumers and communities at all levels
- Valuing all tiers of the health and disability support sector including, pre-primary, primary, voluntary, secondary, tertiary, quaternary community and non-government organisations; including physicians, nurses, management, specialists and multidisciplinary workers and others
- The development and preparation of the health workforce for an integrated health and disability support service
- An integrated, coordinated continuum of care
- Innovation and collaborative approaches to create new partnerships and collaborative models of practice, so public have greater choice
- Evidential based decision making to make best use of the available resources

3.1.4 Values

- Integrity; we are open, honest, direct and transparent in our communications and dealings with others
- Collegiality; we acknowledge and aim to understand diversity and differences to value people, and staff. We want to work well in teams
- Humanity; we deal with others with compassion, and take risks and act with courage in our roles and work so we can achieve our vision
- Innovation; we value challenging current ways of working that introduce better and simpler ways for achieving desired outcomes
- Research and development; we aim to be well informed and use information as a base for decisions and actions
- Excellence; we strive for high standards of quality in our service delivery, that embraces a spirit of pride that reflects our public service orientation
- Access; we strive to find ways that enhance engagement of others and maximize our contribution, so we fulfill our responsibilities as a publicly funded organisation
- Fun; we create a positive stimulating environment that balances informality and discipline.

3.2 Goals and objectives

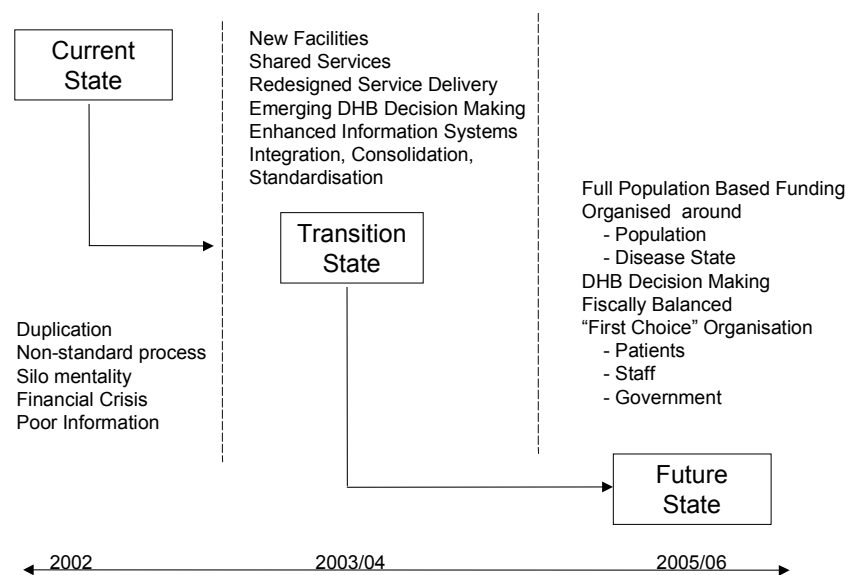
3.2.1 Managing the process of evolution

The District Strategic Plan for the Auckland District Health Board 2002–2007 demonstrates to the local population and the Minister of Health how the Auckland DHB will achieve the Government's priorities for health within the funding available over the next five years. The Government's priorities are outlined in the New Zealand Health Strategy and the New Zealand Disability Strategy, both of which provide the framework for future health service development.

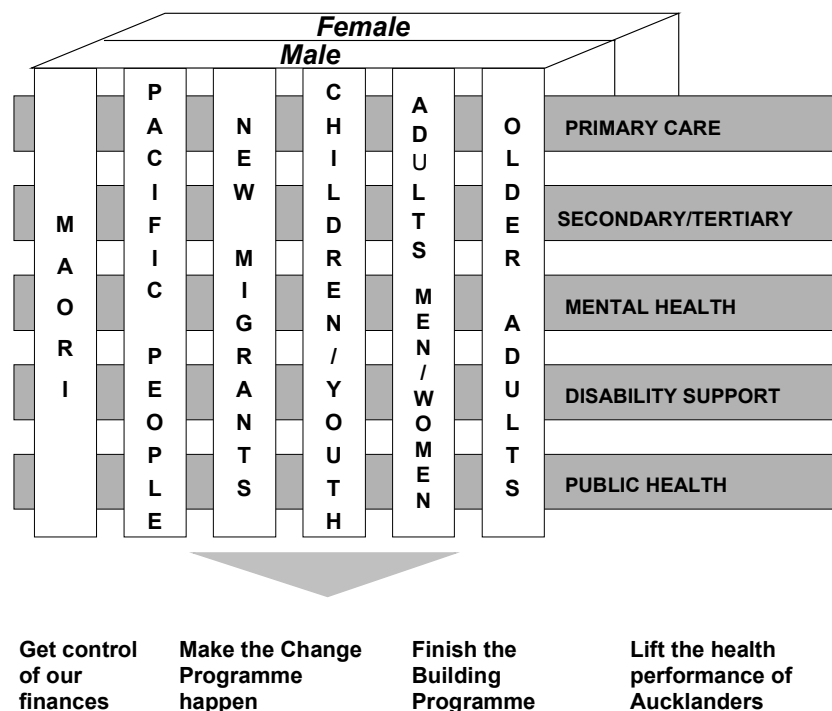
The Auckland DHB has the vision of 'Healthy Communities, Quality Healthcare'. This reflects a focus on population health that is wider than health services and involves working with other agencies, organisations, iwi and community leaders. We want the best possible health and independence for the district and region within our available resources.

There are three stages of evolution that the ADHB will manage over the next three years from current state through transition to the future state as illustrated below:

ADHB Future State



This programme of work is aligned with the District Strategic Plan and acknowledges the health sector is continuing to change and develop. The Strategic Plan includes the proposed future directions for health improvements, covers the populations within the Auckland area and examines the key issues and health priorities for these. It also discusses the health services, how these are orientated, and priority directions for the future. This approach forms a matrix of people and services that concentrates on people and their health while also focusing on the health services which make up the ADHB.

Matrix of population groups and service areas with emerging goals

The four key goals are woven through each of the areas in this plan. These translate into priorities for the future and are based on:

- The need to live within the finances available and reduce the level of deficit.
- Government policy as set out in the NZ Health Strategy and NZ Disability Strategy
- National strategies to assist various services, e.g. the National Mental Health Strategy, Reproductive and Sexual Health Strategy, Older People and Positive Aging Strategies
- The outcome of the 2001 Auckland DHB health needs assessment including community engagement work
- Joint work with the other DHBs in the region

The four goals provide the setting for the work that will be undertaken in the 2001-02 financial year and beyond:

3.2.2 Get control of our finances

We lost over \$66 million in the year to 30 June 2002 and we need to do things very differently to stop these losses.

3.2.3 Make the change programme happen

We need to speed up the move to standardise, consolidate and integrate our services to improve patient care and capture the required operational

efficiencies of \$40 million per annum by the completion of the programme. This will require collaboration across all health services to streamline care and to secure more cost-effective health gain. The Change Programme has been established to manage this process and has completed its organisation design phase and is proceeding with five projects designed to transform systems and processes and a full analysis of its work is set out in this plan.

3.2.4 Finish the building programme

The Building Programme is managing the construction of the new buildings on the Grafton and Greenlane sites. This provides the platform to enable the gains from the Change Programme to work to maximum effect by the opening date for the new Grafton facilities in October 2003. There is high level of collaboration with the Change Programme to ensure that essential changes in systems and processes are achieved before the migration to the new facilities take place.

The new Auckland City Hospital will offer acute medical and surgical inpatient services. It will be nine levels high (five levels lower than the existing Auckland Hospital building) and have an opening capacity for 752 beds. ADHB has already opened a new laboratory and mortuary (LabPlus), and a new carpark building (Helipad Carpark) on the Grafton site. Construction of a new acute mental health unit (to replace the Conolly Unit) is underway north of the existing Auckland Hospital building and will be completed in January 2003. The ADHB Greenlane site will be transformed into the Greenlane Clinical Centre with completion of the new buildings in September 2003 and refurbishment of existing buildings by October 2004.

3.2.5 Lift the health performance of Aucklanders

The commentary on the nature and scope of activities above has already provided an indication of the challenges that are being managed for this goal. These challenges include:

- Reflecting our Treaty of Waitangi responsibilities within the framework of the NZPHD Act by establishing and maintaining strong relationships that inform funding decisions through a better understanding of the health needs of Maori
- Focusing on population health through analysis of needs and the further development of processes to inform funding decisions
- Reducing inequalities through analysis of needs and the use of priority setting criteria to inform funding decisions
- Managing continuums of care through initiatives that improve information flows between providers and assist the provision of care by primary care providers thereby reducing the level of acute admission to hospitals
- Strengthening the primary care sector by prioritising funding for new initiatives, improving information and collaborating with other government agencies and groups to enable issues to be addressed at a more holistic level

- Improving quality and safety of services by maintaining and improving quality and risk management systems and engaging with other DHBs on key issues such as the management of inter district flows

Reflect our Treaty of Waitangi responsibilities within the framework of the NZPHD Act

In line with the government's 13 health priorities we will lead by example to stop smoking, reduce obesity, be more active, reduce impacts of alcohol, drugs and violence, reduce incidence and impact of cancer, cardiovascular disease and diabetes.

- Recognise Maori status as tangata whenua, ensuring protection, partnership, and participation.
- Improve the health status of Maori living in our area.
- Reduce the barriers to services to meet the needs of Maori.

Focus on population health

- Health promotion, problem prevention and early intervention.
- Good systems to measure positive and negative health indicators.
- Build the research and analytical base of the organisation.
- Assess health needs, prioritise and allocate resources to best match health and disability service needs.
- Work with other sectors and agencies.
- Focus on the NZ Health Strategy priority areas.
- Have a special focus on the prevention of diabetes

Reduce inequalities

- In the health status of groups within the city.
- Prioritise Pacific people, new migrants, and people living in poverty.
- Reduce the barriers to services to meet the needs of Pacific people, new migrant people and other groups with high need.

Continuums of care

- Have a strong focus on the person, so that service provision is well integrated, co-ordinated and culturally appropriate.
- Attention to acute demand, chronic care and high and complex needs including the links between primary, secondary, tertiary and nationally provided tertiary services.
- Reconfigure our hospital and related services to maximise effectiveness and encourage integration.

Strengthen the primary care sector

- Dedicate work to strengthen primary care services
- Initiatives that circumvent serious ill health and acute admissions
- Reduce the problems people have obtaining access to primary health services including language and cultural barriers
- Develop a network of PHOs to assist the processes of integrating care and managing costs
- Rework the current model of service delivery to follow the national strategy for primary care

Improve quality and safety of services

- Ensure health and disability services are safe, effective, efficient, innovative and comprehensive (community, public, primary, secondary and tertiary).
- Progress our hospital and service developments planned to improve quality and safety.
- Manage growth within the resources available.
- Maintain our role as a national centre providing financially and clinically viable services.
- Foster collaborative and co-operative relationships.
- Maintain a skilled workforce able to provide to the diverse range of people and their health needs.
- Reduce waiting times for elective surgery.
- Manage inter-district flows.
- Plan for the move to Population Based Funding.
- Encourage research into clinical effectiveness and audits and implement the findings of this work (including primary sector, clinical governance, costing systems).
- Build capability of the infrastructure to work well in the new health environment.

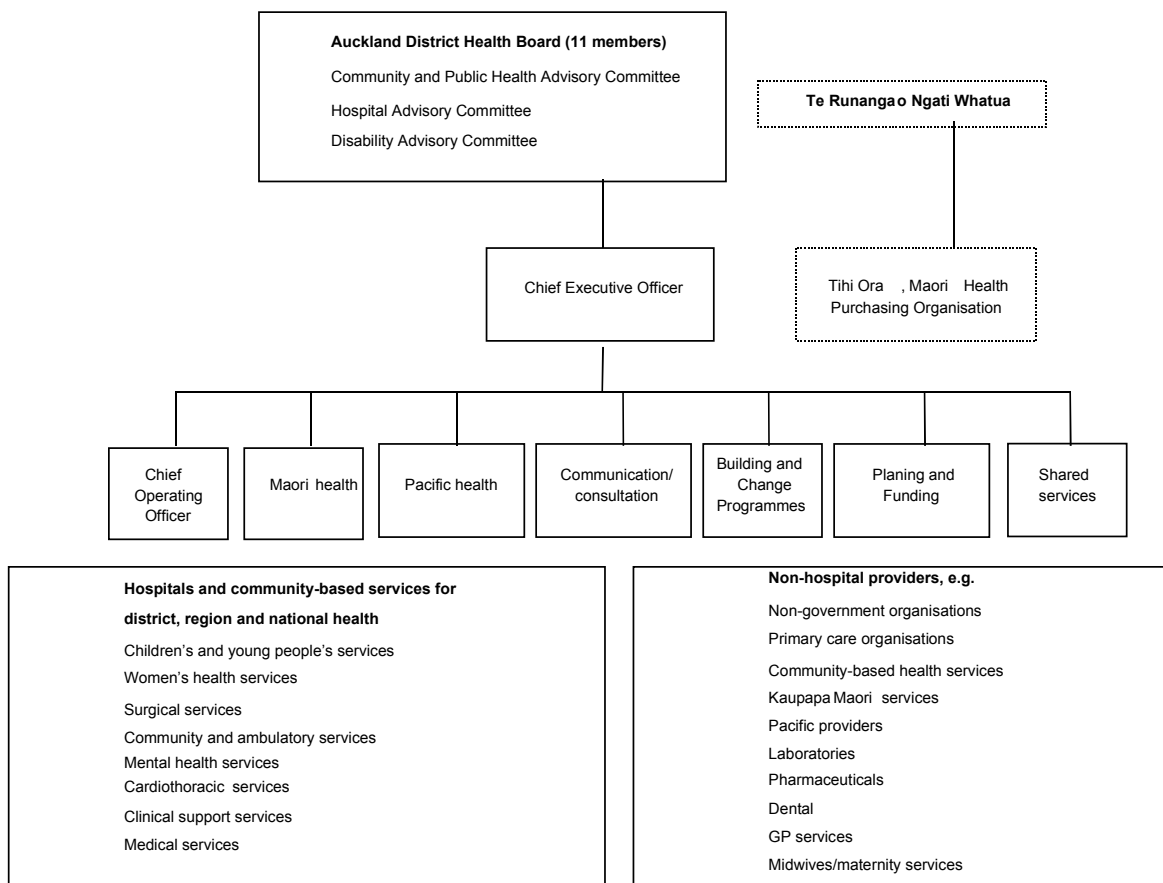
The goals listed are key to the future development of the Auckland DHB and the health services it purchases and provides for the population. These priorities are linked to all the population groups and the service areas.

4 ADHB Performance

4.1 Ownership and governance

4.1.1 Organisation structure

The following organisational chart shows the basic structure with the funding and hospital (and related services) arms of the organisation and key relationships with Treaty partners and providers.



4.1.2 Ownership interests of the ADHB

The current list of subsidiaries is:

- LabPlus Limited – non-trading name protection company
- Green Lane Hospital Limited – non-trading name protection company
- Auckland Hospital Limited – non-trading name protection company
- National Women's Hospital Limited – non-trading name protection company

An in-substance subsidiary is an entity that is controlled by ADHB but is not a subsidiary. The ADHB has one in substance subsidiary:

- Auckland Healthcare Charitable Trust – charitable trust

The following interests are held in other entities that are associates being entities over which ADHB has significant influence, but not control, over the operating and financial policies. The list of associates in which the ADHB holds up to and equal to a 50% shareholding is:

- The Treaty Relationship Company Limited – holding company for the relationship with Ngati Whatua
- Westkids Limited – paediatric services
- Northern Clinical Training Network Limited – training services
- Biomed Investments Limited - holding company owned with Waitemata DHB
- Biomed Trading Limited (formerly Health Support Limited) – holding company owned with Waitemata DHB

4.1.3 Organisational management

The ADHB management structure has evolved to meet the needs of the new environment with three key functional groups: Funding and Service Planning, Support Services and Provider Services. The organisation is undertaking a wider ranging Change Programme to ensure that the administrative structure of the ADHB is efficient and cost effective. The organisation design chart is illustrated in section 4.1.1 above.

The funding arm of the organisation contracts with approximately 970 health service providers, including hospital and non-hospital services. More responsibility for funding local health services may be devolved over time to the funding team, such as public health and disability services funding. This team is responsible for assessing population health need and ensuring that services are planned for the future to meet these needs and make best use of available resources.

The hospitals (and related services) arm of Auckland DHB includes the four ADHB owned hospitals. The ADHB hospital system has an arrangement with government to provide specialist services to people from other DHB areas and from other parts of New Zealand.

4.1.4 Organisational capability

The ADHB will manage its business in a manner that is consistent with the strategic goals. On a day to day operational basis this will require a focus which manages the potential conflict between the demand for and quality of services and the available funding and includes a commitment to:

- Maintaining the quality of services
- Managing systems to equip staff with the information and skills they need

- Collaborating within and across the sector
- Good communication processes
- Engagement with our community
- Appropriate community engagement and consultation processes
- Responsible fiscal management

These building blocks will be used to help ensure that the strategies and programmes are achievable by providing the appropriate tools for the work. This will be supported by day to day management processes and a programme called Leadership and Action. Leadership and Action involves the senior management group comprising some 50 persons and meets twice a year to plan and assess performance and agree corrective action where required. This work is focused on the ADHB's four goal areas and is led by the Chief Executive.

4.1.5 Nationwide Consistency

The ADHB actively collaborates with the other two District Health Boards in the greater Auckland region, Counties Manukau and Waitemata. It also collaborates and at a wider level through its participation in national bodies such as joint working committees with the MOH (e.g. Clinical Services Review Group) and the District Health Boards NZ committees and projects. This fosters a regionally and nationally consistent approach to key issues such as inter district flows and the national service framework. This is important to ensure that at the local, regional and national level developments in one area of health do not create problems for other District Health Boards.

The ADHB also works in accordance with our Memorandum of Understanding with Te Runanga o Ngati Whatua to ensure that Ngati Whatua, as manawhenua, are partners with the Auckland DHB at the governance level. This health partnership ensures that we actively protect Maori interests in our health planning and funding activities. Further commentary on these processes of interaction with Maori and with Pacific communities is set out in sections 4.1.11-13, 4.2.7.3-4.

4.1.6 Risk Management

The ADHB has processes for managing risk within the organisation, and risk external to the organisation. Specific requirements of the Board are the setting of risk tolerance levels, and governance of operations within these levels. The Chief Executive Officer is directly responsible for management of risks across the organisation. The CEO is also responsible for reporting to the Board on risk.

General Managers have overall responsibility for the proactive management of risk for their area of business as defined by internal policy, or as delegated by the CEO. Clinical Leaders share this responsibility for ensuring that the risk management processes are implemented efficiently in their areas of responsibility. All ADHB employees have a role in the management of risk.

Employees are responsible and accountable for identifying and managing the risks in their day to day work.

The Quality and Safety Manager is responsible for implementing an organisation wide risk management framework and to ensure that risk management is integrated into daily operational management throughout all levels of the organisation. The Quality and Safety manager has an ongoing responsibility to ensure compliance with the risk management policy and procedures throughout the organisation. This function is supported by the internal audit function that conducts compliance audits of the organisation applying the Risk Management policy and processes.

A risk management framework has been developed and includes a risk management policy, risk management process and reporting templates. There are standardised and comprehensive processes for risk management that apply to all areas in the ADHB regardless of whether the risks identified are commercial or clinical.

The risk management framework is based on AS/NZS 4360:1999 Standard for Risk Management and HB228: 2001 Guidelines for Managing Risk in Healthcare. Risk management in the ADHB will be a component of quality management the CEO, GMs and line management accountable for managing risk, both clinical and commercial. There is appropriate clinical input into the management of risk through the advice and monitoring functions of the Clinical Board.

Business planning will require risk analysis of business strategies and these risks will be added to risk schedule. The Ministry of Health Risk Management database "Risk Assessor" is used to inform the ADHB risk management system.

In the period to 30 June 2003 the ADHB will:

- Continue the refinement of risk reporting systems that use the MOH standard reporting templates. The system has been implemented and will be refined over the period to 30 June 2003
- Ensure responsibilities for managing different risks are understood within the ADHB and by other providers and Government agencies;
- Develop the following strategies to manage emerging financial risks once devolution of funding occurs:
 - ✓ Consistent and robust expenditure forecasting methodologies
 - ✓ Purchasing strategies that decrease the percentage of the ADHB expenditure driven by demand
 - ✓ Service development strategies to improve their cost effectiveness
 - ✓ Managing a financial risk reserve for forecast and unbudgeted expenditure in each year
- The communications department continues to ensure the good management of all corporate communications and media inquiries;
- The risk management service continues to ensure that legal exposures are appropriately managed.

Treaty Risks

The ADHB recognises that the Treaty of Waitangi is a partnership between the Crown and iwi. As a Government agency the ADHB will respect the mana whenua status of Ngati Whatua within its boundaries. It will also work to include other Maori through engagement with key stakeholders such as Maori health professional organisations, Maori health providers, key Maori social service organisations, hapu, Maori Urban Authorities, and Maori patients and their whanau. The MHDS as advisor to the ADHB will provide Treaty of Waitangi risk management advice on clinical, management and cultural matters.

Risk issues with the Crown

Major incidents:

The respective responsibilities of the ADHB and the Crown and the processes to be followed in the event of a major incident, disaster or epidemic are governed by the Crown Funding Agreement.

Government funding decisions and legislation:

The ADHB expects the cost consequences of Government policy decisions to be clearly identified. The ADHB also expects decisions on the appropriate levels of funding and redirection of existing funding for such new policy decisions to be agreed with the ADHB.

4.1.7 Special arrangements

Service agreements

In order to ensure the provision of the services referred to in this Plan and the service coverage document issued by the Ministry of Health, ADHB may enter into service agreements (as defined in the NZPHD Act) in relation to both its provider and funding arm activities.

Entry into such agreements will not require the prior approval of the Minister of Health under clause A12 of ADHB's Crown Funding Agreement unless approval is otherwise required by that agreement or the Operational Policy Framework.

Outsourcing

ADHB currently out-sources a range of services including:

- Hotel and estate services (e.g. security, cleaning, laundry, maintenance)
- Clinical services including:
 - ✓ MRI scanning services from Auckland Radiology Group
 - ✓ CT scanning services from Green Lane Imaging
 - ✓ Mental health services from community-based mental health service providers

The Operational Policy Framework requires the ADHB to identify in this Plan any significant proposals to out-source services, or to start providing services

previously provided by a non-government provider. As at the date of this Plan the following matters are being reviewed:

- The most efficient means for managing community laboratory services
- Compounding of pharmaceuticals (for use by Auckland DHB)
- Extension of current contract arrangements for the provision of postnatal maternity care by Birthcare

Involvement in Private Service Provision

ADHB is currently involved in the provision of private (non-publicly funded) services as follows:

- Provision of non-essential, non-clinical, hotel-type services by the Cornwall Suite in Women's Services
- Provision of fertility services by Fertility Plus in Women's Services
- The use of operating theatres in Women's Services by surgeons in private practice for the purpose of such procedures as second trimester termination of pregnancy
- Provision of cardiac services to overseas clients by Cardiac Services
- Lease of land to Auckland Radiology Group and Green Lane Imaging for the provision of scanning services by those entities to both ADHB patients and private patients
- Lease of land to Auckland Obstetric Centre for the provision of maternity and gynaecology services to private patients
- The provision of rent free premises for the private operation of creches on the Grafton and Greenlane sites. These services are used predominantly by ADHB staff (see also co-operative arrangements below)
- The provision of rent-free premises to Starship Foundation and the A+ Charitable Trust in support of their work for the hospitals (see also co-operative arrangements below)
- Research commitments to commercial organisations on a paid basis to support development of better treatment options and quality measures hospitals (see also co-operative arrangements below)

The Operational Policy Framework requires Auckland DHB to identify in this Plan all proposals for involvement in privately funded service provision. As at the date of this Plan the ADHB is in preliminary discussions with CordBank, a private organisation offering storage facilities for stem cells harvested during the birthing process. This would involve ADHB agreeing to collect the stem cells from maternity patients who wish to purchase the CordBank storage service. There are no plans for the ADHB to fund this as a public service and the ADHB would be paid a fee to cover the cost of collecting the stem cells so as to ensure that public patients would not cross subsidise this service.

Co-operative Agreements and Arrangements

ADHB is negotiating or has entered into the following co-operative agreements or arrangements (as defined in the NZPHD Act): These arrangements are identified to enable their approval by the Minister:

Organisation	Agreement purpose	Status	Term
Te Runanga O Ngati Whatua	<ul style="list-style-type: none"> Memorandum of Understanding with Tihi Ora MAPO 	Signed	Ongoing
Housing New Zealand Corporation	<ul style="list-style-type: none"> Memorandum of Understanding in relation to the healthy housing development strategy 	Signed	12 months from date of execution
University of Auckland School of Medicine	<ul style="list-style-type: none"> Strategic alliance to achieve sustainable advantages in health education Memorandum of understanding with respect to reimbursement of employees providing services to both organisations 	Signed Under review	Ongoing Ongoing
Other tertiary training institutions	<ul style="list-style-type: none"> Collaboration on the training matters Cooperation in recruitment of staff to the ADHB 	Ongoing	Ongoing
Auckland City Council	<ul style="list-style-type: none"> Memorandum of Understanding for information sharing and co-operation on joint projects 	Under discussion	Ongoing
Metrowater, United Water, Ecowater, Northshore City Council, Rodney district Council and Manukau Water	<ul style="list-style-type: none"> Regional Drinking Water Incident Co-operation Plan 	Signed	Ongoing
The Domestic Violence Centre and Age Concern NZ Police and CYFS	<ul style="list-style-type: none"> Establishment of a Multi-Agency Centre [MAC] to provide an intersectoral approach to management of child and young persons abuse. MAC is planned to open in November October 2002. This involves the relocation of some services from Children's Services and other Police and CYFS offices in Auckland. The MAC's Whakaruruhau will work collaboratively with its partners to implement the Family Violence Guidelines within Children's Services over the next 2 years. 	Approved by all parties in April 2002	Ongoing
CYFS	<ul style="list-style-type: none"> Memorandum of Understanding providing 1 FTE CYFS social worker to work within Children's Services 	Approved 2000	Ongoing
The Domestic Violence Centre	<ul style="list-style-type: none"> Contract for 2 FTE Domestic Violence Advocates to work from ADHB facilities (1 at NWH and 1 on the Grafton 	Contract signed effective 1/7/02	Ongoing

Organisation	Agreement purpose	Status	Term
	site) to provide education to staff and support for patients		
Research for commercial organisations (see also involvement with private service provision above)	<ul style="list-style-type: none"> The ADHB has approximately 90 different research commitments to commercial organisations on a paid basis. This supports the development of better treatment options and quality measures This activity is undertaken in collaboration with various medical research trusts 	Ongoing	Ongoing
ACC	<ul style="list-style-type: none"> Treatment provided to ACC patients 	Ongoing	Ongoing
Auckland Hospital Preschool Society Incorporated	<ul style="list-style-type: none"> Occupation licence and Services Supply Agreement for Early Childhood Education and Care Services for the licensor's staff sited on ADHB Grafton. campus 	Service in place since 1986, formal documents under discussion	10 years with one right of renewal of 5 years
Green Lane And National Women's Hospital Crèche Incorporated (see also involvement with private service provision above)	<ul style="list-style-type: none"> Occupation licences for Early Childhood Education Centre and Children's Out Of School and Holiday Programme and Services Supply Agreement for Early Childhood Education and Care Services all being for the Licensor's Staff sited on ADHB Green Lane campus 	Early Childhood Service in place since 1985 and Out of School Service in place since 1994; formal documents under discussion	10 years with one right of renewal of 5 years.
Starship Foundation and A+ Charitable Trust (see also involvement with private service provision above)	<ul style="list-style-type: none"> Collaborative process to assist the procurement of equipment and certain services to the hospitals ADHB provides rent free premises to these organisations 	Ongoing	Ongoing

4.1.8 Arrangements for Quality Management

The ADHB has established new risk and quality structures and related processes to support clinical governance. The transition to a DHB created a new set of responsibilities for the Board and senior management in the areas of quality and risk management particularly in the areas of risk assurance, quality monitoring and clinical effectiveness in relation to purchasing decisions. The existing structures did not meet the needs of a DHB.

Clinical Governance requires a framework through which ADHB is accountable for continuously improving the quality of the services and safeguarding high standards of care. The Board requires assurance that structures and systems to support quality improvement are in place and are effective.

The structure also needs to support the DHB'S ability to meet Ministry of Health requirements in regard to meeting health goals, regulatory requirements and quality improvement activities.

