INDEX

EVIDENCE OF JOHN KENNETH HAZELDINE, 9 FEBRUARY 2018

TAB	Description	Page
1.	New Zealand Health System Reforms	1
2.	Legal and regulatory framework	22
3.	Vote Health	26
4.	Other statutory bodies, committees and office holders	27
5.	Public hospitals in New Zealand	35
6.	Generic version of the Letter of Expectations for 2017/18	37
7.	2017/18 Operational Policy Framework	41
8.	2017/18 Service Coverage Schedule	173
9.	2017/18 DHB Planning Package documents	
9.(a)	2017/18 DHB Annual Planning Guide	279
9.(b)	2017/18 DHB Annual Planning Priorities	302
9.(c)	2017/18 DHB Health Targets	445

RECEIVED
Waitangi Tribunal
10 Feb 2018
Ministry of Justice
WELLINGTON

APPENDIX 1:

NEW ZEALAND HEALTH SYSTEM REFORMS

Source: New Zealand Parliament website https://www.parliament.nz/en/pb/research-papers/document/00PLSocRP09031/new-zealand-health-system-reforms

Summary

- Between 1938 and 1983 the New Zealand health system developed as a dual system of public and private provision. Social Security Act 1938.
- 1983-1993 Gradual establishment of 14 Area Health Boards (AHBs) funded by a population-based formula. Area Health Boards Act 1983.
- 1993 Four Regional Health Authorities (RHAs) were established. Purchasing and provision of health services were separated. The 14 Area Health Boards were reconfigured into 23 Crown Health Enterprises (CHEs) structured as for-profit organisations and subject to ordinary company law. Public health services were unbundled and a separate public health purchasing agency, the Public Health Commission, was established. Health and Disability Services Act 1993
- 1997 The National-New Zealand First Coalition Government, through the Coalition Agreement on health, reformed the structure of the health system. In 1998, 4 RHAs were combined into one national purchasing agency, the Health Funding Authority (HFA). The 23 CHEs were reconfigured as 24 not-for-profit Crown-owned companies and renamed Hospital and Health Services (HHSs). Health and Disability Services Amendment Act 1998.
- 2000 The Labour-Alliance Coalition Government initiated a health system reform. In 2001, 21 District Health Boards (DHBs) were formed. Primary Health Organisation (PHOs) were developed in 2002 to manage primary care, including general practitioners and their services. New Zealand Public Health and Disability Act 2000.

Introduction

Since 1983 the New Zealand public health sector has undergone four structural transformations. With each change there was a new set of organisations to fund and deliver health services: 1983-1993 Area Health Boards (AHBs); 1993-1997 Regional Health Authorities (RHAs) and Crown Health Enterprises (CHEs); 1998-2001 Health Funding Authority (HFA) and Hospital and Health Services (HHSs); and 2001 District Health Boards (DHBs). These changes were designed to improve health outcomes, increase accountability and efficiency and to reduce escalating health expenditure. New Zealand was not alone in change, a health reform movement developed around the world focused by the needs of an aging population, increased medical technology and growing public expectations of health systems. This paper discusses the development and structures of the New Zealand health system over each of the four change periods. The health sector before 1983 is discussed first to contextualise the later reforms.

New Zealand health system prior to 1983

Overview

New Zealand, like other advanced industrial countries, has experienced dramatic changes in health and health care over the last century. [1] The leading causes of death have changed from infectious diseases such as cholera and smallpox to chronic conditions such as heart disease, cancer and strokes. [2] The number of older people, who suffer most from these conditions, has steadily increased. The focus of health services shifted from community primary care and disease prevention to the modern hospital equipped with the latest medical technology aimed at curing the new diseases. [3]

A free health system, with hospital and other health services universally available to all New Zealanders was the vision behind the Social Security Act 1938. [4] This was never fully realised due to ongoing disputes between the medical profession and the Government. [5] Health services evolved as a dual system of public and private health care subsidised through a series of arrangements known as the General Medical Service (GMS) benefits established in 1941. [6]

The escalating expenditure on health and the inequity of health provision became a source of concern for governments and the health sector. These issues were highlighted by a series of reviews: *The Barrowclough Committee* 1953, *The Department of Health review* 1969, *The Royal Commission on social security* 1972 and *A health service for New Zealand* 1975.

Governance

The State was the main contributor to the provision and organisation of health care in New Zealand. The centralisation of control and funding of the New Zealand health system put overall power in the hands of the Minister of Health advised by the Board of Health and the Hospitals Advisory Council. The Board of Health's principle function, as set out in the Health Act 1956, was to advise the Minister of Health on general health policy including the prevention, promotion, and effective treatment of diseases. The Board also had mandatory powers over Territorial Local Authorities in regard to environmental health services. [7] The Hospitals Advisory Council, under the Hospitals Act 1957, advised the Minister on matters relating to the provision, control, and management of the Hospital Boards. [8]

The Department of Health had the combined responsibility for policy, purchasing, and the provision of health services. Health care was structured around 18 District Health Offices and 29 locally elected Hospital Boards that provided hospitals and hospital services as well as a range of community services, such as district nursing and domiciliary care. The Hospital Boards were also charged with encouraging the provision and maintenance of private hospitals. A hospital board of 8 to 14 members was elected every three years for each hospital district. [9] Some 230 Territorial Local Authorities had basic responsibility for environmental health and town planning. [10]

High priority was given to increasing health funding after 1938. Expenditure on health continued to grow through the 1970s. From the 1980s onwards, governments have made a determined effort to decentralise the control of health and restrict expenditure. [11]

Secondary care

As modern scientific medicine developed (through the 1950s and 1960s) health care became oriented towards the search for cures to disease rather than the prevention of illness. Hospitals made large investments in technology and specialist medical staff. By the 1980s they had become the centre point of health care, utilising complex technologies and dispensing sophisticated and up-to-date medical treatment. [12] In 1980 there were 186 public hospitals with 26,345 hospital beds and 163 private hospitals with 5,139 hospital beds. [13]

Since April 1958 the cost of hospital treatment in public hospitals, pharmaceuticals, and laboratory diagnostic services [14] has been fully funded by the State out of general tax revenue. [15] Private health care was funded largely through health insurance premiums with government subsidies. [16]

During the 1970s and early 1980s long public hospital waiting lists for particular surgical procedures, especially for some kinds of non-urgent surgery, developed into a problem. [17] Consumers facing waiting times could alternatively pay for private hospital services which offered no waiting times.

An extensive range of voluntary health and social care organisations has developed in New Zealand. These organisations, such as the Salvation Army, Plunket Society, the Intellectually Handicapped Children's Association, and St. John Ambulance, were dependent on government support. Many are now taking on a health provider role, seen by the state as a way of increasing choice and competition. [18] Small community health groups developed in reaction to dissatisfaction with health services and, influenced by new social movements, formed the beginnings of health consumerism. [19]

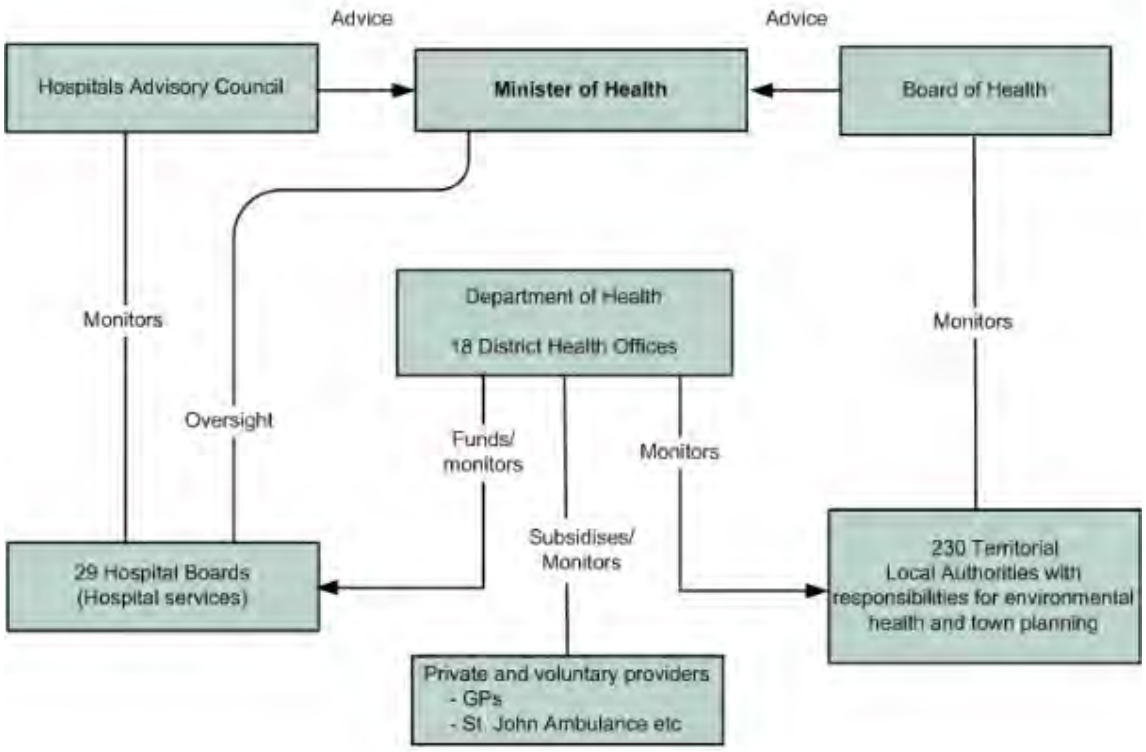
Primary care

Primary care includes services provided by general practitioners (GPs), laboratories and radiology and the dispensing of pharmaceuticals. [20] In contrast to the publicly funded hospital sector, primary care was dominated by GPs and other medical specialists who received payment for services through state subsidies (GSM benefits) and a 'fee for service' charged to the patients. GSM benefit subsidies failed to keep up with inflation and over time the patient charges increased disproportionately, creating inequalities in health care based on the patient's ability to pay. [21]

ACC

The Accident Compensation Corporation (ACC) scheme introduced in 1974, supplied 'no fault' accident insurance coverage which compensated people for medical bills and loss of wages. The scheme was intended to be self-funding from a range of levies. [22]

Figure 1. The structure of New Zealand's health system, 1980



Source: Based on Figure 16.1 OECD. 'New Zealand'. *The reform of health care systems: a review of seventeen OECD countries.* Health Policy Studies No. 5 OECD, Paris, 1994, p227.

Area Health Boards 1983-1993

Overview

Inconsistencies in health care quality and unequal access to health care services caused public and political concern. [23] A white paper, issued by the 1972 to 1975 Labour Government, entitled A health service for New Zealand [24] listed the problems of the existing structure and provided a template for health reform. There was some unease among stakeholders, including medical practitioners who disagreed with aspects of these reforms. [25]

Nevertheless, reform of the health system progressed slowly through the 1970s and 1980s. The newly elected 1975 National Government took a pragmatic approach to health reform by working with stakeholders in the Special Advisory Committee on Health Services Organisation (SACHSO). [26] The Committee's recommendations were similar to those of the 1975 White Paper: the establishment of fourteen regional, locally elected Area Health Boards (AHBs) combining both the curative functions of the Hospital Boards with the preventative functions of the Department of Health's District Health Offices. [27]

Cautiously, the Government chose to pilot the AHB scheme in the Wellington and Northland regions. [28] With the trial proving successful, the Area Health Boards Act 1983 was passed. Again change was not swift, as the Act did not make the development of AHBs compulsory.

The Fourth Labour Government came to power after the snap election of 1984. [29] Significant state sector reforms followed a market driven framework. Certain advisers recommended a commercial approach for health, but the Government chose to continue with the AHB system. This system was fully formed after the Local Government Act 1989 reformed local government and abolished Hospital Boards. [30]

Summary of significant changes

- 14 Area Health Boards formed between 1983 and 1989 with locally elected and appointed board members
- Early version of population based funding for AHBs
- Decentralisation of the Department of Health's responsibilities to AHBs
- Move from curative to preventive health services
- Emphasis on management and accountability structures for AHBs
- National health goals and targets – strategic health delivery

Significant policy documents

- Department of Health, *A health service for New Zealand*, 1975
- Department of Health, *Health services reorganisation: a discussion document*, 1982

Governance

While major reform was slow, it was still a time of considerable uncertainty in the health sector. From 1987 to 1990 there were three ministers of health each with a different outlook and style. [31] Robin Gauld (2001:64) says that "[w]ith each of the new Labour ministers, there was a change in direction of a magnitude normally expected of a change in government".

A major provision of the Area Health Boards Act 1983 was the decentralisation of power away from the Department of Health. Once the AHB system was fully functioning the Department released its operational and public health responsibilities to the regional AHBs. [32] Working under budgetary constraints and with a ceiling on staff numbers, the Department of Health undertook a fundamental restructuring, moving primarily towards policy formulation, advice to the Minister of Health, [33] the development of health targets and budgets to guide the AHBs, and the monitoring and evaluation of their performance against national requirements. [34] As part of the restructuring the Department was organised into six new management blocks: Corporate Management, Operations, Workforce Development, Medicines and Benefits, Policy and Communications and Corporate Services. [35]

Secondary care

The Area Health Boards Act 1983 saw the merger of Hospital Boards and Health Development Units (District Public Health Units of the Department of Health). The first AHBs were formed in 1985 in Northland, Nelson and Wanganui and by the end of 1989 the restructuring of 27 Hospital Boards as 14 AHBs was completed. [36] The AHBs' responsibilities included hospital services, health promotion, health protection, and environmental health. [37] Each AHB was required to sign a performance oriented accountability agreement with the Minister of Health [38] based on the health goals and

targets described by The New Zealand Health Charter 1989. [39] This brought the health system into line with the management reforms reflected in the State Sector Act 1988 and the Public Finance Act 1989. Previous to this, no clear requirements for health outputs existed and hospitals were taken to be fulfilling government expectations if they remained within their budgets. [40]

AHB populations varied in size from 35,000 to 900,000 people. Until 1991, board members were elected for a three year term in the same way and at the same time as local bodies. The Minister of Health had the power to appoint four additional board members to supplement perceived deficiencies in a board, for example business management skills or a Maori perspective. [41] In 1991, in preparation for the Government's intended reforms, (see next section) all 14 Boards were replaced by Commissioners appointed by the Minister of Health. [42]

A major turning point in health policy was the introduction in 1983 of a population-based funding (PBF) formula [43] for allocating resources to Hospital Boards and later AHBs. [44] The capping of hospital budgets was an attempt to contain government spending in relation to rising demand and expectation for health services. [45] Hospitals dominated health expenditure, with approximately 70 percent of the health vote spent on hospital services in 1989. [46]

In 1987 there were a total of 344 hospitals in New Zealand with 30,645 beds. One hundred and seventy one of these were public hospitals with 24,488 hospital beds available. The remaining 173 hospitals were privately owned and had 6,157 beds. [47]

User charges

In February 1992 user charges were introduced for services provided by public hospitals. These were dropped in 1993. The rationale for their introduction was to discourage free hospital use over primary care, to reduce health expenditure, to improve equity of primary care by making higher income people pay more and to encourage healthy living. [48] The scheme proved costly in terms of negative publicity and financially cost the AHBs $8.012 million. [49]

Primary health

In the 1980s General Practitioners were essentially independent providers with no direct contract with the government. Under the General Medical Services scheme of 1941 GP visits were subsidised by the government. GPs supplemented these low subsidies with user co-payments (these varied); approximately $31 (NZ) per adult consultation in 1991. [50] These user charges were monitored by the New Zealand Medical Association, with an informal agreement to keep payments at a reasonable level. [51] As GP user charges increased, people opted to use the free public hospital system for primary care. In order to remove some of the pressure (and expense) from the hospital system, and make primary care more accessible, the newly appointed Minister of Health (the Hon. Dr. Michael Bassett) tried to cap patient fees and increase the subsidy to GPs. [52] There was strong opposition by GPs to this proposal and it was dropped.

Figure 2. The structure of New Zealand's health system, 1992

Source: Courtesy of Ministry of Health

Regional Health Authorities and Crown Health Enterprises 1993-1997

Overview

In 1991 the newly elected National Government embarked on a comprehensive restructuring of the health sector. Early that year a Ministerial Taskforce chaired by Roderick Carr commenced work on plans to address perceived deficiencies in the system. [53] The Taskforce's recommendations were launched on Budget night July 1991 in a paper entitled Your health and the public health. The paper borrowed heavily from the 1988 Gibbs report [54] (Unshackling the hospitals) and the 1986 *Choices for health care: report of the Health Benefits Review* [55] both published during the 1980s.

Your health and the public health recommended the separation of the purchaser and provider roles of the Area Health Boards and the establishment of a competitive, quasi-market approach to the provision of health services. [56] Four Regional Health Authorities (RHAs) were designed to purchase services from a range of providers in a competitive health market. Area Health Boards were transformed into 23 Crown Health Enterprises (CHEs) which were to be run on a commercial basis with boards of government appointees. [57] A new Ministry of Health was to replace the existing Department of Health. [58]

Implementation was scheduled for 1 July 1993 allowing two years for consultation, development and implementation of a new health infrastructure. Work began immediately with Area Health Board members replaced by Government appointed commissioners to lead the change-over. The implementation process was managed by the Government through the Health Reform Directorate (HRD) located within the Department of the Prime Minister and Cabinet (DPMC) and not the Department of Health. In turn, the HRD oversaw the work of the National Interim Provider Board (NIPB) set up shortly after July 1991. The NIPB, chaired by Sir Ronald Trotter, was set the task of managing the transition from 14 Area Health Boards to 23 Crown Health Enterprises (all but one based on major acute hospitals). [59]

Another substantial change was the relocation, in 1993, of the 'disability support budget' to the new Regional Health Authorities. This was an attempt to unify funding and delivery of services which had been fragmented between Vote Health and Vote Social Welfare. [60]

Summary of significant changes

- Four RHAs established and 23 CHEs established.
- The Public Health Commission (PHC) established as a Crown agency.
- Department of Health (1900 to 1993) becomes the Ministry of Health.
- Separation of the provision of public hospital services from purchasing functions.
- Purchasers free to purchase from public or private sector providers.
- CHEs accountable to shareholding ministers and monitored by Crown Company Monitoring Advisory Unit (CCMAU).
- Public hospitals corporatised and granted operational autonomy.
- Public hospitals paid in relation to volume and quality of services according to legally binding contracts negotiated with purchasers.

Significant policy documents

- Scott, C. et al, *Choices for health care: report of the Health Benefits Review*, 1986.
- Gibbs, A. et al, *Unshackling the hospitals*, 1988.
- Upton, S. *Your health and the public health*, 1991.

Governance

The Ministry of Health (MOH) was established on 1 July 1993 as a streamlined version of the Department of Health. [61] The MOH was given the task of monitoring the performance of the Regional Health Authorities and the newly established Public Health Commission (PHC) against their funding agreements with the Crown. It also took up a regulatory role for all purchasers and providers, assessed and interpreted broad trends and influences in the health sector, serviced the national advisory committees, such as the National Advisory Committee on Core Health Services, provided some national specialist services and administered health legislation, including public health regulations. [62] The reforms provided for two ministers, a Minister of Health and a Minister of Crown Health Enterprises.

The Public Health Commission (PHC)

The Public Health Commission (PHC) was established as a Crown agency, independent of the Ministry of Health, with the task of advising the Minster of Health on public health policy, health monitoring, consultation and the purchase of public health services. [63] The PHC entered into contracts with CHEs and other service providers for the provision of public health services. [64] The PHC was decommissioned in 1995 because the government saw an unnecessarily complex public health structure developing, and according to Gauld (2001:125), because it produced advice that clashed with other government policy. [65] See Figures 3 and 4 below for the structure of the health system in 1994, including the PHC, and then in 1996 after it had been decommissioned.

Core services

Central to the health reforms was the need to control expenditure. [66] The National Advisory Committee on Core Health Services, known as the National Health Committee, was

established to rank health services and advise the Minister on which core personal health services RHAs should purchase and which services would no longer be offered. Defining core health was complex and a list of 'core services' was never developed.

Regional Health Authorities

With the introduction of the Health and Disability Services Act 1993 four Regional Health Authorities were established as purchasers of health care and 23 Crown Health Enterprises as providers. Regional Health Authorities had the responsibility of monitoring the health needs of their populations, purchasing the appropriate health and disability services [67] and monitoring the performance of providers with whom the RHAs entered purchase agreements. [68] The four RHAs were: Northern, Midland, Central and Southern each with a legislative responsibility for the health needs of between 750,000 to 1000,000 people and financial responsibility for purchasing primary, secondary and continuing care and accident related services from both Crown owned and privately owned providers. [69]

Regional Health Authorities were funded by the MOH according to a population–based formula. [70] RHA budgets were capped to promote macroeconomic efficiency. Locally elected Area Health Boards were replaced by non-elected government appointed boards of directors for both RHAs and CHEs. [71] The appointments of directors, largely from outside the health sector and with predominately business backgrounds, was seen as a way of reducing provider vested interests and achieving more rational decision-making. [72] RHAs were accountable to the Minister of Health and to Parliament. [73] The purchaser/provider split also meant that the public hospitals no longer had privileged access to public funding over similar private providers. [74] When the RHAs were fully established, the intention was to introduce competition between public and private purchasers by giving people the choice of obtaining their health care through RHAs or through other (non-government) health care plans using a public voucher. However, this plan was not implemented. [75]

Pharmac was initially set up under the Health and Disability Services Act 1993 with the specific purpose of improving the management of government expenditure on pharmaceuticals. Subsidised medicines and related products (the pharmaceutical schedule) were formerly managed by the Department of Health, but the worldwide growth in pharmaceutical expenditure led the four RHAs to form the joint venture Pharmac, the Pharmaceutical Management Agency of New Zealand, to manage the pharmaceutical schedule on their behalf. [76]

Secondary care

Crown Health Enterprises were designed to make hospital care more efficient. They were created as autonomous, publicly owned business units and typically included a single metropolitan hospital or a group of hospitals and related services. [77] CHEs were established along the lines of the state-owned enterprise (SOE) model and were able to contract with staff, raise capital and operate independently under the Companies Act 1993 as limited liability companies and were subject to commercial legislation. [78] RHAs funded CHEs on a contractual price volume basis. Directors of the CHEs were appointed by the shareholding ministers. The Crown Company Monitoring Advisory Unit (CCMAU) was established to ensure that the CHE directors and boards met their financial targets.

In 1994 there were a total of 330 hospitals in New Zealand with 24,120 beds. One hundred and twenty six of these were public hospitals with 16,468 hospital beds available. The remaining 204 hospitals were privately owned and had 7,652 beds. [79]

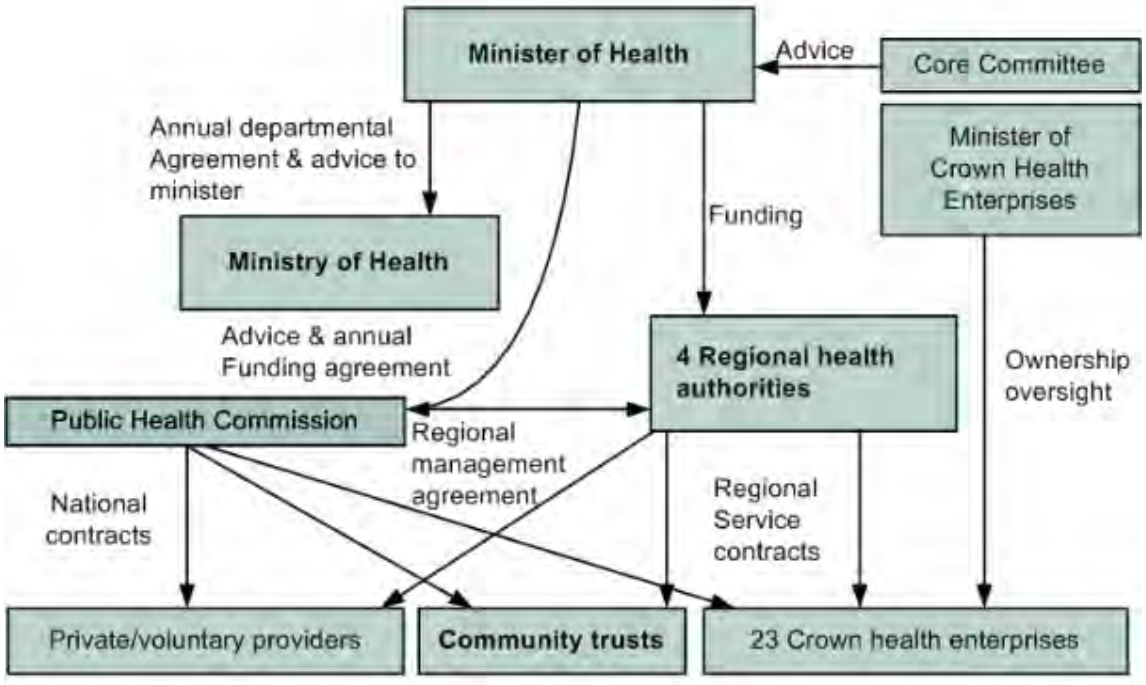
Community trusts

Not all Area Health Board facilities were transferred to CHEs. Some facilities were established as community trusts. The majority of community trusts consisted of facilities and services designed to serve local communities. The trusts, like CHEs, were private or independent providers, who owned their facilities and could contract to the RHAs. [80]

Primary care

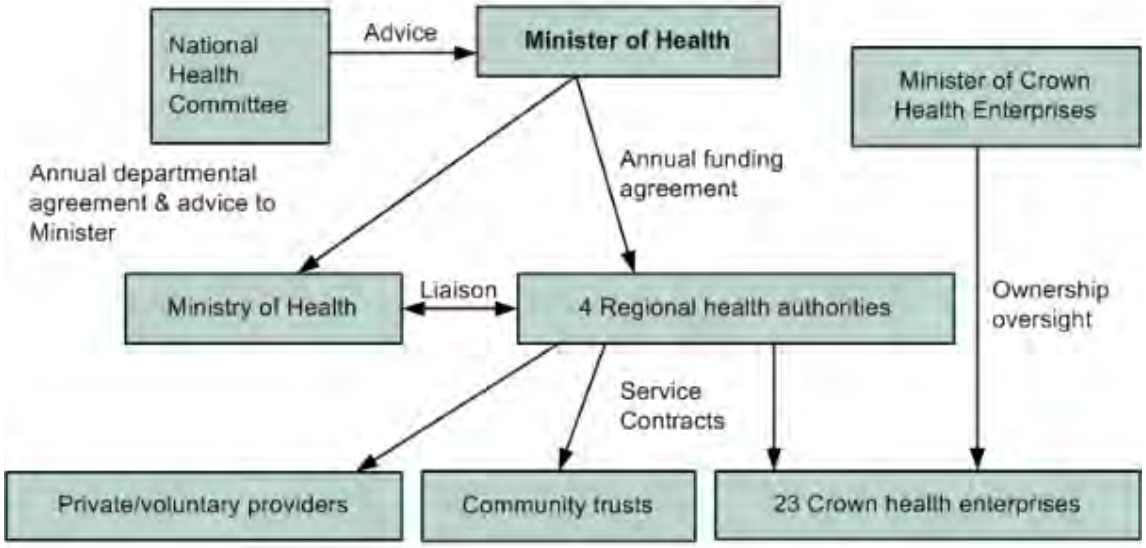
Apart from relatively small changes to subsidy levels, the organisation of primary care had not changed for decades. [81] During the 1990s however, primary health sector reform made significant moves towards capitated funding [82] and increased accountability. Regional Health Authorities were given the responsibility for purchasing primary care. This devolved the function from the Ministry of Health and integrated it within the secondary care environment. [83] The decentralisation of funding meant that for the first time GPs could negotiate new initiatives, including budget holding. [84] GPs formed Independent Practitioner Associations (IPAs) which were networks of (30-40) doctors conducting contract negotiations with RHAs for the delivery of primary health care services, including general medical services, maternity services and immunisation. [85] About 30 IPAs existed in 1996, the largest, ProCare Health in Auckland had 340 GP members.

Figure 3. The structure of New Zealand's health system after enactment of 1993 reforms



Source: Courtesy of Ministry of Health

Figure 4. The structure of New Zealand's health system, 1996



Source: Courtesy of Ministry of Health

The Health Funding Authority and Hospital and Health Services 1998-2001

Overview

The 1996 general election was the first under the new MMP electoral system. A National – New Zealand First Government formed around the Coalition Agreement. The Coalition Agreement on health was the result of negotiations between the two political parties with briefing advice from Treasury, MOH and CCMAU. [86] The agreement on health policy signalled a shift from the market model towards a more cooperative system. [87] Key changes indicated in the agreement were: The Minister of Health to combine the portfolios of Health and Crown Health Enterprises; one independent funding body (instead of four RHAs) with a focus on developing good collaborative relationships with providers; CHEs to be renamed Hospital and Health Services; health provision to be 'business like' not 'for-profit'; increased health funding; reduced elective surgery waiting times; boosted child and mental health services; support for Maori health developments; and free doctors visits and prescription medicine for children five years and under. [88]

Advice on the implementation of the Coalition Agreement on health came from the Steering Group chaired by the Director General of Health Karen Poutasi. [89] Disagreement developed over the Coalition Government's health policies and the Steering Group's recommendations. Gauld (2001:147) says that only "elements of the coalition policies were promoted; other changes indicated attempts to repackage ideas introduced in 1993." [90] The following 18 months included uncertainty as restructuring proceeded. The coalition partnership eventually broke down in August 1998 [91] leaving a minority National

Government. [92] From 1999 the focus was on consolidating the changes, working towards nationally consistent purchasing and service delivery frameworks and stabilising the health sector. [93]

Summary of significant changes

- Four RHAs become centralised into one Health Funding Authority (HFA)
- CHEs become Hospital Health Services (HHS)
- Centralisation of health funding
- More emphasis on collaboration
- Hospitals to be less commercially focused with some community representation on the hospital boards

Significant policy documents

- New Zealand Government, *Coalition Agreement: health*, 1997

Governance

While the New Zealand First Party was the primary driver in the Coalition Agreement on health the changes also allowed the Government to remedy some of the problems from the 1993 reforms. [94] The Coalition Government contained the Minister of Health, Hon Bill English from the National Party and the Associate Minister of Health, Hon Neil Kirton from the New Zealand First Party who differed on many issues and principles. [95]

The Ministry of Health and the Health Funding Authority (HFA) came under increased scrutiny because of the conflict and duplication of work being done. The two bodies encountered difficulty in building a good relationship. The MOH was the principal statutory body charged with monitoring the performance of the HFA. In practice however the HFA had direct access to the political executives which allowed it to circumvent the hierarchy and undermine the policy and relationship building work of the Ministry. [96] In 1998, the MOH issued a five year strategic business plan for 1997 to 2002 in which it concentrated on its leadership role and focused closely on three core functions: strategic policy advice, performance management of the HFA, and ministerial servicing. It shed a number of its traditional operational responsibilities to the HFA and other yet to be established agencies. These included public health policy and regulation, the licensing of public and private hospitals and rest homes, regulating therapeutic medicines and equipment, acting as secretariat of health occupational registration boards, and the operation of the New Zealand Health Information Service. [97]

Health Funding Authority

Soon after the general election of 1996, work started on the integration of the four RHAs into one central purchasing agency, the Health Funding Authority. In mid 1997 the Transitional Health Authority (THA) was created to assess the problems of the previous purchasing system and to oversee the amalgamation of the four RHAs. Following the Health and Disability Services Amendment Act 1998, the Health Funding Authority replaced the THA and assumed legal responsibility for the purchase and monitoring of health and disability services for the public. [98] While the primary functions of the HFA were the same as those of the RHAs (see previous section), the rationale for a single funder was to reduce cost shifting among different agencies and service levels. [99]

The HFA reviewed the organisation of purchasing and developed a new national structure to replace the four RHAs. Transformation 98 (T98), as it became known, had a major effect on the sector; 520 staff were made redundant and 370 new posts created. [100] 1998 was a year of some uncertainty for both purchaser and providers of health as both became acquainted with Government expectations and awaited completion of the new institutions arrangements. [101] From 1999 however, collaborative relationships between purchasers and providers began to develop. [102]

In 1998 the National Advisory Committee on Health and Disability Services (commonly known as the National Health Committee (NHC) and formerly the National Advisory Committee on Core Health and Disability Services (1992) (see Core Services in last section)) was set up to provide a second opinion on the range, mix and quality of services the HFA was purchasing, as well as continuing with its existing work programme. The National Guidelines Group was launched under NHC sponsorship and was subsequently funded by the HFA (presently by the MOH) to give evidence based health advice. [103]

Secondary care

The 23 CHEs became Hospital and Health Services (HHS) through the Health and Disability Services Amendment Act 1998. The underlying structures and governance stayed the same. [104] Despite the legislative changes, new policy directions and funding increases, the hospital sector continued to downsize and reconfigure. The mandate to be profit driven was replaced with the requirement to be business like, which still meant that HHSs continued to search for ways to live within their budgets. The Health Funding Authority imposed capped funding growth levels from mid 1997. This meant substantial change in the services delivered by the hospitals. There was a reduction in financially unviable hospital beds. Some services were considered to be non-core business, such as midwifery services, sexual health services, and mental health staff training and a reduction in the provision of services in provincial hospitals occurred. Some of these services were taken over by other HHS or community providers. [105]

In 1998 there were a total of 387 hospitals in New Zealand with 30,282 beds. One hundred and nine of these were public hospitals with 14,298 hospital beds available. The remaining 278 were privately owned hospitals with 15, 984 beds. [106]

Elective surgery, the national booking system

Long waiting lists for publicly funded, non-urgent surgical and medical procedures are considered to be an indicator of poor hospital performance and a significant political issue. [107] Treatment for patients on waiting lists was traditionally based on list position and not on need. After 1 July 1998, under the guidance of the HFA, all hospitals were required to have booking systems in place. [108] The new booking system saw patients scored against a predetermined series of medical and social criteria, including the level of severity or disability, the capacity to benefit from the treatment, and the ability to work and maintain independence. Patients would gather points until they had enough to obtain an appointment for surgery on a specific date. [109] Those without enough points went back to their GP for treatment or paid for an operation in the private sector. Further changes were made in 2000 when the HFA announced the introduction of a new pilot integrated scoring system in which sub-specialities would be ranked in order of their relative clinical importance. [110] New Zealand has been seen as a world leader in the development of scoring and booking systems. [111]

Primary care

Independent Practitioners Associations (IPAs) led the primary care sector during this period and set the scene for a more integrated approach to health with the later introduction of the Primary Health Organisations (PHOs) in 2002. IPAs were a GP-initiated move to increase sector bargaining power while remaining independent. Malcolm (2000:199-200) says that IPAs have made a number of key achievements with improved information systems being an important move in professional accountability. Nearly all IPA practices have computerised age-sex registers leading to the extension of the National Health Index (NHI) to practice registers. The National Health Index number is a unique number assigned to identify patient use of health and disability services and all health care expenditure. At the time of publication, several IPAs were still operating providing management infrastructure and support services for Primary Health Organisations (PHOs).

Figure 5. The structure of New Zealand's health system, 1999

Source: Courtesy of Ministry of Health

District Health Boards 2001

Overview

The release of Labour's 1999 health policy reinforced its pre-election pledge to restructure the health system. [112] *Focus on patients: Labour on health* became the basis for the Coalition Government's new District Health Board system. Labour considered the previous Health Funding Authority system to be overly competitive, low in community input, and lacking adequate efficiency and accountability.

Through the *New Zealand health strategy* 2000 the Labour – Alliance Coalition Government set about change. With the introduction of the New Zealand Public Health and Disability Act 2000 the Ministry of Health became the principal agency responsible for policy advice, funding and monitoring the health and disability sector; the Health Funding Authority was abolished, with its functions transferred to the newly restructured Ministry of Health; 21 District Health Boards (DHBs) replaced the Hospital Health Services and took responsibility for the purchase and provision of health services. The Primary Health Care Strategy 2001 guided the reorganisation of GPs and IPAs into Primary Health Organisations (PHOs).

Summary of significant changes

- 21 DHBs were established
- Centralisation of health funding with MOH
- Hospitals less commercially focused
- DHB governance by mostly locally elected boards
- Emphasis on preventative health services
- National health goals and targets
- PHOs were established in July 2002 and are funded by DHBs

Significant policy documents

- Ministry of Health, *The New Zealand health strategy*, 2000
- Ministry of Health, *The Primary health care strategy*, 2001

Governance

Soon after the 1999 election the newly elected Labour-Alliance Coalition Government began to restructure the health system. The Health Funding Authority was slowly phased out, with its operations absorbed by the newly restructured Ministry of Health. The Ministry's new role involved national policy development, the purchase of health services, and monitoring DHB performance. [113] District Health Boards New Zealand (DHBNZ) developed out of the old hospital representative body, the Crown Health Association (CHA), to assist the Ministry in its new role. [114] DHBNZ represents the DHBs' interests by overseeing and coordinating workforce development, benchmarking and efficiency-related projects, and the development of nationally consistent funding contracts.

Secondary care

In 2001, 21 District Health Boards were established through the New Zealand Public Health and Disability Act 2000. DHBs are Crown entities that are responsible to the Minister of Health and funded via a population-based formula by the Ministry of Health. District Health Boards are responsible for planning, funding and ensuring the provision of health and disability services to a geographically defined population [115] , thus removing the funder / provider split, dominant in the previous reforms of 1993-2001. DHBs are required to focus on reducing inequalities among their populations, prioritising health services within budget and providing access to disability support, mental health services and primary health care. [116] District Health Boards range in population size from about 30,000 at smallest to nearly 500,000 for the largest. [117]

DHBs are governed by an 11 member committee; seven locally elected, and up to four ministerial appointees, including the Chair. Each Board must have at least two Maori members

(they are appointed if not elected). DHB elections are timed to coincide with local body elections. Under the New Zealand Public Health and Disability Act 2000, DHBs are required to develop partnerships with Maori by developing formal iwi relationships in their regions.

The Crown Entities Act 2004 requires District Health Boards to produce a statement of intent and an annual report to Parliament. Monitoring and accountability of individual DHBs is achieved through Crown funding agreements with the Minister, a district strategic plan and a district annual plan. [118] Population based funding was introduced on 1 July 2003. Previously, DHBs were funded to provide hospital services and to administer contracts for providers who were based in their districts. [119]

In 2002 there were 445 hospitals in New Zealand with 23,825 beds. Eighty five of these were publicly funded and had a total of 12,484 hospital beds available. The remaining 360 were privately owned hospitals with 11,341 hospital beds. [120] Public health services are split between the 12 Ministry of Health funded (but DHB owned) Public Health Units and some 200 non-governmental organisations (NGOs). [121]

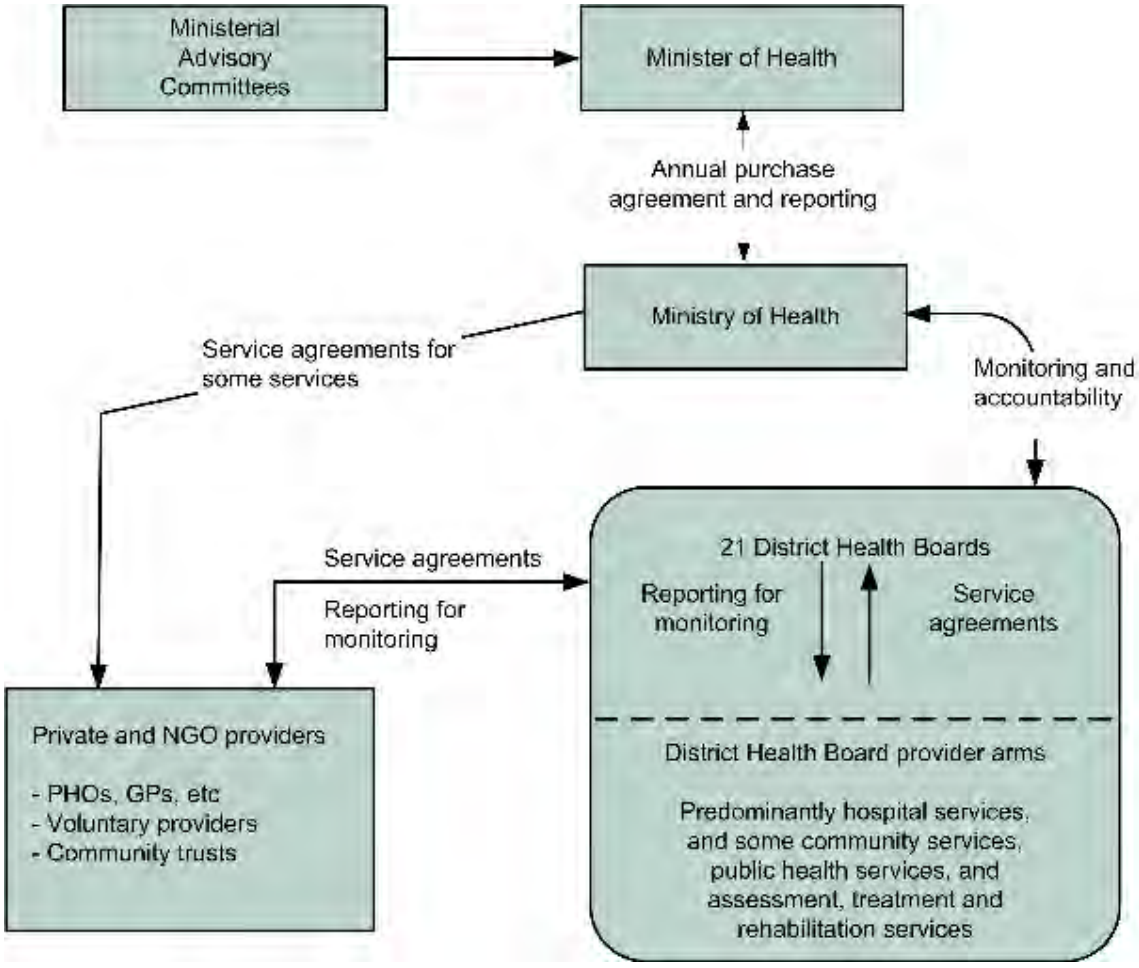
Primary care

Since July 2002, the Government's primary healthcare strategy has been to reform the primary health system by encouraging GPs to join non-profit, community-based Primary Health Organisations (PHOs). PHOs comprise doctors, nurses and other health professionals in the community (such as Maori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives). Their role is to serve the health needs of their enrolled populations. PHOs contract to DHBs on a per capita basis to provide primary health care services, including preventative services. The funding is based on the demographic details of the people enrolled with them. Before July 2007 there were two types of PHO, interim and access PHO (high needs populations), each catering to a different demographic population and each with a different funding system. [122] From July 2007, PHOs with similar demographics and special needs now receive similar funding. In October 2007, very low cost practices were introduced, these practices receive extra government subsidies provided they offer free services for children under six and a range of lower charges for other patients. There are currently 82 PHOs around the country with more than 4 million enrollees. [123] GPs' fees vary between practices and PHOs, and are monitored by DHBs and an independent Fee Review Committee. [124] General Practitioners fees are now displayed in GP practices and published on DHB and PHO websites.

Non-government organisations (NGOs)

Many health and disability support services are delivered by NGOs. They include independent community and iwi/Māori organisations operating on a not-for-profit basis. Some organisations identify more closely with other categories, for example third sector organisations, voluntary organisations, community organisation etc, rather than under an NGO category. [125]

Figure 6. The structure of New Zealand's health system, 2008



Source: Diagram based on the Ministry of Health *Structure of the New Zealand health and disability sector*. www.moh.govt.nz

Peter Quin, Research Analyst

Social Policy Team

Parliamentary Library

For more information contact Peter at ext. 9019

Copyright: © NZ Parliamentary Library, 2009

Except for educational purposes permitted under the Copyright Act 1994, no part of this document may be reproduced or transmitted in any form or by any means, including information storage and retrieval systems, other than by Members of Parliament in the course of their official duties, without the consent of the Parliamentary Librarian, Parliament Buildings, Wellington, New Zealand.This document may also be available through commercial online services and may be viewed and reproduced in accordance with the conditions

applicable to those services.

1. OECD. 'New Zealand'. The reform of health care systems: a review of seventeen OECD countries. Health Policy Studies No. 5. OECD, Paris, 1994.
2. Blank, R. F. New Zealand health policy: a comparative study, Oxford University Press, Auckland, 1994.
3. Davis, P. Health and health care in New Zealand, Longman Paul, Auckland, 1981, pp. 5-7.
4. Hyslop, J., Dowland, J., & Hickling J. Health facts New Zealand, Department of Health,1983, p. 9.
5. Gauld, R. Revolving doors: New Zealand's health reforms, Institute of Policy Studies and Health Services Research Centre, Wellington, 2001, p. 18.
6. Minister of Health. A health service for New Zealand, Appendices to the Journals of the House of Representatives, 1975, H-23 and OECD, 1994, p. 227.
7. Minister of Health. 1975, p. 63.
8. Minister of Health. 1975, pp. 64-65.
9. New Zealand official year book, Department of Statistics, Wellington, 1981, p. 137.
10. OECD, 1994, p. 228.
11. Gauld, 2001.
12. Davis, 1981, pp. 1-6.
13. New Zealand official year book, 1981, p. 137.
14. OECD, 1994, p. 228.
15. Lang, H. G. 'Health policy formulation in New Zealand', International Journal of Health Planning and Management, vol. 2, 1987, pp.143-160.
16. Gauld, 2001, p. 18-19 and New Zealand official year book 1981, p. 137.
17. Fougere, G. M. 'From market to welfare state? State interventions in medical care delivery in New Zealand', In the public interest: health, work and housing in New Zealand eds C. Wilkes and I. Shirley, Benton Ross Ltd, Auckland, 1984, p.81.
18. Ovretveit, J. 'The Kiwi way: lessons from New Zealand', British Medical Journal, 312, 1996, p.645.
19. OECD, 1994, p. 228.
20. Malcolm, L. 'Primary-care reform in New Zealand: key contrasts with Australia', Health reform in Australia and New Zealand, ed A. Bloom, Oxford University Press, Melbourne, 2000, p. 184.
21. Gauld, 2001, p. 19.
22. St John, S. 'Accident compensation in New Zealand: a fairer system' Redesigning the welfare state in New Zealand: problems, policies, prospects, eds J. Boston, P. Dalziel, & S. St John, Oxford University Press, Auckland, 1999, p.156. Also see History of ACC in New Zealand at http://www.acc.co.nz/index.htm
23. Gauld, 2001, pp. 31-32.
24. Also available as Department of Health, A health service for New Zealand, Government Printers, 1975 and Minister of Health, A health service for New Zealand, Appendices to the Journal of the House of Representatives, H-23, 1975.
25. Gauld, 2001, pp. 32-34.
26. Special Advisory Committee on Health Services Organisation (SACHSO), Proposed Northland pilot scheme: a framework for discussion. Department of Health, unpublished paper, 1977.
27. Gauld, 2001, p. 35.
28. Department of Health, Health services reorganisation: a discussion document, Department of Health, 1982.
29. Gauld, 2001, p. 40.
30. Gauld, 2001, p. 37.

31. Michael Bassett commissioned the Gibbs report, David Caygill issued his own policy document Health: a prescription for change, 1988 while Helen Clark detached the Department of Health from the policy circuitry (Gauld, 2001, p. 65) see Clark, H. (1989) A New Relationship: introducing the new interface between the government and the public health sector, Wellington, Minister of Health.
32. Blank, 1994, p. 124.
33. Department of Health, General briefing notes for the Minister of Health, 1984, p.5.
34. Department of Health, Report of the Department of Health for the year ended 31 March 1989, 1987-1990, VII, Appendices to the Journals of the House of Representatives, E10, p.4
35. Department of Health, Report of the Department of Health for the year ended 31 March 1987, 1987-1990, VII, Appendices to the Journals of the House of Representatives, E10, p.8
36. OECD, 1994, p. 230.
37. Department of Health, Briefing notes for the Minister of Health, 1989, p. 2 [back]
38. Blank, 1994, p. 126
39. Department of Health, The New Zealand health charter, Wellington, Department of Health, 1989. The New Zealand Health Charter broadly describes the operations and goals for the operation of a nationwide publicly funded health system.
40. OECD, 1994, p. 231
41. OECD, 1994, p. 228
42. OECD, 1994, p. 230
43. The population based funding (PBF) system was revised in 1990 for Area Health Boards. 1993-1997 PBF occurred at a regional level and the four Regional Health Authorities funded the 23 Crown Health Enterprises (providers) on a contractual price-volume basis. 1998-2000 the Health Funding Authority maintained this approach. PBF was introduced on 1 July 2003 for DHBs. Previously, DHBs were funded to provide hospital services and to administer contracts for providers who were based in their districts.
44. Blank, 1994, p. 124.
45. Blank, 1994, p. 124 and Department of Health, Funding for health: an allocation formula, special report, series No. 58, 1981.
46. Department of Health, 1989, p. 1.
47. New Zealand official year book, Department of Statistics, Wellington, 1988/89, p316.
48. Ashton, T. 'User charges for hospital services: will they achieve their stated aims?', NZ Nursing Forum, vol 20, No.1, 1992, p. 6.
49. Gauld, 2001, p. 96.
50. OECD, 1994, p. 230.
51. OECD, 1994, p. 230.
52. Gauld, 2001, pp. 54-55.
53. Gauld, R.' Introduction'. Continuity amid chaos: health care management and delivery in New Zealand, Oxford University Press, Dunedin 2005, p. 17.
54. Gibbs, A., Fraser, D. and Scott, J. Unshackling the hospitals 1988, Government Print, Wellington, 1988.
55. Scott, C., Fougere, G. and Marwick, J. Choices for health care: report of the Health Benefits Review. Government Print, Wellington, 1986.
56. Blank 1994, p.128.
57. Gauld, R. 'Beyond New Zealand's dual health reforms', Social Policy & Administration Vol. 33, No. 5, 1999, p. 569.
58. Gauld, 2001, pp. 84-85.
59. Gauld, 2001, p. 87.
60. OECD, 1994, p. 237.

