

### **3 Ensuring Services for the Population**

*Ensuring Services for the Population* allows us to focus and align our annual strategies/objectives with the organisation's four key goals (see Section 1 Executive Summary). 2003–04 will see the ADHB go through massive changes in relation to our provider arm services as we move from four hospitals on individual sites to one major hospital at Grafton, with community and ambulatory services at the Greenlane Clinical Centre. The annual objectives in Sections 3.1 and 3.3 relate to the realignment of provider arm services through completion of the Building and Change Programmes that will ultimately support an *Improvement in our Business Performance*. At the same time we have emphasised *Lifting the Health of Aucklanders* with a focus on Maori, Pacific and New Migrant communities (refer Section 3.2).

#### **3.1 Auckland DHB organisational performance**

This section presents ADHB's strategic objectives from our strategic plan that aligns with the organisational goal *Improved Business Performance*. The strategies and objectives presented look for the reduction of operating deficit, through prioritisation, implementation of costing systems, management of the transition to Population Based Funding; working with our Change and Building Programmes and Human Resources (Section 3.3) and regional collaboration initiatives. Each objective is linked to the Section 5.1 *Consolidated List of Indicators of DHB Performance*.

## Strategic Objective: He Korowai Oranga

<b>Annual objectives</b>	Progress the implementation of the ADHB Maori Health Strategy consistent with He Korowai Oranga – Maori Health Strategy	
<b>Linkages</b>	He Korowai Oranga – Maori Health Strategy New Zealand Health Strategy New Zealand Disability Strategy Primary Health Care Strategy ADHB Maori Health Strategy Human Resource Strategy	
<b>Approach</b>	ADHB and Tihi Ora MaPO will continue to jointly undertake health purchasing functions in order to address Maori health needs. The key areas of focus in the ADHB provider arm will include: <ol style="list-style-type: none"> <li>1. Consolidate ADHB's relationship with Tihi Ora MaPO.</li> <li>2. Review of Maori Health (He Kamaka Oranga) completed.</li> <li>3. Tikanga Best Practice completed and implemented.</li> <li>4. Manage the roll out <i>Whare Oranga Pasefika</i> (one-stop-shop service at the new Green Lane Clinical Centre).</li> <li>5. Maori Did Not Attend (DNA) initiative implemented through the ADHB change programme.</li> <li>6. Undertake a Maori health workforce profile of ADHB including NGOs to provide baseline data. Identify all Maori health professionals undertaking post entry training and assist with access funding.</li> <li>7. Maori ethnicity collection initiative implemented through the ADHB change programme.</li> <li>8. Review of Manawanui Maori mental health service completed.</li> <li>9. ADHB Maori workforce and provider development plan implemented.</li> <li>10. Focus on reducing inequalities in Maori health status by informing service providers and planning improvements to service delivery including access to services.</li> <li>11. Continue the Maori Provider Development Scheme and joint venture with tertiary institutions and Hauora.com to support major career pathways.</li> <li>12. Primary Investment Fund to assist Maori providers involved in the Maori-led PHO.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. December 2003 and ongoing</li> <li>2. December 2003</li> <li>3. December 2003</li> <li>4. June 2004 and ongoing</li> <li>5. June 2004 and ongoing</li> <li>6. June 2004 and ongoing</li> <li>7. December 2003 and ongoing</li> <li>8. June 2004 and ongoing</li> <li>9-12. June 2004</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> Treaty of Waitangi paper accepted by the ADHB Board. Maori health ability to meet change and building programme timeframes. Maori health ability to implement initiatives within current budget.	<p style="text-align: center;"><b>Mitigation strategy</b></p> Affirm that Maori health deals with health and disability issues in the Auckland DHB. Affirm that Te Tihi Oranga O Ngati Whatua are ADHB's Treaty partner in health. Affirm Maori health priorities of primary health, public health, intersectoral initiatives and integration.

<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• FIN-02: The percentage of the DHB's total expenditure on services provided by Maori providers compared to the percentage of the DHBs total expenditure on services provided by Maori providers at 1 July 2002.</li> <li>• PRI-04: Participation of Maori in decision-making within the Primary Health.</li> <li>• STR-01: Local Iwi/Maori are engaged and participate in decision making and the development of strategic gains.</li> <li>• STR-02: Progress in development of Maori workforce and Maori providers.</li> <li>• STR-04: Improve mainstream effectiveness.</li> <li>• Men-01: Progress towards improving Maori mental health.</li> </ul>
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**Strategic Objective: Reducing the operating deficit**

<b>Annual objectives</b>	Ensure that all costs are managed to enable the reduction of the operating deficit agreed by the Board with the Crown equitably across all services over a three-year period.
<b>Linkage to strategic objectives</b>	To all strategic objectives in Sections 3.1, 3.2 and 3.3.
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Manage volumes to within permitted contracted levels.</li> <li>2. Maintain accurate coding to support revenue recognition and contract management.</li> <li>3. Maintain data collection obtained for all Section 88 claims to ensure cost profiling and recovery from other DHBs is appropriate.</li> <li>4. Control all costs within approved budget levels.</li> <li>5. Explore and maintain opportunities for cost recovery from organisations such as ACC.</li> <li>6. Ensure all approved capital programmes deliver savings stated in business cases.</li> <li>7. Deliver the planned savings targets required to support the Change and Building Programmes Business Cases.</li> <li>8. Change and Building Programmes work within allocated budgets.</li> <li>9. FTE levels to be kept at or below budget levels.</li> <li>10. Maintain systems for tracking cost savings.</li> <li>11. Reduction of and ongoing management of annual leave.</li> </ol>
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004</li> <li>2. June 2004</li> <li>3. June 2004</li> <li>4. June 2004</li> <li>5. June 2004 and ongoing</li> <li>6. June 2004 and ongoing</li> <li>7. June 2004–05</li> <li>8. June 2004</li> <li>9. June 2004</li> <li>10. June 2004 and ongoing</li> <li>11. June 2004</li> </ol>

<b>Risks and mitigation strategies</b>	<b>Risk</b> Services under/over deliver volumes, budgets are exceeded and inaccuracies occur with data collection.	<b>Mitigation strategy</b> Ongoing implementation of COO monthly meetings, costing systems, Balanced Scorecard, and service monitoring of services by to ensure services remain within contracted volumes and budgets.
	Building and Change Programmes budgets are exceeded.	Monitoring of expenditure and early reporting to CFO on issues that may cause budget “blow outs”.
	Human resources are not managed organisationally or by service.	Human resource planning is completed, implemented and monitored.
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>FIN-01: Actual financial performance compared with approved DAP of the Funder, provider and Governance functions of the DHB.</li> </ul>	

### Strategic Objective: Prioritisation framework

<b>Annual objectives</b>	Establish and maintain an organisational Prioritisation Framework that is aligned with the national project and meets DHB and Ministry of Health requirements regarding investment and disinvestment of health services.	
<b>Linkage to strategic objectives</b>	To all strategic objectives in Section 3.2 and reducing the operating deficit. Aligns with previous GOV-03 requirements.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>Continue active participation in the national prioritisation framework as part of joint MoH/DHBNZ project.</li> <li>Work within region to ensure coordination of approach and good collaboration when we implement the framework locally and regionally.</li> <li>Complete investment/disinvestment reviews using the approved national prioritisation framework.</li> <li>Establish and maintain <i>Primary Health Care New Initiatives Committee</i> for new funding initiatives.</li> </ol>	
<b>Milestones</b>	All to be achieved by June 2004.	
<b>Risks and mitigation strategies</b>	<b>Risk</b> National working group does not complete assigned tasks that align with regional and local needs.	<b>Mitigation strategy</b> Active participation in national, regional processes to ensure ADHB is actively engaged in the development of the prioritisation framework.  Ensure good links with national prioritisation work to other workstreams (e.g. National Service Reconfiguration work).
	<ul style="list-style-type: none"> <li>QUA-05: Prioritisation.</li> <li>QUA-06: Progress towards implementing the reducing inequalities in health intervention framework.</li> </ul>	
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>QUA-05: Prioritisation.</li> <li>QUA-06: Progress towards implementing the reducing inequalities in health intervention framework.</li> </ul>	

## Strategic Objective: Population based funding and inter-district flow management

<b>Annual objectives</b>	Ensure appropriate management of the PBF Transition Year, to address all issues related to Inter-District Flows and pricing deficiencies through the timely monitoring of services delivery across the sector.	
<b>Linkage to strategic objectives</b>	Linked to strategic objectives: Reducing the operating deficit, prioritisation framework, maintenance of costing systems, balanced scorecards and benchmarking, Greater Auckland Collaboration, information systems infrastructure, quality and safety systems, all strategic objectives of 3.2. Section 3.2.5 Regional Service Planning.	
<b>Approach</b>	<p>1. <b>PBF/IDF management</b> Complete regional and national processes for readiness to move to full PBF including the management of IDFs.</p> <ul style="list-style-type: none"> <li>• Monitor adherence to Business Rules.</li> <li>• Monitor agreed volumes and access levels with other DHBs or Ministry of Health depending on Crown funding path adopted under PBF.</li> <li>• Establish business systems to support IDF management.</li> </ul> <p>2. <b>Pricing</b> Continue to support the national process to further develop and maintain existing agreed national price schedule used for IDF pricing for the Transition Year to PBF. Active engagement with the MoH/DHBNZ working groups related to pricing issues such as:</p> <ul style="list-style-type: none"> <li>• service specifications</li> <li>• cost weights</li> <li>• pricing</li> <li>• the treatment of community services</li> <li>• transport and accommodation.</li> </ul> <p>3. <b>Volume management/contract management</b> Develop and maintain management systems to monitor volume management to contract and within budget allocation.</p>	
<b>Milestones</b>	For all – June 2004 is the timeline for achievement.	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>PBF/IDF management processes cannot be agreed with regional and other DHBs.</p> <p>MHO/DHBNZ working groups fail to deliver work assigned for 2003–04 which will have impact on ADHB 2004–05.</p> <p>Volume management within contracted volumes and budget over/under delivers.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Work collaboratively with regional and other DHBs to provide transparent processes to reach consensus on issues related to PBF and IDFs.</p> <p>ADHB Funder and Provider Arm staff actively engages in national working groups to both influence and bring expertise within specialised areas.</p> <p>Ongoing implementation of COO monthly meetings, costing systems, Balanced Scorecard, and service monitoring of services by to ensure services remain within contracted volumes and budgets.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-04: Responding to and resolving service coverage issues.</li> <li>• STR-04: Improving mainstream effectiveness.</li> <li>• QUA-01: Quality systems.</li> <li>• FIN-01: Actual financial performance compared to DAP of the funder, provider and governance functions of the DHB.</li> </ul>	

### Strategic Objective: Referred services management

<b>Annual objectives</b>	Ensure that strategies developed to manage Referred Services expenditure within funding stream are maintained.	
<b>Linkage to strategic objectives</b>	All Strategy Objectives listed in Section 3.2., and reducing the operating deficit, population based funding and inter-district flow management.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Implementation of strategy for regional and local management of referred services expenditure in light of PHO development.</li> <li>2. Pharmaceutical dispensing fee alternatives managed.</li> <li>3. Volume management for pharmaceutical services.</li> <li>4. Diagnostic Medlab in collaboration with Planning and Funding Arm develop and implement systems that enable laboratory services to remain within allocated funding stream.</li> <li>5. Review of market structure for laboratory services in Auckland region.</li> <li>6. Community laboratory contract for Labplus implemented and managed within allocated funding stream.</li> <li>7. Advocate for national policy review of eligibility of private specialists to refer patients to publicly funded laboratory testing.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004</li> <li>2. December 2003</li> <li>3. December 2003</li> <li>4. December 2003 and ongoing</li> <li>5. December 2003</li> <li>6. June 2004 and ongoing</li> <li>7. June 2004</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Pharmaceutical services [local/regional] do not reach resolution over both appropriate service delivery and alternatives to the dispensing fees.</p> <p>Laboratory services exceed budget allocations across the region.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Collaborative and co-ordinated processes put in place to ensure both funders and providers work towards resolution and ongoing appropriate service delivery within allocated budgets.</p> <p>Regional risk pool in situ to ensure any "blow out" of regional laboratory budgets can be compensated within justification of service delivery. Contracts capped.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-01: Quality systems.</li> <li>• QUA-04: Responding to and resolving service coverage issues.</li> <li>• FIN-01: Actual financial performance compared to DAP of the funder, provider and governance functions of the DHB.</li> </ul>	

**Strategic Objective: Maintenance of costing systems, balanced scorecards and benchmarking**

<b>Annual objectives</b>	Ensure maintenance of costing systems, balanced scorecard and appropriate benchmarking within the services to ensure best practice, processes and performance against contract.	
<b>Linkage to strategic objectives</b>	Linked to strategic objectives: Reducing the operating deficit, prioritisation framework, population based funding and inter-district flow management, Greater Auckland Collaboration, information systems infrastructure, quality and safety systems, all strategic objectives of 3.2.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. <b>Costing systems</b> <ul style="list-style-type: none"> <li>• Establish costing systems consistently across Provider Arm services.</li> <li>• Maintenance of costing systems and processes to substantiate pricing models.</li> </ul> </li> <li>2. <b>Balanced scorecard</b> <ul style="list-style-type: none"> <li>• Maintain delivery of monthly balanced scorecards from individual HBO to monitor service delivery against contract.</li> </ul> </li> <li>3. <b>Benchmarking</b> <ul style="list-style-type: none"> <li>• Key benchmarking projects identified are completed for all services.</li> <li>• Maintain involvement in SEAHBC for Casemix benchmarking and selected Patient Satisfaction surveys.</li> <li>• National and international benchmarking projects are considered according to their value to services.</li> <li>• Clinical indicator report completed on a regular basis.</li> </ul> </li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004 and ongoing</li> <li>2. June 2004</li> <li>3. June 2004–05</li> <li>4. June 2004</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Services under/over deliver volumes, budgets are exceeded and inaccuracies occur with data collection.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Ongoing implementation of COO monthly meetings, costing systems, Balanced Scorecard, and service monitoring of services by to ensure services remain within contracted volumes and budgets.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-01: Quality systems.</li> <li>• FIN-01: Actual financial performance compared to DAP of the funder, provider and governance functions of the DHB.</li> </ul>	

## Strategic Objective: Greater Auckland collaboration

<b>Annual objectives</b>	Ensure that collaboration, co-ordination and co-operation of regional processes and programmes are maintained with neighbouring DHBs for current and future years.	
<b>Linkage to strategic objectives</b>	Linked to strategic objectives: Reducing the operating deficit, prioritisation framework, maintenance of costing systems, balanced scorecards and benchmarking, population based funding and inter-district flow management, information systems infrastructure, quality and safety systems, NZ Disability Strategy, consultation, all strategic objectives of 3.2.	
<b>Approach</b>	<p>Maintain co-ordination, collaboration and co-operation for regional processes and programmes with neighbouring DHBs on issues agreed for, or where common interests exist, with a particular focus on:</p> <ul style="list-style-type: none"> <li>• shared services</li> <li>• regional service planning</li> <li>• pricing</li> <li>• funding and planning</li> <li>• mental health</li> <li>• PHOs</li> <li>• referred services</li> <li>• monitoring and audit systems for contract management</li> <li>• regional IT solutions for pharmacy, primary health care</li> <li>• DSS devolution and implementation of NZDS</li> <li>• prioritisation</li> <li>• oral health services.</li> </ul>	
<b>Milestones</b>	June 2004 and ongoing.	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Regional working groups fail to deliver work assigned for 2003–04 which will have impact on ADHB 2004–05.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Work collaboratively with regional DHBs to provide transparent processes to reach consensus on all issues that are of common interest to all.</p> <p>ADHB Funder and Provider Arm staff actively engages in working groups to both influence and bring expertise within specialised areas.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-01: Quality systems.</li> <li>• QUA-02: Mental health quality measures.</li> <li>• QUA-03: National consistent clinical assessment – elective services.</li> <li>• QUA-04: Responding to and resolving service coverage issues.</li> <li>• QUA-05: Prioritisation.</li> <li>• QUA-06: Progress towards implementing the reducing inequalities in health intervention framework.</li> <li>• QUA-07: Progress towards WAVE implementation.</li> </ul>	

## Strategic Objective: Communication

<b>Annual objectives</b>	Open and honest communication to support the vision, values, goals and objectives, and the implementation of strategies. This ensures that ADHB meets our requirement to engage with local communities and ensure planning and funding decisions reflect community views.	
<b>Linkage to strategic objectives</b>	All strategic objectives in Section 3.2 and 3.3.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Link activities to the Communication Strategy to support HBO units to achieve organisational goals.</li> <li>2. Support culture change within ADHB by building on the platform already underway of monthly newsletters and assisting CEO/COO forums.</li> <li>3. Communication structure designed to cascade messages, ideas and information to ADHB employees and feedback upwards is complete and in use by Change Programme.</li> <li>4. Address problem areas identified in the review of communication process via implementation of the Communication Strategy.</li> <li>5. Provide information on what is expected of people to deliver on goals, provide tools to help them communicate and contribute; provide feedback on progress made.</li> <li>6. Clarify the varying needs and roles that stakeholders at different levels of the ADHB have in communications.</li> </ol>	
<b>Milestones</b>	All by June 2004.	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Lack of ownership of ADHB key goals and imperatives for 2003–04 activities. Existing communication problems continue.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Consultation plan written to guide activities. Communications plan written to guide activities.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• STR-01: Local Iwi/Maori are engaged and participate in DHB decision-making and the development of strategic and plans for Maori health gain.</li> <li>• STR-05: Pacific people are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain.</li> </ul>	

## Strategic Objective: Community engagement and consultation

<b>Annual objectives</b>	Community engagement will reflect the ADHB commitment to Treaty of Waitangi and related principles of partnership, participation and protection. This practice will further ensure that local communities are informed about health and disability issues, can participate in planning, and that community needs and preferences are reflected in local health plans, funding decisions and service delivery.	
<b>Linkage to strategic objectives</b>	All strategic objectives in Section 3.2 and 3.3.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Treaty of Waitangi consultation obligations and consultation protocols put into effect throughout the development of new services (PHOs, Joint Sector work, stakeholder groups). Direction will be informed by the Board ethnicity project</li> <li>2. Local communities of interest, NGOs and agencies participate in community engagement and consultation approaches and have their needs and preferences considered.</li> <li>3. Community engagement influences ADHB funding and planning decisions (and is available for regional and national planning).</li> <li>4. The community is well informed about health and disability services via regular publications, news items, public meetings and engagement in local networks.</li> <li>5. Build positive community perceptions and relationships of trust regarding the people and activities of ADHB by timely and honest responses to enquiries.</li> <li>6. Older people's stakeholder group established and working on integration project (ongoing).</li> <li>7. Consultation with disability sector regarding priority actions re implementing the NZ Disability Strategy and improving access to services.</li> <li>8. Link to existing health networks maintained (e.g. older people's group, Mental Health stakeholder group, Asian Network (ongoing)).</li> <li>9. Central Auckland Mental Health forum continues to involve wider sector involvement in capacity building, networking and input into sector improvements (ongoing).</li> <li>10. Implement consultation findings from 2003 Asian Public health project.</li> <li>11. Public, NGOs and providers well informed about PHO development and able to participate in PHO community engagement structures as they evolve.</li> <li>12. Consultation completed for joint sector project for Maori children with high and complex needs in Glen Innes.</li> <li>13. Ongoing liaison with the Pacific and other high needs communities to ensure strategies to reduce health disparities have their involvement.</li> <li>14. ADHB Maori provider stakeholder group ongoing.</li> <li>15. Consultation on options to support an expanded scope of abortion services.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. to 6. June 2004</li> <li>7. By July 2003</li> <li>8. to 14. June 2004</li> <li>15. December 2003</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Consumers and stakeholders not involved in key decisions.</p> <p>Problems and barriers not identified in planning and funding.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Consultation plan written to guide activities.</p> <p>Communications plan written to guide activities.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• STR-01: Local Iwi/Maori are engaged and participate in DHB decision-making and the development of strategic and plans for Maori health gain.</li> <li>• STR-05: Pacific people are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain.</li> <li>• PRI-04: Participation by Maori in decision-making within Primary Health.</li> </ul>	

### Strategic Objective: Occupational health and safety

<b>Annual objectives</b>	Review all current OHS policies and procedures, and associated support services relative to future business and organisational needs and benchmark against industry practice.	
<b>Linkage to strategic objectives</b>	All strategic objectives of Sections 3.1, 3.2 and 3.3.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Measure current OHS performance and benchmark against health sector.</li> <li>2. Identify and evaluate best practice service delivery options.</li> <li>3. Develop an action plan to improve ADHB's employee health and safety performance inclusive of information reporting systems.</li> </ol>	
<b>Milestones</b>	All by March 2004.	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Migration of services prevents review of current OHS and subsequent action plans to improve safety performance are incomplete.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>OHS co-ordinates and collaborates with both Building and Change Programmes to ensure services are reviewed and new facilities align with requirements within the sector.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-01: Quality systems.</li> <li>• QUA-02: Mental health quality measures.</li> <li>• NUR-01: Nursing practice and development.</li> </ul>	

### Strategic Objective: Information systems infrastructure

<b>Annual objectives</b>	Ensure Information Systems objectives agreed to by the ISSC are co-ordinated and implement to achieve goals for year and remain within the capital and operational allocation.	
<b>Linkage to strategic objectives</b>	All strategic objectives of Sections 3.1, 3.2 and 3.3.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. All IS infrastructure (required for the new facilities) is in place at time of the new buildings becoming operational.</li> <li>2. IS objectives agreed to by the ISSC are co-ordinated and implemented for year and remain within the capital and operation allocations.</li> <li>3. Develop strategy to support ADHB population health responses with systems that interface with primary care and the provider arm.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. October 2003</li> <li>2. June 2004</li> <li>3. June 2004</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Information Systems Infrastructure is not operational in line with migration to new facilities, and exceeds budget allocation.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>IS works/plans with Building and Change Programmes to align work with completion of facilities and migration.</p> <p>Budgets are reviewed monthly and managed within allocation.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-07: Progress towards WAVE implementation.</li> <li>• IS Work Plan.</li> </ul>	