The following changes are being made:

- A revised risk management framework is being implemented which meets the requirements of AS/NZS 4360:1999 and HB 228:2001 Guidelines for managing risk in healthcare
- The Internal Auditor for the Audit Committee of the Board will carry out an annual audit of risk and quality processes
- The CEO is providing risk schedules and reports on quality and safety activities to the Board monthly
- The Clinical Quality Council and the Medical Advisory Committee are replaced by a new Clinical Board for the provider arm of the organisation with effect from 1 July 2002
- The development of a Clinical Effectiveness Unit is proposed dependent on available funding

A wider commentary on this area has already been covered in section 4.1.6 above

Population Funding Effectiveness

The ADHB is working to ensure that population based funding and service-planning decisions are appropriately informed and are clinically effective in regard to recognising needs, prioritisation and purchasing of health services. The processes by which this will be achieved include.

- Developing clinical strategies to improve delivery systems for the population
- Establishing criteria, policy and procedures for needs analysis and priority setting. This includes participating in initiatives at a national level
- Assisting the primary, secondary and tertiary sectors to become better integrated and better co-ordinated
- Monitoring, analysis and audit of provider service quality
- Supporting the development of clinical standards based on best practice, clinical governance, management of complaints and incident systems, peer review, clinical indicators and credentialing
- Liaising with professional bodies including educational institutions and the Ministry of Health on clinical and related areas (e.g. clinical training, workforce planning)

These functions will be actively managed through normal management and Board processes and collaboration with other DHBs and professional bodies.

Clinical Board

The Clinical Board provides the focus of clinical leadership and governance including governance of clinical quality and safety. Initially this is in respect of the ADHB provider arm only. It provides clinical advice to the Chief Operating

Officer (COO), Chief Executive Officer (CEO), and through the CEO to the ADHB Board. It is chaired by the Chief Medical Officer and has a membership of 18 comprising the COO and 17 clinical appointments. The CEO and Manager Quality and Safety attend but are not members of the Board.

The Clinical Board has the power to co-opt other persons up to a 20 person Clinical Board in total and will regularly review its composition and recommend changes to the Chief Executive Officer. In carrying out its duties the Clinical Board:

- Advises on clinical matters
- Provides clinical leadership.
- Provides governance and oversight of clinical quality and safety
- Makes recommendations on operational or resource allocation changes
- Promotes quality and safety and best use of resources.
- Gives advice on ADHB policy and strategy e.g. equity of access planning
- Promotes best practice and provide the necessary clinical discipline
- Receives direct input from clinician or consumer committees
- Gives advice on matters not resolved in normal management process

The Clinical Board operates on the basis of consensus decision-making. However, when this is not possible, a majority view prevails. A conflict resolution process is being developed. The Board proceedings are published to the organisation with appropriate recognition of privacy and commercial sensitivity.

Review Committee

The Review Committee, which audits complaints and is an important component of quality and risk management for the organisation will report through the Chief Operating Officer to the Quality Committee of the Board. The function of the Review Committee may be expanded in time to include complaints to the funder arm of the organisation.

4.1.9 Information Management

The ADHB has adopted a shared service approach to the internal provision of business management and information services. This is discussed in detail below. The ADHB maintain the necessary data systems to manage and report information on the indicators and performance data required by the MOH. An IS strategy plan has been prepared addressing provision of the systems required for the ADHB to succeed with its building and change programmes.

4.1.10 Support Services

The ADHB maintains a wide range of support services to assist the funding and provider activities of the organisation. These services are grouped in two ways, those held within the "shared services" structure and others that remain with a separate operational function.

Shared services include those services that are required to support the business activities of the organisation. Shared services provide appropriate, cost effective business services that assist the organisation in meeting its strategic targets. The progressive move to a shared services model is designed to offer a low cost service with a high degree of specialisation. The programme of work to develop the shared services model within the ADHB will continue throughout the 2002-03 year. The ADHB operates with the following shared services:

Internal Audit, Treasury, Legal, Facilities Management

These functions have been moving down the shared service path over the last three years. Over the next 12 months these functions will perform the same service with an increased customer focus and greater consistency in how these four services interact.

Materials Management

Materials management has been transforming into a share services function over the last 18 months. The procurement and purchasing activities have been centralised and information systems have been improved with the upgrade of the Oracle ERP financial systems. The focus of the next 12 months will be inventory management and developing a closer interrelationship to the financial systems. When the original plan for ERP was submitted to the Board it was planned to implement the Oracle Human Resource Information System. This would then enable delegated authorities to be used in that system to provide greater control around ADHB wide purchasing activities. This investment is outside the current capital plan for 2002-03 and will be addressed as a future priority.

Information Services (IS)

The IS function has had service level agreements in place with its key customers for two years and has more recently reorganised with the centralisation of IS coordinators from the hospital services. Clinical support is the only service remaining to be integrated and that process will be completed by 30 June 2002. The focus on IS for 2002-03 is the delivery of the IS Strategic Plan to ensure information systems required prior to the ASB Building opening in October 2003 are achieved including appropriate help desk support and call centre management.

Payroll

The payroll function has been operating as a shared services model for some time across ADHB. Their focus is on improved customer service aligned to the new customer service model and the review of payroll software as part of the investment in future HR information systems. Preliminary work has been undertaken to assess payroll software as part of this process and the programme will continue over the 2002-03 financial year.

Finance

Over the last 18 months the finance function has been streamlined with the implementation of an ERP finance model as part of the move to the shared services model. The accounts payable function has been centralised. The

lines of accountability for finance managers have largely been realigned to the General Manager of finance services. It is planned to have the total alignment of those accountability lines in place by the second quarter of the 2002-03 financial year.

Human Resources

A review of the HR function from a customer perspective was undertaken earlier this year and the outcomes from this review form the basis for the development of a strategic plan for human resources across ADHB. The short-term focus in the ADHB function is to ensure the HR function is stable through this period of change.

As previously noted not all support services are included within the shared service management structure. These other services include:

Business Development and Information

The Information Management Unit manages patient and activity data collation and reporting and the Business Development Unit is responsible for contracting and revenue planning processes

Quality and Safety

The Quality and Safety Unit previously referred to under the discussion of quality above is responsible for the management of clinical and non clinical risk factors and the management of the following programmes:

- Management of quality initiatives and processes
- Analysis of quality data
- Infection control
- Civil defence management
- Complaints management

Clinical support services (CSS)

CSS services are largely demand takers in that the services exist to meet the needs of internal customers. External customers are essential to some services to reduce fixed costs by utilisation of spare capacity and hence reduce the cost to ADHB customers.

Service Level Agreements (SLA's) are in place with all HBOs within ADHB. There are six clinical Services within Clinical Support Service, plus sponsorship of the PACS (Picture Archiving and Communication System) Project.

Clinical Genetics

The Northern Regional Genetics Service is provided on an outpatient basis. There is some ward consultation especially for neonates and for cancer families. Services are as follows:

- Consultation (Clinical diagnosis, risk assessment and testing)
- Counselling (including pedigree analysis, risk assessment and testing)

Both of these encompass diagnostic testing by high technology methods e.g. DNA tests, cytogenetics. These are high technology and expensive procedures, which are continuously improving and extending the scope of the service.

Imaging Services

The main purpose of ADHB imaging service is to provide a comprehensive diagnostic/interventional radiology service and photographic imaging and media service, which meets the needs of its internal customers. The diagnostic/interventional radiology service includes angiography, computed tomography, fluoroscopy, general radiology, mammography, nuclear medicine, ultrasound and magnetic resonance imaging. In addition to the internal demand, the service provides an imaging service for outpatient and community patients, for which A+ is directly funded by MOH.

The Photography, Design and Graphics Service includes clinical photography; ophthalmic photography; non clinical photography (e.g., supporting presentations at conferences, etc); darkroom/processing and printing facilities; graphic design and illustration; video and audio tape production; video library and equipment loan; web site design and projectionist services.

LabPlus

The principal purpose of the laboratory service is to provide a wide range of both scheduled and non-scheduled diagnostic tests for ADHB and external users. Many of these tests are not available elsewhere and consequently the laboratory is regarded as a referral centre by a number of other DHBs and the private sector. As a result approximately 16% of the Laboratory revenues are from external sources. LabPlus also holds a contract with the Department for Courts for the provision of mortuary services and with the MOH for community non-schedule tests. Consideration is also being given as to whether a community laboratory contract should be awarded to LabPlus enabling the ADHB provider arm to offer a wider service.

The principal activities of the laboratory service include the following: immunology and virology, histopathology, cytogenetics, biochemistry, haematology, microbiology, molecular medicine and mortuary service. Together these laboratories offer a range of over 900 tests, a medical interpretation and advice service and electronic result reporting.

Clinical Engineering

Clinical Engineering provides clinical equipment management services over the whole equipment life cycle. The major services are as follows:

- Specifications and tender evaluations
- Acceptance testing of new equipment
- Breakdown maintenance
- Preventive maintenance
- Quality assurance and performance testing
- Electrical safety testing
- Hazard alerts

- Equipment manufacture or modification.

Nutrition Services

The Nutrition Service provides the following services:

- Patient meal services
- Patient nutrition support
- Patient nasogastric feeds and infant formulas
- Patient clinical dietetic consults - inpatients and outpatients
- Staff cafeteria meal services
- Visitor / outpatient meal services (Green Lane site only)
- Staff function catering
- University teaching and post graduate supervision
- New Zealand Therapeutic Database of Brand Name Foods.
- Modified Food Database

Pharmacy

The Pharmacy exists to meet the pharmaceutical requirements of clinical staff and patients supported with professional advice and information. The principal activities of the Pharmacy include:

- The purchase and supply of medicines
- Inpatient and clinical trial dispensing
- Clinical pharmacy service (advice and information)
- Medicines Information service
- Formulary and Drug Utilisation Reviews
- Cytotoxic, sterile and extemporaneous product dispensing

PACS

This is a Picture Archiving and Communication System (PACS). This system is currently being implemented and will acquire images directly from radiology equipment. The images will be stored on large disks (short term) and tapes (long term). The images will be available at computer workstations for reporting and review throughout the organisation. A radiology information system is also a core part of the overall system architecture. The PACS project is due to be completed in October 2002.

4.1.11 Consultation Process

Consultation contributes to the development of good public policy. It assists the ADHB to:

- Implement Treaty of Waitangi obligations
- Gain the full picture, understand and identify different communities' needs and priorities.
- Provide opportunities for communities (geographical, professional and communities with common interests) to participate in the development of policy and strategic directions and to test new ideas.

- Enhance decision-making by receiving information, opinions and ideas – as well as feedback from communities to help identify and avoid pitfalls.

At the same time, consultation assists in building positive relationships with consumers, providers and the wider community, encouraging co-operation, understanding, respect and support. It encourages stakeholders to feel a sense of ownership towards their public health system and ultimately, it works towards producing better health outcomes.

Community engagement services are committed to ensuring that Treaty of Waitangi and legislative obligations to consult are met, that local communities are informed about health and disability issues, and that community needs and preferences are reflected in funding decisions.

Protocols are in place to ensure full participation of Maori and Pacific communities in planning activities. These protocols vary depending on the nature of the consultation. Guidelines for engaging with Maori and Pacific communities have also been developed.

The specific objectives required are:

Give effect to Treaty of Waitangi consultation obligations:

- Establish formal protocols for Tangata Whenua participation in decision making
- Establish mechanisms to ensure good participation of all Maori in core ADHB activities
- Monitor the performance of ADHB regarding Maori health gain and ability to meet the health needs of Maori

Ensure communities participate in engagement and consultation:

- Establish protocols to secure full participation of Pacific communities in planning activities
- Ensure that disabled people participate fully in community engagement
- Ensure that the hard to reach communities are prioritised for inclusion

Ensure community engagement impacts on ADHB funding decisions:

- Creating sound systems to establish and report on identified population needs
- Ensure community needs are an integral component of funding decisions. This information also needs to be available to NDSA and Ministry of Health
- Set in place mechanisms (special interest groups, intersectoral groups, cross disciplinary work and associations) that will progress community needs and resolve problems
- Assist funding teams to develop or reorient existing service contracts to better meet local needs
- Monitor the responsiveness of services to the identified need

Ensure communities are well informed about services:

- Put effective channels of communication in place between ADHB and all stakeholders
- Enhance understanding of the health and disability issues that face the ADHB
- Foster informed debate
- Engage with communities who have the highest health needs
- Manage community expectations

Build positive community perceptions on the activities of the ADHB:

- Respond to community requests and involvement in ways that are culturally appropriate, open, honest, responsive and competent
- Communicate how ADHB has achieved gains in health status and improvements in service delivery
- Ensure all engagement activities, at all levels in the DHB, are aligned and complementary

Ensure the community engagement activities meet legal requirements:

- Use engagement practices that reflect the legal, policy and best practice requirements

The ADHB has specialist managers that are responsible for managing consultation processes. This includes the obligations that exist with respect to the ADHB's planning processes including the District Strategic Plan and the District Annual Plan documents.

4.1.12 Relationship with Maori

The ADHB recognises the special relationship of Maori as tangata whenua with the Crown, and is committed to its obligations to Maori. This includes a commitment to addressing the high health needs of Maori as a population. The ADHB ensures key Maori stakeholders are involved in Maori health gain strategies on behalf of their Maori communities. The ADHB is committed to:

- Community engagement and consultation in respect of the differing cultural expectations for health and disability services to be provided to Maori
- Identification and implementation of appropriate funding and service delivery for Maori patients and their whanau

4.1.13 Maori Health

The ADHB will maintain and enhance its relationship with Tihi Ora MAPO and other key Maori stakeholders to improve Maori health gain across the wider Auckland region. This includes the establishment and maintenance of relationships with key Maori stakeholders and the wider Maori communities in the ADHB. Consulting with them around health needs assessment and the strategic and annual plans will assist in identifying Maori health priorities for services. The ADHB is committed to:

- Grow relationships that support the principles of partnership, participation and protection embodied in the Treaty of Waitangi
- Whanau ora through effective implementation of primary health care, public health, integration and co-ordination and intersectoral strategies including population health, planning and funding
- Develop Maori health providers within the ADHB region
- Enhancement of ADHB health and disability support services responsiveness to Maori
- Improve Maori health status by undertaking quality reviews
- Maori health workforce development

Objectives will be supported and achieved through the implementation of primary health care, public health, integration and intersectoral strategies.

4.1.14 National and regional services

The ADHB provides a wide range of regional and national service as part of its role as a referral centre. The extent of this work is outlined under each of the sections for the provider arm services in section 4.3.

4.1.15 Relationships

Co-ordination and Joint Activities

There is close collaboration within the northern region and with other DHBs on areas of joint interest. This is important to avoid unnecessary duplication and make best use of skills and recognises the significant mobility of the population in accessing services across district boundaries. There is a high interdependence of district and regional services as well as a wide range of shared interests in national projects. The DHBs are establishing a joint collaboration agreement so that in working together they will:

- Use funder resources as efficiently as possible
- Ensure appropriate Maori and Pacific Island input to those decisions
- Maintain service coverage across the region
- Confirm lead DHB business rules and protocols
- Establish effective regional governance to serve common interests

Joint planning and decision-making is managed in the northern region using various forums for regional planning, co-ordination and decision making. There is a CEOs / Chairs Forum which meets monthly that is responsible for:

- Providing the link with DHBNZ
- Resolving regional issues

In addition there is a CEO's Funder Forum which also meets monthly and has oversight and decision-making regarding the regional collaborative work programme. MOH staff attend this meeting as observers.

The Regional Funding Forum (RFF) is made up of the four DHB Funding General Managers, the MAPO and the GM Pacific Health delegates. This monthly forum is responsible for:

- Providing overall direction to the regional funder work programme
- Reporting progress to the CEOs forum
- Gaining approval from CEOs as required
- Removing any local DHB impediments to project progress
- Prioritising projects
- Identifying appropriate local expertise for each project
- Linking the regional work programme with the local DHB work programme
- Linking the regional work programme with the national DHB work programme
- Resource use.

The DHBs are reviewing a range of potential activities to address high priority issues. These include:

Issue	Likely action
Population Based Funding	Ensure equity and use of accurate data
Site Adjuster for Cost of Capital, Interest and Depreciation	Develop a basis for future adjustment to recommend to the MOH
Inter-district Flows	Establish a working group to develop an agreed process in support of national initiatives
Regional provider configuration	Establish as regional governance process
ACC	Develop better information processes to ensure appropriate claiming
Community Pharmaceutical Growth	Joint risk containment strategies
Community Laboratory Growth	Joint risk containment strategies
Non resident bad debt	Develop information to brief Government
National role of Auckland DHBs	Develop a better understanding of pricing issues
Impact of private medicine	Understand impact of referrals and develop new systems and processes to contain risk
Shared Services	Investigate and commit to making efficiency savings
Implementation of PHO strategy	Analyse and manage impact

Regular liaison meetings are held with a wide variety of disability service providers and other agencies. ADHB also takes a key role in the Strengthening Families programme in Auckland central, which has maintained a focus on disability issues.

The ADHB has a close working relationship with the tertiary teaching institutions with respect to ADHB's teaching and research functions.

Northern District Support Agency (NDSA)

The role of the NDSA is to provide support to the northern region DHBs (Auckland, Counties Manukau, Northland and Waitemata) in their role as health and disability service funders, in functional areas specifically delegated to the NDSA. The agency is a limited liability company jointly owned by

Auckland, Counties Manukau and Waitemata DHBs. Northland DHB utilises the services as a customer.

A Board of Directors manages governance of the company with two representatives from each shareholding DHB. DHB requirements of the NDSA are prescribed within Shareholder and Service Level Agreements with performance managed against agreed terms.

The Board approves an annual plan and the NDSA is required to prepare and submit an annual Statement of Intent.

The distribution of funding functions between regional and local levels is summarised in the table below.

NDSA on behalf of individual DHBs	Each DHB individually
Personal Health: <ul style="list-style-type: none"> • Pharmacy • Oral health • Section 88 notices and GP administration • General Primary Healthcare support 	Personal Health: <ul style="list-style-type: none"> • Maori health • Pacific health • General practice • Integrated care • Well child services • Secondary/tertiary care • Laboratory services • Maternity (anticipated in 2002/03) • Pharmacy • Individual Service Providers
Mental health	
Disability support (when devolved)	
Public health (when devolved)	

Currently MOH funded Disability Support Services are components of an integrated continuum of care approach for older people's services. This Plan outlines how the ADHB will engage with Disability Issues localities and national teams to ensure that MOH funded support services are considered in any service plans/changes for older people. The Plan also confirms the ADHB is ready and willing to engage with the MOH to develop toolkits that will be used by DHBs to implement the criteria that shows that they are capable of meeting the objectives of the Health of Older People Strategy.

Ministry of Health (MOH)

The ADHB will maintain a close relationship with the MOH. Primary channels of communication for accountability and performance matters will be via the MOH's designated "account managers" within the DHB Funding and Performance Directorate. In addition to the more formal accountability and performance issues, the ADHB will be exchanging information and collaborating with the MOH over a wide range of policy and funding initiatives, at different levels within both organisations.

District Health Boards New Zealand (DHBNZ)

DHBNZ is the national organisation set up by the 21 DHBs to assist with representation, help co-ordinate joint DHB processes and activities, and

undertake work that can be done more effectively and efficiently on a national basis. The ADHB has close channels of communication with DHBNZ and will participate in and share responsibility for joint work.

The DHBNZ provides project management for a variety of projects. These fall into three main groups that affect most if not all of the DHBs. In some areas they provide sector wide input to MOH processes such as the national service framework and include:

- Workforce development
- Primary health
- National service framework

HealthPAC (HP)

HP is owned by the MOH and provides contract administration and certain audit functions to all DHBs. The ADHB will continue to have a close day-to-day operational relationship with HP. Relationships are underpinned by a national Service Level Agreement and protocols.

In addition to supplying a provider contract documentation system HP processes provider claims and payments and undertakes information management for primary and maternity services. HP also works closely with the ADHB to provide and refine financial management and forecasting information.

PHARMAC

PHARMAC manages the national pharmaceutical schedule that determines eligibility and criteria for pharmaceutical subsidies. The work, functions and strategic initiatives undertaken by PHARMAC need to be closely aligned with the activities of, and in some cases agreed with, the DHBs. It is expected that much of this work will be co-ordinated through DHBNZ processes. Direct relationships are also maintained between the DHB staff involved with the funding of pharmaceuticals and their counter-parts in PHARMAC for collaboration on local developments and exchange of information.

4.1.16 Sector Change Processes

The ADHB is actively engaged in supporting sector change processes at a local, regional and national level through implementation of the sector policy initiatives and its participation in regional and national projects. The DHBNZ acts as a focal point for much of the nationally based work. The ADHB Chief Executive Officer is also a member of nationally based committees involving the MOH such as the Clinical Services Review Group. A Greater Auckland Collaboration group has also been formed to develop and have oversight of key sector change processes in the Auckland region as discussed in section 4.1.15.

This level of involvement will be maintained as part of the ADHB's commitment to the sector and the continuing change it will undergo over the next two to three years. Further initiatives such as population based funding

will be introduced and further devolution of funding such as the DSS funding for older persons will be devolved by the MOH. These processes require a high degree of commitment from all DHBs for the processes to work effectively.

4.1.17 Intersectoral Collaboration

Intersectoral collaboration spans all areas of funding and service provision. Examples can be illustrated by the close working relationship with tertiary teaching institutions such as the Auckland University and public health initiatives to ensure that the ADHB district initiatives are aligned with those of other public bodies such as water supplies and other aspects of local government. In other areas collaboration focuses on such areas as the adequacy of housing.

A number of these intersectoral relationships are evidenced in formal agreements and these are set out in the section on Special Arrangements in 4.1.7 above. Areas that are not identified in this way but have equal importance are illustrated below in two examples.

The strengthening families initiative involving:

- Groups representing Maori
- Principles of Schools
- Police
- Children and Young Persons Service
- Immigration Services
- Work and Income New Zealand
- Refugee agencies

Children and Young People Local Mortality Review Committee involving:

- The national children and young persons mortality review committee
- Local city councils
- Transport authorities to ensure safety regulations are implemented
- Paediatricians
- Pathologists
- Police
- Community groups
- Groups representing Maori and Pacific Islanders
- Children and Young Persons Service
- Housing NZ.

4.1.18 Interface with ACC

The ADHB purchases various services related to accident claimants on behalf of the ACC. Details of the services purchased, and related access and information requirements, are included in the ADHB's agreement with the Crown. The ADHB will work co-operatively, and where appropriate consult,

with ACC to ensure these functions are carried out in accordance with these provisions.

4.1.19 Governance Practices

The New Zealand Public Health and Disability Act 2000 established District Health Boards and statutory advisory committees to ensure that the community has a voice in health and disability service planning and funding. The Boards have 11 members, seven of which are elected during the three-yearly local body elections. The Minister of Health appoints four additional members and the Board's Chair. Boards are required to have Maori representation and in general should reflect the diversity of people and interests within the Auckland DHB area.

The Board is responsible for funding health services and disability support services and for reducing health disparities by improving health outcomes for Maori. The Minister of Health approves these activities and approaches through the Strategic and Annual Plans, the Statement of Intent and Crown Funding Agreement.

The Board has three permanent advisory committees, each of which must provide for Maori representation.

Community and Public Health Advisory Committee

Membership of this committee comprises the whole Board and considers advice on health gains and how to manage the interface between primary and secondary care. The role of the committee is to:

- Consider the health status of the ADHB population
- Prioritise the use of health funding
- Ensure the overall health gain of the population is maximised and consistent with the New Zealand Health Strategy.

A process is in place to secure a replacement on the Board's Community & Public Health Advisory Committee position recently vacated by the resignation of its founding Pacific Board member.

Representation for Maori and Pacific health matter is further enhanced through the General Manager of Maori Health and General Manager of Pacific Health who report to the Board and CPHAC on monthly basis and are actively involved in ADHB policy development.

Disability Support Advisory Committee (DiSAC)

Membership of this committee comprises the whole Board and considers issues facing people with disabilities and the priorities for disability support funding. The committee meets quarterly. There is also a quarterly programme of regional DiSAC meetings to support good coordination within the region.

DiSAC is overseeing the implementation of the NZDS in funding services. This includes incorporating a 'disability culture' throughout the organisation to

be achieved by a variety of methods such as staff orientation and awareness training programmes.

The Building Programme is being evaluated to ensure compliance with accessibility needs of people with a disability. Consideration is being given to the involvement of people with a disability as service users in planning and evaluation of services.

Consultation processes and the involvement of the community are limited at this stage to those services currently provided by the provider arm. Intentions with respect to the future management of funding for disability support services have been outlined in the District Strategic Plan.

Hospital Advisory Committee

The role of this committee is to give advice arising from its monitoring of financial and operational performance of the hospitals (and related services) of the DHB and its assessment of strategic issues relating to the provision of hospital services by or through the ADHB

4.1.20 Arrangements for Board and Committees

Board and committee meetings are open to the public and are notified in the New Zealand Herald. Meeting details are listed on the website www.adhb.govt.nz or are available on request from the Board Administrator.

The ADHB maintains appropriate Maori representation on all its board committees. The ADHB does not have Pacific Board representation but is open to the concept and actively involves the Pacific Health team in decision making and development of ADHB policy for Board consideration.

There are defined roles, membership and functions for the Disability Support Advisory Committee (DiSAC) within the DHB and wider community. All Board processes are open to the influences of the wider consideration of “disability issues” rather than just disability support services. There are also processes in place to ensure input from people with knowledge and experience in the treatment of areas such as mental illness. This is managed through the development of specialist expertise in the funding and service planning team as well as the networks that the provider and funding team members have with the sector.

Information and meeting dates are advertised in a regular newsletter put out by Disabilities Directorate of the MOH and has a wide distribution.

4.2 Funding health services

4.2.1 Needs Analysis - results

The New Zealand Public Health and Disability Act (2000) sets out the requirement for DHBs to improve, promote and protect the health of people in their respective communities. Under the Act, DHBs are required to regularly assess and monitor health status and service need among the people whom they serve. This process is the initial step in the funding cycle and the ADHB completed its first population health needs assessment of the ADHB resident population in 2001.

A number of key health and service issues were identified by the population health needs assessment process and these issues were developed into a set of health gain and service priority areas that are included in the ADHB five-year District Strategic Plan. Issues arising from this assessment include:

- Cardiovascular disease and cancer are the leading causes of death
- Diabetes is predicted to increase markedly over the next 10 years, especially among Maori and Pacific peoples
- Maori and Pacific children that live within the district have poor oral health compared to others
- Disturbing increases in the incidence of disease among young children (tuberculosis, rheumatic fever, meningitis, cellulitis and gastro-enteritis) especially among Maori, Pacific peoples and people from refugee backgrounds
- About 20 percent of the population has a disability, and 3 percent have a severe disability
- Alcohol and illicit drug use is increasing with concerns about the use of these substances among young people, Maori and Pacific peoples
- Concern for the high youth suicide rates among males, particularly young Maori men
- Family violence (including domestic violence and child abuse) is recognised as a key social and health issue in society.

Given the number of health gain priority areas, ADHB has initially selected diabetes as a focus. About 90 to 95 percent of people with diabetes have type 2 diabetes and those with undiagnosed diabetes have a much higher risk of developing serious medical complications. The increase in diabetes has been linked to inactive lifestyles and obesity however prevention of type 2 diabetes has been effective using lifestyle changes with high risk people. Reducing diabetes will assist the ADHB in achieving health gain in the other health gain priority areas identified.

A comprehensive ADHB Maori Health Needs Assessment is being undertaken and is due for completion in October 2002.

4.2.2 Needs analysis - resources

The ADHB is progressively investigating, assessing, and monitoring the health status of its resident population for any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services. This process is aligned with the findings of the Health Needs Analysis above and includes the analysis the needs of Maori, Pacific and migrant people in the district. This work is also aligned with the Mental Health regional network and the plan developed to identify the work programme for that service area.

4.2.3 Additional funding responsibilities

The ADHB will gauge the ongoing needs of the local and regional Maori population, and identify and address current gaps in service delivery for Maori within available resources and without limiting the rights of other to access services. This process will be assisted by the initiatives outlined in Section 4.2.7.3.

The ADHB has an active Pacific Health team that is managing its funding responsibilities by identifying strategies to address health inequalities for Pacific peoples. Many of the initiatives related to Maori above also apply for Pacific health initiatives and additionally:

- A Pacific Health plan has been prepared including mechanisms for addressing inequalities
- Pacific Health team capabilities have been extended to include provider support roles

Further information on Pacific Health matters is covered in 4.2.7.4

The ADHB is developing the capacity for funding and establishing additional mental health services with Blueprint funding in accordance with national guidelines.

The ADHB is ensuring that it is able to manage its responsibilities for services for older people funding responsibilities in keeping with intended devolution path by engaging with stakeholders and through the Board's Disability Support Advisory Committee work processes. The process for devolution of this funding is discussed at length in section 4.2.7.7.

4.2.4 Prioritisation process

Prioritisation will focus on developing and implementing prioritisation processes that can be applied at clinician level rather than service level. This will be supported by nationally determined prioritisation decisions such as service reductions and changes in booking systems criteria.