61. Gauld, 2001, p. 113.
62. OECD, 1994, p. 239.
63. Blank, 1994, p. 128.
64. Bloom, 2000, p. 35.
65. Gauld, 2001, p. 125.
66. Gauld, 2001, pp. 96-97.
67. Bloom, A., 'Context and lead-up to health reform' in Abbey Bloom (ed) Health reform in Australia and New Zealand, Oxford University Press, Melbourne, 2000, p. 35.
68. New Zealand official year book, Statistics New Zealand, Wellington, 1997, p.179.
69. Coster, G. and McAvoy, P., 'Editorial: Health reforms: a New Zealand perspective', British Journal of General Practice, July 1996, pp.391-392.
70. Blank, 1994, p. 128.
71. Barnett, P. and Barnett, R., 'Reform and change in health service provision' in Kevin Dew and Peter Davis (eds) Health and society Aotearoa New Zealand, Oxford University Press, Australia, 2000, p. 225.
72. Barnett, and Barnett, 2000, p. 225.
73. OECD, 1994, p.238.
74. Easton, 2002, 'The New Zealand health reforms in context', June 28, 2002, accessed June 2008-06-04. http://www.eastonbh.ac.nz/?p=35
75. Ashton, T., Mays, N. and Devlin, N. 2005, Continuity through change: The rhetoric and reality of health reforms in New Zealand, Social Science and Medicine, vol 61, No. 2, p253-262 , p.254.
76. Gauld, 2001, pp. 125-127.
77. OECD, 1994, p. 238.
78. OECD, 1994, p. 238.
79. New Zealand official year book, Statistics New Zealand, Wellington, 1996, p169.
80. OECD, 1994, p. 239.
81. Malcolm, 2000, p. 186.
82. A capitation based payment system is based on a payment per capita (per head) of population not per visit to the general practitioner.
83. Blank, 1994, p. 128.
84. Malcolm, 2000, p. 188.
85. Coster, and McAvoy, 1996, pp. 391-392.
86. Gauld, 2001, pp. 144-145.
87. Ashton, T. 'Implementing the Coalition health policy: the baby and the bath water', Health Manager, vol 5, no. 1, 1997 p. 5.
88. Gauld, 2001, p. 145 and Martin, J. 'Health structures and the Coalition', Health Manager, vol 4, no. 2, 1997 p. 3.
89. Gauld, 2001, p. 147. and Steering Group to Oversee Health and Disability Changes. Implementing the coalition agreement on health, The report of the Steering Group to oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health, Steering Group, Wellington, 1997.
90. Gauld, 2001, p. 147 and Laugesen, R. 'NZ First health imprint getting fainter by day', Sunday Star Times, 7 September, 1997, p. A:2 .
91. The immediate cause of the breach was a disagreement over the decision to sell the government's 66% shareholding in Wellington Airport. See Boston, J., S. Church & H. Pearse, 'Explaining the demise of the National-New Zealand first Coalition', Australian Journal of Political Science, Vol. 39, no. 3, pp585-603.
92. Gauld, 2001, p. 143.
93. Gauld, 2001, p. 142.
94. Gauld, 2001, p.142.
95. Gauld, 2001, p.143.
96. Gauld, 2001, p. 153.

97. Gauld, 2001, pp. 156-157.
98. Gauld, 2001, p. 149.
99. Bloom, 2000, p. 35.
100. Gauld, 2001, p. 151.
101. Gauld, 2001, p. 152.
102. Gauld, 2001, p. 152.
103. Gauld, 2001, pp. 157-159.
104. Gauld, 2001, p. 159.
105. Gauld, 2001, p.160.
106. New Zealand official year book, Statistics New Zealand, Wellington, 2000, p192.
107. See Gibbs, A., Fraser, D. and Scott, J., Unshackling the hospitals: report of the hospital and related services taskforce, Hospital and Related Services Taskforce, Wellington,1988. (aka the Gibbs Report), Upton, S. Your health and the public health: a statement of government health policy, government printer, Wellington (aka Green and White Paper) and Fraser, G., Alley, P., and Morris, R., Waiting lists and waiting times: their nature and management, Core Services Committee, Wellington, 1993.
108. Gauld, 2001, p. 170.
109. Gauld, 2001, p. 169.
110. Gauld, 2001, p. 172.
111. Gauld, 2001, p. 173 and British Medical Association, Waiting list prioritisation scoring systems: a discussion paper, 1999. http://www.bma.org.uk/ap.nsf/Content/Waiting+list+prioritisation+scoring+systems
112. Gauld, 2001, p. 179. Also see New Zealand Labour Party, Focus on patients: Labour on health, 1999.
113. Gauld, 2001, pp.191-192.
114. Gauld, 2001, p. 191.
115. Ministry of Health. Annual report 2005/06 including 'The health and independence report'. Ministry of Health, Wellington, 2006. p. 14.
116. Gauld, 2001, p. 190-192, and Gauld, R. 'Health policy and the health system' in Raymond Miller's (ed) New Zealand Government and Politics, 4th editions, Oxford University Press, Auckland, 2006.
117. Ministry of Health, New Zealand health and disability support sector: the organisations, Advice to the Incoming Minister of Health 2005, p 10. http://www.moh.govt.nz/moh.nsf/pagesmh/2840?Open
118. Ministry of Health, 2005, p 12.
119. Ministry of Health, Population based funding, 2008.http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/262d2106244fe595cc257093000ac48e?OpenDocument
120. New Zealand official year book, Statistics New Zealand, Wellington, 2004, p146.
121. Ministry of Health, 2006. p. 16.
122. Hutton, C. 'GPs' fees: survey', Consumer, 469, 2007, pp. 16-18.
123. Ministry of Health, Enrolment demographics, http://www.moh.govt.nz/moh.nsf/indexmh/phcs-pho-enrolment#demographics
124. Gauld, R. and N. Mays, 'Reforming primary care: are New Zealand's new primary health organisations fit for purpose?' British Medical Journal, Vol. 333, 2006, pp. 1216-1218.
125. Ministry of Health, Health and disability non-government organisations, http://www.moh.govt.nz/ngo

Appendix 2:

LEGAL AND REGULATORY FRAMEWORK

Legislation the Ministry administers

1. The Ministry administers a wide range of acts, regulations and other legislative instruments such as orders-in-council. The following is a brief description of the principal acts administered by the Ministry.

Alcoholism and Drug Addiction Act 1966	Provides for the care and treatment of people with alcohol and drug addictions.
Burial and Cremation Act 1964	Outlines the law relating to the burial and cremation of the dead.
Cancer Registry Act 1993	Provides for the compilation of a statistical record of the incidence of cancer in its various forms, as a basis for better direction of programmes for research and for cancer prevention.
Care and Support Workers (Pay Equity) Settlement Act 2017	This settlement addresses a historic undervaluing of care and support workers in New Zealand's aged and disability residential care, and home and community support services.
Children's Health Camps Board Dissolution Act 1999	Dissolves the Children's Health Camps Board, transfers its assets to a foundation incorporated under Part 2 of the Charitable Trusts Act 1957 and provides for incidental matters.
Compensation for Live Organ Donors Act 2016	Provides for compensation for lost income to be paid to live donors of organs.
Disabled Persons Community Welfare Act 1975, Part 2A	Sets out the right of people in residential care to a review of the adequacy of any disability services, and whether or not a person's disability service needs are appropriately met by the residential care received.
Epidemic Preparedness Act 2006	Provides statutory power for government agencies to prevent and respond to the outbreak of epidemics in New Zealand, and to respond to particular possible consequences of epidemics (whether occurring in New Zealand or overseas). This Act also aims to ensure that certain activities can continue during an epidemic in New Zealand, and to enable the relaxation of some statutory requirements that might not be capable of being complied with, or complied with fully, during an epidemic.
Health Act 1956	Sets out the roles and responsibilities of individuals to safeguard public health, including the Minister, the Director of Public Health and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies and the National Cervical Screening Programme.
Health and Disability Commissioner Act 1994	Aims to promote and protect the rights of health consumers and disability service consumers to secure fair, simple, speedy and efficient resolution of complaints. It provides for the appointment of a Health and Disability Commissioner to investigate complaints, and defines the Commissioner's functions and powers. It also provides for the establishment of a Health and Disability Services Consumer Advocacy Service, and for the promulgation of a Code of Health and Disability Services Consumers' Rights.
Health and Disability Services (Safety) Act 2001	Promotes the safe provision of health and disability services to the public, and establishes consistent and reasonable standards of service for providers.
Health Benefits (Reciprocity with Australia) Act 1999	Provides for reciprocity with Australia in relation to pharmaceutical, hospital and maternity benefits.
Health Benefits (Reciprocity with the United Kingdom) Act 1982	Provides for reciprocity with the United Kingdom in relation to medical, hospital and related benefits.

Health Practitioners Competence Assurance Act 2003	Aims to ensure health practitioners are competent and fit to practise their professions. It provides for: (a) a consistent accountability regime for all health professions (b) the determination of the scope of practice within which each health practitioner is competent (c) systems to ensure that no health practitioner practises outside his or her scope of practice (d) power to restrict specified activities to particular classes of health practitioner (e) certain protections for health practitioners who take part in protected quality assurance activities.
Health Research Council Act 1990	Defines the functions and powers of the Health Research Council of New Zealand, a Crown entity responsible for managing government's investment in health research.
Health Sector (Transfers) Act 1993	Governs the sale or transfer of assets, liabilities or functions from DHBs and certain health Crown entities to the Crown or other specified bodies.
Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016	Provides for payment of wages to home and community support workers for travel between clients.
Human Assisted Reproductive Technology Act 2004 (in conjunction with the Ministry of Justice)	Governs assisted reproductive technology, including by: providing a framework for the regulation and performance of assisted reproductive procedures; prohibiting certain procedures, types of research and transactions; and establishing an information keeping regime for people born from donated embryos or cells to find out about their genetic origins.
Human Tissue Act 2008	Governs the collection and use of human tissue to ensure that this is done in an appropriate way, without endangering the health and safety of members of the public, and that it does not involve payment.
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003	Provides for the compulsory care and rehabilitation of individuals with an intellectual disability who have been charged with, or convicted of, an imprisonable offence.
Medicines Act 1981	Covers the law relating to the manufacture, sale and supply of medicines, medical devices and related products.
Mental Health (Compulsory Assessment and Treatment) Act 1992	Defines the circumstances and conditions under which people may be subjected to compulsory psychiatric assessment and treatment. It defines and protects the rights of such people, and generally defines the law relating to the assessment and treatment of people suffering from mental disorders.
Mental Hospitals Reserves Act 1908	Authorises the disposal by lease or otherwise of certain Mental Hospitals Reserves.
Misuse of Drugs Act 1975	Aims to prevent the misuse of drugs.
New Zealand Council for Postgraduate Medical Education Act Repeal Act 1990	Dissolves the New Zealand Council for Postgraduate Medical Education and repeals the New Zealand Council for Postgraduate Medical Education Act 1978.
New Zealand Public Health and Disability Act 2000	Establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes DHBs and certain health Crown entities, and sets out the duties and roles of key participants, including the Minister and ministerial advisory committees.
New Zealand Public Health and Disability (Southern DHB) Elections Act 2016	Cancelled the 2016 triennial general election of the Southern DHB in order to provide, until the repeal date, for the continuation of the term of office of a commissioner for the Southern DHB.
Psychoactive Substances Act 2013	Regulates the importation, manufacture and supply of psychoactive substances in New Zealand to protect the health of, and minimise harm to, individuals who use psychoactive substances.
Radiation Safety Act 2016	Establishes a framework to protect the health and safety of people and protect the environment from the harmful effects of ionising radiation while allowing for the safe and beneficial use of ionising radiation. Enables New Zealand to meet international obligations relating to radiation and nuclear non-proliferation.

Smoke-free Environments Act 1990	Aims to: (a) reduce the exposure of people who do not themselves smoke to any detrimental effect on their health caused by others' smoking (b) regulate the marketing, advertising and promotion of tobacco products, whether directly or through the sponsoring of other products, services or events (c) monitor and regulate the presence of harmful constituents in tobacco products and tobacco smoke.
Social Security (Long-term Residential Care) Amendment Act 2006	Sets out the regime for determining liability in respect of the cost of providing long-term residential care.
Substance Addiction (Compulsory Assessment and Treatment) Act 2017	Enables people to receive compulsory treatment if they have a severe substance addiction and their capacity to make decisions about treatment for that addiction is severely impaired.

Other regulatory roles and obligations

2. In addition to administering legislation, key personnel within the Ministry (such as the Directors of Public Health and Mental Health) have specific statutory powers and functions under various pieces of legislation.

3. The Ministry also has certain statutory roles and relationships defined in other legislation, including:

   3.1 Biosecurity Act 1993;

   3.2 Civil Defence Emergency Management Act 2002;

   3.3 Education Act 1989;

   3.4 Food Act 1981;

   3.5 Gambling Act 2003;

   3.6 Hazardous Substances and New Organisms Act 1996;

   3.7 Human Assisted Reproductive Technology Act 2004;

   3.8 Litter Act 1979;

   3.9 Local Government Act 2002;

   3.10 Maritime Security Act 2004;

   3.11 Prostitution Reform Act 2003;

   3.12 Sale and Supply of Liquor Act 2012;

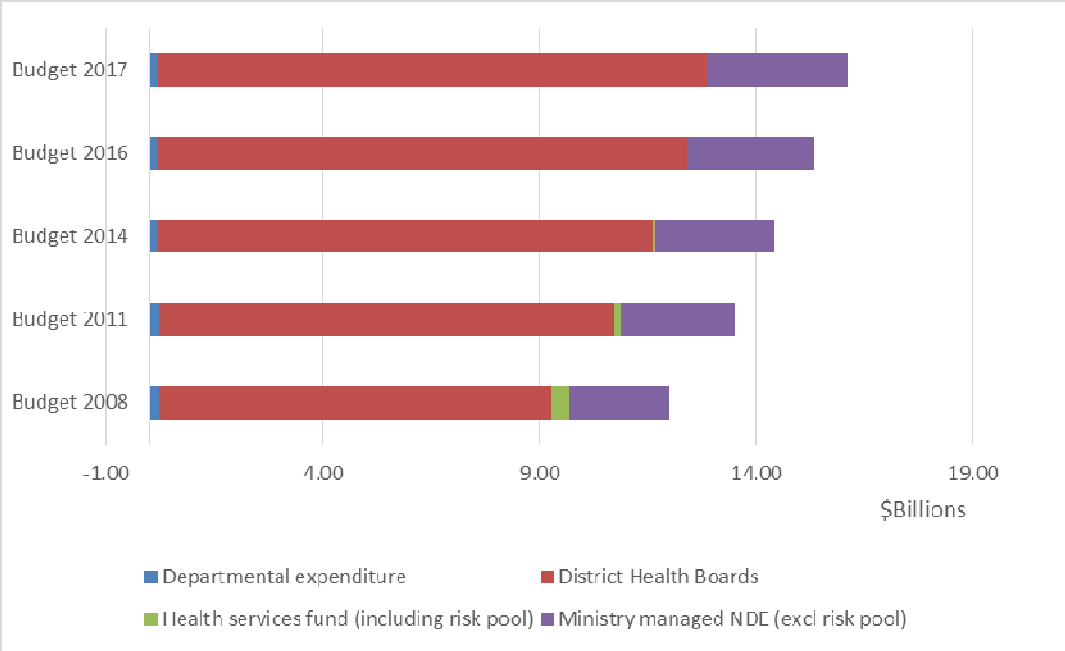
3.13 Social Security Act 1964;

3.14 Victims' Rights Act 2002; and

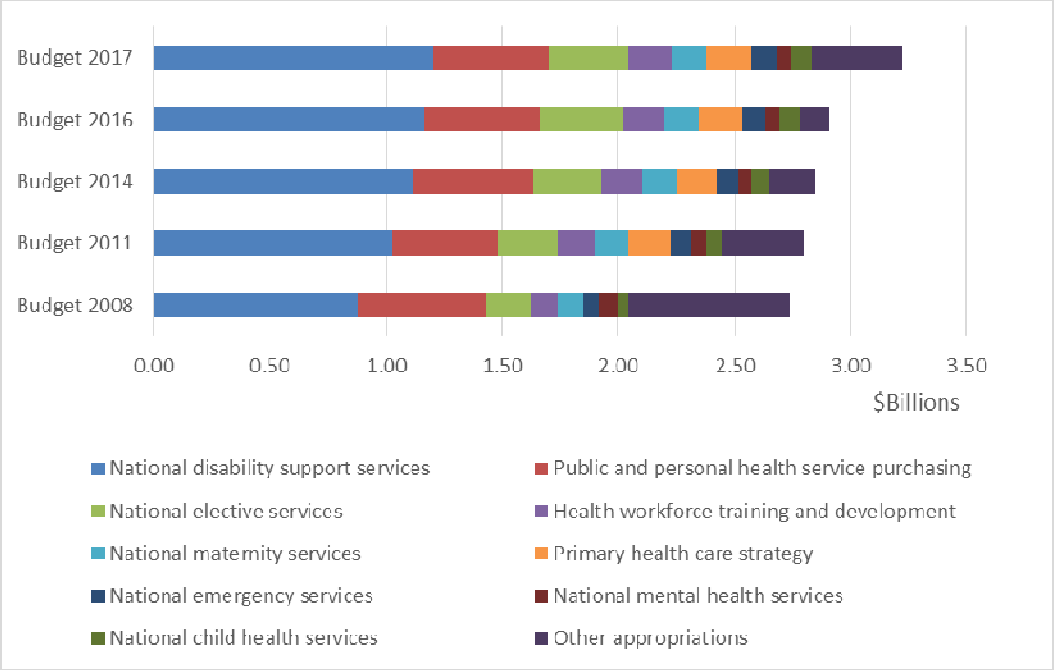
3.15 Waste Minimisation Act 2008.

Appendix 3: Vote Health

Components of Vote Health operating expenditure – excluding capital, $billion



Components of Ministry-managed non-departmental operating expenditure, $billion



Appendix 4:

OTHER STATUTORY BODIES, COMMITTEES AND OFFICE HOLDERS

1. This appendix provides a brief description of the roles and functions of those bodies, committees and individuals appointed by the Minister which have not already been discussed. Some bodies also have members appointed in other ways (eg, through elections), or by virtue of their job. The appendix is ordered alphabetically, by statute of establishment.

Health Act 1956

National Kaitiaki Group

2. The National Kaitiaki Group is established under the Health (Cervical Screening (Kaitiaki) Regulations 1995. It ensures Māori control and protection of Māori women's cervical screening data. The group:

    2.1 considers applications for approval to disclose, use or publish protected information

    2.2 responds to the requests for data release as soon as reasonably practicable after receiving the request

    2.3 grants approval for such disclosure, use or publication in appropriate cases.

National Cervical Screening Programme review committee

3. The Minister must establish a review committee at least once every three years, to review the operation of the National Cervical Screening Programme and evaluate the programme's service delivery and outcomes.

Health Practitioners Competence Assurance Act 2003

Responsible authorities

4. There are currently 16 responsible authorities under the Health Practitioners Competence Assurance Act 2003:

    4.1 Chiropractic Board;

    4.2 Dental Council;

    4.3 Dietitians Board;

4.4 Medical Council;

4.5 Medical Radiation Technologists Board;

4.6 Medical Sciences Council;

4.7 Midwifery Council;

4.8 Nursing Council;

4.9 Occupational Therapy Board;

4.10 Optometrists and Dispensing Opticians Board;

4.11 Osteopathic Council;

4.12 Pharmacy Council;

4.13 Physiotherapy Board;

4.14 Podiatrists Board;

4.15 Psychologists Board; and

4.16 Psychotherapists Board.

5. Responsible authorities describe scopes of practice for their professions (these set the boundaries within which a practitioner can practise), prescribe necessary qualifications, register practitioners and issue annual practising certificates. They also set standards of competence. Responsible authorities, via professional conduct committees, can investigate individual practitioners' competence and conduct.

6. These authorities are funded by a levy on their professions and have their own staff and premises (some authorities do share certain back-office functions). While the Minister has a power of audit, the regulatory authorities have autonomy in making decisions such as setting scopes of practice or fees.

7. The Minister appoints a mix of health practitioners and laypersons to each board/council. The chair and deputy chair are elected from among each board's/council's members. The Minister is able to make regulations so that a proportion of the health professional members of an authority are elected by

members of the profession. Such regulations have been made with respect to the Medical Council and the Nursing Council.

Health Practitioners Disciplinary Tribunal

8. The Health Practitioners Disciplinary Tribunal hears and determines more serious cases against health practitioners. It comprises a chair, a number of deputy chairs and a panel of layperson and health practitioner members (there are approximately 140 Tribunal members in total).

9. When the Tribunal sits to hear and determine a charge, it comprises five people: the chair or one of the deputy chairs, a layperson appointed from the panel, and three health professionals appointed from the panel who are professional peers of the health practitioner who is the subject of the hearing.

Human Assisted Reproductive Technology Act 2004

Ethics Committee on Assisted Reproductive Technology

10. The functions of the Ethics Committee on Assisted Reproductive Technology (ECART) include:

    10.1 considering and determining applications for assisted reproductive procedures, extending the storage period of gametes and embryos, and human reproductive research;

    10.2 keeping under review any approvals previously given, and monitoring the progress of any assisted reproductive procedures performed or any human reproductive research conducted under current approvals; and

    10.3 any other functions the Minister assigns to it.

Advisory Committee on Assisted Reproductive Technology (ACART)

11. Advisory Committee on Assisted Reproductive Technology (ACART) formulates policy and provides advice to the Minister of Health on assisted reproductive technology in New Zealand. The Committee is made up of 10 members with Māori, legal, human reproductive research, ethics, disability, consumer, children, and layperson perspectives.

12. ACART has two key functions:

12.1 to provide independent advice to the Minister; and

12.2 to issue guidelines and provide advice to the ECART on procedures and research requiring case by case ethical approval.

13. ACART also monitors:

13.1 the application and health outcomes of assisted reproductive procedures and established procedures; and

13.2 developments in human reproductive research.

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

District inspectors

14. District inspectors appointed under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 monitor, protect and give effect to the rights of people receiving compulsory care and rehabilitation (as set out in the Act) by making regular visits to facilities, investigating alleged breaches of rights or employees' duties, and assisting with enquiries by High Court judges.

Medicines Act 1981

Medicines Adverse Reactions Committee

15. The Medicines Adverse Reactions Committee advises the Minister on the safety of approved medicines. Its functions are to:

15.1 provide expert advice to the Director-General of Health and the Minister in relation to the safety or efficacy of a medicine that is the subject of a notice issued under section 36 of the Medicines Act 1981

15.2 consider information about the safety of medicines (including vaccines) that is referred to the Medicines Adverse Reactions Committee by Medsafe, and provide expert advice to the Minister and Medsafe on:

15.2.1 the interpretation of the information

15.2.2 the significance of the information in relation to the risk–benefit profile of the medicines

15.2.3 whether a regulatory intervention under the Medicines Act 1981 is desirable to minimise the risks from use of the medicine.

Medicines Assessment Advisory Committee

16. The Medicines Assessment Advisory Committee provides advice to the Minister on the benefits and risks of new medicines. Its functions are to:

16.1 consider applications for the Minister's consent or provisional consent to the distribution of a new medicine referred to the Medicines Assessment Advisory Committee

16.2 report to the Minister with a recommendation on the decision the Minister should make in respect of applications referred to the Medicines Assessment Advisory Committee

16.3 annually review a sample of reports of the evaluation of applications for the Minister's consent or provisional consent to the distribution of new medicines, and provide expert advice to Medsafe and the Minister on the quality of the risk–benefit assessments that have been completed.

Medicines Classification Committee

17. The Medicines Classification Committee makes recommendations on whether medicines should be classified as prescription, restricted or pharmacy-only. This affects the public availability of medicines and how they are funded. The Committee also reports to the Minister more generally on the classification of medicines and their accessibility.

18. The Committee's membership must include two nominees each from the New Zealand Medical Association, the Pharmaceutical Society of New Zealand and the Ministry (one of whom is required to be the chair).

Medicines Review Committee

19. The Medicines Review Committee's functions are to:

19.1 inquire into any objections to recommendations regarding applications for ministerial consent to distribute new medicine, and to report its findings to the Minister

19.2 hear appeals under section 88 of the Medicines Act 1981, such as refusals by the Ministry to issue licences to manufacture, pack or sell medicines or operate a pharmacy; appeals against refusal by the Director-General of Health of an application for approval to carry out a clinical trial of a medicine; and appeals against a decision by the Director-General that a medical device may not be sold until the Director-General is satisfied as to its safety.

Mental Health (Compulsory Assessment and Treatment) Act 1992

Mental Health Review Tribunal

20. The Mental Health (Compulsory Assessment and Treatment) Act 1992 empowers the state to deprive people of their liberty should they be found to be mentally disordered and a danger to themselves or others. The Act provides for a District Court judge to make compulsory treatment orders for comprehensive procedures of review and appeal of decisions about the patient's condition and legal status.

21. The principal role of the Mental Health Review Tribunal is to consider whether or not a patient is fit to be released from compulsory status. There is a requirement for every person subject to a compulsory treatment order to have his or her condition reviewed at least every six months. Should a patient disagree with their responsible clinician's decision that they are not fit to be released from compulsory status, the patient is able to apply to the Tribunal for a review of his or her condition. The patient can appeal a Tribunal decision to the District Court or High Court.

District inspectors for mental health

22. District inspectors are lawyers appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to assist people being assessed or treated under the Act, be it in a psychiatric unit or in the community. District inspectors provide information and ensure the rights of those being assessed and treated are upheld. As such, they are independent of the Ministry but are not patient advocates. District inspectors are also required to be detached from the clinical decision-making processes that affect individual patients and care recipients.

Misuse of Drugs Act 1975

Expert Advisory Committee on Drugs

23. The Expert Advisory Committee on Drugs:

23.1 conducts reviews of psychoactive substances to assess harm to the individual and society

23.2 recommends to the Minister whether and how such substances should be classified as controlled drugs under the Act

23.3 increases public awareness of its work by (for instance) releasing papers, reports and recommendations.

New Zealand Public Health and Disability Act 2000

Cancer Control New Zealand

24. Established under section 11 of the New Zealand Public Health and Disability Act 2000, Cancer Control New Zealand provides an independent, sustainable focus for cancer control. Cancer Control New Zealand leads the sector in horizon scanning for future trends, thereby helping to reduce the incidence and impact of cancer, evaluate system effectiveness, reduce inequalities and promote research with respect to cancer. Cancer Control New Zealand provides advice and recommendations to the Minister.

Health and Disability Ethics Committees

25. The Health and Disability Ethics Committees are a group of four regionally focused ethics committees (Northern A, Northern B, Central and Southern), established under section 11 of the New Zealand Public Health and Disability Act 2000. Their purpose is to check that health and disability research (such as clinical trials) meets or exceeds ethical standards established by the National Ethics Advisory Committee.

National Ethics Advisory Committee

26. The National Ethics Advisory Committee is established under section 16 of the New Zealand Public Health and Disability Act. Its purpose is to:

26.1 provide advice to the Minister on ethical issues of national significance in respect of any health and disability matters (including research and health services)

26.2 determine nationally consistent ethical standards across the health and disabilities sector and provide scrutiny for national health research and health services.

Psychoactive Substances Act 2013

Psychoactive Substances Appeals Committee

27. The function of the Psychoactive Substances Appeals Committee is to determine appeals against decisions of the Psychoactive Substances Regulatory Authority made by or under the Psychoactive Substances Act 2013.

Psychoactive Substances Expert Advisory Committee

28. The function of the Psychoactive Substances Expert Advisory Committee is to evaluate, with regard to trials, and advise the Psychoactive Substances Regulatory Authority on approval for use of psychoactive products.

Radiation Protection Act 1965

Radiation Protection Advisory Council

29. The functions of the Radiation Protection Advisory Council are to advise the Director-General of Health on applications for licences to use irradiating apparatus and/or radioactive materials. It also advises the Minister in respect of regulations under the Radiation Protection Act 1965, the exercise of the Minister's powers, and other matters, including those referred to it by the Minister.

Appendix 5:

PUBLIC HOSPITALS IN NEW ZEALAND

Public hospitals in New Zealand are listed in the table below, by DHB area.

DHB	Public hospitals
Northland	Bay of Islands Hospital
	Dargaville Hospital
	Kaitaia Hospital
	Whangarei Hospital
Waitematā	Elective Surgery Centre
	North Shore Hospital
	Waitakere Hospital
	Wilson Centre
Auckland	Auckland City Hospital
	Buchanan Rehabilitation Centre
	Fraser McDonald Unit
	Greenlane Clinical Centre
	Mason Clinic
	Pitman House
	Rehab Plus
	Starship Child Health
	Te Whetu Tawera
Counties Manukau	Auckland Spinal Rehabilitation and Tamaki Oranga
	Botany Downs Hospital
	Franklin Memorial Hospital
	Manukau Surgery Centre
	Middlemore Hospital
	Papakura Obstetric Hospital
	Pukekohe Hospital
Waikato	Henry Rongomau Bennett Centre
	Matariki Hospital
	Puna Whiti
	Rhoda Read Hospital
	Taumarunui Hospital and Family Health Team
	Te Kuiti Hospital and Family Health Team
	Thames Hospital
	Tokoroa Hospital
	Waikato Hospital
Lakes	Rotorua Hospital
	Taupo Hospital
Bay of Plenty	Opotiki Health Care Centre
	Tauranga Hospital
	Whakatane Hospital
Tairāwhiti	Gisborne Hospital
Taranaki	Hawera Hospital
	Taranaki Base Hospital

DHB	Public hospitals
Hawke's Bay	Central Hawke's Bay Health Centre Hawke's Bay Hospital Napier Health Centre Wairoa Hospital & Health Centre
Whanganui	Whanganui Hospital
MidCentral	Horowhenua Health Centre Palmerston North Hospital
Hutt Valley	Hutt Valley Hospital
Capital & Coast	Kāpiti Health Centre Kenepuru Hospital Porirua Hospital Campus (Mental Health Services) Wellington Hospital Wellington Hospital (Mental Health Services)
Wairarapa	Wairarapa Hospital
Nelson Marlborough	Alexandra Hospital Mental Health Admissions Unit Murchison Hospital and Health Centre Nelson Hospital Tipahi Street Mental Health Wairau Hospital
West Coast	Buller Health Grey Base Hospital Reefton Health Services
Canterbury	Ashburton Hospital Burwood Hospital Chatham Island Health Centre Christchurch Hospital Christchurch Women's Hospital Darfield Hospital Ellesmere Hospital Hillmorton Hospital Kaikōura Hospital Lincoln Maternity Hospital Oxford Hospital Rangiora Hospital The Princess Margaret Hospital Tuarangi Home Waikari Hospital
South Canterbury	Timaru Hospital
Southern	Dunedin Hospital Lakes District Hospital Southland Hospital Wakari Hospital

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

16 DEC 2016

Dear

Letter of Expectations for DHBs and Subsidiary Entities 2017/18
The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2016 Vote Health received an additional $568 million, the largest increase in seven years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy
The refreshed New Zealand Health Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to ensure that all New Zealanders live well, stay well and get well.

The DHB annual plans are the primary document for demonstrating DHB delivery of the Strategy, and your 2017/18 annual plan is expected to clearly demonstrate the linkages between the five themes of the Strategy and your DHB's performance story, activities and outcomes, while also maintaining a focus on Māori health outcomes and health equity.

In particular I want to see a strong focus on providing care in the community and for services to be provided closer to home, especially for the management of long-term conditions.

Finally, I want your Board to very carefully consider how any new local initiatives fit within the context of the Strategy.

Living Within our Means
While the global economic environment continues to be challenging, DHB funding has continued to be increased year on year. DHBs need to budget and operate within allocated funding and must have clear plans to improve year-on-year financial performance. Your DHB's financial performance is currently tracking to plan for 2016/17, and I trust that you will continue to consider where your DHB can make efficiency gains. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. In particular your Board must work closely with NZ Health Partnerships Ltd on ensuring the delivery of their current work programmes and services.

Working Across Government
I expect DHBs to continue supporting cross-agency work to support vulnerable families and progress outcomes for children and young people, including working with the new Ministry for Vulnerable Children, Oranga Tamariki once this has been established.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

All DHBs must continue to work closely with other social sector organisations to achieve cross-sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as the Prime Minister's Youth Mental Health Project, the Childhood Obesity Plan and the *Living Well with Diabetes* Plan.

Locally, I expect that DHB will continue working with other agencies to reduce rheumatic fever through the delivery of its rheumatic fever prevention plan, increase immunisation coverage rates to target levels and improve outcomes for children not enrolled with a PHO, and reduce the use of seclusion in inpatient mental health services.

National Health Targets

All of the national health targets are very important for driving overall performance, and have resulted in major improvements in the health outcomes of New Zealanders. I expect DHBs to remain focussed on achieving and improving performance against all six health targets. The *faster cancer treatment* target remains a top priority for service delivery for DHBs and further progress is expected during 2017/18.

The first national result for the *raising healthy kids* health target is 49 percent. I expect results for all DHBs to improve considerably each quarter as referral processes and clinical pathways are fully implemented.

Locally, DHB has shown good performance in relation to the *improved access to elective surgery* health target. However, performance in relation to the other health targets needs to be improved, particularly for the *increased immunisation* health target. Please ensure delivery of these health targets is a priority for your DHB.

Streamlining of DHB Annual Planning

In order to ensure that the Health Strategy is informing DHB planning, DHB annual plans will be streamlined in 2017/18 so that they are focussed on my key expectations for your DHB. Your DHB should also be considering longer-term strategic planning (ten-year horizon) as a way to deliver on the vision of the Health Strategy, and I expect that in the future you will be able to demonstrate this planning.

Working regionally also continues to be important, and I expect that when you are considering your long-term strategic planning you are also considering this in a regional context.

There are a number of key planning priorities for 2017/18 that DHBs will need to clearly respond to in their annual plans. These planning priorities have been selected in order to progress the key Government expectations outlined above, and also to progress other key health initiatives, such as Bowel Screening, implementation of the Healthy Ageing Strategy and continued integration of health care in order to better prevent and manage long term conditions, and provide services and care in the best ways to meet local needs. This will require ongoing engagement with your primary and community partners, including implementation of the System Level Measures.

The full list of my planning priorities for 2017/18 is attached for your information. I have asked the Ministry to provide separate advice about how each of these should be reflected in your plan.

Concluding comments

In implementing your annual plan it is important that clinicians are engaged and involved throughout; clinical leadership is fundamental in delivering high-quality health services.

Please note that I am not requiring DHBs to refresh their statements of intent (SOIs) for tabling in 2017/18. However, please ensure you review your SOI produced in 2016/17 to confirm that there are no significant changes. The statements of performance expectations will still need to be produced and tabled.

Keep in mind that the Budget 2017 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available, including information on planning priorities.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2017/18.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

2017/18 DHB Annual Planning Priorities

Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target
Supporting Vulnerable Children Better Public Service Target
Reducing Rheumatic Fever Better Public Service Target
Increased Immunisation Better Public Service and Health Target
Shorter Stays in Emergency Departments Health Target
Improved Access to Elective Surgery Health Target
Faster Cancer Treatment Health Target
Better Help for Smokers to Quit Health Target
Raising Healthy Kids Health Target
Bowel Screening
Mental Health
Healthy Ageing
Living Well with Diabetes
Childhood Obesity Plan
Child Health
Disability Support Services
Primary Care Integration
Pharmacy Action Plan
Improving Quality
Living Within our Means
Information Technology
Workforce.

MINISTRY OF HEALTH
MANATŪ HAUORA

newzealand.govt.nz

Operational Policy Framework

2017/18

December 2016 (updated July 2017)

This Operational Policy Framework (OPF) is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000.

The OPF is released subject to endorsement by the Minister of Health in accordance with Crown Funding Agreement requirements.

The OPF is also subject to ongoing updates.

Published in December 2016
by the Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

This document is available at www.nsfl.health.govt.nz

Contents

1 Purpose and overview of the Operational Policy Framework 1

1.1 Scope of this document 1

1.2 Structure of the OPF 1

2 DHB governance 3

2.1 Purpose of the chapter 3

2.2 Legislative compliance 3

2.3 New Zealand health and disability strategies 3

2.4 Conflicts of interest 4

2.5 Board self-assessment 6

2.6 Political neutrality 7

3 Planning and accountability 8

3.1 Purpose of the chapter 8

3.2 Crown Funding Agreement 9

3.3 DHB accountability and planning documents 9

3.4 The Annual Report 10

3.5 Key financial information 11

3.6 National services planning and implementation 11

3.7 Emergency planning and management 11

3.8 The DHB Health Emergency Plan 13

3.9 Reducing health disparities and achieving health equity 16

3.10 Improving the health of Māori 16

3.11 Improving the health of other population groups including Pacific peoples and ethnic peoples 16

3.12 Acceptability of services 17

3.13 Prioritising health needs and services 17

3.14 Implementation of evidence-based guidelines 18

3.15 Research ethics and governance 18

3.16 Service information for consumers 18

3.17 The Pharmaceutical Schedule 19

3.18 Selection of service providers 20

3.19 Provider selection protocols 20

3.20 The Nationwide Service Framework 23

3.21 Contracting for services 26

3.22 Fees Related to National Professional Services or National Software License Agreements 28

4 Service change 29

4.1 Purpose of the chapter 29

4.2 Key service change processes 30

4.3 Why good management of service change and consultation matters 30

	4.4	DHB service change protocols and requirements	30
	4.5	Service change process	31
	4.6	Significant service change and consultation	33
	4.7	Funding implications of significant service change	33
	4.8	The facilitation role of the Regional Relationship Manager	33
	4.9	DHBs as providers of last resort	35
	4.10	Strategic Prioritisation	35
5	**Service planning and policy**		**37**
	5.1	Purpose of the chapter	37
	5.2	Primary health care	37
	5.3	Cervical screening	39
	5.4	Tobacco control	39
	5.5	Health of older people	40
	5.6	Family care policy	41
	5.7	Disability and long-term support services	41
	5.8	Long-term support – chronic health conditions	43
	5.9	Supporting Vulnerable Children	43
	5.10	Management of elective services	43
6	**Improving Māori health**		**47**
	6.1	Purpose of the chapter	47
	6.2	Māori health planning	47
	6.3	Working with Māori	48
	6.4	Engagement with and participation of Māori	48
	6.5	Other means of providing for the needs of Māori	48
7	**Inter-district flows**		**50**
	7.1	Purpose of the chapter	50
	7.2	Principles guiding the IDF rules	50
	7.3	Residence criteria for the purposes of the IDF rules	51
	7.4	General IDF referral and management principles	52
	7.5	Referral and management of IDFs for inpatient elective services	52
	7.6	Referral and management of IDFs for acute/ arranged services	53
	7.7	Referral and management of national services	53
	7.8	Referral and management of IDFs for aged residential care services	54
	7.9	Referral and management of IDFs for other services	54
	7.10	Setting and management of IDF volumes	54
	7.11	Special arrangements for residential mental health services	54
	7.12	Travel, accommodation and inter-hospital transfers	55
	7.13	Management of exceptional situations	55
	7.14	Payments and ‘wash-ups’	55
	7.15	IDF supplementary payments	56
	7.16	Privacy of patient information	57
	7.17	Explanation of terms used in this chapter	57

8 Dispute resolution 59
8.1 Purpose of the chapter 59
8.2 Legislative provisions for resolving planning disputes 59
8.3 The national dispute resolution process 60
8.4 Mediation stages and deadlines 60
8.5 Arbitration stages and deadlines 60
8.6 Submitting notification of a dispute 60
8.7 Information requirements 61
8.8 Expectations of DHBs and other publicly owned health and disability organisations engaged in disputes 61

9 Quality 62
9.1 Purpose of the chapter 62
9.2 Provider quality specifications 62
9.3 Service Standards 62
9.4 Quality improvement 63
9.5 Improving the quality of services 63
9.6 Provider quality plans 64
9.7 Consumer rights 64
9.8 Capturing consumer experience 65
9.9 Infection control 65
9.10 Clinical effectiveness 65
9.11 Mortality review 66
9.12 Complaints procedures 66
9.13 Effectiveness of services 66
9.14 Service delivery 67
9.15 Prevention of abuse and neglect 69
9.16 Facilities 69
9.17 Death 69

10 Workforce 70
10.1 Purpose of the chapter 70
10.2 DHBs as good employers 71
10.3 Registration and continuing education of DHB employees 71
10.4 Health Workforce New Zealand 72
10.5 Planning requirements 72
10.6 Vulnerable Children Act – safe and competent workforce 72
10.7 Employment relations and management of bargaining 73
10.8 Pay and employment equity 74
10.9 Protected disclosures 74
10.10 In-between travel and guaranteed hours 75
10.11 Introduction of pay equity for care and support workers 76

11 Information technology 78
11.1 Purpose of the chapter 78
11.2 eHealth systems development strategy 78

11.3 IT change processes in the National Collections 79
11.4 IT change processes in the National Systems 80
11.5 Government Chief Information Officer – All of Government ICT Mandate 80

12 Financial and capital operations 81
12.1 Purpose of the chapter 81
12.2 Legislative compliance 82
12.3 Statements of Intent 83
12.4 Statement of Performance Expectations and forecast financial statements 83
12.5 Financial statements 83
12.6 Accounting policies 84
12.7 Good financial management 84
12.8 Internal financial controls 84
12.9 Information available on procurement policies and practices 84
12.10 Bank accounts 85
12.11 Financial risk management 86
12.12 Derivative transactions 87
12.13 Insurance 88
12.14 Working capital management 88
12.15 Deficit support 89
12.16 Non-working capital financing 90
12.17 Finance leases 90
12.18 Withholding of money from DHBs 91
12.19 Retention of surpluses by DHBs 92
12.20 Capital charges 92
12.21 Mental health 93
12.22 Guarantees and indemnities 95
12.23 Cooperative agreements and arrangements 96
12.24 Acquisition of securities, shares and other interests 96
12.25 DHB subsidiaries 97
12.26 Full-time equivalent definition 97
12.27 Asset valuation 98
12.28 Asset management planning 98
12.29 Investment Management and Asset Performance 98
12.30 Business cases 99
12.31 Dealings with land 99
12.32 Contribution to financial cost associated with membership of the Australasian Health Infrastructure Alliance 100

13 Monitoring and reporting 101
13.1 Purpose of the chapter 101
13.2 DHB annual reporting process 102
13.3 DHB quarterly reports (non-financial) 102
13.4 DHB risk management 102
13.5 DHB monthly financial reports 103

13.6 Monitoring and intervention framework 103
13.7 Information for the Minister 105
13.8 Ministry–DHB relationship protocol 106
13.9 The provision of quality information 108
13.10 Quality, standards and completeness 108
13.11 National Health Index 108
13.12 Audit of data collection and reporting 109
13.13 Privacy and security 109
13.14 Ethnicity reporting 109
13.15 National Collections 110
13.16 Health Practitioner Index 111
13.17 Medical Warning System 112
13.18 National Minimum Data Set (NMDS) 112
13.19 National Booking Reporting System 113
13.20 National Patient Flow 113
13.21 Programme for the Integration of Mental Health Data 113
13.22 National Immunisation Register 114
13.23 B4 School Check Information System 114
13.24 National Non-admitted Patient Collection 115
13.25 Accident Compensation Corporation 115
13.26 Ministry reports to DHBs 115

Appendix 1: Abbreviations and definitions 117

Appendix 2: Amendments to the 2016/17 Operational Policy Framework for 2017/18 120

References 123

List of Tables

Table 4.1: Overview of the service change process 31
Table 4.2: Decision tool for triggering service change protocols 32
Table 4.3: Information guideline for early discussion of a proposed service change 34
Table 13.1: The Ministry and ministerial levels of the MIF 104
Table 13.2: Ministry MIF levels 104
Table 13.3: Minister of Health MIF levels 105
Table 13.4: The Ministry–DHB relationship protocol 107

List of Figures

Figure 4.1: Process flow chart for DHB service change proposals 32

1 Purpose and overview of the Operational Policy Framework

The Operational Policy Framework (OPF) is a set of business rules, policy and guideline principles that outline the operating functions of district health boards (DHBs). Clause A.3.2 of the Crown Funding Agreement (CFA) is signed by the Minister of Health (the Minister) and each DHB confers DHB agreement to the OPF. All parties must adhere to the requirements set out in the OPF.

A summary of the relevant mandatory statutes, policies and rules is provided at the beginning of each section.

1.1 Scope of this document

1.1.1 DHBs are required to adhere to:

- legislation
- ministerial directions
- Government policy (Cabinet decisions and published policy statements), in which case the Minister or Director-General of Health (Director-General) is exercising a statutory power
- the Crown Funding Agreement (CFA)
- rules set out by the Cabinet Social Policy and Health Committee (SPH) (00) 160 (2 November 2000) report
- the New Zealand Health Strategy 2016
- the New Zealand Disability Strategy 2016–2026
- He Korowai Oranga: Māori Health Strategy 2014.

1.1.2 A DHB or the Ministry of Health (the Ministry) may request a DHB-specific variation to a part or parts of the OPF. The Ministry will consider such a request as part of the relevant annual plan and CFA variation processes. Any variation or exemption will be recorded in the DHB's CFA.

1.1.3 The issue and dispute management provisions set out in the CFA with each DHB apply to this document. The provisions set out the formal pathway for dealing with issues arising in relation to this document.

1.1.4 Although every care has been taken to identify the main statutory requirements of DHBs in this document, the OPF does not cover DHB statutory obligations exhaustively. DHBs should be aware that all relevant statutory obligations apply regardless of whether this document refers to them. Each DHB should obtain legal advice regarding any statutory compliance to which it is subject.

1.1.5 In addition to the OPF, each DHB is further obliged by its CFA to comply with the Service Coverage Schedule (SCS). The SCS sets out, on a national basis, the minimum services in terms of range, level of access and standards that DHBs must ensure are provided to their populations.

1.2 Structure of the OPF

1.2.1 Each chapter contains:

- the purpose of the chapter
- a summary of mandatory requirements

- relevant legislation, guidelines and policy principles
- context
- any other relevant information.

1.2.2 This document makes no distinction between ongoing, longer-term requirements and short-term, or transitory, requirements. Timeframes relating to particular requirements are clearly indicated in the text.

1.2.3 Some terms have been defined only where a specific or expanded meaning applies to the term in the context of a particular description, chapter or appendix. Some chapters include a glossary of terms specific to their content. For more commonly used terms and abbreviations relevant to the overall document, see Appendix 1.

1.2.4 Appendix 2 summarises amendments to the previous year's OPF.

2 DHB governance

2.1 Purpose of the chapter

This chapter sets out various general organisational requirements of DHBs relating to legislative compliance, conflicts of interest, the process of self-evaluation by Board members, and political neutrality.

Summary of mandatory requirements

Each DHB must:

- meet legislative requirements (Section 2.2)
- apply an open approach to disclosing interests and an active approach to managing conflicts of interest as they arise as set out in the New Zealand Public Health and Disability Act 2000 (NZPHD Act) and CAB (00) M32/2A (2) (Section 2.4)
- conduct Board member self-evaluation as part of Board business (Section 2.5)
- maintain neutrality and be able to serve successive governments that may be drawn from different political parties (Section 2.6).

2.2 Legislative compliance

2.2.1 In carrying out its objectives and functions, each DHB should act in a lawful manner and in compliance with all relevant legislation (ie, Acts, regulations and legislative instruments). DHBs should seek legal advice regarding their statutory obligations and how to comply with them. DHBs are established under the NZPHD Act. As Crown entities, they also fall within the scope of the Crown Entities Act 2004 (CE Act).

DHBs also should be aware of other legislation and any legislative amendments that may impact their operations.

2.3 New Zealand health and disability strategies

(See s 8(1) s 8(2) and s 38(2)(d) of the NZPHD Act.)

2.3.1 The New Zealand Health Strategy sets the platform for the Government's action on health. It identifies the Government's priority areas and aims to ensure that health services are directed at those areas that will ensure the highest benefits for our population, focusing in particular on tackling inequalities of health.