## Strategic Objective: Quality and safety systems

<b>Annual objectives</b>	ADHB to collaborate with Quality Health New Zealand to ensure maintenance of full accreditation across the organisation and continuous quality and safety improvements are integrated into all operational activities and mitigates risks.	
<b>Linkage to strategic objectives</b>	All strategic objectives of Sections 3.1, 3.2 and 3.3.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Train services in the 2001 Accreditation Standards.</li> <li>2. Achieved accreditation with Quality Health NZ.</li> <li>3. Credentialling requirements commenced/completed as per requirements.</li> <li>4. Recommendations Implement from the Quality Health NZ Survey undertaken in Q3 of 2002–03.</li> <li>5. Prepare for progress survey 2004 and full resurvey 2005.</li> <li>6. Ongoing clinical and non-clinical risks are identified with appropriate action taken, and monitored.</li> <li>7. Staff awareness training at pre-employment and orientation, training of health and safety representatives, including monitoring.</li> <li>8. Quality plan developed with nominated delivery of care/service process identified for improvement and completed.</li> <li>9. Workplace hazards managed in a timely manner.</li> <li>10. All services develop and implement a safety focus programme that incorporates medico-legal requirements, accreditation standards, consumer rights, legislative compliance and risk management credentialling of all medical clinicians.</li> <li>11. Implement plan for clinical pathways.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. December 2003</li> <li>2. June 2004 and ongoing</li> <li>3. June 2004</li> <li>4. December 2003</li> <li>5. December 2003</li> <li>6. June 2004 and ongoing</li> <li>7. June 2004 and ongoing</li> <li>8. June 2004 and ongoing</li> <li>9. June 2004 and ongoing</li> <li>10. June 2004 and ongoing</li> <li>11. June 2004</li> <li>12. June 2004</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>ADHB unable to achieve accreditation standards with Quality Health NZ for individual HBOs.</p> <p>Quality and Safety Plan not implemented according to timelines.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Services work collaboratively with Quality Services to maintain accreditation standards.</p> <p>Quality and Safety Plans signed off and implemented with input from services and in line with Ministry of Health and Quality NZ guidelines.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-01: Quality systems.</li> <li>• QUA-02: Mental health quality measures.</li> <li>• QUA-04: Responding to and resolving service coverage issues.</li> <li>• QUA-05: Prioritisation.</li> <li>• QUA-06: Progress towards implementing the reducing inequalities in health intervention framework.</li> <li>• QUA-07: Progress towards WAVE implementation.</li> </ul>	

**Strategic Objective: Pacific Health: Improve mainstream responsiveness<sup>1</sup>**

<b>Annual objectives</b>	Develop and implement appropriate models of service delivery, in partnership with key stakeholders, for Pacific people who access mainstream services.	
<b>Linkage to strategic objectives</b>	This strategic objective is linked to all of the strategic objectives of Sections 3.1, 3.2 and 3.3.	
<b>Approach</b>	<p><b><i>Continuous quality improvement</i></b></p> <ol style="list-style-type: none"> <li>Invest in the further development of mainstream hospital services to determine which models deliver improved outcomes for Pacific peoples. The priority being: <ul style="list-style-type: none"> <li>children's health services</li> <li>women's health services.</li> </ul> </li> <li>Develop comprehensive education and support training programmes for Pacific and mainstream providers which will supply them with the implementation tools for: <ul style="list-style-type: none"> <li>continued quality and clinical practice improvement</li> <li>cultural competency.</li> </ul> </li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>June 2004 and ongoing.</li> <li>March 2004 and ongoing.</li> </ol>	
<b>Risks and mitigation strategies</b>	<p><b><i>Risk</i></b></p> <p>ADHB's HBO units are unable to respond to the development and implementation of the strategies because of the Change Freeze being in place from July–October 2003.</p>	<p><b><i>Mitigation strategy</i></b></p> <p>Development and implementation of the strategy to be time lined appropriately to ensure that there is limited impact upon the oncoming migration. Strategy to be developed in association with ADHB's Change Programme.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>STR-05: Pacific people are engaged and participate in DHB decision making and the development of strategies and plans for Pacific Health Team.</li> <li>STR-06: Progress in the development of Pacific workforce and Pacific providers.</li> <li>QU*A-06: Progress towards implementing the reducing inequalities in health intervention framework.</li> </ul>	

<sup>1</sup> Pacific Health and Disability Action Plan objective, MoH 2002.

## Strategic Objective: Pacific Health: Building strategic alliances<sup>2</sup>

<b>Annual objectives</b>	Establish and maintain effective working and consultative relationships with key stakeholders to ensure the health and wellbeing of Pacific people are being addressed.	
<b>Linkage to strategic objectives</b>	All strategic objectives of Sections 3.1, 3.2 and 3.3.	
<b>Approach</b>	<p><b>Intersectoral collaboration</b></p> <ol style="list-style-type: none"> <li>1. Develop and implement the Joint Sector Initiative for high and complex needs children in partnership with the Strengthening Families Management Group.</li> </ol> <p><b>Community engagement</b></p> <ol style="list-style-type: none"> <li>2. Develop and implement an effective long term communications strategy to promote awareness and understanding of ADHB's purpose and how Pacific communities can contribute to the process.</li> <li>3. In partnership with the Pacific Community Co-ordinators develop an information strategy which will see the effective and responsive dissemination of information to Pacific communities, including church groups and providers of effective ADHB funded and provided health services to health issues affecting Pacific peoples.</li> <li>4. A process for ADHB to establish an ADHB Pacific Policy Advisory Group is developed and agreed to guide the development of ADHB's Pacific programme to ensure there are effective Pacific strategies to seek improvements in healthcare, quality and safety for Pacific peoples.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. July 2004</li> <li>2. Ongoing</li> <li>3. June 2004</li> <li>4. December 2003</li> <li>5. December 2003</li> </ol>	
<b>Risks and mitigation strategies</b>	<p><b>Risk</b></p> <ol style="list-style-type: none"> <li>(2,3) Resources are not available to implement the required responses for Community Engagement.</li> <li>4. Process is not approved by the ADHB's Board.</li> </ol>	<p><b>Mitigation strategy</b></p> <ol style="list-style-type: none"> <li>(2,3) Negotiate and agree with the MoH and appropriate allocation to fund the key community engagement strategies from within Pacific Provider Development.</li> <li>4. Negotiate appropriate steps to undertake which allow the Board to be fully informed of ADHB's requirements under the Pacific Health and Disability Action Plan.</li> </ol>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• STR-05: Pacific people are engaged and participate in DHB decision making and the development of strategies and plans for Pacific Health Team.</li> <li>• STR-06: Progress in the development of Pacific workforce and Pacific providers.</li> <li>• QU*A-06: Progress towards implementing the reducing inequalities in health intervention framework.</li> </ul>	

<sup>2</sup> Pacific Health and Disability Action Plan objective, MoH 2002.

## 3.2 Funding health services

This section relates to our DSP strategic objectives and the Ministers “*Start Here*” list and focus on reducing inequalities of, and access to services, as well as appropriateness and affordability of those services in line with the organisations goal *Lifting the Health of Aucklanders*. Each objective is linked to the Section 5.1 *Consolidated List of Indicators of DHB Performance*.

Each of the following strategic objectives are integrally linked to He Korowai Oranga- Maori Health Strategy and the MoH Pacific Health and Disability Action Plan.

### Strategic Objective: He Korowai Oranga

<b>Annual objectives</b>	Progress the implementation of the ADHB Maori Health Strategy consistent with He Korowai Oranga – Maori Health Strategy.
<b>Linkage to strategic objectives</b>	Primary Health Care, Diabetes, Cardiac Disease, Oral Health, Child Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Prevention of Family Violence, Cancer Reduction, Smoking Cessation, NZDS, Human Resource Strategy
<b>Approach</b>	<p>ADHB and Tihi Ora MaPO will continue to jointly undertake health purchasing functions in order to address Maori health needs. The key areas of focus in service planning and funding will include:</p> <ol style="list-style-type: none"> <li>1. Consolidate ADHB’s relationship with Tihi Ora MaPO.</li> <li>2. Consolidate ADHB’s relationship with Maori health and disability providers.</li> <li>3. ADHB Maori needs assessment complete and informs service planning and funding decisions.</li> <li>4. ADHB and Tihi Ora MaPO contract with a Maori led PHO and attend to Maori workforce development requirements.</li> <li>5. Joint sector service initiative proposal for Tamariki and Rangatahi with high need developed.</li> <li>6. Manage Maori Provider Development Scheme (MPDS) with the Ministry of Health. This includes infrastructure support, workforce development, integration, accreditation and best practice policies.</li> <li>7. Retain focus on Maori providers and kaupapa Maori health and disability services.</li> <li>8. Prioritise primary health care including PHO development, public health, intersectoral initiatives and service integration.</li> <li>9. All Maori providers in our district involved in the Maori led PHO launched 1 April and in the further development of this PHO.</li> <li>10. Focus on development of community health workers as integral part of PHO establishment.</li> <li>11. Ongoing reviews of pathways of care towards improving Maori health including a focus on discharge planning (Whakatataka 3.2).</li> <li>12. Improve mainstream responsiveness through input into service planning.</li> <li>13. Establish Maori health advisory committee to provide Maori governance across the organisation on all issues that impact on health gain.</li> </ol>
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. December 2003 and ongoing</li> <li>2. December 2003 and ongoing</li> <li>3. December 2003</li> <li>4. June 2004 and ongoing</li> <li>5. December 2003</li> <li>6. December 2003</li> <li>7 to 13. June 2004</li> </ol>

<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
<b>Indicators and targets</b>	<p>Treaty of Waitangi paper accepted by the ADHB Board.</p> <p>Maori health able to implement the Maori led PHO within allocated funding.</p> <p>Maori health able to agree on a shared vision with a range of agencies.</p>	<p>Affirm that Maori health deals with health and disability issues in the ADHB.</p> <p>Affirm that Tihi Ora MaPO is ADHB's Treaty partner in health.</p> <p>Affirm Maori health priorities of primary health, public health, intersectoral initiatives and integration.</p>
	<ul style="list-style-type: none"> <li>• PRI-04: Participation of Maori in decision-making within the Primary Health.</li> <li>• FIN-02: The percentage of the DHBs total expenditure on services provided by Maori providers compared to the percentage of the DHBs total expenditure on services provided by Maori providers at 1 July 2002.</li> <li>• STR-01: Local Iwi/Maori are engaged and participate in decision making and the development of strategic gains.</li> <li>• STR-02: Progress in development of Maori workforce and Maori providers.</li> <li>• STR-04: Improve mainstream effectiveness.</li> <li>• Men-01: Progress towards improving Maori mental health.</li> </ul>	

### Strategic Objective: Pacific Health: Effective funding and service planning<sup>3</sup>

<b>Annual objectives</b>	To ensure that resources are identified and services appropriately configured, within areas of high health priority, to see a reduction of health disparity for Pacific peoples by June 2007.
<b>Linkage to strategic objectives</b>	Primary Health Care, Diabetes, Cardiac Disease, Oral Health, Child Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Prevention of Family Violence, Cancer Reduction, Smoking Cessation, NZ Disability Strategy
<b>Approach</b>	<p><b>Operationalise the primary health care strategy</b></p> <ol style="list-style-type: none"> <li>1. Develop and establish a Pacific PHO within the Auckland DHB area.</li> <li>2. Assist the Pacific PHO to include all the Pacific providers within the ADHB area to ensure there is a focused strategy for increasing access to primary care and ancillary services for Pacific people within the ADHB area.</li> </ol> <p><b>Reducing inequalities</b></p> <ol style="list-style-type: none"> <li>3. Develop an appropriate model of care that will improve equity of access and reduce disparities for Pacific peoples within the priority areas of: <ul style="list-style-type: none"> <li>• diabetes</li> <li>• outreach immunisation services</li> <li>• parish nursing services.</li> </ul> </li> </ol> <p><b>Population health</b></p> <ol style="list-style-type: none"> <li>4. Strengthen public health programmes by providing support to the ADHB Public Health Unit, Pacific PHO and Pacific providers to ensure Pacific communities are aware of: <ul style="list-style-type: none"> <li>• the benefits of regular physical activity and good nutrition, and breastfeeding</li> <li>• uptake of immunisations</li> <li>• smoking cessation benefits and programmes</li> <li>• injury prevention</li> <li>• minimising harm from alcohol and gambling</li> <li>• reducing risk behaviours, suicide, sexual and reproductive health, child abuse, domestic/sexual violence.</li> </ul> </li> </ol> <p><b>Regional collaboration</b></p> <ol style="list-style-type: none"> <li>5. Lead the process for delivering a regional approach of care with the PHOs in Counties Manukau and Waitemata so that they are able to deliver a comprehensive model of care within the Greater Auckland region, this includes services within primary allied health, mental health and secondary specialist input.</li> </ol> <p><b>Disease state management</b></p> <ol style="list-style-type: none"> <li>6. Develop a model of service delivery that meets the needs of Pacific peoples for complex and chronic conditions, such as diabetes, respiratory illness, cardiovascular disease and elderly care.</li> </ol>
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. April 2003–June 2004</li> <li>2. June 2004</li> <li>3. June 2004 and ongoing</li> <li>4. June 2004 and ongoing</li> <li>5. June 2004 and ongoing</li> <li>6. December 2003</li> </ol>

<sup>3</sup> Pacific Health and Disability Action Plan objective, MoH 2002.

<b>Risks and mitigation strategies</b>	<b>Risk</b> Strategies may not be able to be developed or implemented as a result of being reliant on development and new service monies being unavailable to implement.	<b>Mitigation strategy</b> Develop and agree a dedicated work programme with the key stakeholders (MoH, Pacific and mainstream providers, HBOs, etc) so that funding may be identified from existing sources for service provision and provider development for the service development.
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• STR-05: Pacific people are engaged and participate in DHB decision making and the development of strategies and plans for Pacific Health Team.</li> <li>• STR-06: Progress in the development of Pacific workforce and Pacific providers.</li> <li>• QU*A-06: Progress towards implementing the reducing inequalities in health intervention framework.</li> </ul>	

**Strategic Objective: Reduce the incidence and impact of diabetes in the community**

<b>Annual objectives</b>	In collaboration with inter- and intrasectoral partners work to reduce the incidence and impact of diabetes within the local community.
<b>Linkage to strategic objectives</b>	Obesity, Nutrition, Physical Activity, Pacific Health, Maori Health, Primary Care, Oral Health, Cardiac Disease
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Maintain and institutionally strengthen Diabetes Leadership Group that works with all providers to develop and implement a Diabetes Strategic Plan.</li> <li>2. Develop Business Case for Diabetes Projects within primary investment funding allocation.</li> <li>3. Maintain Local Diabetes Team profile and reporting requirements to MoH.</li> <li>4. Contracted providers [continuum] have fully developed implementation plans including KPIs for monitoring of activities.</li> <li>5. Continue implementation of the Diabetes <i>Get Checked Project</i> in primary care sector.</li> <li>6. Access for Maori enhanced/improved through collaborative processes between Iwi groups, Maori providers, provider arm services, public health and primary care providers for culturally appropriate health promotion/prevention activities and diabetes services.</li> <li>7. Access for Pacific peoples and new migrant groups improved through collaborative processes with specific communities, provider arm services, public and primary health care providers for culturally appropriate health promotion/ prevention activities and diabetes services.</li> </ol>
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004</li> <li>2. July 2003</li> <li>3. June 2004 and ongoing</li> <li>4. June 2004 and ongoing</li> <li>5. June 2003 and ongoing</li> <li>6. June 2004</li> <li>7. June 2004</li> </ol>

<b>Risks and mitigation strategies</b>	<p><b>Risk</b></p> <p>Competing agendas impact on intra- and intersectoral groups working collaboratively together.</p> <p>Maori, Pacific and New Migrant service access is not improved.</p>	<p><b>Mitigation strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>Maori, Pacific and New Migrant providers actively engage in planning and implementation of projects.</p>
<b>Indicators and targets</b>	<p>Directly related indicators are:</p> <ul style="list-style-type: none"> <li>• DIA-07: Implementation of the minimum diabetes dataset</li> <li>• DIA-01: Diabetes case detection rate</li> <li>• DAI-02: Diabetes case management</li> <li>• DAI-04: Retinal screening of people with diabetes in the last two years.</li> </ul>	

**Strategic Objective: Reduce the incidence of and impact of cancer in the community**

<b>Annual objective</b>	In collaboration with inter- and intrasectoral partners work to reduce the incidence of and impact from cancer within local and regional communities
<b>Linkage to strategic objectives</b>	Primary Health Care, Oral Health, Child Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Smoking Cessation, Maori and Pacific Health.
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Health promotion and prevention programmes that target the reduction in the incidence of cancers are funded and supported.</li> <li>2. Screening programmes [breast/cervical] are promoted and target all population groups, particularly those hard to reach groups of Maori, Pacific and New Migrant women.</li> <li>3. Annual renegotiation of contract for the National Cervical Screening Programme completed with Women's Health Services.</li> <li>4. Management and monitoring of waiting times for radiotherapy and chemotherapy are within Ministry of Health Guidelines.</li> <li>5. Management of DNAs at cancer clinics of provider arm, with a focus on Maori.</li> <li>6. DHB input to Ministry of Health Cancer Register.</li> <li>7. Access for Maori improved through collaborative work with Iwi, Maori Health, provider arm and primary care providers for culturally appropriate health promotion/prevention activities and oncology services.</li> <li>8. Access for Pacific peoples and New Migrants improved through collaborative initiatives with specific communities for culturally appropriate health promotion/prevention activities and oncology services.</li> <li>9. Develop, implement and evaluate palliative care services for adults.</li> <li>10. Identify research opportunities into basic mechanisms, novel therapies and clinical trials and appropriate funding sought through research funding agencies.</li> </ol>
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004</li> <li>2. June 2004 and ongoing</li> <li>3. September 2003</li> <li>4. June 2004 and ongoing</li> <li>5. June 2004</li> <li>6. June 2004 and ongoing</li> <li>7. June 2004 and ongoing</li> <li>8. June 2004 and ongoing</li> <li>9. June 2004</li> <li>10. June 2004 and ongoing</li> </ol>

<b>Risks and mitigation strategies</b>	<p><b>Risk</b></p> <p>Competing agendas impact on intersectoral groups working collaboratively together.</p> <p>Maori, Pacific and New Migrant service access is not improved.</p>	<p><b>Migration strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>Maori, Pacific and New Migrant providers actively engage in planning and implementation of projects.</p>
<b>Indicators and targets</b>	<p>Indirectly related indicators are:</p> <ul style="list-style-type: none"> <li>• STR-04: Improving mainstream effectiveness</li> <li>• QUA-06: Progress towards implementing the Reducing Inequalities in Health Intervention Framework</li> <li>• CAN-01: Waiting times for radiotherapy.</li> </ul>	

### Strategic Objective: Reduce smoking within the local community

<b>Annual objectives</b>	Collaborate and co-ordinate intra- and intersectoral activities to reduce smoking within the local community, in line with national strategies.	
<b>Linkage to strategic objectives</b>	Primary Health Care, Maori and Pacific Health, Obesity, Nutrition and Physical Activity, Cardiac Disease, Oral Health	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Complete the implementation of the ADHB Smokefree Policy/rollout smoking cessation programme on ADHB property/premises.</li> <li>2. Maori Iwi and community providers continue work with Public Health, and primary care initiatives that are culturally appropriate health prevention programmes for smoking cessation that particularly target young Maori.</li> <li>3. Pacific and New Migrant communities and providers continue to implement initiatives that are culturally appropriate health prevention programmes for smoking cessation, particularly targeting young people.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004</li> <li>2. June 2004 and ongoing</li> <li>3. June 2004 and ongoing</li> </ol>	
<b>Risks and mitigation strategies</b>	<p><b>Risk</b></p> <p>Competing agendas impact on intra- and intersectoral groups working collaboratively together.</p> <p>Maori, Pacific and New Migrant reduction in smoking is not achieved and lacks community support.</p>	<p><b>Mitigation strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>Maori, Pacific and New Migrant providers actively engage in planning and implementation of projects with local Iwi and communities.</p>
<b>Indicators and targets</b>	<p>Indirectly related indicators are:</p> <ul style="list-style-type: none"> <li>• CHI-08 and CHI-09: Discharge rates for paediatric asthma children aged under 5 and 5–14.</li> <li>• CHI-13: Percentage of babies born in public hospital with low birth weight.</li> </ul>	

**Strategic Objective: Reduce incidences of obesity, improve nutrition and physical activity**

<b>Annual objectives</b>	Maintain inter and intrasectoral work with individuals, families and communities to promote good nutrition and physical activity as a means of reducing incidences of obesity and associated diabetes and cardiovascular diseases.	
<b>Linkage to strategic objectives</b>	Primary Health Care, Maori and Pacific Health, Diabetes, Cardiac Disease, Oral Health	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Health Promoting Schools <i>Food with Attitude Programme</i> delivers annual targets.</li> <li>2. Intrasectoral activities between Public Health and Ministry of Education continue promoting good nutrition, physical activity etc.</li> <li>3. Diabetes and cardiac services and GPs/PHOs continue to deliver services that promote good nutrition, appropriate physical exercise.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004 and ongoing</li> <li>2. June 2004 and ongoing</li> <li>3. June 2004 and ongoing</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Competing agendas impact on intra- and intersectoral groups working collaboratively together.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>All providers, particularly Maori, Pacific and New Migrant providers actively engage in planning and implementation of projects with their Iwi and communities.</p>
<b>Indicators and targets</b>	<p>Indirectly related indicators are:</p> <ul style="list-style-type: none"> <li>• DIA-07: Implementation of the minimum diabetes data set</li> <li>• DIA-01: Diabetes case detection rate</li> <li>• DAI-02: Diabetes case management.</li> </ul>	

**Strategic Objective: Reduce the incidence and impact of cardiovascular diseases in the community**

<b>Annual objectives</b>	Intra- and intersectoral groups continue to work with individuals, families and communities to reduce the incidence and impact of cardiovascular disease in the district.
<b>Linkage to strategic objectives</b>	Primary Health Care, Maori and Pacific Health, Obesity, Nutrition and Physical Activity, Diabetes, Oral Health
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Procure Central Heart Failure Project continues to deliver project activities throughout 2004 in collaboration with cardiac services.</li> <li>2. Manage growth in acute and elective CTSU (paediatric/adult) and vascular volumes within allocated budget and within Ministry of Health Guidelines for Elective Services.</li> <li>3. Optimise utilisation of cardio-surgical capacity within allocated budget.</li> <li>4. Review cardiac services (cardiology, cardiothoracic and catheter laboratories) for region to inform purchasing, equity of services and health gain.</li> <li>5. Identify research opportunities into basic mechanisms, novel therapies and clinical trials and appropriate funding sought through research funding agencies.</li> </ol>

<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004</li> <li>2. June 2004 and ongoing</li> <li>3. June 2004 and ongoing</li> <li>4. Deadlines per research funding schedules.</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Competing agendas impact on intra- and intersectoral groups working collaboratively together.</p> <p>Maori, Pacific and New Migrant service access is not improved.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>Maori, Pacific and New Migrant providers actively engage in planning and implementation of projects related directly to cardiovascular services, indirectly with other services that improve access (i.e. nutrition services for weight reduction, smoking cessation with their own communities/lwi).</p>
<b>Indicators and targets</b>	CAR-03 and CAR-05: Number of people with certainty who have been waiting for more than six months for a coronary artery bypass graft/angioplasty.	