A focus on technical efficiency will assist in minimising the resource required to obtain the desired health outcomes. Improvements will also be sought through reconfiguration, improved alignment and integration of services.

The following principles will guide the prioritisation process:

Treaty of Waitangi

- Rangatiratanga (self determination)
- Whanau Ora (family and community based models of care)
- Hauora (services to reflect Maori paradigms of health and well being)

Equity

- Benefit to Maori
- Benefit to Pacific people
- Benefit to other groups of low health or socio-economic status

Cost-Effectiveness

- Measures of burden of disease
- Degree to which the issue or problem is modifiable
- Cost in relation to some measure of benefit
- Local service effectiveness

Acceptability

- Relationship to New Zealand Health Strategy
- Acceptability to public
- Acceptability to clinicians

The ADHB prioritisation framework and wider processes have been documented and forwarded to the MOH in a draft report. The document is not replicated here and prioritisation is now subject to a national process led by the MOH that replaces the previous instruction to implement a process at district level. Specifics relating to the various population groupings such as Maori and Pacific peoples are not recounted in this plan although they have been fully considered as noted above.

4.2.5 Organisational structure

The structure of the ADHB is set out in section 4.2.5 and Board processes are summarised in section 4.1.19.

With respect to clinical governance matters the ADHB has established a Clinical Board with effect from 1 July 2002. The management structure has also been altered to provide for joint management of operating units between a General Manager, a Clinical Leader and a Nurse/Maternity Leader working as a triumvirate. This allows for dynamic management of the clinical aspects of operational management using the structure set out in section 4.1.1.

The Quality and Safety unit also supports the clinical governance process and work closely with the Funding and Service Planning Unit. The Quality and Safety Unit is responsible for administering quality, safety and risk management activities within the ADHB. These groups also work with the

Medical Advisory Council that represents clinicians' interests via membership of the senior management team.

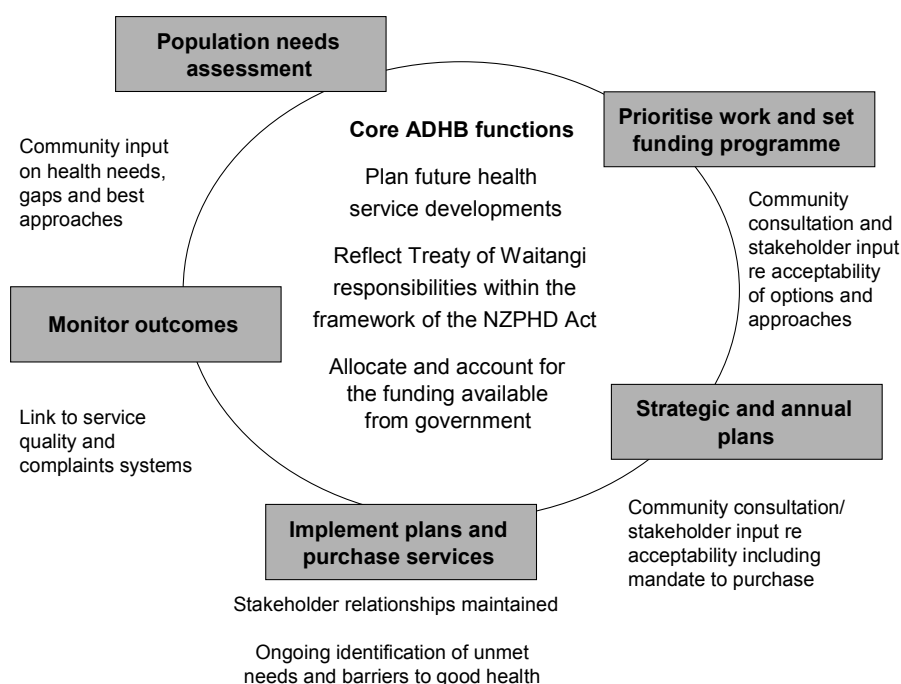
Underpinning these matters is the work of the Maori and Pacific Health units that monitor activities and support new initiatives to address health inequalities for these population groups and work to ensure culturally appropriate services are maintained.

The public also has the opportunity for input to the operational intentions of the ADHB with respect to clinical matters through the public consultation processes completed for the District Strategic Plan and the public Board and Committee meetings. Deputations may address the Board with prior approval.

The ADHB is also responsible for a number of multi-district service agreements. There are also multi-district service agreements allocated to other DHBs in the northern region that include providers or services in the ADHB district. Many of the multi-district service agreements have strategic importance to more than one DHB. These DHBs are involved in managing and negotiating these service agreements as part of the regional collaboration process. There are also significant financial risks attached to some of the multi-district service agreements that need to be jointly managed by the DHBs.

4.2.6 Service outcomes

The diagram below summarises the core funding activities of the ADHB funding function and the main work activities that inform appropriate decisions about funding and service planning. Community engagement and consultation is an integral component of our core business, which reflects the requirements in the New Zealand Health Strategy, the New Zealand Disability Strategy and New Zealand Public Health and Disability Act for a community voice in planning and funding.



The ADHB will sustain its Treaty of Waitangi obligations and work to ensure Maori in the ADHB area experience good health outcomes. There is a need to reduce inequalities in the health status of Pacific and new migrant¹ populations in the district. People on low incomes have poorer health status and this is associated with the inequalities in health for Maori, Pacific people and new migrants, particularly those people from refugee backgrounds.

In 2002-03 the ADHB will work towards ensuring that integration occurs across the sector [primary, secondary, tertiary] for efficiency of health service delivery to our population and, to maximise health outcomes and health gains. Integration processes that will be undertaken in 2002-03 include the following:

- Creating and providing impetus for primary and secondary interface/integration Initiatives such as acute care management, diabetes management
- Involvement in the establishment of PHOs
- Establishing and maintaining demand driven services to ensure that we mitigate the risks that such contracts present to the Auckland DHB
- Determining areas where funding will facilitate achievement of integration goals
- Capitation strategies that encourage integration between services
- Intersectoral cooperation to optimise funding available to the population.

A key role for the Funding and Service Planning Unit in 2002-03 is the monitoring and evaluation of service provision by contracted providers. This will be used to confirm that providers are complying with the requirements of contracts both in terms of the quality and quantity of services provided. This will be achieved by review of monitoring information and audit of providers with mitigation and resolution of issues where required.

4.2.7 Service coverage

Service coverage is the mechanism by which the Crown articulates the national minimum level of services that will be made available to communities. The ADHB is accountable for managing the service delivery aspects of service coverage including monitoring and resolution of delivery and compliance issues.

Service coverage for the 2002-03 financial year includes all those services funded under Personal and Family Health, and Mental Health. Public Health and Disability Support Service coverage continues to be managed by the MOH. The ADHB is committed to meeting the national service coverage requirements specified in the Operational Policy Framework and Service Coverage Specification and to ensuring that health services the ADHB funds

¹ New Migrants includes peoples from refugee backgrounds.

are accessible and responsive to the needs of disabled people and other higher needs groups.

Whilst the service coverage document provides guidance as to the range of services that a DHB is expected to fund it does not provide a cap on those services. As a consequence some areas that have traditionally not been funded could be regarded as a gap in service coverage. This logic also applies to changes in technology and practice and makes it difficult to judge the extent of any potential non-compliance.

The ADHB is limited in its capacity to apply funding to services or vary existing contractual arrangements. Prioritisation criteria are used to assist this process whilst acknowledging ring fence requirements for funding. At the present time the limitation on services funded and provided relates mainly to elective services where financially sustainable thresholds apply that result in certain services being potentially available but in practice are not funded or provided. Examples of these services include:

- Varicose veins treatment
- Sex change operations
- Some types of low risk hernias
- Plastic surgery for social purposes
- Second trimester abortions for social reasons
- MRI scans other than for pre-operative purposes
- Treatment of other low acuity conditions such as non malignant cysts and ingrowing toenails
- Services rationed on the basis of clinical need at the discretion of clinicians e.g. an 80 year old receiving cardiac surgery where the patient risk factors indicate it would not be appropriate

Additionally the ADHB has determined it will not fund or provide the following services:

- Second trimester abortions where they are not clinically indicated

There are also a small number of areas where service changes are planned. These are already known to the MOH and include:

- Exit of the Children's Needs Assessment/Service Co-ordination (NASC) service (\$270,000)
- Exit of part of the current Social Workers in Schools service in Otahuhu (\$175,000). This is funded by the Department of Child, Youth and Family.

4.2.7.1 Children and Young Peoples Health

The majority of service areas are routine in nature with the exception of the specialist medical and surgical services provided in Children's Services for those children whose condition is of such severity or complexity that it is beyond the capacity and technical support of the referring service.

Ongoing development of these services will be aligned with the National Child Health Strategy, the National Review of Paediatric Tertiary Services (also referred to as "Through the Eyes of the Child") and the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary "Learning from Bristol". This latter study provides a broad overview of the treatment of all children in hospitals and the community and provides an important source of information for funders.

The ADHB has funded the establishment and implementation of the Children and Young Person District Mortality Review that is now operational. A regional intersectoral working group [DHBs, Police, CYFS, Education] was established in 2001, to work through the preliminary setup requirements regarding data collection, governance, review composition, and cultural issues to ensure a regionally consistent approach.

Work commenced in January 2002 to develop a health status report for children and young people in the district. This work is being undertaken over a 6-9 month period and a final report should be available by the end of 2002.

The ADHB has been active member of Strengthening Families since July 2001, with team members on the Core Management Group, the Steering Group and on two sub-groups [refugees and new migrants, and youth].

A regular meeting of all Well Child providers was established in 2001 and work with this group will be consolidated during 2002-03 with the implementation of the new national Well Child Framework. The group is also actively involved in working with Children's Services in the winter campaign in the district for acute management of care in the community.

The Multi-Agency Centre [MAC] that will provide an intersectoral approach to the management of child and young persons abuse was approved by all parties in April 2002, and should be opened in October 2002. The MAC's Whakaruruhau will work collaboratively with its partners [the Domestic Violence Centre and Age Concern] to implement the Family Violence Guidelines within Children's Services over the next 2 years.

The ADHB work programme will be integrally linked to the outcomes of the Health Needs Assessment (HNA) and forms an important part of the work programmes for the primary care and hospital secondary and tertiary services.

4.2.7.2 Women's Health

Women's health services cover primary, secondary and tertiary services and relate to reproductive health, sexual health and well women's services in the community including family violence.

In April 2002 the Domestic Violence Centre (ADHB NGO provider funded) appointed a Partner Abuse Advocate to work along side Women's Services staff for the implementation of the Family Violence Guidelines. The Funding and Service Planning Unit will work with its partners (Whakaruruhau, Domestic Violence Centre and Age Concern) to implement the Family Guidelines for all ADHB Hospitals subject to available funding.

The National Cervical Screening Programme is now in Year 2 of implementation. The Funding and Service Planning Unit will continue to work with the various services involved (primary and secondary) with monitoring and evaluation of service delivery to National MOH guidelines requirements, and to ensure all reporting requirements are met in a timely manner.

The work programme for women's health services is linked to the outcomes of the HNA and forms an important part of the work programmes for the primary care and hospital secondary /tertiary services.

4.2.7.3 Maori health

The ADHB will work with Maori health providers, Maori communities and other key Maori stakeholders to understand the Crown obligations to Maori under the Treaty of Waitangi.

The ADHB will also work with Tihi Ora MAPO to identify clear direction for future primary health, public health, integration and co-ordination and intersectoral initiatives, secondary and tertiary service provision, identify future service development needs, management requirements, and develop agreed systems for monitoring and evaluating performance. This includes the development of a Maori PHO strategy in a way that builds upon previous primary health development and is consistent with the aims of the primary health care strategy. The development of a primary, secondary and tertiary integration strategy and introduce initiatives for disease state management and chronic illness will also form part of this collaboration.

The promotion of population health strategies in primary health and identification of opportunities to fund public health activity, together with refinement of the ADHB's Maori health needs analysis will inform service planning and funding decisions. Maori Health will have a key role in this work.

Pilot ADHB discharge planning models for Maori whanau, hapu and iwi with Maori health providers will be undertaken together with the evaluation of the model for expansion across the wider Auckland region.

The ADHB has developed Tikanga recommended best practice guidelines and will implement these across ADHB's mainstream services. It will also develop strategies to reduce Maori Did Not Attend (DNA) rates. Protocols will be adopted for future regional workstreams to maximise Maori health gain.

There is also a need to build the ADHB Maori health workforce capacity through recruitment and retention of Maori staff. The ADHB will also ensure the development of facilities within the ADHB Building Programme reflect the aims and aspirations of the Maori community.

Other initiatives have been put in place to focus on health improvement in the next three years and include:

- A Memorandum of Understanding (MOU) with Tihi Ora MAPO. The MOU protocols are fully operational with Maori representation on all Board committees, in service planning and provision (e.g. Manawanui) and the Building and Change Programme
- Maori health funding capabilities have been improved through the appointment of specialist funding staff and preparation of a Maori health plan
- The District Strategic Plan has been completed with a high level of commitment and involvement with the Maori community. This establishes the framework for the next five years
- The health needs assessment has identified priority areas
- In recognising the need for early detection and prevention strategies the ADHB has established a project to target high needs groups in Glen Innes. This project provides a platform for reducing acute hospital admissions
- Collaboration with Tihi Ora MAPO has enabled completion of the Maori Provider Development Scheme. This project has resulted in securing contracted providers. Funding under these contracts will be used to enhance information systems and extend primary care facilities and service delivery
- Child health discharge planning processes are being implemented for discharge of Maori patients to the care of Maori community health providers
- Tikanga best practice guidelines completed and approved for appropriate clinical management of Maori patients in all care settings
- Maori workforce development strategy prepared and approved. This targets Maori medical and nursing graduates
- Close working relationship with Tihi Ora MAPO and other Maori community groups has ensured the design of culturally appropriate facilities in the new buildings
- Tuhonohono and Bi-cultural management training will continue to be delivered
- Key work streams in relation to Maori Health that will be implemented as part of the Change Programme. These include:
 - ✓ The re-organisation and collection of Maori ethnicity data
 - ✓ Reducing Maori did not attend rates
 - ✓ Maori clinical indicators

4.2.7.4 Pacific health

The Health Needs Assessment completed in 2001 showed that for Pacific peoples a large proportion of hospitalisations could have been avoided through effective primary health care prevention and management. However, there are significant barriers to accessing these types of services. This review noted that Pacific people are heavily over represented in mortality and morbidity statistics and die early compared to other ethnic groups.

Of the 970 health service providers funded by the ADHB, the ADHB's Pacific Health Team are responsible for managing approximately \$2.1m by value of health and disability support contracts. Contracted services are with organisations which are Pacific governed and aspire to the "for Pacific by Pacific" philosophy. Funding of such services sits largely within the Personal Health ring fence where the core services delivered are:

- Pregnancy Support
- First Year of Life Support
- Well Child
- School Based Nursing
- Asthma DSM for Pacific Island Child and Youth
- General Practice
- School Based Nursing
- Mobile Nursing (including Youth at Risk)
- Dental Education (under 5 years)
- Free GP Annual Diabetic Review

There is also a significant Public Health component that is still managed by the MOH. These service components are:

- Immunisation Awareness
- Breast Cancer Screening
- Child Health Promotion
- Hepatitis B

Additional service provision within the DHB in the hospital based areas of:

- Mental Health (Pacific Island Mental Health Services)
- Children's Services (Pacific Island Family Support Service)
- Public Health (Pacific Health Fono).

The Pacific Health Team are actively working to assess the relevant service coverage, mix for the Pacific population.

Additional one off funding of \$786,000.00 (GST Excl.) had been received from the MOH over the 2001-02 year for Pacific Provider Development. Part of this funding has been carried over to 2002-03 due largely to timing issues experienced by the MOH. Funding from this one off allocation is being used to:

- Establish a Parish Nurses initiative
- Develop a Pacific PHO
- Develop a Pacific Cultural Competency Policy for the ADHB
- Site specific provider initiatives that focus on:
 - ✓ Provider Assistance;
 - ✓ Service Development;
 - ✓ Best Practice Development;
 - ✓ Workforce Development.

The ADHB is working with Counties Manukau DHB and Waitemata DHB to develop strategies to manage this funding that is estimated at \$5 million per annum. A regional Pacific Planning Forum has been formed to address the needs of Pacific people across the three DHB areas. Key areas of focus for this group are:

- Develop a strategy including contracting to manage inter district flows within the PHO environment
- Implement the collective purchasing agreements with Pacific providers for the regional allocation of Pacific Provider Development
- Assist change within the health sector on Pacific and mainstream policy initiatives

Counties Manukau DHB is currently the lead DHB on any regional contracts affecting the area and support is provided by both ADHB and Waitemata.

The focus for 2002-03 year is on the following areas:

- Workforce Development
- Pacific PHO Development
- Parish Nursing Service
- Pacific Health Schedule
- Whare Oranga - Pasefika development
- Pacific Provider Development

The work plan will begin the process of developing the tools to progressively:

- Reduce health disparities between Pacific peoples and non Pacific peoples
- Improve access to preventative and primary care services
- Develop relationships with Pacific communities, church groups, non-government organisations, Pacific providers and intersectoral agencies which will maximise resources for maximum health gain
- Invest in evidence based approaches that demonstrate improved outcomes for Pacific populations
- Ensure that services accessed by Pacific people meet quality standards including cultural competency

These initiatives are consistent with the Pacific Health Action Plan

4.2.7.5 Primary care – General practice, pharmacy and laboratories

Overview

Primary care is the first point of contact people have with the health system. This includes a range of services that aim to be accessible to all people, have the involvement of communities and are provided as close as possible to where people live.

The range of services includes activities that improve health and prevent problems, such as health education and counselling, disease prevention and screening. It comprises generalist services such as general practice, accident and medical centres, community nursing services (paediatric and medical and surgical services), community health services and pharmacies. There are also Services with a special focus such as primary maternity, family planning, reproductive and sexual health, dentistry and family violence centres. Other primary therapies include physiotherapy, occupational therapy, chiropractors, osteopathy, traditional and alternative healing. Some primary care services are publicly funded or part funded through the ADHB while others are fully paid for by the user.

Primary Care Organisations

The national Primary Health Care Strategy promotes a new direction for primary health care across the country. This involves the establishment of PHOs that improve the health of their enrolled populations through more collaboration between various service providers, co-ordination and community participation. The ADHB is continuing the development of primary care provider networks that build relationships within the sector, form partnerships with the ADHB and ensure that primary health care groups are involved in service planning. This includes the production of a paper on the development of PHOs and a plan for managing relationships and contracts with providers and populations who do not join PHOs.

A PHO contract is being developed and piloted in identified high need areas, including the use of age/sex registers in primary care organisations and population enrolment. There is also ongoing work with primary care organisations on the move to capitation including the strengthening of incentives to develop the appropriate mix and use of skills and technologies (including pharmaceuticals and diagnostic services).

Referred Services

The control of referred services expenditure such as pharmaceuticals and laboratories is causing concern. Escalating costs are putting the primary care budget under severe pressure and the national strategy has not addressed this issue. Whilst regional contracts increase risk for the ADHB there are also a large number of people from other DHBs who coming into the ADHB area during the day to work and use primary care services that are funded by the ADHB without Crown funding to support the cost. In the absence of a regional risk sharing pool the ADHB would prefer to see regional contracts broken into

their constituent parts and a recharging basis introduced for visitors to the ADHB area.

Developing capabilities and systems for monitoring and forecasting primary care expenditure, utilisation and outcomes is a key requirement allied with work with stakeholders to identify areas that will help manage the pressure from escalating acute demand. This includes the review of community pharmacy and laboratory expenditure to determine the drivers for the district and region.

Planning Initiatives

The ADHB participates in national policy development and planning through the DHBNZ, which acts as the forum for the nationwide primary care group. Regional strategies are also being developed for oral health and palliative care with input from key stakeholders.

These planning processes include engagement with Maori, Pacific and other ethnic communities and providers in the planning and funding of primary care services to ensure that barriers to accessing health services are reduced and are in alignment with national policies. The use of multidisciplinary family/whanau health teams will assist the link to cultural services. Specifications and indicators for cultural competence will be used in key service areas.

The use of demographic, epidemiological and service use data when combined with outcome information will assist in setting explicit local health goals and targets (aligned to the New Zealand Health Strategy) and in monitoring progress against the goals. Primary providers will be involved in the development of health promotion and prevention plans, in particular with plans to promote lifestyle changes associated with meeting priority Government objectives (e.g. reducing incidence of type 2 diabetes).

Other Initiatives

Strengthening specialist support for the management of medical, surgical, children, younger people and older persons in primary settings will be supported by good communication and relationships between community mental health services and primary health care services. The development of integrated systems and processes for management, clinical communication and clinical accountability will be necessary including requests for specialist assistance/referrals, consultation feedback, hospital discharges and follow-up.

The ADHB will implement a range of quality improvement strategies. An integrated plan for emergency and after-hours primary care services will also be developed.

4.2.7.6 Public Health Services

Cabinet decided in April 2001 that the MOH would retain overall responsibility for the funding and planning of public health services. The MOH will work with DHBs to identify an agreed range of public health services to transfer to DHB responsibility if this can be shown to improve health outcomes.

The current focus is on integrating decisions and planning around public health across the health sector. DHBs and the MOH Public Health Directorate have joint responsibilities to improve, promote and protect the health of people and communities in the geographical areas they serve. Over the last 12 months the ADHB has been working with other DHBs in the Northern region, the DHBNZ Public Health Group, and the Public Health Directorate to develop collaborative mechanisms to promote wider involvement of MOH, DHBs, providers, the wider sector and communities in public health planning and funding. This work has culminated in a joint MOH/DHBNZ agreement to share decision-making for public health planning and funding.

The ADHB is committed to ongoing participation in the collaborative mechanisms that have developed in the Northern Region over the last year. These mechanisms operate at the following four levels.

1. Relationships between the MOH/DHBs as planners and funders.

The ADHB will continue to participate in the Northern Region Public Health Steering Group which is the regional funding forum set up to share decision-making for public health planning and funding. It will also, via the Steering Group, participate in the equivalent national forum, the DHBNZ Public Health Group.

At an individual DHB level the ADHB will continue to liaise with its assigned Auckland Public Health Locality Team member on day-to-day district public health matters.

2. Wider sector involvement in public health planning and funding

The ADHB will continue to participate in the Northern Region Public Health Sector Reference Group that has been established in the Northern Region. The reference group provides for wider sector consultation on public health issues to better inform decision-making.

3. Specific joint projects and information sharing

The ADHB will continue to participate in the joint venture projects that are being developed under the auspices of the Steering Group. These currently include projects around delivering public health strategies through primary care, particularly those that relate to diabetes prevention.

4. Reorienting provider service plans and specifications

The ADHB will work with the Auckland PHD Locality Team and other Northern region DHBs to, where appropriate, progressively amend provider service plans and specifications to reflect a more collaborative way of working. By way of example this might include reorienting regional public health provider

plans to respond to ADHB priorities and involving the Locality Team in approving health promotion plans submitted by PHOs.

4.2.7.7 Disability Support Services

Disability Support Services (DSS) are currently funded by the Disability Issues Directorate (DID) of the MOH. The MOH's Northern Office retains the HFA's key partnering relationship with disabled people through its contract with Disabled Persons Assembly, Auckland.

Full devolution of DSS funding to DHBs appears unlikely. The ADHB has been advised the age care component will devolve to DHBs possibly by the start of the 2003-04 year.

To prepare for devolution the three Auckland DHBs have undertaken to review current service utilisation and, combined with population analysis and consumer consultation, establish a basis for determining disability service development priorities for the northern region for the 2003-04 financial year and beyond.

Common areas of interest have been agreed for information and analysis work to identify gaps in funding and services. The key elements of this work include:

- While each DHB is undertaking a population health needs assessment process for its district population, part of which relates to disability, disability itself is not a formal part of this process.
- As the Disability Support Services (DSS) funder the MOH requires a good understanding of the disability specific aspects of the district and regional populations.
- To best advise their Boards the DiSACs need to be provided with information and understand:
 - ✓ the size and profile of population, particularly in relation to disabled people and older persons
 - ✓ current and historical disability service utilisation and funding patterns
 - ✓ local and national policies that impact on funding and services
 - ✓ disability support services
 - ✓ key issues facing disabled and older people in current service approaches

The MOH is undertaking a transition project to prepare for the implementation of cabinet's decision to split DSS funding according to younger and older age groups. The New Zealand Disability Strategy will provide the over arching direction for funding and service development for disability services for people under 65. The Health for Older People strategy will provide this direction for funding and developing integrated care for older people.

Establishing baseline information of current service utilisation and population based demographics, combined with analysis of the gap between current practice and the directions depicted in the two overarching strategies, will

provide a basis for the determining service development priorities for the future. The participation of consumers, the disability community and wider disability sector in this process to validate the analysis and to determine priorities for development, is an essential requirement of the project.

The intention is to:

- Quantify utilisation of Services for possible service split by region
- Estimate Future Service Requirements
- Complete consumer and community consultation
- Research alternative funding methodologies
- Complete a gap analysis between current utilisation and strategy
- Develop recommendations

Some information on utilisation of services by disabled people and the disability community is held nationally in the DID. Generally this information is related to contracts with providers and payment to these providers. As data is retrieved, it will be entered into an Access database and analysed using Crystal reports by the Project Manager. Information held only by providers and others may also be used where this enhances the project outcomes.

The reliability of DID information will be validated by sampling some provider information. To avoid overlap and duplication with the DID national project regular review of the scope and processes will be undertaken by the Project Manager and the Steering Group.

4.2.7.8 Secondary and Tertiary Services

Overview

Secondary, tertiary and nationally provided tertiary services are those health services that are usually provided in a hospital setting. These services receive referrals from primary providers, through the emergency department or from other secondary/tertiary providers and provide greater complexity of care than could be provided in a primary setting. This is generally due to the increased level of specialisation, equipment or technology available in a secondary, tertiary or national tertiary service.

Secondary and tertiary services at the ADHB are provided to all eligible people in New Zealand. Many patients treated come from the Auckland DHB population, although a significant level of service is provided to the Waitemata and Counties Manukau populations as well as other populations of New Zealand. This is due, mainly to the level of sub-specialisation that Auckland DHB has achieved. In some cases we are the only district health board in the country who is able to provide health services at a complex level in particular specialties.

There has been a rapid development of new and often costly health technology that raise public expectations regarding health care capability and therefore increase demand for specialist care. This has occurred in a period when the year on year increases in acute demand has been significant, with a corresponding impact on the requirements for services.

During the last decade the Auckland region has experienced rapid growth. Population projections have used medium migration assumptions and have substantially underestimated population growth in the Auckland region. As previously noted the ADHB services are heavily used by people from other districts and more than 50 percent of Auckland hospital services are provided to people from outside the ADHB area. This has added to the demand for services as those populations have also grown. These factors put pressure on the pool of funding available to the ADHB and require the purchase, maintenance and replacement of capital equipment for which funding is heavily constrained.

Delivery of health care trends mean that there are changes required including more decentralised primary and secondary care (care provided close to people's neighbourhoods) and increased focus on ambulatory care and use of non-inpatient care sites. The increased potential for integration between disciplines will lead to health credentials being broadened, which in turn increases the number of multi-skilled providers. This needs to be supplemented by a greater emphasis on self-care and self-determination of care.

Changes in Funding

Population Based Funding (PBF) when implemented will impact on the secondary, tertiary and national tertiary services provided by ADHB. Individual DHBs will have the opportunity to buy these services from their service provider of choice and potentially the quantum of services available to be purchased will change. The impact will be fragmentation with some diseconomies of scale and increased clinical risk. Decisions such as how tertiary and nationally provided tertiary services will be treated and high cost treatments covered are yet to be made at national level.

Changes in purchasing by Accident Compensation Corporation (ACC) and other funders will impact on the configuration of services currently provided by Auckland DHB. Potentially this could lead to 'cherry picking' of services by private providers, fragmenting service provision and leaving less desirable services with Auckland DHB. It could also change the cost structures associated with provision of services by ADHB adversely.

Changes to services as a result of Regional Service Planning (RSP - formerly known as Sub Regional Equity of Access (SREA)) boundary changes will have a similar impact to the PBF funding change noted above. It will impact upon the mix of services to be provided in individual specialties. RSP for ADHB will mean that the efficiency of service provision will decrease as volumes are moved from the ADHB to other DHBs in the region. To help address this issue the Building and Change Programmes are working on the basis that secondary service volumes will be transferred from ADHB's hospitals to the other two DHBs in the region by the building completion date in 2003. The principles underpinning the process include:

- Maximising health gain for the population while providing an agreed level of access
- Providing primary and ambulatory services as close as practicable to the consumer
- Providing secondary services as close to the patient's residence as practicable provided that the service is high quality and cost effective
- Providing tertiary services in generally from one location to maximise efficiency and provide a critical mass of staff and expertise

The ADHB will work alongside the other two Auckland Regional DHBs to ensure that there are no timing gaps and that the bed numbers required will be provided. In addition we will work to ensure that support processes (community outreach, follow-ups and GP contacts, etc) are in place to support the reduced bed numbers.