2.3.2 The New Zealand Disability Strategy provides a framework to guide the direction of planning to improve disability support services and change New Zealand from a disabling to an inclusive society.

Incorporation of strategies into DHB plans

2.3.3 Every DHB plan must reflect the overall direction set out in, and must not be inconsistent with, the New Zealand Health Strategy and the New Zealand Disability Strategy.

New Zealand Disability Strategy

2.3.4 DHBs should illustrate that they have:

a. a plan for advancing the objectives of the New Zealand Disability Strategy that addresses the health needs of people with disabilities[1] of all ages, including the disability support needs of the groups for whom DHBs have funding and planning responsibilities.[2] This plan will require DHBs to incorporate the needs of people with disabilities in their population health needs assessment so that comprehensive information on the health and support needs of people with disabilities in their districts is available

b. an accessibility plan that addresses physical and non-physical access for people with disabilities; for example, all facilities should be accessible and all information should be available in appropriate, accessible formats. Staff should also have an understanding of different disabilities and can tailor their communication and interactions appropriately. This plan should include an outline of how DHBs are responding to the New Zealand Sign Language Act 2006; for example, by having a written New Zealand Sign Language policy that considers other forms of communication with Deaf people to remove barriers to accessing information and services.

2.3.5 Each DHB's Disability Support Advisory Committee is required to have clearly defined responsibilities and to have a work programme in place for the year ahead.

2.3.6 DHBs are expected to:

a. monitor their service delivery in relation to the requirements of the New Zealand Disability Strategy such as access to services by people with disabilities

b. encourage primary health organisations (PHOs) and any associated non-governmental organisations (NGOs) to implement the requirements of the New Zealand Disability Strategy through developing and implementing work plans to improve services and access for disabled people

c. develop, implement and monitor the implementation of the plan referred to in paragraph 2.3.4(a) above in relation to the New Zealand Disability Strategy

d. promote the inclusion and independence of people with disabilities both in wider society and in their local communities

e. implement initiatives to reduce inequalities of service access and provision for Māori with disabilities, Pacific peoples with disabilities and people of other ethnicities with disabilities

f. implement policies for collecting information, within their populations, about people with disabilities

g. co-ordinate the health and support services they fund with those of other agencies (for example, the Ministry of Social Development and Accident Compensation Corporation [ACC]) to the maximum extent possible.

2.4 Conflicts of interest

(See clauses 36 and 37 of Schedule 3 and clause 38 of Schedule 4 to the NZPHD Act and CAB (00) M32/2A(2).)

2.4.1 The appropriate management of conflicts of interest is important for maintaining the transparency and openness of the DHB model. It also allows the public to have confidence that the decisions DHBs make, and the processes the DHBs use to make those decisions, benefit the public interest rather than the interests of individuals.

2.4.2 Conflicts of interest should be approached carefully and thoughtfully. The Ministry recommends an open approach to disclosing interests and an active approach to managing conflicts of interest as they arise. If in doubt, disclose more rather than less. Errors in handling conflicts of interest can have major ramifications for DHB decisions.

[1] In the context of the New Zealand Disability Strategy and DHBs' roles, 'people with disabilities' refers to anyone eligible for Vote: Health funded services, irrespective of their age, and the cause or the type of their impairment(s), including, for example, people with intellectual disabilities and/or a neurodevelopmental disorder.

[2] For example, older people and people with chronic health conditions needing ongoing support.

2.4.3 Further information on conflicts of interest can be found in the Ministry's (2016) publication *Conflict of Interest Guidelines for District Health Boards.*

Legal requirements

2.4.4 The statutory framework for conflicts of interest is set out in the NZPHD Act. DHBs need to be familiar with this framework and with the general law relating to conflicts of interest. Conflicts of interest are defined in section 6, and the statutory process for their management is set out in Schedules 3 and 4.

2.4.5 A transaction, in relation to a DHB, is defined in section 6 of the NZPHD Act.

2.4.6 Section 6(2) of the NZPHD Act defines what it is to be interested in a transaction.

2.4.7 For the avoidance of doubt, 'conflict of interest' is defined as including the employment or engagement of the person, or of the person's spouse or partner, as an employee or contractor of the DHB. As such, all family and whānau employment connections with the DHB should be disclosed.

2.4.8 A person is not interested in a transaction for the purposes of subsection (2) of section 6 (as above) if they either:

a. have an interest in a transaction that is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in carrying out their responsibilities under the NZPHD Act or another Act, or

b. receive remuneration or other benefits authorised under the NZPHD Act or another Act unrelated to the transaction.

2.4.9 The NZPHD Act outlines how an interest in a transaction should be disclosed, and what must be done subsequently, in clause 36 of Schedule 3 to the NZPHD Act.

Ethical and good practice considerations

2.4.10 In addition to the above legal requirements, DHBs should take account of ethical and good practice considerations.

2.4.11 First, disclosures must fully and fairly inform the Board of the nature and extent of the interest, sufficient for the Board to be able to make appropriate decisions concerning management of possible conflicts. More should be disclosed rather than less, and at the earliest opportunity. The disclosure of interests is an ongoing process, and requirements to disclose may arise not just in the case of 'new' interests, but also if the nature of existing interests changes.

2.4.12 Disclosures should be accurately listed in each DHB's interests register. DHB Boards are required to maintain an interests register under clause 36(3) of Schedule 3 to the NZPHD Act. DHB management should also maintain an interests register.

2.4.13 Boards should have in place robust processes for managing conflicts of interest. A specific time on the agenda should be reserved for disclosing and discussing conflicts of interest. Members should not hesitate to question other members in detail about their conflicts of interest. The issue should also be raised during meetings where it is felt another member's proper participation could be compromised by their conflicts of interest.

2.4.14 Clause 36(4) of Schedule 3 to the NZPHD Act allows members who have disclosed interests to take part in deliberations (but not the decision-making) relating to a transaction they are interested in, if the majority of other Board members agree. The benefit of their participation is that interested members can offer relevant facts about the transaction to the Board, to assist in its consideration of an issue. However, extreme care is required where the Board permits an interested member to take part in the deliberations. An interested member may – inadvertently or otherwise – shape or influence Board opinion towards a particular decision, which may end up creating an environment that would benefit the interested member, either then or at some point in the future. Board members should err on the side of caution when considering whether to allow an interested member to participate in discussions.

2.4.15 The DHB must also ensure that it declares instances where such waivers (of disclosure under clause 36(4) of Schedule 3) have been granted in its Annual Report, in accordance with section 42(4) of the NZPHD Act.

2.4.16 In managing conflicts, a Board will need to make a determination on the appropriate course of action in the circumstances. There are many different ways of dealing with conflicts of interest. For example, where relevant, members should consider how to manage communications with DHB staff. Despite having management strategies in place, the Board must always be prepared to act further (eg, exclude Board members from involvement with a transaction, or cancel a procurement, or other, process where that is necessary to ensure a fair and proper process).

2.4.17 The Foreword in the Auditor-General's good practice guide, *Managing Conflicts of Interest: Guidance for public entities* (Office of the Auditor-General 2007), provides further assistance with ethical and good practice considerations.

Duty not to disclose information

2.4.18 The CE Act standardised the duties that apply to members of all Crown entities. One of these duties is the duty not to disclose information in accordance with section 57 of the Act.

2.4.19 In regard to the disclosure of information, DHBs may need to exercise caution in accepting tenders or proposals where people involved with the tenders or proposals have also been involved in the DHB process leading up to the procurement. This caution is warranted because in such situations it may be difficult to remove any actual or perceived unfairness from the process.

State services code of conduct

2.4.20 The State Services Commissioner's *Standards of Integrity and Conduct* came into force on 30 November 2007. The Standards were issued by the Commissioner under section 57 of the State Sector Act and apply to all DHB employees. (Board member conduct is regulated by members' individual and collective duties under the CE Act.)

2.4.21 DHBs must:

a. comply with the minimum standards of integrity and conduct set out in the Standards
b. have in place policies and procedures that are consistent with the Standards.

2.4.22 DHBs should also note that the Standards apply to all DHB subsidiaries.

2.4.23 A number of elements of the Standards apply to conflicts of interest. For example, DHB employees must:

a. ensure their actions are not affected by their personal interests or relationships

b. never misuse their position for personal gain

c. decline gifts or benefits that place them under any obligation or perceived influence

d. avoid any activities (work or non-work) that may harm the reputation of their organisation or of the State Services Commission.

2.5 Board self-assessment

2.5.1 Board and Board member self-evaluation is a commonly accepted part of good practice governance. Given the widely perceived benefits of such self-assessment, DHBs are required to conduct such exercises as a routine part of Board business. Self-assessment also demonstrates that Boards and individual Board members are willing to be held accountable for the effectiveness of their contribution.

2.5.2 Boards are required to conduct self-assessment within the following parameters.

a. All Boards should formally assess the performance of individual members, the Chair and the Board as a whole, against best practice standards for their own performance that they have developed.

b. Self-assessment should be performed on a regular basis, preferably annually, at an appropriate time in the Board's work programme (eg, at the end of each calendar year to coincide with anniversary of most members' election/appointment, or at the end of each financial year).

c. Self-assessment tools should address how the Board and its members have:

- complied with their duties, both collective and individual

- conducted their business, using structures and processes that reflect good governance practice (eg, that the Board has a conflict of interest policy in place to which the Board, its members and management adhere)
- helped the organisation fulfil its objectives and functions
- contributed to the organisation achieving its goals and upholding its values.

d. The Chief Executive should participate in the process at an appropriate level.

e. The output of the process will be that the Board:

- makes a report that covers its overall performance and key focus areas for continuing development (ie, identification of the Board's strengths and areas for improvement, along with actions proposed to address these areas and relevant timeframes), provides assurance that the self-assessment process has been appropriately implemented (ie, by providing a brief outline of the process) and comments on any other significant issues that should be brought to the attention of the Ministry or the Minister
- supplies the Ministry with a copy of that report as soon as practicable after its completion, while the DHB retains the individual assessments or plans, which are not shared with the Ministry[3]
- considers the extent to which its committees would benefit from a similar self-assessment exercise.

2.6 Political neutrality

2.6.1 DHBs are a component of an apolitical state sector. They must be able to serve successive Governments, which may be drawn from different political parties. DHBs must therefore behave in ways that maintain their neutrality.

2.6.2 DHB employees must comply with the *Standards of Integrity and Conduct* issued by the State Services Commissioner under section 57 of the State Sector Act. Under the Standards, DHB employees must among other requirements:

a. maintain the political neutrality required to enable them to work with current and future Governments

b. carry out the functions of the DHB, unaffected by their personal beliefs

c. support the DHB to provide robust and unbiased advice

d. respect the authority of the government of the day.

2.6.3 DHBs should be aware it is a constitutional convention for Ministers to avoid making major decisions in the lead-up to the general election. During election times, DHBs should also take particular care to avoid taking actions that may appear politically motivated, such as the use of premises for electioneering, costing of party policies, the launch of new programmes or initiatives, communication campaigns, or criticism of Government policy.

2.6.4 Information on the obligations of state service agencies, and on topics such as when members of Parliament can be briefed, is available on the State Services Commission website.

[3] There is the potential for members to be less forthcoming in individual self-assessments if these are reported to the Ministry. Chairs may also be less candid with members about their views on that member's performance for the same reason.

3 Planning and accountability

3.1 Purpose of the chapter

This chapter sets out DHBs' requirements for the preparation of planning and accountability documents. These requirements relate to:

a. the plans DHBs are required to prepare or contribute to under the NZPHD Act

b. the planning and accountability documents DHBs are required to prepare under the CE Act as amended by the Crown Entities Amendment Act 2013 (CE Amendment Act)

c. the accountability requirements for DHBs under the Public Finance Act 1989 (Public Finance Act) and the Public Finance Amendment Act 2013 (Public Finance Amendment Act)

d. the reduction of health inequalities

e. the acceptability and effectiveness of services

f. improvements to service quality

g. consumer responsiveness

h. selection of and contracting with service providers

i. the Nationwide Service Framework (NSF).

Summary of mandatory requirements

DHBs must:

- prepare and provide Annual Plans in accordance with the requirements of the NZPHD Act **(Section 3.3)**
- prepare and provide Statements of Intents and Statements of Performance Expectations in accordance with the requirements of the CE Act as amended by the CE Amendment Act **(Section** Error! Reference source not found.**)**
- prepare and provide other plans, such as Regional Service Plans, in accordance with the requirements of the Planning Regulations under the NZPHD Act **(Section 3.3)**
- provide Annual Reports in accordance ss 150–157 of the CE Act **(Section 3.4)**
- prepare and provide key financial information under the Public Finance Act **(Section 3.5)**
- develop, maintain and exercise a Health Emergency Plan **(Section 3.8)**
- demonstrate the use of equity tools (eg, the Reducing Inequalities Intervention Framework and Health Equity Assessment Tool) in all service planning and demonstrate how this has informed service reconfiguration and other actions **(Section 3.9)**
- aim to reduce health disparities by improving health outcomes for Māori and other population groups, such as Pacific peoples and ethnic peoples **(Section 3.14)**
- take account of the needs within the community to be served in order that access to services and communication about those services are effective and responsive, and that services are safe and effective for all people **(Section 3.12)**
- continue to coordinate and monitor the implementation of the updated evidence-based guidelines **(Section 3.14)**
- have written and implemented policies and procedures for seeking ethical review and advice from an approved research ethics committee **(Section 3.15)**
- have service information for consumers **(Section 3.16)**
- act consistently with the Pharmaceutical Schedule **(Section 3.17)**

- adhere to the selection of service providers, particularly the Provider Selection Protocols **(Sections 3.18 and 3.19)**

- follow the mandatory components, processes and information in the Nationwide Service Framework **(Section 3.20)**

- use standard contract forms and use the services of the Ministry's Sector Operations group for all contract generation **(Section 3.21)**
- give effect to the guidelines for contracting with NGOs developed by The Treasury, Audit New Zealand and the State Services Commission **(Section 3.21)**
- use an integrated contract when the service provider is contracting with one or more government funders **(Section 3.21)**.

3.2 Crown Funding Agreement

(See s 10 of the NZPHD Act)

3.2.1 The Crown Funding Agreement (CFA) is the output agreement between the Crown and a DHB. The Crown (the Minister of Health) agrees to provide funding in return for service provision as specified in the agreement. The CFA links the Annual Plan to the funding and the performance requirements of the DHB. Clause A.3.2 of the CFA incorporates the Operational Policy Framework and the SCS as part of the CFA. For more detail on the CFA, refer to section 10 of the NZPHD Act and the CFA.

3.3 DHB accountability and planning documents

3.3.1 Each DHB has a statutory responsibility to prepare:

- an Annual Plan for approval by the Minister of Health (Section 38 of the NZPHD Act) – providing accountability to the Minister of Health
- a Statement of Performance Expectations (SPE) (Section 149C of the CE Act) – providing financial accountability to Parliament and the public annually
- a Statement of Intent (Section 139 of the CE Act) – providing accountability to Parliament and the public at least triennially.

3.3.2 In 2010 Cabinet determined that the above documents could be brought together into a single DHB Annual Plan with Statement of Intent (SOI) and SPE included. The SOI needs to be prepared and tabled in Parliament every three years. However, the Minister of Health can request that DHBs prepare new SOIs in any year (Section 139A (1) of the CE Act).

3.3.3 In addition to the above, DHBs are also required to prepare or contribute to one or more other plans if directed by the Minister of Health (Section 38(1)(b) NZPHD Act), such as Regional Service Plans (New Zealand Public Health and Disability (Planning) Regulations 2011).

3.3.4 When preparing the Annual Plans and Regional Service Plans, DHBs must take account of:

- the Minister of Health's annual Letter of Expectations to DHBs and subsidiary entities, and/or any other direction on the Government's health priorities for the year in question
- the DHB's role in aiming to reduce disparities and achieve health equity by improving health outcomes for Māori and other population groups (section 22(e) of the NZPHD Act) (see chapter 6 for guiding principles to improve Māori health)
- the planning guidelines developed as part of the annual DHB Planning Package, which are developed in a collaborative process between the Ministry of Health and the DHB sector, with advice from central government agencies.

3.3.5 Further information about the content of, and procedural requirements for, the Regional Service Plans and the Annual Plans are specified in the New Zealand Public Health and Disability (Planning) Regulations 2011.

3.4 The Annual Report

(Sections 150–157A of the CE Act. See also Section 13.2 of the OPF)

3.4.1 The Annual Report is one of a suite of annual public accountability document that must be tabled in Parliament and made publicly available. . It is the key document for the financial review of the performance and operations of each DHB. DHBs are required to produce Annual Reports in accordance with ss 150–157A of the CE Act.

Contents of annual reports

3.4.2 The form and content of a DHB's Annual Report is specified in sections 151 to 153 of the CE Act. A DHB's Annual Report must also contain information required by section 42 of the NZPHD Act.

3.4.3 A DHB's Annual Report must also contain:

- A statement of performance (s153 of the CE Act)
- A statement of responsibility (ss151(1)(d) and 155 of the CE Act)
- financial statements for the financial year (ss 151(1)(c) and 154 of the CE Act)

3.4.4 In accordance with the letter sent from the Minister to DHB Chairs dated 10 February 2012, a DHB must continue to include in its Annual Report a schedule of meeting attendance for Board and committee members. All schedules are to include attendance of both elected and appointed Board members, as well as members appointed by the Board to committees. The schedule is to show the total number of meetings members were required to attend against their actual attendance.

Audit and process

3.4.5 Not all the information provided in the Annual Report requires a formal audit opinion, but the auditor will comment if the DHB has not met the legislative requirements, or the information provided elsewhere in the report is not consistent with the audited statements. .

3.4.6 The process that DHBs are to follow for the auditing of the Annual Report by the Auditor-General is set out in section 156 of the CE Act.

a. DHBs must provide Annual Reports to the Minister no later than 15 working days after receiving the audit report provided under section 156 of the CE Act (see section 150(1)(b) of the CE Act).

b. The Minister must present each DHB's Annual Report to the House of Representatives in accordance with section 150(3) of the CE Act).

c. Each DHB must publish its Annual Report in a manner consistent with any instructions given by the Minister of Finance under s174 of the CE Act (see section 150 of the CE Act).

Publication

3.4.7 DHBs obligations to prepare, publish and present their Annual Reports are outlined in s150 of the CE Act. Also note, guidance on the Presentation of Papers to the House is available on the New Zealand Parliament website.

3.4.8 In accordance with section 174 of the CE Act, the Minister of Finance may issue instructions to Crown entities that prescribe:

a. the minimum requirements concerning the publication of information that Crown entities must publish

b. non-financial reporting standards that Crown entities must apply and the form in which the Crown entities must provide the information that they are required to present to the House of Representatives.

3.5 Key financial information

Public Finance Act 1989

3.5.1 Key financial information must be provided under the Public Finance Act. This information includes statements of financial position at balance date, revenue and expenses, cash flows, projected financial performance and accounting policies to illustrate financial intentions as well as significant service changes, and service coverage exceptions within the Annual Plan.

3.6 National services planning and implementation

3.6.1 One of the principal functions of the Ministry's Service Commissioning business unit is to be a planner and funder of services that are national in scope, defined under two areas.

- The Ministry plans and funds the delivery of services for the catchments of all DHBs through contracts with service providers
- The Ministry engages lead DHB(s) to plan and co-ordinate the delivery of the national service for the catchments of all DHBs:
    - Ministry funding for these services may be through either top slice funding or inter-district flows, with some services also attracting funding from alternative sources such as ACC
    - DHBs with national or regional provider roles have the same obligations to their external and internal populations to ensure equitable access and quality outcomes.

3.6.2 The Ministry will advise the Minister on services where national involvement can improve patient care, access, and clinical and financial viability. The two approaches to be used for development of services at a national level are:

a. **National Services** – services that are to be nationally planned and/or funded

b. **National Service Improvement Programmes** – services that require centrally coordinated planning and/or performance improvement activities.

3.6.3 DHBs are required to continue to support all National Services and National Service Improvement Programmes. This involves working collaboratively with the Ministry and providers of specific national services and across the sector to ensure the appropriate planning, funding, contracting and monitoring model is implemented for each national service to achieve the desired outcomes.

The Ministry may also advise that a national clinical network is needed, where one does not exist, to support decision-making and drive action through greater clinical leadership and engagement.

3.6.4 Leading up to and following the release of the Annual Planning Package, the Ministry will work with DHBs to:

- review nationwide service specifications and arrangements for the services that are planned and funded nationally, as required
- confirm terms and the funding methodology for providers if required
- develop national clinical network arrangements, where required, for both National Services and National Service Improvement Programmes.

3.7 Emergency planning and management

Introduction to Health Emergency Management

3.7.1 The Ministry and each DHB have a duty under the Civil Defence and Emergency Management Act 2002 (CDEM Act) to:

a. ensure that the DHB is able to function to the fullest possible extent, even though this may be at a reduced level, during and after an emergency

b. make available to the Director of Civil Defence and Emergency Management in writing, on request, its plan for functioning during and after an emergency.

Further, emergency services (including health) must:

a. participate in the development of the national civil defence emergency management strategy and civil defence emergency management plans

b. provide an active member for each of the Emergency Management Coordinating Executive Groups, as required by section 20 of the CDEM Act.

3.7.2 DHBs have a responsibility to be able to respond to and provide health care for their communities during periods of emergencies under various Acts, regulations and national guidelines including but not exclusive to the following:

a. legislation and regulations
   i. Health (Burial) Regulations 1946
   ii. Health Act 1956 (Health Act)
   iii. Health (Infectious and Notifiable Diseases) Regulations 1966
   iv. Medicines Act 1981
   v. Health (Quarantine) Regulations 1983
   vi. NZPHD Act
   vii. CDEM Act
   viii. Health Practitioners Competence Assurance Act 2003
   ix. International Health Regulations 2005
   x. Epidemic Preparedness Act 2006

b. other documents
   i. National Civil Defence Emergency Management Plan Order 2015 (in particular, but not limited to, clauses 47-51 and 71)
   ii. National Health Emergency Plan (NHEP)
   iii. National Health Emergency Plan: Guiding Principles for Emergency Management Planning in the Health and Disability Sector, 2005
   iv. National Health Emergency Plan: Hazardous Substances Incident Hospital Guidelines 2005
   v. National Health Emergency Plan; H5N1 Pre-Pandemic Vaccine Usage Policy (latest published edition)
   vi. National Health Emergency Plan: National Reserve Supplies Management and Usage Policies (latest published edition)
   vii. New Zealand Influenza Pandemic Action Plan (latest published version)
   viii. any other published National Health Emergency Planning documents
   ix. The Environmental Health Protection Manual
   x. Health and Disability Standards (2008) Part 4.7: ‘Essential emergency and security systems’.

Intention

3.7.3 Each DHB will develop, maintain and exercise a Health Emergency Plan (HEP), which is a health emergency management function and capability to meet its responsibilities under the CDEM Act, CDEM Plan Order and the NHEP, and any subsequent appendices and amendments. This function shall led by a designated Health Emergency Manager.

3.7.4 The purpose of DHB health emergency management is to:

a. develop, maintain, exercise and operate the DHB Health Emergency Plan

b. ensure essential service providers have a corresponding ability to plan, maintain, exercise and continue the delivery of health services in an emergency. These services include but are not restricted to:
   i. ambulance services
   ii. primary health care (including pharmaceutical services)
   iii. secondary health care

iv. tertiary health care
v. public health
vi. mental health
vii. disability support
viii. aged residential care.

3.7.5 Within its health emergency management function, each DHB is required to have:

a. a designated manager/coordinator with appropriate qualifications and skills responsible for all aspects of health emergency management

b. other individuals appropriately trained and skilled in emergency planning and management, in sufficient numbers to support the functions defined in this document during the time of an emergency or to meet the responsibilities outlined in this document.

Note: DHBs recognise that emergencies impacting on health services can have a technical (eg, IT outages, utility failures), natural (eg, earthquake, volcanic, pandemic, flood) or human (industrial action, crime, staff illness) cause and can continue for a protracted period.

3.7.6 The minimum legislative and Ministry requirements relating to the DHB emergency planning and management function is to be funded by the DHB. Sustainable funding is provided for the purpose of enhancing health sector emergency management capability and capacity through the Crown Funding Agreement and other Ministry contracts.

3.7.7 Funding required to be met through the need to respond to an emergency will be covered by the DHB as per this document. If the funding exceeds 0.1 percent of the DHB total population based funding, the Crown will determine on a case-by-case basis, and in consultation with the DHB, whether:

- the DHB is able to fund additional services purchased
- the DHB will be provided with additional funding
- there will be any negative effects on the DHB's baseline services.

3.8 The DHB Health Emergency Plan

3.8.1 The Health Emergency Plan (HEP) will take an all-hazards approach, and provide for both immediate, short-duration events and extended emergencies, on both small and large scales as relevant to the DHB population. The HEP will be built around the four 'R's of emergency management – reduction, readiness, response and recovery. It will identify and describe:

a. health-related physical, technological and environmental hazards and risks relevant to the DHB district

b. proactive measures that will reduce the health impacts of emergencies or other events

c. actions taken to ensure a state of readiness for health emergencies

d. how DHB-funded ambulance, primary, secondary, tertiary, mental health, disability support, aged residential care and public health services will be prioritised, structured and delivered during the response phase of health emergencies, or other emergencies affecting health services

e. health recovery measures, actions and operations during the recovery phase of health emergencies through the production of a DHB Recovery Plan.

3.8.2 The HEP will:

a. meet all relevant requirements defined in the National Civil Defence Emergency Management Plan Order (latest published version)

b. meet all relevant requirements defined within the NHEP (latest published version)

c. use the Coordinated Incident Management System (CIMS) structure and functional roles, and identify the human resources required for these roles

d. identify and document the specific roles and responsibilities of the major health agencies, units and providers involved in an emergency response[4]

e. provide for the use of communications networks, structures, data standards and formats defined in NHEP documents for all communications by DHBs (and, where appropriate, by DHB providers)[5] with the Ministry of Health, the National Health Co-ordination Centre or National Crisis Management Centre during an emergency, threat of emergency, or exercise

f. describe the education, training and orientation programmes that will provide a pool of appropriately trained people with competencies in CIMS roles, communications systems (specifically including the Ministry Emergency Management Information System, information management, decision-making and emergency management)

g. include plans for the emergency vaccination of part or all of the DHB workforce and/or population as described and prioritised in any published NHEP pandemic or emergency vaccination policy, planning and guideline documents

h. describe the HEP's linkages with, assumptions about and critical dependencies on the emergency response plans of other government and/or non-government agencies that may be involved in an emergency response (eg, Civil Defence, ambulance, fire, police, the defence forces and other relevant agencies)

i. identify the health-related roles and resources of relevant non-government, volunteer, iwi/Māori and Pacific organisations, and describe the HEP's linkages with, assumptions about and critical dependencies on the emergency response plans of these organisations

j. describe the protocols and processes for transferring human resources, and/or supplies maintained under national programmes (eg, medications, personal protective equipment and other clinical supplies) to other DHBs and for receiving and managing such resources from other DHBs

k. describe plans for rotation, storage and management of national reserve supplies (eg, pandemic antibiotics, personal protective equipment and critical clinical supplies) as required through the respective CFA variations and funded through sustainable baseline funding

l. provide for DHB coordination, direction and support of health-related community responses to a very large scale or extended emergency such as pandemic disease.

m. Provide for the coordination of local agencies and ensure relationships are in place to provide for psychosocial support in an emergency.

n. Ensure local plans identify vulnerable clients/groups and include strategies to manage changes in demand over any recovery period.

3.8.3 Each DHB will respond to local health emergencies and/or contribute to the response to a regional or national health emergency, or threat of an emergency, by using local (ie, DHB), regional and NHEP structures, processes and communication networks as defined in DHB, regional and NHEP documents.

Regional and national health emergency plans

3.8.4 Each DHB's HEP is required to define links with and critical dependencies on regional health emergency plans (ie, plans for the Northern, Midland, Central and South Island regions, as defined in the NHEP) by:

a. clarifying and describing (in alignment with regional plans) the anticipated emergency structures and functions to be used locally and regionally, the processes for escalation of the response, and any anticipated progressive relocation, realignment or rationalisation of emergency operations centres

[4] Specifically including but not limited to DHB emergency management, DHB planning and funding, DHB hospitals, DHB public health units and PHOs.

[5] Specifically including but not limited to public health units.

b. describing the DHB's contributions to the response to a regional or national health emergency, or the threat of an emergency, in the context of the regional and national health emergency plans

c. describing the protocols and processes that provide for the delivery of services to the populations of other DHBs, as necessary and appropriate in the context of regional and national HEPs and any relevant national policies.

3.8.5 Each DHB is to contribute to the development, implementation and revision of its regional health emergency plans. Regional plans shall be jointly developed by the DHBs in that region.

3.8.6 The DHB will contribute to the development, implementation and revision of the NHEP.

Provider health emergency plans

3.8.7 Each DHB will ensure that:

a. all DHB agreements with health service and other service providers[6] contain contractual commitments requiring the provider to have an HEP or emergency service provision plan (as appropriate), relating to the services provided

b. all DHB-funded ambulance, primary, secondary, tertiary, mental health, disability support, aged residential care and public health providers have plans and resources in place that ensure that their emergency responses are integrated, coordinated and exercised with the DHB's HEP.

Exercising the Health Emergency Plan

3.8.8 The DHB's HEP will describe the exercise programme planned to further develop and test it in all of its aspects. The exercise programme will include DHB-funded ambulance; primary, secondary, tertiary, mental health, disability support and public health providers, and other DHB service providers within its scope.

3.8.9 All or part of the DHB's HEP will be exercised at least annually. The DHB will advise the Ministry of the HEP section or sections to be exercised, and of the exercise dates and times. The Ministry will cooperate with individual DHB exercises as appropriate if requested by the DHB.

3.8.10 The DHB will engage in regional and NHEP exercises as required by the regional group or the Ministry, and will fully participate in all national Tier 4 exercises. Exercises will include tests of single point of contact communications at various times of the day and night.

3.8.11 Each DHB will be expected to engage in an EmergoTrain Exercise on a biannual basis. The exercise will be administered through a programme by the current contract provider St John. At the conclusion of each exercise St John will provide the DHB and the Ministry with a detailed report discussing key performance indicators and outcomes from the exercise. Each DHB will be required to report on corrective actions taken as a result of the Emergo exercise outcomes within six months of the final report.

DHB health emergency plan sign-off and publication

3.8.12 The DHB's HEP must be signed off by the DHB Chief Executive.

3.8.13 The HEP sign-off process must be repeated either:

a. after any significant revision of the plan informed by exercise or experience, or

b. every third year at a minimum.

3.8.14 The DHB's HEP is a discoverable document. The DHB must maintain its current signed-off HEP (less appendices containing personal telephone numbers, locations of stores, or similar confidential information) on a permanent basis in an easily accessible place on its public website.

[6] Other service providers are suppliers to the DHB of goods or services other than health services, such as facility support, maintenance, laundry, catering services, fuel and transport.

3.9 Reducing health disparities and achieving health equity

3.9.1 To reduce health disparities, in particular for Māori, Pacific and ethnic people, and low-income groups, each DHB is required to demonstrate the use of equity tools in all service planning. Each DHB is also required to demonstrate how this use has informed service reconfiguration and other actions.

3.9.2 Equity tools include:

- *Equity of Healthcare for Māori: a framework* published by the Ministry in 2014 guides health practitioners, health organisations and the health system to achieve equitable health care for Māori.[7]
- *Reducing Inequalities Intervention Framework* can be used to review current practice and ensure that actions contribute to improving the health of individuals and populations and to reducing inequalities in health.[8]
- Health Equity Assessment Tool should be used in all service planning as it provides questions to assist you to consider how particular inequalities in health have come about, and where the effective intervention points are to tackle them.[9]

3.10 Improving the health of Māori

(See Section 6 below, and ss 4, 22 and 23 of the NZPHD Act, and ss 5 and 8 of the Planning Regulations 2011.)

3.10.1 It is one of the explicit purposes of the NZPHD Act 'to reduce health disparities by improving the health outcomes of Māori'.

3.10.2 Each DHB (in both its funder and provider functions) must aim to reduce health disparities by improving health outcomes for Māori.

3.10.3 Each DHB must provide relevant information, including ethnicity data, to Māori to enable Māori to participate in, and contribute to, strategies for Māori health improvement.

3.10.4 Each DHB (in both its funder and provider functions) must establish and maintain processes to enable Māori to participate in, and contribute to, strategies designed to improve the health of Māori. These processes include the development of effective relationships with iwi and Māori, and consultation with Māori, as well as service delivery and monitoring.

3.10.5 Each DHB must foster the development of Māori capacity for participating in the health and disability sector, and for providing for the needs of Māori. This work includes contributing to Māori provider and workforce development and improving access to, and the effectiveness of, mainstream services for Māori eg, cultural competency training, and a focus on health literacy.

3.10.6 Each DHB must aim to achieve health equity between various population groups within New Zealand, including Māori, by developing and implementing services and programmes, in consultation with Māori.

3.11 Improving the health of other population groups including Pacific peoples and ethnic peoples

(See s 22 of the NZPHD Act, CAB Min (02) 31/13, POL Min (03) 27/3 and CAB Min(04)42/5A.)

3.11.1 Each DHB (in both its funder and provider functions) must aim to reduce health disparities and achieve health equity by improving health outcomes for other population groups, including Pacific and ethnic peoples.[10]

[7] This framework can be found on the Ministry's website www.health.govt.nz/publication/equity-health-care-maori-framework

[8] This framework can be found on the Ministry's website www.health.govt.nz/publication/reducing-inequalities-health

[9] This tool can be found on the Ministry's website www.health.govt.nz/publication/health-equity-assessment-tool-equity-lens-tackling-inequalities-health

3.11.2 Each DHB must foster the development of capacity for Pacific peoples to participate in the health and disability sector, and provide for the needs of the Pacific population. (This work includes contributing to Pacific provider and workforce development and improving access to, and the effectiveness of, mainstream services for Pacific peoples.)

3.11.3 Each DHB must aim to reduce health outcome disparities between various population groups within New Zealand (including Pacific and ethnic peoples) by developing and implementing services and programmes as well as monitoring results in consultation with those population groups concerned.

3.11.4 DHBs should ensure all ethnic peoples have access to health services that are timely, appropriate and culturally sensitive.

3.12 Acceptability of services

(See Health and Disability Services (Core) Standards 1.1 and 2, CAB Min (02) 31/13, POL Min (03) 27/3 and CAB Min (04) 42/5A.)

3.12.1 Each DHB must take account of the particular needs within the community to be served, in order that access to services and communication in relation to those services are effective and responsive, and that services are safe and effective for all people.

3.12.2 It is expected that each DHB will:

a. deliver services in a culturally appropriate and competent manner, with acknowledgement of and respect for the integrity of each consumer's culture

b. include significant local groups or service-specific ethnic and other cultural groups in assessing satisfaction with services, in order to facilitate consultation and encourage involvement in planning, implementing, monitoring and reviewing services

c. deliver services to the highest clinical and quality standards (taking into account the need for cultural as well as clinical safety) within available funding.

3.13 Prioritising health needs and services

(See ss 22(1)(h) and 23(1)(c) of the NZPHD Act, CAB Min (02) 31/13, POL Min (03) 27/3 and CAB Min (04) 42/5A.)

3.13.1 Each DHB must:

a. use a principle-based framework that links directly to the principles of the New Zealand Health Strategy and New Zealand Disability Strategy to improve health outcomes and to reduce inequalities, and apply the framework of He Korowai Oranga (Māori Health Strategy).

b. involve Māori in considering and responding to their needs, and support Māori capacity building throughout the development and implementation of the prioritisation process

c. use a framework for the consultation of different groups and communities, such as Māori, Pacific peoples, ethnic peoples, people with a disability and NGOs, in the service planning process that is consistent with Kia Tūtahi, Standing Together: The Relationship Accord between the Communities of Aotearoa New Zealand and the Government of New Zealand signed in August 2011

d. collaborate with other DHBs in relation to regional and national services in regard to:

- why decisions were made
- who the decision-makers were
- what the decision-making process was
- if the community was involved in the decision-making process, how it was involved
- if the community was not involved in the decision-making process, why it was not.

[10] The Office of Ethnic Affairs (2002) defines 'ethnic' peoples as that group of people whose ethnic heritage distinguishes them from the majority of other people in New Zealand, including Māori and Pacific peoples.

3.14 Implementation of evidence-based guidelines

3.14.1 To achieve demonstrable quality improvement, DHBs should continue to coordinate and monitor the implementation of the updated evidence-based guidelines relating to diabetes, cardiovascular disease and stroke including implementing the *Quality standards for diabetes care* and *Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020*.

3.14.2 DHBs should continue to collaborate regionally and/or nationally where such activity will improve health outcomes within existing resources.

3.15 Research ethics and governance

Research ethics

3.15.1 All health and disability research in New Zealand must comply with established ethical guidelines determined by the National Ethics Advisory Committee.

3.15.2 DHBs have a responsibility to check that these standards are met in research that is to be conducted within their organisation. To meet this responsibility, it will be sufficient for them to check that:

- approval of the Health and Disability Ethics Committee (HDEC) has been obtained (if it is required) or
- the research team has fully considered the ethical issues their study may raise, by completing the online application form for HDEC review on the Online Forms website.

Research governance

3.15.3 DHBs must implement robust and efficient research governance processes, to ensure that they are suitable for the safe and effective conduct of health and disability research. At a minimum, this involves ensuring that the issues listed at section 10 of the Standard Operating Procedures for HDECs have been satisfactorily addressed.

3.15.4 DHBs should record the satisfactory completion of research governance processes by authorising the study in question in Online Forms.

3.15.5 Wherever possible, DHBs should use and promote the use of standard contracts and standard indemnity agreements, such as those developed by the New Zealand Association of Clinical Research.

3.16 Service information for consumers

3.16.1 It is expected that potential and current consumers of DHB services, and referrers to those services, will have access to appropriate information about eligibility to access publicly funded DHB services. This information should set out the terms of access and must be made available before any person is offered the option of private treatment (either in a private specialist practice or as a private patient of the DHB).

3.16.2 Information must be presented in a manner appropriate to the communication needs of consumers and communities. Service information may be in the form of a brochure and must include at least:

a. the services the DHB offers

b. the location of those services

c. the hours the service is available

d. when the service may be available to the person

e. how to access the service (eg, whether a referral is required)

f. consumer rights and responsibilities, including a copy of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights and the DHB's complaints procedure

g. the availability of cultural support

h. after-hours or emergency contact, if necessary or appropriate

i. any other important information that people need to access DHB services.

3.17 The Pharmaceutical Schedule

(See ss 23(7), 47 and 48(a–b) of the NZPHD Act.)

3.17.1 Section 23(7) of the NZPHD Act provides that in 'performing any of its functions in relation to the supply of pharmaceuticals, a DHB must not act inconsistently with the Pharmaceutical Schedule'. The definition of 'pharmaceutical' within the NZPHD Act, and the Schedule, includes medical devices and refers to both the community and hospital setting. The purpose of this section is to clarify what DHBs must do to give effect to this requirement.

3.17.2 DHBs must support the Pharmaceutical Management Agency Ltd (PHARMAC) in its objective, 'to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided' (section 47), and its functions under the NZPHD Act:

a. section 48(a) – to maintain and manage a Pharmaceutical Schedule that applies consistently throughout New Zealand, including determining eligibility and criteria for the provision of subsidies

b. section 48(b) – to manage incidental matters, including in exceptional circumstances providing subsidies for pharmaceuticals not on the Pharmaceutical Schedule. PHARMAC does this primarily via its Named Patient Pharmaceutical Assessment (Exceptional Circumstances) Policy (July 2013)

c. section 48(e) – any other functions it is for the time being given by or under any enactment, or authorised to perform by the Minster by written notice to the board of PHARMAC after consultation with it. [This includes managing the purchasing of any or all pharmaceuticals, whether used in a hospital or outside it, on behalf of DHBs (Ministerial Authorisation dated 4 September 2001).

3.17.3 Each DHB is required to:

a. comply at all times with the rules of the Pharmaceutical Schedule and with any of PHARMAC's decisions related to the Pharmaceutical Schedule, which includes, for the avoidance of doubt, medicines and medical devices used in the community or hospital and other items that may be listed on the Pharmaceutical Schedule.

b. not exclude any pharmaceutical listed on the Pharmaceutical Schedule from supply, or restrict or limit the availability or supply of any listed pharmaceutical beyond these conditions specified in the Pharmaceutical Schedule

c. not supplement the Pharmaceutical Schedule by providing additional pharmaceutical subsidies or by broadening the availability of listed pharmaceuticals in each case beyond the conditions specified in the Pharmaceutical Schedule (unless it is in accordance with the provisions and rules of the Pharmaceutical Schedule, or relating to the Named Patient Pharmaceutical Assessment Policy)

d. abide by the Memorandum of Understanding agreed between the 20 DHBs and PHARMAC

e. consult with PHARMAC in respect of any health and disability strategies that are likely to impact on PHARMAC and on its ability to perform its functions under the NZPHD Act and the PHARMAC Statement of Intent

f. provide all appropriate services related to subsidised pharmaceuticals eg, dispensing and administrative services, for its resident population and for other people as specified in the SCS exclusively from providers approved for the purpose under the Medicines Act

g. provide data in relation to hospital pharmaceuticals, including medical devices, as requested by PHARMAC

h. comply with any specific rules relating to medical devices as these are developed and implemented by PHARMAC.

i. pay any amounts due to PHARMAC according to the terms of any arrangements between each DHB and PHARMAC.

3.18 Selection of service providers

(See CAB (00) M32/2A (2), CAB (01) 12/12 and Statement of Government Intentions: Community Government Relationships, CAB Min (02) 31/13, POL Min (03) 27/3, CAB Min (04) 42/5A and SOC Min (09) 13/1.)

3.18.1 In 2000 Cabinet agreed a set of protocols that were developed to assist DHBs in making decisions about the delivery of publicly funded health and disability support services. The context for these protocols is the relationship between the public and private sectors. The private sector can assist the public sector to deliver care in some circumstances and it can provide products and services that complement the public health and disability sector. In certain instances DHBs will be heavily dependent on private providers to deliver some publicly funded services.

3.18.2 After the protocols described in Section 3.19 below were originally agreed by Cabinet, they were amended by the Minister in 2005, and further amended by Cabinet in 2009. The 2009 amendments enable DHBs to make much smarter use of the private sector. These protocols make judgements about which services DHBs purchase from private providers and how to manage the associated risks. In some circumstances, the protocols indicate that it is appropriate for a DHB to inform the Ministry or seek the approval of the Minister before making a decision that involves the private sector.

3.19 Provider selection protocols

3.19.1 The provider selection protocols set out the following requirements for the process of choosing a provider.

a. The providers and facilities chosen for publicly funded services should, first and foremost, be the most effective option to achieve gains in health and independence for New Zealanders and meet Government objectives within available funding.

b. In respect of services for Māori, the choice should be one that continues to build Māori capacity for providing for Māori people's needs. In respect of services for Pacific peoples, it should continue to build Pacific capacity for providing for the needs of Pacific peoples.

c. DHBs should purchase services that best meet the needs of their population. They are free to use the private sector to complement their own service delivery, but must ensure that in harnessing this resource, the long-term viability of their own resource and delivery is not undermined.

d. The choice must be consistent with any specific requirements set out in other Government policies (eg, those for PHOs).

e. Where a DHB has a significant[11] proposal to shift services from a public provider to a non-government provider, the shift must result in demonstrable benefits to patients that outweigh any costs (in terms of any flow-on effects such as deterioration in financial performance, reduced viability of existing DHB services or facilities, or reduced certainty of service provision in the long term). (For the purposes of clarity, the Ministry expects this clause to be also applied vice versa.)

f. Where a DHB has a significant proposal to shift services out of a public provider,[12] or to start providing services previously provided by a non-government provider, this change is subject to approval by the Minister.

g. The provider chosen is required to provide the same set of information to the DHB (eg, on numbers of patients seen, details of services provided) regardless of whether the provider is publicly owned or not.

[11] Significant proposals may be significant in terms of funding (possibly over a multi-year contract), or in terms of the potential impact on the DHB provider arm and its capacity to deliver the remaining services in the long term.

[12] Including a service run jointly by a number of DHBs.

h. Where a DHB employee or contractor has a financial interest in a non-government provider (eg, as an owner, director or employee) and has influence over a decision to enter a service agreement with that provider, the Board must:

- be advised of the potential conflict
- explicitly approve the arrangement, together with any measures that may be required to manage the conflict (with this approval coming specifically from the Board, rather than from a committee or individual/group acting under delegation from the Board).

i. If the arrangement is approved by the Board, the DHB must disclose details of this arrangement in its Annual Report.

j. There should be no cross-subsidy of non-government/independent providers by the public sector.

NOTE: Where a DHB contracts a private provider to deliver publicly funded services on behalf of the DHB, the provider must act consistently with the Pharmaceutical Schedule (as outlined in section 3.17 above). This includes complying with the rules set out in Section H of the Pharmaceutical Schedule, 'the Hospital Medicines List'.

For further information, refer to the Protocol on the Public Interface with Private Radiation Oncology Services and Protocol for Sharing of Public Radiation Oncology Capacity Between Cancer Centres.

3.19.2 Overall, the protocols are explicit in stating that the paramount consideration for each DHB considering the use of private providers is that the option selected must be the one that most effectively achieves the goals of the public health and disability sector. A DHB must exercise its best judgement as to when to escalate the decision-making process by either informing the Ministry or seeking ministerial approval before making a decision.

Nationwide providers

3.19.3 Some privately owned organisations delivering health and disability services have a nationwide presence and deliver services for all or most of the country alongside locally based providers of similar services. The Ministry manages service agreements with a number of nationwide providers on behalf of DHBs. Each DHB may also be managing a number of service agreements directly with nationwide providers for services in addition to those purchased by the Ministry. In some instances, as the lead DHB, one DHB may manage an agreement for services on behalf of a number of DHBs.

3.19.4 In all of these situations, DHBs and the Ministry must comply with the requirements in the Nationwide Service Framework (see Section 3.20 below). Prior to making any significant changes to service agreements with nationwide providers, a DHB must inform the Ministry of the substance of the proposal, discuss the proposal and gain its approval. The Ministry's interest in such proposals is to minimise any potential impact that local decisions may have on other DHBs or the health and disability sector as a whole.

3.19.5 In assessing whether a proposal is one that must be discussed with the Ministry, a DHB should consider that a significant change means any of the following.

- A change to the provider.
- A material change to the level, nature or volume of services provided.
- A material change to funding method or contracting arrangement.

Involvement in privately funded service provision

3.19.6 There may also be instances where it is appropriate for DHBs to become involved in the provision of privately funded services. This could mean allowing a private provider to run services from spare DHB facilities, or it could mean the DHB's provider arm treating patients on a private basis.

3.19.7 For a DHB to be involved in the provision of privately funded services, Cabinet has agreed a set of protocols that are focused on benefit to public patients, transparency and managing conflicts of interest.

Private involvement protocols

3.19.8 Each DHB must notify its DHB Regional Relationship Manager of any intended proposals for involvement in privately funded service provision and include these in its Annual Plan for approval by the Minister. Use of a public provider or public facility for privately funded services is only likely to be acceptable if all of the following conditions are met.

a. There is no reduction in service quality to publicly funded patients or people with disabilities.

b. There must be spare capacity beyond that required for services to public patients; that is:

- the level of publicly funded service already meets or exceeds any service guidelines set out in the CFA with the Minister
- the private involvement must not interfere with service provision for publicly funded patients and must not compromise the drive to reduce waiting times for elective surgery.

c. Patients must be advised of publicly funded options before choosing to pay for treatment in public facilities, and be offered the opportunity of independent vetting of any referral by a DHB specialist to themselves in a private capacity.

d. If DHB staff will be directly involved in the delivery of privately funded services (as opposed to the DHB simply making spare facilities or land available), the services must be part of the range and standard of services (clinical and non-clinical) that are publicly funded.

Note: If DHB staff will be directly involved in the delivery of privately funded services, they must act consistently with the Pharmaceutical Schedule (as outlined in section 3.17 above). For the avoidance of doubt, DHBs must not use these private involvement protocols to enable privately funded pharmaceuticals to be given in DHB facilities.

e. There is public disclosure of the arrangement in the DHB's Annual Report.

f. Where a DHB employee or contractor has influence over a decision for a DHB to be involved in privately funded care, and has a financial interest in the arrangement (including through the potential for patients to be referred to the privately funded service from a DHB-funded service):

- the Board must be advised of the potential conflict
- the Board (rather than a committee or individual/group acting under delegation from the Board) must explicitly approve the arrangement, together with any measures that may be required to manage the conflict
- if the arrangement is approved by the Board, details must be disclosed in the DHB's Annual Report.

g. There is no cross-subsidy of non-government/independent providers by the public sector.

Note: As established in CAB (00) M32/2A (2), these protocols do not apply to:
services funded by ACC and other accident insurers

h. the treatment of ineligible patients from overseas who require urgent care but have not come to New Zealand seeking that care.

3.19.9 As clarification of protocol (d) in paragraph 3.19.8 above, DHBs cannot branch into new service lines on a purely private basis.