### Strategic Objective: Continuums of care/integration of health sector services

<b>Annual objectives</b>	Continue to improve and grow the primary/secondary/tertiary interface across the sector, including access, appropriateness and affordability of services for the whole population for both acute and chronic care management.
<b>Linkage to strategic objectives</b>	Primary Health Care, Diabetes, Maori Health, Pacific Health, Cardiac Disease, Cancer Prevention and Reduction, Oral Health, Child Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Prevention of Family Violence, Older Persons Health Strategy, Smoking Cessation, NZ Disability Strategy
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Identified additional projects that integrate chronic care services across the continuum for possible funding (e.g. diabetes, asthma, child health services).</li> <li>2. Review infrastructure needs to support chronic care management.</li> <li>3. Continue existing projects that are collaborative between primary/secondary care to manage "Acute Demand Management" and appropriate hospital admissions only occur.</li> <li>4. Elective services management continues working across the continuum and within Ministry of Health requirements.</li> <li>5. Implement the reconfiguration of Primary Maternity Services across two facilities.</li> <li>6. Complete the reconfiguration of Fertility Services for the region to ensure continuums of care for couples requiring fertility interventions.</li> <li>7. Continue to support Procure Saving Initiatives: <ul style="list-style-type: none"> <li>• Heart Failure project</li> <li>• Mental Health</li> <li>• Minor Surgery</li> <li>• CV Predict</li> <li>• Choose 2B Free</li> <li>• U22 (Sexual Health).</li> </ul> </li> </ol>
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. December 2003</li> <li>2. December 2003</li> <li>3. June 2004 and ongoing</li> <li>4. June 2004 and ongoing</li> <li>5. February 2004</li> <li>6. October 2003</li> <li>7. June 2004 – ongoing</li> </ol>

<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
	<p>Competing agendas impact on intersectoral groups working collaboratively together across the continuum.</p> <p>Maori, Pacific and New Migrant service access is not improved.</p>	<p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland and reduce the number of inappropriate admissions to hospitals.</p> <p>Mainstream providers work collaboratively with Maori, Pacific and New Migrant providers to ensure equitable access to appropriate services for acute and chronic care health services.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-03: Nationally consistent clinical assessment – elective services.</li> <li>• QUA-04: Responding to and resolving service coverage issues.</li> <li>• QUA-05: Prioritisation.</li> <li>• QU*A-06: Progress towards implementing the reducing inequalities in health intervention framework.</li> </ul>	

### **Strategic Objective: Improve children and young people's health**

<b>Annual objectives</b>	In collaboration with neighbouring DHBs, primary, secondary and tertiary health care providers, and intrasectoral partners continue to work to improve children and young people health across the continuum.
<b>Linkage to strategic objectives</b>	Primary Health Care, Diabetes, Cardiac Disease, Oral Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Prevention of Family Violence, Cancer Reduction, Smoking Cessation, Maori and Pacific Health, NZ Disability Strategy
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Review Feasibility of an Integrated Child Health Services for ADHB including workforce issues.</li> <li>2. Review Emergency Department services deliver options for emergency acute/ chronic care for children.</li> <li>3. Implementation of National Well Child Framework for children, fully supporting Maori and Pacific providers in line with mainstream providers, Child and Women's Health Services of Provider Arm.</li> <li>4. Immunisation targets reached for all children within the district.</li> <li>5. Immunisation register established and maintained.</li> <li>6. Outreach immunisation programme in situ for Maori/Pacific.</li> <li>7. Meningococcal vaccine pilot for Eastern Corridor implemented.</li> <li>8. Vision and Hearing Programme annual targets met.</li> <li>9. Women's Services progress to full implementation of Baby Friendly Hospital Initiative (BFHI). Birthcare accreditation in 2002.</li> <li>10. Monitoring of low birth weight babies including ethnicity and domicile.</li> <li>11. Maintain joint intersectoral (ADHB/WDHB) local Child &amp; Youth Mortality Review Committee.</li> <li>12. Contribute to the development of an ADHB Child Health Status Report.</li> <li>13. Provider arm child health services continue to work co-operatively with and interface with primary services for management of acute and chronic disease management.</li> <li>14. Paediatric specialists continue to contribute to and lead where necessary National Paediatric Service requirements, in conjunction with the MoH, including leading New Zealand as its primary centre for paediatric research.</li> <li>15. Joint sector projects for high and complex needs children.</li> </ol>

<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. December 2004</li> <li>2. June 2004</li> <li>3. June 2004 and ongoing</li> <li>4. June 2004 and ongoing</li> <li>5. June 2004</li> <li>6. March 2004</li> <li>7. June 2004</li> <li>8. June 2004 and ongoing</li> <li>9. June 2005</li> <li>10. June 2004 and ongoing</li> <li>11. June 2004 and ongoing</li> <li>12. December 2003</li> <li>13. June 2004 and ongoing</li> <li>14. Within research funding and Ministry of Health timelines</li> <li>15. Within Ministry of Health timelines</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Competing agendas impact on intra- and intersectoral groups working collaboratively together across the continuum for child/young person's health services.</p> <p>Maori, Pacific and New Migrant service access for children and young people is not improved.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>Mainstream providers work in collaboration with Maori, Pacific and New Migrant providers to ensure active engagement of their communities in planning and implementation of health or health-related children or young people's services.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• CHIQ-01: Progress towards improving immunisation coverage.</li> <li>• CHIQ-02: Progress in implementing Baby Friendly Hospital Initiative in maternity facilities.</li> <li>• CHI-06: Percentage of children passing school entry hearing screening.</li> <li>• CHI-08 and CHI-09: Discharge rates for paediatric asthma children aged under 5 and 5–14.</li> <li>• CHI-13: Percentage of babies born in public hospitals with low birth weight.</li> <li>• CHI 17, 18 and 19: Ambulatory sensitive admissions.</li> </ul>	

### Strategic Objective: Strengthening inter- and intrasectoral work

<b>Annual objectives</b>	ADHB Child Health and Disability Services and Planning team actively engages in the representation of health needs in the Auckland City Strengthening Families programme.	
<b>Linkage to strategic objectives</b>	Primary Health Care, Maori Health, Pacific Health, Diabetes, Cardiac Disease, Oral Health, Child Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Prevention of Family Violence, Cancer Reduction, Smoking Cessation, NZ Disability Strategy	
<b>Approach</b>	<p><b>Strengthening Families</b></p> <ol style="list-style-type: none"> <li>1. Planning team and Community Child Health and Disability Services representatives' engagement continues with the Core Management and Steering Groups of Strengthening Families.</li> <li>2. All appropriate healthcare professional staff undertake Strengthening Families training.</li> <li>3. Continued case referrals to Strengthening Families within interagency guidelines from health agencies.</li> <li>4. Plan and proceed to implementation of projects funded for high and complex need children for Maori, Pacific and New Migrants.</li> </ol> <p><b>Multi-Agency Centre</b></p> <p>The Multi-Agency Centre [MAC] provides an intersectoral approach to manage the abuse of children and young people. Involves the relocation of some services from Starship and other Police and CYFS offices in Auckland. The MAC's Whakaruruhau works collaboratively with its partners to implement the Family Violence Guidelines within Starship.</p>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004 and ongoing</li> <li>2. June 2004</li> <li>3. June 2004 and ongoing</li> <li>4. December 2003 and June 2004</li> </ol>	
<b>Risks and mitigation strategies</b>	<p><b>Risk</b></p> <p>Competing agendas impact on intra- and intersectoral groups working collaboratively together.</p>	<p><b>Mitigation strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>Appropriate ADHB staff actively engages in various working groups associated with strengthening Family Services in the Auckland District.</p>
<b>Indicators and targets</b>	Reporting to SF project KPIs.	

### Strategic Objective: Implementation of Ministry of Health Family Violence Intervention Guidelines

<b>Annual objectives</b>	Commence implementation of the Ministry of Health <i>Family Violence Intervention Guidelines</i> to train service providers in the identification of violence and early response.	
<b>Linkage to strategic objectives</b>	Primary Health Care, Maori Health, Pacific Health, Child Health, Mental Health, Suicide Prevention, Older Persons Health, NZ Disability Strategy.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Development and implementation of organisational wide policies intervention of family violence, and for Zero Tolerance of Violence in the Workplace.</li> <li>2. First tranche of training programmes for staff in Emergency Departments of Children's Health Services/Auckland Hospitals commenced.</li> <li>3. Ongoing implementation at Women's Health Services of Ministry of Health <i>Family Violence Intervention Guidelines</i>.</li> <li>4. DSAC doctors commence implementation of Ministry of Health Guidelines with primary care providers.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. December 2003</li> <li>2. June 2004</li> <li>3. June 2004 and ongoing into 2005</li> <li>4. June 2004 and ongoing into 2005</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Competing agendas impact on intra- and intersectoral groups working collaboratively together.</p> <p>Access to appropriate Family Violence Interventions is not improved.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>Training of all staff ensures greater understanding, recognition and appropriate referral to services that can intervene in violent situations.</p>
<b>Indicators and targets</b>	Quarterly reporting indicators to Ministry of Health on pilot project both quantitative and qualitative.	

### Strategic Objective: Implementation of oral health strategy

<b>Annual objectives</b>	Ensure ongoing collaboration and co-ordination with primary care providers across the region for the implementation of the new oral health strategy.
<b>Linkage to strategic objectives</b>	Primary Health Care, Maori Health, Pacific Health, Diabetes, Cardiac Disease, Child Health, Obesity, Nutrition, Physical Activity, Cancer Reduction, Smoking Cessation.
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Complete the implementation of the new Oral Health Strategy across the region.</li> <li>2. All primary providers of oral health services have new contracts in situ.</li> <li>3. Monitoring of services and reporting to Ministry of Health on gains, issues etc, undertaken as required quarterly.</li> <li>4. Attendance at regional co-ordination meetings.</li> </ol>
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004</li> <li>2. June 2004</li> <li>3. June 2004</li> <li>4. June 2004</li> </ol>

<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
	<p>Competing agendas impact on regional DHBs preventing working collaboratively together.</p> <p>Maori, Pacific and New Migrant service access is not improved.</p>	<p>Regional DHBs work through NDSA Co-ordinating Group and agree on principles of transparency and co-operation for best outcomes for the oral health of our population.</p> <p>Mainstream oral health providers work with Maori, Pacific and New Migrant providers to ensure they actively engage in planning and implementation of oral health promotion strategies with their communities.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>ORA-04: Mean MF score at Form 2 (Year 8).</li> <li>ORA-01: Percentage of children caries free at age 5.</li> </ul>	

### **Strategic Objective: Mental health services – Blueprint funding**

<b>Annual objectives</b>	Improve equity of access to quality mental health services through the integration and linkage of services across the continuum within allocated mental health blueprint funding.
<b>Linkage to strategic objectives</b>	Primary Health Care, Child Health, Obesity, Nutrition, Physical Activity, Suicide Prevention, Prevention of Family Violence, Older Persons Health, Maori and Pacific, NZ Disability Strategy.
<b>Approach</b>	<p>1. Restructure/reconfiguration of Regional Mental Health Services according to MHC/MoH recommendations.</p> <p>The recent MHC review of Auckland's Mental Health Acute services resulted in 6 recommendations to improve integration and mental health services delivery across the region.</p> <p>A new Regional Director of Mental health services has recently been appointed. As recommended, he will be taking a leading role in establishing the Service coalition, whose purpose will be to strengthen integration across service groups, improve outcomes for consumers by establishing more effective clinical pathways, and ensuring effective continuums of care for all service users.</p>
	<p>2. Review data management systems and track improvement to service access.</p> <p>Current data management systems (eg MHINC) allow us to evaluate the performance of service providers (Provider arm, and to a lesser degree NGOs) at a fairly superficial level. These systems need to be refined to provide more valid and reliable information regarding service users access to services. ADHB will prioritise the development of a more sophisticated approach to data gathering, including the alignment of internal and external reporting requirements to allow us to more effectively track improvement to service access.</p>
	<p>3. Development of, and implementation of quality monitoring framework.</p> <p>The Northern region has commissioned the development of a Regional Mental Health Quality framework. The first draft has been completed, and phase 2 (ie implementation) is currently being scoped.</p> <p>ADHB has committed to developing a localised Quality-monitoring framework in 2003/04, which will be consistent with the regional framework. ADHB funded Providers have been resourced to participate in this process, with stage one (ie data gathering and analysis) due for completion in October 2003. The second stage will involve developing a plan to build provider capacity in areas identified as needing strengthening in stage one of the project (eg specific training needs, up-skilling requirements).</p>

	<p>4. Implement MHC Acute Services Review findings.</p> <p>A proportion of additional Blueprint funding, and new funding made available to ADHB as part of the outcome of the MHC review for 2003/2004 (\$4.49m) has been committed to implementing the MHC review recommendations including the four Intensive Support Packages of Care (\$480,000) and ADHB's contribution to the appointment of a Regional Director, Mental Health Services and Mental Health Coalition (\$140,056 approximately). The Regional Director is to take up a new position in early June 2003 and the development of the Mental Health Service Coalition will occur shortly afterwards.</p> <p>An NGO provider has been selected to provide the four Intensive Support Packages of Care and dedicated clinical support has been allocated to ADHB Provider Arm Clinical Services to support this initiative. Transition planning for the clients is occurring. The Regional Mental Health Plan (RMHP), which is still in draft form will inform any remaining funding for 2003/04.</p>	
	<p>5. Blueprint funding allocation within Ministry of Health requirements.</p> <p>As previous correspondence has indicated we submitted our penultimate draft of the RMHP on 15 August 2003. This detailed our intended allocation of the remaining ADHB 2003/04 Blueprint allocation funding. Priorities within ADHB are likely to be older persons services and building capacity within community mental health services (provider arm and NGO).</p>	
	<p>6. Local and regional stakeholder networks participate in planning and service development.</p> <p>ADHB is actively participating in the Northern Regional stakeholder network and has established our local ADHB Stakeholder network. These networks are actively involved in participating in local planning and service development initiatives, including the development of the regional mental health plan.</p> <p>Local resourcing for 0.5 administration function has been funded by ADHB (approximately \$40,000) and ADHB is contributing funds for the administrative function for the regional stakeholder network (approximately \$40,000).</p>	
<b>Milestones</b>	<p>2. Commence August 2003, completion by June 2004</p> <p>3. Commenced March 2003, stage one completed by October 2003. Full project due for completion by June 2004</p> <p>4. February 2003</p> <p>5. August 2003</p> <p>6. June 2003 and ongoing</p>	
<b>Risks and mitigation strategies</b>	<p><b>Risks</b></p> <p>Restructure of regional mental health services is flawed.</p> <p>Restructuring deflects from operational monitoring, data systems, and funding day-to-day activities.</p>	<p><b>Mitigation strategies</b></p> <p>Regional team works with MoH/MHC to work through issues and achieve restructure.</p> <p>Regional team works with MoH/MHC to work through issues and achieve restructure to ensure day-to-day activities are able to occur.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• MEN-01: Progress towards improving Maori Mental Health.</li> <li>• MEN-02: Comprehensive accurate and timely data is provided to MHINC.</li> <li>• MEN-03: Access to Services.</li> </ul>	

### Strategic Objective: Suicide prevention

<b>Annual objectives</b>	Identify strategies to reduce the rate of suicides and suicide attempts and implement practical solutions in collaboration with other agencies where indicated.
<b>Linkage to strategic objectives</b>	Primary Health Care, Child Health, Obesity, Nutrition, Physical Activity, Mental Health, Prevention of Family Violence, Maori Health, Pacific Health.

<b>Approach</b>	<ol style="list-style-type: none"> <li>Public health promotion/prevention programmes for young people continue.</li> <li>High school health programmes deliver health promotion strategies in relation to suicides in collaboration with MOE and Public Health school services.</li> <li>Primary care providers work collaboratively with public health re health promotion/prevention programmes.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>June 2004 and ongoing</li> <li>June 2004 and ongoing</li> <li>June 2004 and ongoing.</li> </ol>	
<b>Risks and mitigation strategies</b>	<p><b>Risk</b></p> <p>Competing agendas impact on intra- and Intersectoral groups working collaboratively together.</p> <p>Access to appropriate support mechanisms/services in the community is not improved.</p>	<p><b>Mitigation strategy</b></p> <p>Groups work on principles of transparency and co-operation for best outcomes to reduce the incidence and impact of suicide in the community.</p> <p>Mainstream providers work collaboratively and include with Maori, Pacific and New Migrant communities to develop strategies to improve access to appropriate health services.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>PRI-02: Progress in developing the capacity of primary care providers to impact on suicide prevention.</li> </ul>	

#### Strategic Objective: Primary health care services

<b>Annual objectives</b>	Institutionally strengthen the primary health care sector to ensure appropriate, accessible and affordable services are available to a diverse urban population.	
<b>Linkage to strategic objectives</b>	Primary Health Care, Diabetes, Cardiac Disease, Oral Health, Child Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Prevention of Family Violence, Cancer Reduction, Smoking Cessation Continuums of Care/Integration of Health Services, NZ Disability Strategy	
<b>Approach</b>	<ol style="list-style-type: none"> <li>Implementation of NZ Primary Health Care Strategy.</li> <li>PHO development strategy implemented through full participation of primary providers including, GPs, Nurses, Pharmacists, Laboratories, LMC, etc.</li> <li>Maori, Pacific PHOs established and maintained and alternative PHO models explored.</li> <li>Models for integrating primary, secondary care for people with multiple and complex needs, particularly children, young people and, older people reviewed.</li> <li>Complete reviews regarding transport availability, culture and language barriers and model of care.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>June 2004 and ongoing</li> <li>June 2004</li> <li>October 2003 and ongoing</li> <li>June 2004</li> <li>June 2004</li> </ol>	
<b>Risks and mitigation strategies</b>	<p><b>Risk</b></p> <p>Competing agendas impact on intra- and intersectoral groups working collaboratively together for the development of PHOs within Ministry of Health guidelines.</p> <p>Maori and Pacific peoples access to primary health services not improved.</p>	<p><b>Mitigation strategy</b></p> <p>Providers work collaboratively with the Funder using principles of transparency and co-operation for best outcomes for the population of Auckland.</p> <p>PHOs established for Maori and Pacific communities work in collaboration with Iwi and local communities to ensure active engagement in planning and implementation of appropriate health services for their populations.</p>

<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• PRI-01: Progress towards implementing the Primary Health Care Strategy.</li> <li>• PRI-04: Participation by Maori in decision making within primary health care.</li> <li>• CHI-08 and CHI-09: Discharge rates for paediatric asthma children aged under 5 and 5–14 years.</li> <li>• OLD-01: Standardised discharge rates for ambulatory sensitive admissions for older people aged 65 and under 75.</li> <li>• OLD-02: Progress based indicator.</li> </ul>
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### Strategic Objective: Elective services and radiotherapy waiting times

<b>Annual objectives</b>	Elective services including radiotherapy waiting times are managed within the Ministry of Health Guidelines for the population of Auckland and other DHBs.	
<b>Linkage to strategic objectives</b>	Strategic objective related to elective services contract volume management, quality management, primary health care services and all strategic objectives within Sections 3.1, 3.2 and 3.3.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Project management of elective services and reporting to Ministry of Health undertaken on a monthly basis, quarterly reports and face-to-face Steering Group meetings and one-on-one meetings in relation to areas that may face difficulties [see point 2].</li> <li>2. Extended waiting times beyond Ministry of Health Guidelines are notified to appropriate personnel and workout plans developed to manage same.</li> <li>3. Regular Steering Group meetings conducted to monitor contract volume management in tandem with waiting times for FSA and elective services; discuss issues and management of same coupled with interface with the primary health sector.</li> <li>4. GP liaison work continues with individual and targeted services and GP services in the community, including cross boundary liaison work.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004</li> <li>2. June 2004 and ongoing</li> <li>3. June 2004</li> <li>4. June 2005</li> </ol>	
<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
	Competing agendas impact on health providers working collaboratively together across the continuum to manage elective health services.	Health providers' work on principles of transparency and co-operation for best outcomes to manage elective services. Ministry of Health Guidelines are maintained.
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• QUA-03: Nationally consistent clinical assessment – elective services.<sup>4</sup></li> </ul> <p>Ongoing monthly review and management of all FSA/Elective Service Waiting Lists to ensure that patients are not waiting longer than 6 months and/or are referred to back to GPs for appropriate management when FST score not achieved.</p>	

<sup>4</sup> QUA-03 replaces the 2002–03 Elective Services indicators [x3] regarding waiting times etc.