The next area of focus will be the specialist services plan from July 2004 to 2021. Given the expected population growth during this period, planning will start to allow the region to align its capacity with requirements. The terms of reference for RSP should be expanded to incorporate tertiary and nationally provided tertiary services and thus the specialist services plan for the region. A model will be developed to predict the capacity needs for secondary and tertiary services in both the short term (from 2000 to 2004) to the longer term (2005 to 2021).

4.2.7.9Mental health Services

Mental health services cover primary, secondary and tertiary services and relate to children and young people's mental health services, maternal mental health, community and inpatient services and older people services.

The primary care role is critical to supporting the full range of mental health services but it is acknowledged that the majority of patients also require access to specialist services. Planning for the funding and provision of all these services is comprehensively covered in the regional mental health plan which has not been reproduced in full in this document.

The Ministry of Health's National Mental Health strategy directs that mental health funding is specifically targeted at the 3% of the population who have serious mental health disorders and prioritises the 0.6% of the population who also have high support needs.

The Mental Health Commission's Blueprint details the benchmark quantities of service required per 100,000 of any given population to meet the Government agreed 3 percent access target. In essence this allows DHBs to identify specific gaps in service delivery against national benchmarks and allows planning to be prioritised by being directed toward addressing these gaps.

New funding is prioritised and directed at specific regional and local priorities within the context of the national scene. This has meant that the main thrust of funding has been directed toward the continued development of community

based mental health services to address existing gaps. This strategy aims to address mental health problems earlier and provides effective support post discharge as a method of driving down acute demand.

Particular priority groups are:

- 1 Children and Young People
- 2 Maori
- 3 Pacific Peoples
- 4 People with an Ongoing Mental Health Disorder
- 5 Older People.

Global surveys conducted by the World Health Organisation show that mental and neurological disorders currently form 11 percent of the worldwide disease burden. By 2020, this burden is expected to rise to 14.6%. Five mental health disorders are among the diseases causing the highest disability ratings in the world:

- Unipolar depression
- Schizophrenia
- Alcohol use
- Bipolar affective disorder
- Obsessive compulsive disorders.

Successive governmental strategies have been based on a shift in philosophy away from an emphasis on institutional care to a focus on treatment and support for recovery in the community. This approach has been demonstrably successful in those parts of the world where it has been embraced and adequately resourced.

Specialist mental health services, which provide assessment, treatment and disability support for eligible people within the 3% of the population with the most severe problems and the highest needs, are provided by DHBs and Non Government Organisations (NGOs). To support these services further information, research, planning and service implementation is required in the areas of needs analysis, current service gaps and service quality in particular. This will allow a better determination of the best allocation of funding particularly where new funding is available.

This work also has a focus on sustaining equity in access to services to ensure that population groups are not disadvantaged and to sustain our Treaty of Waitangi obligations and work to ensure Maori in our district experience good health. There is also a need to reduce inequalities in the health status of Pacific and new migrant populations in the district.

The ADHB will develop recovery oriented services for adults (including older adults who do not have complicating physical conditions) with the highest needs, children, young people and their families and older adults. This will be achieved by identifying individuals in need of these services (including those involved with alcohol and drug services and the criminal justice system) and

working collaboratively with all stakeholders at both a regional and local level. This will assist in the development of relationships ways to integrate the range of services (within health and in other sectors) available to these identified individuals.

Ensuring access to adequate training for service staff and for consumers and families will also be a key workstream. This will assist in enhancing equity in access to services for all age groups and ensure access issues for priority groups are addressed first.

Developing a cohesive and affordable approach to monitoring services and continually improving service quality will inform the funding process and help ensure funding mechanisms are equitable. The ADHB will observe the ring fencing of mental health funding in managing its deficit problem.

The ADHB will focus on improving the range and effectiveness of community based treatment and support services to people with the highest needs on whom the bulk of mental health funding is currently spent. Over time this will:

- Improve outcomes
- Reduce use of support and/or inpatient services generating savings for treatment of others with severe mental disorders

By June 2003 good summary level information will exist about people in this group and about the services they use. The ADHB will also collaborate with the other Auckland DHBs in the following areas:

Serious mental health disorders

For people who have recently been diagnosed with a serious mental health disorder we will ensure equivalent levels of early intervention services to other parts of the Auckland region. Early intervention services work with recently diagnosed people and their families to achieve a shorter recovery time, maintain health and prevent the development of dependency on support services until such time as these people are able to maintain their health with relatively little healthcare provider input.

We will also identify people with serious mental health disorders who currently have the highest needs and will ensure each one is engaged with intensive, mobile service coordination and clinical services and can access other needed supports for community living. In line with the Ministry's Framework for Forensic Mental Health Services, these General Mental Health services will provide intensive support to forensic consumers in the community.

For people in crisis we will ensure equitable access to crisis respite wherever a person lives within the northern region

Maori

The ADHB will work with MAPO to ensure that by June 2004 Maori diagnosed with a serious mental health disorder will have the option of accessing Maori services. These services where possible will be provided as Kaupapa Maori

services and at levels of services that are equitable with other parts of the region. Work will also focus on improving collaboration between Maori and mainstream mental health services in northern region.

Pacific

For Pacific people service development will increase integration between services and will ensure services are delivered as close to the family as possible. The regional mental health funding team will work with Pacific planners and funders to ensure that by June 2004 Pacific people diagnosed with a serious mental health disorder will have the option of accessing services provided by Pacific people specifically for Pacific people. The levels of these services will be equitable with other parts of the region

Maternal Mental Health

The ADHB will collaborate with the other Auckland DHBs to move towards equity in access to maternal mental health services within the region. We will base "equity of access" on the number of births in each DHB.

Eating disorder services

The ADHB will ensure increased access to the regional community service in view of population growth.

Consumer networks

Although there have been developments in consumer networking over recent years in the northern region, some areas have lower levels of resourcing for consumer advisors or networking than others. The ADHB will provide resourcing for consumer networks in areas that have not previously received specified resourcing, Consumer networks and existing consumer advisors will provide input into planning and service improvement through local and regional stakeholder networks.

Family engagement

The ADHB will develop and resource pilot approaches to family engagement with the services, and peer support options for families where these have not previously been resourced, developing models that meet our unique population needs and in particular the needs of Maori and Pacific families.

Regional Forensic Services

Following on from their development of a framework for Forensic Mental Health Services, the MOH is providing tagged funding for additional Forensic inpatient beds and for Prison Liaison services. These services will be developed in line with MOH directions, and through a planning process involving Forensic Services, General Mental Health Services, funders and other stakeholders.

Monitoring

The ADHB will collaborate with the other Auckland DHBs to develop an agreed approach to evaluating and enhancing service quality that is consumer driven, family inclusive, outcome focused and highly responsive. This will be developed collectively with input from the regional network and the four

northern DHBs. Since DHBs do not have the capacity within current funding to adequately monitor services, this component of service enhancement will be funded out of Blueprint funding.

The ADHB is undertaking a wide range of activities to streamline its services as part of the Building and Change Programmes. This anticipates the impact of previously noted activities such as SREA and the need to address efficiency issues in order to fund the operational cost of the new buildings and contribute to management of the deficit. The impact of these changes is seen as positive and forms part of the consultation process being managed by the ADHB for the District Strategic Plan and this Plan.

It is possible that the management of the deficit will require wider reaching change than is currently represented in this document. The extent of this change has yet to be agreed in discussion with the MOH and the Minister.

4.2.8 Potential service disinvestment

The organisation does not intend to disinvest from services in 2002-03. Consideration has been given to the process that would be employed if disinvestment were considered at a future date. The process would use the principles for disinvestment presented to the MOH in the Prioritisation Framework Report submitted in May 2002. This has been discussed in section 4.2.4 and would result in disinvestment from non-clinical services before clinical services. With respect to ADHB non-clinical services it is noted that:

- Non-clinical services in the provider arm have been/are currently being restructured as part of the Change Programme
- Remaining non-clinical services in the Provider-arm support clinical services and as such are an essential part of the wider clinical service network and ADHB infrastructure
- Many of the remaining non-clinical services provided are externally funded (e.g. research)
- Many of the remaining non-clinical services are services that the ADHB is obliged/required to fund/provide as a health service organisation
- A detailed analysis of non-clinical services would be required in order to identify those suitable for disinvestment. It is anticipated that the savings to be realised from non-clinical service disinvestment are likely to be minimal given the extent of other work completed or already planned

As a consequence of this assessment the focus for disinvestment would be towards clinical services.

The prioritisation framework would be applied to disinvestment in services catering for non-life threatening conditions before considering services that cater for life-threatening conditions. In addition local health priorities would be used as a guide for prioritising and identifying services to be considered for disinvestment. This process would be managed in accordance with the

delegated authority structure within the ADHB to ensure that appropriate controls and approval processes are applied to all decision making.

The ADHB would take action on two fronts. Disinvesting from some loss-making regional and national services where there is evidence that ADHB supports the health needs of a large non-ADHB population. Simultaneously engaging in a longer-term process of service reconfiguration and disinvestment from local services where there is an expectation of marginal gains and minimal health impact:

The ADHB has a large number of regional and national loss-making services that are inadequately funded and are provided to large numbers of people who reside outside of the ADHB catchment area. It can be argued that the ADHB, as the lead DHB, is taking both the health and financial risk for these regional and national services.

The services would be prioritised taking account of considerations such as timing, service deficit size and minimising disinvestment impact. The assessment represents a pragmatic approach to a financial crisis.

Clinical input would be required before going forward with any proposed disinvestments. The ADHB would also need confirmation from the MOH as to whether funding released by these measures would be retained by the ADHB for deficit management.

The ADHB would engage with DHBs affected by proposed service disinvestments, the MOH, the Minister of Health and the wider community. It is likely that services identified for disinvestment would be contested by other DHBs and affected providers in the community. It is likely that service disinvestments would represent unacceptable choices for many of the stakeholders involved.

ADHB services identified for potential disinvestment and reconfiguration would be profiled with estimates of the costs of disinvestment and the potential savings to be realised together with any risks involved. As it is unlikely that the ADHB would obtain agreement to disinvest from all of the services that it might nominate the review would need to identify a range of options.

The steps that would be taken conform with the process communicated to the MOH in the ADHB Prioritisation Framework report of May 2002:

1. Confirm level of additional savings and disinvestment required
2. Notify MOH/Minister of intention to exit specific services
3. Commence consultation with affected DHBs and other stakeholders
4. Commence wider public consultation
5. Obtain sign-off for disinvestment from the Minister of Health
6. Develop service workout plans
7. Implement service workout plans (disinvest)

A summary of areas for potential disinvestment is not included in this plan, as the Board has not approved any reduction of services at this time. The dialogue above is included to indicate the process that would be undertaken if disinvestment was undertaken.

4.3 Providing services

4.3.1 Introduction

Overview

Maintaining core business for the Auckland DHB Hospitals, New Zealand's largest public hospital provider, means the continuation of:

- Almost two million patient contacts annually
- Local hospital and outpatient services for more than 350,000 people in Auckland
- Tertiary services for over 1.3 million people
- Provision of national tertiary services for New Zealand.

Change processes

The organisation is experiencing a period of extraordinary and extensive change. In particular, the Building Programme that is our response to continued population growth, changing health needs, cultural diversity, and an aging population. This \$447 million redevelopment will be completed in 2004.

At the heart of the construction will be the new Auckland City Hospital, combining the acute services of Medical, Surgical, Cardiac and Women's Services. This will be built next to the existing Hospital on the Grafton site and linked to the adjacent Children's Services facility. By bringing acute services together under one roof, patients will benefit from being able to access the skills of multidisciplinary teams of specialists and specialist equipment, and there will be more health gain from the funding available.

Although there is an ongoing need for acute services, advances in clinical techniques mean many conditions can now be more effectively treated at day-care or outpatient centres. Many patients will spend less time in hospital and benefit from faster recovery times. The Greenlane site will be converted into an advanced day-care surgical hospital and comprehensive medical centre focusing on outpatient service, rehabilitation and hospital in the home services.

There are also eight other major programmes currently in progress within the ADHB:

- Clinical effectiveness – to ensure enhanced clinical outcomes by co-ordination of all related clinical activities
- Service contracting – managing service contracting in the new Auckland DHB environment

- Supply chain – co-ordinating purchasing of utilities, information service equipment, supplies, and consumables
- Services design and integration – managing projects such as primary care, regional service provision in Auckland, clinical service integration, and national service delivery
- IS Strategic Plan – development of all information management activities
- Organisational development – development of a framework to guide and assist the movement of Auckland DHB Hospital staff towards our vision
- Treaty of Waitangi – to ensure the integration of Treaty of Waitangi obligations across all programmes
- Shared services – co-ordinating services that may be shared on a local, regional, or national basis for maximum efficiency.

Projects and initiatives that have already been initiated by ADHB to meet our patients' needs include:

- Streamlining of administrative processes relating to referrals and discharges
- Improving communications within the provider arm of the ADHB
- Inclusion of primary care providers in the joint planning of service delivery
- A joint ADHB and ProCare project targeted at elderly people living at home to reduce unplanned admissions and re-admissions
- A joint ADHB and ProCare project to reduce waiting times for mental health patients.
- Another key project is the implementation of the booking system, in accordance with the Ministry's expectations. This will create certainty for our patients in terms of their treatment and the active management of their condition during the intervening waiting time period.

These projects create challenges for ADHB. As an example current information systems do not support the booking system reporting requirements, timely specialist assessment or the development of alternative treatment paths with primary care support. The requirement for certainty with the booking system will mean that specialties need to be able to accommodate a significant increase in their elective inpatient and outpatient services. The funding for such an increase is severely constrained.

Supporting other DHBs

ADHB provides tertiary services for a population of about 1.3 million in the northern region. The ADHB also supports other tertiary hospitals, as the patient profile treated is wider than that seen in other areas. For example, the intensive care unit (Department of Critical Care Medicine) has received referrals for critically ill patients from every other hospital in the country. The Department of Critical Care Medicine also includes a phone consultation service, which allows better treatment of patients out of the region and appropriate transfers into the unit where necessary.

ADHB also has a number of tertiary services, e.g. neurosurgery, clinical genetics and paediatric oncology for patients in the northern and midland

regions. Paediatric oncology is based on a shared care and an outreach model, which allows the patients to reduce the need for travel and the consequent stress that that imposes.

There are also a number of national tertiary services that include major organ transplants such as lungs and livers. The ADHB has the only paediatric intensive care unit in the country that is used by all hospitals. Although no formal protocols have been agreed, a number of hospitals have a practice of transferring children who will be intubated for longer than 24 hours to Children's Services to ensure that the best care can be given.

Within the immediate Auckland region, ADHB provides a tertiary support service for the other two hospitals. This at times extends to services that were previously considered to be secondary, such as general surgery, where patients are often transferred to ADHB, as they become more complex.

ADHB currently provides disability services for Assessment, Treatment and Rehabilitation services, Community services, Needs Assessment and Service Co-ordination services (65+ years), Child Development services, and Therapy services.

As discussed in Section 4.2.7.8 the ADHB is participating in a process of moving volumes between ADHB, Waitemata DHB and Counties Manukau DHB as part of the SREA programme of work.

In summary these issues raise risks for the successful performance of the hospital services. These risks include:

- Fragmentation of national and regional services, if individual DHBs seek to develop local solutions
- Inadequate revenue for tertiary services as focus is shifted to population health measures
- A risk of conflict between the population health objectives of the DHB and the hospital's position as a national provider of high-cost complex services. If the purchasing framework continues to poorly compensate the hospital business, Auckland DHB may have difficulties managing the financial risk.
- Failure of the national purchase framework to adequately compensate hospital services for inflationary and other pressures.
- Financial risks for the hospital as ADHB has the greatest number of inter-DHB patient flows. These patients are also high cost. The requirement to negotiate individual contracts will significantly increase compliance costs in this area.
- A risk of cost shifting of high-cost patients in the greater Auckland region between other DHBs.

Elective Services

The ADHB is committed to improving access to Elective services in accordance with the New Zealand Health Strategy and Government principles within available funding. This requires prioritisation of services. The principles

and guiding framework of the Elective Services programme provides support for the prioritisation process and funding decision-making.

The key targets for ADHB during the next financial year and beyond will be:

- To continue to embed the use of financially sustainable threshold methodology and prioritisation scoring to determine access to publicly funded assessment and treatment (including elective surgery).
- To implement clinical audit for each major surgical department (including internal and external benchmarking) to improve the quality and consistency of clinical decision making and care pathways for patients.
- To safely manage clinical risk and responsibility within the integrated environment by ensuring there is clarity and certainty of the plan of care provided for patients seeking access to publicly funded treatment.
- To ensure equity of access to treatment is provided within the timeframe parameters set out within the Governments objectives.

The measures of this commitment will be recognised within the performance indicators set out in section 5.2.2.

4.3.2 Strategies and Initiatives

The provider objectives are aligned with the four goals referred to earlier in this plan. These objectives are included in Section 4.4.

4.3.3 Provider Resources

4.3.3.1 Workforce overview

The ADHB employs around 7,500 staff with a full time equivalent (FTE) of just over 7,000 including the impact of casual staff supplied by the ADHB Bureau and paid overtime. This workforce comprises clinical, management and support staff in the four hospitals, the community and mental health services, clinical support services, and governance and support functions.

The management of the Human Resource function forms part of the shared services structure in the 2002-03 financial year. The Human Resource function will actively support the Change Programme as one of its key work programmes. The changes in organisation design will result in progressive change to the management structure and a need to support both management and employees as the changes are implemented. The work of the Change Programme absorbs large amounts of the Human Resource team time and this is likely to continue for the foreseeable future.

The table on the next page indicates the staff mix with a comparison to the previous year. For the purposes of this analysis the definition of paid FTEs is standard worked hours plus paid leave taken (e.g. annual, sick, conference, etc) plus bureau staff and School of Medicine appointments.

FTE Numbers by Area	June 2002	June 2003	Change
Medical	1003	1018	15
Surgical	1047	1043	-4
Cardiac	722	745	23
Women's	658	642	-16
Children	762	762	0
Community/Mental	1234	1285	51
Clinical Support	874	887	13
Total Provider Division	6300	6382	82
Funder	6	7	1
Building Programme	5	9	4
Change Programme	25	40	15
Support Services	581	724	143
Total ADHB	6917	7162	245

A small part of the increase in FTE numbers represents the annualised effect of appointments made in the year to 30 June 2002. There are also some new service requirements that have associated FTE increases. The increase in the Change Programme and Support Services represents the filling of vacancies in support services previously covered by temporary staff at 30 June 2002 and the engagement of staff to complete the systems and process changes in readying the organisation for the move to the new facilities. Most of the process change staff have been engaged for specific tasks and a defined period of time within the Crème project which is completing the scanning of documents as part of the creation of the new electronic patient record systems.

Staff members are engaged under a mixture of individual and collective employment agreements. Under section 44(2) of Schedule 3 of the NZPHD Act the ADHB is required to consult with the MOH regarding collective employment agreement negotiations. During the course of the year this will result in collaboration between the ADHB and MOH on the basis of the bargaining strategy and how it supports the ADHB's overall strategic direction. This Annual Plan incorporates the impact of estimated collective employment agreement negotiations for the year to 30 June 2003.

ADHB recognises that high quality and culturally competent staff are key to achieving our vision. Over the years workforce issues have become increasingly challenging and the following list of consideration forms part of the ADHB's ongoing strategy for sustaining a viable work force.

- Recent changes in regulation, educational requirements and programme standards have increased the amount of training required for some health professionals. Specialisation and sub-specialisation and expectations,

educational and accreditation requirements all place constraints on the ADHB's ability to recruit and retain staff

- The focus of recent years on Doctor and Nursing shortages has been essential but this exclusive approach has masked major pending shortages in less profiled but critical support professions (e.g.: Medical Photographers are no longer trained in New Zealand)
- In some professions the number of people who can undertake tertiary study is limited by the number of available clinical placements
- To gain experience in sub-specialty areas, trainees are required to travel overseas, often for a number of years
- Health professionals have qualifications that are valued across the world and the Auckland DHB is not always able to offer rates of pay that can compete with hospitals overseas hospitals and health care services. Globally the supply and demand curves for key health occupational groups will not match in a 5-10 year timeframe
- Vigorous recruitment campaigns from off-shore health employers will continue because of New Zealand's has a strong reputation as a nursery for supply of well trained new graduates and highly skilled health professionals
- Student debt levels and the benefits and opportunities from overseas experience are strong incentives for migration from New Zealand of recently graduated health professionals. Some do return and the challenge for ADHB is to maintain relationships with these individuals while they are out of New Zealand
- Specialisation and sub-specialisation, lifestyle changes and expectations, educational and accreditation requirements all place constraints on the ADHB's ability to recruit and retain staff
- The tax payer funded health sector will continue to provide and be monitored against a complex range and depth of health services
- The ADHB financial position is deteriorating. It is projected that demand for health services will increasingly exceed the funding cap
- Efficiency and effectiveness gains will continue to be achieved by standardising and streamlining current recruitment practices
- The current and projected population growth of Maori and Pacific peoples, combined with their disproportionate illness and injury rates directly and increasingly affects demand for health services. And the requirement for a culturally responsive workforce
- Multi-employer collective employment agreements are gaining momentum and terms and conditions of employment within the New Zealand publicly funded health sector will increasingly become standardised;
- The aging workforce (NB: the average age of nurses is 42 years) and the increase in frail elderly patients/clients who live longer are key challenges for delivery of healthcare;
- Generation X (born 1961-1980) and Generation Y (born since 1981) each have different expectations from the workplace and different motivations for working than Baby Boomers (born 1945-1960). These are especially evident and well researched with regard to work life balance and expectations for childcare provision

- Efficiency and effectiveness gains will continue to be achieved by standardising and streamlining current recruitment practices;

The ADHB is also aware of the need to maintain a viable primary sector workforce in order to achieve higher levels of integration between secondary and primary providers and the greater emphasis on early detection and prevention strategies. Whilst many of General Practitioners (GPs) are supported by their own administrative and training structures the ADHB is concerned that entry into general practice has become a less attractive option for graduating medical students. The ADHB is collaborating with the GP network to help address this issue.

Working with educational institutions and professional bodies will help influence the level, quantity of placements. The quality of the education being provided is critical to ensuring future planning for training healthcare professionals meets workplace needs.

These processes will be matched by a commitment to build the Maori and Pacific workforce capacity through human resource policy that impacts on the recruitment and retention of the Maori and Pacific health workforce and the recruitment of Maori and Pacific medical and nursing graduates. Maintaining a strong working relationship with hauora.com, the national Maori workforce development organisation based at Auckland and Middlemore hospitals and the national Pacific Health strategy will assist this process.

Maori Health management, Service Advisors and Kaiatawhai are also located at Women's Services, Cardiac Services Lane, Medical and Surgical Services, Children's Services and Community Health. They provide an interface with senior management, the Funding and Service Planning division, Provider Services and Maori and their whanau. Tikanga Best Practice guidelines support this process that is led by the Chief Advisor Tikanga. The guidelines and training address culturally appropriate care for Maori and their whanau with Tuhonohono and bi-cultural management training also continuing to be delivered. These initiatives are supported by key Maori Health workforce roles that include:

- General Manager, Maori Health
- Associate Director Nursing and midwifery
- Maori Funding and Service Planning Manager
- Maori Public Health Advisor
- Service Advisor, Community Health

Retention strategies are required to keep intellectual capital within the organisation for the long term (for example, internal talent pool management, and by creating opportunities for external placement with ties back to Auckland DHB). This includes co-ordinating the existing workforce so that there is succession planning, and are opportunities for staff to obtain appropriate career and professional development without the need to leave the organisation.

The Auckland DHB has developed effective and efficient research management processes to support advances in clinical care, training and cost management. This is the largest clinical research facility in New Zealand and engages in work that attracts funding and high quality healthcare professionals and also encourages the uptake and adoption of research practice and their findings. Commercially sponsored research makes up a large component of ADHB's current research portfolio. There are opportunities to expand this involvement, which will involve specialised workforce development.

The table below summarises the key linkages between HR strategies and ADHB's four major business goals:

Goal area	Linkage	Comment
Business performance	<ul style="list-style-type: none"> • Recruitment & Admin. Centre • Performance Management • Employee Relations • Remuneration • People Development 	More efficient processes will save costs and improve business effectiveness. Managers are provided with the tools and resources to effectively lead and manage.
Change Programme	<ul style="list-style-type: none"> • Workforce Management Plan • Change Implementation • Recruitment & Admin. Centre • Employee Relations • Remuneration 	HR strategies and services will enable implementation of the new organisation structure.
Building Programme	<ul style="list-style-type: none"> • Change Implementation • Performance Management • People Development 	Manage successful migration to new building through effective change implementation, robust performance management, staff training and OSH planning.
13 Health Strategies	<ul style="list-style-type: none"> • Workforce Management Plan • People Development • Recruitment & Admin. Centre 	HR strategies and services ensure ADHB has required staff numbers and skills to deliver on health strategies. Address Maori & Pacific workforce development and specific skill shortages.

4.3.3.2 Optimise Workforce Capability

The ADHB has developed a vision, strategic intent and integrated strategic Human Resources (HR) goals to support the achievement of ADHB's business and healthcare service objectives. These aim to ensure that ADHB staff are:

- Flexible
- Patient - focused
- Capable
- Accountable
- Performance-driven
- Team-oriented

And that ADHB values diversity and promotes the wellbeing of its workforce.

The ADHB will align workforce capability to business and service requirements. This will identify workforce requirements for both short, medium and long-term business needs, taking account of population-based funding and ADHB's proximity to other DHBs in the region. A Workforce Management Plan (WMP) will be prepared to identify the occupational types, skills/competencies and numbers of staff required by the organisation for the next 1-3 and 3-5+ years together with the action plans to meet these objectives.

4.3.3.3 Recruitment and Retention

All recruitment will be linked to the WMP to ensure that positions, skills and experience sought match ADHB's current and future business needs. Prior to completion of the WMP a review will be conducted to improve recruitment and retention strategies and the associated administrative processes.

The ADHB will reduce costs and improved effectiveness of recruitment by establishing a centralised Recruitment & Administration Centre (RAC) with improved administrative processes. This centre will assume responsibility for the bulk of other HR administrative or transactional tasks such as payroll, benefits administration, leave administration, shift-rosters and HR record keeping.

4.3.3.4 Employee Relations

The ADHB will align employment relationships with business drivers and service delivery requirements. This will provide clarity for employee relations (ER), particularly in the negotiation of collective employment agreements (CEA's) and include an examination of the structure of individual employment agreements (IEA's) to ensure this group of employees is not disadvantaged.

It is recognised that management of employee relations must be achieved within the constraints of government funding and health sector collective bargaining. Employee relations strategies will also be closely linked to objectives of the Change Programme, in particular the organisational culture, roles and new work processes that ADHB is seeking to develop. There will be a strategic linkage with the WMP to:

- Support strategic and operational business requirements
- Support staff recruitment and retention
- Improve staff commitment to ADHB's organisational goals
- Encourage open communication between management and staff
- Enable compliance through simple and, wherever possible, consistent contractual terms
- Take into account regional (i.e. healthAlliance) and national health sector trends in employee relations
- Support establishment and implementation of a remuneration strategy for the organisation as a part of the employee relations framework

Operational GMs, operational managers and appropriate clinicians will be involved in the preparation for employment-related negotiations. This ensures that the resulting agreements are professionally and operationally integrated, and have support for their implementation.

4.3.3.5 Remuneration and Recognition

Remuneration policy is a key component of the recruitment and retention strategy. It also provides a tool for performance management. ADHB is continually developing and maintaining consistent, integrated remuneration policies that include incentives for superior performance and consequence management for non-performance.

4.3.3.6 Performance Management

The performance management process is only a formalised communication tool between managers and staff. Critical requirements for development of a performance culture include well-defined roles and individual performance objectives that are clearly aligned to ADHB business objectives. Senior managers will make it clear through their behaviour that superior performance will be rewarded and poor performance not tolerated. The ADHB will enhance policy and processes to:

- Clearly link business objectives with team and individual performance through cascading of objectives from the ADHB District Strategic Plan
- Integrate performance management with remuneration and people development strategies
- Provide managers and supervisors with the skills to hold effective “performance conversations”
- Clearly distinguish between superior, average and poor performers in terms of rewards, recognition and other consequences
- Enable managers to deal effectively with unsatisfactory performance
- Clarify the roles and accountabilities of managers (relative to HR managers) in the performance management of staff

Once enhanced, management will support the performance management process and staff education process, supplemented with ongoing support to ensure that it remains consistently applied across the organisation.