Sponsorship

3.19.10 The principles that guide a DHB's involvement in privately funded service provision are also relevant to the question of private involvement more generally through sponsorship. In any sponsorship arrangements, the following additional principles apply:

a. any sponsorship must lead to a benefit for publicly funded patients

b. there must be transparency

c. conflicts of interest should be avoided.

Furthermore, sponsorship arrangements should not be entered into where they:

a. directly or indirectly increase costs for another funder, or

b. are in conflict with Government or health policy.

3.19.11 These principles apply both when a DHB is considering providing sponsorship and when a DHB is being offered sponsorship as a means of raising funds.

3.19.12 In all proposals for private sponsorship, a judgement is required against these principles. Before committing to a sponsorship arrangement that raises any concerns, a DHB should inform the Ministry of the substance of the proposal and discuss it, including in terms of how it would manage the concerns. On gaining support, DHBs should forward details of the proposed sponsorship to the Ministry for referral to the Minister where appropriate.

3.20 The Nationwide Service Framework

(See CAB (00) 319, CAB (00) 418 and SPH (00) 160 of the Nationwide Service Framework (NSF):

3.20.1 The Nationwide Service Framework (NSF) is a collection of common definitions, processes and information that both the Ministry and DHBs must use to ensure an agreed level of nationwide consistency and clarity of the services to be funded or provided.

3.20.2 The NSF supports:

a. analysis, monitoring, prioritisation and benchmarking of health services, and

b. more efficient sharing of information and interactions to facilitate a focus on value-adding activities, and avoidance of duplication.

3.20.3 The mandatory components of the Nationwide Service Framework (NSF), including information and links to related documents, are published on the Ministry's NSF Library[13] website.

Mandatory components of the NSF

3.20.4 Both DHBs and the Ministry must use the core NSF components listed in 3.20.5 below and the Ministry's central processing and information services that support the integrity of the NSF.

3.20.5 The core components of the NSF include:

a. common service agreement forms[14], the Streamlined Contracting Framework for NGOs[15] (including contract templates for use between a NGO service provider and a single DHB but also for integrated contracting) and other documentation (including notices issued under section 88 of the NZPHD Act), (see section 3.24 Contracting for Services.)

b. nationwide service specifications with a mandatory status published on the NSF Library website

c. purchase unit codes, their units of measure, general ledger codes and output classes contained in the Purchase Unit Data Dictionary and the Ministry/DHB Common Chart of Accounts

d. the Common Counting Standards and the Common Costing Standards

e. established business rules, including wash-ups, inter-district protocols and risk management requirements

f. clinical coding, Diagnostic Related Groups and cost weights.

Table One: Nationwide Service Framework components and outputs they support

NSF components and standards	Explanation	Outputs dependant on NSF components

[13] The Nationwide Service Framework Library website: http://www.nsfl.health.govt.nz/

[14] Some DHB service agreements have not been lodged in Ministry files/databases. These are agreements that were historically entered into by Hospital and Health Services before the NZPHD Act came into effect. DHBs will use best endeavours to lodge these agreements inMinistry systems at the time of their renegotiation, if not before.

[15] The Ministry of Business, Innovation and Employment (MBIE) is responsible for the Streamlined Contracting with NGOs framework.

Common service agreement forms central processing and information services	Provides a centralised nationally consistent contracting process and reporting to national data collections.	Supports the integrity of the NSF Provides data to national data collections such as NNPAC, NMDS, NBRS, PRIMHD etc.
Nationwide service specifications	A description of nationwide minima of specific services to be publicly funded.	Provides a standard level of consistency and clarity of the services to be funded.
Purchase Unit Code	Part of a nationally consistent counting classification system in the Purchase Unit Data Dictionary.	Used to measure, quantify and value or fund a service through an agreement.
Common Chart of Accounts	Nationally consistent General Ledger coding system recording transactions by DHBs and the Ministry.	Supports the Common Costing Standards and all cost reporting, comparative analysis and benchmarking.
Common Costing Standards	Standards to be used for costing of DHB services.	Provides consistency in costing and cost allocation, benchmarking, DHB inter-district flow pricing guidance.
Common Counting Standards	Rules on how health activity should be defined measured and counted.	Supports analysis and costing of health and disability services eg, Population Based Funding Formula Reviews, National Patient Flow.
Established business rules, inter-district protocols and risk management requirements	Used by DHB and the Ministry for consistency of purchasing and contracting processes.	Supports service funding and analysis.
Clinical coding, Diagnostic Related Groups and cost weights.	Used by DHB and the Ministry for consistency of coding frameworks.	Supports service funding and analysis.

National costing collections

3.20.6 All DHBs must provide cost data at least annually in accordance with a provider arm data request issued annually by the Ministry. The data request will be based on the NSF – in particular the Purchase Unit Data Dictionary, Common Costing and Common Counting Standards. The national cost data collection process provides a comprehensive data set consisting of fields in the national collections (National Minimum Data Set, National Non-admitted Patient Collection) linked to costs by cost pool. This data set supports:

a. updating inter-district flow (IDF) and reference prices (casemix pricing and reviews of non-casemix purchase unit price relativities)

b. populating the National Event Level Cost Data Cube

c. service planning – analysis of activity, cost and revenue across DHBs, tertiary and secondary services, and inpatient and outpatient activity. development and maintenance of versions of New Zealand WIES (costweights)

d. running of the Tertiary Adjuster Pool and National Paediatrics Adjuster

e. supporting work on key health priority areas, such as mental health and elective services

f. supplying data to the Hospital Quality and Productivity programme and the Health Round Table when requested

g. reproducing data for DHBs to allow DHBs and key groups to undertake further analysis, such as benchmarking and productivity work.

Governance and maintenance of the NSF

3.20.7 Endorsement of the components of the NSF and oversight of the related work plans are the roles of the joint Ministry and DHBs' representative groups.

3.20.8 Where consensus cannot be reached on an NSF issue, the matter will be referred to the l Director, Service Commissioning, through the Manager, Accountability, for decision. The Director, Service Commissioning (as the Minister's agent) retains final decision-making rights in relation to mandatory components of the NSF.

3.20.9 NSF components will be maintained and updated as required on the NSF Library website and approved by the Manager, Accountability, or delegated authority. Changes will be made when:

a. the work is the result of formal work programmes agreed by key cross-Ministry/sector stakeholders.

b. the final documents are fit for purpose and have been consulted appropriately via group processes.

c. the final documents have been approved or endorsed by appropriate Ministry/sector stakeholders, following agreed processes.

d. there is evidence of robust analysis of budget and compliance implications.

3.20.10 DHBs will be informed of any changes to the mandatory elements of the NSF in writing by the Director, Service Commissioning, or their delegate. In addition, any amendments will be published on the NSF Library website.

Nationwide service specifications

(See s9 of the NZPHD Act, Health and Disability Services (Safety) Act 2001 and Government policy.)

3.20.11 A nationwide service specification with mandatory status clarifies the minimum level of a health service to be funded in a consistently measurable manner and incorporates standard quality and reporting requirements. It provides a mechanism for ensuring that nationwide service specific requirements are provided throughout the sector and enable comparisons of aspects of service delivery and service availability.

3.20.12 Whenever the DHB enters into a new service agreement, or when the DHB is varying or rolling over existing service agreements, the latest relevant nationwide service specification(s) must be included, or referenced/referred to with a web page link provided. Nationwide service specifications are published on the NSF Library website. Local specifications are developed by the funder where a service or new initiative is not covered by a specific nationwide service specification. The National DHB Services Agreements are available on the Central TAS website.

3.20.13 The most appropriate purchase units for the funded services and their correct general ledger codes must be used for purposes of consistency. The Purchase Unit Data Dictionary is available on the NSF Library website and lists the range of purchase unit codes and general ledger codes.

3.20.14 Each DHB must comply with the quality requirements in the nationwide service specifications for services that it funds. Each DHB may include additional non-discretionary quality requirements in its agreements with its service providers. Chapter 9 Quality sets out the existing requirements that DHBs are to follow when developing provider quality specifications.

3.20.15 Nationwide service specifications may have either a mandatory, recommended or local status.

a. Mandatory status: these service specifications must be included or referenced in agreements as appropriate, when purchasing health services as these reflect the national minima[16] of services to be funded.

b. Recommended status: these service specifications can be used by DHBs as a guide for purchasing services or amended to meet local needs.

c. Local status: may be amended to meet local needs.

d. In some cases, DHBs may continue using a previous mandatory service specification for the term of the agreement, but are usually expected to plan for the transition to the latest service

[16] The MBIE Contracting Framework uses Results Based Accountability (RBA). Specific RBA measures and outcomes may be included in the funder's Provider Specifics contract schedule, and replace (by agreement with the Ministry) or add to, the standard minimum reporting requirements described in the nationwide service specification(s).

specification within an agreed time frame when renewing or preparing a new agreement for the service.

3.20.16 All tier one nationwide service specifications must include or reference the Māori health clause[17] as services are expected to contribute to achieving health equity for Māori in areas of key need.

3.21 Contracting for services

3.21.1 DHBs must use the services of the Sector Operations group in the Ministry's Finance and Performance business unit when contracting for health services[18]. Sector Operations provides the following services to DHBs including:

- making payments on behalf of DHBs
- providing contact centres
- generating agreements for DHBs.

3.21.2 DHBs will use the range of standard templates for agreement generation, payment against agreement and support in terms of monitoring against the agreements.

3.21.3 When a service provider enters into a contract with more than one Government funder, the parties are required to use an Integrated Streamlined Contract. Also see 3.21.8 below.

Alliance contracts with primary health care providers

3.21.4 Alliance contracting used as part of the Better Sooner More Convenient (BSMC) business cases, underpins the BSMC Alliance Agreement. From 1 July 2013 all DHBs and PHOs will enter into an Alliance arrangement. The overall approach for Alliance arrangements is to promote integrated resource management, with decisions about health care services being made by all of the relevant professional and organisational parties. The Alliance approach is dependent on shared values, agreed outcomes and principles and open, transparent processes and information sharing.

Section 88

(See ss 88 and 89 of the NZPHD Act and CAB (01) 12/12.)

3.21.5 For notices issued under section 88 of the NZPHD Act, each DHB must comply with the principles of national consistency and requirements in section 89 of the Act.

3.21.6 DHBs will be required to obtain ministerial permission for a notice under section 89(3) of the Act.

3.21.7 Before considering whether to issue a new notice or an amendment notice, a DHB must first consult with the Ministry, so the Ministry can monitor and comment on issues that arise in relation to national consistency. When issuing any new notices, a DHB must consult with the Ministry about the audit and reporting requirements to be included in the notice, to mitigate the risk of double payments and ensure that quality services are provided. In this context, 'issuing a notice' refers to the development of a new generic notice or the amendment of an existing generic notice. This process differs from the process of granting coverage under an existing generic notice to an individual provider and subsequently issuing that provider with its own copy of the relevant document.

[17] Māori health clause: An overarching aim of the health and disability sector is the improvement of health outcomes and reduction of health inequalities for Māori. In addition to the generic objectives of the service specification it is expected that the services will:

- address the health needs of Māori
- be clinically sound, of quality and culturally appropriate
- be accessible, timely and effective
- ensure equitable outcomes for Māori
- collect ethnicity data for Māori in accordance with the Ethnicity Data Protocols for the Health and Disability Sector 2004.

[18] The definition of agreement, in this instance, includes service agreement under section 25 and notices issued pursuant to section 88 of the NZPHD Act 2000. It also includes all agreements for health and disability services, including those subcontracted to another DHB.

Contracting with non-governmental organisations

3.21.8 The Ministry of Health uses the streamlined contracting framework to contract NGOs to deliver services to people and communities. For other services (such as contracts for research, evaluation etc) the standard Ministry long or short form agreement for non-departmental services is used.

3.21.9 Documents that form the Streamlined Contracting Framework and guidelines on how to use them are available on the Ministry of Business, Innovation and Employment's (MBIE's) website.

3.21.10 Streamlined contracts are part of a number of cross-Government initiatives to reduce compliance costs for NGOs and improve outcomes from services. Streamlined contracts include the Results Based Accountability Framework to assess outcomes services are achieving.

3.21.11 The Inter-Agency Accreditation initiative works alongside the streamlined contracting with NGOs programme. This initiative provides tools and guidance to assist social sector agencies to work together to plan and carry out contract monitoring, reporting and audit or accreditation for NGOs they fund in common. Information about the Inter-Agency Accreditation initiative is also available on MBIE's website.

3.21.12 DHBs should also give effect to the following.

- Government Rules of Sourcing - Rules for planning your procurement, approaching the market and contracting (second edition May 2014) represents the government's standards of good practice for procurement planning, approaching the market and contracting. As a result of the Whole of Government Direction to take effect from 1 February 2015 DHBs will be required to follow the Rules of Sourcing.
- Guidelines for Contracting with Non-government Organisations for Services Sought by the Crown, version 2.2 and subsequent replacements developed by The Treasury (2009) in conjunction with Audit New Zealand and the State Services Commission
- Office of the Controller and Auditor General's Procurement Guidance for Public Entities (2008)
- Principles to Underpin Management by Public Entities of Funding to Non-governmental Organisations (2006) and subsequent replacements
- Office for the Community and Voluntary Sector's The Code of Funding Practice (2010) and subsequent replacements.

3.21.13 Each DHB must be able to demonstrate that increases in fair pricing and fair funding over time to provider arm and NGO providers are affordable to the DHB.

3.21.14 DHBs must make every effort to prevent double payments for the same services and eliminate them where they are identified. The Ministry will work with DHBs to progress DHB initiatives to minimise the risk of double payments.

3.21.15 The Government also requires agencies (including DHBs) to report on the contracts entered into with NGOs, by both name and value.

Specific variation requests to the Crown Funding Agreement

3.21.16 DHBs or the Ministry can request a DHB-specific variation to the mandatory parts of the NSF, including transitional requirements (see paragraph 3.20.4). Where timing allows, such a request will be considered as part of the CFA process, using the provisions for variation specified in the CFA. Furthermore:

a. where the CFA has already been signed, or the matter is urgent, the Group Manager, Operational Excellence, Service Commissioning, will consider any DHB request for a DHB-specific variation or exemption

b. any variation or exemption must be recorded in the appropriate DHB accountability documentation with a clear, time-bound resolution or improvement path. In the case of special circumstances relating to a geographical area, a review date must be included.

3.22 Fees Related to National Professional Services or National Software License Agreements

3.22.1 Where the Ministry or another national organisation (e.g. the Health Quality & Safety Commission) has an agreed role to negotiate a new national professional service or national software license agreement on behalf of the sector, and licence fees are to be split by DHB, the license fee will be divided in accordance with the DHB Population Based Funding Formula unless otherwise agreed by all parties.

4 Service change

4.1 Purpose of the chapter

4.1.1 This chapter describes how DHB service change and public consultation is managed within the DHB planning framework and the requirements resulting from the NZPHD Amendment Act 2010. It outlines the service change protocols and process for DHBs when planning and implementing local, regional or national service change and service reconfiguration. It also provides:

- some tools and resources for DHBs to support sound, clinically appropriate decision-making and determine the need for public consultation
- an explanation of significant service change and related terms specific to this chapter (Section 4.6 and Section 4.11 respectively)

(See Planning Regulations (section 92(1) of the NZPHD Act and SOC Min (10) 15/2, *Consultation Guidelines for the Ministry of Health and District Health Boards* (Ministry of Health 2002).

4.1.2 This chapter is also to be read in conjunction with the following other chapters and sections of the OPF where relevant:

3.18	Selection of service providers (service change)
7	Inter-district flows (service change)**Error! Hyperlink reference not valid.**
12.23	Co-operative agreements and arrangements (service change)
12.24	Acquisition of securities, shares and other interests (consultation)
12.30	Business cases (service change)
12.31	Dealings with land (consultation).

Summary of mandatory requirements

DHBs must:

- engage at an early stage with their Regional Relationship Manager to discuss a proposed service change or when the proposed change triggers the service change protocols (Section 4.4)
- adhere to the Planning Regulations. Where the Minister directs DHBs to make significant changes, the Minister may also require DHBs to consult on how those changes should be made (Section 4.6).

DHBs as providers of last resort

- DHBs shall be deemed the provider of last resort in all circumstances, for example, when a third party contractor fails to provide or deliver care (Section 4.9).

4.2 Key service change processes

4.2.1 The following are the key service change processes.

- When it is required, all of a DHB's service change proposals must be discussed at an early stage, prior to Board approval, with the DHB's Regional Relationship Manager (Relationship Manager) to clarify if the Minister is to be notified, and to facilitate the Minister's prior approval or approval in principle, where appropriate. The responsibility lies with the DHB, when considering service change proposals as part of its annual planning documentation, to ensure the proposals align with Government expectations and legislation. Note: a DHB's plan may be amended at any time in the same manner in which it was made.
- Early discussion of service change proposals with the Relationship Manager must also include any service change implications that will occur as a result of the implementation of Information Technology or Capital business cases. (Where there are service change implications the Relationship Manager should be contacted prior to the approval of the business case).
- Where the Minister directs DHBs to make significant changes, the Minister may also require them to consult on how those changes should be made. The Minister has a role in determining the need for DHBs to engage in public consultation for any proposed major service reconfiguration or significant service change.

4.3 Why good management of service change and consultation matters

4.3.1 Implementing health policy is complex and challenging: DHBs face a multitude of difficult and potentially contradictory policy choices. The Ministry of Health Statement of Intent discusses the many and varied pressures faced by DHBs and by policy makers when considering the best health outcomes.

4.3.2 Service change is best managed in a planned and staged manner to avoid adverse financial, resource and clinical impacts on the affected population(s). Well-managed service change provides the Government and DHBs with confidence that a robust process is followed (as per the Minister's expectations of DHBs), that there are sufficient controls in place to avoid unnecessary service instability, and the change is clinically appropriate and public confidence is managed by each DHB.

4.4 DHB service change protocols and requirements

4.4.1 DHBs have the mandate to improve the health of their population through local and regional initiatives and are accountable for their investment decisions and consultation processes. Not all DHB service change requires the Minister's direct involvement. When required, the Relationship Manager will facilitate effective decision-making of the proposed service change, and provide support and scrutinise funding and purchasing methods proposed.

4.4.2 If a critical situation arises that has an immediate impact on patient care and service delivery, the DHB will immediately alert the Relationship Manager and affected DHBs. The Ministry will agree necessary action with the DHB(s) involved to ensure a timely decision.

4.4.3 All proposed service change must be consistent with:

a. the mandatory components of the Nationwide Service Framework, including the Service Change, Rules, Principles and Processes, SCS and nationwide service specifications (see Section 3.200)

b. the sector's needs as a whole and not detrimentally affect:

- service delivery
- any necessary longer-term service changes
- the local, regional and national services objectives
- generic service reconfiguration protocols that provide for short-term adjustments needed to address particular financial or service viability problems.

A proposed service change must also consistent with the sector's needs as a whole. It must not compromise either other DHBs or other funders,[19] or any necessary longer-term service reconfiguration.

4.4.4 A DHB's current arrangement for funding and/or provision of services will continue until the agreed service shift process is approved and completed. (See Section 4.5.)

4.4.5 DHBs will have developed a well-argued case for the service change and will follow a robust process through stakeholder engagement and management, including Māori participation as required under the NZPHD Act, and secure stakeholder support for the service change. The relevant parties must reach agreement on the proposed service change and implementation process.

4.4.6 DHBs are required to act reasonably in terms of information requested and provided about the proposals, response times and proposed implementation – this applies equally to the DHB initiating the change and responding DHBs. Any affected DHBs are required to respond with the requested information within 15 working days.

DHB collaboration

4.4.7 To assist another DHB in managing short-term adjustments to address particular financial or service viability problems, other DHBs are expected to cooperate by providing advice, assisting with patient loads (where appropriate) and proactively working with the DHB.

4.4.8 A DHB's service change will have effective funding mechanisms for planning to implement its services collaboratively or nationally to achieve aims.

4.4.9 Not all DHB service change requires input from the Ministry or the Minister. The Decision Tool for Triggering Service Change Protocols (Table 4.2 below) identifies the level of service change that requires a DHB's early engagement with the Relationship Manager. This tool supports DHBs in planning service change and decision-making and increases confidence that there are sufficient controls in place to manage potential risks of proposed service change.

4.5 Service change process

4.5.1 Table 4.1 reflects the three stages of the service change process. Table 4.2 sets out the Decision Tool for Triggering Service Change Protocols.

Table 4.1: Overview of the service change process

Joint evaluation	**A. Proposal in development** (DHB evaluates if the proposal triggers the protocol for service change). Refer to Decision Tool in Table 4.2. • Proposal evaluation is provided for Ministry information only. • Does it meet the service change requirements?
	B. Discuss with Relationship Manager. Refer to the information guideline for early discussion of a proposed service change in Table 4.3 (Section 4.8). • Agree what level of initial information is needed, depending on the level of service change and the Minister's likely involvement. • Further information may be required to make a decision.
Advice	**C. The Ministry triages proposal** to action as appropriate. Refer to the service change process flow chart in Figure 4.1. The process may lead to the following actions. a. No action is needed by the Ministry – DHB to continue business as usual, OR b. Relationship Manager facilitates analysis to support advice on proposal, which may be: i. not to proceed – proposal does not meet requirements ii. proceed (with riders if applicable) – prepare information for noting for the Minister iii. the proposal requires the Minister's prior approval. c. Proposed change is sent to the Minister with all the information required to inform the decision.

[19] Other funders in this context means funders such as ACC, Ministry of Social Development and other government agencies.

Decision	**D. The Ministry communicates the advice** and/or the Minister's decision on the proposed service change to the DHB in writing.

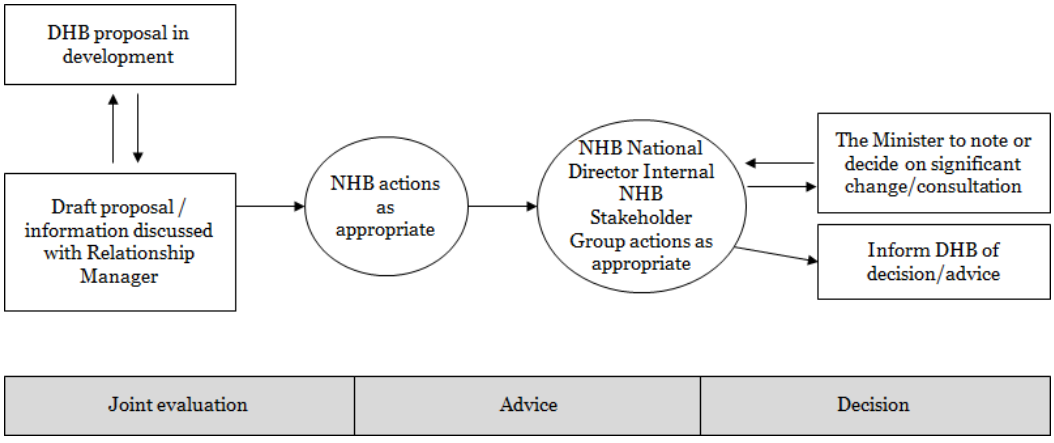
Table 4.2: Decision tool for triggering service change protocols

A. Does this proposal meet the current SCS and/or the mandatory components of the Operational Policy Framework?	• If YES proceed to B. • If NO, the DHB(s) discuss with the Relationship Manager(s) before proceeding to secure ministerial approval for SCS exceptions or approval for OPF mandatory component exceptions.
⬇	
B. Does this proposal trigger any of the existing protocols that require ministerial approval (ie, significant service change, the capital approval process, the public/private service protocols)?	• If YES the DHB(s) discuss with the Relationship Manager(s). The Ministry will use agreed criteria as to whether the Minister needs to be consulted using the service change protocols. • If NO, proceed to C.
⬇	
C. Does one or both of these situations apply to this proposal? a. The proposal requires public consultation under the Planning Regulations (section 92(1) of the NZPHD Act, as amended by the NZPHD Amendment Act 2010). b. The proposal is likely to result in substantial public comment.	• If YES, the DHB(s) discuss with the Relationship Manager(s) to facilitate the proposal as to whether the Minister needs to be consulted on the substance of the proposal. • If NO, the DHBs can proceed with the change proposed, provided the change is clinically appropriate, that a robust process is followed (as per the Minister's expectations of DHBs) and public confidence is managed by the DHB.

4.5.2 Early engagement with the Relationship Manager(s) to discuss the proposed service change and its implications or progress is an important part of the success of the service change approval process. To assist this discussion, Table 4.3 (Section 4.8) provides the initial key information to be considered. Where significant service changes require the Minister's approval in principle or prior approval, the DHB(s) will need to provide more in-depth information to support a timely decision.

4.5.3 Service change proposals discussed with the Relationship Manager will follow the service change process set out in Figure 4.1 below. A more detailed discussion of the service change process, with high-level examples, is described in *Service Change – Rules, Principles and Protocols for District Health Boards* (Ministry of Health 2011).

Figure 4.1: Process flow chart for DHB service change proposals



4.6 Significant service change and consultation

4.6.1 DHB(s) will manage any service change as significant service change if the proposed change will have a material or significant impact on the recipients of services, their caregivers or service providers such as:

- service eligibility criteria
- access to services by the DHB's population including access to services provided in other DHBs or the way that services are provided
- the financial position of DHB(s) proposing the change or for the other DHBs.

4.6.2 Where the Minister directs DHBs to make significant changes, the Minister may also require DHBs to consult on how those changes should be made.

4.6.3 The Minister will require DHBs to consult where the Minister considers DHBs are proposing changes to service eligibility, access or the way that services are provided that will have a significant impact on recipients of services, their caregivers or providers.[20]

4.6.4 Significant change is a specific criterion for DHB planning processes; refer to the Planning Regulations and the *Consultation Guidelines for the Ministry of Health and District Health Boards* (Ministry of Health 2002) or the Minister's decision about significance triggering consultation. When consultation is required, the DHB's proposed service change will not be implemented until appropriate consultation has been undertaken with the affected population(s).

4.7 Funding implications of significant service change

4.7.1 A change in technology may result in a significant service change, so that the DHB needs to consider national IDF reference prices for the service, or to come to an agreed alternative arrangement with the affected DHBs. This kind of service change can only be made available to other DHB populations if the DHB of domicile agrees to be invoiced by the DHB of service.

4.7.2 In many cases, a new advanced clinical practice for a procedure or drug treatment will substitute for current services that may result in a saving to the DHB.

4.7.3 DHBs manage service change that falls on the boundary of technology change or a completely new service, on a case-by-case basis at an early stage through the IDF volumes regional groups. The volumes of the new service will be included in the subsequent year's IDF volumes. They will appear as IDFs in the National Minimum Data Set (NMDS) data (or other national data sets as applicable) and be used for volume-setting for future IDF volumes.

4.8 The facilitation role of the Regional Relationship Manager

4.8.1 The Regional Relationship Manager will facilitate the Ministry's involvement for service change proposals where:

- the proposed service change triggers the process for notification to or prior approval by the Minister
- there are issues of national interest that potentially override the district or regional solution
- there has been a failure to resolve a DHB- or regional-level issue between the parties concerned.

4.8.2 To support the discussions, an information guideline for proposed service change is provided in Table 4.3 below. An initial discussion will take place with the Relationship Manager, covering the relevant bolded key points of the proposed service change. Depending on the significance of the proposed change, the Relationship Manager may ask for further information to facilitate timely decision-making before forwarding the proposal to the Minister for noting or decision-making.

[20] SOC Min (10) 23.

Table 4.3: Information guideline for early discussion of a proposed service change

a. The name and nature of proposed service change

This is a description of the proposal that may include, for example:

- the relationship and alignment with NZ Health Strategy, NZ Disability Strategy, Health Needs Assessment, DHB's Regional Service Plans, Annual Plan, Tertiary Services Review and DHB prioritisation process
- the timeframe for implementation
- the scale of the proposal – is it a change to an existing or a new district, regional or national service? Confirm that the current service cover will not be diminished
- the community/population to be affected
- other stakeholders who will have input into this proposal
- the consultation process that is proposed
- why the service change has been proposed – ie, rationale for change.

b. What collaboration has taken place in planning the service?

For example, consider:

- how you will demonstrate the effectiveness of the funding mechanisms in the proposal in achieving the aims of planning services collaboratively (ie, local, regional or national services)
- Where a regional or multi-DHB service change is proposed a lead DHB (including both a lead Chief Executive and lead General Manager Planning and Funding) must be identified.
- what agreement on the proposed service change (where it is necessary) is to be reached with other DHB(s) and the Ministry's Service Commissioning business unit in regard to:
  - the proposed effect on service volumes/capacity
  - funding arrangements
  - changes to access and eligibility of recipients of the services (if any)
  - the level of support from affected DHBs. (Attach letters of support from affected DHB(s) if requested by the Regional Relationship Manager.)

c. What is the impact on community/population?

For example, consider:

- health outcomes/disparities
- Māori
- access to services
- eligibility
- consumer choice
- quality of services
- costs (including opportunity costs faced by consumers)
- likely perspective of community/population and other stakeholders
- clinical appropriateness and clinical perspective.

d. What is the impact on your own DHB?

For example, consider:

- clinical impact analysis
- patient impact analysis
- revenue impact analysis, net present value, proposed financial impact
- workforce implications
- infrastructure (buildings, information systems, etc).

e. What is the impact (if any) on other DHBs?

For example, consider:

- clinical impact analysis
- patient impact analysis
- revenue impact analysis, net present value, proposed financial impact
- workforce implications
- infrastructure (buildings, information systems etc)
- letter(s) supporting the proposal from the affected DHB(s).

f. Funding (if any) that is needed to finance the service change

Funder(s) will be expected to provide sensitivity analysis around the modelling of the fiscal and economic impacts of their proposals, costs of proposal, cash flow and source(s) of funding needed to

finance the service change.

4.8.3 The DHB that wishes to make a service change (as either a service provider or a funder) will engage with and write to the other DHB(s) affected outlining the planned service change. The affected key stakeholder/funder must be given an opportunity to review it and provide comment before a service change proposal is discussed with the Relationship Manager for facilitating the Minister's approval in principle. If the parties:

- agree on the proposal, a letter to this effect will be included with the proposal
- are unable to agree on the proposal, the affected funder will prepare a dissenting submission and send it to the Relationship Manager.

- Where a regional or multi-DHB service change is proposed a lead DHB (including both a lead Chief Executive and lead General Manager Planning and Funding) must be identified when the change is signalled to the Relationship Manager.

4.8.4 The Relationship Manager will facilitate final sign-off in relation to any significant service change and, where applicable, the Minister will decide whether to give prior approval or approval in principle. The Minister also has a role in determining the need for DHBs to engage in public consultation for any proposed major service reconfiguration or significant service change.

4.8.5 Changes to methods of funding services that have a significant impact or that affect government policy or legislation will continue to go to the Minister for decision and, as appropriate, to the Cabinet.

4.8.6 A timely response will be provided to the DHB via the Director, Service Commissioning or delegate.

4.9 DHBs as providers of last resort

(See ss 22 and 23 of the NZPHD Act)

DHBs shall be deemed the provider of last resort in all circumstances – for example, when a third party contractor fails to provide or deliver care. In circumstances in which a DHB is required to act as the provider of last resort, the Ministry will work with the DHB to assess the implications, including the impact on the provider arm, and to agree service delivery plans.

4.10 Strategic Prioritisation

Note: The strategic prioritisation function of the former National Health Committee now sits within the Ministry of Health. This section will be revised once the operating model for this work programme is finalised. Further information about strategic prioritisation is available on the Ministry's website.

Explanation of terms used in this chapter

National services	For the purposes of planning and funding, national services are defined under two areas. a. **The Ministry** plans and funds the delivery of services for the catchments of all DHBs through contracts with service providers. b. **Lead DHB(s)** plan, coordinate and fund the delivery of the national service through contracts with service providers when they provide a specified service for the catchments of all DHBs, or for most DHBs. DHBs with national or regional provider roles have the same obligations to their external and internal populations.
Regional services	For the purposes of DHB planning, a region is defined as the current four geographic regions.[21] A DHB provides a regional service when it provides a specified service for all DHBs within a geographic region. This does not preclude other collaborative arrangements such as cancer networks, shared information technology and stroke services. A DHB is providing a sub-regional service when it provides a specified service for part or all of the catchment of another DHB.
Service Coverage Schedule	The current Schedule to the Crown Funding Agreement endorsed by the Minister that sets out the services the Ministry funds, and/or a DHB must ensure are delivered to its population.
Service shift	A transfer of an existing service to another service provider at the current level of service.
Significant change	A change that has or is likely to have a noticeable or measurable impact on a new or current service, and/or that may have associated risks, financial impacts or consequences for service users, their caregivers or service providers.
Significant service change	A service shift and service reconfiguration where there is a significant change for the affected population, such as: a. a material change to the level, nature or volume of services provided, or b. a material change to funding method or contracting arrangement,[22] or c. a significant impact on recipients of services, their caregivers or service providers, particularly a material change in access and/or eligibility of the recipients of services. When assessing whether a proposal is one that must be discussed with the Relationship Manager, a DHB must consider that a significant service change is one that has any of the impacts described in (a) to (c) above.
Reconfiguration	A planned approach to achieve a more effective service arrangement to support clinical and financial viability to manage within the funding available. Service reconfiguration may include a change in the way a service is designed and delivered such as: a. changing the setting of the service b. transferring the service to another provider – eg, from inpatient to outpatient services, or from hospital to community due to the introduction of new technology or treatment methods c. moving a hospital-provided clinical activity to delivery by another organisation – eg, by a primary health care provider or the private sector d. moving from individual DHB responsibility to national procurement of supplies and services – eg, pharmaceuticals or medical equipment.
National IDF reference price	The price for IDFs as advised by the Ministry on an annual basis; the prices cannot be varied without authorisation by the Ministry.

[21] Cabinet decision that confirmed these regions for Regional Service Plans SOC Min (10) 15-2 (rec9).

[22] Operational Policy Framework 2013/14, Selection of Service Providers.

5 Service planning and policy

5.1 Purpose of the chapter

5.1.1 The purpose of this chapter is to highlight specific service areas of key operational policies.

Summary of mandatory requirements

DHBs must:

- meet the National Cervical Screening Programme (NCSP) Policy and Standards for colposcopy services (Section 5.3)
- have a system to ensure the entire health system is meeting the needs of smokers to achieve the Health target of 'better help for smokers to quit' (Section 5.4)
- ensure that their work programmes reflect the Government's priorities for aged care and work towards implementing the health component of the New Zealand Positive Ageing Strategy annual action plans (Section 5.5)
- treat patients in accordance with the principles of the elective services policy (Section 5.10)
- manage funding responsibility of Long-term Support – Chronic Health Conditions on a regional basis (Section 5.8).

5.2 Primary health care

Guidance on DHB management of PHO cash balances

Note: This section requires further review to ensure the monitoring required is useful and accurate, and to summarise and refine the information.

5.2.1 Total cash balances include all cash assets shown in the current assets section of the Statement of Financial Position as at the end of the financial year, including any term investments.

Net PHO cash balances are calculated by subtracting income in advance (classed as a liability) from total cash in the bank.

5.2.2 PHO cash reserves are calculated by subtracting the PHO's working capital requirements and income in advance from total cash in the bank. Working capital requirements are the cash buffer that each PHO needs to maintain in order to meet its short-term liabilities. Working capital requirements are not the same as actual working capital. Actual capital is calculated by subtracting total current assets from total current liabilities.

5.2.3 DHBs should actively exercise their stewardship role in regard to the public funding provided to PHOs. DHBs should be particularly concerned about PHOs with both increasing cash balances and increasing income in advance. Income in advance is an important consideration because, if year on year income in advance is increasing, this indicates that the PHO is receiving more income than it is spending in a 12-month period. This can lead to the PHO accumulating income that then flows into its cash balances.

5.2.4 DHBs should discuss with their PHOs that each PHO needs to have a formal policy for managing working capital.[23] The DHB should discuss and agree the PHO's working capital requirements to cover risks and liabilities and fluctuations in cash flow.

5.2.5 DHBs should monitor PHOs with substantial and/or increasing cash balances and increasing income in advance on a quarterly basis. PHOs that do not demonstrate reducing cash balances

[23] Working capital comprises current assets and current liabilities. Positive working capital means that a business is able to meet its short-term liabilities. Negative working capital means a business cannot meet its short-term liabilities with its current assets (cash, accounts receivable and inventory).

and timely expenditure of income in advance should be required to provide forecast expenditure plans for both cash balances and income in advance, including quarterly targets for reductions in cash balances to the agreed level.

5.2.6 If a PHO continues not to meet its targets for reductions in cash balances over a period of time (eg, three or more successive quarters), the DHB should discuss with the PHO the option of putting a hold on month-on-month income in advance, such as Services to Improve Access (SIA) and Health Promotion funding, until such time as it meets its targets. If this option is agreed with the PHO, then the DHB should notify the Ministry and the Ministry can suspend SIA and Health Promotion funding until such time as the DHB notifies the Ministry to recommence the payments.

Appropriate and inappropriate uses of PHO cash balances

5.2.7 As NGOs, PHOs are not governed by the provisions of the Public Finance Act or the Ministry's Capital Assessment Guidelines.

5.2.8 There is potential for PHO cash balances to be applied toward accelerating change that aligns with the Government's BSMC priorities, including:

a. better services through primary and secondary health professionals working more collaboratively

b. earlier access to services for patients through providing more services in the community and creating smoother patient flow between different parts of the health system

c. more convenient access for patients through moving some services from hospital settings to primary health care settings.

5.2.9 The following are considered appropriate uses of PHO cash balances.

a. developing services directly for patients

b. capital investment in developing integrated family health centres

c. project management, change management and technology to support shifting services from hospital settings to primary care settings and to support primary and secondary service integration and implement initiatives for new models of care

d. workforce development and funding to free-up clinical time to participate in service redesign initiatives

e. investment that contributes to increasing the clinical and financial sustainability of primary health care services.

5.2.10 In the case of consolidating PHOs that are part of a BSMC Primary Care Business Case, DHBs should agree with the consolidating PHO how any residual funding is to be used to further the development and provision of effective primary health care services. An appropriate use would be to transfer consolidating PHOs' residual funding to the business case's flexible funding pool.

5.2.11 The DHB should ensure that governance or ownership arrangements (eg, a trust that has as its purpose to return profits to the local health system) or contractual arrangements (eg, to restrict the activities of an agent and/or profit and risk-sharing arrangements of integrated family health centres) protect against inappropriate use of public funds.

5.2.12 The following are considered inappropriate uses of PHO cash balances.

a. Loans, personal or commercial, to employees and/or non-employees.

b. Procurement and/or purchase methods in conflict with best practice.

c. Capital assets (buildings, vehicles, communications equipment, etc) used for non-work-related activity.

d. Distributions to individual clinicians and dividends to shareholders.

e. Investing in non-health-related commercial activities.

Forecast expenditure plan requirements

5.2.13 PHOs are required to develop forecast expenditure plans if they have:

a. large and/or increasing cash reserves

b. stable and/or increasing levels of income in advance, which indicate that the PHO is not using funding to provide services in a timely manner.

5.2.14 In its forecast expenditure plan, a PHO should include its:

a. agreed working capital requirements

b. total and net cash balances at the start date of the plan, and the line items for which expenditure is planned, for example, workforce development and project management

c. total income in advance at the start date of the plan and the line items for which expenditure is planned

d. quarterly targets for reducing cash reserves to the agreed level.

5.2.15 The forecast expenditure plan should extend for the length of time it will take for the PHO's cash balances to reduce to its working capital requirements.

5.2.16 The forecast expenditure plan should show the amounts by which cash balances and income in advance will reduce each quarter and the resulting totals per quarter until the PHO's cash balances have reduced to its working capital requirements.

Guidance on DHB management of PHO Financial Reporting

Placeholder - work is under way to include guidance on DHB management of PHO financial reporting, following approval by relevant stakeholders and agreement from the PHO Service Agreement Amendment Protocol (PSAAP).

5.3 Cervical screening

(See Part 4A of the Health Act)

5.3.1 Colposcopy providers must meet the relevant legislative requirements as set out in Part 4A of the Health Act. Of particular relevance is section 112M relating to the duty of persons performing colposcopic procedures and reporting to the National Cervical Screening Programme (NCSP) Manager through the NCSP Register.

5.3.2 DHBs must also meet the NCSP Policies and Standards and for colposcopy services. They must provide a high-quality service, in particular ensuring that women referred to colposcopy receive timely and adequate assessment, treatment and follow-up.

5.3.3 Laboratories that provide NCSP services must meet the relevant legislative requirements as set out in Part 4A of the Health Act. Of particular relevance is section 112N relating to reporting to the NCSP Register. These laboratories must also meet the NCSP Policies and Standards, and NCSP Guidelines, for laboratory services, particularly in relation to timeliness of assessment and reporting. PHOs and other primary health care providers that offer cervical smear taking services must meet the requirements of Part 4A of the Health Act – in particular, section 112L relating to the duties of persons taking specimens for screening tests. They must also meet the NCSP Policies and Standards and for cervical smear takers, particularly in relation to informed consent, managing women with abnormal cervical smears and the recall of women into the NCSP.

5.3.4 DHBs have a three-yearly coverage target for women aged 25–69 years under the NCSP. This target is 80 percent coverage for Māori, Pacific, Asian and European/Other ethnic groups and for total women.

5.4 Tobacco control

5.4.1 The Government has set a long-term goal of reducing smoking prevalence and tobacco availability to minimal levels, thereby making New Zealand essentially a smokefree nation by 2025. To achieve the long-term smokefree 2025 goal, it is necessary that by 2018:

a. daily smoking prevalence has fallen to 10 percent

b. the Māori and Pacific smoking rates have halved from their 2011 levels.

5.4.2 To support these goals, all DHBs have a Tobacco Control Plan (TCP) in place. The TCP outlines the DHB's strategic approach to tobacco control across its district (in line with the national strategic direction for tobacco control), including leading work to support smokers to quit and working with relevant organisations, such as primary health care organisations, non-government organisations and stop-smoking services, to develop joint initiatives. TCPs may cover up to three years. New or revised TCPs are required to be submitted to the Ministry for review and feedback before they are finalised.

5.4.3 All DHBs should have in place a consistent system to ensure the entire health system is meeting the needs of smokers and achieving the Health target of 'better help for smokers to quit' for hospitals as well as for general practice and in maternity provider settings. The Health targets are similarly designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers (ie, ABC).

DHBs can achieve the Health targets by:

a. including the following clauses within their contracting documents: 'each provider will develop an appropriate smokefree policy and will deliver services that address smokefree best practice'

b. ensuring their contracted providers understand their responsibilities to achieve the Health target by routinely asking about smoking status, providing brief advice and offering quit support

c. ensuring that robust processes and systems are in place to document, audit, monitor and report against this Health target

d. supporting clinical leadership and ownership

e. developing local networks of stop-smoking providers, ensuring that clinicians are aware of the services available and how to refer to them.

5.4.4 The New Zealand Guidelines for Helping People to Stop Smoking (Ministry of Health 2014b) provide health workers with updated guidance for use with people who smoke. These Guidelines remain structured around the ABC pathway, which was introduced in the 2007 Guidelines. However, the definitions of A, B and C have been improved to emphasise the importance of making an offer of cessation support and referring people who smoke to a stop-smoking service. The Guidelines include best practice examples of how to deliver ABC to people who smoke, and the Guidelines' background document makes recommendations for the use of evidence-based interventions in priority population groups, such as Māori, Pacific peoples, pregnant women and people who use mental health and addiction services. It is expected that all clinical staff follow these guidelines when giving brief advice and making of offer of cessation support to their patients/clients who smoke.

5.4.5 All stop-smoking services funded by DHBs must adhere to the tier three Public Health Services Stop Smoking Services service specification and be consistent with the Pharmaceutical Schedule.

5.5 Health of older people

Residential care

5.5.1 DHBs are required to adhere to the national process for the management of the Aged Related Residential Care (ARRC) Service Agreement.

5.5.2 Adhering to this process includes enforcing the provisions of the ARRC Service Agreement.

5.5.3 DHBs are to ensure that there is an adequate number of contracted care beds for all people assessed as needing residential care.

5.5.4 DHBs must put in place mechanisms to monitor that no eligible residents assessed as needing residential care (whether or not they are subsidised) are paying additional charges for services they are assessed as requiring.

Community care

5.5.5 DHBs are expected to ensure provision of community-based care and support services that:

a. are flexible and support older people's preference to live at home where sustainable

b. are responsive to the varied and changing needs of older people

c. where appropriate to the needs and aspirations of individual older people, offer restorative approaches that aim to assist people to be in control, and to regain, maintain and increase function

d. promote effective transfers between services (eg, primary, secondary, specialist and long-term support services) to support a continuum of care for older people

e. support informal carers

f. include collaborative relationships with primary health care and public health services to promote and maintain healthy ageing and effective management of chronic conditions.

5.6 Family care policy

(see Part 4A – sections 70A to 70G of the NZPHD Act, inserted by the Amendment Act 2013)

5.6.1 From 1 October 2013, the Ministry of Health provides direct funding for some eligible disabled people aged over 18 with high or very high needs to pay a family member to provide personal care or household management.

5.6.2 DHBs also have paid family care policies in place that reflect the Ministry's Funded Family Care Operational Policy. DHBs purchase services through contracted providers which, in turn, employ the family carer. Family care policies should be posted on each DHB's website.

5.7 Disability and long-term support services

(See section 3(1) of the NZPHD Act.)

5.7.1 Government, through Vote Health, funds ongoing support services for people with a wide range of disabilities and impairments. These services are referred to as disability support services for some groups, and long-term support services for others.

5.7.2 On 1 July 2011 DHBs assumed planning and funding responsibility for long-term support services for people with chronic health conditions and ongoing support needs aged under 65 years, who do not meet other Vote Health funders' eligibility and access criteria (see HR 20110411). This responsibility is additional to DHBs' responsibility for funding disability support services for people between the ages of 50 and 65 years who are clinically assessed as 'close in interest' to older people (see CAB Min (03) 23/8).

Relationships between the Ministry and DHBs as funders of support services

Communication between funders

5.7.3 The SCS sets out eligibility and access criteria relating to disability and long-term support services. As funding responsibility for disability and long-term support services is split between DHBs (and within DHBs) and the Ministry,[24] there is potential for some providers of these services to receive funding from more than one funder or funding stream. Funders need to maintain an ongoing dialogue about their service funding intentions to ensure effective and unambiguous communication with those providers.

It is particularly important that:

a. any potential change in the terms and conditions of service agreements that are funded by both the Ministry and a DHB (or more than one funding stream within a DHB), where that change may affect the other funder, is discussed first, in good faith, with the other funder

[24] Relevant Service Cover Schedules include: Disability Support Services; Health and Support Services for Older People; Long-term Support Services for People with Chronic Health Conditions; Mental Health and Addiction Services Continuum; Provision of Equipment, Modifications and Other Supplies and Services.

b. where the Ministry is one of the funding parties, if an issue has not been resolved between needs assessment and service coordination services or equivalent services, the DHB contacts the Contract Relationship Manager, Disability Support Services Group (the Ministry) who covers the DHB's region, in the first instance

c. with respect to Long-term Support Services for People with Chronic Health Conditions, a regional approach to managing the funding and governance of the framework is expected, though some aspect of managing the services will be managed at the individual DHB level

d. all service changes are consistent with the service change protocols set out in Chapter 4: Service Change

e. in addition to communication between health funders, DHBs are expected to ensure that the funding of disability and long-term support services is coordinated with other disability services funders, for example, the Ministry of Social Development and ACC.

Shared funding

5.7.4 Where a person's situation is so complex (eg, they need support due to a combination of health conditions, disabilities and a complex social situation) that significant input (generally a high-cost support package) is required from two or more funders, the funders will agree a pragmatic approach to funding support.

Dispute resolution

5.7.5 Disputes about access to Ministry- or DHB-funded services will be resolved by discussion between needs assessment and service coordination services or equivalent services. Where resolution cannot be achieved through this process, the following will apply:

a. The issue will be escalated in the first instance to the relevant DHB Portfolio Manager and the Ministry's Disability Support Services Contract Relationship Manager who covers the DHB's region.

b. Parties to a dispute are required to exhaust all avenues to achieve resolution (see Sections 8.3 to 8.8).

Transfer of clients between funders

5.7.6 The following conditions apply when transferring disability clients of the Ministry and DHB Health of Older People's services from one funder to the other (see CAB (03) M 23/8).

a. The Ministry's clients can become DHB Health of Older People clients, but DHB Health of Older People clients cannot become Ministry clients.[25] A Ministry client will become a DHB Health of Older People client only if they are assessed as requiring aged residential care.

b. People aged between 50 and 65 years who have been clinically assessed by a DHB and/or needs assessor as having health and support needs because of long-term conditions more commonly experienced by older people (the 'close in interest' group) are a DHB's responsibility under Health of Older People funding.