## Strategic Objective: NZ Disability Strategy

<b>Annual objectives</b>	Co-ordination and collaboration regionally and with Ministry of Health in managing local and regional disability support services through and beyond devolution. Implementing the NZ Disability Strategy.	
<b>Linkage to strategic objectives</b>	Primary Health Care, Maori Health, Pacific Health, Older Persons Health, Diabetes, Cardiac Disease, Oral Health, Child Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Prevention of Family Violence, Cancer Reduction, Smoking Cessation, Human Resource Strategy and Planning.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Co-ordinate with Maori, Pacific people and new migrant providers to provide information and support for services to disabled people and families.</li> <li>2. Management of devolution of older person services including mitigating any associated risks.</li> <li>3. A model for the integration of respite care with NASC is developed which meets clients' needs, and proceed to implementation.</li> <li>4. Changes to contracts to require providers to develop a plan to implement the NZ Disability Strategy are agreed and implemented.</li> <li>5. Guidelines developed in consultation with disability groups to assist providers meet the requirement to devise a NZ Disability Strategy Plan.</li> <li>6. The ADHB provider arm identifies key areas of focus for implementation of the NZ Disability Strategy and reports to DiSAC on progress.</li> <li>7. A wider Auckland area approach to service development continues to provide consistent levels and types of service delivery for disabled people and families: <ul style="list-style-type: none"> <li>• regional meetings continued to monitor and plan for disability services and share information</li> <li>• complete review the effectiveness of the shared NASC position with WDHB and maintain if indicated.</li> </ul> </li> <li>8. Consultation within the disability sector on priorities for implementation of the NZ Disability Strategy and actions to improve access to services and to address workforce requirements.</li> </ol>	
<b>Milestones</b>	All June 2004 and ongoing.	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Funding devolved from Ministry of Health to ADHB is inadequate to address services requirement for the population and to fully implement the NZ Disability Strategy.</p> <p>Regional meetings to monitor, share information and plan for services do not occur as providers unwilling to participate/co-ordinate.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>ADHB continues to work collaboratively with the Ministry of Health to ensure that funding is appropriate and adequate to provide services to Auckland population.</p> <p>NDSA/MoH continue to co-ordinate and facilitate meetings.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Annual Work Programme for DiSAC/DEAS.</li> <li>• Devolution of Older People's Services occurs in a timely manner.</li> <li>• OLD-01: Standardised discharge rates for ambulatory sensitive admissions for older people aged 65 and under 75.</li> <li>• OLD-02: Progress based indicator.</li> <li>• ADHB workforce development plan and EEO strategy.</li> </ul>	

## Strategic Objective: Older people's health strategy

<b>Annual objectives</b>	Co-ordination and collaboration regionally and with Ministry of Health in managing local and regional disability support services through and beyond devolution for older people.	
<b>Linkage to strategic objectives</b>	Primary Health Care, Diabetes, Cardiac Disease, Oral Health, Obesity, Nutrition, Physical Activity, Mental Health, Suicide Prevention, Prevention of Family Violence, Cancer Reduction, Smoking Cessation, Maori Health, Pacific Health, consultation, NZ Disability Strategy.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Management of devolution of older peoples DSS contracts including mitigating any associated risks.</li> <li>2. Work with older people, all required services and DHBs to establish integrated continuums of care and consistency of access</li> <li>3. Services for older people strengthened in health promotion and problem prevention with dedicated approaches for Maori and Pacific.</li> <li>4. Older people networks established for service planning and monitoring.</li> <li>5. Mental health of older people is reflected in implementation of the mental health strategy.</li> <li>6. Actions to prevent elder abuse and discrimination of older people.</li> <li>7. Develop and test a range of initiatives with the MoH to support older people stay at home (Ageing in Place Initiatives).</li> </ol>	
<b>Milestones</b>	All June 2004 and ongoing (Funding levels unconfirmed for 2003/04 year).	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Funding devolved from MoH to ADHB is inadequate to address services requirement for the population and to fully implement the NZ Disability Strategy.</p> <p>Regional meetings to monitor, share information and plan for services do not occur as providers unwilling to participate/co-ordinating.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>ADHB continues to work collaboratively with the MoH to ensure that funding is appropriate and adequate to provide services to Auckland population.</p> <p>NDSA/MoH continue to co-ordinate and facilitate meetings.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Devolution of Older People's Contracts occurs in a timely manner.</li> <li>• OLD-01: Standardised discharge rates for ambulatory sensitive admissions for older people aged 65 and under 75.</li> <li>• OLD-02: Progress based indicator.</li> </ul>	

## Strategic Objective: Nursing and midwifery practice and development

<b>Annual objectives</b>	Nursing and midwifery practice will be responsive to the health needs of the population through the promotion of clinically effective practice, quality improvement initiatives, workforce development and implementation of innovative models of service delivery across the continuum of care.	
<b>Linkage to strategic objectives</b>	Primary Health Care Strategy, Investing in Health: Whakatohutia te Oranga Tangata – A Framework for activating primary health care nursing in New Zealand, He Korowai Oranga – Maori Health Strategy, ADHB Maori Health Strategy, Pacific Health and Disability Action Plan, National Pacific Health Workforce Strategy, ADHB Nursing & Midwifery Leadership Strategic plan, NZ Disability Strategy	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Continue participation in the National Magnet Advisory Group and preparation for Magnet Hospital Accreditation in 2006 to support the recruitment and retention of a skilled nursing workforce.</li> <li>2. Investment in quality nursing and midwifery education and workforce development responsive to the health needs of the population.</li> <li>3. Advancement of nursing research agenda and clinically effective practice including service evaluation and evidenced-based purchasing through the Centre for Evidence-Based Nursing Aotearoa (CEBNA).</li> <li>4. Nursing and midwifery workforce data and nursing workload/acuity/patient outcomes indices and systems are developed in partnership with the Ministry of Health and key stakeholders.</li> <li>5. Development of nurse-led disease management/ chronic care models for patients with diabetes, renal, cardiac or respiratory disease.</li> <li>6. Provision of nursing and midwifery leadership in PHO establishment, implementation and service delivery.</li> <li>7. Development of the primary health care nursing and midwifery infrastructure to support workforce development and innovative service delivery models to improve access to primary health care services.</li> <li>8. Planned development of Nurse Practitioner roles in primary health care and provider arm services.</li> <li>9. Development and implementation of regional Maori nursing and midwifery workforce development plan to address health and workforce disparities</li> <li>10. Support for Pacific Health Parish nursing service and workforce development and work collaboratively with the Samoan Nurses Association on National Survey of Pacific Nurses and Nursing students.</li> </ol>	
<b>Milestones</b>	All June 2004 and ongoing.	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risks</b></p> <p>Inadequate funding to support workforce development or service innovation.</p> <p>Nursing leadership not engaged in decision-making.</p> <p>Resistance to the introduction of nurse practitioner role and nurse-led services.</p> <p>Inadequate IT systems for collecting nursing sensitive indicators and patient outcome data.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Work with provider services and MoH to identify dedicated resources for workforce development and explore collaborative opportunities.</p> <p>Director of Nursing &amp; Midwifery part of all key decision-making forums.</p> <p>Communication strategy to inform the public and health sector about nurse practitioner roles and scope of practice.</p> <p>Collaboration with Change Programme and IT Services to develop nursing acuity information system.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• NUR-01: Nursing practice and development.</li> <li>• QUA-01: Quality systems.</li> <li>• QUA-06: Progress towards implementing the Reducing Inequalities in Health Intervention Framework.</li> <li>• PRI-01: Progress towards implementing the Primary Health Care Strategy.</li> <li>• STR-02: Progress in the development of Maori workforce and Maori providers.</li> <li>• STR-06: Progress in the development of Pacific workforce and Pacific providers.</li> </ul>	

### 3.2.1 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 2003–04 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 Ministry of Health. 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 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 those women that certifying consultants deem do not meet the criteria
- MRI scans other than for pre-operative purposes.

ADHB has for many years maintained a policy of providing second trimester terminations of pregnancy that our certifying consultants have determined meet the following clinical criteria:

- women in psychiatric care
- women pregnant as a result of rape
- women pregnant as a result of incest
- women with an existing severe mental illness with a threat of suicide who present in pregnancy
- women who have a permanent mental or physical disability such that they are incapable of looking after a child
- fetal abnormalities.

The Ministry of Health has directed that ADHB shall fund all second trimester terminations of pregnancy for women of our district that certifying consultants consider meet any of the criteria for a legal abortion as defined by the Act. This broadens the scope above to include women who elect to have an abortion up to 20 weeks' gestation.

Women's Health Services will continue to provide second trimester termination of pregnancy in the public sector as per existing clinical criteria. The service is in discussion with ADHB funder arm to develop a basis for funding non-clinical terminations up to 20 weeks' gestation. Elected second trimester terminations outside the clinical criteria but within the Contraception and Sterilisation Act will only be made available for the women of central Auckland. Other DHBs will be responsible for the provision and purchase of second trimester termination of pregnancies for their populations.

### **3.2.2 Service delivery through the provider arm**

The Provider Arm Price Volume Schedule has been attached in Section 7 of the Plan, demonstrating, by standard purchase unit definitions, the areas of service delivery we will provide in 2003–04. The Service Level Agreement (SLA) will follow the national SLA template and be completed at the time of the Crown Funding Agreement sign-off by the Ministry of Health.

The management of IDFs is important as we transition to full PBF implementation in 2004–05. The management of volumes for service delivery to our neighbouring DHBs (70% of our IDFs) and other DHBs nationally will therefore remain a key focus. The ADHB is collaborating with other DHBs to successfully manage this process.

The migration into new facilities on the Grafton and Green Lane sites and the impact of regional service planning (RSP) shifts with Waitemata and Counties Manukau DHBs will also require continued management focus during 2003–04. This will include careful monitoring through the year and management of capacity within our hospital as the number of beds will be lower than the current complement.

Other areas of work regarding service delivery to note include:

- Mental Health Services for Older People in the Western Corridor involving a shift of services from Waitemata DHB to ADHB with no attributable funding transfer
- Provision of Neonatal Intensive Care: managing capacity issues.

#### **Mental health services for older people in the western corridor**

ADHB will take over the provision of Mental Health Services for people in the Western corridor from WDHB as of 1 July 2003. The required service mix and service levels for this population will be informed by the Regional Mental Health planning process, Blueprint Benchmark gaps and the regional mental health for older person's strategy. Additional acute inpatient services are planned as part of the Building programme, and the capacity of community teams will be enhanced.

#### **Provision of neonatal intensive care**

There have been a significant number of antenatal and neonatal transports occurring from regional neonatal units during 2002–03. Traditionally Women's Health Services have been viewed as the "overflow unit" for New Zealand and has managed the Auckland regional volumes and the "rest of New Zealand volumes" when the neonatal units around the country are at full capacity.

2002–03 saw high rates of nursing staff vacancies in ADHB Women's Health Services with difficulty recruiting nursing staff (experienced or not experienced in Newborn care). The Newborn Service at times was unable to admit, or had to significantly restrict, the number of inter-regional babies admitted to the unit as there were not the nursing staff to clinically manage the additional volumes. This had a flow-on effect as other units either managed the greater volumes in their own units or transferred to other regional services, which were also close to capacity.

Wherever possible, both ADHB Women's Health Services and Middlemore transferred out women antenatally (babies in-utero), to ensure optimum birthing and neonatal care at the

receiving hospital. This is an accepted international standard of care, when a hospital is at full capacity and the neonate is requiring a safe level of secondary or tertiary care.

### Capacity issues

The Auckland region currently has 81 neonatal cots in two units. From 2004 there will be four neonatal units with a total of 102 cots, a 26% increase in neonatal cots in the Auckland region, excluding Northland DHB.

Capacity and management of infant volumes is linked closely with workforce planning and the level of staff expertise. A critical level of expert staff is required, particularly in the tertiary Level 3 units.

Women's Health Services have achieved good nursing staff levels. There have been no transfers out to other hospitals since late December 2002, and NWH has accepted a number of neonate admissions from other centres (e.g. Middlemore, Wellington and Waikato NICUs). There is the capability to manage both capacity and complexity locally and regionally.

Women's Health Services currently has the capacity to flex with increased workloads. This will be significantly diminished on migration to the new Auckland City Hospital. However with the increase in cots within the Auckland region, transfers will increase as Women's Health Services manage to the lower level of neonate volumes (particularly Level 2 cots), and bed capacity.

### Agreed cot numbers for the Auckland region

Review of neonatal cot requirements within the Auckland region:

Cot location	Cot numbers	
	2003	2004
Waitemata DHB: North Shore Level II	–	12
Waitemata DHB: Waitakere Level II	–	12
Counties Manukau DHB: Level II and III	22	30
Auckland DHB: Level II and III	59	48
<b>Total</b>	<b>81</b>	<b>102</b>

Auckland District Health Board:

- Level of service provision:
  - Level 4 neonatal care – regional and New Zealand
  - Level 3 for babies in Central, North and West Auckland, and Northland
  - Level 2 for Central Auckland.
- Women's Health Services currently has 59 Level 2 and Level 3 cots. To commence reduction in cots once the Waitemata DHB North Shore Hospital's, Level 2 Special Care Baby Unit opens, a total of 11 cots will be transferred to Waitemata DHB between September 2003 and April 2004.
- The planned end state for ADHB is 46 cots, plus two isolation rooms.

Counties Manukau District Health Board:

- Level of service provision:
  - Level 2 and Level 3 neonatal care
  - Manage whole Counties Manukau region.
- Middlemore Hospital's Level 2 and 3 2002–03 occupancy remains at around 100%.
- Continues to transfer women and babies to ADHB Women's Health Services, Waikato and other regional hospitals if Women's Health Services are at capacity. Counties Manukau DHB plan to increase the number of cots from 22 to 30. The eight cots

comprise two Level 3 cots and five Level 2 cots. The initial plan was an increase in cots in 2004, but this is not confirmed.

Waitemata District Health Board:

- Level of service provision:
  - Level 2 North Shore
  - Level 2 Waitakere
  - Babies requiring Level 3 neonatal care will be transferred to Women's Services. Transfer back occurs as appropriate
  - Transfer from Women's Health Services to Waitemata units if parents live in North or West.
- Development of Level 2 services planned for North Shore (originally July 2002) and Waitakere Hospitals (2004) with a total of 24 cots by 2004. Further delays have occurred in the opening of the North Shore Special Care Baby Unit, and the current projection is for the SCBU is to be operational by September 2003.
- ADHB Women's Health Services will be required to actively transfer babies to assist with Waitemata achieving volumes/occupancy. Women may choose to have their baby at Women's Health Services, but there will be no choice as to where their baby will receive secondary neonatal care.
- North Shore will clinically manage babies born at 32 weeks' gestation / 1500 grams birth-weight onwards. Currently North Shore care for babies greater than 36 weeks' gestation. Babies requiring tertiary care will be transferred to National Women's, and will be transferred back to the North Shore facility when the baby is stable in Level 2 care.

Risk identified: Waitemata does not have its capacity ready in time for Women's Health Services move to Auckland City Hospital.

### **Principles**

1. Continue choice of delivery site for women (political imperative).
2. Require regional policy to manage workload peaks. A regional neonatal group (the Neonatal Network) meet to discuss capacity, volume management, workforce planning, teaching and training issues. This group will be key in managing future Auckland workloads and policies for transfers etc.

### **Regional workforce planning**

General principles for workforce planning for neonatal services are as follows:

1. Risks in recruitment.
2. Staff inexperienced in early stages of Waitemata DHB neonatal services.
3. Co-operation in deployment of staff.
4. Share resources in staff training.
5. Regional planning for staff education programmes.
6. Set up working groups to review training requirements.

### **Auckland neonatal regional network**

Proposed network of neonatal services in the Auckland region, with links to Northland. Make recommendations and monitor:

- development of regional service planning linking all four units
- develop and review clinical practice guidelines and clinical audit
- database to monitor neonatal outcomes on a regional basis
- regional training programme, shared resources, rotation of staff.

### **Neonatal emergency transport service**

- "Mobile" intensive care by road, air ambulance or helicopter to a tertiary Neonatal provider. Specialist training required.

- Current service provided by Women's Health Services for Northland (Whangarei), Waitemata and central Auckland. CMDHB provide a transport service to the South Auckland area.
- Proposed central co-ordination of neonatal emergency retrievals, inclusive of CMDHB.

### **3.2.3 Service monitoring and evaluation**

The DHB monitors the delivery of the services it funds regularly. Reports on performance are received from service providers and reviewed to ensure that service provision is as expected. Where this is not the case any issues are followed up directly with the provider and a process is put in place to resolve issues.

#### **Provider arm services monitoring and evaluation**

Provider arm services are monitored on a monthly basis with the expectation that action plans are provided by the provider detailing how under or over delivery will be managed back to what has been contracted for the year.

The DHB monitors the quality of provision of services by its provider arm through its quality managers, customer satisfaction surveys, complaints and compliments and incident reporting frameworks.

A paper trail is kept to demonstrate the outcome of the monitoring entered into. Where we do not have the internal capacity to undertake monitoring (i.e. auditing of providers) we will contract in those services from an independent provider.

#### **Funder arm contracting monitoring and evaluation**

We have established reports for each provider, documenting the returns that are received from each primary care provider with respect to each contract. This provides a historical record of deliverables under each contract. These reports are presented to funding managers at their periodic meetings with the providers concerned. Performance to contract is a condition for contract renewal.

#### **Improving contributions to national data systems**

ADHB has made a commitment to contributing to technical working groups within the DHB sector, DHBNZ and the Ministry of Health. We will be actively engaged in all technical working groups related to the national service framework during 2003–04.

#### **He Korowai Oranga**

ADHB commits to involve Iwi and Maori in monitoring progress against He Korowai Oranga and has completed a monitoring framework with Tihi Ora MaPO.

The DHB monitors and evaluates the delivery of services via a Maori provider contract monitoring framework which is now complete. The framework is used to report on ADHB's progress against objectives.

Ongoing service monitoring is managed with Tihi Ora MaPO.

### **3.2.4 Additional funding responsibilities**

#### **The transition to population based funding**

One of the key areas of preparation for the impact of the planned introduction of PBF is ensuring the accuracy of the information identifying the domicile of the patient using the services. This message is being conveyed through the various communication forums and networks that we operate.

Our monitoring systems are being amended to ensure that we are able to monitor effectively by the domicile of the patient treated against what we are contracted to provide. We work closely with our regional neighbours to ensure they understand what services are provided to their populations through our provider and have the opportunity to confirm they are appropriate. This assists us in managing our service capacity and planning for growth where this is indicated by needs.

### **Integrated continuum of care – Health of Older People Strategy**

This plan recognises the need to move towards an integrated continuum of care consistent with the health of Older People Strategy and has made progress in this area. A research project has been used to evaluate a primary care based model for integrating services for older people with multiple and complex needs in Auckland. Following this process, plans are underway to establish 'clinical co-ordinator' services with emerging PHOs over the next 12 months. The clinical co-ordinators will work closely with and complement local NASC services. A small group of older consumers will form a consumer advisory group to support the development and implementation of the co-ordinated care services.

### **DSS devolution planning**

ADHB is working in co-operation with other regional DHBs and the Ministry to establish a plan for the devolution of DSS services for older people. The following table covers key considerations for the transfer of funding and responsibilities.