4.3.3.7 Change Implementation

The ADHB will manage the successful implementation of the Change Programme by appropriately managing:

- Selection and appointment process for new roles
- Termination and support processes for those staff made redundant;
- Development programmes for those staff requiring new skills;
- Negotiations for new work processes and contractual terms;

- Effective recruitment, remuneration and performance management processes

4.3.3.8 People Development

In a large complex organisation undergoing significant change, development of effective leaders and managers is a top priority

An organisation wide People Development Plan will be prepared. An assessment will be made as to whether the delivery of learning and development programmes is maintained internally or outsourced. Specialised clinical areas and perhaps some of the information technology areas that are specific may need this internal support. Management and leadership development programmes may be contracted to specialist providers who have national and international resources at their disposal.

4.3.3.9 People's Well Being

The ADHB commits to ensuring the work environment is healthy and safe for all staff, both physically and mentally. It takes a holistic view of the organisation working on enhancing peoples' well being. There are a number of legislative requirements that the ADHB must comply with for occupational health and safety (OSH) and the review of in-house resources required to meet these obligations will be maintained.

4.3.3.10 People Information Management

There are projects underway to implement improved information systems. The Recruitment & Administration Centre (RAC) will be accountable for the management of the HR database. Managers will remain accountable for the utilisation of the HR information for business planning and associated reporting on staffing. The proposed rostering service will also provide information to managers, obtained through the RAC database.

4.3.3.11 Support services

Section 4.1.9 and 4.1.10 provides a comprehensive commentary on the capabilities of the support functions within the ADHB. The key management functions are provided using a shared services approach. As previously noted the move to a shared services model is designed to offer a low cost service with a high degree of specialisation. It concentrates the organisation's skill base and helps justify investment in more efficient technology. It encourages continuous improvement and the use of performance-based rewards and incentives and includes:

- Information Management - the ADHB has adopted a shared service approach to the internal proviso of business management and information services. This is discussed in detail below.
- Internal Audit, Treasury, Legal, Facilities Management

- Materials Management - the procurement and purchasing activities have been centralised and information systems have been improved with the upgrade of the Oracle ERP financials
- Information Services - recently reorganised with the centralisation of IS coordinators from the hospital services. It includes:
 - ✓ Helpdesk support/network administration
 - ✓ Call centre
 - ✓ IS Strategic Plan management, with assistance from the Programme Management Unit
- Payroll - the payroll function has been operating as a shared services model for some time across ADHB
- Finance - it is planned to have the total alignment of those accountability lines in place by the second quarter of the 2002-03 financial year.
 - ✓ Finance
 - ✓ Facilities management
 - ✓ Material Management
 - ✓ Treasury
 - ✓ Legal and governance
 - ✓ Internal Audit
- Human Resources - this includes
 - ✓ Provision of strategic and operational human resources advice
 - ✓ Learning and Development
 - ✓ Health and safety
 - ✓ Clinical education and training support
 - ✓ Payroll Services
- Business Development and Information - the Information Management Unit manages patient and activity data collation and reporting and the Business Development Unit is responsible for contracting and business planning processes
- Quality and Safety - the Quality and Safety Unit is responsible for the management of clinical and non clinical risk factors and the management of the following programmes:
 - ✓ Management of quality initiatives and processes
 - ✓ Analysis of quality data
 - ✓ Infection control
 - ✓ Civil defence management
 - ✓ Complaints management

4.3.4 Planned Financial Performance

We are committed to delivering health services to the people we serve within the funding available. We must gain control of our current financial crisis and reduce the deficit.

While the ADHB is expecting to receive more money from the Government to fund primary health services, if our deficit is not under control then this new funding will not be sufficient to meet our needs. Therefore, we will need to identify other ways of increasing the investment in primary health services.

We are also reviewing the likely impact of population based funding. The risks associated with PBF include inter-district flows, the provision of high cost treatments and costs associated with administering PBF with its greater administrative requirements to manage inter district flows.

Further detail on the ADHB's projected financial position is included in section 5 of the plan.

4.3.5 Planned Investment - Building Programme

The ADHB site bordered by Park and Grafton Roads is undergoing major change. The biggest change to the ADHB Grafton site, is the construction of a new Auckland City Hospital adjacent to the existing Auckland Hospital building.

The new Auckland City Hospital will offer acute, medical and surgical, inpatient services. It will be nine levels high (five levels lower than the existing Auckland Hospital building) and has an opening capacity for 752 beds. The new Auckland Hospital will link with Children's Services and opens in late 2003.

ADHB has already opened a new laboratory and mortuary (LabPlus), and a new carpark building (Helipad Carpark) on its Grafton site. Construction of a new acute mental health unit (to replace the Conolly Unit) is underway north of the existing Auckland Hospital building. The ADHB Greenlane site will be transformed into the Greenlane Clinical Centre.

Currently ADHB operates four hospitals on two separate sites with Grafton incorporating the Medical and Surgical and Children's Services and Green Lane housing the Cardiac and Women's Services. By 2004 ADHB will operate just one integrated hospital on one site at Grafton. This new Auckland City Hospital complex will include Children's Services.

Planning for the new Auckland City Hospital and the Greenlane Clinical Centre has already involved a lot of patients and staff. Special interest groups have participated in a wide-ranging programme of consultation. As part of the planning for ward design, a mock-up of a generic ward for the new hospital was built in a Glen Innes warehouse. ADHB staff and groups with a vested interest in the designs visited the ward mock-up and made many useful suggestions. Where appropriate they will be incorporated into the new hospital.



When the building programme is completed, the inpatient and outpatient facilities offered by ADHB will be the best in New Zealand. The new and refurbished buildings will have many of the finest features available.

The opportunity to design and build a new public hospital is a rare one. Much thought is going into every aspect of design. There will be separate toilet and shower facilities for most rooms, with ensuites in the remaining rooms. Women in the maternity ward will have either a single or a double room, each with an ensuite bathroom. The Building Programme gives us an opportunity to introduce new technologies. The x-ray box will be a thing of the past as all x-ray and scanning images will be computerised. Patients' records will eventually be managed by a paperless, fully computerised system.

Patient meal production has been fundamentally overhauled. A cook/chill system of meal production has been introduced. Food is prepared, blast chilled, then reheated when required. This ensures patient meals retain their nutritional value and appetite appeal. It has also been an opportunity to revamp the menu.

The Medical School welcomes the proximity of the new Auckland City Hospital, which will provide training opportunities formerly available at the Greenlane site only. The patient base benefits from the presence of health professionals actively involved in health research and whose research findings can be implemented to improve health services and health outcomes.

The ADHB Building Programme is a very significant project for Auckland. Already the local economy is benefiting from such a major building programme. The new Auckland Hospital will have over 1,000 people working on site during its internal fitout phase.



Both the Grafton and Greenlane sites' buildings will be attractive, sympathetic to their environments, and well landscaped. There will be additional facilities for the visiting public, a food court at the new Auckland City Hospital precinct, with florists, a pharmacy, cafes and other retail outlets on both sites.

The new hospital presents an opportunity to display ADHB's substantial donated art and medical artifact collections.

The new Auckland City Hospital will offer the most complex procedures available in New Zealand, for example, heart procedures and organ transplants. As such it will be a national resource, with referrals from all around New Zealand. It will also have maternity services and newborn intensive care units.

The many diverse services in the new hospital building have been carefully placed to complement one another, and to meet patient needs for privacy and security. From the outset, design of the new hospital has been patient focused. The new hospital has an interesting 'H' shape within a footprint the size of the Eden Park playing field. It has a very large internal courtyard, which will provide plenty of natural light into the wards. The internal design features are non-clinical in character, with a use of colour and texture not usually found in an acute public hospital. The overall effect will be friendly and reassuring.



A feature of the developing Grafton site is the linkage of old and new buildings. The new Auckland City Hospital is taking up most of the space which used to be the Wilson's carpark, west of the existing Auckland Hospital building, and as such acts as a central focus connecting all the major buildings on the site.

There will be two linkages between the new Auckland City Hospital and the existing Auckland Hospital building. A linking glass atrium will be built at levels five to nine with vehicle access underneath. A tunnel will also link the two buildings.

The new Auckland City Hospital is placed between the existing Auckland Hospital building and the new laboratory and mortuary building (LabPlus). A tunnel will link the new hospital with the mortuary at level one. There will also be an air bridge link at level three.

Children's Services and the new Auckland City Hospital will have separate emergency departments adjacent to one another. Both emergency entrances will share an air bridge that links them to the landing pads on the roof of the Helipad Carpark. There will also be a pedestrian link from the Helipad carpark to level three of Children's Services.

A second stand-alone carpark is being planned for the Domain entrance side of the existing Auckland Hospital building. It will have a linking walkway through the existing Auckland Hospital building and the new atrium, through to the new hospital.

There is currently a walkway link between Children's Services and the existing Auckland Hospital Building.

From its historic role as the centre of the most advanced cardiac procedures in New Zealand, the current facilities at Green Lane will be transformed into a more relaxed outpatient, day surgery clinic. Patients will be able to access services that do not usually require an overnight in hospital, such as cataract

surgery and minimally invasive laser procedures. There will be a wide range of specialists resident at the Greenlane Clinical Centre, including dentists and pharmacists.

A rehabilitation clinic is also being planned. Here physiotherapists will work with people such as those who may have suffered a stroke or been involved in a serious accident.

The Greenlane site project is quite different from the Grafton site project, although both must dovetail very closely. When the new Auckland City Hospital opens in 2003, there will be a major transfer of Greenlane-based services and personnel over to the Grafton site. A smaller number of Grafton-based services and personnel will transfer to the Greenlane site. In some cases, there will be interim transfers to enable demolitions or refurbishments to take place.

The ADHB Greenlane site is large and spacious. The reconstructed hospital building and the new rehabilitation building will be comparatively low rise, with a Cornwall Park focus. The historic Costley Wards building will be retained.

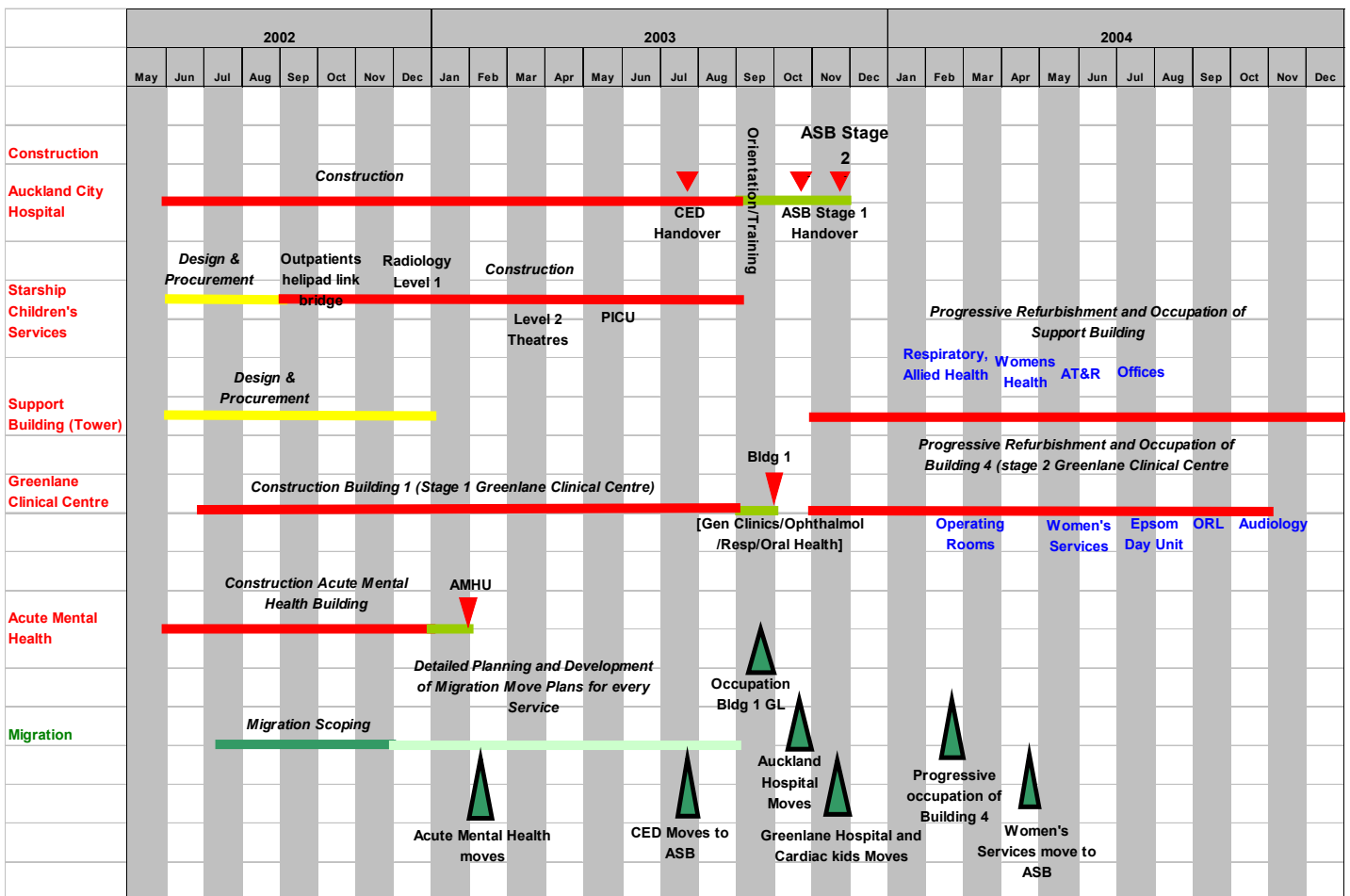
The existing Auckland Hospital building will be mostly refurbished as an administration and support building with completion by 2005. Children's Services will be expanded to include children's heart services and a larger intensive care unit. It will continue to offer children's (15 years and younger) acute inpatient services. From 2003 it will operate as part of the integrated, new Auckland City Hospital complex.

With few exceptions, many of the ADHB clinical and administration buildings needed major financial investment just to meet minimum legislative, building and earthquake standards. Operating four inpatient hospitals on two sites means expensive duplication of staff and facilities.

The Auckland population is changing. It is growing and aging. The average age of a patient in Auckland Hospital is 67 years, and growing older. Population changes demand a different approach to health service delivery. The main ADHB hospitals are old and not well suited to modern health care. New medical technologies are best accessed in purpose-built facilities.

Each year 4000 ADHB patients are transferred between its Grafton and Green Lane sites. This has a number of inherent risks for patients.

Patients and staff will benefit a great deal from carefully designed and technologically advanced facilities. Overall, the changes brought about by the Building Programme will represent an investment of \$447 million over five years. They will clearly position ADHB's health services for the future.



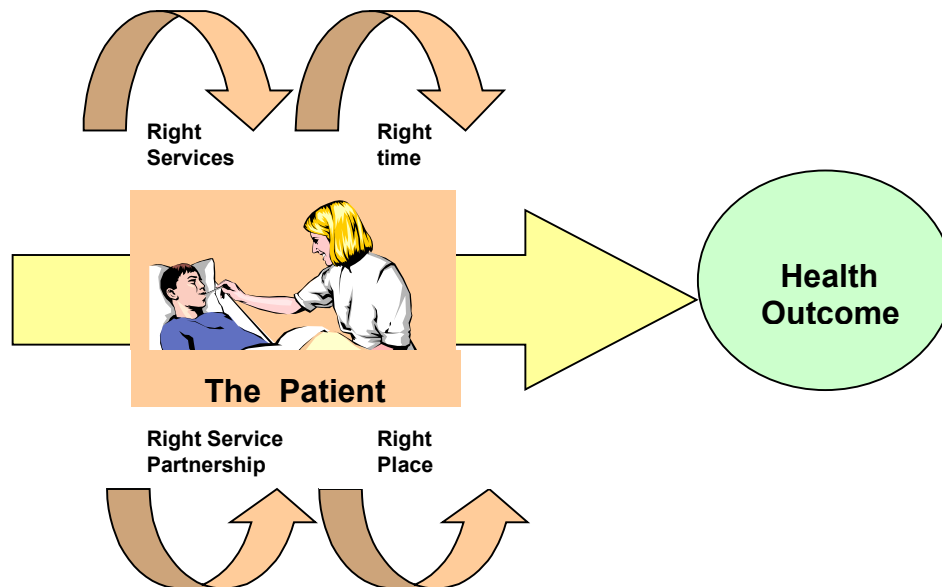
4.3.6.1 Change Management

The health services provided by the ADHB include tertiary services for the greater Auckland region, regional services and a number of national quaternary services. As previously noted the ADHB is responsible for managing four specialist training hospitals with teaching services, and more than 7,000 staff.

The structure and delivery of services will undergo significant change as part of the Building Programme that will result from the redevelopment of the Grafton and Greenlane sites.

As part of the process of developing service delivery the ADHB is working to adopt a patient focus in care delivery that works to remove the separation that currently occurs as a consequence of the separation of the different service components that a patient needs over time.

A Patient Centred Approach



The Change Programme will assist the organisation in reviewing and changing its systems and processes so that they are able to:

- Manage in the new hospital with 200 less beds than currently available
- Provide efficient, effective and safe services to patients, with the right staffing levels, and supported through the introduction of clinical information systems
- Reduce operating costs through the elimination of duplicated processes or processes that do not add any value to the patient or the organisation.

The Maori Health team is providing advice to the Change Programme. There are a number of key work streams in relation to Maori Health that will be implemented as part of the Change Programme. These include:

- The re-organisation and collection of Maori ethnicity data
- Reducing Maori did not attend rates
- Maori clinical indicators

The Change Programme is undertaking the following five pieces of process design work:

1. Admit, Discharge and Transfer (ADT) Project

This project is designed to 'smooth' the patient flow to enable improvements to their access and discharge from ADHB's services. It will include the establishment of some physical facilities i.e. short stay, acute assessment and their integration with other ADHB facilities.

This project acknowledges that the number of inpatient beds will be reduced in the new facilities. It will also work to simplify processes for patients ensuring patients' needs are met in an effective and efficient manner.

2. Surgical Process Project

This project is focused on maximising the utilisation of resourced theatres to reduce patient wait times for elective and acute surgery. Integration with the ADT project is required in the Admissions area. The split between these projects is largely clerical and clinical, with the Surgical Project having responsibility for the clinical requirements of the surgical admission.

The project will support the Building Programme in ensuring that the new theatre numbers are sufficient to meet the expected patient throughput. Patients will benefit through reduced waiting times and also having greater options for day surgery and day of surgery admission.

3. Outpatient and Clerical Project

This project will assist the Ambulatory HBO with the establishment of the new outpatient clinic and clerical processes. This will include changes to roles, systems and management structures.

This project will ensure that the new split site facilities will support ADHB's patient care processes on opening day. This will also provide a more effective service for patients by reducing their waiting times and co-ordinating their appointments.

4. Clinical Rosters and Bed Management Project

This project supports the other projects by ensuring that medical staff and bed resources are managed to meet the patient's needs. The first phase of work will be focused on understanding the current resource conflict. The second phase of work will be in designing new schedules that will support the new process requirements.

This project will ensure the two sites will be adequately resourced to meet the patients' needs. Clinicians will not be scheduled to be in two places at one time, and this will improve patient care and satisfaction.

5. Staff Roles and Responsibilities Project

This project will ensure that the responsibility for coordinating a patient's care throughout their healthcare experience with ADHB is managed by the appropriate healthcare professional. It will also ensure that the appropriate skill mix and patient assignments are appropriately managed in all of ADHB's services.

This project will support the new ward designs by ensuring patient workload is well managed with the right level of support.

4.3.6.2 Medical and Surgical Services

Medical and Surgical Services based on the Grafton site is the largest tertiary service facility in New Zealand. It provides secondary, tertiary and quaternary health services to the people of Auckland and beyond. To manage this range of health services ADHB supports health research, training and education of staff in conjunction with the School of Medicine, Auckland University and other teaching institutions. The service also has New Zealand's National Liver Transplantation Centre.

Services include emergency, acute and elective medical and surgical services, inpatient, outpatient and day-patient services. The list below does not include services for plastic surgery and cardiothoracic and this is being addressed under the Building Programme in order to support Auckland Hospital's role in the provision of trauma services for the region. The range of services offered includes:

<u>Medical</u>	<u>Scope of service</u>
Endocrinology	Regional
Emergency Medicine	Sub Regional
Infectious Diseases	Regional
Renal	Regional
General	Sub Regional
Gastroenterology	Sub Regional
Rheumatology	Sub Regional
Cardiology	Sub Regional
Pain Service	Regional
Cancer/Oncology	Regional
Immunology	Regional
Haematology	Regional
Community Diabetes	Sub Regional
A+ Links, Home & Older Peoples Health	Sub Regional
 <u>Surgical</u>	
Ophthalmology	Regional
Urology	Regional
General Surgery	Sub Regional
Vascular	Regional
Intra-abdominal Transplant	National / Regional
Trauma	Regional
Critical Care Medicine	Regional
Neurosurgical	Regional
ORL/head and neck	National / Regional

The growth in acute volumes is affecting Auckland Hospital's capacity to manage within funded targets, as well as having an impact on the hospital's ability to run services in the most efficient manner.

4.3.6.3 Respiratory and Cardiac Services

These services are located on the Green Lane site and provide services to the catchment of Auckland Central, as well as specialist tertiary services to other DHBs in New Zealand, particularly Waitemata and Counties Manukau DHB. Because of the specialist nature of the cardiac services provided an increasing number of overseas patients are treated and the services have world renown in the areas of cardiovascular and respiratory research.

The services deliver 69% percent of their health services to the populations of other DHBs, predominantly Counties Manukau and Waitemata DHB, which will require careful financial management during 2002-03 and out years. Customers can be broken down into the following categories:

Customer	Comment
DHBs	National & regional services
Other A+ Divisions	Cardiac and Respiratory Investigations
ACC	No current Green Lane contracts
Overseas purchasers	Cardiac Services
MFAT	Cardiac Services
Ministry of Education	Play Specialist Service
Research	Research Funders GLR& EF
Other Private Providers	Sub contracted
CTA	Important to maintain a training environment - under funded

Profile of the services:

Respiratory

Specialist services can be either secondary or tertiary and include both in-patient and outpatient services. These are as follows:

- General /specialist respiratory conditions such as Chronic Obstructive Pulmonary Disease and asthma. (including smoke cessation services)
- Cancer inpatients for medical and surgical interventions, including chemotherapy, radiotherapy and palliative care.
- Management of Muscular Dystrophy and other sympathetic nervous system conditions that ultimately impact on respiratory function.
- Management of young adults with Cystic Fibrosis.
- Sleep apnoea, including a sleep laboratory for the monitoring of, and management of sleep apnoea.

- Tuberculosis inpatient services for those patients in the region with multi-drug resistant TB, establishing DOT management of TB and the management of those patients that are non-compliant with treatment.
- Lung transplantation
- Interventional bronchoscopy

Cardiac Services

Specialist services can be either secondary or tertiary and include both inpatient and outpatient services. Services are as follows:

- Cardiology services both outpatient and inpatient (includes Green Lane and Auckland Hospitals)
- Insertion of Cardiac Pacemakers and ICDs
- Diagnostic transthoracic and transoesophageal and stress echocardiography
- Cardiac catheterisation both diagnostic and interventional (angioplasty, stenting, balloon valvotomy)
- Cardiac Electrophysiology
- Paediatric Cardiac and Cardiothoracic services – this is a national service
- Adult Cardiothoracic services – provide services to the region and some other DHBs.
- Heart transplantation, including donor co-ordination.

Preparing the services for the impact of the Building Programme changes remains a key focus.

4.3.6.4 Children's Services

Children's Services are situated in a standalone hospital entirely dedicated to child health services. Core services include secondary and tertiary paediatric services. This activity is complemented by Outreach Clinics delivered by multidisciplinary teams both intra and inter-regionally. It is the home of the Children's Research Centre, which supports researchers by the hospital as well as the Department of Paediatrics at the University of Auckland.

Children's Services provides over 80,000 patient contacts each year with a staff of over 770. The core strategy for Children's Services is high quality service delivery whilst maintaining cost effectiveness. The hospital is organized into four Clinical Business Units, (CBUs), each with several operating units. From July 2002 the management of Paediatric and Congenital Cardiac Services will transfer from the Green Lane site to Children's Services. The General Manager provides commercial support to the clinical leadership of the business units. Operational accountability is to the Clinical Leader/General Manager/Nurse Leader partnership through the Managers of the CBUs and respective Clinical Director.

The business units are headed by a Clinical Director and a Charge Nurse, who have delegated accountabilities for patient care, training, research, operational and financial performance. The structure of the hospital is:

Medical

- General Paediatrics
- Whakaruruhau and Te Pua Pohutakawa
- Medical Specialties – Neurology, Gastroenterology, Nephrology, Endocrinology, Immunology, Rheumatology, Metabolic, Respiratory Infectious Diseases and Developmental Paediatrics.
- Haematology/Oncology
- Children's Emergency Department

Surgical

- Orthopaedics
- Ear, nose and throat (ORL)
- General surgery
- Neurosurgery
- Anaesthesia
- Theatres and Day Stay Unit
- Radiology

Community, Mental and Allied Health

- Child and Family Unit
- Liaison Psychiatry
- Physiotherapy, Speech and Occupational Therapy
- Outpatients
- Family Information Services
- Social Work
- Play and Volunteers
- Paediatric Homecare Nursing Service
- Palliative Care & Family Options Service

Paediatric Cardiology, Cardio-thoracic Surgical Unit & Paediatric Intensive Care

- Paediatric Cardiology
- Paediatric Cardio-thoracic Surgical Unit
- Paediatric Intensive Care

Children's Services is planning construction to accommodate the transfer of Paediatric and Congenital Cardiac Services under the Building Programme.

Children's Services continues to share with the MOH information that demonstrates the gap between revenue and the cost of service and tertiary paediatric service provision. The most recent example of the activity was a report on the cost of National Paediatric Haematology/Oncology service provision. Children's Services continues to maintain a focus on financial viability whilst monitoring and responding proactively to changes in demand. These arise from developments such as the General Paediatric Service Developments initiative at Waitemata DHB and the impact of Waikato DHB establishing a Neurosurgical Service.

4.3.6.5 Women's Services

Our customers are women, their sources of referral, families/ whanau, and, in some cases, their babies. In a health provider such as Women's Services, the words and concepts "specialist" and "tertiary" are not synonymous. Specialist women's health services and specialist women's health workers operate with the woman as the key point of focus. This method of operation helps reduce the unnecessary effects of medicalisation and institutionalisation.

Women's Services operates the largest women's health service in New Zealand, and the Maternity Service is one of the largest in Australasia. As a specialist service it provides primary, secondary and tertiary levels of care for women and the newborn through maternity, gynaecology and newborn services. In all these areas it also provides specialised services which are accessed by other districts. Primary services are provided through such areas as health education, antenatal care and low risk maternity care. This includes a large research component.

Secondary and tertiary services are available through Maternal Fetal Medicine, the Parent Infant Nursery and Neonatal Intensive Care Unit, Gynaecological Oncology, Reproductive Endocrinology, and the Maternity High Dependency Unit. Specialist services for women who have recurrent miscarriages, pregnancy complications from diabetes, drug and other substance abuse, a broad range of medical conditions, mental health disorders and gynaecological problems are also covered by our extensive services. An emergency transport service for sick and premature babies, also staffed by Women's Services specialists, ensures such patients receive the best possible care at the earliest possible time.

The hospital's focus on population health includes a plan to review of screening programmes will be reviewed to gain improvements. A domestic violence screening programme will also be developed. There will be a continuing focus on health education through "Smoke Change programme", breast feeding and diabetes detection and prevention.

Women's Services will continue to provide ethnicity data for both clients and staff and monitor equity of access via booking systems and waiting times. Primary Care providers and community groups will be engaged to ensure appropriate agencies are involved in planning and providing care.

The hospital will continue to support SREA by inter-district planning and development of services and strengthening strategic relationships. This includes continuing to improve relationships with primary providers by clear communication and appropriate referral to Primary providers to meet the needs of women and babies in our care.

Clinical and non-clinical risk will be managed ensuring compliance with relevant legislation, ongoing accreditation, credentialing and education programmes. Clinical pathways and guidelines will be developed to assist in this area.

4.3.6.6 Ambulatory Care

The great majority of Ambulatory Services patients are outpatients. The age range varies from service to service. Audiology, for example, focuses very much on services to children, while others, Dermatology in particular, would tend to have a much older average age profile amongst their patients. Sexual Health's principal target market is young adults (17 to 29 years).

Services specifically for Maori are provided, by Audiology for example, through its Maori community worker and through its other community services that interface with, for example, Kohanga Reo. Similarly Oral Health, through its relief of pain clinics at the ADHB Green Lane site and Middlemore Hospitals, and at its Mangere Clinic, provided significant services that are well utilised by Maori. Dermatology on the other hand is less utilised by Maori, because Maori have a lower predisposition to condition such as skin cancers, than do Europeans.

Non-English speaking patients are over-represented amongst Endocrinology's clientele - estimate 30%. Maori are under-represented; Asian people are over-represented.