5.7.7 In respect of moving DHB Long-term Supports – Chronic Health Conditions clients to another funder, the following conditions will apply.

a. Movement from DHB funding to Ministry funding or shared funding may apply where a person receiving services under DHB Long-term Supports – Chronic Health Conditions funding acquires a disability that meets the Ministry's Disability Support Services eligibility and access criteria and this disability is now the main reason why the person needs ongoing support.

b. Movement from support under DHB Long-term Supports – Chronic Health Conditions funding to support under DHB Health of Older People funding will occur when a needs assessment (informed by a clinical assessment, along with input from the person and their

[25] Even if the client had previously been a Ministry client, having moved to become a DHB client, they cannot return to the Ministry for funding. All movements are one way – from the Ministry to a DHB unless both funders agree that the funding associated with that person has been incorrectly devolved or incorrectly assessed. In cases of disagreement between funders, the dispute resolution processes in the CFA will apply.

family and whānau) confirms that the person's needs and goals are likely to be better met through DHB Health of Older People services.

c. Movement from Ministry funding to DHB funding or shared funding may apply where a person receiving services under Ministry Disability Support Services funding acquires a chronic health condition that is now the main reason why the person needs ongoing support as assessed against the access criteria of the DHB's needs assessment and service coordination processes.

5.8 Long-term support – chronic health conditions

5.8.1 The Minister approved the transfer of responsibility for funding and managing long-term support services for people aged under 65 years who have chronic health conditions to DHBs from 1 July 2011.

5.8.2 Existing Disability Support Services clients will have grandparenting arrangements applied, so support packages should only reduce if an assessment indicates this is appropriate.

5.8.3 The SCS includes services for people aged under 65 years who have chronic health conditions, who prior to November 2006 were unable to receive long-term support services as they did not meet the eligibility criteria for Disability Support Services or for any support services funded by DHBs. From 1 July 2013 funds were allocated to DHBs through the Population Based Funding Formula and incorporated into DHB baseline funding to meet their SCS obligations.

5.8.4 DHBs are required to manage funding responsibility under a regional approach for the funding and delivery of services.

5.9 Supporting Vulnerable Children

5.9.1 The Vulnerable Children Act 2014, the Children's Action Plan and the Ministry of Social Development's Investing in Children Programme rest on the belief that no single agency alone can protect vulnerable children. The Chief Executives of five government agencies (Ministries of Health, Education, Justice, Social Development and New Zealand Police) are jointly accountable for acting together to develop and implement a plan to protect our children from harm, working with families/whānau and communities.

5.9.2 Further information about supporting vulnerable children is available in Appendix 4 of the SCS.

5.10 Management of elective services

Objectives for elective services

5.10.1 The key principles underlying the elective services system are: clarity, where patients know whether or not they will receive publicly funded services; timeliness, where services can be delivered within the available capacity and patients receive them in a timely manner; and fairness, ensuring that the resources available are directed to those with the greatest need and ability to benefit. The objectives for elective services are focused on improving access to elective surgery and reducing waiting times.

a. **Improving access** – DHBs will ensure that the hospital(s) provide the amount of elective operations, procedures and assessments agreed to in their Annual Plan. They will review the key operations performed to ensure the right level of service is delivered for the people in the region. DHBs will demonstrate innovative strategies, or alternative delivery options aimed at increasing productivity and efficiency, particularly theatre efficiency, and workforce development, to improve elective capacity. Innovation and efficiency should be within the DHB and across the primary–secondary interface.

b. **Reducing waiting times** – DHBs will comply with required standards on Elective Services Patient Flow Indicators (ESPIs), which demonstrate that the DHB is managing patients in accordance with the three principles (clarity, timeliness and fairness), matching their commitments to capacity. DHBs will focus on meeting the commitments given to patients for specialist assessment and treatment, and ensure that patients wait no longer than four months.

c. **Improving quality** – There is to be ethical and equitable access to elective services. Patients with similar need are to have similar access to elective services, regardless of where they live. DHBs will have in place, and maintain, effective clinical prioritisation systems as agreed with the Ministry. Patients are to be prioritised using the appropriate assessment tools and processes.[26] DHBs will ensure that patients are assessed and prioritised for surgery on a consistent basis, and that they then receive surgery according to the priority they were given.

Clarity of access to elective services

5.10.2 The following process applies for first specialist assessment (FSA), including non-contact FSA. When any request for a specialist opinion is received, it will be logged into the patient management system (upon receipt at the DHB). Referrals will be triaged within five working days. The outcome of the triage will be recorded. The patient and their general practitioner (GP) (and referrer where this is not the GP) are to be notified in writing within 15 days or less[27] from the date of receipt of referral whether or not a FSA is indicated and can be provided (within capacity available). If an FSA is not offered, advice on alternative care options should be provided if applicable. Where the ongoing demand for specialist assistance and advice cannot be met within the capacity available, the DHB must:

a. prioritise referrals and requests for assistance to ensure that patients with the greatest need and ability to benefit are seen within the resources available
b. provide referrers with information that indicates the level of need or priority that can be serviced together with referral or management guidelines to support general practice to manage the patient's care and review or reassess their condition as appropriate.

5.10.3 All patients are to be given clarity of their status regarding treatment at completion of clinical assessment. This is to be confirmed in writing, together with notification to their GP (and to the referrer where this is not the GP), within 15 days or less[28] of the assessment. Status regarding treatment will be within one of the following categories:

a. certainty of treatment within maximum waiting time expectation – this commitment will be given to patients based on their assessed priority

b. active review – a care pathway for patients for whom elective surgery is considered to be the best option for their care, but where:

- this service is not available within the current public funding or provider capacity
- there is a realistic probability that the patient's condition may meet the threshold for treatment in the foreseeable future

These are the patients who would next receive treatment if provider capacity increases.

c. return to GP care – the patient's priority has been assessed as low relative to others referred to the same service. The patient's priority score will be recorded. The patient is returned to the care of their GP and can be re-referred for secondary assistance if their condition changes.

Timeliness of access to elective services

5.10.4 Each DHB is to ensure that it either:

- meets its contractual obligations itself, to deliver elective surgical service volumes in a timely way, or
- implements suitable and timely alternative solutions to provide these services.

5.10.5 Patients accepted for an FSA should wait no longer than four months to be provided with their assessment

[26] Where a national clinical priority assessment criteria (CPAC) tool exists, there is an expectation that it will be used. If there is no national CPAC tool, then a nationally recognised tool must be used.

[27] This time frame is amended from 10 working days from 2016/17 to reflect the introduction of the National Patient Flow collection

[28] As above

5.10.6 Patients given a commitment to treatment should receive that treatment within a timeframe consistent with their relative priority and wait no longer than four months.

5.10.7 Patients given an active review status should receive a clinical review at least every six months. If at any time a patient's condition deteriorates to the point where their priority score exceeds the actual treatment threshold, they should be given a commitment to treatment. If a patient's condition remains unchanged by the time of the third assessment, they should be returned to the care of their GP.

Fairness of access to elective services

5.10.8 There is to be ethical and equitable access to elective services. Patients with similar need are to have similar access to elective services, regardless of where they live.

5.10.9 All services will have in place, and maintain, effective prioritisation systems based on individual need and ability to benefit. All patients are to be prioritised using the appropriate assessment tools and processes. DHBs are expected to evaluate the effectiveness of the prioritisation processes and systems in use and to facilitate quality improvement where required.

5.10.10 No patient should be considered for elective surgical treatment without first being clinically assessed to determine their relative priority. It is recognised, however, that clinical judgement may override a particular patient's priority. Such clinical exceptions must be documented, with the cause of the exception noted.

5.10.11 All services will develop and maintain a reliable commitment threshold to determine the priority level above which patients can be offered treatment within the capacity available. Patients are to be offered access to a service if their assessed priority is equal to or above the commitment threshold for that service. It is acknowledged that, for a variety of reasons, it is appropriate to accept a small percentage of patients who are prioritised below the commitment threshold for treatment.

Other processes for elective services

5.10.12 DHBs are expected to improve the supply of elective services by:

a. fostering primary and secondary relationships and adopting improvements to service redesign and delivery to better manage demand for elective services

b. developing and using systematic comparisons of their provision of services relative to other DHBs

c. developing systematic processes to evaluate and manage unmet need in consultation with primary health care.

5.10.13 To improve referral quality and appropriateness, DHBs are to:

a. identify core work that should be retained in the secondary sector and work that could be performed by alternative providers (eg, primary sector)

b. develop relationships with all referrers for assessment and/or treatment

c. develop and agree referral processes and review mechanisms.

5.10.14 To improve waiting times for diagnostics, DHBs are to:

a. have robust processes in place to ensure timely and patient-focused scheduling of diagnostic appointments

b. monitor and report on key diagnostic modalities waiting times for all publicly funded patients

c. develop plans to address any gaps in reporting.

5.10.15 DHBs will be expected to continue to contribute to the development and review of referral information, including assessment criteria and prioritisation systems for FSA.

5.10.16 Each DHB will contribute towards the development and ongoing refinement of national clinical priority assessment criteria (CPAC) and clinical priority systems (CPS). In addition, DHBs will work towards 100 percent implementation of national tools where available – otherwise nationally recognised tools – to ensure patients are seen and treated equitably and in the order of greatest priority.

5.10.17 Each DHB will demonstrate that individual patients are clinically assessed and then systematically assigned priority for surgery on an equitable and transparent basis. Treatment will be offered according to the priority assigned.

Quality requirements

5.10.18 DHBs will participate in a continuous quality improvement programme, which will include:

a. ongoing audit and review of processes to improve the quality and consistency of:
   - prioritisation for outpatient assessment and inpatient treatment, including audit of referral and management guidelines, access criteria and CPAC tools
   - management and scheduling of referrals from primary care for FSA
   - management and scheduling of referrals for inpatient treatment

b. development of appropriate plans to implement service improvement processes to address identified deficiencies, including plans to:
   - improve the quality and effectiveness of prioritisation
   - ensure patients wait no longer than four months to receive their FSA or treatment
   - reduce the waiting time for assessment or treatment for elective patients

c. Introduction of appropriate reporting and monitoring frameworks to track performance for key indicators.

Provision of elective services

5.10.19 DHBs will plan and deliver elective services in accordance with the Electives Funding Policy. This policy refers to ongoing access to elective services funding based on compliance with expected patient flow processes.

5.10.20 Each DHB is expected to fulfil its commitments for any elective services initiatives, as specified in the CFA variations for these initiatives.

6 Improving Māori health

6.1 Purpose of the chapter

6.1.1 One of the explicit purposes of the NZPHD Act is 'to reduce health disparities by improving the health outcomes of Māori.' Each DHB (in both its funder and provider functions) must aim to reduce health disparities and achieve health equity.

6.1.2 The NZPHD Act provides for mechanisms to enable Māori to contribute to decision-making on and to participate in the delivery of health and disability services. DHBs are required to establish and maintain processes to enable Māori to participate in and contribute to strategies designed to improve Māori health.

6.1.3 DHBs have formed health relationships with iwi/Māori and continue to consolidate these relationships within the context of engagement with and participation of iwi, hapū and other Māori communities in their regions at all levels of the health and disability sector. It is exciting to be building sound relationships between DHBs and iwi/Māori with the aim of enhancing Māori health and the health of all New Zealanders because it allows scope for shared thinking, planning, achievements and successes.

6.1.4 This chapter sets out what DHBs are required to do in relation to reducing health disparities for Māori, engaging Māori in decision-making on and the delivery of services, planning for Māori health, developing the Māori health workforce, improving the effectiveness of mainstream services in achieving health equity, and providing for the needs of Māori by other means.

Summary of mandatory requirements

DHBs must:

- DHBs are required to consider and include actions in their annual plans that will help them to reduce health disparities for Māori and achieve health equity for all of their populations **(Section 6.2**)
- work with Māori at both governance and operational levels **(Section 6.3)**
- enable Māori to contribute to decision-making on and to participate in the delivery of health and disability services **(Section 6.4)**
- provide for the needs of Māori as set out in section 4 of the NZPHD Act to ensure there are mechanisms to enable Māori to contribute to decision-making on and to participate in the delivery of health and disability services, as well as responding to the Government's desire to achieve health equity and improve health outcomes for Māori **(Section 6.5)**.

6.2 Māori health planning

(See ss 4, 22 and 23 of the NZPHD Act.)

6.2.1 DHBs are required to consider and include actions in their annual plans that will help them to reduce health disparities for Māori and achieve health equity for all of their resident populations. DHBs need to engage with relevant stakeholders when developing their annual plans.

DHBs must consider the characteristics of the current and future population of the district, including demography, socioeconomic determinants, health status and demand for health services within their district, when identifying areas of focus for health equity.

Further information on planning expectations for Māori health is contained in the Annual Plan Guidance for DHBs. This is supported by the DHB non-financial monitoring and framework and performance measures definitions, where the previous Māori health plan measures have now been incorporated.

6.3 Working with Māori

(See ss 4, 23(1)(d), 34, 35 and 36, and Schedule 3, clause 38(2) of the NZPHD Act, Crown Māori Relationship Instruments: Policy Framework POL Min (04) 16/8 and Statement of Government Intentions: Community Government Relationships.)

6.3.1 DHBs will work with Māori at both governance and operational levels.

6.3.2 The electoral and ministerial appointment processes will determine membership of Boards. Boards will then decide the appropriate level of representation of Māori on committees, consistent with the statutory provisions outlined above. Under ss 34, 35 and 36 of the NZPHD Act, Māori must be represented on community and public health advisory committees, disability support advisory committees and hospital advisory committees. In making appointments to other committees, the Board must endeavour, where appropriate, to ensure representation of Māori on the committee (Schedule 3, clause 38(2) NZPHD Act). It is recommended that each DHB:

a. seeks guidance from iwi and Māori communities

b. is aware that different arrangements may be appropriate in different areas, and may vary over time.

6.3.3 Each DHB should be guided by the New Zealand Health Strategy, the New Zealand Disability Strategy and He Korowai Oranga: Māori Health Strategy. DHBs should note in particular the importance of Māori aspirations for health and Māori participation in all levels of decision making and delivery (see pathway two of He Korowai Oranga).

6.4 Engagement with and participation of Māori

(See ss 22(1)(e) and 23(1)(d)–(e) of the NZPHD Act.)

6.4.1 Part 3 [of the NZPHD Act] provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in, the delivery of health and disability services' (section 4 of the NZPHD Act). In particular, DHBs are to:

a. reduce health disparities by improving health outcomes for Māori and other population groups

b. establish and maintain processes to enable Māori to participate in and contribute to strategies for Māori health improvement

c. continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori

d. provide relevant information to Māori for the purposes set out above.

6.4.2 Each DHB is required to ensure that processes for engagement of and participation and input by iwi/Māori are in place in respect to:

a. health needs assessments

b. prioritisation

c. planning (including Annual Plan and Regional Service Plan)

d. service delivery

e. monitoring

f. evaluation of services

6.5 Other means of providing for the needs of Māori

(See Government policy (good employer requirements, He Korowai Oranga: Māori Health Strategy), and ss 4, 22(1)(e), 23(1)(b)–(f) and Schedule 3 clause 43 of the NZPHD Act.)

6.5.1 To provide for the needs of Māori, each DHB is also expected to:

a. make progress in developing its Māori workforce, and promote workforce development among its contracted mainstream providers by ensuring that mainstream services are culturally effective and that they promote the development of Māori providers

b. participate fully with other government agencies in implementing the Government's objectives of strengthening coordination of Māori social services and improving health outcomes for Māori

c. hold consultations with its resident population, including iwi/Māori within its resident population, when it intends to sell or exchange any land, in order to satisfy the Minister, and be aware of the views within the population about the proposed sale or exchange.[29]

6.5.2 These provisions reflect the Government's responsibilities under section 4 of the NZPHD Act to ensure there are mechanisms to enable Māori to contribute to decision-making on and to participate in the delivery of health and disability services. In addition, they reflect the Government's desire to reduce health inequalities and improve health outcomes for Māori.

[29] Clause 43 in Schedule 3 to the NZPHD Act states the rules that apply in order for the Minister to be satisfied that a DHB has consulted, and any approval the Minister gives to a DHB to proceed with the sale and exchange of land. It does not state the rules for the actual process of the sale or exchange of any DHB land. This process is dealt with in other statutes. Māori land is specifically dealt with under the Māori Land Act 1993 and section 41 of the Public Works Act 1981. Section 40 of the Public Works Act deals with public works land and has the mandatory requirement that the original owner has a pre-emptive right to purchase such land.

7 Inter-district flows

7.1 Purpose of the chapter

7.1.1 This chapter sets out a system and rules for managing inter-district flows (IDFs). It includes an explanation of terms specific to this chapter (Section 7.17).

Definition of IDF

7.1.2 The DHB of Domicile (DoD) is the DHB that is responsible for funding services for its resident population. The DHB of Service (DoS) is the DHB that provides the service.

7.1.3 An IDF occurs when an eligible person receives treatment and the DoS is not the DoD for that person.

7.1.4 Eligibility is determined by the Minister of Health's Health and Disability Services Eligibility Direction 2011 or any other Direction of the Minister in force from time to time.

Summary of mandatory requirements

Each DHB must:

- follow the key principles governing the referral and management of IDFs **(Section 7.4)**
- the DHB of Service will manage elective referrals to national services in line with Electives policy and will meet all national collection reporting requirements including submission of data. **(Sections 7.5 and 7.7.8)**
- adhere to the setting and management of IDF volumes **(Section 7.10)**
- follow guidelines in managing exceptional situations **(Section 7.13)**
- reimburse each other for IDFs from their appropriations, with systems in place to facilitate such reimbursement **(Section 7.14)**
- follow a set dispute resolution process **(see Chapter 8: Dispute resolution)**
- adhere to the guidelines regarding service change (see Chapter 4: Service change)
- be aware of and meet their obligations relating to privacy of patient information **(Section 7.16)**.

7.2 Principles guiding the IDF rules

7.2.1 The rules for managing IDFs are informed by, and should be read in the light of, the following general principles.

All eligible people are able to access public hospital services anywhere in the country in an emergency situation – that is, DHBs are obliged to provide acute services regardless of where a person lives.

a. The management of IDFs is operated in a fair, cost-effective and transparent manner.

b. The DHB funder arm is accountable for determining access to services for its population.

c. The management of IDFs enables effective clinical referral practice. Part of effective clinical practice is to enable clinicians to refer patients to services that are appropriate to each individual's clinical circumstances within the constraints of available resources and capacity.

d. DHBs ensure that patient access to appropriate care is not compromised by inter-DHB disputes over liability to pay.

7.2.2 IDFs will continue to be described using the Nationwide Service Framework and reported through the national data sets where they exist.

7.2.3 As part of implementing the IDF rules, DHBs are expected to work continually to improve IDF data quality and reporting mechanisms. The Ministry will support this work by developing appropriate systems to minimise the transaction costs of administering IDFs.

Application of and exclusions from the rules

7.2.4 DHBs may expressly enter into agreements with each other that override the rules outlined below. However, any such agreement should not result in clinical risk to a patient as a result of restricting IDFs. When two DHBs have an agreement between them governing the management of IDFs across one or more service categories, these IDF rules apply to that agreement, except to the extent that the agreement expressly provides otherwise.

7.2.5 The IDF rules do not apply in the following situations:

a. people who are not eligible for publicly funded health and disability services in New Zealand, as set out in the Health and Disability Services Eligibility Direction 2011

b. New Zealand citizens residing overseas living in the areas of Ross Dependency, Cook Islands, Niue or Tokelau, or any person eligible for service through reciprocal health arrangements with other countries; in this situation the DoS is funded via the Overseas Adjuster component of the Population Based Funding Formula (PBFF), rather than through any IDF mechanism

c. care that remains in the funding realm of the Ministry, such as non-devolved Disability Support Services for people under the age of 65 years

d. people whose care is the funding responsibility of third parties, such as ACC

e. people who have authorised medical treatment provided outside New Zealand.

7.2.6 DHBs should ensure that their staff are familiar with the process for identifying ineligible patients. DHBs should also have in place appropriate data collection and billing processes for ineligible patients.

7.3 Residence criteria for the purposes of the IDF rules

7.3.1 The ‘resident population’ of a DHB is defined in section 6 of the NZPHD Act as ‘the eligible people residing in the geographical area of the DHB’. A DHB and its geographical area are defined by the territorial authority and ward boundaries outlined in Schedule 1 to the NZPHD Act.

7.3.2 Residence is self-defined and does not include a time criterion. An exception is for aged residential care IDFs (see paragraph 7.3.4(e) below).

7.3.3 DHBs should use the following guidelines in determining a person’s usual residence for the purposes of the IDF rules.

a. Where the person is a minor, the ‘usual residence’ is the usual residence of that person’s parent(s) or guardian(s).

b. Children who board at another residence to attend primary or secondary school and return to the home of their parent(s) or guardian(s) for the holidays ‘usually reside’ at the address of their parent(s) or guardian(s).

c. Post-secondary students ‘usually reside’ at the address where they live while studying.

d. Children in joint custody ‘usually reside’ at the place where they spend more nights; if they spend an equal amount of time at each parent’s residence, their DoD is considered to be that of the residence where they were when they first sought care for the current health episode.

e. A person whose home is on any ship, boat or vessel permanently located in any harbour is deemed to ‘usually reside’ at the wharf or landing place (or main wharf or landing) of the harbour.

f. In cases of involuntary changes in residence for health services where a person is in institutional treatment or receiving support services over the long term, the person’s last ‘voluntary’ residence is considered to be their ‘usual residence’, for the length of the service or until a change in service supports a review of domicile.

g. In cases of involuntary changes in residence for prison services where a person is in institutional treatment or receiving support services over the long term, the person’s last ‘voluntary’ residence is considered to be their ‘usual residence’, for the length of the service.

h. Where a person has no fixed abode, the DoD will be the DoS for the event except in the case of prison services. Where a person has no fixed abode at the time of entering Prison Services, the prison that the person resides will be considered their residence for determining the DoD.

7.3.4 DHBs should use the following rules in determining a person's usual residence where the patient moves into another DHB and receives service for a long duration.

a. Where the patient is in the hospital, the DHB of domicile at admission pays for the cost of treatment.

b. Where the patient moves to another DHB for a time-limited period to receive a service, such as alcohol and drug rehabilitation, then the DHB of domicile at admission pays for the cost of treatment.

c. In relation to hospice inpatient services, the DoD for the purposes of identifying hospice inpatient services IDFs is based on the patient's last residential address prior to entry into care. For all other services (eg, a subsequent public hospital admission), DoD is based on the hospice address (DoS).

d. In relation to people in aged residential care services and long-term services for people with chronic health conditions (long term conditions), the DoD for the purposes of identifying IDFs is based on the person's last residence prior to entry into care. For all other services (eg, a subsequent public hospital admission), DoD is based on the aged residential care facility address (DoS).

7.3.5 These guidelines are consistent with the Statistics New Zealand Census definitions of residence (Usual Residence, Statistics New Zealand (accessed September 2014)) that are used in the distribution of funding via the PBFF.

7.4 General IDF referral and management principles

7.4.1 The key principles governing the referral and management of IDFs, from a DoD to a DoS, are outlined below. These principles need to be read in conjunction with the management rules discussed in Sections 7.5–7.9 below.

a. All eligible people may be referred by their DoD to regional or national specialist services for care.

b. Any issue arising in relation to the management of IDFs that could impact on the service coverage of any DoD needs to be promptly identified and managed by that DoD and any relevant DoS. When an agreement on management cannot be reached between the DoD and the DoS, a proposal for a variation may need to be sought by the DoD from the Ministry through the Annual Plan process.

c. Arrangements between DHB funder and provider arms will incorporate IDF volumes in base volumes, with mechanisms in place to manage associated risks.

d. Both the DoS and the DoD should monitor all information available and discuss material variations from plan.

7.5 Referral and management of IDFs for inpatient elective services

7.5.1 DHBs that provide regional or national services must ensure equity of access on the basis of clinical need. They should not prioritise access based on where a patient lives.

7.5.2 Regions should ensure that clear referral pathways are in place and known to all clinicians.

7.5.3 Where a DoD provides a treatment, referral to another DHB would only occur in exceptional circumstances (see Section 7.13).

7.5.4 Where a region provides a treatment, referral to another region would only occur in exceptional circumstances and should be a specialist to specialist referral.

7.5.5 Where a patient has been accepted on to a DoS's waiting list, they should not be removed due to the patient changing DoD while on the list unless the patient chooses to seek treatment elsewhere.

7.6 Referral and management of IDFs for acute/ arranged services

7.6.1 Acute and arranged IDF services are included in the revenue/volume schedules for DHBs. However each DoS must accept all IDFs for this category whether they arise by referral or presentation at a health care facility.

7.7 Referral and management of national services

7.7.1 The following national services are purchased from a single lead DHB (the DoS) on behalf of all other DHBs (DoDs), through top sliced funding:

a. heart transplants

b. heart–lung transplants

c. lung transplants

d. donor coordination and retrieval

e. liver transplants

f. paediatric cardiac and congenital service

g. paediatric and adult metabolic services

7.7.2 The following services are nationally purchased from two or more lead DHBs on behalf of all other DHBs:

a. clinical genetic services

b. hyperbaric decompression services

c. forensic mental health

7.7.3 For the following services, the lead DHBs receive supplementary funding:

a. paediatric rheumatology

b. high-cost burns.

7.7.4 Other services may be added, as agreed with the Ministry of Health and DHB General Managers, Planning and Funding.

7.7.5 The DoS must deliver these services to eligible people from DoDs, providing that those people meet the national clinical criteria. The DoS will not prioritise its own resident population ahead of eligible people from other DHB areas for the purposes of providing national services.

7.7.6 The DoS will agree minimum volumes and quality standards for national services with the Ministry by the date at which the DoS's Annual Plan is finalised. The revenue for these services has been top-sliced, based on levels determined in the CFA.

7.7.7 The DoS will manage national services within the agreed funding, which includes a risk pool for some services.

7.7.8 The DoS will manage elective referrals to national services in line with Electives policy, as outlined in Sections 5.8 and 5.9 above.

7.7.9 The DoS will meet all national collection reporting requirements for national services, including submission of data to the following collections where appropriate:

a. National Minimum Dataset

b. National Non Admitted Patients Collection (NNPAC)

c. Programme for the Integration of Mental Health Data

d. National Booking Reporting System

e. National Patient Flow.

7.8 Referral and management of IDFs for aged residential care services

7.8.1 Patients must be assessed by needs assessment and service coordination or equivalent services prior to entry to government-funded aged residential care services. Where a patient transfers from one DHB to another, either on first entry to aged residential care services or as a subsequent transfer, the needs assessment and service coordination or equivalent services transfer protocols must be followed.

7.9 Referral and management of IDFs for other services

7.9.1 GPs, nurse practitioners (NPs) or medical specialists refer patients to outpatient departments and most other provider arm services (except emergency departments) that are not Diagnostic Related Groups, in accordance with applicable referral protocols in place from time to time.

7.9.2 Patients self-refer to their GP or NP services or receive services from laboratories, pharmacies, etc, according to GP or NP requests.

7.9.3 All other referrals occur under agreed protocols and criteria as specified in the relevant regional agreements.

7.10 Setting and management of IDF volumes

7.10.1 In consultation with the Inter-District Flow National Coordinating Group (IDF NCG), the Ministry will produce an annual list of IDF volumes/revenue (adjusted for any population changes). DHBs must supply volume data in order to receive payment for their IDFs. However, in exceptional circumstances in which a DHB cannot comply, the IDF NCG may agree an alternative methodology; this will be documented in the IDF methodology notes. The IDF volumes will be inserted into DHBs' Funding Packages and reflected in DHBs' Annual Plans. These volumes can only be changed by formal agreement between affected DHBs.

7.10.2 A detailed explanation of how forecast IDF volumes are set is contained in the IDF methodology notes, which are updated annually and are available on the DHB Funding Quickr website (password required).

7.10.3 Regions may agree to implement their own methodology for IDFs between their DHBs.

7.10.4 If DHBs cannot agree on a technical issue, the IDF NCG will have authority to resolve the issue.

7.10.5 If either DHBs or the Ministry identify any administrative or clear technical errors in the forecast IDFs, the IDF NCG will have authority to resolve the issue.

7.10.6 If DHBs cannot agree on a non-technical issue, the dispute resolution process (Section 8.3) should be followed.

7.10.7 From time to time, two DHBs may agree on an adjustment between themselves, covering additional services. Such an arrangement may modify IDF revenue/volume schedules.

7.10.8 IDF wash-ups occur for personal health case-weighted, Health of Older People Assessment, Treatment And Rehabilitation, Pharmaceutical Cancer Treatments (PCTs), Community Pharmacy, PHOs and Selected NNPAC Purchase Units. DHBs may opt out of the wash-up arrangement with the agreement of all other DHBs.

7.11 Special arrangements for residential mental health services

7.11.1 Other than ad hoc flows, if a DHB requires additional capacity in a mental health service in another region where no planned IDF is in place, the DHB will pay for the service on a fee-for-service basis. The amounts should be agreed by the DHBs concerned and sent to the Ministry to be included in the IDF cash payments. In the case of forensic mental health services, any agreements should take into account current top sliced funding arrangements.

7.12 Travel, accommodation and inter-hospital transfers

7.12.1 No IDFs are required in relation to travel and accommodation as the DoD pays directly through Sector Operations. If there is a DHB-held contract for inter-hospital transfers (either road or air), the DoD will pay.

7.12.2 In relation to inter-hospital transfers, the DoD pays. Local arrangements may vary as to how this is given effect (eg, IDFs, invoicing).

7.13 Management of exceptional situations

7.13.1 The following set of guidelines applies to elective/acute/arranged services IDFs when a person who is seeking IDF services does not fall within the criteria set out in Sections 7.4–7.12.[30]

7.13.2 In the interests of continuity of care, the Ministry's minimum expectation (based on sector custom and practice) is that, where capacity exists, a DoS will provide services in the following exceptional circumstances.

a. There are compelling social reasons to refer the person to the DoS; for example, the eligible person's immediate family, who have agreed to provide support, live in the area of the proposed treatment DHB.

b. There are compelling reasons (eg, major incident, industrial strike, key surgeon/physician unavailable, major equipment failure, full capacity) why the DoD cannot provide the required service at that time.

c. The patient has previously received related treatment for the same condition from a particular DoS (either at the DoS's facilities, or by one of the DoS's clinicians) and elects to travel to that DoS to maintain continuity of care.

7.14 Payments and 'wash-ups'

Payments

7.14.1 The Ministry will pay each DoD annual appropriations for its population according to 'Schedule B: Funding and payments' in each DHB's CFA. The Ministry will not provide any additional funding for IDFs.

7.14.2 As DHBs are funded for their resident population, funding for IDFs is included in DHBs' appropriations, and DHBs are required to reimburse each other for IDFs from their appropriations. Systems are in place to ensure that this can occur. Sector Operations manages payments on behalf of DHBs.

7.14.3 The Capital and Operating Team will set up payment for IDFs on a 1/12 per month basis. These are payable in advance on the fifth day of every month. If the fifth day is a non-working day, the payment will be made on the first working day prior. Sector Operations will make the IDF transfers.

7.14.4 The Capital and Operating Team will change IDF payments based on written agreement of the DHBs involved. Reasonable notice of changes is required.

7.14.5 The final wash-up payments are usually made in October. A year-end estimate is supplied by the end of July for accounting purposes.

Wash-ups

7.14.6 When 'wash-ups' against actual volumes are necessary, they will be carried out as follows, unless agreed otherwise by the DoD and DoS.

7.14.7 Sector Operations will provide a download of National Minimum Data Set data[31] for the applicable 'wash-up' period four weeks following the end of the relevant period for all inpatient-

[30] There will be some other custom and practice situations, involving procedures being undertaken by a DoS, that are in IDF volume allocations.

[31] NMDS data will be based on the filters advised annually by the Ministry to the IDF National Coordinating Groups.

related wash-ups. For PCT wash-ups, claim data from Sector Operations will be used. For PHO wash-ups, the quarterly PHO registers will be used. For wash-ups on selected NNPAC purchase units, data will be provided by Sector Operations in the form of a download from NNPAC.

7.14.8 The DoD and DoS will have two weeks to review the data and make comments to the Ministry on the validity of the data. If it is established that a DHB submitted data on time, but that systemic failure meant data was excluded, damaged or duplicated, the Ministry will rectify the situation and advise the affected DHBs of the additional IDF implications. Data that has been submitted late and systemic failures that are discovered outside of the two-week timeframe are excluded.

7.14.9 Volumes will be netted off at an aggregate level. The DoD is required to make a payment to the DoS for any over-delivery at an aggregate level. The DoS is required to make a payment to the DoD for any under-delivery at an aggregate level once the wash-up process has been completed.

7.15 IDF supplementary payments

7.15.1 In extraordinary circumstances DHBs may apply for approval to request an IDF Supplementary Payment from other DHBs where they believe that reimbursement at national prices does not cover the cost of providing treatment; for example, where the full cost of a new treatment is not included in current national pricing methodology. The following process is required for IDF Supplementary Payments to be approved.

a. The treatment should have first been reviewed and approved by the appropriate regional clinical practice committee.

b. The treatment should not be eligible for any other additional source of funding (eg, research, high-cost treatment).

c. All IDF Supplementary Payment request forms must be sent with approval from the DoS's General Manager Planning and Funding to the DHB's respective Regional IDF Coordinator and copied to the National General Manager's Planning and Funding Group.

d. Regional IDF Coordinators will forward completed requests to the National Cost Collection and Pricing Technical Reference Group to validate that the supplied costs are reasonable and that the cost to revenue variance exceeds the expected variation in event costing.

e. For IDF Supplementary Payment requests that are validated, the National Cost Collection and Pricing Technical Reference Group will collaboratively develop a marginal premium that can be used as the IDF Supplementary Payment by all DHBs.

f. Payment for events that incur an IDF Supplementary Payment will be included in the national personal health case-weighted wash-up. The DoS for the event will be responsible for submitting the event data to their respective IDF Regional Coordinator for inclusion in the applicable national wash-up.

7.15.2 For a new treatment, if no comparable treatment is offered by another DHB, access to the treatment must be provided based on the guidelines set out in section 7.5.1.

7.15.3 An exception to 7.15.1(7.15.1a) is where the treatment may be offered as part of an official pilot. In these cases, access criteria should be defined prior to commencement of the pilot.

7.15.4 A national register will be kept of treatments eligible for IDF Supplementary Payments to prevent duplication, give visibility of requests and approval status, and enable end dating when incorporated into national processes. Treatments approved for IDF Supplementary Payments will remain valid until they have been recognised and absorbed by the national costing, case-weight and pricing process.

7.15.5 The IDF NCG will determine an appropriate start date for payments for each successful application. For payment with major financial implications this is likely to be the start of the following financial year. IDF Supplementary Payments will not be applied retrospectively to events that began prior to the date of the request being made.

7.15.6 Where a request for an IDF Supplementary Payment is declined, standard IDF payment rules will apply.

7.16 Privacy of patient information

7.16.1 When the DoD and DoS need to share and/or compare information about a patient who has received services provided by the DoS for the purposes of administering these IDF rules, they will do so in a way that is compliant with the Privacy Act 1993 and the Health Information Privacy Code 1994 (HIPC).

7.16.2 To this end, any disclosure by one DHB to another DHB of provider arm information about any identifiable individual will be limited to the following data elements:

a. National Health Index number

b. high-level location information that confirms the DoD, but does not contain a person's full residential address

c. case-weighted information that confirms the fact of service provision and the type of service provided.

7.16.3 The name of the patient should not be disclosed unless:

a. disclosure of the patient's name is necessary in order to confirm either the fact that IDF services were provided, or the type of services that were provided

b. the patient has consented to having their name or other identifying information disclosed for such purposes.

7.16.4 DHBs should be aware of their obligations under rule 3 of the HIPC, ensuring that individuals are aware of the purpose for which identifying information is being collected and of the intended recipients of that information. Existing HIPC 3 statements should be reviewed for compliance and, if necessary, amended to state that patient information may be disclosed to a patient's 'home' DHB for the purposes of auditing the provision of out-of-district services.

7.17 Explanation of terms used in this chapter

Acute service	An unplanned admission on the day of presentation at the health care facility.
Arranged service	An admission when the admission date is less than seven days after a specialist's decision that the admission was necessary.
Case Weighted services	All medical, surgical and neonatal intensive care unit services that are funded using Weighted Inlier Equivalent Separation (WIES).
DoD	DHB of domicile, that is, the DHB that is responsible for funding services for its resident population.
DoS	DHB of service, that is, the DHB that is responsible for providing health services for residents of another DHB.
Diagnostic Related Group	(Australian) Diagnostic Related Groups, current version
Elective services	Services covered by the data clarification WN (booking list), as defined by the Sector Operations data definitions.
IDF Supplementary Payment	Reimbursement for an agreed premium over and above the national IDF reference price.
Medical services	Services with an 'M' service health specialty code in the volume schedules.
National IDF reference price	The price for IDFs as advised by the Ministry on an annual basis; it cannot be varied without authorisation by the Ministry.
Revenue/volume schedule	For the purposes of these rules, the schedule of agreed IDF volumes in the Annual Plan that will be provided by a DoS on behalf of a DoD or a number of DoDs. Volumes will be identified in the volume schedules at a purchase/service unit level in Annual Plans in the following way: • volumes to be provided for a DHB's local population • volumes to be provided by the DHB provider arm on behalf of all other DHBs.
Service change	A shift of all or part of a service from one DHB to another.
Surgical services	Services with an 'S' service health specialty code in the revenue/volume schedules.

Top-sliced	The revenue the Ministry will remove from the overall population-based funding pool before the remainder is allocated to the DHBs for their populations' services.
Wash-up	The payment adjustment mechanism as between two DHBs, used to recognise the difference between the agreed or default capped volumes for services to be provided by the DHB and the actual volumes delivered by that DHB.

8 Dispute resolution

8.1 Purpose of the chapter

8.1.1 The NZPHD Act includes provisions to ensure the resolution of disputes over contents of plans (as described by section 38 and 39 of the NZPHD Act) between DHBs and/or other publicly owned health and disability organisations.

8.1.2 This chapter includes information on*:*

a. the legislative provisions for resolving disputes in the health and disability sector

b. details of the national dispute resolution process

c. expectations of DHBs who are engaged in dispute resolution processes.

Summary of mandatory requirements

Each DHB must:

- follow legislative provisions for resolving planning disputes (**Section 8.2**)
- follow the national dispute resolution process (**Section 8.3**)
- include the information required when notifying the Minister or the Director-General of Health of the planning dispute (**Section 8.7**)
- act in good faith, ensure continuity of services and abide by the public sector code of conduct when engaged in disputes (**Section 8.8**).

8.2 Legislative provisions for resolving planning disputes

8.2.1 Section 39 of the NZPHD Act governs disputes over contents of plans.

8.2.2 After the Minister directs one or more DHBs to prepare or contribute to a plan under section 38, the Minister may act if:

a. two or more DHBs that are parties to the plan cannot agree on its contents, or

b. one or more DHBs that are parties to the plan and the Minister cannot agree on its contents.

8.2.3 The Minister may establish an advisory body and refer the dispute to it for its consideration and advice. The advisory body must consist of at least three members, each appointed by the Minister on any terms and conditions (including terms and conditions as to the remuneration and travelling allowances and expenses) that the Minister determine by written notice to the member.

8.2.4 The Minister must:

a. make a decision on the dispute by taking into account the advice given by the advisory body

b. as soon as practicable after making the decision, publish the decision in general terms on an internet site operated by the Ministry.

8.2.5 A DHB that is a party to the dispute must give effect to the Minister's decision.

8.2.6 The Governor-General may by Order in Council make regulations prescribing rules by which disputes or differences between any one or more publicly owned health and disability organisations or providers of services or other persons may be mediated or arbitrated (see s 92(2) of the NZPHD Act).

8.3 The national dispute resolution process

Acceptance criteria

8.3.1 Disputes must meet the following acceptance criteria to be accepted for a decision by the Minister.

a. The dispute must involve DHBs or other publicly-owned organisations.

b. Parties to a dispute are required to exhaust all avenues to achieve resolution before submission to the national process. The dispute must not be trivial, vexatious or an abuse of procedure.

c. The dispute must not prejudice any other processes that are under way (including arbitration initiated under the Arbitration Act 1996).

8.4 Mediation stages and deadlines

Mediation may be initiated by parties to the dispute or by the Minister (subject to meeting acceptance criteria). Where the dispute is initiated by either of the parties, the Minister must be notified of the dispute (see Section 8.7 below).	Day 0
If parties cannot agree on a mediator within 10 days, the President of the Arbitrators' and Mediators' Institute of New Zealand will nominate a mediator.	Day 10
Mediation between the parties must be completed within 30 days. (Parties are to notify the Minister of the result.) Where agreement is not reached within this timeframe, the process will move automatically to arbitration. In some cases it is appropriate to move straight to arbitration.	Day 30

8.5 Arbitration stages and deadlines

Notice to parties of the dispute moving to arbitration. At a minimum, notification will outline: • the expected process and timeframe for advisory body advice • the advisory body members who will advise on the case • any information requirements from the parties including the need to meet with the advisory body • any experts to be called and other evidence to be sought.	Within 10 days
Advisory body advice to the Minister . Advisory body advice is to be published on the Ministry's website. Advisory body advice will include: • a description of the process advisory body has been followed • a description of the information provided to the advisory body and the analysis undertaken by the advisory body • the advisory body's advice and the reasons for that advice • the advisory body's recommendations as to the action, if any, that should be taken by the relevant adjudicator (Minister or the Director-General).	As agreed
Decision of the adjudicator (Minister or the Director-General) is to be published along with required actions of parties.	Within 10 days following panel advice

8.6 Submitting notification of a dispute

8.6.1 By submitting a notification of dispute to the Ministry, the party confirms consent to the resolution of the issue by an advisory body and a decision by the Director-General of Health or the Minister. Parties are encouraged to raise all disputes within a reasonable timeframe so that the advisory body can contemporaneously investigate the matter and the Director-General or Minister can

make a timely decision. The Ministry's Service Commissioning business unit will send a version of this notice to the parties named in the dispute.

8.6.2 In the first instance the DHB Regional Relationship Managers should be contacted.

8.7 Information requirements

8.7.1 When notifying the Minister or the Director-General of Health of its dispute, the submitter must include the following information.

a. The name of the organisation.

b. Contact details:
   - full name and business address
   - work telephone and/or mobile phone
   - email address

c. A brief summary of the dispute including:
   - background
   - parties affected
   - services concerned
   - key dates (chronology of events)
   - names of any other relevant people or organisations outside of the disputing organisations
   - key points of the dispute
   - attempted resolution to date
   - remedy sought
   - contact details of the disputing parties
   - description of any time-critical issues relating to the dispute (eg, requirement to finalise plans)
   - summary of any supporting documentation submitted.

8.8 Expectations of DHBs and other publicly owned health and disability organisations engaged in disputes

8.8.1 While engaged in disputes, DHBs must:

a. act in good faith

b. ensure continuity of services to patients

c. align their actions with the State Services Commissioner's (2007) *Standards of Integrity and Conduct*.

9 Quality

9.1 Purpose of the chapter

9.1.1 This chapter sets out the existing requirements that DHBs are to follow when developing provider quality specifications. In addition, it describes other quality standards that DHBs must adhere to both in developing the provider quality specifications and in related processes.

Summary of mandatory requirements

Each DHB must:

- comply with the provider quality specifications set out in this chapter **(Section 9.2)**
- encourage an organisation-wide commitment to quality improvement as well as quality improvement across the wider sector **(Section 9.4)**
- ensure that providers have a written, implemented quality plan designed to improve outcomes for consumers and that they review it at least every three years **(Section 9.6)**
- survey patients' experience of the care they received and participate in a national review process facilitated by the Health Quality & Safety Commission **(Section 9.8)**
- safeguard consumers, staff and visitors from infection as far as is reasonably practicable **(Section 9.9)**
- implement quality processes that demonstrate the effectiveness of their services **(Section 9.10)**
- support the national mortality review committees **(Section 9.11)**
- have a process that enables consumers, their families and whānau and other people to make complaints **(Section 9.12)**
- ensure effectiveness of services (**Section 9.13)**
- safeguard consumers, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment, or neglect, as far as is reasonably practicable **(Section 9.15)**
- provide services from safe, well-designed, well-equipped, hygienic and well-maintained premises, so far as is reasonably practicable **(Section 9.16)**
- comply with legislative requirements following the death of a consumer **(Section 9.17)**.

9.2 Provider quality specifications

9.2.1 Agreements processed by Sector Operations on behalf of the Ministry of Health include Standard Terms and Conditions and Provider Quality Specifications (PQS). Variations to these templates may be captured in the Provider Specific Terms and Conditions sections of an agreement. The contracts/agreements applicable to each provider and all relevant legislation must be consulted to determine the full rights and liabilities applicable to any service provider or funder.

9.2.2 Each DHB will ensure that:

a. the requirements of the PQS are met for services delivered by the DHB, as well as services subcontracted by the DHB

b. employees and subcontractors are aware of the DHB's and their own responsibilities for implementing the requirements of the PQS as they relate to services provided.

9.3 Service Standards

9.3.1 Providers must comply with the Health and Disability Services (Safety) Act 2001. This Act requires all hospitals, aged residential care facilities (rest homes), disability residential care facilities and fertility providers to be audited by a designated audit agency and to be certified by the Director-General of Health. Hospitals, rest homes, and some providers of disability

residential care need to meet the Health and Disability Services Standards 2008. Providers of fertility services are required to meet the Fertility Services Standards 2007. The Standards can be viewed on and downloaded from the Ministry of Health's website.

9.3.2 Air and road ambulance service providers for patient transfer services, including inter-hospital transfers, are to be members of Ambulance New Zealand and are required to be certified as compliant with the Standards New Zealand Ambulance and Paramedical Services Standard (NZS 8156). In addition, air providers are required to meet the Ambulance New Zealand Air Ambulance/Air Search and Rescue Service Standard (AA/ASAR Std) and NZ Transport Passenger Licence rules and standards.

9.3.3 All aged residential care facilities (rest homes) are certified and audited to ensure they meet the standards set out under the Health and Disability Services (Safety) Act. Full audit reports for rest homes are available on the Ministry's website. DHBs may wish to provide a reference to this site on their own DHB website. The full audit reports and audit summaries include:

- an overview of the rest home's performance at the last audit
- a table showing how well the rest home does against the six outcome areas in the Health and Disability Services Standards (NZS8134:2008).

As rest homes are audited, any issues from their latest audit (the corrective actions required by the auditor) will appear on the rest home's page. As the rest home completes the required actions the status on the website will update.

9.4 Quality improvement

9.4.1 Each provider is expected to continue to encourage an organisation-wide commitment to quality improvement and quality assurance initiatives, and to develop an environment that fosters a quality improvement ethic and quality improvement practices. In addition, DHBs must encourage quality improvement across the wider sector through ensuring that other funded providers demonstrate a commitment to, and implement, quality standards appropriate to the size and scope of their organisation.

9.5 Improving the quality of services

(See Health and Disability Services (Core) Standards 2.3.)

9.5.1 Each provider is required to develop, document, implement and evaluate a transparent system for managing and improving the quality of services to achieve the best outcomes for consumers.

9.5.2 DHBs are required to implement and comply with the New Zealand Health and Disability Services National Reportable Events Policy 2012. The National Reportable Events Policy is currently being reviewed and will be updated in April 2017.

9.5.3 *Improving Quality (IQ): A systems approach for the New Zealand health and disability sector* and the associated *IQ Action Plan: Supporting the improving quality approach* were released in September 2003 (Minister of Health 2003a, 2003b). They represent a strategic approach to quality improvement that includes the identification of 11 goals to support the commitment to continuous quality improvement.

9.5.4 The Health Quality & Safety Commission (HQSC) leads and coordinates the health quality and safety agenda in New Zealand. It is committed to working across the health and disability sector, with an initial focus on DHBs.

In promoting the Triple Aim, the HQSC has three high-level goals:

- improved quality, safety and experience of care
- improved health and equity for all populations
- best value from public health system resources.

9.5.5 The HQSC's Statement of Intent (SOI) outlines its work programme until 2018 and DHBs are expected to participate in that programme. All DHBs are expected to produce quality accounts that are locally owned with a strong focus on local quality improvement priorities, according to guidance provided by the HQSC. The enablers to achieve sustained quality improvement initiatives will be for the HQSC and DHBs to focus on:

- building capacity, capability and clinical leadership
- measurement and evaluation to monitor progress and patient outcomes
- consumer engagement and partnership.

9.5.6 The HQSC is committed to working with the sector to ensure its prioritised quality improvement programmes can be translated into action. This may be achieved through regional collaborations with DHBs.

9.5.7 The HQSC has developed Quality & Safety Markers (QSMs) which include both process markers and outcome measures to monitor the progress of its priority programmes. DHBs are expected to collect data to support the QSMs and the HQSC will engage with DHBs in developing, implementing and reporting back on the QSMs.