<b>Initiative</b>	<b>Action</b>
<b>(a) Operate effectively as a funder of health services</b>	
Develop an understanding of the issues	<p>ADHB has funder capabilities as part of its core funding and planning team. However, in light of the Auckland cross boundary flows, the Northern District Support Agency will play an important role in managing the administrative and payment functions in the first instance.</p> <p>The Northern region DHBs have discussed further funding management mechanisms noting the paucity of demographic data, particularly in the non DHB provider area. The DHBs are working towards a workable risk sharing agreement that ensures that continuity of care is not compromised.</p> <p>A project team has been established that will be responsible for managing two streams of work:</p> <ul style="list-style-type: none"> <li>• working with the Ministry on the mechanism of devolution, focusing on HR and revenue devolution (including payment mechanisms and information requirements)</li> <li>• developing an integrated continuum of care.</li> </ul>
<b>(b) Criteria for DHB Planning (integrated continuum of care)</b>	
Involving older people, their family/whanau carers and those approaching 65 years of age in relevant planning	<ul style="list-style-type: none"> <li>• A consumer advisory group is being formed to support implementation of integrated continuums of care for older people with multiple and complex needs in Auckland.</li> <li>• The group includes older people representing Maori, Pacific, European, male, female and Personal Health with a range of perspectives including personal mental health perspectives and includes a DiSAC member.</li> </ul>
Stakeholder feedback on proposals	<ul style="list-style-type: none"> <li>• Will be managed via the advisory group.</li> <li>• A provider network is being formed to keep all providers up to date via ADHB newsletter.</li> </ul>
Assess and prioritise health and disability needs of older people	<ul style="list-style-type: none"> <li>• The consumer advisory group will work closely with the DHB to conduct consultation within the appropriate cultural population.</li> </ul>
Joint service planning within their DHB	<ul style="list-style-type: none"> <li>• Appropriate providers are involved in all planning via projects as relevant to their area of service and interest.</li> </ul>

Initiative	Action
Joint service planning with other relevant DHBs and service providers	<ul style="list-style-type: none"> <li>A regional group has been formed with Counties Manukau and Waitemata DHBs and a regional overall approach and plan developed for older people.</li> </ul>
Identify barriers to integrated continuum of care in current planning and service practises	<ul style="list-style-type: none"> <li>We will implement integrated continuums of care for older people with multiple and complex needs. This will build upon a tested primary care/ PHO based model and be adapted to meet the specific needs of older Maori and Pacific people. The next stage will be to adapt the model for older people with less complex needs.</li> </ul>
Identify and access internal funding that supports integrated continuum of care	<ul style="list-style-type: none"> <li>Provider arm services will be included in the integrated continuums of care as appropriate for each older person.</li> </ul>
Identify and access external funding that support integrated continuum of care	<ul style="list-style-type: none"> <li>Need to have more information regarding external funding. Co-ordinators of care will need to be kept informed of any non-health funding available.</li> </ul>
Identify and plan to use both internal and external funding to support integrated continuum of care	<ul style="list-style-type: none"> <li>Integrated continuum of care services will begin with the individual (establish their goals, priority personal health and social/cultural needs) and develop a plan which meets these as far as possible within the community.</li> </ul>
Evaluate and monitor the quality of the services, based on continuous quality improvement	<ul style="list-style-type: none"> <li>Assume that all contracts devolved will have clear measures/ quality standards within the contracts and will have been audited to ensure high service quality and financial viability and prior to transfer. Assume sufficient funding will be devolved to continue the current processes.</li> </ul>
(c) Understand disability support services	
Engage with Ministry in information exchange around the context, scope and shape of disability support services	<ul style="list-style-type: none"> <li>Initial dialogue has been entered into with Ministry. In particular, the northern DHBs have commissioned a report on actual delivery within the region. This has highlighted issues with the quality of performance information, particularly in relation to domicile statistics.</li> <li>Currently working with the Ministry on projects when invited (e.g. Ageing in Place initiatives and RFP for dementia beds).</li> <li>Once the final decision around devolution has been made we will be seeking detailed financial and performance information from the Ministry.</li> </ul>
Understand social and medical models of care	<ul style="list-style-type: none"> <li>See integrated continuums of care.</li> </ul>
Relationships with (non-DHB) DSS providers	<ul style="list-style-type: none"> <li>See (b) above.</li> </ul>
Build relationships with interest groups for older people	<ul style="list-style-type: none"> <li>See consumer advisory group discussion above.</li> <li>Maintain ongoing and active involvement with the greater Auckland older people's network via monthly meetings.</li> <li>Ensure older people are a distinct group to be included in future consultation/community engagement work</li> </ul>

Initiative	Action
Effective management of “demand driven services” including provider development. Managing services and service risk (e.g. regionally)	<ul style="list-style-type: none"> <li>• As the majority of rest home beds (the highest cost component of the demand driven area) are within the ADHB catchment and the quality of domicile information is poor, it is important that regional processes are developed to manage service risk and access in a consistent manner. The first arm of the project team will need to develop mechanisms to manage this.</li> <li>• In the longer term, demand driven risk will be managed through service initiatives developed through the integrated continuum of care project. As this is a regional project, we will be aiming to get as much consistency as appropriate for the population.</li> </ul>
(d) Criteria for DHB funding (capacity to manage)	
Identify changes re transfer of funding between services within their Support integrated continuum of care, with plan to implement the changes	<ul style="list-style-type: none"> <li>• While this area will be important in the future, the 2003/04 will be focused mainly on managing contracts that have been rolled over in the first instance. We have yet to identify the required funding changes to enable us to implement the continuum of care projects as we have not received full details of available funding from the Ministry. We expect greater detail once the decisions around devolution have been finalised.</li> </ul>

### 3.2.5 Service changes since 2002/03

#### Regional service planning

The migration of our provider arm services into their new facilities in 2003/04 sees several service reconfigurations planned to enable us to be appropriately structured for the future. We have worked collaboratively with Waitemata DHB and Counties Manukau DHB through the regional service planning process to reconfigure services so that populations have access to appropriate services as close as possible to where they reside. Higher complexity services will continue to be provided from one location in the metro Auckland region.<sup>5</sup> Services significantly impacted by this in 2003–04 will be:

- cardiothoracic
- general medicine
- general surgery
- haematology
- otorhino laryngology (ORL)
- respiratory
- urology
- orthopaedics
- neonates (outlined in 3.2.2)
- mental health services for older people (3.2.2).

All risks related to regional service planning have been fully identified throughout the planning stages. Risk management strategies will be put in place to ensure that the capacity shifts happen between facilities according to timelines. This will include the stringent monitoring of performance with any lapse identified and remedy determined.

The process entered into to analyse the impact of these service shifts has been a transparent process and has occurred over an extended period of time to ensure that it complies with minimum service coverage requirements and that safety and quality standards are adhered to and appropriate funds shift with reconfiguration. Service reconfiguration across the region will result in an improvement in health equity and access as secondary level services will be provided closer to their DHB of origin/residence.

<sup>5</sup> This section is linked to Section 3.2.6 regional service configuration.

### **Reconfiguration of primary maternity services**

Women's Health, Maternity Services has a 99-bed capacity for primary, secondary and tertiary maternity services. As of April 2004 when these services migrate to the Auckland City Hospital, the capacity will be reduced to 82 inpatient beds, with a focus on secondary and tertiary maternity services for the district, region and nation. This reduction in bed numbers reduces the capacity for primary maternity services.

Birthcare Auckland Ltd has a four space delivery suite and 41 postnatal beds. There is a significant level of under-utilisation of this capacity. As it stands, almost 2000 women transfer to Birthcare postnatally per annum from Women's Health Services. It has been agreed that a further 1400 primary maternity women per annum will be accommodated at Birthcare for their post natal stay to ensure that we have appropriate primary maternity capacity for the women of central Auckland.

The gains from the reconfiguration of primary maternity services is closely aligned to ADHB's four key goals and includes:

- a cohesive and collaborative interface between primary, secondary and tertiary maternity facilities within the district (Lifting the Health of Aucklanders)
- net cost benefit savings to the organisation (Improve our Business Performance)
- capped volume contract with Birthcare (Improve our Business Performance)
- work with existing and future maternity facility capacity within the district (Finish the Building Programme and Making the Change Programme Happen)
- maximise utilisation of the workforce (midwives in the Region) and provide the women of Auckland with a broader choice (Lifting the Health of Aucklanders and Making the Change Programme Happen).

### **Reconfiguration of regional mental health services (links to 3.2.6)**

Currently ADHB provides a mix of regional and local mental health inpatient and community services. The recent review of Auckland mental health services recommended the appointment of a Regional Director Mental Health and Mental Health Coalition to provide leadership and direction for the configuration and integration of mental health services. Any future regional reconfiguration of services will be informed these new functions, in conjunction with the Regional and Local stakeholder networks, and Regional Mental Health Funding and Planning team.

### **Primary health organisations (PHOs)**

ADHB will make dedicated efforts during 2003–04 to further implement the government's Primary Health Care Strategy in order to improve access to services for populations with high health needs; improve service co-ordination; and have more health problems resolved in the primary sector. We want to make the most of this nationwide opportunity to achieve the following aims:

- better health for our ADHB population
- reduced health inequalities
- community participation in planning, service delivery and monitoring/evaluation
- greater emphasis on population health
- primary health care fully integrated in the health system
- co-ordination, collaboration and co-operation to provide continuity of care
- access to primary health care services that are affordable and appropriate.

Locally, doctors and related primary care services have been encouraged to work in high need locations to reduce the level of co-payment required of patients, and to work closely with other health workers. Two PHOs have formed with start dates of 1 April 2003 and over time they will take increased responsibility for:

- liaising with the DHBs on health planning and co-ordination issues

- changing practice, involving a more flexible role for practice nurses with patients, and clinical staff adopting a preventative and population health focus
- improving the way in which laboratory and pharmacy services are managed
- improving the way in which referrals to hospital services are managed
- reducing chronic disease problems, including public health activities that improve health or reduce the incidence and impact of certain diseases.

Our PHO development is underpinned by a focus on people, notably:

- the right services delivered at the right time, in the right place, in the right setting, and by the right people
- introduction of culturally appropriate management tools for service delivery (whanau ora)
- community interests served, which means PHOs may need to form across the boundaries of Waitemata or Counties Manukau DHBs.

We believe that PHOs should provide a range of services that help to prevent the health problems identified as priorities for our community. These include diabetes, heart disease, cancer, mental health problems (including alcohol and drug abuse, and suicide), family violence (including domestic violence and child abuse), oral health and the diseases that affect children, young and older people. Along with health promotion for the population, PHOs will be able to increase access and improve service delivery for people with disabilities and take responsibility for implementing the NZ Disability Strategy in the primary care area.

There is also a need to provide services focused on improving family/whanau health outcomes through, for example, the Well Child/Tamariki Ora Schedule, sexual health services, cancer screening, programmes, and family planning.

The ADHB Board signed off on a Primary Health Organisations (PHO) Establishment Plan in 2002–03. This Plan aims to have between three and seven PHOs established in the district by 2005 and 70% of Aucklanders enrolled under the new scheme. A Maori-led PHO and Pacific led PHO were established 1 April 2003. Emphasis in 2003–04 will be on the further development of PHOs for high needs groups in the community and the facilitation of shared support services required by the newly-formed entities.

### **Diabetes services**

Diabetes is a priority for ADHB and one of the Government's 13 health objectives. The management of diabetes in New Zealand has been spearheaded by the Ministry of Health development of evidence-based guidelines for the management of diabetes in primary care settings.

The Ministry of Health guidelines have been implemented into primary care practices through the *Get Checked* programme. These guidelines are for known diabetics, the view being that it is an ethical imperative that we have effective services for known diabetics prior to considering systematically seeking out at-risk or undiagnosed diabetics.

While there is good access to secondary care services<sup>6</sup> the ability of primary care to manage known diabetics effectively is variable. The emphasis of the Ministry of Health National Diabetes Framework is on increasing the effectiveness with which primary care is managing known diabetics.

While it is recognised that changing people's lifestyle and nutritional habits will reduce the impact (or incidence) of diabetes on people's lives, there is little evidence to support any particular model for achieving such lifestyle changes.

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<sup>6</sup> ADHB is, through its provider arm, implementing a programme for Maori and Pacific people with diabetes and renal disease to effectively manage their blood pressure, the outcome being to slow the onset of renal failure. This is another platform for the development of chronic care management.

Of the 9600 “known” diabetics in the ADHB catchment including 892 Type 1, approximately 26% or 2500 of these received the *Get Checked* services (free) in 2002–03. Sufficient funding exists for all the identified diabetics in the district to receive this free service. The issues for ADHB are:

- provider capability
- consumer awareness
- accessibility and appropriateness of services.

To address this issue, the ADHB has allocated \$350,000 of the Primary Investment Fund of 2002–03 into increasing the uptake of *Get Checked* within the ADHB diabetic population and this funding will carry over into 2003–04. Included within this allocation is support to mainstream services.

This investment is specifically targeting access issues for Maori and Pacific peoples and will focus on:

- increasing *Get Checked* access by Maori and Pacific (e.g. use hepatitis B experience to access)
- providing advice, training and education support to primary care practices
- providing education and management advice to consumers
- increasing retinal screening
- raising consumer awareness
- reviewing and developing youth community-based services.

ADHB’s interim target is to raise the level of *Get Checked* from the current estimate of 26% up to 42%. This target will be subsequently raised and expressed in terms of an outcome measure such as average HBA1c score.

We believe the investment will deliver an increase in the effectiveness of managing individuals with diabetes, and ultimately their families, and that it will reduce the need for other secondary interventions, for example, renal dialysis, cardiac surgery, vascular surgery.

### **Primary investment fund**

ADHB has allocated \$1 million of provider arm funding to the funder arm for investment in primary care services. The Board has also given provisional approval for a further \$500,000 to be added to this pool for 2003–04. These funds are expended in an effective manner that seeks to maximise the health gain from this expenditure and reduce utilisation of secondary services.

The principles we will apply for investment in primary care initiatives include:

- consistency with government health priorities and ADHB priorities
- investment is primarily funded by Vote Health and not other public or private funding streams
- client/service outcome measurement focus
- marginal additional service revenue to largely improve the integration and effectiveness of existing services
- flexible enough to meet and access the target populations while preserving the critical mass of valuable health knowledge
- preference on existing known providers where we can optimise the value of the additional revenue, rather than invest in start-up costs for new services, or in building provider capacity
- will not be applied to where other funding streams are available, for example, inequalities funding, PHO development, Blueprint funding.

Year 1: 2002–03 Primary Care Funding Initiative funding was utilised for the following services:

- Acute Care Management – Procure joint initiative with Auckland/SSH – ongoing funding
- Pacific Parish Nursing Initiative– ongoing funding
- Diabetes projects – ongoing funding
- Glen Innes project – one-off funding for intersectoral initiative for the management of cellulitis in the community. This project will continue into 2003–04 due to a late start date.

Year 2: 2003–04 Primary Care Funding Initiative funding will be utilised for those initiatives commenced in 2002–03 with further initiatives likely including:

- Children's and young person's diabetes prevention and management project
- Enhancement of Palliative Care Services for Adults in line with the Ministry of Health Palliative Care Strategy
- Primary mental health services
- Integrated continuum of care for older people
- Outreach immunisation services for new migrants
- Enhancement of palliative care for adults with hospice services

### **Pacific health – parish nursing**

The Parish Nurse Service is currently being delivered by Health Star Pacific Trust, a community-based Pacific health provider, within the Pacific Islands Presbyterian Church in Glen Innes. This is the first initiative of this type to be initiated by a District Health Board. The Parish Nurse Service is expected to extend its services to include the Pacific Islands Presbyterian Church in Newton within the central Auckland area by May 2003.

The context for service delivery is to focus at the following key elements of service delivery.

- A registered nurse and team of community health workers, who may be part of the parish, working within an identified church community to identify and assess health needs in the form of a health profile. This profile will assist the development of individual and parish health plans identifying strategies that will address health issues presented by members of the church.
- The registered nurse and team of community health workers will facilitate access to primary care services with a view to restoring, maintaining and improving health status. The service will be expected to look at the priority health needs of the church community.
- Reducing health inequalities as determined by the health profile and various national and regional health strategies.
- Emphasis on parish and individual responsibility for health care.
- Providing services in a culturally appropriate setting by culturally competent Pacific people.
- Ensuring the effective co-ordination and integration of services to the target population by working collaboratively with other primary and secondary care providers, community groups, other sectors and agencies to facilitate access to their services.

To date the parish nurse initiative has completed the following key outputs.

- Enrolments into the programme are 227 parishioners. Initial estimates are that this represents approximately 70% of the regular parishioners.
- Health assessments have been completed for all but one enrollee.
- Health care plans are actively being completed for individual enrollees as the availability of the baseline health assessment information for each of the enrolled parishioners is collected.

- As the health priority areas of diabetes, cardiovascular disease, cellulitis and child health are actively being achieved, Health Star Pacific Trust have also been able to identify that there are similarly other areas of health priority which are currently being screened for and assessed. These are:
  - asthma
  - hepatitis B
  - food allergies
  - drug allergies.

The focus for Health Star Pacific Trust, ADHB and the church for the 2003–04 year is on:

- integrating the current model of service delivery into a greater sphere of service delivery
- focusing on achieving 100% activation of individual health care plans to ensure that clients are managed appropriately
- rolling out the service to central Auckland using the knowledge from the first church
- exploring principles of holistic health (physical, mental and spiritual) and their contribution to improved health status
- identifying ways of incorporating Parish Nursing Services into the PHO setting.

### **Nursing**

The nursing and midwifery workforce has undergone significant change over the last year. Investment in Nursing and Midwifery leadership has resulted in a major contribution to the ADHB strategic objectives and achievement of the organisational goals. The implementation of the Model of Care including team nursing, the introduction of Health Care Assistants (HCAs) and the integration of the senior nursing workforce will mean changes in the way that nurse's work to deliver patient care and more effective use of resources.

Part of the focus for the 2003–04 year will be to consolidate these achievements and work towards Magnet Hospital Accreditation in 2006 as a key strategy to recruit and retain a skilled nursing and midwifery workforce in the new Auckland City Hospital.

The introduction of the nurse practitioner role both in provider arm services and primary health care will be another critical development for improving patient health outcomes and making a cost-effective contribution to the health sector. Funding from the Ministry of Health Primary Health Care Nursing Innovation Fund and PHO establishment provides an opportunity to further develop innovative nurse-led models of service delivery, support nurse practitioner development and explore pathways for nurses to transition to the community.

### **3.2.6 Greater Auckland collaboration programme and initiatives**

The three DHBs that make up the Greater Auckland (metro) have fostered collaborative working arrangements in a number of areas. The work currently being undertaken and planned for 2003–04 by various working groups facilitated by the NDSA are integrally linked and tied back to our DSP and ultimately this plan. Section 3.1 has a strategic objective related to this collaborative venture and we have detailed the work to illustrate the links between provider and funder arm activities, and across DHB boundaries.

### **Public health**

Cabinet decided in April 2001 that:

- the Ministry will retain responsibility for the funding and planning of public health services
- the Ministry 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.

To date there are no detailed plans or timeframes for transferring public health responsibilities to DHBs, other than the health promotion funding which is being made available to primary health organisations through DHBs. The focus over the last 12–18 months has been to integrate decisions and planning around public health across the health sector. DHBs and the Ministry's Public Health Directorate have joint responsibilities to improve, promote and protect the health of people and communities in the geographical areas they serve.

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

1. Relationships between the Ministry / 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.
  - Via the Steering Group, participate in the equivalent national forum, the National Public Health Steering Group (facilitated by DHBNZ).
  - At an individual DHB level, we will continue to liaise with an assigned Auckland Public Health Locality Team member on day-to-day district public health matters including consultation on PHO health promotion programmes.
2. Wider sector involvement in public health planning and funding. We will continue to participate in the (Northern Region/Northland) Public Health Sector Reference Group that provides for wider sector consultation on public health issues to better inform decision making.
3. Specific joint projects and information sharing. We will continue to participate in joint venture projects developed under the auspices of the Steering Group. These currently include a project around delivering public health strategies through primary care and a project developing programmes to address Asian public health issues.
4. Reorienting provider service plans and specifications. We will work with the Auckland Public Health Directorate 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. This will, for example, include reorienting regional public health provider plans to respond to ADHB priorities, and public health objectives (as set out in Achieving Health for All People).

### **Regional service configuration**

On 17 February 2003 a Regional Service Configuration planning day was held and attended by the Regional Funding and Planning, Service Planning and Capital Planning groups. The main objectives of the planning day were to agree processes for Regional Service Configuration in the short term and how to take a more planned approach towards Regional Service Configuration in 2003–04.

The tables below provide information on the activities of each of the component parts of Regional Service Configuration in the short and medium term, and processes to improve communication and informed planning across the groups.

<b>Short-term activities</b>		
<b>Regional funding and planning</b>	<b>Regional service planning</b>	<b>Regional capital planning</b>
<ul style="list-style-type: none"> <li>• Advice to ad hoc requests</li> <li>• Signal volume intentions 2003–04</li> <li>• Indicative volumes 2004–05</li> <li>• Brief to be considered by NDSA Board, 29 April 2003</li> </ul>	Implementation planning for the following services: <ul style="list-style-type: none"> <li>• AT&amp;R</li> <li>• Neonatology</li> <li>• Orthopaedics</li> <li>• MHSOP</li> <li>• Urology</li> <li>• ORL</li> <li>• Haematology</li> <li>• Respiratory</li> </ul>	<ul style="list-style-type: none"> <li>• Development of cath lab business case</li> <li>• Development of mental health business case</li> <li>• Development of renal business case</li> </ul>
<b>Short-term processes</b>		
<p>In the short term (2002–03), progress on the implementation of specific services and the development regional business cases will be communicated through:</p> <ul style="list-style-type: none"> <li>• monthly updated written reports, via the NDSA (Regional Service Planning critical issues 2003) to the members of each Regional Service Configuration project stream and the NDSA Board.</li> </ul> <p>In the short term, recommendations on regional business cases will be from:</p> <ul style="list-style-type: none"> <li>• The Regional Service Configuration group (i.e. Funding and Planning, Service Planning and Capital Planning) and clinicians. Each group will provide written views on the business case as early as possible and there will be an iterative process in which feedback on the implications of views/advice received is then provided by the business case leader/team.</li> </ul> <p>In the short term, a standard business case brief and full business case table of contents will be developed for future/upcoming regional proposals. The NDSA will facilitate the above processes.</p>		

<b>Medium-term activities</b>		
<b>Regional funding and planning</b>	<b>Regional service planning</b>	<b>Regional capital planning</b>
<p>Strategic framework:</p> <ul style="list-style-type: none"> <li>• proportion of funding package available for hospital and specialist services</li> <li>• planning assumptions and principles (including prioritisation)</li> <li>• pricing assumptions</li> <li>• volume trends</li> <li>• IDF business rules</li> <li>• population health.</li> </ul> <p>Regional funding and planning parameters will provide the framework for regional service configuration to work within.</p>	<ul style="list-style-type: none"> <li>• Implementation planning for: AT&amp;R, Neonatology, Orthopaedics, MHSOP, Urology, ORL, haematology, oncology, ophthalmology, paediatric orthopaedics, plastics and respiratory.</li> <li>• Inform NDSA Board of costs of service reconfiguration, where costs associated with change are potentially significant.</li> <li>• NDSA Board to advise on implementation.</li> <li>• Services that do not have a critical impact or timeframe for the regional building programmes (and have no significant funding or capital impact) will be assigned to the operational units for development.</li> </ul>	<p>Future regional business case proposals to be addressed as per process outlined below.</p>
<b>Medium-term processes</b>		
<p>In the medium term (2003–04):</p> <ul style="list-style-type: none"> <li>• regional business cases will be 'worked up' through the Regional Service Configuration group, which will meet quarterly</li> <li>• a prioritisation tool/evaluation criteria will need to be developed for the purpose of assessing and ranking regional business case briefs</li> <li>• business case briefs will go the NDSA Board with a recommendation from the Regional Service Configuration group as to whether or not a full business case be developed</li> <li>• the NDSA Board will advise on the development of a complete business case</li> <li>• the NDSA will facilitate the above processes.</li> </ul>		

### **Audit regional workstream**

The need to improve non-government organisation audit has been identified by DHBs as a priority that could be best handled regionally. A regional group chaired by the NDSA has been formed under the direction of the Regional Funding Forum.