Oral Health, through its relief of pain service, and Audiology, through its Pacific Island community worker and its involvement in community outreach to pre-schools and schools, both have significant services of benefit to Pacific peoples.

Though Maori & Pacific people access Sexual Health's services only in line with their respective percentage of the population, the incidence of infection in these populations is significantly higher (between two & eight times higher)

A significant subset of the work of the Oral Health Service is targeted specifically at patients with psychiatric problems or intellectual disabilities. The Oral Health service also provides dental health care to refugees at the Mangere Refugee Centre.

Ambulatory Services provides a wide range of services:

- Specialised tertiary treatments (e.g., Mohs surgery, cochlear implant, prosthodontic reconstruction, acute facial trauma, orthognathic surgery)
- Secondary treatment upon referral by GPs (e.g., oral health specialties, audiometric testing, dermatology consultations, diabetes consultations, endocrinology consultations, rheumatology consultations).
- Primary treatment (e.g., ear nurse services, dental relief of pain, clinical sexual health care)
- Health education (e.g., Sexual Health's peer sexuality support programme).
- Primary detection & prevention (e.g., vision hearing testers)
- National public health services (e.g., deafness detection database)

- Research in the areas of diabetes, endocrinology, sexual health, and rheumatology

The aims of the services, and therefore the outcomes include the following:

- Early detection of health problems (in order to enable)
- Early intervention, to prevent later complication
- Habilitation
- Alleviation of pain & suffering
- Changed behaviour/lifestyles from health education
- Treatment
- Management of chronic conditions
- Minimisation of hospital stay
- Early restoration to fitness, health, home, work & education
- Restoration/rehabilitation
- Improved/restored quality of life

It is likely that the cochlear implant programme will be reduced from national to North Island coverage. Dermatology are also considering a reduction in services to Waitemata patients with a focus on Auckland & Counties Manukau DHB patients. This reflects the funding of some secondary dermatological care at Waitemata DHB' hospital facilities.

With respect to service coverage requirements the Dermatology, Endocrinology, Oral Health, Sexual Health & TARPS provide regional (i.e. Auckland-wide) services, as required. There is pressure for Dermatology to decrease acceptance of referrals from Waitemata DHB's district, in light of funding of dermatological care at Waitemata.

Diabetes & Rheumatology provide mostly secondary care to Auckland district patients.

4.3.6.7 Community Health Services

The health status of children and young people in Central Auckland will be improved by the provision of integrated community based health services and older people will be assisted to remain independent for as long as possible.

These services are offered to:

- Maximise the healthy development of children in a culturally appropriate manner by the provision of primary healthcare;
- Promote healthy lifestyles to children, young people and their families;
- identify those families where children are at risk and to provide targeted services in these instances;
- Provide therapy services to disabled children and assist them to integrate into home and educational settings in a functionally independent manner;
- Provide Maori tamariki, rangatahi and whanau with health education and personal care services which facilitate their improved health status;

- Educate Pacific Island communities about healthy lifestyles; reduce the incidence of particular illnesses amongst Pacific Island people; and maximise the use of primary health care.
- Older people (aged over 65) with a disability will have their needs assessed and the services required to meet those needs will be co-ordinated.

Services provided are aligned with New Zealand Health Strategy, the New Zealand Disability Strategy and the Child Health Strategy.

The vision is to be the leading provider of a comprehensive community-based health service that optimises the health of children, young people and their families, and older people in Auckland and reflects our commitment to the Treaty of Waitangi.

The client groups for the services provided are:

Children

Child health services are offered to all well children in central Auckland as well as to those with disabilities. In all areas the needs of children who are recent immigrants, and in particular refugees, is placing an additional demand on our services.

The total population of central Auckland is almost 400,000 of which 27% are children and young people aged 0-19 years. This is expected to decline to approximately 24% by 2010. Almost 30% of the usually resident population were born overseas, compared to a national average of 17.5%.

Ministry of Education decile weightings of Auckland region schools shows that Auckland Central has more schools in the highest needs categories (1-5) than either South Auckland or Waitakere. It has almost one third of the total decile 1 and 2 schools in the country. 12% of private dwellings house more than one family. 26% of families with dependent families are sole parent families. This equates with the national average.

Older People (65 years and older)

Older people comprise an increasing proportion of the total population. Although the numbers of older Maori and Pacific Island peoples have increased, this increase is small proportionately.

ADHB	European	Maori	Pacific Island	Asian	Others	Total
	#	#	#	#	#	#
65-74	13,449	660	1,458	1,869	1,431	18,867
75-84	11,352	222	570	573	963	13,680
85+	4,686	63	102	153	378	5,382
Total 65+	29,487	945	2,130	2,595	2,772	37,929

The changes since the 1996 census are set out below:

	ADHB Change #	ADHB %	NZ %
65-74	-1,977	-9.5	-0.2
75-84	-225	-1.6	13.1
85+	708	15.1	26.4
Total 65+	-1,494	-3.8	6.6

An emerging client group over the last 2-3 years is people from refugee backgrounds and asylum seekers. It is estimated that there are currently approximately 40,000 from refugee backgrounds in Auckland central and up to 40 asylum seekers applying for refugee status in Auckland each week.

An unknown number of people enter NZ under the Family Reunification scheme but no record is kept of where these people eventually settle. It is known however that the majority of people from refugee backgrounds and asylum seekers settle in Auckland central and it is likely that family members settle nearby.

People entering NZ under Family Reunification, and asylum seekers, are likely to have similar high and complex health needs as refugees but receive no health screening and other assistance on arrival. No health statistics are currently available on this group as they are subsumed under the ethnic category "other". "Refugee" of course is a legal status not an ethnicity.

A major strategy adopted by the funder for central Auckland has been to fund Maori and Pacific Island providers while monitoring and auditing mainstream providers to ensure culturally appropriate service provision. Community Child Health & Disability Service remains committed to a continual examination and development of service delivery methods and processes in order that Maori and Pacific Island clients have real choice and their health status is improved.

Community Child Health & Disability Service

This service offers a mix of primary personal care programmes and health promotion programmes in a variety of settings including pre-schools, schools, homes, community centres and marae. It also provides therapy services to children with a disability and Needs Assessment and Service Co-ordination services for people aged over 65 years who have a disability. The services are offered to:

- Maximise the healthy development of children and promote healthy lifestyles
- Identify families where children are at risk and provide targeted services;
- Assist disabled children to integrate into home and educational settings in a functionally independent manner
- Assess the needs of older people with a disability and co-ordinate services
- Promote healthy lifestyles to Pacific Islands communities; reduce the incidence of particular illnesses amongst Pacific Islands people; and maximise the use of primary health care

- Undertake health promotion and provide Maori tamariki, rangatahi and whanau with personal care services that facilitate their improved health status

Multi-disciplinary teams operate from a central base in Newmarket, Auckland, while the Needs Assessment/Service Co-ordination Team is based at the Greenlane site.

Child Development Team

The child development team is a multi-disciplinary team providing assessment, therapy and support for children with physical and / or intellectual disabilities. The team includes Speech and Language Therapists, Social Workers, Physiotherapists, Occupational Therapists, and a Dietitian. Areas of assessment and therapy include:

- Physical development
- Play
- Learning skills
- Speech / language
- Feeding and dressing
- Specialised equipment
- Family support / counselling

Early Childhood Health

The aim of the Early Childhood Health Team is to promote health and development through the integrated provision of well child care, health promotion and family support to newborn infants and young children (0-5 years age group). This is targeted to particular children identified as being at higher risk of adverse health and social outcomes.

This multidisciplinary team consists of Public Health Nurses, Social Workers, Maori Community Health Workers, Dietitians, Health Promotion Advisors, Medical Officers and Refugee Community Health Workers. Services provided include:

- Well child health and development monitoring
- Family support
- Health promoting early childhood settings programme
- Assessment, referral and follow up of health issues
- Targeted services to children identified as having higher health and support needs, arising from:
 - ✓ parenting issues
 - ✓ children not receiving well child monitoring
 - ✓ refugee or new migrant families
 - ✓ psychiatric illness of parent
 - ✓ substance abusing parents
 - ✓ assessment of risk of abuse or neglect
 - ✓ family violence
- Participation in Strengthening Families Programme

Child and Youth Team

This multidisciplinary team consists of Public Health Nurses, Social Workers, Maori Community Health Workers, Health Promotion Advisors, Dietitians, Medical Officers, Health Promoting Schools Facilitators and Refugee Community Health Workers. The aim of the team is to promote the health and well being of school-aged children and young people and to prevent ill health. Services provided include:

- Health screening, assessment, case management and referral
- Assessment and referral of child protection issues
- Self referral clinics in schools
- Immunisation information and vaccination for Year 7 students
- Health education and promotion for students, parents and school staff
- Support/consultancy in schools for students with chronic health problems
- Social Workers in Schools programme
- Programmes to address specific health issues e.g. asthma education, obesity, enuresis
- Health Promoting Schools programme
- Participation in Strengthening Families programme
- Mana Health Clinic (Wesley School)

Needs Assessment and Service Co-ordination Team

This team of social workers provides comprehensive needs assessment of older people (65 and over) with a disability and the co-ordination of services both external to Auckland Healthcare and internal as required. The Ministry of Health defines 'disability' in this case as:

"A person who has been identified as having a physical, psychiatric, intellectual, sensory or age-related disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing, support is required".

Relationships

Major day-to-day functional relationships are with other community health providers as well as intersectoral, particularly for the child health teams. The importance of integration across primary, secondary and tertiary care is recognised however and considerable effort is expended in building relationships and collaboration with the secondary and tertiary sectors, in particular Children's Services, Mental Health services and Older People's Health (A+ Links). This will continue as a key direction over the next five years.

4.3.6.8 Mental Health Services

The ADHB Mental Health Service endorses the principles outlined in the New Zealand Health Strategy. Those principles and values therefore guide our practice and decisions. While all thirteen objectives in the strategy are relevant to us, two of them relate directly to our key service strategies. These are:

- To reduce the rate of suicides and suicide attempts
- To improve the health status of people with severe mental illness

The vision for mental health care delivery is built on partnerships with our consumers, our community and other providers, and on partnerships between our managers and clinicians. It is based on the belief that the foundation for effective service delivery is full participation to achieve integration of services across the whole continuum of care.

The Mental Health Services provider group of Auckland District Health Board will provide high quality comprehensive and integrated mental health services to consumers and their families, who live in Central Auckland and beyond.

The services will be delivered in a culturally appropriate manner, and in an environment of continuous improvement. Our vision requires commitment to a set of key values specific to the Mental Health Service:

The population/clients of the service

The purpose of the Auckland District Health Board's Mental Health Service is to achieve the best possible outcomes for diverse service users with enduring mental health problems through delivery of a recovery focused service, which assesses and responds to their needs.

The primary customers for Mental Health Services are the consumers and their families who reside in Central Auckland. The population needs analysis process has supported the strategic objectives outlined in the blueprint, to which the government has committed funding as a priority over the next two years.

The cultural mix of the population in the ADHB locality strengthens our position in relation to the development of services for Maori (9%), Pacific Islanders (12%) and people from other cultural backgrounds (20%).

The range and level of service activities

The Mental Health Service provides a broad range of services that aim to meet the needs of people with serious and enduring mental illnesses living within the ADHB area and beyond. The range of services includes assessment, treatment and rehabilitation that are available on an inpatient basis where necessary, as well as through interventions based in the community - including the homes of consumers. Services are provided directly or indirectly, to all age groups and cultures. Child and Adolescent inpatient services are currently provided by the Children's Services, including Liaison

Services. Services continue to develop for Maori and Pacific Island people and future developments will also focus on people from other cultures, especially the growing Asian population, refugees and other immigrants.

The current service mix is split between secondary services and those, which are provided on a tertiary, regional or sub regional basis. These are detailed below:

Acute Inpatient & Associated Services

Conolly Unit is a 58-bed acute inpatient unit located on the Grafton site. The service provides intensive inpatient care to the population of Central Auckland in response to need identified by Community Mental Health Service. A locked ward provides eight intensive care beds. The two open wards can accommodate 24 and 26 patients respectively. With some exceptions adults between 18 and 65 years access the service. Admissions are accepted from Central Auckland and beyond as space permits. The Community Mental Health teams make most referrals and admissions are usually of a limited duration – an average of twenty-two days, as our objective is to provide support in the community wherever possible. The Kai Atawhai team ensures the cultural needs of patients are met. Liaison Psychiatry services are provided to the Green Lane and Grafton sites for patients requiring specialist psychiatric input.

Medical Information service

The Medical Information Service provides mental health records support for inpatient and community mental health services. The service tracks the legal status of mental health patients to ensure legal requirements under the Mental Health (Compulsory Assessment and Treatment) Act (1992) are maintained, co-ordinates judicial hearings, codes Mental Health data for the Ministry of Health, provides statistical information as required and co-ordinates the release of patient information.

Rehabilitation Services

Buchanan Rehabilitation Centre on the Pt Chevalier site currently provides post acute, reduced stay, recovery focussed rehabilitation for forty patients. The service structure has two components - a twenty-bed early rehabilitation intervention service and a twenty-bed late rehabilitation intervention service. The service enjoys positive relationships with a range of other providers. This is critical to ensuring that an adequate range of accessible clinical, support and accommodation options are available for consumers' timely transition back into the community.

The Community Support Work Service provides for people with mental health problems that have high and ongoing support needs related to community living and self-management of their problems. The service assists people in determining their support needs and using this information provides a lead service/co-ordination role between the person, their family/whanau, the community, the services and resources they wish to access and use, to optimise independent functioning.

Community Mental Health Centres (CMHC)

Community based services are delivered from four centers located throughout Central Auckland. Multidisciplinary teams provide acute, crisis, early intervention/relapse prevention and continuing care interventions for adults aged 18-65 years. Specialist teams provide a range of focused services, for clients with a first episode of psychosis, or who are homeless, for example. The community centres liaise with the Conolly unit, Buchanan Rehabilitation Centre, and the Maori inpatient service (Manawanui) to secure admissions and to facilitate discharge. The teams also work in partnership with a wide range of other support and accommodation services to enable clients to remain in their communities.

Pacific Island Mental Health Service

This service, known as Lotofale operates from the Carrington site and provides an integrated clinical and community support work service to the Pacific Island population of central Auckland. Clinical governance is provided by a lead clinician at the CMHC and the teams liaise with them to ensure culturally appropriate assessment and support is provided.

Acute Child and Adolescent Inpatient Services

The Child and Family Unit (CFU) forms part of Children's Services. It is a 25 bed unit that provides acute inpatient and daypatient mental health services to children and adolescents. The CFU was redeveloped and opened in 2001 and provides developmentally appropriate care in separate children's, adolescent and high dependency units. Admissions are accepted from the Northern and Midland regions. The CFU and the equivalent unit in Christchurch currently provide New Zealand's only acute inpatient beds for this age range. An 8 bed unit will open in Wellington this year.

Community Child, Adolescent and Family Service (Kari Centre)

The Kari Centre provides community based mental health services for the children, adolescents and their families of Central Auckland. The service offers assessment and interventions for families where a child or young person has emotional, psychological or behavioural problems indicative of a serious mental health disorder. Consultation, education and training for allied child and adolescent service providers are also supplied.

The core services are provided by the Community team located in Grafton Road. The Youth Early Intervention Service provides specialist assessment and multi-modal treatment for first episode psychosis, obsessive-compulsive and bi-polar disorders. The Child and Adolescent Liaison Service is a sub regional team and offers a consultant liaison and assessment service to the Child, Youth and Family agency. The Youth Forensic Service is a regional team and provides a screening and assessment service to the youth court.

Mental Health Services For Older People

Mental Health Services for Older People provide assessment, treatment and rehabilitation services for people over the age of 65 years. The Community (CARE) team is located on the Green Lane site along with a day programme facility, and works to assess, treat and manage people within their home or

community setting. Those requiring inpatient treatment access the Fraser McDonald unit on the Grafton site. Staff of this 12-bed facility liaise with Health Services for Older People and the Community (CARE) team, to ensure continuity of care for their clients

Maori Services

Three teams provide a comprehensive range of services for Maori consumers. A post acute inpatient rehabilitation service consisting of sixteen beds, known as Manawanui is located on the Carrington Hospital site. Some Consumers also attend on a daily basis to participate in the range of programmes offered there. These Kaupapa Maori services have the opportunity to provide leadership in the development of service delivery models that ensure good outcomes for Tangata Whaiora. A service redesign process is a priority for the year, as we need to address issues such as under utilisation of post acute beds and the lack of clear referral and discharge management processes.

Arahina is the community team, staffed by clinicians, which assesses, treats and manages clients in their homes and other community settings. The team provides cultural assessments as required. Te Puau Ora located at Panmure, is the Maori community support work team that supports people with mental illness to function safely and well within their community, without recourse to institutional care.

Specialist Services

Four independent specialist teams provide highly focussed services to people who reside in central Auckland and beyond. These have been redesigned in the last year to ensure service delivery is based on evidence of best practice.

Segar House is a well-established centre for psychotherapy services and offers individual and group treatment models. Staffed by a small multidisciplinary team of health professionals it has worked hard over the years to ensure that psychotherapy continues to be available within our service options. A residential component of the service has been developed this year and is operating very successfully.

Maternal Mental Health works with women who have a mental disorder prior to, during or after childbirth. It is mainly an acute service and provides an essential assessment and support service for Women's Services clients as well as accepting referrals from primary practitioners and our own service.

The Eating Disorders team, located in Ponsonby, provides an outpatient service with a small multidisciplinary team. They accept referrals from the sub-region and provide consultation services to Northland and education to Health Waikato.

The Community Neuro-behavioural Service is based on the Carrington site. The team provides assessment, treatment and support services for people with head injury, or intellectual disability, who have problems of challenging behaviour.

The aims of the services, and therefore the outcomes for consumers are varied, but our service is delivered in alignment with the recovery principles as defined by the Mental Health Commission, which means that the outcome we work in partnership with service users to achieve is that of recovery.

Service Capacity

In common with most other Mental Health Services throughout the country access levels are below the targets contained in the Mental Health Commission's Blueprint. The service operates predominantly as an acute service. The ADHB is unable to control demand for services and this demand generally exceeds the resources available.

During the 2002/03 year it is expected that pressure on all services will continue. The Acute Inpatient Unit has little option but to operate at undesirably high levels of occupancy. Lack of access to acute beds places demands upon the community centres to manage very unwell people in community settings. A shortage of suitable community based accommodation options extends length of stay at Connolly and "blocks" beds. Respite beds are used as alternative acute settings, rather than the purposes for which they were intended. The ADHB continues to work at a regional level to address these issues and is participating in the Acute Services regional project, the scope of which is to review and determine need in the region and develop collaborative arrangements for service delivery. .

People cared for in the community are more unwell and therefore demand more care and oversight as a consequence of the above situation. Whilst the number of contacts has increased overall the number of people able to access the service has decreased.

Services for children and adolescents are also poorly funded and demand outstrips the ability to respond. The Ministry has funded the development of a regional strategy for Child and Youth services to address this issue.

Because of the publicity surrounding mental health there is a higher public expectation that more mental health services will be available. This may result in demand increasing at a greater rate than the growth in the services can sustain.

The Crown sets minimum access criteria and quality standards, and defines the range of publicly funded services (Service Coverage Requirements), which will be provided by the ADHB mental health service. In this context there is a commitment to meet the National Blueprint for mental health services over the medium term, and a requirement to apply consistent national funding and pricing frameworks based upon a common costing methodology.

The National Mental Health Standards issued in 1997 continue to underpin our service delivery, although as yet it has not been defined how they will be used in the future structure. The service provided by the ADHB has achieved compliance with these standards.

Under these service coverage agreements ADHB Mental health services provide services to the population of Central Auckland and in addition provide service to other District Health Boards through regional or sub-regional contracts. At the present time our arrangements are:

- Buchanan Rehabilitation Centre (for Waitemata)
- Manawanui Maori Mental Health Services (for Waitemata and Northland)
- Psychotherapy Services at Segar House (for Waitemata)
- Eating Disorders Services (for Waitemata, South Auckland and Northland)
- Behaviour Support Service (for Waitemata, South Auckland and Northland)
- Child and Family Unit provides services for children and adolescents from the Northern and Midland regions

The acute beds at Connolly unit are part of a regional resource and there is ongoing pressure from South Auckland and Waitemata whose clients are entitled to admission to Connolly, particularly the ICU. This creates problems for our own community teams who are unable to access beds and it is difficult to ensure successful transition for out of area service users who re-enter their local community, after an inpatient episode.

Other District Health Boards

Each of the District Health Board Mental Health Services is highly motivated to achieve an equitable allocation of revenue for acute beds and community services. All would agree that management of service provision at a local level is desirable and regional co-operation is essential.

Increasing co-operation is emerging evidenced by the extent to which providers are working together on projects and planning around regional and national service priorities and service delivery models. In the last year a DHB Provider Forum was established and the basis for collaboration has been agreed.

Each District Health Board holds contracts for regional services. For example, ADHB has sub-regional Eating Disorders, Psychotherapy, and Inpatient Rehabilitation Services while Waitemata DHB provides Forensic and Drug and Alcohol Services on this basis.

Revenue enhancements are generally achieved as a consequence of allocation decisions made by the Ministry, and equity across the region is a main principle. There is minimal competitive bidding for work, but increasingly the NGO sector is competing for services, particularly for day programme and high intensity residential care provision, and in the area of Child & Youth service provision.

The MOH has been made aware of the areas where a lack of competition constrains effective service delivery. This is most evident in the area of dual diagnosis. While we do not have a contract to provide drug and alcohol services a high percentage of our service users present with a Dual

Diagnosis. This compromises our ability to provide seamless treatment options, and in many instances delays recovery. While the principle of collaboration exists, the logistics involved in “shared care” on occasion compromise the service user.

NGOs

Under the DHB structure close working relationships have been established with NGOs to develop collaborative rather than competitive service delivery arrangements. These enable a focus on consumer recovery through provision of seamless support.

NGOs (Te Korowai Aroha, Richmond Fellowship, Framework Trust) are important providers of supported accommodation and rehabilitation services, on whom we depend to facilitate discharge and ongoing care. Further collaboration and co-operation is required to ensure that their services develop to meet the needs of our consumers. We anticipate that we will develop further subcontract and shared care arrangements with them in the coming years.

General Practitioners

GPs see the majority of people with mental health problems and yet there is no liaison service currently available to them, nor is there any formal process for increasing their knowledge and understanding of mental illnesses and their treatment.

Improving links with GPs is part of the role of the Clinical Coordinator for the Community Mental Health Centres, where informal relationships are frequently good, but formal systems for communication and support are lacking. The ADHB will consolidate existing relationships and build new relationships on the basis of evidence of good practice identified in this area. The ADHB will also work closely with the IPAs, particularly ProCare in this regard.

It is recognised that mental health consumers are more time consuming and can be disruptive to the GPs. The ADHB service has participated in the national pilot shared care project where patients are jointly managed by general practitioners and the mental health service. This project recently received further funding to assist this process.

Other Parts of the ADHB

Mental Health provides services to other parts of the ADHB. These include Liaison Psychiatry Services to the hospitals. The Liaison Psychiatry Service on the Grafton site includes a crisis service in the Emergency Department. This team of people is available from 8am to 11pm and provides the psychiatric input to all individuals presenting at the Emergency Department - including all suicide attempts. Team members provide mental health expertise to the transplant teams as well. There is an increased demand for the liaison service particularly from increasing tertiary and quaternary activity. We have acquired some additional revenue for the service through an internal service billing agreement for this type of support.

With the shortening of post-natal stays in Women's Services, Maternal Mental Health services have become a more important part of post-natal care.

ACC

A developing partner is the Accident Compensation Corporation, particularly in the area of people with head injuries with associated behavioural problems or those who have been subjected to some form of abuse.

Clinical Training Agency (CTA)

The ADHB works closely with the CTA with whom there are three contracts. Recent improvements in management of registrar training across the region have met with CTA approval and an increase in the number of places for the new Graduate Nursing Programme has been welcomed. This has enhanced our relationship and enabled effective workforce development.

Objectives

The Mental Health Service Provider Operating Plan has been developed in alignment with the strategic goals and objectives that have been agreed for ADHB as a whole. In addition the ADHB will progress the strategic direction for the mental health service through a collaborative approach, which is inclusive of National Mental Health policy goals and the regional plan, which informs the process. The Regional 5 year strategic plan will inform the development of our strategy as a key service provider.

Funding approaches

The Government has committed additional (Blueprint) money to mental health service delivery over the coming two years, and has nominated the responsiveness of mental health services as one of five priority service delivery areas for the short to medium term.

Mental health funding will remain "ring-fenced" and funding approaches will continue to be in line with the national strategy outlined in the MOH documents "Looking Forward" and "Moving Forward". The focus will be on delivering specialist mental health services for people with the most serious mental health disorders. Prioritisation processes will reflect both national and local priorities and will be based on local population characteristics, identified need and the size of the gaps between existing local service levels and Blueprint benchmarks. Key priority areas for funding are Maori Mental health, Pacific Island and child and youth services.

The Mental Health Commission's guidelines to DHBs recommending regional mental health networks have informed development of a collaborative approach to funding mental health services within Auckland and with Northland. At present there is a regional mental health DHB funder network that includes the NDSA mental health team and each mental health funder in participating DHBs. This group work together to optimise use of a critical mass of scarce expertise, support regional linkages and ensure regionally consistent approaches to planning, prioritisation, funding and monitoring services where a regional approach is considered appropriate. This team has

developed a regional funding plan, which has been submitted to the DHB CEO's for approval.

The service is aligned with the plans set out in the Regional Mental Health plan that covers the next five years. From a Mental Health Funding perspective the following strategies and development initiatives are required in 2002-03:

- Develop the regional network
- Comply with legislated requirements to develop a 5-10 year strategic plan and consult with the community
- Comply with MOH Funding Agreement performance measures and legislated requirements to monitor funded services inherited from MOH
- Meet requirements to commit additional Blueprint Funding to service delivery in line with national and local priorities
- Prepare for introduction of the Population Based Funding
- Improve equity in access to services across DHBs
- Enhance flexibility of Drug and Alcohol Services
- Enhance regional consistency and integration between services
- Enhance flexibility of Residential Rehabilitation Services
- Enhance integration and effectiveness of acute services

Work will be completed in partnership with the regional group to ensure these tasks and functions are achieved.

Service Monitoring

The Mental Health Commission continues to report directly to Parliament and acts as a watchdog to monitor the performance of the sector in the delivery of mental health services. The ADHB works closely with them in the development, delivery, and review of services

In November 1997, the Commission produced a working document entitled *Blueprint for Mental Health Services in New Zealand*. The blueprint was developed as the Commission's statement of mental health service developments required for implementation of *Moving Forward*. This is the strategy that requires mental health services to be delivered to the 3% of adults and 5% of children and young people who are most severely affected by mental illness in any one month, while the Blueprint gives guidance on how this can be achieved. The Commission has recently produced an update report that identifies key areas for both purchasers and providers to focus on, and makes broad recommendations regarding future funding priorities.

The Commission has recently reiterated their concern that despite Mason and Blueprint funding of service development there are still gaps in core service provision. Further investment will be required in the areas of Child & Youth and Maori and Pacific Peoples services to meet the Blueprint targets for service access.

Regional Issues

The ADHB is in the process of an organisational culture and process/systems change designed to foster collaboration and achieve agreed health sector goals. This approach will be consistently reflected in all the activities of the Mental Health Service.

At a regional level we need to focus on developing a process to ensure key internal and external stakeholders are encouraged to participate in future needs assessment, the development and implementing of a transparent priority setting process for resource allocation, service development, and service monitoring and evaluation. In the absence of a regional network through which to facilitate this approach a DHB Provider forum/development group has been established to speed the process up. In addition there are close working relationships with NGO's, the NDSA and MAPO. To date the regional DHB provider forum members have agreed to collaborate to:

- Avoid unnecessary duplication
- Manage shared interests in many national projects
- Ensure a simple streamlined approach to service deliver, workforce issues and future planning
- Establish regional project teams that have an appropriate skill mix and representation to progress development of clinical pathways.
- Participate in regional strategic planning activities to ensure consistency and equity of services for the benefit of consumers.

4.4 Strategies and Initiatives

In addition to the initiatives list below the ADHB will manage normal business activities through the year. These include the management of initiatives that have been previously reported as part of prior District Annual Plans. The listing below covers the ADHB funder, provider and support service initiatives that will be undertaken over the plan period. These initiatives form part of individual performance plans and project processes such as the Change Programme so as to provide the operational basis for the work to be completed.