9.6 Provider quality plans

9.6.1 Each provider must have a written, implemented quality plan designed to improve outcomes for consumers and must review it at least every three years. The quality plan will cover all services funded and delivered by the provider and link to national priorities identified by the Ministry and/or HQSC. It will be kept in a format that is available to the Ministry, the HQSC and the general public on request. The quality plan will outline a clear quality strategy and identify the organisational arrangements to implement it. The size and scope of the quality plan are to be appropriate to the size of a provider's organisation and services. As a minimum, the quality plan should include:

a. an explicit quality philosophy

b. clear quality objectives

c. key features of the quality improvement and risk management systems

d. effective systems for monitoring and quality audit compliance

e. designated organisational and staff responsibilities

f. designated plans and processes for working in partnership with consumers to drive service improvement and the development of the quality plan

g. processes for working in partnership with consumers

h. processes for improving ethnicity data collection

i. processes for the development and implementation of culturally effective services.

9.7 Consumer rights

(See Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights and Health and Disability Services (Core) Standards, 1.1 Consumer Rights.)

9.7.1 Each provider will comply with all aspects of the Code of Health and Disability Services Consumers' Rights in the Health and Disability Commissioner Act 1994. DHBs will:

a. ensure that each consumer receives services in a manner that complies with the Code

b. make the Code known and available to consumers, family, whānau and other visitors to the service(s)

c. ensure staff are familiar with and observe their obligations under the Code

d. undertake and report the results of a mental health patient survey.

9.7.2 All providers will inform consumers, in a manner appropriate to their communication needs, of their right to have an advocate, including supporting the resolution of any complaint. Providers

will allow advocates reasonable access to facilities, consumers, employees and information, to enable them to carry out their roles as an advocate. DHBs will know of, and facilitate access to, a Māori advocate for consumers who require this service.

9.8 Capturing consumer experience

9.8.1 All DHBs will work in partnership with consumers to implement a system for capturing consumer experience appropriate to the size and scope of the DHB and its population and services to achieve changes and improvements in services. DHBs will demonstrate internal and external accountability for their system for capturing consumer experience through reporting to the public and clinical community that includes reporting on the achieved changes and improvements resulting from this activity. This activity will also be reported in the DHB annual Quality Accounts. DHBs are required to participate in activities led by the Ministry of Health and the HQSC to measure consumer experience nationally.

9.8.2 DHBs are required to survey patients' experience of the care they received. They must also participate in a national review process facilitated by the HQSC to assess mechanisms designed to collect information about patient experience and to make recommendations for future data collection strategies.

9.8.3 All DHBs are required to consider local findings of patient experience surveys and design strategies to address and improve lower scoring areas.

9.8.4 All DHBs will have a mechanism to enable patients' voices at the governance level. This includes developing and supporting a representative consumer council. This patient voice mechanism will also contribute to demonstrating internal and external accountability for capturing consumer experience, and reporting on achieved changes and improvements resulting from this activity.

9.9 Infection control

(See Health and Disability Services (Infection Prevention and Control) Standards 3.1–3.6.)

9.9.1 Each provider will safeguard consumers, staff and visitors from infection as far as is reasonably practicable.

9.9.2 Providers will have environmental and hygiene management/infection control policies and procedures that minimise the likelihood of adverse health outcomes arising from infection for consumers, staff and visitors. These will meet any relevant profession-specific requirements and the requirements of the standard Universal Precautions Guidelines. They will include definitions and will clearly outline the responsibilities of all employees, including immediate action, reporting, monitoring, corrective action and staff training to meet these responsibilities.

9.9.3 All DHBs will also participate in Hand Hygiene New Zealand's national programme and the surgical site infection improvement (SSII) programme, and will submit the required data for the HQSC's related QSM for all sections including the CLAB (central line associated bacteraemia) insertion bundle.

9.10 Clinical effectiveness

(See Health and Disability Services (Core) Standards 2.3.)

9.10.1 Clinically effective health care is a building block of high-quality health care. It requires the application of the best available knowledge, derived from research, clinical expertise, cultural competence and patient preferences, to achieve optimum processes and outcomes of care for patients. Each provider is expected to implement quality processes that demonstrate the effectiveness of its services.

9.10.2 Each DHB:

a. will have in place clinical audit and peer review processes that incorporate input from consumers and relevant health professionals from all services

b. is expected to participate in the development of clinical performance indicators and information collection processes

c. is required to build capacity in research and evaluation of services, as well as developing decision processes that act systematically on conclusions.

9.10.3 Each DHB must have mechanisms in place to reduce mortality and morbidity, including:

a. formal morbidity and mortality review meetings

b. best practice guidelines and clinical pathways

c. clinical indicator monitoring processes

d. reporting and investigation of serious adverse events

e. clinical audits.

9.11 Mortality review

9.11.1 The HQSC has statutory responsibility for the functions of national mortality review. This responsibility is currently enacted through four national mortality review committees that investigate mortality, morbidity, causal pathways and interventions, and advise on reducing mortality and morbidity nationally.

9.11.2 The Child and Youth Mortality Review Committee and the Perinatal and Maternal Mortality Review Committee have developed review processes that are supported by DHBs. These processes provide a good base for undertaking systematic mortality review, and each DHB is expected to contribute to the national processes. The Perioperative Mortality Review Committee is developing review processes for deaths associated with operative procedures and DHBs will be expected to support these processes, once established.

9.11.3 Each DHB must ensure that requests made by any national mortality review committee under the section 59E and Schedule 5 to the NZPHD Act are responded to appropriately, and that requests for advice from experts within the DHB are supported.

9.11.4 Systems of local mortality review within DHBs should contribute to DHB quality improvement, while also contributing to national mortality review systems as appropriate and when requested.

9.11.5 DHBs should consider advice from national mortality review committees highlighted by the HQSC and ensure it is implemented where appropriate.

9.12 Complaints procedures

(See Health and Disability System Services (Core) Standards 1.13.)

9.12.1 Each provider will have a process that enables consumers, their families and whānau and other people to make complaints.

9.12.2 Providers' complaints procedures will be in accordance with Part 4 of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights.

9.12.3 For requirements regarding the acceptability of services, see Section 3.12.

9.13 Effectiveness of services

(See Health and Disability Services (Core) Standards 3.1–3.13.)

9.13.1 Each provider will:

a. manage consumer entry to its services in a timely, equitable and efficient manner to meet assessed needs

b. develop and maintain for each consumer a written, up-to-date care or service plan and/or record of treatment

c. deliver services that meet each consumer's individual assessed needs, reflect current good practice and are coordinated to minimise potentially harmful breaks in provision

d. ensure services are provided by suitably qualified, skilled and experienced staff in a timely manner according to the individual's assessed needs.

9.14 Service delivery

9.14.1 Providers will develop a plan for each consumer that:

a. is based on an assessment of individual needs, including cultural needs

b. includes consultation with the consumer and, where appropriate and with the consent of the consumer, includes consultation with the consumer's family, whānau and/or caregivers

c. contains detail appropriate to the impact of the service on the consumer

d. facilitates the achievement of appropriate outcomes as defined with the consumer

e. includes plans for discharge/transfer

f. provides for referral to and coordination with other medical services, and links with communities, iwi, Māori and other services as necessary.

Planning discharge from the service or transfer between services

9.14.2 DHBs will collaborate with other service providers to ensure consumers have access to all necessary services. When a consumer is transferred or discharged from a DHB's services and accesses other appropriate services, they will do so without avoidable delay or interruption.

9.14.3 Providers will have policies and procedures for planning discharge, exit and transfer from their services. These will facilitate appropriate outcomes as defined with the consumer. These policies and procedures will include:

a. defined employees' responsibilities for discharge planning

b. incorporating discharge planning into the consumer's care/service plan, where appropriate, from or before admission

c. full involvement of consumers in planning their discharge

d. involvement of family and whānau, including advising them of discharge, as appropriate

e. assessment and management of any risks associated with the discharge

f. informing consumers about their condition, its possible future course, any risks, emergency contacts and how to access future treatment, care or support services

g. where appropriate, involving the original referrer and the health professional having ongoing responsibility for the consumer in planning discharge and informing them of confirmed discharge arrangements

h. a process for monitoring that discharge planning takes place and includes assessment of the effectiveness of the discharge planning programme.

9.14.4 Each provider will have policies and procedures to manage the immediate safety of consumers who are declined entry to services and, where necessary, the safety of their immediate family and whānau and the wider community. These policies and procedures include:

a. applying agreed criteria for providing services

b. ensuring all reasonable diagnostic steps have been taken to identify serious problems requiring a service

c. advising the consumer and/or their family and whānau of appropriate alternative services

d. where appropriate, advising the family and whānau or other current services that the DHB has declined service

e. recording that entry has been declined, giving reasons and other relevant information

f. having in place processes for providing this information to the Ministry, where it is requested.

Inter-DHB referrals

9.14.5 Effective information transfer between primary, secondary and tertiary providers will occur when the provider communicates with the patient's GP and the referrer (where the referrer is not the GP) by:

a. acknowledging receipt of the referral

b. advising on the outcome of the first assessment when completed.

9.14.6 Where a hospital-based clinician refers to another secondary or tertiary provider, the:

a. patient's GP contact information will be included to enable communication with the patient's GP (as above)

b. DHB will have a system in place to ensure that the referral sent has been received

c. DHB will have a system in place to ensure that each stage of the appointment process has been completed.

Risk management

(See Health and Disability Services (Core) Standards 2.3 and 2.4, Health and Safety in Employment Act 1992.)

9.14.7 Each provider is required to continue to maintain systems to manage financial and non-financial risks effectively. Each DHB is required to comply with public sector risk management standards as set out in *AS/NZS ISO 31000:2009, Risk management - Principles and guidelines.* This document can be purchased from Standards New Zealand via its website (www.standards.co.nz).

9.14.8 Each provider must:

a. establish and maintain a risk management system that protects consumers, visitors and staff from exposure to avoidable/preventable risk and harm

b. ensure, so far as is reasonably practicable, that equipment used is safe and maintained to comply with safety and use standards

c. safeguard consumers, employees and visitors from intrusion and associated risks, as far as is reasonably practicable, and ensure that buildings, equipment and medicines are secure

d. have written, implemented and reviewed policies and practices relating to security

e. have systems for recording, managing and investigating reportable events (incidents, adverse, unplanned or untoward events) and accidents

f. adopt, implement and comply with the national reportable events policy.

9.14.9 Each provider will have policies, processes and procedures for:

a. identifying key risks, including risks to health and safety

b. evaluating and prioritising those risks based on their severity, the effectiveness of any controls the provider has, and the probability of occurrence

c. minimising, isolating and, where reasonably practicable, reducing the risks

d. minimising the adverse impact of internal emergencies and external or environmental disasters on the provider's consumers, staff and visitors

e. working with the organisations that have responsibility for coordinating internal and external disaster services, health emergencies and disaster response services

f. accident and hazard management that safeguards consumers, staff and visitors from avoidable incidents, accidents and hazards.

9.14.10 Each provider must have policies, processes and procedures that will include definitions of incidents and accidents. It should also clearly outline the responsibilities of all employees, including in relation to:

a. taking immediate action

b. reporting, monitoring and undertaking corrective action to minimise incidents, adverse events, accidents and hazards, and to improve safety

c. debriefing and staff support as necessary.

9.15 Prevention of abuse and neglect

(See Health and Disability Services (Core) Standards 1.3.7.)

9.15.1 Each provider must safeguard consumers, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment, or neglect.

9.15.2 Each provider will have policies and procedures on preventing, detecting and removing abuse and/or neglect. These policies will include definitions of abuse and neglect, and clearly outline the responsibilities of all staff who suspect actual or potential abuse, including immediate action, reporting, monitoring and corrective action. These procedures will include reference to the complaints procedure. DHBs will ensure that relevant employees are able to participate in family, inter-agency or court proceedings to address specific cases of abuse and neglect.

9.15.3 For information on the registration and continuing education of DHB employees, see Section 10.4.

9.16 Facilities

(See Health and Disability Services (Core) Standards 4.1–4.8.)

9.16.1 Each provider must provide services from safe, well-designed, well-equipped, hygienic and well-maintained premises, so far as is reasonably practicable.

9.16.2 Each provider's facilities and equipment are to meet regulatory quality standards or have an agreed plan to secure compliance. Providers must have quality control and maintenance programmes suitable for the quantity, range and complexity of equipment.

9.16.3 Each provider is to support consumers in accessing its services, so far as is reasonably practicable, by the physical design of its facilities. DHBs will make specific provision for consumers with a mobility, sensory or communication disability available and make the provision known to consumers. DHBs will make services available to deaf people by providing interpreters and devices to assist communication.

9.17 Death

(See Health and Disability Services (Core) Standards 2.4.)

9.17.1 Subject to the Coroners Act 2006 and the Births, Deaths, Marriages, and Relationships Registration Act 1995, each DHB is to comply with legislative requirements following the death of a consumer. (Note the new requirements in section 13(1)(d) of the Coroners Act 2006 apply to 'any death that occurred while the woman concerned was giving birth, or that appears to have been a result of that woman being pregnant or giving birth'.)

9.17.2 Providers must have policies and procedures to follow in the event of a death, including in relation to:

a. immediate action

b. appropriate and culturally sensitive procedures for the notification of next of kin

c. any necessary certification and documentation

d. appropriate and culturally competent arrangements, particularly to meet the special needs of Māori, to be taken into account in the care of the deceased, until responsibility is accepted by the family or a duly authorised person.

10 Workforce

10.1 Purpose of the chapter

10.1.1 This chapter is to ensure that DHBs are fully engaged with workforce development and planning. Full engagement will assist with recruitment and retention of workers.

Summary of mandatory requirements

Each DHB must:

- comply with section 22 of the NZPHD Act and section 118 of the CE Act to be a good employer **(Section 10.2)**
- ensure employees have access to professional registration and continued education **(Section 10.3)**
- work regionally to address local and regional workforce needs **(Section 10.4)**
- comply with section 17 of the Vulnerable Children Act and adopt a child protection policy, ensuring: compliance with reporting requirements, availability and review of the policy, and that in every contract or funding arrangement the DHB enters into with an independent person, concerning the provision of children's service, that person adopts a child protection policy **(Section 10.6)**
- comply with the requirements for workers' safety checks and compliance with all aspects and reporting requirements of the children's worker safety checking contained in the Vulnerable Children Act **(Section 10.6)**
- comply with the requirements specified in the Vulnerable Children (Requirements for Safety Checks of Children's Workers) Regulations 2015 for how the worker safety check required under sections 25, 26 or 27 of the Vulnerable Children Act must be done
- operate collaboratively on matters concerning employment industrial relations and management of bargaining **(Section 10.7)**
- participate in implementing the agreed recommendations of the national response plan, and ensure processes that meet pay and employment equity requirements are established and ongoing **(Section 10.8)**
- establish and publish internal procedures as required in the Protected Disclosures Act 2000 **(Section 10.9)**.
- manage the funding responsibility relating to regularisation of the workforce for home and community support services expected to be from 1 July 2018 across all relevant contracts **(Section 10.10)**
- comply with the Care and Support Workers (Pay Equity) Settlement Act 2017 **(Section 10.11)**

Safe and competent workforce

10.1.2 The Vulnerable Children Act 2014, contains some workforce legislative requirements relating to children's worker safety checks. The Vulnerable Children (Requirements for Safety Checks of Children's Workers) Regulations 2015 set out how the worker safety check required under the Vulnerable Children Act must be done. These requirements must be part of the process of recruiting workers.

10.1.3 Strengthening the workforce should be a high priority for DHBs. Workforce accounts for nearly 70 percent of total public health expenditure. This chapter aims to ensure there is a sufficient and sustainable supply of skilled workers to deliver high-quality health services in a timely manner. Workforce shortages threaten the sustainability of some services and addressing these shortages requires increased flexibility in the way health professionals work. Improved responsiveness to rising demand for services and changing health system priorities should always include a component of workforce planning and development. Innovation will also contribute to addressing workforce needs.

10.1.4 The Ministry administers the Health Practitioners Competence Assurance Act 2003 which provides a framework for the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession. Under the requirements of that Act, DHBs have a role in supporting their employees to maintain competence.

Employment relations

10.1.5 The employment relations sections of this chapter set out the various organisational requirements of DHBs relating to employment responsibilities including bargaining. Each DHB must comply with section 22 of the NZPHD Act and section 118 of the CE Act to be a good employer; operate collaboratively on matters concerning employment industrial relations and management of bargaining; and ensure that processes that meet pay and employment equity requirements are established and ongoing.

10.1.6 The Ministry's Employment Relations team monitors the development of bargaining strategies for DHBs and other Crown entities. It also ensures compliance with the consultation and good employer requirements of the NZPHD Act and the establishment and maintenance of employment equity requirements. Advice is developed on all issues relating to employment relations, including how decisions on employment relations will impact on the ability of the sector to implement the Government's health and disability strategies.

10.2 DHBs as good employers

(See s 22(1)(k) of the NZPHD Act and s 118 of the CE Act.)

10.2.1 Each DHB is required to be a good employer as indicated by section 22(1)(k) NZPHD Act, and as defined under section 6(1) of the NZPHD Act and under section 118(2) of the CE Act.

10.2.2 Each DHB is to include a good employer statement in its Statement of Intent and its annual report.

10.2.3 DHBs are required to operate human resource policies that comply with being a good employer. They must also maintain overarching policy for employment and workplace relations based on demonstrating good faith, natural justice, human rights, good employer practice and meeting all statutory requirements in accordance with section 118 of the CE Act and section 22(1)(k) of the NZPHD Act. Such policies should include an equal employment opportunities programme.

10.3 Registration and continuing education of DHB employees

(See Health and Disability Services Standards 2.6, 2.7 and 1.1, and Health Practitioner's Competence Assurance (HPCA) Act 2003.)

10.3.1 Each DHB is required to implement systems to maintain competency of all clinical staff and credential senior medical officers. It is also required to have nursing practice standards in all areas where nurses work.

10.3.2 It is expected that employees will have access to continuing education to support them in maintaining professional registration and enhancing their service delivery/clinical practice, and to ensure that practices are safe and reflect knowledge of recent developments in service delivery. DHB employment policies and practices are to support professional career pathway development for Māori health workers, Māori service advisory positions, Māori change management positions, and the recruitment and retention of Māori employees at all levels of the organisation to reflect the consumer population.

10.3.3 Assistants, volunteers and other relevant support employees should receive training to enable them to provide services safely and will work only under the supervision and direction of appropriately qualified staff. Trainees are to be identified and will provide services only under the supervision and direction of appropriately qualified staff.

10.3.4 Employees, volunteers, students or subcontractors undertaking or observing service delivery are to identify themselves, including their name and role/position, to all consumers and their family and whānau.

10.4 Health Workforce New Zealand

10.4.1 Health Workforce New Zealand (HWNZ) [32] provides national co-ordination and strategic leadership for a sector-wide response to New Zealand's workforce challenges, underpinned by a mandate to simplify and unify the health workforce development system. HWNZ aims to ensure a fit-for-purpose, high-quality and motivated health workforce, keeping pace with clinical innovations and the growing needs and expectations of service users and the public.

10.4.2 HWNZ recognises the central role DHBs have in ensuring New Zealand has a high-quality workforce to deliver our health services. DHBs' partnership, co-operation and involvement in training are critical to the successful planning and development of the New Zealand health workforce.

10.5 Planning requirements

(See CAB Min (11) 24/5A.)

10.5.1 Each DHB will work with its Regional Workforce Development Director in the Regional Training Hub whose focus is on developing and delivering a workforce strategy as part of the current Regional Service Plan. The workforce strategy will outline regional actions and key milestones. Further advice is contained in the current Regional Service Plan Guidelines in the DHB Planning Package.

10.6 Vulnerable Children Act – safe and competent workforce

(See ss17, 19, 20 and 25–28 of the Vulnerable Children Act.)

- The Vulnerable Children Act sets out various organisational requirements of DHBs relating to obligations to adopt and report on a child protection policy. Section 17 of the Vulnerable Children Act requires DHB Boards to: have a child protection policy report in its Annual Report (under s150 of the CE Act) on whether, or on the extent to which, its operations have implemented its child protection policy
- ensure that a copy of its child protection policy is made available on an internet site maintained by or on behalf of the Board
- ensure that after the commencement of every contract, or funding arrangement, that the Board enters into with an independent person, concerning the provision of children's services the person adopts a child protection policy as soon as practicable
- review its child protection policy within three years.

Children's worker safety checking

(See ss 25–38 of the Vulnerable Children Act and the Vulnerable Children (Requirements for Safety Checks of Children's Workers) Regulations 2015)

The Vulnerable Children Act requires people employed or engaged in work that involves regular or overnight contact with children to be safety checked to reduce the risk of harm to children. Section 27 of the Act requires workers to be reassessed on a three-yearly basis.

The Vulnerable Children (Requirements for Safety Checks of Children's Workers) Regulations specify how the check required under sections 25, 26 or 27 of the Act that must be done.

[32] CAB Min (10) 7/5 confirmed SOC Min (10) 2/2

Section 39 of the Act requires each DHB to provide information to the Director-General of Health, as the Chief Executive of a key agency, regarding the safety checking of children's workers employed or engaged by the DHB.

10.6.1 Every safety check must include:

- confirmation of identity of the person (prescribed by [s5] Regulations)
- consideration of specific information (prescribed by [ss6-7] Regulations) a risk assessment carried out as prescribed by regulations made under s32 that assesses the risk the person would pose to the safety of children if employed or engaged as a children's worker (prescribed by (s8) Regulations).

10.6.2 Recruitment policies must also describe the DHB process for ensuring that no person in the core workforce convicted of one of the specified offences listed in schedule 2 of the Act is employed or remains in the employment of the DHB unless the person holds an exemption under s35 of the Act.

10.6.3 Employment policies must describe the DHB process for ensuring that the suspension and possible termination process prescribed in s28(4-8) of the Act is followed if the organisation believes that a worker whom it employs or engages is a person convicted of one of the specified offences listed in schedule 2 of the Act and does not hold an exemption under s35 of the Act.

10.6.4 An exemption can be granted by the Chief Executive of any key agency in circumstances where the individual applying for the exemption is not considered to pose an undue risk to the safety of children despite the specified conviction. The exemption process is administered by the Ministry of Social Development on behalf of the Chief Executives of the key agencies

10.7 Employment relations and management of bargaining

(See clause 44(2) of Schedule 3 to the NZPHD Act and Schedule 1B to the Employment Relations Act 2000 (Employment Relations Act.)

10.7.1 Each DHB is accountable for its employment relations processes and outcomes. The NZPHD Act requires DHB Chief Executives to consult with the Director-General of Health before finalising collective employment agreements with any or all groups of employees.

10.7.2 DHBs will act collaboratively on employment relations issues. A collaborative approach is particularly important: where the DHBs are considering overall strategy for particular workforce groups; where there is potential for flow-on from one workforce group to others; and during negotiations for regional and national multi-employer collective agreements. DHBs should ensure that effective strategy development and negotiation processes are followed, and that their negotiation teams are adequately resourced.

10.7.3 DHBs will have durable and robust contingency plans in place for dealing with a range of employment relations situations, including staff taking industrial action, and will ensure that these plans can be called on in such an event. During industrial action, contingency planning must include provisions for Life Preserving Services and agreements on Life Preserving Services must be in place, where appropriate, for each notice of industrial action. A clinical adjudicator must be agreed in the Bargaining Process Agreement for each set of negotiations.

10.7.4 To meet their obligation to consult with the Director-General, DHB Chief Executives are expected to provide the Ministry's People and Transformation business unitwith details of their employment relations and specific bargaining strategies, as well as information on progress with negotiations.

10.7.5 DHBs should have regard to the Government's Expectations for Pay and Employment Conditions for the State Sector (May 2012) (the Expectations). The Key Bargaining Messages released by the State Services Commission (May 2014) should be read in conjunction with the Expectations. Bargaining strategies, and subsequent updates, should incorporate the elements of the Expectations, cover effective risk identification, mitigation and management and include full costings and approvals. The Ministry should be kept fully informed so it can provide Ministers with timely advice and information on employment relations activity in the health and disability sector (including potential flow-on effects from bargaining) and assurances that any risks are being appropriately managed.

10.7.6 DHB Chief Executives are expected to fulfil their obligations by:

a. formally consulting with the Ministry during:

- the development and any subsequent review of overarching employment relations strategy
- any review of the DHBs' generic and detailed document on employment relations processes
- the development of negotiation-specific bargaining strategies for all collective and individual employment agreements, including risk management plans, remuneration information, fiscal parameters for bargaining and any process for adjusting pay or conditions prior to the commencement of bargaining

b. regularly sharing free and frank comprehensive information by DHB negotiating teams as bargaining proceeds, including formally consulting the Ministry prior to any substantive change in bargaining strategy and/or fiscal parameters

c. providing the Ministry with details of the final agreed terms and cost of settlement, the signed collective agreement, and an analysis of the impact and rationale for any differences existing between these and the bargaining strategy.

10.7.7 Schedule 1B to the Employment Relations Act provides a Code of Good Faith for Public Health Sector that binds DHBs, the New Zealand Blood Service (NZBS) and other employers to the extent that they provide services to DHBs or the NZBS (in their roles as providers of service), their employers and the relevant unions. DHBs are required to inform third party employers that the Code of Good Faith for Public Health Sector will apply to them, before entering into agreements or arrangements for the provision of services.

10.8 Pay and employment equity

(See CAB Min (05) 42/5 dated, CAB Min (07) 16/2 and CAB Min (09) 5/5A and EGI Min (09) 16/12.)

10.8.1 Following the reviews conducted in the DHBs in 2008, each DHB is required to include pay and employment equity requirements ongoing, internal review processes, such as internal audit plans.

10.8.2 DHBs are required to continue to address and respond to any identified gender inequities as part of good management practice and being a good employer, consistent with pay and employment equity commitments.

10.8.3 DHBs are required to have regard to the Government's Pay and Employment Equity Responsible Contracting Policy when entering into outsourcing contracts for services that DHBs have an operational obligation to ensure are provided.

10.9 Protected disclosures

(See Protected Disclosures Act 2000 [Protected Disclosures Act].)

10.9.1 The Protected Disclosures Act applies to disclosures of protected information by an employee of a DHB if the:

a. information is about serious wrongdoing in or by a DHB

b. employee believes on reasonable grounds that the information is true or likely to be true

c. employee wishes to disclose the information so that the serious wrongdoing can be investigated

d. employee wishes the disclosure to be protected.

10.9.2 The Protected Disclosures Act provides for the identification of the employee where either the:

a. employee consents in writing to the disclosure of the protected information, or

b. person who has acquired knowledge of the protected disclosure reasonably believes that disclosure of identifying information is essential to:

- carrying out an effective investigation of the allegations in the protected disclosure, or
- prevent serious risk to public health or public safety or the environment, or
- having regard to the principles of natural justice.

10.9.3 Each DHB must establish and publish internal procedures for receiving and dealing with information about serious wrongdoing in accordance with the requirements of the Protected Disclosures Act. A DHB must ensure that every employee is aware that it is every employee's responsibility to report suspected wrongdoing in the DHB.

10.10 In-between travel and guaranteed hours

(See Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016)

10.10.1 In 2014, the Ministry, DHBs, unions and providers entered into a Settlement Agreement concerning the funding of travel time and travel costs incurred by non-salaried employees providing home and community support services (HCSS). Negotiations were successfully concluded in September 2014, with a ratified agreement in June 2015.

10.10.2 The Settlement Agreement was in two parts. Part A relates to HCSS workers being paid for the time they spend travelling between clients and is referred to as in-between travel (IBT). Part A has been implemented and is now included in the Act. Part B relates to the overarching review of the HCSS sector, aspects of which are regularisation of the HCSS workforce and future models of care. Part B is ongoing and involves various initiatives and work streams.

10.10.3 Regularisation was due to commence in September 2016 (i.e. two years after the signing of the Settlement Agreement). However, the Settlement Agreement was varied on 20 October 2016 to change the implementation date to 1 April 2017, and to focus primarily on guaranteed hours in the first instance.

10.10.4 Part A of the Settlement requires funding agencies, including DHBs, to fund HCSS providers to pay travel time and travel expenses as agreed by the Settlement Parties.

Broadly, DHBs as funders are required to pay the employers with whom they contract to provide HCSS at least:

- $20.10[33] per hour for Qualifying Travel Time from 1 July 2015; and
- an agreed rate per kilometre for Qualifying Travel Cost reimbursement, beginning with 50 cents per kilometre, plus a 6 percent margin, from 1 March 2016.

The Employers, the DHBs and the Ministry agree to ensure that all Qualifying Employees receive payment for:

- qualifying travel time as defined in the IBT agreement at, at least the equivalent of the minimum wage based on the travel band; and
- qualifying travel costs as defined in the IBT agreement at, at least 50 cents per kilometre based on travel bands from 1 March 2016.

10.10.5 DHBs as funders must refer to the ***Home and Community Support (Payment for Travel Between Clients) Settlement Act*** to ensure their payments enable providers/employers that they fund comply with the Act.

10.10.6 The Act allows for an annual review of Schedule 4 (covering mileage rate, qualifying distance, qualifying travel time and maximum travel distance). The first review must take place on or before 30 May 2017 and every 12 months after that date. DHBs will be consulted on each review and will also be consulted if there are any recommendations to amend Schedule Four.

10.10.7 Part B of the Settlement requires funding agencies, including DHBs, to fund HCSS providers to pay for qualifying guaranteed hours. From 1 July 2017 funders must pay each qualifying cancelled visit at the worker's appropriate pay band plus on-costs of 21.7 percent. Travel time for qualifying cancelled visits is funded at the IBT rate specified in 10.9.4.

10.10.8 Funding is provided in the context that all parties adhere to the following principles.

- All parties will act consistently and in good faith with the principles and obligations set out in the IBT Settlement Agreement and Variations, the Employment Relations Act and existing contracts.

[33] This was increased to $20.79 per hour when the minimum wage increased to $15.25 per hour on 1 April 2016 and again on 1 April 2017 to $21.46 when the minimum wage increased to $15.75 per hour.

- Funders will apply a fair and reasonable tolerance regarding claims during the transition period to reflect the time and effort required for providers to move to new systems and processes.
- Ensure providers take all reasonable action to find other work for employees before proposing a reduction in an employee's guaranteed hours.
- Ensure providers will take all reasonable steps to minimise the number of employees who have their guaranteed hours reduced.

10.10.9 In setting out these expectations, the Ministry does not intend to restrict the ability of funders or providers to explore other models of care for the provision of HCSS.

10.10.10 More detail for providers and funders about these requirements is available on the Ministry of Health's website.

10.11 Introduction of pay equity for care and support workers

(See Care and Support Workers (Pay Equity) Settlement Act 2017.)

10.11.1 On 18 April 2017, the Government announced a $2 billion pay equity settlement for 55,000 care and support workers. The settlement recognises the systemic underpayment of care and support workers due to it being a predominantly female workforce in the aged and disability residential care, and home and community support services sectors. The full background to the settlement is in the Agreement and the Act[34].

From July 1 2017 care and support workers, who are mostly on or around minimum wage, will receive a pay rise of between 15 and 49 percent depending on their qualifications or experience. The settlement means over the next five years, employees in the workforce will receive an increase in their wages according to the agreed and prescribed pay rates range of between $19 to $27 per hour.

As specified in variation by way of letter to the 2012/13 Crown Funding Agreement

10.11.2 DHBs are required by the Pay Equity Settlement Agreement and the Act[35] to pay employers the additional funding for pay equity. The funding methodology for the funding agreement is documented in the Care and Support Workers (Pay Equity) Settlement Operational Policy Document that is available on the Ministry of Health's website[36].

10.11.3 As the employer representatives were not parties to the Agreement, there is no mutual arrangement for the funding agreements to be varied contractually; accordingly they are varied by deemed variation imposing a statutory obligation on funders to pay employers[37].

10.11.4 The DHB must pass on additional funding to eligible providers to:

- pay the additional amounts towards offsetting their additional costs for the care and support workers pay rates
- pay the additional amounts towards offsetting their additional costs to assist with their statutory obligation to support the training for their care and support workers
- pass on funding for other cost pressures at a rate no less than 2.2 percent in 2017/18 (2.4 percent in out years) of care and support workers wages
- ensure that providers pass on the funding to their care and support workers so that they are paid no less than their minimum statutory amount as specified in the Act.

10.11.5 In the event that a DHB has been paying below the sector average rate for a service covered under the settlement, the DHB will be required to contribute extra funding to ensure provides are appropriately funded to pay the rates specified in the Act.

[34] Agreement [Background pages 2 and 3]; Act [General Policy Statement pages 1 and 2, and the Regulatory impact statement - http://www.health.govt.nz/new-zealand-health-system/care-and-support-workers-pay-equity-settlement Departmental disclosure statement - http://disclosure.legislation.govt.nz/bill/government/2017/267]

[35] Ministry of Health, ACC and DHBs; Agreement [clause 5, and Appendix]; Act [section 18]

[36] http://www.health.govt.nz/new-zealand-health-system/care-and-support-workers-pay-equity-settlement/pay-equity-settlement-information-providers/pay-equity-settlement-community-and-residential-living

[37] Agreement [clauses 5 and 7(g) and relevant footnotes]; Act [section 18]

10.11.6 DHBs must send the standard Ministry Letter of Notification (provided with variation by way of letter) to eligible providers, with the exception of aged residential care providers, notifying them that their contract(s) with the DHB have deemed to be varied by the Act [section 18] to increase funding to contribute to their increased costs.

11 Information technology

11.1 Purpose of the chapter

11.1.1 . This chapter sets out the general requirements for DHBs' investment in and use of information and communications technology (ICT).

Note: The content of this section will be subject to further changes throughout the 2017/18 year.

Summary of mandatory requirements

Each DHB must:

- work to implement and operate appropriate information systems according to the standards and guidelines listed in **Section 11.2**.
- develop and deliver ICT services in accordance with the Government Chief Information Officer (GCIO) mandate as noted in **Section 11.5**

11.2 eHealth systems development strategy

11.2.1 Each DHB is expected to actively support the Digital Health programme 2020.

11.2.2 Each DHB should be developing, implementing and maintaining appropriate information systems that support the requirements of its Regional Service Plan and Annual Plan.

11.2.3 To deliver on the New Zealand Health Strategy DHBs are expected to:

a. work with other DHBs in the region to develop, maintain and implement a Regional Service Plan that includes agreed regional and national initiatives

b. include the process for implementing national solutions and programmes according to nationally agreed milestones in their Regional Service Plan

c. follow guidelines and advice provided by the Ministry of Health

d. work with the Ministry's Technology and Digital Services business unit in the development and approval of significant ICT business cases for amounts greater than the threshold investment amount (see Section 12.30)

e. support and participate in relevant projects being led by other accountable agencies and organisations.

11.2.4 In undertaking this work, each DHB must take the following actions.

a. Update and maintain a list of its applications and projects. Updates are to be provided quarterly and should include:

- notification of new projects
- high-level status reporting against projects indicating progress against milestones, quality and scope of deliverables, and budget
- modifications and changes to such projects including, but not limited to, changes in scope, risks, milestones or budgets
- a rolling four-year forecast showing key quarterly project milestones and changes of applications or systems

b. Report back to the Ministry on at least a quarterly basis, recording progress made as a region against the ICT activity detailed in the Regional Service Plan, including progress made by each individual DHB. Status reports are to comment on at least: progress made, key issues, risks and their mitigations, and planned activities for the next quarter including any significant adjustments to the Plan.

c. Proactively support the development and adoption of Health Information Standards Organisation (HISO) standards by:

- adhering to and meeting the requirements of all published HISO standards
- identifying and reporting on needs or opportunities for new standards and updates to existing standards
- participating in the development or enhancement of standards
- supporting trial implementation of interim HISO standards
- implementing SNOMED CT (Systematized Nomenclature of Medicine-Clinical Terms) with all new investment in clinical information systems, electronic medical record systems and electronic health record systems
- registering as a SNOMED CT user with the SNOMED CT National Release Centre operated by the Ministry.

11.3 IT change processes in the National Collections

11.3.1 Changes to the National Collections are managed by the National Collections Annual Maintenance Project (NCAMP). This is a Ministry-led project with a joint Ministry/Sector Governance Board.

11.3.2 Costs for changes to information to national systems are to be paid by the entity generating the information.

11.3.3 To meet the sector's information needs, the Ministry will:

a. consult with sector stewardship groups and interested parties, including the DHB-led project groups coordinated by DHB Shared Services, when changes are proposed to the data collected in the National Collections

b. communicate with software vendors when changes to the National Collections are approved

c. provide DHBs with:

- a point of contact for communication
- monthly reports showing DHB performance against known data quality issues
- technical support and training for DHB clinical coding staff when there are changes in the clinical coding classification

d. monitor data submitted directly to the National Collections for compliance with data delivery timeframes and levels of accuracy as outlined in the file specification for each collection

e. ensure that processing of all National Health Information Batch Systems is complete within two working days of receipt of data from a provider and that the appropriate infrastructure is maintained and the National Health Index (NHI) system is available according to mutually agreed service levels

f. in respect of any changes to the reporting requirements for the National Collections:

- provide six months' advance notice. All parties affected by any change may waive this six-month notice period if there is agreement to a shorter notice period
- report to DHBs on implementation progress and provider compliance requirements or status.

11.3.4 DHBs must ensure that they and their providers deliver on any additional information required by the Ministry, on behalf of the Minister. In this circumstance, the Ministry and DHBs will agree to a mutually acceptable timetable for delivery of the additional information. Any changes will be agreed through mechanisms approved via the formal governance process in place for each element of the National Collections. Once agreement is reached, DHBs will require providers to deliver against this timetable.

11.3.5 The Ministry and DHBs may identify ways to develop and improve information. Each DHB will assist the Ministry to develop a joint approach and contribute resources as it is able for this work.

11.3.6 Each DHB must ensure that any change to national health data standards and classifications is reflected in the information that it provides to the Ministry. Changes will be made by the Ministry and approved by either the HISO or other duly mandated sector-wide reference groups and notified to DHBs.

11.3.7 Each DHB must ensure that the Ministry is notified of all changes to the systems that support National Collections. In these cases reporting will be subject to appropriate compliance testing as determined by the Ministry. This ensures that DHB data does not corrupt the National Collections and changes made locally have not impacted on the quality of data provided to the National Collections.

11.4 IT change processes in the National Systems

11.4.1 This section will be populated in a further revision. It will cover a new initiative to amalgamate all Ministry and Sector driven changes affecting PAS systems into one annual cycle of changes based on a go-live release of 1 July.

11.5 Government Chief Information Officer – All of Government ICT Mandate

11.5.1 The GCIO is responsible to the Minister of Internal Affairs for delivering the All-of-Government requirements for ICT services: https://www.ict.govt.nz/governance-and-leadership/providing-ict-functional-leadership/

11.5.2 The Chief Technology and Digital Services Officer is responsible for maintaining the line of communication between the health and disability sector and the GCIO.

11.5.3 DHBs are expected to develop and deliver ICT services in accordance with the mandated requirements expressed by the GCIO and, where requirements are not specifically mandated, to operate in accordance with the principles promulgated by the GCIO.

11.5.4 From time to time DHBs will be expected to respond in a timely manner to specific requests for information from the GCIO.

12 Financial and capital operations

12.1 Purpose of the chapter

12.1.1 This chapter sets out various financial operating rules and requirements, including in relation to fixed assets and capital.

Summary of mandatory requirements

Each DHB must:

- comply with all applicable legislation governing DHB financial operations and with generally accepted accounting practice, Crown accounting policies and Ministry accounting policies **(Section 12.2)**
- operate in a financially responsible manner **(Section 12.7)**
- have appropriate internal financial controls for the procurement of goods and services **(Section 12.8)**
- properly authorise the withdrawal or payment of money from a bank account of the DHB **(Section 12.10)**
- have a formal written Treasury policy to address key financial risks it faces, and gain approval for that policy from its Board **(Section 12.11)**
- ensure that working capital facilities for its provider arm comply with legislation in terms of maximum limits and counterparty **(Section 12.14)**
- be aware that equity injections for deficit support will only be provided where the DHB cannot fund its deficits from its own balance sheet, and that there are constraints on how this funding can be applied **(Section 12.15)**
- ensure all new long-term debt is appropriately authorised by the Ministers of Health and Finance and issued or refinanced by the Ministry in conjunction with the Debt Management Office **(Section 12.16)**
- be aware that it is permitted under joint ministerial authority to enter into a finance lease, or group of finance leases for similar or related assets **(Section 12.17)**
- be aware that the Crown must not incur expenses or capital expenditure, except as expressly authorised by an appropriation, or other authority, by or under an Act **(Section 12.18)**
- follow required processes regarding retention of surpluses by DHBs **(Section 12.19)**
- pay capital charge instalments into the Ministry's Crown Receipt Account at the notified rate based on six-monthly invoices from the Ministry **(Section 12.20)**
- abide by restrictions on the use of funding supplied for mental health purposes **(Section 12.21**)
- prudently manage the giving of guarantees and indemnities **(Section 12.22)**
- actively investigate, facilitate, sponsor and develop cooperative and collective agreements and arrangements with people in the health and disability sector or in any other sector, with the aim of providing for and protecting the health of people, and of promoting the inclusion and participation of people with disabilities in society and their independence **(Section 12.23)**
- adhere to section 28 of the NZPHD Act relating to the acquisition of securities, shares and other interests by DHBs **(Section 12.24)**
- ensure that its subsidiaries prepare Statements of Intent, Statements of Performance Expectations, annual financial statements and Annual Reports (if required), and comply with ss 161–164 (financial provisions) of the CE Act **(Section 12.25**)
- use the full-time equivalent (FTE) definition for all financial planning and reporting **(Section 12.26)**
- revalue property, plant and equipment in accordance with Public Sector Public Benefit Entity Accounting Standards (PBE Standards) (PBE International Public Sector Accounting Standards [IPSAS]) 17 Property, Plant and Equipment, as interpreted in the Crown accounting policies **(Section 12.27)**

- undertake formal asset management planning **(Section 12.28)**
- present a business case fully supported by its Board and the Regional Capital Committee **(Section 12.30)**
- comply with section 22 and clause 43 of Schedule 3 to the NZPHD Act and ss 40–42 of the Public Works Act 1981 under which no DHB may sell, exchange, mortgage or charge land, or grant a lease or licence for a term of more than five years, without the prior written approval of the Minister **(Section 12.31)**

12.2 Legislative compliance

12.2.1 DHBs must comply with all applicable legislation governing their financial operations.

12.2.2 The key legislation governing DHB financial operations comprises the:

a. NZPHD Act

b. CE Act

c. Public Finance Act (as amended by the Public Finance Amendment Act 2004 and the Public Finance Amendment Act 2013).

12.2.3 In relation to their reporting and financial obligations DHBs should especially note the requirements of section 42 of the NZPHD Act and Part 4 of the CE Act.

12.2.4 DHBs must prepare Statements of Intent, Statements of Performance expectations, annual financial statements and Annual Reports in accordance with Part 4 of the CE Act, regulations made under the NZPHD Act and generally accepted accounting practice (GAAP) (defined in Section 12.6 below).

12.2.5 Every DHB, or subsidiary of a DHB, is a Crown entity (specifically a Crown agent or a Crown Entity Subsidiary respectively) as defined in section 7 of the CE Act.

12.2.6 CE Act provisions on default financial powers apply to all Crown entities, unless otherwise authorised by regulation or by the entity's responsible Minister and the Minister of Finance. DHB requirements were included in the Crown Entities (Financial Powers) Regulations 2005.

12.2.7 DHBs must supply any information relating to operations and performance of the DHB that the Minister requests (s133 of the CE Act)

12.2.8 Some provisions of the Public Finance Act continue to affect DHBs, in particular:

a. section 4 (expenses or capital expenditure must not be incurred unless in accordance with appropriation or statutory authority) – as it relates to use of operational and capital funding from the Crown

b. Sections 19, 26Z and 29A (power of Secretary to obtain information)

c. sections 19A and 19C – DHBs must report on end of year performance in relation to appropriations as specified in the most recent Appropriations Act

d. section 26 (terms and conditions of capital injections) – the Minister of Finance may determine terms and conditions of capital injections to DHBs after consultation with the Minister

e. section 27 and 31A (annual and monthly financial statements of government) – as they relate to DHB financial information consolidated into the Crown financial statements

f. section 49 (liability for debts of Crown entities) – the Crown is not liable to contribute towards the payment of any debts or liabilities of a DHB or a DHB subsidiary

g. section 74 (unclaimed money) – at the end of each financial year, any money in any bank account of a DHB that has remained unclaimed for a period of six years from the date it was payable to the entitled person must be deposited with The Treasury

h. section 80 (Treasury instructions) – as it relates to consistency of DHB accounting policies with Crown reporting requirements.

12.3 Statements of Intent

(See ss 139–149A of the CE Act as amended by the CE Amendment Act 2013.)

12.3.1 The Statement of Intent (SOI) is the primary accountability document with Parliament. The requirement for producing and publishing an SOI is summarised and referenced in Chapter 3, section 3.3.

12.3.2 A SOI must relate to the forthcoming financial year and at least the following three financial years.

12.4 Statement of Performance Expectations and forecast financial statements

12.4.1 The Statement of Performance Expectations (SPE) enables the Minister to participate in the process of setting annual performance expectations, to inform the House of Representatives and to provide a base against which annual performance can be assessed.

12.4.2 The requirement for producing and publishing an SPE is summarised and referenced in Chapter 3, section 3.3. An SPE, in relation to a DHB and a financial year, must contain forecast financial statements for the forecast year prepared under GAAP. The forecast financial statements must include:

a. a statement of all significant assumptions underlying the forecast financial statements

b. any additional information and explanations needed to fairly reflect the forecast financial operations and financial position of the entity.

12.5 Financial statements

(See ss 38 to 42 of the NZPHD Act, Parts 3 and 4of the Public Finance Act, (see 12.2.8 above), Part 4 of the CE Act and CAB(00) M 15/10.)

12.5.1 Each DHB must prepare an Annual Plan and provide regular performance reports, including monthly financial and quarterly performance reports against its Annual Plan, to the Minister (CAB (00) M 15/10) (see Section **Error! Reference source not found.**4 for more information about Annual Plans).

12.5.2 DHBs must submit to the Ministry financial templates supporting the Annual Plan that comply with monthly/quarterly financial reporting requirements. DHBs must provide all necessary information in the financial templates to meet Crown Financial Information Systems reporting requirements.

12.5.3 DHBs must:

a. produce consolidated financial statements on a line-by-line basis

b. report using the Common Chart of Accounts

c. determine provider arm revenue through an internal Service Level Agreement and evidence this in a Production Plan

d. comply with the Requirements and Guidelines for Using Financial Templates issued each year by the Ministry

e. ensure that financial templates, Annual Plan financial statements, and monthly/quarterly financial reports:

- comply with GAAP, Crown accounting policies and Ministry accounting policies
- clearly and separately detail each of the dimensions of DHB performance – that is, by governance, funder and provider arms (CAB (00) M 15/10).

12.5.4 Each DHB must prepare an Annual Report (see Section 3.4 for more information about Annual Reports). The Annual Report must contain the DHB's audited annual financial statements and, if a DHB is the parent of a Crown Entity Group, the consolidated financial statements for the group.

12.5.5 The Annual Report must contain the following financial information:

a. financial statements that comply with GAAP

b. any other information or explanations needed to fairly reflect the financial operations and financial position

c. forecast financial statements from the SOI and SPE for comparison with the actual financial statements (s 154 of the CE Act).

12.6 Accounting policies

DHBs must comply with GAAP as stipulated in ss 136 and 154 of the CE Act.

12.7 Good financial management

(See s 41 of the NZPHD Act and s 51 of the CE Act.)

12.7.1 Every DHB must operate in a financially responsible manner, and must:

a. endeavour to cover all its annual costs (including cost of capital) from its net annual income

b. prudently manage its assets and liabilities

c. endeavour to ensure its long-term financial viability

d. act as a successful going concern.

12.7.2 Every DHB is to:

a. have financial systems and staff necessary to manage funding processes effectively and efficiently

b. operate within total funding as agreed through the Annual Plan process. If it appears likely that a DHB will run a deficit or will be unable to meet its cash flow commitments at any time, the DHB must immediately advise the Ministry. Note that applications for equity or deficit support take approximately four weeks to process

c. report to the Ministry within required timeframes

d. ensure that it is not overcommitting itself. If the Ministry has reasonable grounds to believe a DHB is committing itself to expend money that would put the Ministry at risk of breaching its appropriations under sections 4 or 5 of the Public Finance Act, it will follow the process in relation to withholding of money from DHBs set out in Section 12.18

e. cover the cost of additional services purchased in response to a major incident of up to 0.1 percent of the DHB's total population based funding. Above this 0.1 percent level, the Crown will determine on a case-by-case basis, and in consultation with the DHB, whether:

- the DHB is able to fund additional services purchased
- the Crown will provide the DHB with additional funding
- there will be any negative effects on the DHB's baseline services.

12.8 Internal financial controls

12.8.1 Each DHB must ensure it has a robust system of internal financial controls and must sign a statement of responsibility attesting to that.

12.8.2 Procurement policies and practices are an important element of each DHB's internal financial controls.

12.8.3 The procurement of goods and services (including capital items) represents a risk to any organisation. DHBs must ensure goods and services are procured appropriately. The responsibility for having procurement policies and practices that reflect good practice lies with each DHB.