It is proposed that a regional approach to audit would be mutually beneficial to the Northern DHBs for the following reasons:

- consistency of audit programme particularly for providers across DHB boundaries
- shared experience, commonality of problems
- reduction in cost, both administrative and audit
- requirement for and ability to attract specialist skills
- audits are resource intense, DHB staff are already committed to other work
- sharing of expertise across DHBs
- collective perspective to risk management
- benefits using a dispassionate third party for audit function.

A review of audit functions carried out by other agencies on behalf of the DHBs identified two agencies that the NDSA will work with:

- HealthPAC – provides an audit and compliance function relating primarily to Primary Health payments made by HealthPAC on behalf of DHBs and the Ministry
- Medsafe – provides an annual audit function of all pharmacies within the Auckland metro region to ensure they comply with the relevant legislation and work to best practice codes.

The regional NGO audit function is intended to supplement these functions.

It is proposed that a regional NGO audit function will be administered by the NDSA and operational in July 2003. As administrator the NDSA will facilitate:

- regional audit framework
- three-year regional NGO audit plan by DHB
- the selection and engagement of third party auditors
- regular activity reporting against agreed plan to DHBs
- administration of issues based audit requirements
- NDSA Board sign-off being sought in February 2002.

The regional function via its planning process will ensure that audit of providers is structured in a way that limits identified risks and ensures value for money.

An issues based audit function will be included in the process that enables additional audits to be actioned as and when required when issues have been reported either directly or via the monitoring process.

### **Regional information systems collaboration**

There is an active process of Regional Information Systems (IS) collaboration. A shared services agreement has been signed between Counties Manukau and Waitemata DHBs and ADHB has committed to the use of a number of common systems with increasing alignment over time.

iSoft PiMS patient administration, Delphic LIS (Laboratory Information System), Delphic Eclair results reporting and Kidslink child immunisation and Well Child checks, have been implemented as shared services systems between Counties Manukau and Waitemata DHBs. There are also plans to implement the Orion Clinical Information System (CIS) as a shared service. The CIS will include elements of integrated care such as electronic discharge summaries. Further collaboration is planned with systems for Chronic Care Management, and the two DHBs will shortly agree a joint Information Systems Strategic Plan (ISSP).

Over the next three years, the ISSP will deliver systems for PHO care co-ordination, Community and Mental Health, National Immunisation Register and the District Immunisation Register, Acute Demand Management, electronic referrals linked to electronic first specialist assessments and primary electronic access to secondary booking systems, Application Service Provider support for primary care, Clinical Data Repository and Data Warehouse for DHB KPI development and information management and analysis.

The ADHB will implement the same PiMS, Eclair and Orion CIS systems as the other two DHBs with an expectation that regional IS collaboration will eventually extend to health Alliance shared services and a common ISSP for all three DHBs.

### **Regional pharmacy contracting strategy**

The Auckland DHBs are working collaboratively to develop and implement a new service and contracting strategy for the Auckland region.

The objectives are to:

1. split distribution from professional pharmacist services from a contracting and service delivery perspective
2. realise efficiency gains and value maximisation from an enhanced distribution system

3. align pharmacy contracts with DHB funding paths
4. improve pharmacist involvement in the implementation of the Primary Health Care Strategy
5. improve professional services value via integration of professional pharmacy services that will align with primary care teams.

The service strategy will include working with sector workgroups to assist in the development of initiatives.

The development of the strategy will include the milestones and activities required to implement the services. This may include a reconfiguration of existing primary care services and programmes.

From July 2003 implementation of new services will commence. Implementation plans may differ in each district depending on the structure and capacity of services. Implementation planning will be a component of the development process.

### Regional approach for mental health

Regional structures and forums have been developed by DHBs to provide alignment/co-ordination of the funding, planning and delivery functions of mental health services in the Northern region. These include:

<b>Northern DHB Support Agency Limited (NDSA)</b>	The role of the Northern DHB Support Agency Limited (NDSA) is to provide support to the four northern region DHBs in their role as health and disability service funders, in functional areas specifically delegated to the NDSA. This limited liability company is jointly owned by Auckland, Counties Manukau and Waitemata DHBs, with Northland DHB using services as a customer.
<b>The NDSA Mental Health Team</b>	Supports DHBs in funding services that decrease the prevalence of mental illness and reduce the impact of mental health disorders on consumers, their families/whanau, their caregivers and the general community. The Mental Health Team will achieve this by improving the access to, and co-ordination of, services and increasing the range, quantity and quality of services based on assessment of need and most effective and efficient use of resources.
<b>Northern Regional Mental Health Funding and Planning Team</b>	Mechanism for the four DHBs in Northland and Auckland to engage with one another, and with other stakeholders, to ensure coordination/alignment of planning and funding for mental health services. Ensures a regionally consistent approach to planning and development of mental health services (as required by the Ministry of Health and Mental Health Commission). It helps the DHBs align their planning and funding re the Mental Health Commission's Blueprint Benchmark objectives, the Ministry of Health's Mental Health Strategy and the NZ Health Strategy objectives. This includes consultation and collaboration on policy development, needs assessment, strategic planning, annual planning and budget expenditure.
<b>Regional and local networks</b>	<p>The four northern DHBs have established a Northern Regional Mental Health and Addiction Network. This network brings together individuals; DHB funders and planners, families/whanau, community and other organisations ensuring people with serious mental health issues can access effective and efficient services and supports that they determine will help them recover their quality of life and health. The primary focus is to ensure regional planning consistency based on experience and history showing what works best to achieve positive outcomes for people using mental health services. The group meets quarterly to work on issues with regional implications.</p> <p>It ensures information is shared between stakeholders and regional funders and collaborates with funders at a regional level in planning for mental health services.</p> <p>This regional structure is replicated at a local DHB level via local DHB stakeholder networks who bring families/whanau, community and other organisations together that are representative of local communities. The local ADHB network feeds into the regional structure via representation on the Northern Regional Mental Health and Addiction Network. The network is responsible for the Regional Mental Health Plan for 2003–04.</p>

<p><b>Infrastructure development</b></p>	<p>Infrastructure development has been an important focus in the region in 02/03. The Regional Mental Health Funding and Planning Team and NDSA have initiated a number of key projects aimed at developing and strengthening infrastructure and improving existing service delivery in the region. These include the development of Maori, Pacific and Workforce Development Action plans. These key pieces of work feed into the development of the Regional Mental Health Plan 2003–04. This infrastructure development work will continue in the 2003–04 year, and will build on work completed to date. We also plan to advance projects that target Mental Health Services for Older People and the development of a Regional Quality and Audit Framework.</p>
<p><b>Mental Health Commission review of Auckland mental health services</b></p>	<p>In April 2002 the Minister of Health approved the terms of reference for the Mental Health Commission to undertake an independent review of mental health services in metropolitan Auckland. Recommendations released on 20 December 2002 concluded that the funding, planning, delivery and monitoring of mental health services are not satisfactory and must be modified to better suit the complicated environment that exists in Auckland.</p> <p>A six-point action plan was recommended as a way forward. This includes short, medium and longer-term actions with specific DHB, Ministry of Health and Mental Health Commission responsibilities and timeframes for 2003/04 and out-years.</p> <ul style="list-style-type: none"> <li>• Appointing a GM, Regional Mental Health Services and establishing a service coalition to manage the contracting and co-ordination of mental health services across the three Auckland DHBs.</li> <li>• Provide immediate relief from the pressure on acute beds through providing additional packages of care.</li> <li>• Allocation of adequate funding to the three Auckland DHBs.</li> <li>• Ensuring all contracts and service specifications support the implementation of an integrated continuum of services.</li> <li>• Integrating primary care practitioners into the continuum of mental health services.</li> <li>• Establishing better policy and service linkages across governmental agencies.</li> </ul> <p>The three DHBs have initiated a process for the appointment of the Regional leader (Regional Director Mental Health) who will implement the recommendations of the review in 2003–04 and out-years. Work in 2003–04 will focus on the integration of service delivery.</p>

### 3.3 Providing health and disability services

This section presents ADHB's strategic objectives from our District Strategic Plan (DSP) that focus on the Provider Arm of the organisation in relation to Regional Service Planning, our Change and Building Programmes that will prepare us for the move into our new facilities and related human resource management objectives. As in the above sections, this relates to the organisational goals *Improving Business Performance*, *Finishing the Building Programme* and *Making the Change Programme Happen*. Each objective is linked to the appropriate regional plans, business cases, migration or building plans.

### 3.3.1 Regional service planning

#### Strategic Objective: Completion of regional service planning

<b>Annual objectives</b>	Work towards the completion of regional service planning programme to ensure quality services are in the appropriate places for individual populations in the Auckland region.	
<b>Linkage to strategic objectives</b>	Greater Auckland Collaboration, Population based funding and inter-district flows, reducing the operating deficit, referred services management, maintenance of costing systems, balanced scorecards and benchmarking, Pacific Health, Maori Health, Mental Health Services, Cardiac Disease, Oral Health, Child Health, Cancer Reduction, prioritisation.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Continue with inter-district planning and development of services with other DHBs in the region, including service shifts and facility planning.</li> <li>2. Develop strategic relationships with other providers both short, medium and long term.</li> <li>3. Future capital requirements identified regionally.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004 and ongoing into 2005</li> <li>2. June 2004 and ongoing</li> <li>3. June 2005</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Building programmes or reconfiguration of services at neighbouring DHBs do not align with ADHB's shift to new facilities.</p> <p>Future capital requirements are not approved for funding by Ministry of Health.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Regional service planning workplan identifies risks and notifies CEOs of impending risks and solutions to manage these.</p> <p>Regional DHBs work with the Ministry of Health and Treasury regarding future capital requirements.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Regional Service Plan 2003–04</li> <li>• Project KPIs for 2003–04</li> <li>• Building Programme Plans</li> </ul>	

### 3.3.2 Finish the building programme

#### Strategic Objective: New facilities building scheduling

<b>Annual objectives</b>	Design and procure appropriate contractors to deliver new facilities in line with the business case to the Ministry of Health.	
<b>Linkage to strategic objectives</b>	All Building and Change Programme strategic objectives, communication, consultation, occupational health and safety, information systems infrastructure, quality and safety systems, NZ Disability Strategy.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Building design completed.</li> <li>2. Requirements assessed for new equipment – completed.</li> <li>3. Contractors engaged.</li> <li>4. Facilities completed: <ul style="list-style-type: none"> <li>• Grafton – Auckland City Hospital</li> <li>• Greenlane Clinical Centre – new buildings</li> <li>• Greenlane Clinical Centre – Building 4 refurbishment</li> <li>• Starship enhancements.</li> </ul> </li> <li>5. Facilities handover to ADHB property portfolio.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. to 3. July–December 2003</li> <li>3. and 4. October 2003</li> <li>5. October 2003</li> </ol>	
<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
	New facilities completion is delayed resulting in delay in migration and changes to existing buildings.	Penalties for delays imposed on contractor as per contractual agreement. Migration planning rescheduled.
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Business cases timelines/budgets met.</li> <li>• Building plan targets/timelines met.</li> <li>• Migration plan targets met within budget.</li> </ul>	

**Strategic Objective: Building and change programmes migration planning for services into new facilities**

<b>Annual objectives</b>	Development and implementation of migration plan from old facilities across to new premises occurs in accordance with planning schedules for 2003–04 and within Building and Change Programmes identified cost budget.	
<b>Linkage to strategic objectives</b>	All Building and Change Programme strategic objectives, communication, occupational health and safety, information systems infrastructure, quality and safety systems.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Complete migration scoping and planning including costing to ensure appropriate budgeting for 2003–04.</li> <li>2. Building programme and migration team active and collaborative engagement with change programme activities related to migration.</li> <li>3. Resources available to change programme to embed new processes when the migration of clinical areas occurs.</li> <li>4. Manage progressive/phased migration to new premises.</li> <li>5. Implement a risk management programme.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. October 2003</li> <li>2. June 2003–04</li> <li>3. June 2004</li> <li>4. June 2003–04</li> <li>5. June 2003–04</li> </ol>	
<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
	Implementation of migration plan does not run to schedule and within budget.	Risk management programme implemented.
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Building plan targets/timelines and budgets met.</li> <li>• Change programme targets/timelines and budgets met.</li> <li>• Migration plan targets met.</li> </ul>	

**3.3.3 Change programme**

**Strategic Objective: Change programme and human resource management**

<b>Annual objectives</b>	Ensure engagement between human resources and change programme to ensure staff that have been affected by restructuring are treated with respect in compliance with ADHB HR principles.	
<b>Linkage to strategic objectives</b>	All Building and Change Programme, Human Resource strategic objectives, communication, consultation, occupational health and safety, information systems infrastructure, quality and safety systems.	
<b>Approach</b>	Human resource change manager works collaboratively with change, building programmes and shared services to ensure integration and that obligations to staff are met in line with our contractual, legal and ethical requirements.	
<b>Milestones</b>	June 2004	
<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
	Competing agencies impact on building, change and HR programmes working collaboratively together to meet contractual, legal and ethical requirements.	Programme members work on principles of transparency and co-operation for best outcomes for the organisation.
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Human resource workplan</li> <li>• Change programme workplan</li> <li>• Migration workplan</li> </ul>	

### Strategic Objective: Rollout of projects

<b>Annual objectives</b>	Ensure the rollout of projects across the organisation is completed and maintained through migration.	
<b>Linkage to strategic objectives</b>	All Building and Change Programme strategic objectives, human resources, communication, occupational health and safety, information systems infrastructure, quality and safety systems.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Complete the implementation of new processes across the organisation.</li> <li>2. Monitor results.</li> <li>3. Maintain changes throughout migration.</li> </ol>	
<b>Milestones</b>	All to be achieved by June 2004.	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Competing agendas impact on pilot projects being reviewed, analysed and then rolled out across the organisation.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Planning ensures that review allows analysis time to ensure realignment of pilot projects is undertaken prior to rollout across the organisation.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Change programme workplan.</li> <li>• Project review and implementation plan KPIs achieved.</li> </ul>	

### Strategic Objective: Change programme planning

<b>Annual objectives</b>	Extend the work of the change programme to begin a second phase of work that will pick up areas that have been out of scope within the first/current work phase and that all processes meet the accreditation standards.	
<b>Linkage to strategic objectives</b>	All Building and Change Programme strategic objectives, communication, consultation, occupational health and safety, information systems infrastructure, quality and safety systems.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Prepare second phase of change work plan and obtain sign-off.</li> <li>2. Begin data gathering and conceptual design for second scope.</li> <li>3. Continue conceptual design – second scope.</li> <li>4. The accreditation standards have been used to set the minimum standard that needs to be achieved through change programme initiatives.</li> <li>5. Continue to maintain baseline and benefits tracking process.</li> <li>6. Reporting to KPIs of project.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. March 2004</li> <li>2. March 2004</li> <li>3. March 2004</li> <li>4. June 2004</li> <li>5. June 2004 and ongoing</li> <li>6. June 2004 and ongoing</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Competing agendas of building and HR programmes impact on the change programmes work plan – Phase 2 being delayed.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Planning done in collaboration with building programme and other affected areas to ensure that workplan aligns with other agendas/timelines of competing programmes in a timely manner.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Scoping document approved.</li> <li>• Workplan completed and KPIs met within timeframe and budget.</li> </ul>	

### Strategic Objective: Management of bed numbers

<b>Annual objectives</b>	Resourced beds are a key cost driver for ADHB. Through the change programme projects, the goal is to only resource the beds required at any given point in time.	
<b>Linkage to strategic objectives</b>	All Building and Change Programme strategic objectives, communication, occupational health and safety, information systems infrastructure, quality and safety systems.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Implement the use of a short stay inpatient service.</li> <li>2. Increase day of surgery admissions.</li> <li>3. Increase the level of day surgery.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. October 2003</li> <li>2. October 2003</li> <li>3. June 2004</li> </ol>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>That the above strategies will not free up the bed days as forecasted.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Benchmarking indicates the assumptions are conservative. Will monitor LOS and feedback to services.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Performance against LOS targets.</li> <li>• Performance against resourced occupancy targets.</li> </ul>	

### Strategic Objective: Tracking of benefits related to the HSDP business case

<b>Annual objectives</b>	In order to ensure that benefits related to the HSDP are achieved, a process of checking and reporting will be instigated.	
<b>Linkage to strategic objectives</b>	All Building and Change Programme strategic objectives, communication, occupational health and safety, information systems infrastructure, quality and safety systems.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Identify at an RC level the savings that have been taken from that RC.</li> <li>2. Finance managers to check and report through the reviews each month.</li> </ol>	
<b>Milestones</b>	July 2003 – ongoing.	
<b>Risks and Mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>That savings made will not be identifiable over time.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>The cost elements tracked need to be very specific. If service changes occur that require the resources returned, this needs to be documented so that tracking remains transparent.</p>
<b>Indicators and targets</b>	Monthly tracking of benefits achieved and reported through the review processes.	

### 3.3.4 Human resources management including workforce planning

#### Strategic Objective: Human resource strategy and planning

<b>Annual objectives</b>	<p>A. Establish and maintain workforce management plan in line with organisational and Ministry of Health current and future requirements.</p> <p>B. Ensure the development and implementation of an ER strategy for the organisation, ensuring all objectives identified in the strategy document are met.</p> <p>C. Formulate and finalise Learning and Development Plan to recognise and support organisational and individual needs.</p>
<b>Linkage to strategic objectives</b>	<p>All Building and Change Programme strategic objectives, communication, consultation, occupational health and safety, information systems infrastructure, quality and safety systems, Maori Health, Pacific Health, reducing the operating deficit, NZ Disability Strategy.</p>
<b>Approach</b>	<p>A. <b>Workforce management plan</b></p> <p>Enhance previous work to develop workforce including:</p> <ul style="list-style-type: none"> <li>• national health workforce management strategies and initiatives (including DHBNZ, MoH, HWAC, Schools of Medicine, colleges, universities and polytechnics)</li> <li>• action plan to address capability gaps</li> <li>• analysis of Maori and Pacific workforce and objectives to increase the number of Maori and Pacific in the workforce and to improve skill levels.</li> </ul> <p>B. <b>ER strategy</b></p> <ul style="list-style-type: none"> <li>• Approval of ER strategy completed.</li> <li>• Workplan approved for the implementation of ER strategy.</li> <li>• Implementation of ER strategy.</li> <li>• Full implementation of EEO policy and processes that reflect cultural diversity and improve the participation of people with disabilities.</li> </ul> <p>C. <b>Learning and development plan</b></p> <ul style="list-style-type: none"> <li>• Learning and development plan that recognise and support organisational needs developed.</li> <li>• Finalise learning and development plan in readiness for implementation organisationally.</li> </ul>
<b>Milestones</b>	<p>A. <b>Workforce management plan</b></p> <ul style="list-style-type: none"> <li>• June 2004 and ongoing</li> </ul> <p>B. <b>ER strategy</b></p> <ul style="list-style-type: none"> <li>• December 2003</li> <li>• June 2004</li> <li>• June 2004 and ongoing</li> </ul> <p>C. <b>Learning and development plan</b></p> <ul style="list-style-type: none"> <li>• March 2004</li> <li>• June 2004</li> </ul>

<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Competing agendas impact on various workforce development plans being developed in collaboration with appropriate services, service requirements and identified training needs.</p> <p>Lack of HRIS and other reliable employee information will hinder workforce development and EEO objectives.</p> <p>HR ability to take on new projects stretched by the demands of the Change Programme.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>HR works with appropriate services and Ministry of Health requirements to ensure all workforce development requirements are met and new initiatives explored.</p> <p>Objectives of completing business case for integrated HRIS payroll by December 2003.</p> <p>New projects prioritised and planned so that there is sound and consolidated base to work from.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• ADHB workforce development plan.</li> <li>• ADHB ER strategy documentation and workplan.</li> <li>• ADHB learning and development plan.</li> <li>• STR-02: Progress in the development of Maori workforce and Maori providers.</li> <li>• STR-06: Progress in the development of Pacific workforce and Pacific providers.</li> <li>• NUR-01: Nursing practice and development.</li> </ul>	

**Strategic Objective: Pacific health: building Pacific capacity**

<b>Annual objectives</b>	<p>To develop a competent and qualified Pacific health and disability sector to meet the health needs of ADHB's Pacific community with a focus on the following areas:</p> <ul style="list-style-type: none"> <li>• child and youth health</li> <li>• healthy lifestyles and wellbeing</li> <li>• mental health</li> <li>• primary care</li> <li>• management and policy development</li> <li>• research and evaluation.</li> </ul>	
<b>Linkage to strategic objectives</b>	<p>Primary Health Care, Pacific Health strategic objectives, occupational health and safety; human resource strategic objectives, change programme.</p>	
<b>Approach</b>	<p><b>Workforce development</b></p> <p>1. A workforce development plan is developed and implemented within ADHB which actively encourages and supports capacity building and provides guidance for ADHB's Pacific health sector.</p> <p><b>Provider development</b></p> <p>2. In association with the Ministry of Health and Pacific providers implement the Pacific provider development scheme in line with the requirements of the Pacific Health and Disability Action Plan.</p>	
<b>Milestones</b>	<p>1. June 2003 and ongoing.</p> <p>2. March 2003 and ongoing.</p>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>Pacific Provider Development funding is not allocated to support ADHB's workforce and provider development programme.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Work with the Ministry of Health to ensure processes are agreed and aligned to the Pacific Health and Disability Action Plan.</p>
<b>Indicators and targets</b>	<p>STR-06: Progress in the development of Pacific workforce and Pacific providers.</p>	