Strategy/Objective	Initiative/Programme	Time frame
Get control of our finances		
1. Manage costs to reduce deficit in all services	<ul style="list-style-type: none"> • Manage volumes to within permitted contracted levels • Ensure accurate coding occurs to support revenue recognition and contract management • Ensure data is obtained for all Section 88 claims to assist cost profiling and recovery from other DHBs where appropriate • Control all costs within approved budget levels • Secure the remaining \$10 million savings required to achieve a \$61 million deficit • FTE levels to be kept at or below budget levels • Implement systems for tracking cost savings 	June 2003
2. Reduce inefficiencies	<ul style="list-style-type: none"> • Each service to select one process to review for further cost savings • Implement approved project and achieve approved savings 	November 2002 June 2003

Strategy/Objective	Initiative/Programme	Time frame
3. Prioritisation	<ul style="list-style-type: none"> • Agree national prioritisation framework with MOH and implementation pathway • Complete investment /disinvestment reviews using framework • Establish a Prioritisation Advisory Group for new funding initiatives. 	June 2003
4. PBF and Inter-district Flows preparation and management	<ul style="list-style-type: none"> • Complete regional and national processes for move to PBF and the management of IDFs <ul style="list-style-type: none"> ✓ Agree business rules with MOH ✓ Agree volume and access levels with other DHBs or MOH depending on Crown funding path adopted under PBF ✓ Establish business systems to support IDF management 	June 2003
5. Acute Care Management	<ul style="list-style-type: none"> • Establish joint Venture Primary/ Secondary Care for children and adults. • Develop and implement tools to manage acute growth and appropriate hospital admissions. 	June 2003
6. Review of Community Laboratories and Pharmacies.	<ul style="list-style-type: none"> • Develop and implement a strategy for regional and local management of referred services expenditure 	June 2003
7. Change Programme	<ul style="list-style-type: none"> • Develop and maintain process for tracking benefits centrally for ADHB • Manage programme costs within budget 	September 2002 to June 2004
8. Financing	<ul style="list-style-type: none"> • Manage debt/equity requirements in accordance with planned cash flow projections • Secure appropriate Crown equity and debt financing to support all capital and deficit requirements for the next three years 	September 2002 to June 2005
9. Costing System	<ul style="list-style-type: none"> • Implement a costing development project to provide greater knowledge of costs • 	June 2003 June 2003
10. ACC funding	<ul style="list-style-type: none"> • Review specific services for potential increases in ACC funding • Prepare and submit contracts 	June 2003
11. Address pricing deficiencies	<ul style="list-style-type: none"> • Support the national process to develop and maintain a nationally agreed price schedule to be used for inter-district flow pricing under PBF and to inform DHB pricing in support of sustainable service delivery. This will also provide a mechanism to address other specific issues: <ul style="list-style-type: none"> ✓ Service specifications ✓ Cost Weights ✓ The treatment of community services ✓ Rural adjusters ✓ Structure of maternity pricing ✓ Transport & Accommodation 	Complete minimum work required for introduction of PBF by June 2003 Complete a comprehensive update of pricing by June 2004
12. Win back external customers for support services	<ul style="list-style-type: none"> • Visiting any lost customers to investigate reasons for loss • Actively pursue winning back old business. 	June 2003
13. Community laboratory contract for LabPlus	<ul style="list-style-type: none"> • Determine whether a community contract should be granted • Consult with other DHB laboratories to understand key issues in provision of this service 	June 2004
14. Collaboration with neighbouring DHBs	<ul style="list-style-type: none"> • Collaborate with neighbouring DHBs on issues agreed for the Greater Auckland Collaboration and in individual service areas where common interests exist • Communicate regularly on common issues, exploring solutions to areas of mutual concern, working together to resolve them (e.g.: regional IT solution for Pharmacy). 	June 2003
15. Supply chain management	<ul style="list-style-type: none"> • Complete the standardisation of inventory management processes 	March 2003

Strategy/Objective	Initiative/Programme	Time frame
16. Workforce Management Plan	<ul style="list-style-type: none"> • Analyse current workforce and historical trends of recruitment, retention and training • Prepare a plan that aligns with: <ul style="list-style-type: none"> ✓ ADHB District Strategic Plan ✓ New organisation structure, roles and work processes being implemented as part of the Change Programme ✓ Health Alliance regional workforce management strategies ✓ National health workforce management strategies and initiatives (including DHBNZ, MOH, HWAC, Schools of Medicine, Colleges, Universities and Polytechnics) ✓ Action plan to address capability gaps 	Plan completed by September 2003.
17. Recruitment & HR Administration Centre	<ul style="list-style-type: none"> • Map and analyse current recruitment processes and costs • Develop an organisation-wide recruitment policy, with associated procedures, accountabilities and training programmes • Align with proposed 24-Hour Centre • Review recruitment centres in the health sector and non-health businesses to identify best practice • Explore potential for aligning the ADHB RAC with the Health Alliance "Transaction Centre" to enable future integration or cost-sharing • Identify resourcing requirements • Determine information system requirements • Develop a transitional integration plan between the RAC and payroll and rostering services • Develop an overall implementation plan for the establishment of the RAC 	Complete analysis of requirements by October 2002 Establish RAC by March 2003 Implement new HR information systems by June 2004
18. ER Strategy	<ul style="list-style-type: none"> • Concurrently review current and future business requirements, and the potential changes required in CEAs/IEAs • Review all current CEAs and IEAs in terms of identifying problem areas, anomalies, inconsistencies, etc • Work with healthAlliance to better understand their ER strategy and associated CEAs/IEAs 	ER strategy and implementation plan completed by February 2003
19. Remuneration and Recognition Policy	<ul style="list-style-type: none"> • Agree remuneration and recognition philosophy and positioning • Review current remuneration policy and improve alignment to needs of business • Review and compare remuneration structures in IEAs and CEAs • Investigate opportunities for non-monetary recognition • Benchmark current ADHB remuneration policy against public and private health sectors • Integrate the policy with the Performance Management processes • Develop implementation plan developed to emphasise the education of managers, clinicians and staff on reward and recognition processes 	Implementation plan completed by February 2003
20. Performance Management	<ul style="list-style-type: none"> • Implement a performance management process that is linked to remuneration and people development policies and processes for dealing with poor performance: <ul style="list-style-type: none"> ✓ Review of the current performance management policy and processes to identify areas for improvement and its linkages to annual business planning ✓ Integrate the process with the Remuneration Strategy ✓ Integrate with Learning & Development Strategy ✓ Clear processes to confront and deal with poor performance ✓ Implementation Plan developed to emphasise the education of managers, clinicians and staff on enhanced performance management and rewards and recognition processes 	Implementation plan completed by February 2003

Strategy/Objective	Initiative/Programme	Time frame
21. People Development	<ul style="list-style-type: none"> Review current learning and development activities provided by ADHB (including any specialised clinical and technology areas) as they relate to meeting ADHB's future business requirements Identify future management skills and knowledge required and undertake an audit of current management resources Evaluate potential integration or working with healthAlliance and/or joint ventures with other organisations in leveraging the provision of leadership and management development programmes Develop an Implementation Plan (with phased stages) that includes leadership and succession development and has an appropriate structure 	People Development Plan completed by June 2003
22. Occupational Health and Safety	<ul style="list-style-type: none"> Measure current OSH performance and benchmark against health sector Review all current OSH policies and procedures, and associated support services relative to future business and organisational needs and benchmark against industry practice Identify and evaluate best practice service delivery options Develop an action plan to improve ADHB's employee health and safety performance 	OSH performance improvement plan to be completed by March 2003
23. People Information Management	<ul style="list-style-type: none"> Review and identify ADHB's medium to long term people information requirements Identify and evaluate best practice HRIS options in and outside the health sector Investigate possibilities of integrating HRIS services with Health Alliance. 	Implementation plan agreed by March 2004 Implementation completed by June 2004
24. Rostering	<ul style="list-style-type: none"> Rescope the project and seek authorisation for capital required Implement pilot for Women's Services Implement full system 	June 2003 September 2003 December 2004
25. Leave management	<ul style="list-style-type: none"> Reduce outstanding leave balances by 10% 	June 2003
Make the change programme happen		
26. Funding	<ul style="list-style-type: none"> Ensure funding matches change initiatives 	June 2004
27. Human resources	<ul style="list-style-type: none"> Ensure staff that are affected by restructuring as part of the Change Programme are treated with respect in compliance with ADHB HR principles. 	June 2003
28. Concepts	<ul style="list-style-type: none"> Complete the preliminary Concept Design and present to the CEO/COO and Board Subcommittee Validate the business case through an opportunity analysis Confirm process for communication with the Auckland public regarding the proposed changes Initiate planning for the Detailed Design Phase 	July 2002
29. Analysis	<ul style="list-style-type: none"> Complete analysis to confirm HBO and service customisation of processes Confirm impact of the new buildings on modified designs 	September 2002
30. Design completion	<ul style="list-style-type: none"> Complete Detailed Designs for each HBO Identify and prioritise designs that can be implemented after the Building's Opening Day Confirm integration plans with the information system projects 	October 2002
31. Pilots	<ul style="list-style-type: none"> Initiate pilot and implementation sequencing & planning Plan integration with the Building Programme's migration efforts 	November 2002
32. Benefit tracking	<ul style="list-style-type: none"> Complete baseline and benefits tracking process 	January 2003
33. Pilot completion	<ul style="list-style-type: none"> Track pilot results Complete pilot modifications where necessary 	February 2003
34. Roll out	<ul style="list-style-type: none"> Initiate roll out of pilots and begin implementation of new processes 	March 2003

Strategy/Objective	Initiative/Programme	Time frame
	<ul style="list-style-type: none"> Capture results Roll out Theatre system and Orion Concerto Framework 	
35. Migration support	<ul style="list-style-type: none"> Participate in migration of services into new Facilities Obtain sign off for second scope Begin data gathering and conceptual design for second scope 	July to October 2003
36. Conceptual design	<ul style="list-style-type: none"> Continue conceptual design – second scope 	August 2003
37. Design review	<ul style="list-style-type: none"> Review detail design and building new processes and systems 	January 2004
38. Accreditation Survey	<ul style="list-style-type: none"> Undergo a full accreditation survey by Quality Health NZ in 2003 Train services in the 2001 Accreditation Standards Prepare the required documentation for Survey Undergo the survey in March 03 Implement any recommendations from the survey Prepare for Progress survey 2004 and full resurvey 2005 	June 2003 June 2005
39. Credentialing completed	<ul style="list-style-type: none"> The credentialing of units / services is completed. 	Jun 2003
40. Safety Focus within the services	<ul style="list-style-type: none"> All services develop and implement a Safety focus programme that incorporates medico-legal requirements, accreditation standards, consumer rights, legislative compliance and risk management An evaluation survey of quality practices / environment is completed by June 03. The evaluation survey is repeated annually and result compared 2003-05 	June 2003 June 2003 June 2005
41. Benchmarking	<ul style="list-style-type: none"> Appropriate benchmarking occurs within the services to ensure best practice, processes and performance. Key benchmarking projects are identified and completed for the services Maintain involvement in SEAHBC for Casemix benchmarking and selected Patient Satisfaction surveys. National and international benchmarking projects are considered according to their value to services 	June 2003 June 2005 2002/05
42. Service Quality Groups	<ul style="list-style-type: none"> Undertake process improvement activities to improve delivery of care or service. Annual Quality plan nominates a delivery of care or service process improvement to be undertaken Local initiatives to be reviewed against organisational wide initiatives for benefits to patients The process improvement should meet one of the 4 ADHB priorities 	June 2003
43. Develop integrated systems, including information systems	<ul style="list-style-type: none"> Integrated scheduling of outpatient appointments, where appropriate & beneficial Support implementation of Exact into Middlemore, and then integration of Exact at both sites into wider ADHB systems 	June 2004
Finish the building programme		
44. Design and procurement	<ul style="list-style-type: none"> Design building, assess requirements for new equipment and engage contractor 	July 2002 to December 2002
45. Complete construction of buildings	<ul style="list-style-type: none"> Grafton - Auckland City Hospital Greenlane Clinical Centre - new buildings Greenlane Clinical Centre - building 4 refurbishment Children's services enhancements Acute mental health building 	October 2003 September 2003 October 2004 October 2003 January 2003
46. Migration	<ul style="list-style-type: none"> Complete migration scoping and planning Manage progressive migration to new premises Implement a risk management programme 	October 2003 From June 2003 June 2003
47. Manage Acute	<ul style="list-style-type: none"> Determine factors associated with acute demand, bed 	December 2002

Strategy/Objective	Initiative/Programme	Time frame
demand to support move to fewer beds	<ul style="list-style-type: none"> management, capacity and resources. Review the "Winter Workload" strategies of past years and implement appropriate actions Investigate and implement strategies to manage ED admissions, Social Admissions and Length of stay 	
48. Manage ED attendance	<ul style="list-style-type: none"> Develop a graduated response methodology Implement strategies Evaluate 	June 2003
49. SREA	<ul style="list-style-type: none"> Co-ordinate changes with other DHBs Implement recommendations Measure impacts to ADHB 	June 2003 June 2004 June 2005
50. Improve the Primary / Secondary interface	<ul style="list-style-type: none"> Assess potential areas for concern between primary and secondary providers Monitor complaints for issues related to exchange of information Create formal links between the primary and secondary sectors 	June 2003 June 2005
51. Align Services with end-state	<ul style="list-style-type: none"> Create efficiencies through pooling and sharing of equipment and resources 	June 2003
Lift the health performance of Aucklanders		
<i>Reflect our Treaty of Waitangi responsibilities within the framework of the NZPHD Act</i>		
52. Patients and Staff	<ul style="list-style-type: none"> Improve the accessibility and cultural sensitivity in all services: <ul style="list-style-type: none"> ✓ Implement Kai Atawhai Service ✓ Support He Ara Puta (discharge planning) ✓ Reduce barriers to access ✓ Collect and publish ethnicity data to ensure awareness of client base is raised among clinicians ✓ Increase numbers of clinical and non-clinical Maori staff ✓ 60% Level 4 Staff attendance at Advanced Treaty of Waitangi Workshop 	July 2002 July 2002 June 2003 December 2002 July 2002 June 2003 Dec 2002
53. Maori staff receive appropriate cultural guidance & supervision	<ul style="list-style-type: none"> All Maori staff have access to cultural supervision All Maori staff are supported to attend regular hui of Te Roopu Whakamaru, a support group for Maori staff Maori staff attend Kaunihera Kaumatua (Chief Advisor Tikanga) as appropriate 	June 2003 June 2003
54. To increase the number of Maori Health Care Professional staff	<ul style="list-style-type: none"> Maori staff have access to a targeted Workforce Development for Maori Health Gain fund Participate in a project to identify competencies & standards for Maori Community Health Workers Work with He Kamaka Oranga and the AD Nursing (Maori) to identify effective methods of recruitment of Maori health professionals 	June 2003 June 2005 June 2005
55. All staff demonstrate an awareness and understanding of the Treaty of Waitangi and Maori Tikanga	<ul style="list-style-type: none"> All new staff attend a Treaty of Waitangi workshop within 6 months of their employment (if not previously attended) Tikanga Recommended Best Practice guidelines continue to be applied across the service Maori client focus groups are facilitated regularly Agreed protocols with Maori providers continue to be applied and reviewed as necessary 	June 2003 June 2003 June 2003 June 2003
56. Clients of the Child Development and NASC teams receive a culturally appropriate service wherever possible	<ul style="list-style-type: none"> Establish (NASC) an arrangement with Te Whare Ruruhau o Mere for the provision of a Kaumatua counselling service and/or specialist assessment service Establishment both by NASC and Child Development Team of an effective collaborative relationship with the Maori DEAS group 	June 2003
57. Provider liaison	<ul style="list-style-type: none"> Implement proposal to for Sexual Health to work with iwi providers in South Auckland 	June 2003
58. Mortuary services	<ul style="list-style-type: none"> Work with NZ Police and the Department for Courts, use the 	Ongoing

Strategy/Objective	Initiative/Programme	Time frame
	Forensic Post Mortem Services Governance Meeting to receive Maori feedback to improve Mortuary services to Maori	
59. Rheumatic fever pilot	<ul style="list-style-type: none"> Work with He Kamaka Oranga and implement the findings of the Children's Services Rheumatic Fever Pilot. The focus being to provide a more culturally appropriate model of service provision that interfaces proactively with community and primary care. 	June 2003
<i>Reduce inequalities</i>		
60. Reduce incidence & impact of diabetes	<ul style="list-style-type: none"> Establish Diabetes Leadership Group Determine project management requirements Complete stocktake Confirm approach around target groups Confirm provider group linkages and support for target strategy Target existing resources to target groups including <ul style="list-style-type: none"> public health leveraging implementations already underway by other DHBs South Auckland discussions for IT, training, clinical protocols Consider additional resource opportunities/requirements Implement agreed strategies 	June 2003 August 2002 September 2002 October 2002 June 2003
61. Reduce the impact from Cancer	<ul style="list-style-type: none"> Renegotiate contract for the National Cervical Screening Programme Identify reasons for non-attendance at lung cancer clinics Improve access for Maori by collaboration with iwi groups and primary care providers 	December 2002 June 2005
62. Reduce smoking	<ul style="list-style-type: none"> Rollout smoking cessation service Implement a progressive smokefree policy on ADHB premises 	June 2003 June 2004
63. Reduce obesity	<ul style="list-style-type: none"> Prepare case for weight reduction surgery (laparoscopic banding) for patients with obesity related ventilatory failure. 	June 2003
64. Reduce cardiovascular disease	<ul style="list-style-type: none"> Determine regional cardiac catheter lab requirements and the provision of service Manage growth in acute and elective CTSU and vascular volumes within budget Optimise utilisation of cardiosurgical capacity within budget Implement education programme for cardiovascular risk with interface between secondary/ primary care providers Identify research opportunities into basic mechanisms, novel therapies and clinical trials 	June 2003
65. Multi agency centre	<ul style="list-style-type: none"> Commission the opening of the Multi-Agency Centre for child and youth sexual and physical abuse (this is an intersectoral project between Health, CYFS, Police and the community) 	November 2002
66. Child health - collaboration	<ul style="list-style-type: none"> Work co-operatively with Waitemata DHB on the plans for General Paediatric Service provision for the children of North and West Auckland 	June 2003
67. Family Violence Guidelines	<ul style="list-style-type: none"> Family Violence Liaison joint venture between primary/ secondary with placement of a liaison officer in Women's Services Respond to RFP for additional funding for implementation of Family Violence Guidelines Implement Family Violence Guidelines with primary, secondary and tertiary providers 	December 2002 October 2002 June 2003
68. Oral Health	<ul style="list-style-type: none"> Review existing child, young people and elder person oral health status in the district and service availability Work with Waitemata DHB to ensure children and young people in Auckland DHB have access to oral health services Implementation of the new oral health strategy, and new oral health contracts 	September 2002 June 2003 June 2003
69. Mental health	<ul style="list-style-type: none"> Improve access to services and equity of access 	June 2003

Strategy/Objective	Initiative/Programme	Time frame
	<ul style="list-style-type: none"> • Improve service quality • Improve integration between linked services and primary and secondary services subject to available funding • Increase stakeholder participation in planning and service development, including network development • Develop and implement a funding decision framework across the region 	
70. Reduce health disparities between Pacific peoples and non Pacific peoples	<ul style="list-style-type: none"> • Promote culturally appropriate service delivery • Appoint a Pacific Island Liaison person • Improve collection of ethnicity data to identify Pacific service users • Work with the ADHB Pacific Health team to ensure that service provision to Pacific people is delivered in a culturally appropriate manner • Pacific Health Schedule to be adopted by all HBO units • Ensure mainstream contracts reflect Pacific health priorities • Review possible joint venture with Auckland City Council and other agencies with focus on Glen Innes • Scope a Pacific PHO initiative for ADHB • Ensure protocols are in place for Pacific Primary Care providers to participate in Discharge planning process of Pacific clients referred to their services 	<p>June 2005 June 2003</p> <p>December 2002</p>
71. Disability services	<ul style="list-style-type: none"> • Sustain DiSAC work programme of engaging with community providers • Complete population review in collaboration with other Auckland DHBs • Prepare for the devolution of older person services from the MOH 	<p>June 2003</p> <p>March 2003</p> <p>June 2002</p>
72. Ensure services are acceptable to new migrants and refugees	<ul style="list-style-type: none"> • Work with community groups to address needs in service delivery • Determine highest priorities and implement at least one initiative 	June 2003
73. Reduce barriers to access for primary services	<ul style="list-style-type: none"> • Review transport availability, culture and language barriers and model of care • Prepare a plan and assess priorities 	December 2002
74. Suicides	<ul style="list-style-type: none"> • Identify strategies to reduce the rate of suicides and suicide attempts and implement practical solutions in collaboration with other agencies where indicated 	June 2005
75. Improve performance of screening programmes	<ul style="list-style-type: none"> • Develop processes to reduce number of DNA's in colposcopy • Implement domestic violence screening 	<p>September 2002</p> <p>October 2002</p>
76. National Paediatric Service	<ul style="list-style-type: none"> • Contribute to and lead where necessary National Paediatric Service requirements, in conjunction with the Ministry of Health i.e. Paediatric Neurology, Paediatric Sleep Services. This includes leading New Zealand as its primary centre for paediatric research 	June 2003
<i>Strengthen Primary care sector</i>		
77. Develop relationship with primary providers	<ul style="list-style-type: none"> • Improve communication between clinicians to maximize care provision and reduce duplication 	December 2002
78. Primary Health Care Service	<ul style="list-style-type: none"> • Implement PHO development strategy with establishment in priority areas i.e. Glen Innes, Mt. Roskill/Avondale • Move to capitation of GPs in Auckland region • Manage referred services expenditure for pharmacies and laboratories. • Develop models for integrating primary, secondary care for 	June 2004

Strategy/Objective	Initiative/Programme	Time frame
	people with multiple and complex needs, particularly children, young people and, older people.	
79. Develop relationship with primary providers	<ul style="list-style-type: none"> Ensure primary providers are involved in discharge planning and policy development Ensure He Ara Puta is supported and rolled out to all areas 	June 2003
80. Developing relationships	<ul style="list-style-type: none"> Build more effective relationships with Waitemata DHB's School Dental Service to reduce referral volumes of children requiring treatment under general anaesthesia Complete greater Auckland collaboration agreement with other DHBs in the region and begin implementation of initiatives 	June 2004 June 2003
<i>Improve quality and safety of services</i>		
81. Risk management	<ul style="list-style-type: none"> Compliance with all appropriate regulations (e.g. Privacy) Credentialing of all medical clinicians Create development plan for clinical pathways 	June 2003 June 2004 June 2003
82. Reducing waiting times for public hospital elective services	<ul style="list-style-type: none"> Identify current performance issues Implement plan to rectify identified issues 	December 2002 June 2003
83. Improve safety and quality	<ul style="list-style-type: none"> Quality improvement integrated into all operational activities Raise staff awareness through orientation, training of health and safety representatives and the pre-employment Health Assessment Programme Manage health and safety risks through identifying occupational hazards, monitoring staff training, ensuring OOS prevention and back management, workstation assessments, and encourage workplace exercise programmes Manage workplace hazards by supporting health and safety representatives and also implementing changes to workplace hazards which have been identified Maintain accreditation status 	June 2004
84. Neurology service	<ul style="list-style-type: none"> Work co-operatively with Auckland Neurosurgical Service and Waikato to ensure the continuation of appropriate paediatric Neurosurgical Services. 	June 2003
85. Child Health	<ul style="list-style-type: none"> Implementation of National Framework for Well Child Services through all Well Child providers collaborating together on implementation. Women's Services and Birthcare progress to full implementation of Baby Friendly Hospital Initiative (Birthcare looking for full accreditation in 2002) Establish and maintain local Child & Youth Mortality Review in collaboration with regional DHBs. Intersectoral Committee/ Working group to feed to national committee on specific deaths i.e. youth suicide, SIDS etc. 	June 2003 June 2002 March 2003 June 2003
<i>Provide integrated primary care/health promotion child health services and collaborate effectively with other providers and other sectors</i>		
86. SREA	<ul style="list-style-type: none"> Continue the inter-district planning and development of services with other DHBs Develop strategic relationships with other providers 	June 2003
87. Implement the new Well Child Framework	<ul style="list-style-type: none"> Collaborate with Well Child Providers to facilitate a common understanding of the Framework and agree a plan 	June 2003
88. Provide effective personal health and public health services to children and their families	<ul style="list-style-type: none"> Develop a regional Refugee Community Health Work Service (Public Health) in collaboration with other refugee services and government agencies e.g. Housing, WINZ Ensure that interpreter services are available wherever indicated Actively participate in Refugee Services sub/working groups of 	June 2003 June 2003 June 2003

Strategy/Objective	Initiative/Programme	Time frame
from refugee backgrounds	Strengthening Families programme	
89. Take a leading role in representing health needs in the Auckland City Strengthening Families programme	<ul style="list-style-type: none"> All healthcare professional staff undertake Strengthening Families training Cases are referred to Strengthening Families according to the interagency guidelines Community Child Health & Disability Service is represented on both the Strengthening Families Core Management Group and the Steering Group 	June 2003
90. Family violence	<ul style="list-style-type: none"> Implementation strategies to meet the national guidelines for minimising family violence 	June 2004
91. Participate in local and regional planning and service development initiatives (including intersectoral)	<ul style="list-style-type: none"> Contribute to the development of an ADHB Child Health Status Report Work collaboratively with Children's Services on an enuresis programme Participate in the Child & Youth Health Steering Group (3 Auckland DHBs) 	June 2003 June 2003 June 2005
<i>Services provided demonstrate a commitment to evidence-based practice and continuous quality improvement</i>		
92. Maintain an environment of continuous quality improvement	<ul style="list-style-type: none"> Achieve accreditation with Quality Health NZ Gain meaningful client feedback on services and review services accordingly Both clinical and non-clinical risks are identified with appropriate action taken, and monitored 	June 2003 June 2003 June 2003
93. Service delivery is evidence-based wherever possible	<ul style="list-style-type: none"> Staff involvement in relevant research is supported Current practice and proposals for service development are based on relevant current literature and research results Maintain current clinical pathways e.g. Food with Attitude and explore opportunities for new projects 	June 2003 June 2003 June 2003
<i>Disability Support Services provided are consistent with the NZ Disability Strategy</i>		
94. Regional model for the integration of Respite Care	<ul style="list-style-type: none"> Regional model for the integration of Respite Care with NASC is developed and successfully implemented: Work collaboratively with the MOH and other Auckland DHBs on the development of a model which provides greater flexibility to meet client needs Implement the new model with minimal disruption to services 	June 2003 June 2005
95. Effective relationships	<ul style="list-style-type: none"> Establish effective relationships based on partnership principles with relevant disability consumer groups and Maori and Pacific Island providers: Formalise relationships with the different DEAS groups Provide information and support to Maori and Pacific Island providers 	June 2003
96. Auckland area approach to service development	<ul style="list-style-type: none"> A wider Auckland area approach to service development is maintained to ensure consistent levels and types of service delivery: <ul style="list-style-type: none"> ✓ Review the effectiveness of the shared NASC position with WDHB and maintain if indicated ✓ A joint approach with other providers is taken to all service development initiatives and regular meetings are held with other DHB managers and other providers as relevant 	June 2004

5. Financial Statements and Reporting Information

5.1 Financial Statements

As previously noted the achievement of this Plan is dependent on available funding and careful cost management. The ADHB is under extreme financial pressure and incurred a deficit for the 2001-02 financial year of \$66 million. The ADHB's current financial position is unacceptable and will be addressed by actions to reduce costs to bring the organisation back to a viable path for the long term.

Even with the measures being implemented the projected Statement of Financial Performance contains deficits that exceeds the maximum deficit levels set out in the MOH instructions to the ADHB. This issue has in part been resolved by the MOH agreeing to support a higher deficit level for the 2002-03 year. The matter still requires further consideration for outer years.

It is also noted that the funding increase provided to the sector includes substantial new money for Primary Care initiatives. This Primary Care funding is at risk of being used to manage the deficit because the deficit must be paid for first. It is critical that we get our deficit under control in order that new Primary Care funding can be used for Primary Care services.

5.1.1 Capital Expenditure

ADHB continues to apply the business philosophy of investing (cash flow effect) in capital expenditure the equivalent of the depreciation expense within a 10-year time frame. Capital expenditure is front-loaded and is balanced by lower than average expenditure in the outer years to meet business demands.

The 5-year Capital Plan (excluding approved the Building Programme) is:

Baseline	2002-03	2003-04	2004-05	2005-06	2006-07
	\$000	\$000	\$000	\$000	\$000
Baseline	10,000	10,000	10,000	10,000	10,000
Oncology	5,760	3,200	0	0	0
Information Systems	11,655	11,900	11,150	10,650	9,150
Building Programme - FF & E	19,878	15,139	13,296	0	0
Total	47,293	40,239	34,446	20,650	19,150

Building Programme capital expenditure (including capitalised interest) in the Consolidated Projected Statement of Financial Position:

Building Programme	2002-03	2003-04	2004-05	2005-06	2006-07
	\$000	\$000	\$000	\$000	\$000
Building Programme	200,728	84,869	25,918	0	0

5.1.2 Funding

The 2002-03 budget and the out year forecast are based on the three year funding envelope issued by the MOH. This does not recognise the impact that a move to PBF may have on the financial projections for the two outer years.