12.9 Information available on procurement policies and practices

12.9.1 Information on good practice in relation to procurement policies and practices is available within the public sector. Collectively this information provides a broad framework that supports

accountability, sound practice and successful results. DHBs should be aware of and comply with the following guidance.

a. Ministry of Business, Innovation and Employment's Government Rules of Sourcing (2015) and five Principles of Government Procurement.

b. Principles of Government procurement Cabinet Minute (Sec min (12) 1015).

c. Office of the Controller and Auditor General (2008) Procurement Guidance For Public Entities

12.10 Bank accounts

(See s 158 of the CE Act, the Crown Entities (Financial Powers) Regulations 2005 and New Zealand Gazette 21/07/2005 p2644.)

12.10.1 A DHB can establish, maintain and operate one or more bank accounts at a registered bank or a registered building society in New Zealand without further authority as long as the:

a. registered bank or registered building society satisfies a credit-rating test prescribed in regulations (s 158(1)(a) of the CE Act)

b. bank accounts are denominated in New Zealand dollars (s 158(6) of the CE Act).

12.10.2 A DHB must properly authorise the withdrawal or payment of money from a bank account of the DHB (s 158(7) of the CE Act).

12.10.3 Prior authority from the Minister of Finance is required if a registered bank or registered building society does not meet the prescribed credit-rating test (s158(1)(a) of the CE Act).

12.10.4 In the regulations, 'credit' refers to the registered bank or registered building society's long-term unsubordinated debt. Each DHB is responsible for monitoring the credit rating of registered banks or registered building societies at which it holds an account. Credit ratings of registered banks in New Zealand are available on the Reserve Bank website.

12.10.5 If a registered bank or registered building society's credit rating is downgraded to a level below the test specified, DHBs will have to either:

- close all accounts at that bank or building society by the earlier of two months of it ceasing to qualify, or a date specified by the Minister of Finance, or
- request approval from the Minister of Finance to maintain the bank account.

12.10.6 DHBs have ministerial authority to operate foreign currency bank accounts in New Zealand for making payments for goods, services and fixed assets to overseas suppliers in circumstances set out in the CFA as outlined below:

a. there is uncertainty over the exact date a currency will be required or there are delays in delivery of funds

b. lower costs will be incurred than if negotiating overseas purchases in New Zealand dollars

c. overseas suppliers will not accept payment in New Zealand dollars

d. lower costs are incurred than if foreign exchange derivatives were rolled forward.

12.10.7 DHBs are authorised under regulation 8(1) of the Crown Entities (Financial Powers) Regulations 2005 to hold bank accounts at banks outside New Zealand if the:

a. bank account comprises debt owed and payable in New Zealand dollars

b. credit of the bank satisfies the credit-rating test applied to registered banks and registered building societies

c. laws of the jurisdiction under which the bank operates the bank account do not discriminate between classes of unsecured creditors except upon grounds, and only to the extent, set out in a subordination covenant

d. central bank of the jurisdiction in which the bank operates the bank account is a shareholder in the Bank for International Settlements.

12.10.8 Prior authority in writing from the Minister of Finance is required for any other bank accounts at banks outside New Zealand.

12.11 Financial risk management

Treasury policy

(See s 41 of the NZPHD Act and s 51 of the CE Act.)

12.11.1 Each DHB is expected to have a formal written Treasury policy that is approved by the Board.

12.11.2 A DHB's Board has a duty to ensure that the DHB operates in a financially responsible manner, including prudently managing assets and liabilities (s 51 of the CE Act). Having a Board-approved Treasury policy is one component of fulfilling this duty. The Treasury policy should link to, but not replace, authorities and responsibilities in a DHB's Minister-approved delegations policy.

12.11.3 As a minimum, the Treasury policy should include policies to address key financial risks faced by the DHB, which are likely to vary according to DHB size. Key financial risks may include:

a. liquidity and funding risk

b. foreign exchange/currency risk (classified separately by capital and operating)

c. interest rate risk

d. guarantees and indemnities.

12.11.4 Liquidity risk management relates to managing the short-term, day-to-day cash requirements, whereas funding and investment risk management relates to managing the long-term funding issues facing a DHB. Management of these risks includes cash flow management, availability of overdraft facilities, and banking covenants.

12.11.5 Foreign exchange/currency risk management for DHBs relates mainly to mitigating exposure to foreign currency fluctuations. DHBs enter into foreign currency transactions with overseas suppliers, both for operational purchases, such as clinical supplies, and for capital purchases, such as clinical equipment.

12.11.6 Interest rate risk management relates to mitigating the risk of increased interest expense (or reduced interest income) due to changes in market interest rates. The Treasury policy should define how interest rates on debt (or investments) are measured, and set out the extent to which hedging may be desirable (eg, term of hedging, types of instrument to use).

12.11.7 Guarantees and indemnities management provides a level of assurance in relation to giving guarantees and indemnities. The Treasury policy should allow normal commercial practice to operate while controlling the giving of guarantees and indemnities that are irregular, or that invert normal commercial practice, at a Board level. In addition, a register must be kept of any indemnities or guarantees that are given, and insure for them accordingly. (See Section 12.22 for more information about guarantees and indemnities.)

12.11.8 It is unlikely that most DHBs will need to include counter-party credit risk in their Treasury policy as long as they comply with regulations. Counter-party credit risk (which is the risk of losses, realised or unrealised, arising from a counter-party defaulting on a Treasury instrument to which a DHB is a party) is addressed in the regulations, which specify that the credit-rating test is met if an issuer of debt securities is:

a. rated by Standard and Poor's as A– or higher, or A–1 if short term, or

b. rated by Moody's as A3 or higher, or Prime–1 if short term, or

c. authorised and gazetted by the Minister of Finance.

12.11.9 The management policy for each key risk should include:

a. description of the risk, and its nature and extent in relation to the DHB

b. objectives

c. limits and/or targets

d. list of authorised instruments/products used to address the risk

e. monitoring of exposures in relation to limits

f. approval procedures for changing the limits

g. procedures for dealing with a breach of limits.

12.11.10 The Treasury policy should also cover:

a. linkage to authorities and responsibilities set out in the DHB's delegation policy

b. liquidity management

c. investment management

d. key banking relationships

e. Treasury monitoring and reporting (daily, weekly, monthly, to the Board).

12.11.11 DHBs should review their Treasury policy at least annually and:

a. assess the impact of Treasury transactions made during the year (eg, how the result differed from an unhedged position, what was the cost of any hedging)

b. evaluate which risk exposures may be significant in the coming year and out-years

c. recommend any modifications required to the Board for approval.

12.12 Derivative transactions

(See ss 160 and 164 of the CE Act, regulation 15 of the Crown Entities (Financial Powers) Regulations 2005 and New Zealand Gazette, 21/7/2005, no. 110, p 2644.)

12.12.1 DHBs have ministerial authority to enter into foreign exchange and interest rate derivative transactions on the conditions specified in their Crown Funding Agreement (New Zealand Gazette, 21/7/2005, No. 110).

12.12.2 Regulation 15 of the Crown Entities (Financial Powers) Regulations 2005 permits Crown entities (including DHBs) to enter into the following derivative transactions:

a. a foreign transaction with a registered bank or registered building society that satisfies the credit-rating test stipulated in regulation 7(1), or a bank outside New Zealand that satisfies the credit-rating test stipulated in regulation 8(1)(b), for the purpose of:

   i. procuring foreign exchange (including negotiable instruments and other documentary transactions) for use by Crown entity members, officials or employees while in the country of that foreign currency or while en route to that country

   ii. procuring foreign exchange in order to discharge a liability arising under any of the classes of contract or instrument referred to in regulation 14

   iii. procuring foreign exchange in order to: deposit funds into a bank account, invest in debt securities, repay borrowing or pay a guarantee or indemnity

b. a futures contract having the sole purpose of covering any foreign exchange transaction authorised by this regulation

c. a foreign exchange transaction undertaken with a foreign exchange dealer on a cash-for-cash basis

d. the sale and purchase of goods or intangibles (including intellectual property rights, but not including securities) that are not traded in the commodities or the capital markets, delivery of which is to occur in the future

e. an option to purchase or lease, or renew the lease of, real property

f. an option to purchase or bail, or to renew the bailment by way of hire of, goods that are not traded in the commodities markets

g. a covenant to assign intellectual property rights, or other property rights, contained in a contract of employment

h. a contract to acquire debt securities lawfully entered into accordance with section 161 of the CE Act and, if applicable, regulation 9, where delivery must take place in the future.

12.12.3 A Crown entity may procure foreign exchange for the purposes set out in paragraph 12.12.2(a)(iii) above only if the bank account, investment, borrowing, guarantee or indemnity is both:

a. in a currency other than New Zealand currency

b. authorised by either:

- the CE Act or
- the Minister of Finance (either individually or jointly with a responsible Minister).

12.12.4 Permitted derivative instruments, transactions and limits should be covered in the Board-approved Treasury policy.

12.12.5 DHBs should enter into prudent foreign exchange transactions, recognising that the Crown will not provide additional funding to cover foreign exchange rate losses (see s 164 of the CE Act).

12.12.6 Use of such financial instruments should only be to hedge a DHB's actual underlying obligation structure, and not for speculative purposes. A DHB will need to satisfy itself that:

a. it has personnel who are suitably skilled in using financial instruments

b. its use of financial instruments is undertaken and assessed against 'best practice' for the exposure being managed and the instruments being used.

12.13 Insurance

12.13.1 Each DHB must ensure it has appropriate insurance to cover risks.

12.13.2 Each DHB should have reasonable comprehensive insurance covering its activities. A DHB should consider the full range of risks it faces and have appropriate insurance cover as part of its risk mitigation strategy. When assessing its need for insurance, a DHB should consider its ability to self-insure, the legislative environment and the relevant provisions of its CFA.

12.13.3 It is expected that DHBs will, where appropriate, work together to secure a prudent level of insurance that represents good value for money.

12.13.4 Each DHB should inform the Ministry, on request, of the insurance cover that it has in place.

12.13.5 The insurance provisions included in ss 120 to 126 of the CE Act do not apply to DHBs (s 21 of the NZPHD Act).

12.14 Working capital management

(See ss 160 and 162 of the CE Act and regulations 7 and 13 of the Crown Entities (Financial Powers) Regulations 2005.)

12.14.1 A DHB may arrange working capital facilities for its provider arm with a registered bank or building society, with credit rated by either:

a. Standard & Poor's at not less than A– or, A–1 if the credit is short term, or

b. Moody's (or its successors or assigns) at not less than A3 or, not less than Prime–1 if the credit is short term.

12.14.2 A DHB's total working capital financing can be up to the level of one month's total planned Crown revenue for the provider arm as defined in paragraph 12.14.3 below.

12.14.3 The provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST.

12.14.4 DHBs must not borrow to fund deficits.

12.14.5 Prior approval is required from the Ministers of Health and Finance for the following working capital facilities:

a. from private sector providers other than a registered bank or building society

b. for managing expenditure fluctuations in the funder arm.

12.14.6 A DHB may use a credit facility to manage short-term fluctuations in provider arm expenditure. DHBs are restricted to providing security for credit facilities on a negative pledge basis only; that is, the DHB will not offer a bank or any other party any security to cover overdraft borrowings. This is to avoid debt subordination problems and increase incentives on banks to limit credit to prudent levels.

12.14.7 With the prior approval of the Ministers of Finance and Health, DHBs may either individually or collectively enter an arrangement with an 'approved' independent body to manage their daily cash requirements. The terms and conditions of any such arrangement must be specifically approved by both Ministers. For this purpose an 'approved' body is one specifically designated for this purpose, with associated conditions, by the Minister of Finance.

12.14.8 Any cash investments or working capital facilities under such an arrangement must be with one or more registered banks or registered building societies in New Zealand and meet the requirements set out in Section 12.10.

12.15 Deficit support

12.15.1 There is a DHB deficit support appropriation that requires the joint approval of the Ministers of Health and Finance.

12.15.2 The deficit support appropriation has limited funding. Ministers of Health and Finance agreed in 2015 that deficit support should be by way of equity injections, and should be limited to DHBs which are not able to fund their deficits from within their own balance sheets and would otherwise exhaust their cash resources.

12.15.3 The need and amount of equity should be signalled in a DHB's Annual Plan. The Annual Plan should detail separately equity planned for cash flow support (cash shortfalls on operations), capital spending up to the value of depreciation detailed in the Annual Plan and any capital spending that is greater than the value of depreciation. The combination of proper planning and good financial management should mean that requests for equity or debt not signalled in plans will be rare.

12.15.4 DHBs are requested to provide early advice of any changes in the deficit support requirements signalled in their Annual Plans so that the likely requests on the limited funding are known in advance.

12.15.5 Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. Applications for deficit support will be subject to a rigorous approval process.

12.15.6 DHBs should not expect approval of equity if any capital charge payments are overdue.

12.15.7 When requesting deficit support, DHBs must provide the Ministry with sufficient information to enable a clear identification of:

a. the DHB's projected financial position and cash flow showing when the DHB will exhaust its available cash resources. It must also clarify the extent to which it will utilise the available collective overdraft facility

b. whether there are alternatives to the provision of an equity injection.

12.15.8 The formal request for equity support should take the form of a letter from the DHB Chair that is:

a. addressed to the Ministry of Health (Attn: Director, Service Commissioning)

b. supported by a Board resolution.

Requests should be provided to the Ministry's Service Commissioning business unit in electronic format, and hard copies provided of the letter from the Chair and the Board resolution.

12.15.9 The approval process can take up to two months from the time a formal request is received, as a DHB's cash position must be assessed to ensure it meets the tight criteria for an equity injection. It may take longer if additional information is required, inadequate information is provided or it is a complex request.

12.15.10 Once approval is given, distribution of the funds will be arranged between the Ministry and the DHB. In general it takes 10 working days for deficit support to become available for distribution.

12.15.11 Where deficit support is released in instalments, DHBs must for each instalment provide a request that is supported by details of cash flows, both actual and forecast. Actual data should be provided for the 12 weeks prior to the date of deficit support request and weekly cash flow forecasts are required for either the period covered by the request or six months, whichever is longer.

12.15.12 This appropriation must only be used to fund cash requirements caused by operating deficits; capital expenditure must be limited to the level of depreciation planned in the most recently agreed Annual Plan. Long-term debt may not be used to fund either of these cash requirements, even if debt facilities are available. The 'DHB deficit support' appropriation must not be used to fund capital projects.

12.16 Non-working capital financing

(See ss 160 and 164 of the CE Act and regulation 13(1)(a) and (c) of the Crown Entities (Financial Powers) Regulations 2005.)

Long-term debt

12.16.1 Cabinet approved a change in capital finance policy, which means that DHBs no longer have the option of accessing Crown debt issued by the Ministry of Health as lender that are administered by the Debt Management Office (See CBC-16-MIN-0018 and CAB-16-MIN-0516). Existing DHB Crown loans were converted to Crown equity on 15 February 2017.

12.16.2 Access to long term finance leases for major capital investments, for example public private partnership arrangements, can still be considered as part of the *Better Business Case* process. Approval of the final procurement strategy that includes financial lease arrangement will be made by the Ministers of Health and Finance. Refer to section 12.17 Finance leases for further detail.

Long-term painting contracts

12.16.3 Certain long-term painting contracts have been deemed as borrowing. A DHB requires approval from the Ministers of Health and Finance before a DHB enters into such contracts.

12.16.4 The general nature of these long-term painting contracts is that major painting work is carried out in the first years of the contract, with remedial and touch-up work performed in subsequent years. Payments are spread evenly over the life of the contract. These contracts have been deemed borrowing because services provided in the early stages of the contract period are paid for on a time payment basis, which is outside the normal terms of trade.

Energy Efficiency and Conservation Authority loans

(See ss 160 and 164 of the CE Act and regulation 13(1) of the Crown Entities (Financial Powers) Regulations 2005.)

DHBs may borrow money from the Energy Efficiency and Conservation Authority.

12.17 Finance leases

(See ss 160 and 164 of the CE Act, New Zealand Gazette, 21/7/2005, No. 110, p 2644, regulations 11(b) and 13 of the Crown Entities (Financial Powers) Regulations 2005, and Ministry of Health (2003) *Guidelines for Capital Investment*.)

12.17.1 Prior authority from the Ministers of Health and Finance is required for any finance lease, or group of finance leases for similar or related assets:

a. for assets with a market value of $10.0 million or 20 percent of the DHB's gross total assets (including assets owned by DHB subsidiaries), whichever is the lesser

b. with the potential to affect the performance of the DHB in a strategic way.

12.17.2 DHBs are permitted under joint ministerial authority to enter into finance leases from sources other than, and including, the Crown.

12.17.3 In addition to the above approval thresholds, DHBs may only enter into finance leases subject to the conditions that they:

a. comply with the *Guidelines for Capital Investment* (Ministry of Health 2003) (see OPF Section 12.30)

b. comply with the conditions of any letter of comfort from Ministers

c. meet banking covenants

d. meet any conditions imposed in the approval of their Annual Plans.

12.17.4 Judgement is required in determining whether a lease is a finance lease or an operating lease in terms of accounting standard NZ IAS 17 Leases. DHBs will need to seek advice from their auditors or the Ministry if there is uncertainty about whether a potential lease is a finance or an operating lease.

12.18 Withholding of money from DHBs

(See s 4 and 5 of the Public Finance Act.)

12.18.1 The Crown must not incur expenses or capital expenditure, or spend public money, except as expressly authorised by an appropriation, or other authority, by or under the Public Finance Act (s 4(1)). Expense does not include an expense that results from either:

a. re-measuring an asset or a liability, or

b. an operating loss incurred by a Crown entity or other entities whose financial statements are consolidated into the financial statements of the Government (s4(2) of the Public Finance Act).

12.18.2 The Ministry will follow the process for withholding money set out in paragraph 12.18.5 below, when it has reasonable grounds to believe that a DHB is incurring or committing itself to expenses or capital expenditure that would put the Ministry at risk of breaching section 4 or 5 of the Public Finance Act.

12.18.3 It is anticipated that the withholding of money will be rare, especially as Appropriations Acts are passed annually. Any withholding of money is likely to be towards the end of the financial year.

12.18.4 The Ministry is able to withhold money from a DHB to an amount equivalent to that which would put the Ministry at risk, except as provided under a DHB's CFA, until such time that the Ministry is satisfied it would not be in breach of the Public Finance Act by supplying such money.

12.18.5 The process for withholding money is as follows.

a. In the first instance, and prior to giving any written notice, the Ministry will contact the DHB's Chief Executive to discuss concerns that the DHB may be putting the Ministry in breach of its appropriations and that the Ministry may have to withhold money as a result.

b. The Ministry will then immediately notify the Chief Executive in writing if it believes the Crown is entitled to withhold money, outlining the reasons.

c. On receiving the written notice, the DHB must respond within at least 10 working days regarding:

- whether the DHB considers the action to withhold money is reasonable in the circumstances and, if not,
- the reasons why the DHB believes withholding money is not reasonable in the circumstances.

d. If, having considered the reasons provided by the DHB, the Ministry is satisfied that the Crown should not withhold money, then the DHB will be notified and the money will not be withheld.

e. If the Ministry is not satisfied with the reasons provided by the DHB, then the Ministry will advise the DHB of its intent to withhold money, the amount to be withheld and the timing. Money will only be withheld for an amount and time period to alleviate the risk of the Ministry

being put in breach of the Public Finance Act, while minimising disruption to the DHB's operations.

f. Either party may seek dispute resolution in accordance with the CFA. Both parties will endeavour to resolve a dispute in good faith. A referral to dispute resolution shall not prevent withholding from taking place before the matter is so referred or is resolved.

g. In circumstances in which money has been withheld, but subsequently it is decided that some or all of the money will be paid to the DHB, the Ministry will pay the money in full or in part within five working days of resolution.

h. Nothing in this policy will limit the obligations of the Minister, the Ministry, the Director-General of Health or a DHB to carry out their statutory functions, duties or powers at any time.

i. A DHB should still meet its service coverage requirements under the CFA. In the event of non-delivery of services in a DHB's CFA, the Minister reserves the right to withhold funding equivalent to the price of the services not delivered.

12.19 Retention of surpluses by DHBs

(See s 165 of the CE Act.)

12.19.1 After consulting with the Minister of Health and a DHB, the Minister of Finance may, in writing, require the DHB to pay the Crown an amount equal to the whole or any part of a net surplus of the DHB and/or its subsidiaries. In these circumstances, the net surplus includes both an annual profit and an accumulated surplus, as determined in accordance with GAAP, or according to a basis agreed between the Minister of Finance and the DHB.

12.19.2 Subject to a DHB's agreed Annual Plan, the mental health ring-fence provisions (see Section 12.21) and elective service provisions (see Section 5.10), surpluses or deficits from each service area are to be aggregated. Surpluses may be retained by the DHB.

12.19.3 It is generally expected that surpluses arising from provision of public health and disability services will be put back into providing public health and disability support services in the DHB's region.

12.20 Capital charges

(See Crown Entities (Capital Charge Rules) Regulations 2011.)

12.20.1 DHBs will be invoiced and pay capital charge every six months into the Ministry's Crown Receipt Account.

12.20.2 The capital charge will be calculated by:

a. multiplying the DHB's liable net assets as at 31 December or 30 June (as the case may be) each year by the public sector discount rate that applied on that date

b. dividing the sum by two.

12.20.3 DHBs are expected to accrue capital charges monthly.

12.20.4 The Ministry's Service Commissioning business unit will use the 'as at 30 June' audited financial template (due October of each year) to calculate the capital charge, with payment due by 20 December of each year.

12.20.5 Service Commissioning will use the 'as at 31 December' financial template (due in January of each year) to calculate the capital charge, with payment due by 20 June of each year.

12.20.6 Assets donated to DHBs since 1 December 2003 are eligible for exemption from capital charge.

12.20.7 A donation will only be eligible for an exemption from capital charge if it:

a. relates to specifically identifiable non-current assets

b. is not from the Crown or an entity described in section 27(3) of the Public Finance Act, which includes:

- all Ministers of the Crown and all departments

- all Crown entities named or described in the CE Act
- organisations named or described in section 4 of the Public Finance Act (including Crown companies, trusts and councils)
- state owned enterprises
- offices of Parliament
- Reserve Bank of New Zealand
- any other entity whose financial statements are consolidated into the financial statements of the Government.

c. The date of donation is the date at which the relevant donated asset crystallises as a non-current asset on the balance sheet of the DHB.

d. The amount eligible for exemption from capital charge is the net book value (asset at cost or valuation less accumulated depreciation). Only the value attributable to the donated portion of an asset is eligible for exemption.

e. Where donated land and buildings have been revalued in line with NZ IAS 16 Property, Plant and Equipment, for which DHBs have received additional funding for the increase in capital charge and depreciation, the revalued amount is excluded from consideration for exemption.

f. Donated assets must be recorded individually in each DHB's fixed asset register and adequate records must be maintained.

g. In the event of a DHB disputing any matter relating to donated assets and their exemption from capital charge, the matter will be referred to Ministry's Service Commissioning business unit as it has authority to settle all such disputes.

12.21 Mental health

(See CAB (00) M 42/5B.)

12.21.1 The mental health ring-fence originates from a Cabinet decision that ring-fences can be applied within the bulk-funding environment of DHBs for services that need to be protected or encouraged. The mental health ring-fence to protect the development of specialist mental health and addiction services remains in place in 2017/18.

Mental health funding

12.21.2 The following are the imperatives relating to funding for specialist mental health and addiction services in 2017/18.

a. Mental health funding, as agreed by the Minister in the Annual Plan, must be used for specialist mental health and addiction services for people most severely affected by a mental illness or alcohol or other drug issue.

b. Efficiencies created through improved service models will be used to support the implementation of *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* (Ministry of Health 2012).

c. Services include those at the boundary between DHB-funded specialist services and primary health care or other agencies involved in the mental health and addiction treatment and care of service users. Examples are the provision of consultation and liaison services, coordination of shared care arrangements and training, advice and supervision.

d. DHBs' plans for changes in mental health and addiction services in their Annual Plans are subject to the service change provisions outlined in Section 4.

e. DHBs that seek to reduce their ring-fence level because of changes to IDFs related to service changes must be able to demonstrate that other DHBs involved agree to the service change. Documented agreement will allow the ring-fence levels of all affected DHBs to be adjusted appropriately.

f. DHBs should plan for an appropriate application of demographic and cost pressure funding to mental health.

g. DHBs with carried forward surpluses should plan in their Annual Plans for spending the surpluses on specialist mental health and addiction services. The Ministry will consult with

each DHB over the feasibility of its plans to use the accumulated funding during the Annual Plan process and may request that the DHB repays the surplus in whole or part to the Crown.

12.21.3 Total mental health funding for the funder arm for any year comprises:

a. prior year baseline funding

b. incremental funding, such as Demographics and cost pressure adjustments

c. devolved funding

d. prior year carried forward unspent funding.

12.21.3 The ring fence for 2017/18 is calculated according to the following criteria:

a. DHBs must apply demographics and cost pressure adjustments to their underlying expenditure in order to meet the Government expectation to maintain growing mental health expenditure (as a proxy for services)

b. underlying expenditure expectations will be determined from the historical 5 year DHB expenditure trend and 5 year projections based on expected cost pressure and demographic projections.

c. Where there are prior year underspends DHBs will ensure that their expenditure base is lifted back to the planned levels.

d. prior year underspends will be dealt with on a case by case basis with the DHB and will be informed by the following criteria.

- Where there are performance issues, one-off underspends should be used to fund one-off programmes to address the issue(s).
- Where one-off underspends are material the Ministry will discuss spreading the expenditure across years.
- Achievement of 3 percent access to specialist services is a criterion for providing DHBs with greater autonomy about their application of mental health surpluses, such as to primary mental health services.

Financial reporting of specialist mental health and addiction services

12.21.4 The following conditions apply to DHBs' planning and reporting of mental health and addiction services.

a. DHBs must be able to demonstrate fair pricing and fair funding over time to their provider arm and to NGOs that provide mental health and addiction services.

b. DHBs must plan to eliminate accumulated deficits in the funder arm.

c. DHBs must monitor service delivery by the provider arm and pay only for the services delivered. Where there is under-delivery, DHBs must reduce revenue for the provider arm accordingly.

d. If there is over-delivery of planned volumes by the provider arm, the funder arm and the provider arm must work together to identify reasons for the over-delivery and put in place a management strategy.

e. Whatever the reason for over-delivery in any financial year, DHBs must take steps to ensure that the over-delivery does not persist into the following year, either by reducing planned delivery or increasing planned funded levels.

f. If there is a provider arm surplus that is related not to the under-delivery of services but to the unplanned efficiency of the provider arm service, the disposition of this surplus is at the discretion of the DHB.

g. DHBs must plan to eliminate provider arm deficits.

h. Any demographic adjustments should support service expansion in the priority areas identified in DHB Annual Plan, whether provided by the DHB or the NGO sector.

12.21.5 Mental health ring-fence is a criterion for the status of DHBs on the monitoring and intervention framework (see Section 13.6).

Mental health planning

12.21.6 DHBs are required to give effect to the mental health ring-fence in their planning documents. In the mental health section of their Annual Plans, DHBs must:

a. show use of prior year agreed baseline starting position given in ring-fence expectation advice

b. show the mental health share of Funding Package adjusters (cost pressure and demographics)

c. set out new mental health funding devolutions

d. show the reinvestment of prior year funder arm carry-forwards

e. match forecast revenue to expectations

f. match figures, where appropriate, across the Annual Plan text, and the mental health Funder and Eliminations worksheets of the main Annual Plan financial template and the mental health plan template

g. match the Production Plan values to the provider arm's internal revenue figures, as well as to values in the Annual Plan Eliminations worksheet

h. match the sum of the total dollar amounts in the Provider and Funder Production Plan to the funder revenue

i. show phased financial and service growth figures for new funding/application of surpluses to new services, which match the proposed timeframes in the Annual Plan text.

12.22 Guarantees and indemnities

(See ss 160–164 of the CE Act and Guidance for Crown Entities, March 2006 v1.1.)

Statutory background to giving guarantees and indemnities

(See clause 45A of Schedule 3 to the NZPHD Act, ss 160 and 163 of the CE Act, and regulation 14 of the Crown Entities (Financial Powers) Regulations 2005.)

12.22.1 DHBs and their subsidiaries may not give guarantees or indemnities unless an exception applies. Regulation 14 of the Crown Entities (Financial Powers) Regulations 2005 sets out permitted guarantees and indemnities.

12.22.2 Regulation 14(3) of the Crown Entities (Financial Powers) Regulations 2005 provides that an indemnity given by a DHB that relates to a class of contract outlined in subclause 2(d) to (h) may be contained in an ancillary contract or instrument (including a trust) relating to that class of contract, if the indemnity is contained in the standard printed terms and conditions of the DHB, or the counterparty as the case may be.

12.22.3 Restrictions on the giving of guarantees and indemnities by DHBs do not apply if the other person is either:

a. a member, office holder, committee member, employee or other individual indemnified by the Board in relation to any claim or proceeding under section 122 of the CE Act (which relates to any excluded act or omission), section 162 of the Companies Act 1993 (which applies to DHB subsidiaries), or the DHB's natural person powers or any other powers in the NZPHD Act, or

b. a delegate or agent indemnified by the Board under its natural person powers, or the common law, in relation to any claim or proceeding.

Similarly, restrictions on the giving of guarantees and indemnities by DHBs do not apply to any guarantees or indemnities that are implied at law or arise from any transactions that may be authorised under regulations made under Part 4 of the CE Act.

Obligation

12.22.4 A DHB's Board has a duty to ensure that the DHB operates in a financially responsible manner, including by prudently managing the giving of guarantees and indemnities (see Section 12.7).

12.22.5 Each DHB must maintain, as part of its Treasury policy, a policy position on the giving of guarantees and indemnities (covering both procurement and provision of services) in order to provide a level of assurance around the management of guarantees and indemnities. Any such policy should allow normal commercial practice to operate, while controlling the giving of guarantees and indemnities that are irregular, or that invert normal commercial practice, at a Board level.

12.22.6 Each DHB must keep a register of any indemnities or guarantees that it gives, and insure for them accordingly. As a minimum, it is suggested that the register includes:

a. name of person/company/group indemnified

b. detail of the contract entered into (ie, nature of the services)

c. amount of the indemnity

d. terms of contract and total amount of services

e. any special conditions attached to the indemnity

f. a record that DHB insurer has been notified of indemnity issued.

12.23 Cooperative agreements and arrangements

(See ss 22, 23(1)(b), 24 and 28 of the NZPHD Act.)

12.23.1 , A DHB may enter into cooperative agreements and arrangements, for the purpose of performing its functions under section 23(1)(b) of the NZPHD Act, with any person (whether or not that person is involved in the health and disability sector) to:

a. assist the DHB to meet its objectives set out in section 22 of the NZPHD Act, or

b. enhance health or disability outcomes for people, or

c. enhance efficiencies in the health and disability sector.

12.23.2 A DHB must seek Ministerial approval before entering into a cooperative agreement or arrangement. Ministerial authority to enter into a cooperative agreement or arrangement may be given subject to any conditions the Minister specifies (section 28(1) of the NZPHD Act).

12.23.3 Further guidance about the process for obtaining ministerial consent under section 24 of the NZPHD Act, including a copy of the Minister's guidelines, is available from the Ministry's Governance & Crown Entities team. DHBs are advised to contact this team early in the process of developing arrangements that may require ministerial consent.

12.23.4 Section 3.19 contains additional protocols for relationships and arrangements with the private sector.

12.24 Acquisition of securities, shares and other interests

(See s 28 of the NZPHD Act and ss 160 and 161 of the CE Act.)

12.24.1 Sections 160 and 161 of the CE Act restrict the acquisition of securities by DHBs except:

a. those covered by section 28 of the NZPHD Act (see below)

b. debt securities in New Zealand dollars issued by a registered bank or any other entity that satisfies a prescribed credit-rating test

c. public securities

d. when authorised under regulation or joint ministerial authority provisions of the CE Act. (Note: there are none in place at this time.)

12.24.2 Section 28 of the NZPHD Act continues to apply to the acquisition of shares and interests by DHBs. Section 96 (acquisition of subsidiaries) and section 100 (acquisition of shares or interests

in companies, trusts and partnerships etc) of the CE Act do not apply to DHBs (ss 21(3) and 28(4) of the NZPHD Act).

12.24.3 Unless it has the consent of the Minister or is acting in accordance with the regulations made under the NZPHD Act (note: there are none in place related to this matter at this time), no DHB may either:

a. hold any shares or interests in a body corporate or in a partnership, joint venture or other association of persons, or

b. settle, be or appoint a trustee of a trust (s 28(1) of the NZPHD Act).

The Minister's consent for either of the above may be given subject to any conditions the Minister specifies (s 28(1) of the NZPHD Act).

12.24.4 Debt securities are defined in section 2(1) of the Securities Act 1978 (Securities Act) to include debentures, debenture stock, bonds, notes, certificates of deposit and convertible notes, and any interest or right that is declared by regulations to be a debt security for the purposes of the Securities Act. The definition does not include an interest in a contributory mortgage where the interest is offered by a contributory mortgage broker.

12.24.5 Further guidance about the process for obtaining consent under section 28 of the NZPHD Act, including a copy of the Minister's guidelines, is available from the Ministry's Governance & Crown Entities team. DHBs are advised to contact this team early in the process of developing proposals involving interests in other legal entities under section 28.

12.25 DHB subsidiaries

(See ss 7(c), 8, 97-99, 139, 156A, 156B, and 157A of the CE Act)

12.25.1 A 'Crown entity subsidiary' is a company incorporated under the Companies Act 1993 that is controlled by one or more Crown entities (parent Crown entity) (s 7 of the CE Act). DHB subsidiaries come within this definition and are generally covered by the same requirements that govern their controlling DHB (see sections 97 and 98 of the CE Act).

12.25.2 In particular, DHB subsidiaries must not do anything that the parent itself (the DHB) does not have the power to do (s97(a) and must comply with ss 161 to 164 (financial powers provisions) of the CE Act.

12.25.3 If a crown entity subsidiary is not part of a crown entity group (as defined by the CE Act) or has its own subsidiaries, then it must prepare accountability documents (such as SOIs, Annual Reports and SPEs) unless given an exemption for itself and its subsidiaries (section 156A of the CE Act).

12.25.4 If a crown entity subsidiary is part of a crown entity group, the parent crown entity (usually the parent DHB) must include consolidated information about its subsidiary in its own accountability documents (section 156A of the CE Act).

12.25.5 If a DHB subsidiary is a multi-parent subsidiary then it does not need to prepare statements or reports unless required by the Minister of Finance (see sections 156A and 157A of the CE Act).

12.25.6 The Minister of Finance may require members of a Crown Entity Group to prepare statements or reports as if it were not a member of a Crown Entity Group by notice in writing (section 156B CE Act)

12.25.7 A DHB subsidiary must act consistently with parent DHB objectives and ensure that it does not do anything that the parent itself does not have the power to do (s97 of the CE Act). Sections 97 to 99 also set out other restrictions and rules relating to DHB subsidiaries.

12.26 Full-time equivalent definition

12.26.1 Full-time equivalents (FTEs) are defined in the document 'measuring staff resources – counting FTEs' that is available on the NSFL website.

12.26.2 The monthly financial template collects Accrued FTE for all staff types, Establishment FTE for management/administration staff and Employed FTE for medical and nursing staff. The definitions and rationale for each methodology are provided in *Requirements and Guidelines for Using Financial Templates* also available on the NSFL website.

12.27 Asset valuation

(See Public Sector Public Benefit Entity Accounting Standards (PBE Standards) (PBE International Public Sector Accounting Standards [IPSAS]) 17 Property, plant and equipment, PBE IPSAS 31 Intangible assets and Crown Accounting policies.)

12.27.1 DHBs must revalue property, plant and equipment (PPE) in accordance with PBE IPSAS 17 Property, plant and equipment, as interpreted in the Crown accounting policies.

12.27.2 Where an item of PPE is constructed, any borrowing costs associated with the construction must be expensed (Crown accounting policies), unless allowed for in a DHB's CFA (PBE IPSAS Borrowing costs).

12.27.3 Land and buildings are recorded at fair value less impairment losses and, for buildings, less depreciation accumulated since the assets were last revalued. Valuations undertaken in accordance with standards issued by the New Zealand Property Institute are to be used where available. Otherwise, valuations conducted in accordance with the Rating Valuation Act 1998, confirmed as appropriate by an independent valuer, are to be used (Crown accounting policies).

12.27.4 Other PPE (eg, motor vehicles, office equipment) and intangible assets are recorded at cost less accumulated depreciation/amortisation and accumulated impairment losses.

12.27.5 Revalued classes of PPE are to be revalued again at least every five years or whenever the carrying amount differs materially to fair value. For example, some items of PPE experience significant and volatile changes in fair value, which may require annual revaluation. Other items of PPE experience insignificant changes in fair value; for these items, it may be necessary to revalue only every three or five years.

12.28 Asset management planning

(See *Capital Assessment Guidelines* (Capital Investment Committee 2011), and Cabinet Office Circular CO (15) 5 *Investment Management and Asset Performance in the State Services* (29/06/2015). Also, see guidance on Investment Management on the Treasury's websitehttp://www.treasury.govt.nz/statesector/investmentmanagement.

12.28.1 DHBs must undertake formal asset management planning.

12.28.2 Each DHB must prepare an asset management plan showing planned future asset replacement and expected financing arrangements for asset replacement, including the use of cash generated from operations.

12.28.3 Asset management plans must address:

a. strategic asset management
b. strategic asset financing
c. facilities and major equipment
d. Information Services Strategic Plan (ISSP).

12.28.4 Asset management plans must be maintained as a 'live document' and kept up to date. Components of the asset management plan will be required as part of Annual Plans, Regional Service Plans and business case development.

12.29 Investment Management and Asset Performance

(Cabinet Office Circular CO (15) 5 *Investment Management and Asset Performance in the State Services* (29/06/2015). See also Investment Management guidance on the Treasury's website)

12.29.1 All DHBs must provide a Long-term Investment Plan to the Ministry. The Long-term Investment Plans for Investment Intensive DHBs must be submitted to Treasury in line with the requirements of the Investment Management and Asset Performance process supported by the Treasury. All Investment Intensive DHBs must undertake the assessment process as required for the Investor Confidence Rating element of the Investment Management and Asset Performance process supported by the Treasury.

12.30 Business cases

(See *Capital Assessment Guidelines* (Capital Investment Committee 2011), and Cabinet Office Circular CO (15) 5 *Investment Management and Asset Performance in the State Services* (29/06/2015) and The Treasury's Better Business Cases Guidance.) Guidance on Risk Profile Assessments is available on the Treasury's website.

12.30.1 DHBs are required to comply with The Treasury's Better Business Cases process and the Capital Investment Committee's Capital Assessment Guidelines where they fit with the criteria below. DHBs should discuss all material capital cases with the Ministry of Health's Capital and Operating team at the initiation stage to agree the scope and procedural requirements.

12.30.2 Joint approval from the Ministers of Health and Finance is required for:

a. all capital investments in fixed assets, which require Crown equity or new debt support

b. investment projects or programmes totalling $10.0 million or 20 percent of total assets, whichever is the lesser

c. investments that have the potential to strategically affect the performance of DHBs, or investments that the State Services Commission has identified as being of high risk.

12.30.3 The criteria in paragraph 12.30.2 above apply irrespective of the source of funding, for example, including when a public private partnership is used for the investment.

12.30.4 Lower approval thresholds applying to investments in information systems and communications technology are approval by the:

a. Minister of Health for investments over $3.0 million

b. Director-General of Health for investments between $0.5 million and $3.0 million.

12.30.5 Risk Profile Assessments (RPAs) should be completed for all significant investments, in line with the requirements noted on the Treasury website (noted above). If the project is medium or high risk, the DHB must submit an RPA to the Treasury Gateway Team.

12.30.6 The Crown considers funding for health capital as part of the normal Budget process. DHBs should ensure that capital intentions accurately reflect all expected capital expenditure (including placeholders as necessary) to accurately inform the Budget process.

12.30.7 DHB capital projects can be financed from:

a. DHB contribution

b. Crown equity from the Health Capital Envelope

c. finance leases (see Section 12.17 above)

d. private debt with the prior approval of the Ministers of Finance and Health

e. donations from the community

f. public private partnerships.

12.30.8 Once Crown equity has been approved by the Crown, the DHB is required to provide the Ministry, as part of the Project Assurance Report, with a monthly drawdown forecast for the next 12 months for the approved project.

12.30.9 All Crown equity must be drawn by the DHB within 12 months of the completion of the project or it will be returned to the Health Capital Envelope.

12.31 Dealings with land

(See s 22 and clause 43 of Schedule 3 to the NZPHD Act, ss 40–42 of the Public Works Act 1981 (Public Works Act) and *Guidelines for DHB Disposal of Land or Lease/Licence of Land for a Term of More than Five Years*).

12.31.1 No DHB may sell, exchange, mortgage or charge land without the prior written approval of the Minister.

12.31.2 Applications to the Minister for approval for the sale or exchange of any land must:

a. include details of the public consultations held

b. inform the Minister of the views of the resident population

c. state how the sale will assist the DHB to meet its objectives under the NZPHD Act.

12.31.3 DHBs must comply with the offer-back provisions of Public Works Act, which includes requirements relating to the Māori protection mechanism and the sites of significance process when disposing of surplus properties.

12.31.4 Proceeds or payments arising from the sale or exchange of land must be used for the purchase, improvement or extension of publicly owned facilities for health purposes, unless the Minister approves a different use of the proceeds or payments.

12.31.5 No DHB may grant a lease or licence over land for a term of more than five years, without prior written approval from the Minister.

12.31.6 Approvals under clause 43 of Schedule 3 to the NZPHD Act may be subject to any conditions the Minister specifies, and may be given in respect of any land of a class the Minister specifies. A DHB that receives a written approval under this clause must, as soon as practicable, table the approval at a DHB Board meeting.

12.31.7 Detailed guidance for approvals under clause 43 of Schedule 3 to the NZPHD Act is provided in the *Guidelines for DHB Disposal of Land or Lease/License of Land for a Term of More than Five Years.*

12.32 Contribution to financial cost associated with membership of the Australasian Health Infrastructure Alliance

12.32.1 DHBs must contribute to the financial costs associated with the New Zealand membership of the Australasian Health Infrastructure Alliance (estimated total cost for 2014/15 is AU$130,000). From 2014/15 the DHB contributions will be calculated based on PBFF share. DHBs will be invoiced quarterly.

13 Monitoring and reporting

13.1 Purpose of the chapter

13.1.1 This chapter sets out DHBs' monitoring and reporting requirements, encompassing reporting to the Minister and the Director-General of Health, national health information management and reporting requirements, national collections requirements, and requirements relating to ACC. It also sets out the Ministry's obligations to DHBs.

Summary of mandatory requirements

Each DHB must:

- prepare an Annual Report and annual financial statements along with any additional information required by the Minister of Finance or any other Minister under any statutory provision **(Section 13.2 and 3.7)**
- deliver its quarterly report information by the 20th day of the month following the end of the quarter **(Section 13.3)**
- report to its Board the DHB risk management and reporting systems to manage DHB risks **(Section 13.4)**
- submit its monthly financial report **(Section 13.5)**
- adhere to the principles of the monitoring and intervention framework **(Section 13.6)**
- comply with the requirement to supply at a specified time or times any information that the Minister or the Ministry of Health requires in relation to any aspect of the operations of the DHB or its subsidiaries **(Section 13.7)**
- conduct day-to-day relationships with the Ministry in an environment of consultation and collaboration **(Section 13.8)**
- be a good corporate citizen in respect of the information it provides **(Section 13.10)**
- provide information of the highest possible quality, standards and completeness **(Section 13.10)**
- make documentation available on request for audits of data collection and reporting processes **(Section 13.12)**
- follow privacy and security rules **(Section 13.13)**
- collect, report, store and output accurate and complete ethnicity data **(Section 13.14)**
- ensure that all of its providers of publicly funded health services submit data to National Collections Systems **(Section 13.15)**
- follow processes attached to the National Health Index **(Section 13.11)**
- supply the correct Health Practitioner Index data **(Section 13.16)**
- adhere to the guidelines concerning the Medical Warning System **(Section 13.17)**
- ensure all providers that are contracted to provide hospital inpatient and day patient services report the data on those services to the National Minimum Data Set; alternatively the DHB undertakes to submit these data **(Section 13.18)**
- adhere to the rules relating to the National Booking Reporting System **(Section 13.19)**
- by 30 August of each financial year, provide data under its contracts with providers for the Programme for the Integration of Mental Health Data **(Section 13.20)**
- supply data to the National Immunisation Register **(Section 13.22)**
- supply data on B4 School Checks **(Section 13.23)**
- supply data to the National Non-admitted Patient Collection **(Section 13.24)**
- complete medical certificates and forms for individual claimants as required by ACC **(Section 13.25)**

The Ministry must:

- provide each DHB with a report on any planned reviews of the DHB **(Section 13.26)**

13.2 DHB annual reporting process

(See ss 150–157A of the CE Act as amended by the CE Amendment Act 2013.)

13.2.1 DHBs are required to produce an Annual Report in accordance with ss 151–157 of the CE Act. Unless the Minister of Finance requires that a subsidiary is to report in its own right, or a subsidiary also has its own subsidiary, DHBs, as Crown Entity Parents, are to report on their subsidiaries' behalf.

13.2.2 The Service Commissioning business unit is responsible for the oversight of the process and will continue to send out annual reminders each August to DHBs. See Section 3.4 of the OPF for further information about the reporting requirements.

13.3 DHB quarterly reports (non-financial)

(See s 133 of the CE Act and CAB 00 M15/10.)

13.3.1 Each DHB will deliver its quarterly report information by the 20th day of the month following the end of a quarter.

13.3.2 Non-financial quarterly reports should analyse actual performance. They should focus on material variances and material risks, and describe how the DHB is addressing these. Reports will focus on indicators, set out in agreed Annual Plans, and will address any additional reporting requirements as detailed on the Non-Financial Quarterly Reporting website http://www.moh.govt.nz/apps/dhbq.nsf/Logon?OpenForm (DHB password required). Where either targets are not achieved or progress is delayed, a resolution plan must be forwarded with the report.

13.3.3 Where performance against an indicator is assessed as significantly poor, the DHB will be required to report again in subsequent quarters until the issue is satisfactorily resolved.

13.3.4 The Ministry will provide a quarterly Health Report to the Minister on the performance of each DHB. The report will be a consolidated assessment of the information on Health targets, performance measures and a summary of financial performance for the quarter.

13.3.5 DHBs are required to post reports through the Ministry's Non-Financial Quarterly Reporting website. Initial Ministry feedback – providing acknowledgement, seeking clarification or requesting supplementary information – will also be posted on the DHB website. The Ministry will ensure that DHBs have a minimum of five working days in which to respond to its feedback.

13.4 DHB risk management

(See CAB 00 M15/10.)

13.4.1 Each DHB must have a formal risk management and reporting system:

a. to manage DHB risks and report them to its Board

b. that meets current Australia/New Zealand Standard requirements (including *AS/NZS ISO 31000:2009, Risk management - Principles and guidelines* and HB 228:2001) relating to risk management.

13.4.2 It is expected that, where any non-compliance exists (with either (a) or (b) or both in paragraph 13.4.1), DHBs will transition to compliance no later than six months after the non-compliance is first reported. A planned pathway to full compliance, including key milestones and timelines, should be formalised and provided to the Ministry no later than three months after the non-compliance is first reported.

13.4.3 The DHB's Chief Executive or Board will inform the Director, Service Commissioning in writing, as soon as possible, of:

a. any risk that a DHB's Chief Executive or Board deems that the Minister should be made aware of

b. the DHB's mitigation strategy for managing such a risk.

The above notification will be copied to the DHB's Regional Relationship Manager at the Ministry.

13.5 DHB monthly financial reports

(See s 133 of the CE Act and CAB 00 M15/10.)

13.5.1 Each DHB must submit its monthly financial report (including any required supplementary information) in the format specified by the Ministry, based on the Common Chart of Accounts.

13.5.2 Monthly financials, financial commentaries and financial monitoring templates are due by the 12th day of the following month, except where an extension is granted by the Ministry.

13.5.3 Each report must comply with the requirements and standards set out in *Requirements and Guidelines for Using Financial Templates* available on the NSFL website.

Mental health quarterly financial reports

(See s 133 of the CE Act and CAB 00 M15/10.)

13.5.4 Each DHB must submit its quarterly mental health financial report (including any required supplementary information), in the format specified by the Ministry, by the 20th day of the month following the end of the quarter, except where an extension is granted by the Ministry.

13.6 Monitoring and intervention framework

13.6.1 The monitoring and intervention framework (MIF) is in two parts:

a. the part administered by the Ministry (Table 13.2)

b. the part setting out ministerial decisions (Table 13.3).