## Strategic Objective: Provider Arm Health Operating Units, and Pacific Health

<b>Annual objectives</b>	ADHB will ensure that the special needs of Pacific peoples are recognised and addressed in the services purchased and delivered by ADHB Provider Arm.	
<b>Linkage to strategic objectives</b>	This strategic objective is linked to all of the Strategic Objectives of 3.1, 3.2 and 3.3.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. In collaboration with Pacific Health develop and implement processes and practices to effect improved service delivery to Pacific consumers.</li> <li>2. Provider arm collaboratively work with Pacific Health to demonstrate that operating units are committed to Pacific health through the services they purchase and deliver.</li> <li>3. Pacific Health Schedule will be incorporated into the individual Business Operating Units annual planning process.</li> <li>4. Provider are will ensure ethnicity data for both clients and staff is actively collected.</li> <li>5. Provider Arm HBOs develops protocols and document with Pacific Primary Health Care providers [or alternatively a mainstream primary provider] to participate in the discharge planning process of Pacific clients referred to their services.</li> <li>6. Provider Arm HBOs demonstrate a collaborative working relationship with a Pacific provider which enhances service delivery to a targeted group of Pacific clients accessing your services.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. June 2004 and ongoing.</li> <li>2. June 2004 and ongoing.</li> <li>3. June 2004 and ongoing.</li> <li>4. June 2004 and ongoing.</li> <li>5. June 2004 and ongoing.</li> <li>6. June 2004 and ongoing.</li> </ol>	
<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
	ADHB's HBO units are unable or unwilling to respond to the development and implementation improved access and linkages for Pacific peoples.	Development and implementation of the protocols are done in line with other planning activities of HBOs.
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Evidence to show that measures are in place and/or plans that will address the stated targets.</li> <li>• STR-05: Pacific people are engaged and participate in DHB decision making and the development of strategies and plans for Pacific Health Team.</li> <li>• STR-06: Progress in the development of Pacific workforce and Pacific providers.</li> <li>• QUA-06: Progress towards the implementing the reducing inequalities in health intervention framework.</li> </ul>	

## Strategic Objective: Human resources recruitment centre and remuneration

<b>Annual objectives</b>	<p>A. Maintain the recruitment and HR administration centre to ensure development and maintenance of protocols and processes for HR services and systems.</p> <p>B. Ensure implementation and ongoing maintenance of ADHB's remuneration policies.</p> <p>C. Obtain business case approval for new HR information and payroll systems.</p>	
<b>Linkage to strategic objectives</b>	<p>All Building and Change Programme strategic objectives, communication, occupational health and safety, information systems infrastructure, quality and safety systems, Maori Health, Pacific Health building capacity, Maori Health, reducing the operating deficit.</p>	
<b>Approach</b>	<p><b>Recruitment and HR resource centre</b></p> <ol style="list-style-type: none"> <li>1. The development of protocols and processes for the recruitment and retention of staff including interfacing with the appropriate human resource systems in 2003–04.</li> <li>2. Maintenance of process for the recruitment and retention of staff.</li> </ol> <p><b>Remuneration policies</b></p> <ol style="list-style-type: none"> <li>1. Ongoing maintenance of ADHB remuneration policies for IEAs inclusive of performance management systems (PMS) in situ.</li> <li>2. Review and develop PMS for clinical staff.</li> </ol> <p><b>HR information and payroll systems</b></p> <ol style="list-style-type: none"> <li>1. Business case completed and approved.</li> <li>2. Systems established and maintained.</li> </ol>	
<b>Milestones</b>	<p>All activities to be achieved by June 2004.</p>	
<b>Risks and mitigation strategies</b>	<p style="text-align: center;"><b>Risk</b></p> <p>HR recruitment and administration centre does not deliver to workplan for 2003–04.</p> <p>Remuneration policies are not maintained and review of clinical staff not completed.</p>	<p style="text-align: center;"><b>Mitigation strategy</b></p> <p>Protocols and processes developed to ensure centre is effectively and efficiently managed.</p> <p>Remuneration policies are aligned to PMS requirements. Clinical staff review completed.</p>
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Workplan, policies and annual KPIs.</li> <li>• STR-02: Progress in the development of Maori workforce and Maori providers.</li> <li>• STR-06: Progress in the development of Pacific workforce and Pacific providers.</li> <li>• NUR-01: Nursing practice and development.</li> </ul>	

### Strategic Objective: Human resource information systems

<b>Annual objectives</b>	Complete and obtain business case approval for new HR information systems with implementation schedule ready for the final quarter of 2003–04.	
<b>Linkage to strategic objectives</b>	All Building and Change Programme strategic objectives, communication, occupational health and safety, information systems infrastructure, quality and safety systems, Maori Health, Pacific Health, NZ Disability Strategy.	
<b>Approach</b>	<ol style="list-style-type: none"> <li>1. Business case for HR information systems completed.</li> <li>2. Workplan developed for the implementation of HR information systems.</li> <li>3. Implementation of HR information systems.</li> </ol>	
<b>Milestones</b>	<ol style="list-style-type: none"> <li>1. December 2003.</li> <li>2. December 2003.</li> <li>3. June 2004.</li> </ol>	
<b>Risks and mitigation strategies</b>	<b>Risk</b>	<b>Mitigation strategy</b>
	Business case not approved for HR information systems. System installation delayed.	IS works with HR to ensure information systems are appropriate and planning schedules are completed within an allocated budget and timeline.
<b>Indicators and targets</b>	<ul style="list-style-type: none"> <li>• Workplan and annual KPIs.</li> <li>• STR-02: Progress in the development of Maori workforce and Maori providers.</li> <li>• STR-06: Progress in the development of Pacific workforce and Pacific providers.</li> <li>• NUR-01: Nursing practice and development.</li> </ul>	

## 4 Managing Financial Resources

### 4.1 Managing within budget

2003–04 will be a complex year for business planning in which the ADHB will recognise the changing structure of the organisation and manage the impact of migration to the new facilities whilst endeavouring to reduce a significant operating deficit. The ADHB is managing a four-year path to breakeven and the table below demonstrates how this will be achieved. The remainder of the information in this section of the plan relates to the first three years of the plan. The assumptions for the last two years in the five-year table are consistent with the assumptions for the 2005–06 year:

#### Consolidated Projected Statement of Financial Performance

	2002-03 Actual \$000	2003-04 Budget \$000	2004-05 Budget \$000	2005-06 Budget \$000	2006-07 Budget \$000	2007-08 Budget \$000
<b>Total revenue</b>	<b>891,856</b>	<b>1,090,718</b>	<b>1,136,795</b>	<b>1,164,101</b>	<b>1,150,398</b>	<b>1,184,221</b>
Employee Costs	469,363	481,502	473,222	478,303	478,720	493,082
Other Costs (including funder)	426,752	584,488	595,291	603,726	566,874	581,430
Regionality Savings	0	0	(10,000)	(20,000)	(20,000)	(20,000)
<b>Total Operating Costs</b>	<b>896,115</b>	<b>1,065,990</b>	<b>1,058,513</b>	<b>1,062,029</b>	<b>1,025,594</b>	<b>1,054,512</b>
<b>Operating Surplus (Deficit)</b>	<b>(4,259)</b>	<b>24,728</b>	<b>78,282</b>	<b>102,072</b>	<b>124,804</b>	<b>129,709</b>
Depreciation, Interest, Capital charge	(45,893)	(84,669)	(120,458)	(122,249)	(128,451)	(130,379)
Other Contributions	446	20,555	16,100	2,650	3,600	3,650
Migration costs	0	(9,404)	(1,000)	0	0	0
<b>Total Surplus (Deficit)</b>	<b>(49,706)</b>	<b>(48,790)</b>	<b>(27,076)</b>	<b>(17,527)</b>	<b>(47)</b>	<b>2,980</b>

#### Major issues associated with the budget

- Revaluation of assets was not completed for 02/03 but will be completed for 03/04.
- Capitalisation of interest – change of policy.
- Savings required due to:
  - regionality
  - other initiatives.
- CEC employee cost increase in excess of Ministry guidelines.
- Unresolved pricing issues.
- Finance requirements of \$85 million from RHMU.
- \$8 million capitalisation of labour approved – no impact.
- Oncology equipment – equity support required.

- Asset sales to be agreed.
- Maintaining compliance with banking ratios.

**Key assumptions included in the budget**

- Funding for 2003–04 and 2004–05 is based on the agreed Crown funding package. 2005–06 and subsequent years are based on a 2.4% increase for price.
- Additional ACC revenue.
- Average wage settlement increases have been approximately 3.5% for 2003/04.
- Increased operating costs for the Auckland City Hospital and Greenlane Clinical Centre.
- Additional depreciation for new equipment for the new buildings.
- Impact of asset revaluations to be completed for June 04.
- Additional capital charge for asset revaluations offset by the additional revenue expected from the Crown will impact 04/05.
- Sale of helipad carpark licence in 2003–04.
- Sale of land and buildings in 2004-05.
- Change programme savings.

<b>Year</b>	<b>Savings \$ million</b>
2003–04	11
2004–05	18
2005–06	6

<b>Consolidated Statement of Financial Performance</b>	<b>2001-02 Actual \$000</b>	<b>2002-03 Actual \$000</b>	<b>2003-04 Budget \$000</b>	<b>2004-05 Budget \$000</b>	<b>2005-06 Budget \$000</b>
<b>Revenue</b>					
<b>Provider</b>					
MOH Revenue - Provider	516,020	548,631	603,005	624,908	644,420
MOH Revenue - Provider - Other Contracts	43,179	46,328	48,318	70,413	71,838
	559,199	594,959	651,323	695,321	716,258
Inter Provider Revenue	953	1,417	2,836	3,770	3,883
Other Patient Care Revenue	15,934	21,093	21,892	21,842	22,390
External Revenue	48,457	53,909	53,710	47,924	49,355
	624,543	671,378	729,761	768,857	791,885
<b>Funder</b>					
MOH Revenue - Funder	203,131	220,478	278,793	286,718	289,884
MOH Revenue - Provider - Other Contracts	0	0	5,040	1,855	1,855
Inter District Flows	0	0	77,124	79,366	80,477
	203,131	220,478	360,957	367,939	372,216
<b>Total Revenue</b>	<b>827,674</b>	<b>891,856</b>	<b>1,090,718</b>	<b>1,136,795</b>	<b>1,164,101</b>
<b>Operating Costs</b>					
Employee Costs	451,973	469,363	481,502	473,221	478,303
Treatment Costs	138,776	144,559	151,340	152,745	158,760
Funder Payments	203,131	220,719	283,221	288,573	291,739
Funder Payments - Inter District Flows	0	0	77,124	79,366	80,477
Prop, Equip, Transport, & Mjr Mtc	36,636	40,931	50,979	54,220	54,234
Administration	27,963	20,543	21,824	20,388	18,516
Breakeven Initiatives	0	0	0	(10,000)	(20,000)
<b>Total Operating Costs</b>	<b>858,479</b>	<b>896,115</b>	<b>1,065,990</b>	<b>1,058,513</b>	<b>1,062,029</b>
<b>Operating Surplus/(Deficit)</b>	<b>(30,805)</b>	<b>(4,259)</b>	<b>24,728</b>	<b>78,282</b>	<b>102,072</b>
Depreciation	27,338	29,164	48,676	62,941	64,744
Interest	4,241	2,299	17,343	20,873	19,489
Capital Charge	9,569	13,869	18,650	36,644	38,016
	41,148	45,893	84,669	120,458	122,249
<b>Other Contributions</b>					
Associates	482	0	0	0	0
Charitable Trust	724	654	3,055	2,100	2,650
Surplus on Sale of Land & Buildings	4,687	(208)	2,500	14,000	0
Surplus on Sale of Car Park Licence	0	0	15,000	0	0
	5,893	446	20,555	16,100	2,650
Migration Costs	0	0	9,404	1,000	0
<b>Total Surplus/(Deficit)</b>	<b>(66,060)</b>	<b>(49,706)</b>	<b>(48,790)</b>	<b>(27,076)</b>	<b>(17,527)</b>

<b>Consolidated Statement of Financial Position</b>	<b>2001-02 Actual \$000</b>	<b>2002-03 Forecast \$000</b>	<b>2003-04 Budget \$000</b>	<b>2004-05 Budget \$000</b>	<b>2005-06 Budget \$000</b>
<b>Current Assets</b>					
Bank & Deposits	14,490	27,059	6,921	27,757	28,164
Receivables and Prepayments	62,521	86,118	85,548	83,672	86,035
Inventory	5,891	5,912	5,965	5,820	5,820
	<b>82,902</b>	<b>119,089</b>	<b>98,434</b>	<b>117,249</b>	<b>120,019</b>
<b>Current Liabilities</b>					
Payables and Accruals	(142,627)	(178,567)	(168,706)	(160,330)	(164,504)
Borrowings	(30,954)	(1,495)	(825)	(834)	(64)
Funds held in Trust	(799)	(710)	(710)	(819)	(819)
	<b>(174,380)</b>	<b>(180,772)</b>	<b>(170,241)</b>	<b>(161,983)</b>	<b>(165,387)</b>
<b>Net Working Capital</b>	<b>(91,478)</b>	<b>(61,683)</b>	<b>(71,807)</b>	<b>(44,734)</b>	<b>(45,368)</b>
<b>Non Current Assets</b>					
Bank & Deposits	5,407	5,873	5,873	5,428	5,428
Fixed Assets	304,319	469,846	615,528	765,910	735,323
Investment in Associates	2,021	121	121	90	100
	<b>311,747</b>	<b>475,840</b>	<b>621,522</b>	<b>771,428</b>	<b>740,851</b>
<b>NET FUNDS EMPLOYED</b>	<b>220,269</b>	<b>414,157</b>	<b>549,715</b>	<b>726,694</b>	<b>695,483</b>
<b>Non-Current Liabilities</b>					
Payables and Accruals	(13,241)	(12,614)	(12,866)	(13,658)	(14,067)
Borrowings	(121,486)	(242,527)	(342,454)	(364,870)	(350,776)
	<b>(134,727)</b>	<b>(255,141)</b>	<b>(355,320)</b>	<b>(378,528)</b>	<b>(364,843)</b>
<b>Crown Equity</b>					
Crown Equity	(338,984)	(461,068)	(545,237)	(595,085)	(595,085)
Retained Earnings	260,432	309,656	358,446	385,522	403,049
Asset Revaluation Reserve	-	-	-	(131,000)	(131,000)
Donations & Bequests	(6,990)	(7,604)	(7,604)	(7,604)	(7,604)
	<b>(85,542)</b>	<b>(159,016)</b>	<b>(194,395)</b>	<b>(348,167)</b>	<b>(330,640)</b>
<b>Net Funds Employed</b>	<b>(220,269)</b>	<b>(414,157)</b>	<b>(549,715)</b>	<b>(726,694)</b>	<b>(695,483)</b>
	-	-	-	-	(0)
<b>Crown Equity Movements</b>					
Total equity at beginning of the period	(82,636)	(85,542)	(159,016)	(194,395)	(348,167)
Asset Revaluation	-	-	-	(131,000)	-
Net Results for the period	66,060	49,706	48,790	27,076	17,527
Equity Injections - Deficit Support	(35,000)	(56,300)	(35,000)	(13,000)	-
Equity Injections - Building Programme (Already Approved)	(33,966)	(66,880)	(49,169)	(27,538)	-
Equity Injections - Fixed Assets - Oncology	-	-	-	(9,310)	-
	<b>(68,966)</b>	<b>(123,180)</b>	<b>(84,169)</b>	<b>(49,848)</b>	<b>-</b>
<b>Crown Equity Total</b>	<b>(85,542)</b>	<b>(159,016)</b>	<b>(194,395)</b>	<b>(348,167)</b>	<b>(330,640)</b>

## 4.2 Key assumptions included in the budget

### 4.2.1 Revenue assumptions – Ministry of Health – base contract

Revenue from the base contract, inclusive of Inter-District Flows (IDFs), has been built into the DAP based on advice from the Ministry of Health. The basis of that advice in each year has been:

- 2003–04 Specific details of the composition of the fiscal envelope.
- 2004–05 A 2.9% increase in both base envelope and IDFs based on advice from the Ministry of Health.
- 2005–06 A 2.4% increase in both base envelope and IDFs based on advice from the Ministry of Health.

In its initial evaluation of funding under the PBF basis the Ministry assessed the ADHB as overfunded. Subsequent analysis has indicated this is not correct. The funding projection for 2005-06 had been reduced by 1% to 1.4% and this amount has been reinstated in the plan to the 2.4% shown above. This adjustment has increased the funding in the plan as follows:

	2004–05	2005–06
Future funding track – a further 1%	–	8,535

### 4.2.2 Ministry of Health – other contracts

Other major contracts outside the base contract include, Public Health Funding and Disability Support Services (DSS) Funding. The plan does not include the impact of the devolution of DSS funding for older people which is anticipated will occur on 1 October 2003. It is assumed that adequate funding will be provided to cover service costs. This treatment is in accordance with advice from the Ministry.

In view of the increase in capital change flowing out of the revaluation of Land and Buildings an allowance for additional revenue commencing from 04/05 has been included in each year's revenue to offset the impact of this additional cost.

### 4.2.3 Other patient care revenue

The major components of this category are private patient revenue and ACC revenue. The major drivers of the increase over the 2002-03 year is the inclusion of an additional \$3.6 million in ACC revenue, ensuring that all appropriate claims are made.

### 4.2.4 External revenue

The major components of this category are sales to external parties and clinical training and education revenue. Allowance has been made for expected increase in the level of charitable donations for major asset acquisitions. These include the following.

	2003–04	2004–05	2005–06
Starship Foundation			
Neuro/heart	5,000	–	–
Hospital	1,000	2,000	2,000
	6,000	2,000	2,000

In addition, allowance has been made for the loss of car parking revenue as a result of the sale of the carpark service. The impact on outer years is as follows.

	2003–04	2004–05	2005–06
Loss of carparking revenue	–	2,440	2,460

#### 4.2.5 Operating costs

##### Employee costs

Employee costs account for approximately 68% of the operating costs of the ADHB, exclusive of the funder payments.

The ADHB has attempted to stay within the Ministry guidelines of a 2% increase in employee costs. As the average cost of wage settlements that will impact the 2003–04, is approximately 3.5%, then this task becomes difficult. This 1.5% gap equates to approximately \$7.0 million of employee costs or 128 FTEs in 2003-04.

##### Treatment costs

A 2% increase in blood costs has been allowed for in the 2003-04 year, not the 5.7% increase advised by the NZ Blood Service. This increase has not been accepted by ADHB. The cost impact of the additional 3.7% to the ADHB profit and loss would be approximately \$450,000.

##### Utility costs associated with new buildings

Allowance has been made in each budget year for the increased cost of utilities in operating the new facilities. These include allowances for additional cleaning, security, electricity, gas and maintenance.

##### Depreciation

The primary driver of the increase in depreciation is the impact of the completion and capitalisation of the new facilities and associated clinical equipment.

##### Interest

The policy of interest capitalisation is planned to continue for the life of the building programme. The effect of this policy is that the following amounts will be capitalised.

	2003–04	2004–05	2005–06
Interest capitalised	\$5.8 m	\$1.8 m	–

##### Capital charge

Allowance has been made for the capital charge at the rate of 11% per annum on the Crown equity balance for each year. As the Crown equity balance is inclusive of the revaluation of land and buildings of \$131 million, the capital change has increased accordingly effective from 04/05.

## Assumptions in preparing the projected financial statements

The table below provides an understanding of the assumptions adopted in preparing the projected financial statements.

Assumptions	2003–04	2004–05	2005–06
<b>Funding</b>			
Vote health funding			
• Price – provider arm – from ADHB funder and other DHBs	Funding package	Funding package	2.40%
• Demographic growth	Funding package	3,609	12,919
• Mental health blueprint funding (increment)	4,449,012	In base funding	In base funding
• Risk pool adjustment to base funding	800,000	In base funding	In base funding
Reallocation to primary investment fund	1,000,000	1,000,000	1,000,000
Other income (donations, clinical training, sales of services, other MoH contracts and non-resident patients)	2.00%	3.00%	3.00%
Surplus on sale of carpark licence	15,000,000	0	0
Surplus on sale of property assets	0	14,000,000	0
<b>Provider arm cost structure</b>			
<b>Volume related drivers of cost</b>			
Net volume change reflecting impact of population change, IDF changes, acute demand, bed occupancy and ALOS management	0.00%	0.00%	0.00%
<b>Inflation related drivers of cost</b>			
Wage cost inflation	2.00%	3.00%	3.00%
Unfunded quality FTE growth	0.00%	0.00%	0.00%
Other operating cost inflation	3.00%	3.00%	4.00%
<b>Funder arm cost structure</b>			
Governance costs – funder management	2.00%	3.00%	3.00%
Growth in pharmaceutical expenditure			
• New contracts as a % of existing costs	0.00%	0.00%	0.00%
• Pharmacy dispensing	(25.00%)	(25.00%)	(25.00%)
• Pharmaceutical costs	4.00%	4.00%	4.00%
• Total budget increase in costs (33% dispensing and 67% drugs)	(5.67%)	(5.67%)	(5.67%)
Growth in GP services	1.00%	1.00%	1.00%
Growth in laboratory services after allowing for the impact of the MOU with DML	2.00%	2.00%	2.00%
Mental health services	Total movement matches new funding		
PHO development – MoH funded via DHBs	This will be self funding with no budget impact		
PCO savings for referred services	1,000,000	1,000,000	1,000,000
Cost of primary investment fund initiatives	1,000,000	1,000,000	1,000,000
Other services	1.00%	1.00%	1.00%
<b>Other costs and constraints</b>			
Redundancy costs	1,300,000	0	0
Migration costs	9,404,000	1,000,000	0
Building programme costs	5,784,000	4,677,000	1,133,000
Change programme costs	7,015,000	2,507,000	0

Assumptions	2003–04	2004–05	2005–06
New building utility cost increases	5,740,000	6,500,000	6,400,000
Change programme savings (increase in year)	11,000,000	18,000,000	6,000,000
Impact of regional service planning and population growth related costs	FTE numbers in 2004-05 and subsequent years do not reflect unallocated costs related to regional services planning and demographic growth that have been included in employee costs in the statement of financial performance. FTE numbers may increase in the outer years depending on volume decisions taken in these areas.		
Crown equity injections – HSDP	These equity injections are set out in the tables above and are in accordance with the profile provided to Ministry and Treasury		
Crown equity injections – deficit			
Site specific adjuster	0	0	0
Capital works	As per the plan	As per the plan	As per the plan
Interest costs			
• Bonds	7.75%	7.75%	7.75%
• Bank facilities	6.10%	6.10%	6.10%
• Crown loan funding	6.10%	6.10%	6.10%
* Funding assumption for \$85 million new facility	loan	loan	loan
* Equity funding for oncology assets	5,950,000	3,360,000	0
Depreciation – baseline	Per accounting policies	Per accounting policies	Per accounting policies
Depreciation – impact of asset revaluation	0	8,500,000	8,500,000
Increase in capital charge from revaluation			
Capital charge – % of equity	11.00%	11.00%	11.00%
Maximum supported deficit	35,000,000	13,000,000	0

Notes:

\* The equity amounts in the table do not address the requirements for equity funding of working capital.