At a summary level funding has been allocated to maintain volumes at 2001-02 performance levels with remaining funding allocated towards reducing the deficit. \$1 million of funding has been set aside from the ADHB provider arm funding to enhance primary care initiatives. This fund will be used to enhance project initiatives that support the implementation of the government's primary care strategy.

5.1.3 Efficiency and Effectiveness

The ADHB is making efficiencies through two key strategies:

- An immediate savings plan focused on cost reduction
- Planned savings from the Change Programme in support of the Building Programme

5.1.3.1 Immediate savings

There are savings of \$10 million to be achieved in order to reach the \$61 million deficit target for 2002-03 (\$63.5 million including the wage cost deficit support). Strategies have been developed to achieve this target including improvements in ACC claiming, realised benefits on sale of surplus property properties and investments and further operational savings

The ADHB is working to manage the potential for a deficit in the funder arm of approximately \$7 million that is included in the budgeted deficit. The projected deficit reflects high cost levels anticipated for referred services such as laboratories and pharmaceuticals.

A review of equity requirements has been undertaken to confirm the equity required to finance the operational deficit, baseline capital plan for equipment and information systems, building programme and enable the ADHB to at all times remain within its banking covenants. It is noted that the ADHB completed the 2001-02 year below the \$106 million equity cap.

5.1.3.2 Change Programme

The Change Programme is managing changes in organisation design and improvement in the systems and processes to enable the ADHB to utilise the full benefits of its move to the new facilities that are being built. The savings that arise from this programme are necessary to support the business case for the building programme, as the fixed costs associated with the operating infrastructure of the ADHB will increase as a consequence in this investment. The \$40 million savings per annum will be progressively realised over a four

year period. The portion relating to the three year period of this plan is included in the projected financial position that is set out below.

5.1.4 Financing

It is assumed that financing by equity support and external debt continues with a mix of Debt and Equity funding based on a Debt : Equity ratio of 65%.

Interest on borrowings related to financing major Capital Projects and the Building Programme capital investments is capitalised and not expensed through the Statement of Financial Performance. Interest incurred after commissioning is expensed. The banking covenant for interest times cover is 2 times. The forecast includes equity injections (treated as funding) to meet this covenant.

5.1.5 Projected Financial Statements

The Projected Statement of Financial Performance (PSFP) is based on a deficit of \$61 million for the 2002-03 year. This does not include the impact of further potential adjustments to eliminate the funder deficit of \$7million nor the inclusion of a site specific adjuster to compensate for the changing capital profile of the ADHB. An illustrated version of the PSFP is included below the main financial tables to assist a better understanding these additional factors.

AUCKLAND DISTRICT HEALTH BOARD Consolidated Projected Statement of Financial Performance	2001-02 Actual \$000	2002-03 Budget \$000	2003-04 Forecast \$000	2004-05 Forecast \$000
Operating Revenue				
Provider & Governance	634,719	655,556	684,949	709,050
Funder	203,131	218,217	219,348	224,114
Total Revenue	837,850	873,773	904,297	933,164
Operating Expenditure				
Provider & Governance	659,630	658,839	684,330	704,860
Funder	203,131	225,185	226,348	231,114
Total Operating Expenditure	862,761	884,024	910,678	935,974
Earnings before Interest, Depreciation and Capital Charge	-24,911	-10,251	-6,381	-2,810
Analysis by Division				
Provider & Governance	-24,911	-3,283	619	4,190
Funder	0	-6,968	-7,000	-7,000
	-24,911	-10,251	-6,381	-2,810
Less				
Finance Costs	4,242	6,035	19,428	27,352
Depreciation	27,337	30,408	45,600	53,500
Earnings before Capital Charge	-56,490	-46,694	-71,409	-83,662
Capital Charge	9,569	14,306	19,793	22,293
Deficit for Year	-66,059	-61,000	-91,202	-105,955

AUCKLAND DISTRICT HEALTH BOARD	2001-02	2002-03	2003-04	2004-05
Consolidated Projected Statement of Crown Equity Movements	Actual \$000	Budget \$000	Forecast \$000	Forecast \$000
Crown Equity - opening balance	82,634	85,541	173,628	207,532
Deficit for Year	-66,059	-61,000	-91,202	-105,955
Equity Injections				
Deficit - Cash & Covenants	35,000	64,069	84,200	99,000
Funder Arm Deficit	0	6,931	7,000	7,000
Building Programme	33,966	75,687	33,906	45,295
Baseline Fixed Assets greater than depreciation	0	2,400	0	0
	68,966	149,087	125,106	151,295
Crown Equity - closing balance	85,541	173,628	207,532	252,872

AUCKLAND DISTRICT HEALTH BOARD	2001-02	2002-03	2003-04	2004-05
Consolidated Projected Statement of Financial Position	Actual \$000	Budget \$000	Forecast \$000	Forecast \$000
Current Assets				
Bank & Deposits	12,109	1,728	2,312	155
Receivables and Prepayments	62,521	67,539	67,129	72,288
Inventory	5,891	5,891	5,891	10,890
	80,521	75,158	75,332	83,333
Current Liabilities				
Payables and Accruals	142,757	136,973	134,255	98,135
Borrowings	30,954	30,954	30,954	30,954
Funds held in Trust	670	670	670	670
	174,381	168,597	165,879	129,759
Net Working Capital	-93,860	-93,439	-90,547	-46,426
Non Current Assets				
Bank & Deposits	7,788	8,292	8,796	9,300
Fixed Assets	304,319	521,421	606,824	615,335
Investment in Associates	2,021	2,022	2,234	2,446
	314,128	531,735	617,854	627,081
NET FUNDS EMPLOYED	220,268	438,296	527,307	580,655
Non-Current Liabilities				
Payables and Accruals	13,241	13,745	13,745	4,753
Borrowings	121,486	250,923	306,030	323,030
	134,727	264,668	319,775	327,783
Crown Equity				
Crown Equity	337,888	486,975	612,081	763,376
Retained Earnings/Accumulated Deficit	-259,337	-320,337	-411,539	-517,494
Donations & Bequests	6,990	6,990	6,990	6,990
	85,541	173,628	207,532	252,872
NET FUNDS EMPLOYED	220,268	438,296	527,307	580,655

5.1.6 Assumptions in preparing the projected financial statements

The table below provides an understanding of the assumptions adopted in preparing the projected financial statements:

Assumption	2002-03	2003-04	2004-05
Vote health funding	As per funding package plus specific funding such as Blueprint mental health	Same	Same
Other income	Best estimate based on current information	0-1%	0-1%
Wage cost	Base assumption of 2% with economies to contain impact of increments and other CEC/preset increases	2%	3%
Other operating costs	2%	2%	3%
Capital works	As per the plan in 5.1.1	Same	Same
Change Programme savings	\$10 million	\$20 million	\$30 million
Interest costs (Note 1)	7.75%	Same	Same
Depreciation (Note 2)	As per accounting policies	Same	Same
Population growth	Same as growth in Crown funding path	Same	Same
Change in population (age & gender adjusted)*	1.3%	Same	Same
Growth in acute inpatient & day patient demand (CWDs)*	3%	Same	Same
Bed occupancy rate (Average over the year)	85%	85%	85%
% Day case to total discharges (excluding outpatient services as defined by the standard MOH filer)	38%	40%	42%
Growth in pharmaceutical expenses*	2.5%	2%	2%
Growth in GP services*	1%	Same	Same
Growth in Laboratory services*	10%	5%	5%
Change in the prices of imported supplies*	1% (Note 3)	2%	3%
Change in the prices of local supplies*	1% (Note 3)	2%	3%

Notes

* Expressed as a % of the previous year

1. The assumed interest rate of 7.75% is the bond rate for the ADHB's private sector financing.
2. The ADHB base depreciation rate for buildings is 2%. Building fitout costs are depreciated at 7% and bring the average depreciation rate to 4%.

Notes
The average depreciation rate for clinical equipment is 19%. This is based on the Inland Revenue Department rates and has been approved by the ADHB external auditors. Some items such as fibre optic scopes are depreciated at 20%; laser equipment 20%; infusion pumps 20%; laparoscopic equipment 25% and optical equipment at 20%. These items in addition to lower rate depreciated items determine an average rate of 19%.
3. Actual cost increases are in the vicinity of 2.5% but economies made in the budget reduced the overall increase to 1%.

The Consolidated Projected Statement of Financial Performance above is in accordance with the financials disclosures in the ADHB Annual Report. The same information has been presented on the next page in a more detailed form to assist an understanding of the path that the ADHB is following to reduce deficit levels.

Of special note are the following factors:

- Higher costs for nursing of up to \$2.5 million are anticipated and are covered by an agreement with the Crown to allow the approved total deficit to escalate to \$63.5 million
- Change Programme savings are important in assisting the organisation in reaching its maximum cost increase targets of 2%, 2% and 3% over the three-year period of the plan
- There are additional savings of \$10 million to be achieved in order to reach the \$61 million deficit target for 2002-03. Strategies have been developed to achieve this target including improvements in ACC claiming, realised benefits on sale of surplus property properties and investments and further operational savings
- There is a potential deficit in the funder arm should funding prove insufficient to meet costs. The funder arm is engaged in a number of local and regional initiatives aimed at controlling expenditure. These focus on improving both referrer and provider management tools and incentives.
- The site specific adjuster issue previously noted is reflected in the anticipated Crown support for the deficit level budgeted for the 2002-03 year. The MOH will also consider this matter further as part of the work to implement population based funding in 2003-04

AUCKLAND DISTRICT HEALTH BOARD	2001-02	2002-03	2003-04	2004-05
Consolidated Projected Statement of Financial Performance - illustrated version	Actual \$000	Budget \$000	Forecast \$000	Forecast \$000
Ministry of Health - Base Contract				
Provider & Governance	526,646	544,893	569,523	590,160
Funder	187,217	218,217	219,348	224,114
Risk Pool	15,914	0	0	0
	729,777	763,110	788,871	814,274
Ministry of Health - Other Contracts	41,759	46,617	47,549	48,976
	771,536	809,727	836,420	863,250
External Revenue	66,314	64,046	65,327	67,287
Total Revenue	837,850	873,773	901,747	930,537
Operating Costs				
Provider Cost Base	659,631	678,839	691,682	726,609
% Increase in Provider Cost Base		3%	2%	5%
Change Programme Savings	0	-10,000	-9,902	-24,376
Provider	659,631	668,839	681,780	702,233
% Increase in Provider Cost Base (Net of Change Programme savings)		2%	2%	3%
Funder	203,131	225,185	226,348	231,114
Total Operating Costs	862,762	894,024	908,128	933,347
Operating Surplus/(Deficit)	-24,912	-20,251	-6,381	-2,810
Provider & Governance	-24,912	-13,283	619	4,190
Funder	0	-6,968	-7,000	-7,000
Operating Surplus/(Deficit)	-24,912	-20,251	-6,381	-2,810
Additional savings to be achieved	0	10,000	0	0
	-24,912	-10,251	-6,381	-2,810
Depreciation	-27,337	-30,408	-45,600	-53,500
Interest	-4,242	-6,035	-19,428	-27,352
Capital Charge	-9,569	-14,306	-19,793	-22,293
Total Depreciation, Interest, Capital Charge	-41,148	-50,749	-84,821	-103,145
Total Surplus/(Deficit)	-66,060	-61,000	-91,202	-105,955

5.1.7 Statement of Accounting Policy

General Accounting Policies

In the preparation of its financial statements, the ADHB follows the recommendations in the Statements of Standard Accounting Practice and Financial Reporting Standards issued by the Institute of Chartered Accountants of New Zealand

The general accounting principles recognised as appropriate for the measurement and reporting of results, financial position and cash flows on an historical cost basis are followed. Accrual accounting is used to match the cost of services provided and revenues.

Financial statements of the hospital and its related services are prepared on the basis that it is a going concern. The Minister provides written assurance to satisfy this requirement and the Board Members rely on these assurances.

Particular Accounting Policies

The accounting policies that materially affect the measurement of surplus and deficit and the financial position are:

a) Basis of Accounting for Subsidiary and In-substance Subsidiary

The purchase method of accounting is applied in accounting for subsidiaries and in-substance subsidiaries. This involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

An in-substance subsidiary is an entity that is controlled by ADHB but is not a subsidiary. All significant inter-entity transactions are eliminated on consolidation.

The current list of subsidiaries is:

- Labplus Limited – non-trading name protection company
- Green Lane Hospital Limited – non-trading name protection company
- Auckland Hospital Limited – non-trading name protection company
- National Women's Hospital Limited – non-trading name protection company
- In substance subsidiary:
- Auckland Healthcare Charitable Trust – charitable trust

b) Basis of Accounting for Associates

The equity method of accounting is applied in accounting for associates in the preparation of financial statements. Associates are entities over which ADHB has significant influence, but not control, over the operating and financial policies. The list of associates in which the ADHB holds up to and equal to a 50% shareholding is:

- The Treaty Relationship Company Limited – holding company for the relationship with Ngati Whatua
- Westkids Limited – paediatric services
- Northern Clinical Training Network Limited – training services
- Biomed Investments Limited - holding company owned with Waitemata DHB
- Biomed Trading Limited (formerly Health Support Limited) – holding company owned with Waitemata DHB

c) Goods and Services Tax (GST)

All items in financial statements are stated net of GST with the exception of receivables and payables that are stated with GST included. The net amount of GST payable is included as part of payables in the statement of financial position. GST on receipts and GST on payments are offset to present a net amount of GST paid. Where GST is irrecoverable as an input tax it is recognised as part of the related asset or expense.

d) Employee Entitlements

Employee entitlements include liabilities for salary and wages, annual leave, long service leave and retirement gratuities accrued to employees for services rendered up to balance date. In determining the value of employee entitlements, salary and wages and annual leave are calculated on an actual entitlement basis whilst the other entitlements are calculated on an actuarial basis at current rates of pay.

e) Taxation

The ADHB is not subject to income tax.

f) Investments

Investments in associates are shown at a value that represents the ADHB's share of the net tangible assets at acquisition and share of the retained post-acquisition changes in reserves.

g) Foreign Currency

Transactions denominated in foreign currencies (other than forward exchange contracts) are translated at the rate of exchange ruling at the transaction date. Short-term transactions covered by forward exchange contracts are measured and reported at the forward rates specified in the contracts.

At balance date foreign monetary assets and liabilities are translated at the closing rate and exchange differences arising from the translations are recognised in the statement of financial performance.

Where a foreign monetary asset is designated as a hedge of a transaction denominated in a foreign currency, the exchange difference arising from their translations are recognised in the statement of financial performance. The ADHB does not enter into such transactions for speculative purposes but as a risk management measure to cover and match other transactions designated in foreign currencies, such as the purchase of plant and equipment.

h) Accounts Receivable

Accounts receivable are stated at expected realisable value after providing for doubtful and uncollectable debts.

i) Inventories

Inventories are valued on the basis of the lower of cost, determined on a first-in first-out basis, and net realisable value. This valuation includes allowances for slow moving and obsolete inventories.

j) Leases

A finance lease exists where substantially all the risks and benefits incidental to the ownership of an asset is transferred to ADHB. Such leases are reflected in financial statements by recording an asset and a liability of equal amounts at the inception of the lease, to the lower of the fair value of the leased asset or at the present value of the minimum lease payments. The leased asset is depreciated on a straight-line basis over its useful life and the lease payment is apportioned between the interest expense and the reduction of the outstanding liability over the term of the lease.

Payments under an operating lease, where the lessors effectively retain substantially all the risks and benefits of ownership of the leased property, are charged as rental expenses in the periods in which they are incurred.

k) Revenue recognition policy

Contract revenue and interest income are recognised on an accrual basis. Other operating revenue is recognised on invoice or receipt for delivery of the service, whichever is earlier.

Donations and bequests received are treated as revenue on receipt. These funds are administered by the ADHB's in-substance subsidiary, ADHB Charitable Trust.

Donations and bequests from third party trusts are recognised as revenue only when actually received.

l) Funds held in trust

Funds held on behalf of patients and the Ngati Whatua Trust Board are treated as a non-current liability "Funds held in trust" and are distributed to them as required.

m) Research Projects

Research costs are recognised as incurred. Grants received in respect of research projects are recognised when the requirements under the grant agreement have been met. Other research recoveries are recognised when committed to a research project.

n) Fixed Assets

There are five classes of fixed assets:

- Freehold land
- Leasehold land
- Freehold buildings
- Plant, equipment, computer software, vehicles and building fitout
- Work in progress

These assets are valued at the cost at which they were purchased from the Crown by Auckland Healthcare Service Limited, the predecessor to the ADHB, as at 1 July 1993, adjusted by subsequent additions at cost, disposals and depreciation.

Work in progress, which is not depreciated, is the cost of direct material, direct labour and direct overhead of capital works projects unfinished at balance date. When a project is finished the total cost of that project is transferred to buildings and/or plant and equipment.

It is the ADHB's policy to capitalise borrowing costs as part of the cost of an asset by applying a capitalisation rate to expenditures on the acquisition, construction or production of assets that require a substantial period of time to get them ready for their use.

Depreciation of fixed assets, other than land, is calculated on a straight-line basis so as to allocate the cost of the assets, less their estimated residual values, over their useful lives as follows:

- Buildings 10 to 50 years (2% - 10%)
- Plant, equipment and building fitout 3 to 20 years (5% - 33.3%)
- Motor vehicles 5 years (20%)

Gains and losses on disposal of fixed assets are recognised as revenue or expenses in the statement of financial performance.

o) Financial Instruments

As a guardian of public money the ADHB is risk averse and seeks to minimise exposure arising from its treasury activity. The ADHB is not authorised by Treasury policy to enter into any transaction that is speculative in nature.

Financial instruments include cash and bank balances, receivables, payables and borrowings. These instruments are, generally disclosed at their estimated fair value.

The ADHB is party to financial instruments that are not recognised in its financial statements. These include currency and interest options and forward exchange contracts. Their primary purpose is to reduce exposure to fluctuations in foreign currency exchange rates and interest rates. Any gains or losses arising from exposure to these instruments are offset against the related gains or losses on the assets or liabilities being hedged

5.2 Reporting requirements

5.2.1 Reporting

The ADHB will comply with the requirements of the Public Finance Act 1989 in preparing and publishing audited accounts each year. The content of these

accounts will comply with generally accepted accounting principles and the published accounting standards.

ADHB will ensure that all interested parties have appropriate information at their disposal subject to the provisions of the Official Information Act. The ADHB will make the following documents and information available to the MOH:

The ADHB will report each month on its financial performance in its delivery of the output Health Sector Development (Developing Capability). These reports will comply with the requirements agreed with the Sector Funding and Performance and Hospital Monitoring Directorates of the MOH.

In addition to the formal reports the Auckland Board will keep the Minister and the Ministry informed of any material factors that could preclude the achievement of any obligation or expectation and any issue likely to be of significance to the Minister or the Government.

The ADHB will also provide the MOH with information that will enable it to prepare Ministerial briefings and draft speech notes that will enable the relevant Minister to respond to Parliamentary questions, Ministerial correspondence and Select Committee inquiries on a timely basis.

The hospital and its related services will provide all agreed performance measures and monthly statistics required by the MOH as part of its performance monitoring regime within the specified timeframes. In addition the ADHB will work with the MOH on the development of future performance measures to improve their relevance and credibility to clinical staff.

Unaudited reports against the SOI and business plan for each quarter containing brief comments on financial and non-financial performance will be provided within one month of the period end. The quarterly report will include a revenue analysis differentiating revenue for each major class of customer and summary statistics indicating:

- Performance against target for the quarter, including monthly performance measures as required by the MOH in accordance with its performance-monitoring regime.
- Forecasts of both financial and non-financial results and measures.
- The reasons for any significant change in performance targets or variance from targets.
- All Maori and Pacific Island expenditure by category and effectiveness.

Information on the Building Programme will be provided in accordance with the monitoring framework that has been agreed with the MOH and Treasury.

An Annual Plan and Statement of Intent each year and a Strategic Plan for a minimum five year period.

A report will be delivered to the Minister within four months of the end of the year ending 30 June 2003. The report shall incorporate:

- A report of the operations of ADHB during the year ending 30 June 2003.
- Audited financial statements for that financial period consisting of statements of financial position, financial performance, cash flows and such other statements as may be necessary to show the financial position, of ADHB and the financial results of its operations during the reporting period
- The Auditor's Report on those financial statements
- Such information as is necessary to enable an informed assessment of the operations of ADHB including a comparison of the performance of ADHB with the Statement of Intent

5.2.2 Performance indicators and management processes

The Ministry of Health, in collaboration with the DHBs, has developed a standard national set of Indicators to be used for monitoring DHB performance. The indicators cover the Government's key funding priorities, as well as DHBs service provision and governance functions.

This nationally consistent set of accountability indicators is a combination of qualitative and quantitative indicators. DHBs were devolved funding agreements with providers that were mostly based on a roll over of existing contractual expectations. There is therefore limited scope to move towards any improvements in the quantitative indicators this year as they are already specified in the arrangements with providers of health and disability services.

A number of the indicators are qualitative, and as such set an accountability expectation on reporting against achievement as opposed to a predefined numeric target.

The 2002-03 measures used to assess the ADHB's performance are set out on the next page.

Ind No	Title	Report	Frequency	Target (Note 1)
Strategic Development - Maori				
STR-01	Local Iwi/Maori are engaged and participate in DHB decision making and the development of strategic and plans for Maori health gain.	DHB	Six monthly	N/A
STR-02	Progress in the development of Maori workforce and Maori providers	DHB	Quarterly	N/A
STR-03	Progress on the implementation of Maori Health Plan for the DHB Service Arm	DHB	Annually	N/A
Strategic Development - Pacific Peoples				
STR-04	Pacific people are engaged and participate in DHB decision making and the development of strategies and plans for Pacific health gain.	DHB	Annual	N/A
STR-05	Progress in the development of Pacific workforce and Pacific providers	DHB	Annual	N/A
Systems and Quality				
QUA-01	Quality systems	DHB	Quarterly	N/A
QUA-02	Mental Health quality measures	DHB	Quarterly	N/A
QUA-03	Nationally consistent clinical assessment – Elective Services	DHB	Quarterly	N/A
QUA-04	Responding to and resolving service coverage issues	DHB	Quarterly	N/A
QUA-05	Prioritisation	DHB	31 May 2003	N/A
Nursing Practice and Development				
NUR-01	Nursing practice and development	DHB	Quarterly	N/A
Child Health - Ensure access to appropriate child health care services including well child and family health care and immunisation				
CHIQ-02	Progress in implementing the Baby Friendly Hospital Initiative in maternity facilities	DHB	Annual	N/A
CHI-01	Children fully vaccinated by their 2 nd birthday	MOH	Annual	75% for all ethnic groups
CHI-06	Percentage of children passing school entry hearing screening test	MOH	Annual	95% for all ethnic groups
CHI-08,09	Repeat admissions for asthma in children under 5 and in children 5-14	MOH	Six monthly	Minimise repeat admissions Target rate per 100 discharges within a 90% confidence interval of the New Zealand rate Total: 5.8% Maori: 5.9% Pacific: 5.5% Other: 5.9%
CHI-13	Percentage of babies born in public hospital with low birth weight	MOH	Six monthly	Within a 90% confidence interval of the NZ rate
CHI 15,16	Full breastfeeding rate at six weeks and three months	MOH	Six monthly	Within a 90% confidence interval of the NZ rate
CHI 17,18,19	Ambulatory Sensitive Admission	MOH	Six monthly	Within a 90% confidence interval of the NZ rate
Oral Health - Improve oral health - ADHB monitors contract managed by Waitemata DHB				
ORA-04	Mean MF score at form 2 (year 8)	MOH	Annual	Total: 1.3 Maori: 1.6 Pacific: 1.8 Other: 1.2
ORA-01	Caries free at age 5	MOH	Annual	Total: 61.3% Maori: 45.5%

Ind No	Title	Report	Frequency	Target (Note 1)
				Pacific: 40.0% Other: 70.1%
Diabetes - Reduce the incidence and impact of Diabetes				
DIA-07	Implementation of the minimum diabetes dataset	DHB	Annual	N/A
DIA-01	Diabetes case detection rate	DHB	Annual	Target rate within a 90% confidence interval of: Total: 26.0% Maori: 23.0% Pacific: 35.0% Other: 24.0%
DIA-02	Diabetes case management	DHB	Annual	Target rate within a 90% confidence interval of: Total: 31.0% Maori: 57.0% Pacific: 43.0% Other: 22.0%
DIA-04	Retinal screening of people with diabetes in the last two years	DHB	Annual	Target rate within a 90% confidence interval of: Total: 80.0% Maori: 20.0 Pacific: 80.0% Other: 80.0%
Cardiovascular - Reduce the incidence and impact of cardiovascular disease				
CAR-03	Number of people with certainty who have been waiting for more than 6 months for a coronary artery bypass graft	MOH	Six Monthly	Zero people waiting > 6 months for all ethnic groups
CAR-05	Number of people with certainty who have been waiting for more than 6 months for angioplasty	MOH	Six Monthly	Zero people waiting > 6 months for all ethnic groups
CAR-10	Repeat admissions for acute rheumatic fever in people under 30	MOH	Annual	Minimise repeat admissions. Target rate per 100 discharges within a 90% confidence interval of the New Zealand rate: Total: 29.3% Maori: 29.6% Pacific: 31.1% Other: 23.5%
Cancer - Reduce the incidence and impact of cancer				
CAN-01	Waiting times for Radiotherapy	MOH	Monthly	Zero waiting outside best practice times at 30 June 2002
Primary Care - Primary Health Care				
PRI-01	Progress towards implementing the Primary Health Care Strategy	DHB	Annual	N/A
PRI-02	Progress in developing the capacity of primary care providers to impact on suicide prevention	DHB	Annual	N/A
PRI-04	Number of contracted providers of general practice services with a Maori Health Plan that has been agreed with the funder	DHB	Quarterly	75%
Elective Surgery - Reducing waiting times for public hospital elective services				
ELE -01	Level of publicly funded service delivered is sufficient to ensure access to elective surgery for all patients before they reach a state of	DHB	Quarterly	N/A

Ind No	Title	Report	Frequency	Target (Note 1)
	unreasonable distress, ill health or incapacity.			
ELE-02	100% of patients do not wait longer than 6 months for first specialist assessment	Waiting times reporting to MOH	Quarterly, Quarterly Exception	None waiting > 6 months
ELE-03	100% of patients who have been offered publicly funded treatment do not wait longer than 6 months	MOH	Quarterly, Quarterly Exception	None waiting > 6 months
Mental Health - Improve the health status of people with severe mental illness and improving the responsiveness of mental health services				
MEN-01	Progress towards improving Maori mental health	DHB	Annual	N/A
MEN-02	Comprehensive and timely data is provided to MHINC	DHB, MOH	Quarterly	N/A
MEN-03	Access to Services	DHB, MOH	Quarterly (except Q1)	Target rate within a 90% confidence interval of: Total: 0.9% children 0-9: 0.1% children 10-14: 0.5% children 15-19: 0.7% adults 20-64: 1.2% adults 65+: 0.9%
Performance to Annual Plan				
FIN-01	Actual financial performance compared to the approved Business Plan of the Funder, Provider and Governance Functions of the DHB	Captured through DHB financial reporting to HMD	Monthly	N/A
FIN-02	Percentage of DHB's total expenditure on services by Maori providers compared to percentage of DHBs total expenditure on services by Maori providers at 1 July 2001	Captured through DHB financial reporting to HMD	Quarterly	Not less as a proportion than at 1 July 2001

Key to targets:

Code	Comment
Note 1	The targets have been set in discussion with the MOH. In some cases these represent goals that are not achievable within the plan period. This is the result of poor national and/or local data and other factors such as the impact of existing contracts where these do not contain the appropriate data collection requirements and the developing nature of some systems and processes. In the interest of maintaining national consistency the ADHB has agreed to include all the indicators on the basis that performance in each case is dependent on the factors noted above.
N/A	Indicator not quantitative/numerical and will be covered by a narrative report or confirmation

6. Attachments

A Statement of Intent

The Statement of Intent for the year ending 30 June 2003 is consistent with this plan and incorporates the key elements of this document. It is available on application to the GM Communication and Community Consultation at the ADHB.

B Crown Funding Agreement

The Crown Funding Agreement (CFA) for 2002-03 has been signed by the ADHB and is awaiting signature by the Minister at the time of completing this plan. The agreement will be available as a separate document from this plan. The DAP is consistent with the three year funding package issued by the MOH in March 2002 and observes the operational criteria set out in the three sector accountability documents:

- Operational Policy Framework
- Service Coverage Document
- Performance Indicator Guidelines

C Regional Mental Health Plan

This plan has been filed with the MOH and is available as a separate document.

D Price volume schedule

The price volume schedules form the basis for the Internal Service Level Agreement (ISLA) between the ADHB funder and provider arms. They reference the price and volume of the services the provider arm will deliver over the period to 30 June 2003.