1 All percentages expressed as a % of the previous year.

### 4.3 Issues associated with the budget

#### 4.3.1 Efficiency gains

The change programme is leading a series of project and pilot processes that will manage the process of establishing the organisation in its new hospital facilities. This programme of work includes securing efficiency gains of \$40 million on an annual basis.

Other initiatives are also being implemented to support this programme of efficiencies and reduce the level of deficit shown in the preliminary budgets.

#### 4.3.2 Site-specific adjuster

The site-specific adjuster previously paid to compensate DHBs for varying capital structures has been discontinued. The ADHB financial position would be substantially improved by the reinstatement of this methodology. If the methodology that was previously implemented was reinstated the impact on ADHB's financial profit and loss statement would be as set out under Table A below. We have identified this as the base case frozen model. If the frozen model was changed to more accurately reflect capital expenditure for building and construction projects and recognised 100% of the spend not 75% then further enhancements to the ADHB profit and loss statement will occur. Please refer to Table B.

**Table A**

	2002-03	2003-04	2004-05	2005-06
Gross impact of frozen model on ADHB	\$62.3 m	\$79.2 m	\$79.8 m	\$75.3 m
Assessed funding package 2003/04 DAP level	\$48.1 m	\$67.1 m	\$68.9 m	\$69.9 m
Net adverse impact of frozen model on ADHB	(\$14.2 m)	(\$12.1 m)	(\$10.9 m)	(\$5.4 m)

**Table B**

	2003-04	2004-05	2005-06
Gross impact of fully-funded model	\$111.2 m	\$116.2 m	\$111.3 m
Funding package 2003/04 DAP level	\$67.1 m	\$68.9 m	\$69.9 m
Net adverse impact of fully-funded model on ADHB	(\$44.1 m)	(\$47.3 m)	(\$41.4 m)

It is important that the national pricing study being undertaken for the 2004-05 year addresses this issue.

#### 4.3.3 Valuation of assets

As required by Treasury, ADHB has undertaken a revaluation of its capital assets by a third party valuer. As a result of a number of unresolved issues this revaluation will be recognised at 04/05. The impact on depreciation and capital charge of the revaluation of capital assets will be fully offset by a funding increase from the Ministry such that there is no change to the deficit level. The revaluation has been split into 3 different components:

1. valuation of land for resale
2. valuation of land with reserved status at Grafton and Greenlane
3. valuation of all other land and buildings.

Land for resale is accounted for in the books of ADHB at cost. In respect of the reserved status land, the issue of how this will be valued is to be finalised. Due to the restrictions on this property it is believed the land should be valued at zero. The balance of the existing use properties will be recorded at the depreciated replacement cost value as per the valuer's report.

#### 4.3.4 Capitalisation of interest

ADHB's accounting policy, which is consistent with accounting standards, is to capitalise interest on major projects until completion of the project. ADHB defines a major project to be one of \$5 million or more in value. Treasury has instructed Crown entities to expense interest rather than capitalise interest costs with effect from 1 July 2003. The ADHB has made a submission to the Ministry of Health and Treasury that it be permitted to continue with its existing treatment until the building programme is completed to keep consistency with its financial treatment. The impact of changing the policy would add an additional \$5.8 million in 2003-04 and \$1.8 million in 2004-05 to the respective annual deficits stated in this plan.

If this policy was implemented then the Financial Reporting Standard 7 (FRS7) would require ADHB to expense in the 2003-04 year, all interest be capitalised to 30 June 2003. This amounts to \$15,143,000. This one off impact would increase the deficit in 2003-04 and impact on banking covenant ratios in that year. This would necessitate further equity from the Crown in order to maintain banking covenant compliance.

The DAP has been prepared on the basis that the ADHB will be granted a dispensation to continue capitalising interest costs until the building programme is complete.

#### 4.3.5 CEC employee costs

The budget has been built on the basis of following the guidelines set by the Ministry of 2%, 3%, 3%. To manage a cost increase in 2003-04 within the guidelines set, when the average cost of settlements for CECs is approximately 3.5% will mean that the ADHB would have to consider a reduction of 128 FTEs in 2003-04 to comply. It is also expected that the CEC settlements for 2004-05 and 2005/06 will be about 4.5% per each year. For the ADHB to stay within the Ministry guidelines a further FTE reduction of 120 and 113 FTEs respectively may be required.

The ADHB does not intend to reduce FTEs by these amounts if this can be avoided. Measures will continue to be taken to meet overall budget objectives and to the extent that is successful the further FTE reduction will be avoided. This has been possible in 2002-03 and reflects close control of costs in addition to managing FTE numbers.

FTE's (see note #)	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
<b>Base FTE</b>	<b>6,932</b>	<b>7,014</b>	<b>6,678</b>	<b>6,292</b>	<b>6,131</b>	<b>6,163</b>
Mental Health	17	17	17	17	17	17
Public Health	15	15	15	15	15	15
Approved FTE's	28	0	0	0	0	0
Other increases	117	(117)	0	0	0	0
<b>Sub total</b>	<b>7,109</b>	<b>6,929</b>	<b>6,710</b>	<b>6,324</b>	<b>6,163</b>	<b>6,195</b>
Change programme savings	(95)	(251)	(330)	(110)	0	0
Regionality savings	0	0	(88)	(83)	0	0
<b>Total**</b>	<b>7,014</b>	<b>6,678</b>	<b>6,292</b>	<b>6,131</b>	<b>6,163</b>	<b>6,195</b>

#### FTE's if staff reductions are required to meet cost guidelines\*

FTE's (see note #)	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
<b>Base FTE</b>	<b>6,932</b>	<b>7,014</b>	<b>6,550</b>	<b>6,044</b>	<b>5,770</b>	<b>5,696</b>
Mental Health	17	17	17	17	17	17
Public Health	15	15	15	15	15	15
Approved FTE's	28	0	0	0	0	0
Other increases	117	(117)	0	0	0	0
<b>Sub total</b>	<b>7,109</b>	<b>6,929</b>	<b>6,582</b>	<b>6,076</b>	<b>5,802</b>	<b>5,728</b>
Change programme savings	(95)	(251)	(330)	(110)	0	0
Regionality savings	0	0	(88)	(83)	0	0
Staff reductions due to cost guidelines*		(128)	(120)	(113)	(106)	(99)
<b>Total**</b>	<b>7,014</b>	<b>6,550</b>	<b>6,044</b>	<b>5,770</b>	<b>5,696</b>	<b>5,629</b>

\*As previously noted FTE reductions to offset additional wage settlement costs will only be actioned if the ADHB is in danger of not meeting its overall budget targets.

#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 in 2004-05 and subsequent years do not reflect unallocated costs related to regional services planning and demographic growth that have been included in employee costs in the statement of financial performance. FTE numbers may increase in the outer years depending on volume decisions taken in these areas.

#### 4.3.6 Regional initiatives

A significant amount of work and co-operation between CMDHB, WDHB and the ADHB is required to enable regional savings to be achieved. The scoping work for this has commenced but once planning is agreed we will require the support from the Ministry.

#### 4.3.7 RHMU finance \$85 million

Finance is required from RHMU for \$85 million to cover the planned second bond issue proposed for the Building Programme.

#### 4.3.8 Oncology equipment – equity support required

The ADHB has the regional contract for the provision of oncology services. Due to the demand for oncology services there has become a need to replace equipment and purchase new equipment to meet the volumes. This equipment needs to be equity funded.

#### 4.3.9 Assets to be sold

Approval will be required from the Ministry to ensure that the planned sale of the Greenlane land and buildings in 2004-05 and sale of the licence to operate the helipad parking facilities in 2003-04 will eventuate.

#### 4.3.10 Capital

Capital expenditure for the period of this DAP, excluding the Building Programme comprises the following.

<b>Funded by depreciation</b>			
<b>Asset class</b>	<b>2003–04</b>	<b>2004–05</b>	<b>2005–06</b>
Baseline – clinical equipment	10,200	10,000	10,000
Equity funded – oncology equipment	5,950	4,000	0
Building programme fixtures, fittings, equipment	34,761	6,081	0
Information systems investment	11,700	11,150	10,650
<b>Total</b>	<b>62,611</b>	<b>31,231</b>	<b>20,650</b>

<b>Funded by donations</b>			
<b>Asset class</b>	<b>2003–04 \$000</b>	<b>2004–05 \$000</b>	<b>2005–06 \$000</b>
Heart/neuro equipment – Starship	5,000	–	–
Sundry equipment – Starship	1,000	2,000	2,000
Clinical Education Centre – ADHB Charitable Trust	2,545	–	–
Landscaping	300	–	–
Other equipment – ADHB Charitable Trust	–	1,500	2,000
<b>Total</b>	<b>8,845</b>	<b>3,500</b>	<b>4,000</b>

#### 4.3.11 Other assets

- Motor vehicles – the majority of the vehicle fleet are covered by operating leases. The small number of vehicles that are owned will be placed on operating leases at the end of their useful life. It is anticipated that 62 of the total 334 vehicles on lease will be renewed in 2003-04.
- IT equipment – the majority of IT hardware is covered by an operating lease.

## 4.4 Treasury

### 4.4.1 Debt profile

The debt profile assumes finance from RHMU of \$85 million in substitution for the planned second bond issue proposed when the Hospital Services Development Plan (HSDP) was originally developed.

With completion of the building programme and associated equipment fit out, capital expenditure will reduce and free cash flows in excess of the depreciation charge will provide funds to commence repayment of borrowings.

### 4.4.2 Equity support

The Crown has provided a Letter of Comfort in September 2003, undertaking to provide sufficient equity support to ensure that the ADHB complies with covenants constrained in present debt funding arrangements. It is assumed that similar undertakings will be provided by the Crown in future years.

### 4.4.3 Funding structure

Work is presently being undertaken with the Ministry, Treasury and RHMU on the loan structure, bank facilities, working capital requirements and equity levels to provide a balance sheet structure that increases the Crown involvement by way of debt finance. The final structure is yet to be determined so present facilities plus RHMU debt and equity support has been assumed in preparing the plan.

The equity and debt required to sustain the ADHB plan over the three years of the forecast has been included in the three-year plan.

Asset class	2002–03 Actual	2003–04 Budget	2004–05 Budget	2005–06 Budget
<b>Crown equity movements</b>				
Total equity at beginning of the period	(85,542)	(159,016)	(194,395)	(348,167)
Asset revaluation	0	0	131,000	0
Net result for the period	49,706	48,790	27,076	17,527
Equity injections – deficit support	(56,300)	(35,000)	(13,000)	0
Equity injections – building programme	(66,880)	(49,169)	(27,538)	0
Equity injections – fixed assets – oncology	0	0	(9,310)	0
	(123,180)	(84,169)	(49,848)	0
<b>Crown equity total</b>	<b>(159,016)</b>	<b>(194,395)</b>	<b>(348,167)</b>	<b>(330,640)</b>

The final equity injections required to sustain the capital, deficit and working capital requirements of the ADHB need to be finalised in discussion with the Ministry and Treasury in order to support the long-term financial viability of the organisation.

There have been no changes in lenders, limits and borrowing arrangements. The following banking covenants and ratios apply.

Lender	Covenant	Ratio
The covenants and ratios apply to all of the following funders: <ul style="list-style-type: none"> <li>• MBIA and the bondholders</li> <li>• ANZ Bank</li> <li>• Westpac Bank</li> <li>• Bank of New Zealand</li> <li>• ASB Bank</li> </ul>	Interest cover	>2.
	Debt: debt and equity	< = 65%
	ADHB total assets to total group assets	>95%
	Annual and six-monthly reporting requirements	N/A

The balance sheet and interest cover ratios have been calculated for the period of this plan.

Balance Sheets Ratio	2001-02 Actual \$'000	2002-03 Actual \$'000	2003-04 Budget \$'000	2004-05 Budget \$'000	2005-06 Budget \$'000
Finance Leases – Current Portion	1,550	1,496	825	-	-
Finance Leases – Term Portion	1,486	-	-	-	-
Bank Finance	29,404	122,526	27,454	50,704	35,840
Bond Issue	120,000	120,000	120,000	120,000	120,000
RHMU	-	-	195,000	195,000	195,000
<b>Total Debt</b>	<b>152,440</b>	<b>244,022</b>	<b>343,279</b>	<b>365,704</b>	<b>350,840</b>
Equity	78,552	151,412	186,791	340,563	323,035
<b>Total Debt plus Equity</b>	<b>230,992</b>	<b>395,434</b>	<b>530,070</b>	<b>706,267</b>	<b>673,875</b>
<b>Ratio of Total Debt to Debt plus Equity</b>	<b>65.99</b>	<b>61.71</b>	<b>64.76</b>	<b>51.78</b>	<b>52.06</b>

Interest Cover	2001-02 Actual \$'000	2002-03 Actual \$'000	2003-04 Budget \$'000	2004-05 Budget \$'000	2005-06 Budget \$'000
Total Surplus/ (Deficit)	(66,060)	(49,706)	(48,790)	(27,076)	(17,527)
Trustee Income	(724)	(2,197)	(10,335)	(4,100)	(4,650)
Depreciation	27,338	29,725	48,676	62,941	64,744
Profit on Sale of Fixed Assets	(4,687)	208	(2,500)	(14,000)	-
Profit on Share of Associate Co	(482)	-	-	-	-
Capital Charge	9,569	13,869	18,650	36,644	38,016
Interest Paid	4,241	2,299	17,343	20,873	19,489
EBITD	(30,805)	(5,802)	23,044	75,282	100,072
Interest Paid	4,241	2,299	17,343	20,873	19,489
<b>Ratio of EBITD to Interest Paid</b>	<b>(7.26)</b>	<b>(2.52)</b>	<b>1.33</b>	<b>3.61</b>	<b>5.13</b>
EBITD Required	8,482	4,598	34,686	41,746	38,978
EBITD Actual	(30,805)	(5,802)	23,044	75,282	100,072
<b>Shortfall</b>	<b>39,287</b>	<b>10,400</b>	<b>11,642</b>	-	-
<b>Subsequent equity</b>	<b>163,180</b>	<b>64,657</b>	<b>18,938</b>	-	-
	<b>OK</b>	<b>OK</b>	<b>OK</b>	<b>OK</b>	<b>OK</b>

Note: Interest and balance sheet covenants are complied with taking into account subsequent receipt of equity within the required periods as specified in the Banking Negative Pledge Deed.

## 5 Measuring Success

### 5.1 Consolidated list of indicators of DHB performance

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 2003–04 measures used to assess the ADHB's performance are below.

Ind No	Title	Report	Frequency	Target
<b>Strategic Development – Maori</b>				
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	Qualitative Six monthly in 2nd and 4th quarters	N/A
STR-02	Progress in the development of Maori workforce and Maori providers	DHB	Annual 4th Quarter	N/A
STR-04	Improve Mainstream Effectiveness	DHB	Qualitative Six monthly in 2nd and 4th quarters	N/A
<b>Strategic Development – Pacific Peoples</b>				
STR-05	Pacific people are engaged and participate in DHB decision making and the development of strategies and plans for Pacific health gain	DHB	Qualitative Annual – 4th Quarter	N/A
STR-06	Progress in the development of Pacific workforce and Pacific providers DHB	DHB	Qualitative Annual – 4th Quarter	N/A
<b>Systems and Quality</b>				
QUA-01	Quality systems	DHB	Qualitative Six monthly in 2nd and 4th quarters	N/A
QUA-02	Mental Health quality measures	DHB	Quarterly	N/A
QUA-03	Nationally consistent clinical assessment– Elective Services	DHB	Qualitative Six monthly in 2nd and 4th quarters	N/A

Ind No	Title	Report	Frequency	Target
QUA-04	Responding to and resolving service coverage issues	DHB	Quarterly	*N/A
QUA-05	Prioritisation	DHB	Qualitative – 31 May 2004	N/A
QUA-06	Progress towards implementing the Reducing Inequalities in Health Intervention Framework	DHB	Quarterly	N/A
QUA-7	Progress towards WAVE Implementation	DHB	Qualitative Six monthly in 2nd and 4th quarters	N/A
<b>Nursing Practice and Development</b>				
NUR-01	Nursing practice and development	DHB	Quarterly	N/A
<b>Older People Services</b>				
OLD-01	Standardised discharge rates for ambulatory sensitive admissions for people 65 and under 75 years	DHB	Quantitative Six monthly in 2nd and 4th quarters	This funding has yet to be devolved and a target has not been set
OLD-02	Progress based indicator	DHB	Qualitative Six monthly in 2nd and 4th quarters	N/A
<b>Child Health – Ensure access to appropriate child health care services including well child and family health care and immunisation</b>				
CHIQ-02	Progress in implementing the Baby Friendly Hospital Initiative in maternity facilities	DHB	Annual 4th quarter	N/A
CHI-01	Children fully vaccinated by their 2nd birthday	MoH	30 June 2004	75% for all ethnic groups
CHI-06	Percentage of children passing school entry hearing screening test	MoH	30 June 2004	95% for all ethnic groups
CHI-08, and CHI-09	Repeat admissions for asthma in children under 5 and in children 5–14	MoH	Qualitative Six monthly in 2nd and 4th quarters	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 31 December 2003 30 June 2004	Within a 90% confidence interval of the New Zealand rate

Ind No	Title	Report	Frequency	Target
CHI-17, 18, 19	Ambulatory Sensitive Admission	MoH	Six monthly in 2nd and 4th quarters	Within a 90% confidence interval of the New Zealand rate
<b>Oral Health – Improve oral health – ADHB monitors contract managed by Waitemata DHB</b>				
ORA-04	Mean MF score at Form 2 (Year 8)	MoH	Annual 3rd quarter report	Target rate within a 90% confidence interval of: Total: 1.3 Maori: 1.6 Pacific: 1.8 Other: 1.2
ORA-01	Caries free at age 5	MoH	Annual 3rd quarter	Target rate within a 90% confidence interval of: Total: 61.3% Maori: 45.5% Pacific: 40.0% Other: 70.1%
<b>Diabetes – Reduce the incidence and impact of diabetes</b>				
DIA-07	Implementation of the minimum diabetes dataset	DHB	Annual February 2004	N/A
DIA-01	Diabetes case detection rate	DHB	Annual 3rd quarter	Target rate within a 90% confidence interval of: Total: 42.0% Maori: 40.0% Pacific: 50.0% Other: 40.0%
DIA-02	Diabetes case management	DHB	Annual 3rd quarter	Target rate within a 90% confidence interval of: Total: 30.0% Maori: 30.0% Pacific: 30.0% Other: 30.0%
DIA-04	Retinal screening of people with diabetes in the last two years	DHB	Annual 3rd quarter	Target rate within a 90% confidence interval of: Total: 80.0% Maori: 80.0 Pacific: 80.0% Other: 80.0%

Ind No	Title	Report	Frequency	Target
<b>Cardiovascular – Reduce the incidence and impact of cardiovascular disease</b>				
CAR-03– CAR 05	Number of people with certainty who have been waiting for more than six months for a coronary artery bypass graft/angioplasty	MoH	Six monthly in 2nd and 4th quarters	Zero people waiting > six months for all ethnic groups
<b>Cancer – Reduce the incidence and impact of cancer</b>				
CAN-01	Waiting times for radiotherapy	MoH	Monthly Quarterly	Zero waiting outside best practice times at 30 June 2004
<b>Primary Care – Primary Health Care</b>				
PRI-01	Progress towards implementing the Primary Health Care Strategy	DHB	Quarterly	N/A
PRI-02	Progress in developing the capacity of primary care providers to impact on suicide prevention	DHB	Annual 4th quarter	N/A
PRI-04	Participation by Maori in decision-making within Primary Health	DHB	Part A: Quarterly Part B: Annual	90%
<b>Mental Health – Improve the health status of people with severe mental illness and improving the responsiveness of mental health services</b>				
MEN-01	Progress towards improving Maori mental health	DHB	Annual 4th Quarter	N/A
MEN-02	Comprehensive and timely and quality data is provided to MHINC	DHB, MoH	Quarterly	N/A
MEN-03	Access to Services	DHB, MoH	Quarterly	0-9 years: 0.10 10-14 years: 0.45 15-19 years: 0.81 20-64 years: 1.05 65+ years: 0.84
<b>Performance to Annual Plan</b>				
FIN-01	Actual financial performance compared to the approved District Annual 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 2002	Captured through DHB financial reporting to HMD	Quarterly	0.83%

\* Note 1: N/A: narrative reports or confirmation statements form the basis for reporting these indicators.