13.6.2 The purpose of the MIF is to encourage DHB performance. The MIF is based on the principle that DHBs performing satisfactorily should be relatively free from intervention in their business, and should be given full opportunity to achieve their objectives as set out in their approved accountability documents. The MIF, which is set out in Tables 1–3 below, has been developed to give DHBs clarity in:

a. triggers for moving up and down the Ministry's MIF levels

b. actions required by the Ministry and DHBs at each of these levels

c. potential consequences of being at each of these levels.

13.6.3 The MIF provides for increasingly intensive levels of monitoring and, where necessary, intervention to ensure that issues relating to poor performance are addressed. The framework is designed to ensure that Ministry undertakes its monitoring and intervention in a consistent and transparent manner.

13.6.4 The Ministry receives monthly DHB financial data, as well as quarterly non-financial reporting. Where the identified triggers (Table 13.2) indicate that review of a DHB's MIF status is necessary, the Ministry will:

a. validate the information with the DHB, then

b. review the level of monitoring and intervention, unless the DHB can demonstrate that it has robust and convincing action under way to address the situation.

As part of its financial monitoring of DHBs, the Ministry is focussing on the financial reports provided to Boards from management to explore ways to improve the scope and level of detail provided. This includes providing support through external advisors, and development of financial reporting templates to assist DHB Boards under intensive monitoring due to financial performance issues to better understand the trends and patterns in costs and in the activities which drive them, particularly for the hospital provider where expenditure and risk is high. A DHB under intensive monitoring is required to adopt these models as part of the MIF.

13.6.5 Each DHB is expected to manage organisational risk and to strive to retain 'standard monitoring' status. To retain the lowest level of Ministry monitoring, the leadership of each DHB is expected to encourage an organisational culture that ensures that high performance and effective risk management are core activities. Organisational structure, risk management processes, capability building, and constant internal review should maintain performance and facilitate the achievement of the Government's health goals and objectives. DHBs are also expected to monitor contracts they are responsible for, including service agreements (see s 23(1)(i) of the NZPHD Act).

13.6.6 The Ministry is responsible for moving DHBs between three MIF levels – standard monitoring, performance watch, and intensive monitoring. Movement may not always be linear (ie, in serious cases, a DHB could be moved from standard monitoring directly to intensive monitoring).

13.6.7 The MIF also includes two ministerial levels: intermediate governance action and direct governance action. To clarify, there is no direct relationship between any of the Ministry's three monitoring and intervention levels and the two ministerial monitoring and intervention levels. The two ministerial governance actions are at the Minister's discretion, and may be taken by the Minister at any time. These ministerial governance levels are independent of the Ministry's MIF levels, as shown in Table 13.1 below:

Table 13.1: The Ministry and ministerial levels of the MIF

Ministry MIF levels	Ministerial MIF levels
Standard monitoring	Intermediate governance action
Performance watch	Direct governance action
Intensive monitoring	

13.6.8 Intermediate governance action indicates the Minister has appointed one or more Crown monitors to a DHB's Board (s 30 of the NZPHD Act). While the Minister may appoint these Crown monitors as a governance response to issues facing DHBs, the Minister may also appoint Crown monitors in an organisational improvement role, and to address particular issues facing DHBs.

13.6.9 Direct governance action sees the Minister dismissing a DHB's Board and replacing it with a commissioner (s 31 of the NZPHD Act). The Minister is entitled to do this if seriously dissatisfied with the performance of a DHB Board.

Table 13.2: Ministry MIF levels

Level and requirements (triggers)	Actions and potential additional consequences
Standard monitoring The DHB has supported accountability documents/arrangements in place in a timely manner (Regional Service Plan, Annual Plan, CFA, SOI). The DHB is performing to all key areas of its supported Annual Plan (ie, services, financial, and other indicators), and is in a sound financial position. The DHB is complying with timely and accurate provision of information for formal reporting requirements.	**Actions** Standard monitoring and reporting requirements apply as obliged via the CFA.
Performance watch The DHB: • has not complied with standard monitoring requirements, and/or • has an emerging deterioration in its performance against its Annual Plan, and/or • has a supported Annual Plan containing substantial risks that are not yet fully managed.	**Actions** The DHB takes actions as per the Standard Monitoring requirements. It also provides a Board-funded and approved report to the Ministry identifying trends, causes and corrective actions to be taken by the DHB. The Ministry monitors the DHB's progress towards implementation of corrective actions signalled in the Board report. **Potential additional consequences** Regular (up to monthly) review meetings between the Ministry and the DHB to discuss issues. Up to four Chair and Chief Executive meetings with the Ministry to discuss the Board report. Ability to commit capital limited to levels agreed with the Ministry. Likely trigger for Minister of Finance's interest in DHB. Appoint an expert team to engage in a 'turnaround' process (with DHB

Level and requirements (triggers)	Actions and potential additional consequences
	agreement).
Intensive monitoring The DHB: • is unable to achieve Minister's support for its Annual Plan within agreed timeframes set by the Ministry, or • is continuing non-compliance and/or deteriorating in either standard monitoring requirements and/or performance watch requirements, or • has a single event that seriously affects planned performance or creates material risk.	**Actions** The DHB takes action as per the Standard Monitoring requirements. It also conducts a Board-funded in-depth review, for which the Ministry selects reviewer and sets the terms of reference in consultation with the DHB. The DHB provides a Board-funded and approved report to the Ministry identifying trends, causes and corrective actions to be taken by the DHB. The Ministry monitors the DHB's progress towards implementation of the Board-approved action plan. Potential additional consequences The Ministry, with the agreement of the Minister, requires the appointment of an expert team to engage the DHB in a 'turnaround' process. Other potential additional consequences apply as per performance watch. The Minister may require a meeting with the Chair to discuss performance.

Table 13.3: Minister of Health MIF levels

Level and requirements (triggers)	Actions
Intermediate governance action At the Minister's discretion.	The Minister appoints one or more Crown monitors (s30 of the NZPHD Act), either as a governance response to issues facing a DHB or in an organisational improvement role, to address particular issues facing a DHB.
Direct governance action At the Minister's discretion.	The Minister replaces all the Board with a Commissioner and terms of reference.

13.7 Information for the Minister

(See ss 133 and 134 of the CE Act, ss 28 and 41 of the State Sector Act, and CAB 00 M15/10.)

13.7.1 Under section 133 of the CE Act, the Minister may request any DHB to supply, at a specified time or times, any information that the Minister - requires relating to the operations and performance of the DHB . DHBs must comply with this requirement, unless there are good reasons for refusing to supply the Minister with the requested information (see s134 of the CE Act). In order to deliver on this requirement each DHB is expected to provide the Ministry with relevant information relating to the operations and performance of the DHB.

13.7.2 Each DHB is expected to provide the Ministry with:

a. all information within the DHB's control necessary to enable the Ministry to conduct special reviews and audits of the DHB's performance. These reviews and audits may be carried out as often as the Crown reasonably believes they are required

b. information that will enable the Ministry to prepare ministerial briefings and draft speech notes. The DHB is to provide this information in writing and, where practicable, in an agreed format (normally within the timeframe agreed by the briefing writer, but always no later than three days prior to the date required by the Minister)

c. information (in writing and, where practicable, in an agreed format) that will enable the relevant Minister to respond to:

- written Parliamentary questions within two working days
- oral Parliamentary questions on the same day by 11.30 am
- ministerial correspondence within three working days or to meet the timeline the Minister has requested.

13.7.3 Each DHB is to also deal with select committee enquiries within 10 working days in the case of a standard question, and within five working days in the case of supplementary questions, or such other timeframe as specified by the committee.

13.8 Ministry–DHB relationship protocol

13.8.1 It is expected that day-to-day relationships between the Ministry and DHBs will be conducted in an environment of consultation and collaboration. It is also expected that the majority of issues will be satisfactorily resolved by initial dialogue between the DHB Regional Relationship Manager, or another equivalent Ministry contact, and the appropriate and relevant DHB contact.

13.8.2 To deal with situations where it has not been possible to reach an accommodation and to resolve the outstanding issues in a timely manner, all parties are to abide by the Ministry–DHB relationship protocol detailed in Table 13.4.

Table 13.4: The Ministry–DHB relationship protocol

	Condition	Responsibility		Action by Ministry	Suggested timeframe
		Ministry	DHB		
0	Either: Seeking to resolve an outstanding issue, or non-compliance of an already agreed deadline. Lack of compliance may include only partial completion of the total requirement	Regional Relationship Manager	DHB contact	Raise the issue and seek to effect an early resolution. If issue involves a missed deadline, DHB to be reminded as soon as possible that deadline is missed and compliance is required or reason to be supplied. If reason for delay is not considered reasonable, advise that escalation will occur.	As soon as possible
1	If no satisfactory resolution	DHB Relationship Manager Responsible Manager	General Manager or Chief Executive	The DHB Regional Relationship Manager initially seeks to resolve problem with appropriate DHB Relations Manager. If timeline involved, agree a new timeline. The DHB Regional Relationship Manager is to secure a resolution plan in writing If DHB does not comply, advise that escalation will continue after this period and that poor performance will be identified to the Minister.	24–48 hours
2	Disagreement at Level 1, or if no response from DHB within new agreed timeline (if appropriate), or 24 hours if no change to original requirement	Deputy Director-General, Director-General or Director, Service Commissioning	Chief Executive	Letter prepared by responsible manager / DHB Regional Relationship Manager for Deputy Director-General, including options that are available to the Ministry and/or DHB. Deputy Director-General either speaks to or forwards letter to Chief Executive. Deputy Director-General decides whether or not Director-General to release letter. CE should be given sufficient time to reply in writing.	Deputy Director-General, Director-General or Director, Service Commissioning decision
3	If Deputy Director-General unable to reach resolution with DHB Chief Executive	Minister	Chair	Brief prepared by the responsible manager / DHB Regional Relationship Manager for Minister, providing background to escalation including draft letter to be forwarded by the Minister to the Chair. The Minister may wish to initiate discussion with the DHB Chair rather than sending a note of censure. If the Minister agrees to sign off the letter to the Chair, the Deputy Director-General should formally advise the appropriate Chief Executive of this action prior to the Chair's receipt of the Minister's letter.	Minister's decision

13.9 The provision of quality information

Sections 13.11 to 13.26 set out the obligations for DHBs to be good corporate citizens in respect of the information they provide. These obligations and responsibilities are recorded below with the specific authority for the delivery of the information.

13.10 Quality, standards and completeness

(See s 23(1)(k) of the NZPHD Act, ss 133 and 134 of the CE Act, and CAB(00) M22/11.)

13.10.1 In respect of information provided to the Ministry (either directly or via other organisations, particularly those operating under a bulk funding arrangement), DHBs must take the following action.

a. Ensure that the information is of the highest possible quality. The information must be timely, comprehensive, accurate, consistent and a complete representation of the facts.

b. Take proactive action to develop and improve internal processes in order to maximise data quality. This activity must include:

- considering the negative effect any proposed system change may have on data quality and minimising this impact
- providing appropriate training and resources to staff involved in the collection, dissemination and storage of health information
- undertaking timely consultation with the Ministry when changes are going to be applied.

c. Apply sufficient resources to meet high-quality extracts to the National Collections Systems.

13.11 National Health Index

(See s 23(1) of the NZPHD Act and CAB (00) M 22/1.)

13.11.1 To ensure National Health Index (NHI) information is complete and accurate, each DHB is required to:

a. ensure that processes are maintained to assign the correct NHI number to all transactions relating to services for an individual patient provided either by the DHB or its contracted suppliers. Where health information is shared with primary health care providers to facilitate implementation of coordinated care (such as in the case of immunisation), the correct NHI number and associated identity information is required

b. improve the quality of the NHI data collected from patients, including by reducing the use of unspecified values in mandatory fields (particularly ethnicity ‘unknown’) and updating address data

c. eliminate the avoidable registration of duplicate NHI numbers by ensuring that, before registering a new number, NHI searches are conducted as outlined in the NHI Access Agreement and best practice documentation

d. Create an NHI number for all stillborn children and notify this to the Ministry within 48 hours of the birth to enable Ministry staff to enter the date of death on the NHI record (e-mail to [datamanagementservices@moh.govt.nz] and [mortality_administration@moh.govt.nz]).

e. ensure that all NHI data is stored, maintained and transmitted in compliance with relevant codes of information privacy and security, including the Health Information Privacy Code 1994, the Privacy Act 1993, the Health Network Code of Practice 2002 and the Privacy Authentication and Security (PAS) Framework

f. have the ability to identify each user of the NHI at an individual level within the DHB environment and primary health care providers as per the NHI Access Agreement requirements

g. ensure that the daily Ministry NHI link and unlink notifications are actioned in local patient management systems.

13.11.2 DHBs, in conjunction with primary health care providers, are responsible for establishing and maintaining identity data and updating the NHI. They must, as far as possible, ensure NHI data is

complete and accurate as a result of their direct contact with patients. To assist DHBs and primary health care providers with this task, the Ministry (specifically the Ministry's Client Insights and Analytics [CI&A] business unit) will monitor and report back to the DHBs and PHOs regarding the quality of NHI data that each DHB and primary health care provider has submitted (for example, completeness and number of duplicate entries). DHBs and CI&A will work together to continuously improve the accuracy of information on the NHI register.

13.12 Audit of data collection and reporting

13.12.1 Each DHB must ensure that clinical coded data submitted to National Collections complies with ICD-10-AM/ACHI classification standards/guidelines, the New Zealand coding conventions and the National Minimum Dataset (NMDS) requirements by:

a. ensuring clinical documentation is available, complete and consistent at time of clinical coding

b. ensuring clinical coded data reported to the NMDS is a complete representation of the episode of care

c. ensuring processes are in place to continually evaluate and improve the quality of clinical coded data

d. informing the Ministry on activities and actions taken in relation to data quality reports generated by the Ministry

e. reviewing NMDS event and coded data and providing feedback when requested to do so by the Ministry

f. correcting errors in NMDS event and coded data that are identified by the Ministry

g. participate in quality improvement activities to ensure that the quality of the clinical coded data supports research, policy making and planning

h. providing an opportunity for clinical coders to participate in continuing education, both internal and external to the DHB, and ensuring individual clinical coders have an education development plan.

13.13 Privacy and security

(See s 23(1) of the NZPHD Act, s 134 of the CE Act, CAB (00) M 22/11 and the Health Information Privacy Code 1994.)

13.13.1 DHBs are to ensure the following.

a. Personally identifiable information about individuals is treated with the utmost care and is compliant with privacy legislation and security policies.

b. A formal written authorisation is established before their agents access personal information from the National Collections Systems under the 'Information Sharing Agreement between NZHIS & DHBs' that came into effect on 18/12/07. The authorisation is to specify the agency relationship, the purpose(s) for granting the access, and the intended use of the information.

c. When the authorisations (referred to in (b) above) are established or changed, this is immediately reported to the Ministry.

d. Both information and IT systems managed by the DHB are protected to prevent unauthorised access, or damage to or disclosure of information held, whether by individuals, malware or viruses.

13.14 Ethnicity reporting

(See s 23(1)(k) of the NZPHD Act 2000, CAB (00) M 22/11, CAB Min (02) 31/13, POL Min (03) 27/3 and CAB Min (04) 42/5A.)

13.14.1 For all patient-specific services and with particular reference to ethnicity, DHBs must take the following actions.

a. Collect, record, store and output accurate and complete ethnicity data, based on the Ethnicity Data Protocols for the Health and Disability Sector. As part of this process, each DHB must:

- ensure that all service providers meet the national standards indicated in service agreements to monitor provider compliance, and there is effective follow-up where these requirements are not met
- work with the Ministry to educate providers and health and disability sector organisations regarding ethnicity information
- be able to demonstrate that effective processes are in place to monitor and improve the quality of ethnicity data collected.
- include appropriate ethnicity information in reports to:
    - the Ministry to aid the monitoring of Māori health issues and improving policy advice
    - its Māori, Pacific and other ethnic communities for the purposes of monitoring Māori Pacific and ethnic health issues under NZPHD Act.

13.14.2 DHBs can access the following resources about collecting and recording ethnicity.

a. The Ethnicity Data Protocols for the Health and Disability Sector are based on the Statistics New Zealand Census question and existing Ministry NMDS ethnicity standards.

b. Common training and educational materials, developed by the Ministry and DHBs and with input from other sector groups, are available to help data providers understand why high-quality ethnicity data is required.

c. Ethnic Perspectives in Policy: Helping ethnic people be seen, heard, included and accepted was developed by the Office of Ethnic Affairs (Department of Internal Affairs) in 2002 to provide a framework to address policy decisions for ethnic peoples across the government. This document sets out the Government's approach to developing policies and services for ethnic people and has been endorsed by Cabinet [CAB Min (02) 31/13, POL Min (03) 27/3, CAB Min (04) 42/5A].

13.15 National Collections

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.15.1 To meet the sector's information needs, each DHB must take the following actions.

a. Ensure that it and all of its providers of publicly funded health services, including national services, and any bulk funding and contract delegations, submit data to the relevant National Collections that:

- uses the current version of the Data Dictionary or Code Set/Data Set published for each national collection, ensuring that all data definitions used directly correspond with the national standard data definitions issued by CI&A. This includes requiring all DHB providers to adhere to those standards endorsed by the Health Information Standards Organisation or by any other committee and/or other duly mandated sector-wide reference group endorsed by the Minister
- complies with endorsed standards applying to national health information
- conforms with Ministry requirements for data format and quality of data.
- Provide the Ministry with the requisite data for the following National Collections:

    - National Health Index (NHI)
    - Health Practitioner Index (HPI)
    - Medical Warning System (MWS)
    - National Minimum Data Set (NMDS)
    - National Booking Reporting System (NBRS)
    - National Patient Flow (NPF)
    - Programme for the Integration of Mental Health Data (PRIMHD)
    - B4 School Check Information System (B4SC)
    - National Non-admitted Patient Collection (NNPAC)
    - National Diagnostic Waiting Time Collection (NDWTC).

b. Ensure that any DHB providers of Purchased Services directly supply the Ministry with data required for inclusion in the National Collections (particularly the NMDS, PRIMHD, NPF, NBRS and NNPAC), and that providers will notify the Ministry of any changes to their data definitions, standards or computer systems that may or will affect the supply of the above data.

13.15.2 Each DHB and its service providers will use the current version of standards specified by the Ministry when electronically submitting national health data.

a. The Ministry will publish the latest versions of the Data Dictionaries and File Specifications for each National Collection on the Ministry's website. This includes Data Dictionaries, Architecture File Specifications, as well as Host-to-Host Online Transaction Definitions.

b. All clinical data (diagnoses and procedures) are to be classified and reported using the current approved version of the appropriate classification. ICD-10-AM is the International Classification of Diseases and Related Health Problems. This classification must be used for reporting to NMDS and NBRS and may be used for PRIMHD and NPF. DSM-IV may also be used for reporting to PRIMHD. SNOMED CT may be used for reporting to NPF for some fields - please refer to the file specification for more details.

13.15.3 To meet the sector's information needs, the Ministry will:

a. consult with sector stewardship groups, including the DHB-led project groups coordinated by DHB Shared Services when changes are proposed to the data collected in the National Collections

b. communicate with software vendors when changes to the National Collections are approved

c. provide DHBs with:

- a point of contact for communication
- monthly reports showing DHB performance against known data quality issues
- technical support to DHB clinical coding staff to facilitate changes in the clinical coding classification

d. monitor data submitted directly to the national systems for compliance with data delivery timeframes and levels of accuracy as outlined in the file specification for each collection

e. ensure that processing of all National Health Information load files is complete within two working days of receipt of data from a provider and that the appropriate infrastructure is maintained and the NHI system is available according to mutually agreed service levels

f. in respect of any changes to the reporting requirements for the National Collections:

- provide six months' advance notice. All parties affected by any change may waive this six-month notice period if there is agreement to a shorter notice period
- report to DHBs on implementation progress and provider compliance requirements or status.

13.15.4 DHBs must ensure that they and their providers deliver on any additional information required by the Ministry, on behalf of the Minister. In this circumstance, the Ministry and DHBs will agree to a mutually acceptable timetable for delivery of the additional information. Any changes will be agreed through mechanisms approved via the formal governance process in place for each element of the National Collections. Once agreement is reached, DHBs will require providers to deliver against this timetable.

13.15.5 The Ministry and DHBs may identify ways to develop and improve information. Each DHB will assist the Ministry to develop a joint approach and contribute resources as it is able for this work.

13.16 Health Practitioner Index

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.16.1 For the Health Practitioner Index (HPI) information to be complete, each DHB must:

a. supply the correct HPI data to each of the National Collections where it is specified in the requirements for that collection

b. ensure that all HPI-related data is provided to the National Collections using the accurate HPI identifiers for practitioner, facility and organisation

c. engage with CI&A in the:

- mapping of local provider identifiers to unique HPI identifiers
- integration of HPI identifiers into DHB systems and business architectures.

13.17 Medical Warning System

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.17.1 To use the Medical Warning System (MWS) appropriately:

a. each DHB must ensure that appropriate staff accessing the MWS are able to connect to it add, update or delete existing warnings and dangers

b. each DHB must ensure that updates to the MWS are made in a timely manner

c. CI&A will ensure that the appropriate infrastructure is maintained, and that the MWS system is available to mutually agreed service levels.

13.18 National Minimum Data Set (NMDS)

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.18.1 DHBs will require that all providers contracted to provide hospital inpatient and day-case services report that data to NMDS, or else the DHBs will undertake to submit it themselves. Data is to be supplied according to the published NMDS Data Dictionary, appendices and File Specification. Data is to be submitted at least monthly and successfully loaded into NMDS within 21 days from the end of the month of the patient's discharge from, or attendance at, hospital, or the cessation of the provision of health care to that patient.

13.18.2 Each DHB is required to:

a. submit data to NMDS only for patients who are admitted to a hospital (see the Data Dictionary appendices for definitions)

b. engage with CI&A in the development and ongoing management of NMDS, as required. CI&A will ensure that the development and ongoing management of the NMDS meet the needs of DHBs. Feedback regarding DHB requirements will be sought via the Ministry's Technology and Digital Services business unit, NCAMP Board and other interested sector stewardship groups, such as the DHB-led project groups coordinated by the Ministry's Service Commissioning business unit. Recommended changes will be submitted to NCAMP for prioritisation and sign-off. Sector stakeholders will be asked for feedback on proposed changes before they are included in NCAMP

c. ensure that all NMDS data is provided using the health care user's correct NHI number

d. require hospitals to meet deadlines agreed with the DHB for all new compliance requirements. At the time that changes are approved, timeframes for compliance will also be agreed with the DHBs as part of the 1 July change process

e. ensure that the accident flag is activated, and the ACC 45 form number is reported for all NMDS records that fit within ACC criteria for claims and funding

f. ensure that the NMDS event identifier is captured and reported on NBRS and NPF records ie in order to accurately identify the inpatient event relating to a given referral

g. ensure that when records are amended in hospital systems they are included in NMDS load file extracts to ensure that the NMDS has the latest version of data in every field.

13.19 National Booking Reporting System

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.19.1 Each DHB requires all providers that are contracted to provide publicly funded medical or surgical elective services to supply data to the National Booking Reporting System (NBRS), or the DHB will undertake to submit the data itself. Data will be supplied according to the NBRS File Specification and the Ministry of Health's (2013a) *Business Rules*.

13.19.2 Providers must submit records to NBRS at least monthly. Individual NBRS records must be submitted to CI&A by 4 pm on the third-to-last working day of the month following the month to which the record relates.

13.19.3 Each DHB will continue to engage with CI&A and the Ministry's Electives Team in the development and ongoing management of the NBRS as required.

13.19.4 DHBs will require providers to meet mutually agreed deadlines for all new NBRS compliance requirements.

13.19.5 DHBs will ensure that when records are amended in hospital systems they are included in NBRS load file extracts to ensure that the NBRS has the latest version of data in every field.

13.20 National Patient Flow

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.20.1 Each DHB is to require all providers that are contracted to provide publicly funded referred services, specifically medical and surgical elective services, cancer services, and specific diagnostic imaging services, to supply data to National Patient Flow (NPF), or the DHB will undertake to submit the data itself. Data will be supplied according to the NPF File Specification and the Ministry of Health's (2013a) *Business Rules*.

13.20.2 Providers must submit records to NPF at least weekly. Individual NPF records must be submitted by the 20th of the month following the dates to which the record relates.

13.20.3 Each DHB will continue to engage with CI&A and the Ministry's Cancer, Electives and National Services Teams in the development and ongoing management of the NPF as required.

13.20.4 DHBs are expected to link NPF data with NNPAC and NMDS records ie, report the identifiers in NPF records that show the NNPAC or NMDS event arising from the referral.

13.20.5 DHBs will require providers to meet mutually agreed deadlines for all new NPF compliance requirements. If a DHB is aware that it will not be fully compliant with Phase 3 reporting by 30 June 2017, the DHB should arrange for its Chief Executive to apply to the project for an exemption.

13.21 Programme for the Integration of Mental Health Data

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.21.1 To support reporting to the Minister, each financial year all DHBs must provide data to the Programme for the Integration of Mental Health Data (PRIMHD). In addition, a DHB must:

a. under its contracts with providers, require that PRIMHD data (as identified in the PRIMHD File Specification) relating to purchased services is available to CI&A within 20 days from the end of each calendar month and that it meets all compliance and accuracy requirements

b. ensure that all PRIMHD data is provided in accordance with the health care user's correct NHI number and the PRIMHD code set, and data set documentation

c. continue to engage with CI&A in the ongoing management and support of the PRIMHD, as required

d. ensure that NGOs, community services and hospitals meet deadlines agreed with CI&A for all new compliance requirements. Compliance should be undertaken when there are any

changes that affect the PRIMHD data extract, or as part of NCAMP, where there are changes to the PRIMHD reporting requirements.

13.22 National Immunisation Register

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.22.1 The National Immunisation Register (NIR) is a computerised information system that has been developed to hold immunisation details of New Zealand children. To support improved immunisation rates, each DHB must:

a. ensure all newborn children are enrolled with a general practice/practitioner, ideally within the first two weeks of life

b. ensure that high-quality data is supplied to the NIR for all vaccinations administered from the National Immunisation Schedule and other scheduled vaccines

c. ensure that all NIR information is provided using the health care user's correct NHI number

d. be responsible, in conjunction with primary health care providers, for collecting vaccination data for and updating it in the NIR

e. ensure that all vaccinations given to an individual are associated with that individual on the NIR

f. continue to engage with the Ministry in the development and ongoing management of the NIR, as required

g. require providers to meet mutually agreed deadlines for all new compliance requirements

h. ensure data is provided within two working days, or, in the case of data sourced from the school-based vaccination system, provide 70 percent within two working days and 98 per cent within five working days.

i. Support community pharmacies to use the ImmuniseNow web browser to record vaccines administered by a pharmacist who has completed an approved vaccinator training course.

13.23 B4 School Check Information System

(See s 23(1) of the NZPHD Act, s133 of the CE Act and CAB (00) M 22/11.)

13.23.1 The B4 School Check (B4SC) Information System contains and provides data about young children in New Zealand along with their personal demographics and clinical information. It is systems users' responsibility to ensure that appropriate measures are implemented to protect that information from misuse. The DHB / provider manager will determine and support the DHB/provider access control strategy and ensure the satisfactory resolution of issues relating to user access, where the security officer or relevant personnel identifies significant changes are necessary, as per the policy for the management and use of the health information collected as part of the B4SC and held on the national B4SC Information System.

13.23.2 Each DHB must:

a. accurately record and retain B4SC data for all B4SC funded by the DHB, by entering data into the B4SC Information System

b. ensure that all B4SC information is provided using the health care user's correct NHI number

c. establish and maintain a system for contacting parents, coordinating with providers, and ensuring children receive all the components of the service they are entitled to receive

d. enter and store at least the minimum data set, as per the current version of B4SC – Minimum Requirements for Information, into the B4SC Information System

e. ensure that all B4SCs are, at a minimum, entered and completed in the B4SC Information System no later than seven days after the health care user's fifth birthday

f. ensure that all B4SCs are closed in the B4SC Information System

g. continue to engage with the Ministry in on the development and ongoing management of the B4SCs, as required

h. require providers to meet mutually agreed deadlines for all new compliance requirements.

13.24 National Non-admitted Patient Collection

(See s 23(1) of the NZPHD Act, s 133 of the CE Act and CAB (00) M 22/11.)

13.24.1 Each DHB must:

a. ensure all providers contracted to provide publicly funded services supply National Non-admitted Patient Collection (NNPAC) data to CI&A for all mandatory reporting purchase units; providers may also supply data for optional reporting purchase units. These lists are published on NNPAC code tables on the Ministry's website and in the Purchase Units section on the NSF Library website.

b. ensure that the health care user's correct NHI number is used with all NNPAC information provided

c. continue to engage with CI&A in the development and ongoing management of the NNPAC, as required

d. require providers to meet mutually agreed deadlines for all new compliance requirements

e. provide data within 20 days of the end of the month in which the service delivery occurred

f. ensure that the event identifiers included in NNPAC are also reported in NPF and NBRS ie, to ensure that the specific outpatient event can be identified for a given referral

g. provide at least one file every calendar month.

13.25 Accident Compensation Corporation

(See Accident Compensation Act 2001 and CAB(00) M 22/11.)

13.25.1 Where a patient is covered by the Accident Compensation Act 2001, the relevant DHB is to complete medical certificates and forms for the individual claimant as required by ACC.

13.25.2 Each DHB will complete ACC 45 forms for all accident cases in a timely manner where it is aware that a claim has not already been lodged for that injury.

13.25.3 The Ministry requires the following information from DHBs for the purpose of calculating the payment due from ACC for public health acute services:

a. admissions (inpatient and day patient) – each DHB is to submit data to the National Data Collection for inclusion in the NMDS data collection as set out in this OPF for all inpatients and day patients receiving public health acute services

b. emergency patients and outpatients – each DHB is to submit data to CI&A for inclusion in the NNPAC and NNPAC data collections as set out in this OPF for all emergency patients and outpatients receiving public health acute services

c. copies of relevant audit or monitoring reports relating to public health acute services – which each DHB will provided to the Ministry within six weeks of the end of the quarter.

13.25.4 Each DHB is to ensure that ACC has access to relevant parts of DHB service agreements.

13.26 Ministry reports to DHBs

13.26.1 The Ministry, as the Minister's agent, will provide each DHB with a report on any planned reviews of the DHB. This requirement does not apply to unanticipated reviews.

13.26.2 In addition, the Ministry will:

a. notify each DHB of any emerging factors of which the Ministry is aware that could preclude the DHB from meeting any CFA obligation relating to purchase or ownership performance

b. inform the DHB of any issue likely to be of significance to its Board.

Appendix 1: Abbreviations and definitions

Unless otherwise stated, all terms used throughout the OPF use the definitions and meanings set out in the NZPHD Act and/or the Crown Funding Agreement.

Term	Meaning in the OPF document unless otherwise stated
ACC	The Accident Compensation Corporation
Annual Plan	An Annual Plan of a DHB agreed with the Minister of Health under section 9 of the NZPHD Act.
Annual Report	One of a suite of annual public accountability documents that must be presented to Parliament. The Annual Report is the key document for the financial review of the performance and operations of each DHB.
Baseline volumes	All surgical services set out in the volume schedules of a DHB's approved Annual Plan during the current funding period, including IDF volumes incorporated into the volume schedule.
BSMC	Better Sooner More Convenient primary health care is the Government's initiative to deliver a more personalised primary health care system that provides services closer to home and makes New Zealanders healthier.
Catch-up volumes	Volumes of services a DHB agreed to deliver in its Annual Plan but did not deliver in the previous funding period, which the DHB is obliged to deliver during the current funding period in accordance with clause A.1.A of its Crown Funding Agreement and the terms of any phasing plan.
CE Act	Crown Entities Act 2004
CFA	The main Crown Funding Agreement under section 10 of the NZPHD Act between a DHB and the Crown acting by and through the Minister of Health.
Confidential information	Any information, data or know-how disclosed by the DHB to the Ministry, or vice versa, that: • is agreed by both agencies as being confidential • may reasonably be considered to be confidential, taking into account all the circumstances, including without limitation the manner of disclosure and the circumstances in which disclosure occurred.
Current funding period	The current financial year from 1 July to 30 June.
DHB	District health board, an organisation established as a DHB by or under section 19 of the NZPHD Act .
DHB Shared Services	DHB Shared Services delivers services at a national level and, where appropriate, produces work for all DHBs. overall purpose is to help the DHBs meet their objectives and accountabilities to the Crown. DHB Shared Services provides a sector group through which DHBs can coordinate their activities at a national level on selected issues.
District	The representative geographical areas based on territorial authority and ward boundaries for each DHB, as set out in Schedule 1 to the NZPHD Act
Eligible people	People who are eligible to receive services funded under the NZPHD Act, as specified by the Minister of Health in a direction issued under section 32 of that Act.
ESPIs	Elective Services Patient Flow Indicators
Health and Disability Services Standards	Standards made under ss 13–25 of the Health and Disability Services (Safety) Act 2001.
IDF	Inter-district flows
Iwi	A set of people bound together by descent from one or more common ancestors. *Implications for services:* Recognise that the Māori social structure extends to the whānau, (family), hapū (sub-tribe) and iwi (tribe).
Kaumātua	Māori elders of either gender. *Implications for services:* Recognise the mana of the kaumātua and show respect for Māori values and traditions.
NMDS	National Minimum Data Set (Hospital Events). The NMDS is a national collection of public and private hospital discharge information, including clinical information, for inpatients and day patients. The NMDS is used for policy formation, performance monitoring, research and review.

Term	Meaning in the OPF document unless otherwise stated
Mana	A person or organisation of people of great personal prestige or character, authority, and/or standing. *Implications for services:* Dependent on its association or the context in which it is used, one must recognise the mana of all people.
NGO	Non-governmental organisation
NHEP	National Health Emergency Plan
NSF	Nationwide Service Framework is a collection of definitions, processes and guidelines that provides a nationwide consistent approach to the funding, monitoring and analysis of services. A nationwide consistent approach is important to maintain the minimum expectations set by the Ministry, and to enable the comparison of DHBs' performance.
NZPHD Act	New Zealand Public Health and Disability Act 2000
OPF	Operational Policy Framework is a schedule of the Crown Funding Agreement (this document).
Over-delivery	Where the cumulative year-to-date total of baseline volumes and catch-up volumes a DHB actually provided for a service during the relevant quarter exceed the agreed target volumes for that quarter as set out in a DHB's phasing plan.
PBFF	Population Based Funding Formula
Phasing plan	The phasing plan for the delivery of catch-up and baseline volumes agreed by a DHB.
PQS	Provider quality specifications
Quality audit	An audit, inspection, evaluation or review of: • quality • service delivery • performance requirements • organisational quality standards • information standards • information and reporting requirements • safety standards • clinical standards • compliance with any of a DHB's obligations • cultural competency in relation to the provision of the services by a DHB.
Records	May mean: • all written and electronically stored material • all records and information held by a DHB or on its behalf or by its employees, subcontractors or agents • all records kept and held by the DHB relating to the delivery of the other services.
s or ss	Section or sections of an Act.
SCS	Service Coverage Schedule of the Crown Funding Agreement that has been endorsed most recently by the Minister. The document sets out the services a DHB and the Ministry must ensure are delivered to its population.
Service coverage	The service coverage described in the Service Coverage Schedule.
Services	Health services and disability support services provided in accordance with the CFA and Annual Plan.
Service users	Users of any of the services.
SLA	Service Level Agreement
SOI	A Statement of Intent of a DHB to be prepared in accordance with section 139 of the CE Act.
The Minister	The Minister of Health
The Ministry	The Ministry of Health, a department of the public service.
Under-delivery	Where the cumulative year-to-date total of baseline volumes and catch-up volumes a DHB actually provided for a service, during the relevant quarter, do not meet the agreed target volumes for that quarter as set out in a DHB's phasing plan.
Whānau	Immediate and extended family. *Implications for services:* Often the wider family takes responsibility for its members and this should be contextually considered when dealing with issues of access, privacy etc.

Term	Meaning in the OPF document unless otherwise stated
Whānau ora	The concept of supporting families to achieve their maximum health and wellbeing. Implications for services: Facilitate positive and adaptive relationships within whānau and recognise the interconnectedness of health, education, housing, justice, welfare, employment and lifestyle as elements of whānau wellbeing.

Appendix 2: Amendments to the 2016/17 Operational Policy Framework for 2017/18

The Operational Policy Framework has been reviewed and updated to reflect changes to policy, legislation and general accepted accounting practices (GAAP). Content changes are summarised in the table below.

Chapter	Section	Title	Amendment(s)
	General		Amended names of Ministry business units and group, updated references to Ministry strategies.
	General		Updated references to New Zealand Health and Disability Strategies.
2. DHB Governance			
3. Planning and Accountability			
	3.3	DHB accountability and planning documents	Addition of bullet point about achieving health equity and improving Māori health.
	3.4	The Annual Report	Minor amendment to 3.4.1.
	3.6	National Services Planning and Implementation	Additional information added to 3.6.1.
	3.20	The Nationwide Service Framework	Minor updates and clarifications made to 'Governance and maintenance of the NSF' and 'Nationwide service specifications'.
	3.21	Contracting for services	Minor amendments made.
	3.21.8-15	Contracting with NGOs	Section updated with current requirements for contracting with NGOs
	3.22	Fees Related to National Professional Services or National Software License Agreements	Addition of new section
4. Service Change			
	4.10	National Health Committee (NHC)	As the NHC has now been disestablished, this section will be revised with current requirements when available. This section is now called 'Strategic Prioritisation.'
5. Service planning and policy			
	5.2.1		Removal of reference to stand alone Māori health plan and joint PHO development.
	5.9	Supporting Vulnerable Children	Name of section changed to 'Supporting Vulnerable Children' and included reference to the Investing in Children Programme
	5.10	Management of Elective Services	Minor editorial changes

6. Improving Māori health			
	6.2	Māori health planning	Section revised to reflect new planning requirements
7. Inter-district flows			
	7.7	Referral and management of national services	Minor amendments made
	7.15	IDF supplementary payments	Removal of reference to NHC
8. Dispute Resolution			
9. Quality			
	9.2	Provider quality specifications	Minor clarifications to requirements made
	9.3	Service Standards	Minor updates made
	9.3.3		Minor amendments made
	9.4	Improving the quality of services	Updates to 9.4.2, 9.4.4, 9.4.6 and 9.4.7
	9.7	Capturing consumer experience	Inclusion of requirement for DHBs to use findings of patient experience surveys for service design/improvement and to develop and support consumer councils.
10. Workforce			
	10.10	In-between travel and guaranteed hours	Addition of new section in October 2016 for 2016/17 OPF. Further updates to section based on introduction of requirements for Settlement Part B - guaranteed hours in June 2017.
	10.11	Introduction of pay equity for care and support workers	Addition of new section in June 2017 due to new legislation.
11. Information Technology			
	11.1	Purpose of chapter	Purpose statement updated
	11.2	eHealth Systems Development Strategy	Section updated with current planning, HISO, SNOMED and ICT work programme requirements.
	11.5	Government Chief Information Officer – All of Government ICT Mandate	Addition of new section
12. Financial and capital operations			
	12.16	Long-term debt	Amendments to long-term debt policy as per Cabinet decision.
	12.30	Business cases	Amendments to references to long-term debt policy as per Cabinet decision.
13. Monitoring and reporting			
	13.15	National Collections	Addition of reference to National Patient Flow in 13.15.1 b)
	13.18	National Minimum Dataset	Addition of point f) about reporting of event identifiers
	13.20	National Patient Flow	Addition of two points about compliance with phase three National Patient Flow reporting.

	13.22	National Immunisation register	Addition of point i) about recording vaccines administered by pharmacists
	13.24	National Non-admitted Patients data collection	Addition of point f) about reporting of event identifiers

References

Capital Investment Committee. 2011. *Capital Assessment Guidelines*. Wellington: Ministry of Health.

Minister for Disability Issues. 2016. *New Zealand Disability Strategy 2016-2026*Wellington: Ministry of Health.

Minister of Health. 2016. *New Zealand Health Strategy*. Wellington: Ministry of Health.

Minister of Health. 2003a. *Improving Quality (IQ): A systems approach for the New Zealand health and disability sector*. Wellington: Ministry of Health.

Minister of Health. 2003b. *IQ Action Plan: Supporting the improving quality approach*. Wellington: Ministry of Health.

Minister of Health and Associate Minister of Health. 2014. *The Guide to He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.

Ministry of Business, Innovation and Employment. 2012. *Government Procurement – Buying Goods And Services – The Five Principles*. Wellington: Ministry of Business, Innovation and Employment.

Ministry of Business, 2014 Innovation and Employment. *Rules for planning your procurement, approaching the market and contracting* (second edition). The Government Rules of Sourcing replace the Mandatory Rules for Procurement by Departments issued by the Ministry of Economic Development in 2006. They have been endorsed by Cabinet (CAB Min (13) 10/4A).

Ministry of Business, Innovation and Employment. The Contracting Framework. The Contracting Framework is a group of documents and tools to be used when contracting between government agencies and NGOs Government Agency Agreement, Framework Terms and Conditions, Outcome Agreement and Outcome Agreement Management Plan. Published on line: http://www.business.govt.nz/procurement/procurement-reform/streamlined-contracting-with-ngos/the-contracting-framework-1

Ministry of Health. 2011. *Consultation Guidelines for the Ministry of Health and District Health Boards Relating to the Provision of Health and Disability Services.* Wellington: Ministry of Health.

Ministry of Health. 2003. *Guidelines for Capital Investment.* Wellington: Ministry of Health.

Ministry of Health. 2014. *The New Zealand Guidelines for Helping People to Stop Smoking*. Wellington: Ministry of Health.

Ministry of Health. 2010. *Conflict of Interest Guidelines for District Health Boards.* Wellington: Ministry of Health.

Ministry of Health. 2011. *Service Change – Rules, Principles and Processes for District Health Boards*. Wellington: Ministry of Health.

Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health.

Ministry of Health. 2013a. *Business Rules: Capitation-based funding*. Wellington: Ministry of Health.

Office of the Controller and Auditor-General. 2006. *Principles to Underpin Management by Public Entities of Funding to Non-governmental Organisations*. Wellington: Office of the Controller and Auditor-General. URL: www.oag.govt.nz/2006/funding-ngos (accessed 1 October 2014).

Office of the Controller and Auditor-General. 2007. *Managing Conflicts of Interest: Guidance for public entities.* Wellington: Office of the Controller and Auditor-General. URL: www.oag.govt.nz/2007/conflicts-public-entities (accessed 1 October 2014.

Office of the Controller and Auditor-General. 2008. *Procurement Guidance for Public Entities.* Wellington: Office of the Controller and Auditor-General. URL: www.oag.govt.nz/2008/procurement-guide (accessed 1 October 2014).

Office for the Community and Voluntary Sector. 2010. *The Code of Funding Practice*. Wellington: Department of Internal Affairs. URL: www.community matters.govt.nz (accessed 1 October 2014).

Office of Ethnic Affairs. 2002. *Ethnic Perspectives in Policy: Helping ethnic people be seen, heard, included and accepted.* Wellington: Office of Ethnic Affairs. URL: http://ethnicaffairs.govt.nz/

Standards New Zealand. Risk Management Guidelines Companion to AS/NZS ISO31000:2009 URL: www.standards.co.nz

State Services Commissioner. 2007 (updated 2009). *Standards of Integrity and Conduct*. Wellington: State Services Commission. URL: http://www.ssc.govt.nz/code-resources-organisations (accessed 18 September 2014).

Statistics New Zealand. *2006 Census of Population and Dwellings: Definitions and questionnaire*s. Wellington: Statistics New Zealand. URL: www.stats.govt.nz (accessed 18 September 2014).

The Treasury. 2009. Guidelines for *Contracting with Non-government Organisations for Services Sought by the Crown*. Version 2.2. Wellington: The Treasury. http://www.treasury.govt.nz/publications/guidance/mgmt/ngo (accessed 18 September 2014).

Service Coverage Schedule

2017/18

To be used from 1 July 2017 (updated 3 July 2017)

The Service Coverage Schedule is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability (NZPHD) Act 2000, which is subject to endorsement by the Minister of Health.

The Service Coverage Schedule will be updated from time to time as required

Updates

July 2017
Section 3 Specific services with transitional issues in 2017/18
3.7 Immunisation requirements updated

Section 4 Individual
4.11 Palliative Care definition updated
4.13 Primary Care diabetes focus on equity
4.16 Specialist medical and surgical services- edited.

January 2017
Section 4 Individual
4.2 Deletion hyperbaric
4.15 Public Health and Prevention
Minor edits -screening
4.16 Specialist medical and surgical services
Additional quality requirements – 20 Diabetes Quality Standards
Range of services – addition hyperbaric

November 2016
Section 3 Specific services with transitional issues in 2017/18
3.4 Bowel Screening - new
3.5 National Safe Sleep Programme - new
3.12 Regularisation of the Workforce - new
3.13 In-between Travel - new
Section 4 Individual
4.10 Oral Health – updates
Summarised requirements of the current Tier 1 and Tier 2 oral health specifications, updated terminology
4.15 Public Health and Prevention Services – Minor editing and updates
Additional quality requirements – information on key quality documents related to screening programmes
4.16 Specialist medical and surgical services
Co-ordination of Services – Update on Cancer services
Diagnostic waiting times – Minor editing
Appendix 6: 2017/18 Service Coverage Schedule Summary of changes

Citation: Ministry of Health. 2016. *2016/17 Service Coverage Schedule*. Wellington: Ministry of Health.

Originally published online by the Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

This document is available at www.health.govt.nz

Contents

1 Purpose and principles of service coverage information 1
1.1 Definitions of terms used 1
1.2 Responsibility for ensuring delivery of service coverage expectations 1
1.3 Service coverage information 2

2 Key principles underlying the funding of services 3
2.1 Eligibility criteria applying to publicly funded services 3
2.2 Availability of publicly funded health and disability support services 3
2.3 Funding 4
2.4 Prioritising the funding of services and managing service risk 4
2.5 The Government's health priorities for Māori 5
2.6 Services to meet the needs of Pacific peoples 6
2.7 Health emergency coverage 7

3 Specific services with transitional issues in 2017/18 and out years 8
Public health 8
Child and youth 9
Other services 11

4 Individual service coverage schedules 14
General operational service delivery mechanisms 14
Summary schedule: health and support services for children and young people 15
4.1 Blood services 21
4.2 Diagnostic, therapeutic and support services – personal health 22
4.3 Disability support services 25
4.4 Emergency ambulance services 31
4.5 Health and support services for older people 33
4.6 Immunisation services 38
4.7 Support services for people with long term or chronic conditions 41
4.8 Maternity services 44
4.9 Mental health and addiction services continuum 47
4.10 Oral health services 55
4.11 Palliative care 58
4.12 Pharmaceutical services 60
4.13 Primary health care services 64
4.14 Provision of equipment, modifications and other supplies and services 67
4.15 Public health services and prevention services 74
4.16 Specialist medical and surgical services 82

References 91

Appendix 1: Special high cost treatment **93**

Appendix 2: Requirements in relation to accident claimants **96**

Appendix 3: Gateway Assessment Programme **99**

Appendix 4 Vulnerable Children **100**

Appendix 5: Violence Intervention Programme **101**

Appendix 6: 2017/18 Service Coverage Schedule Summary of changes **102**

1 Purpose and principles of service coverage information

The purpose of including service coverage information within, but not limiting it to, the Crown Funding Agreement (CFA) is to allow the Minister of Health (the Minister) to explicitly agree to the level of service coverage for which the Ministry of Health (the Ministry) and district health boards (DHBs) are held accountable.

The Minister is ultimately accountable to Parliament and to the taxpayer for the use of public funds to fund the health service cover for the people of New Zealand. The Minister has the final decision rights over service coverage.

This Service Coverage Schedule (SCS) is released subject to endorsement by the Minister in accordance with the CFA requirement. The SCS is updated annually.

1.1 Definitions of terms used

Throughout the SCS, the following terms are used with the meanings set out below:

- 'responsible funder' is the party/parties that determine the service mix
- 'funding' refers to the exchange of dollars for delivery of health and disability support services
- 'service mix' is the specific quantity and type of services that are used to meet the service coverage
- 'Ministry funded' refers to services funded by the Service Commissioning business unit of the Ministry.

1.2 Responsibility for ensuring delivery of service coverage expectations

Responsibility for service coverage is spread across DHBs and the Ministry and is determined by the party responsible for establishing service mix.

DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high needs groups. This responsibility applies whether services are funded directly by the DHBs or by the Ministry.

Where funding responsibility for services has not been devolved to DHBs, the Ministry is accountable for making service-mix decisions and for ensuring delivery of service coverage, in collaboration with DHBs.

Gaps in service coverage can be related to issues of either funding or service delivery or both. The Ministry and DHBs should work together to ensure resolution of service coverage gaps.

It is the responsibility of funders to decide whether additional levels or standards are or can be funded or provided from the available funding.

1.3 Service coverage information

Service coverage information describes how Government policy is to be translated into the required minimum level and standard of services to be made available to the public.
In most instances, the range of services to be funded will be described, but not the way they should be funded.

1.3.1 Service coverage information

Service coverage information should include the:

- range of health and disability support services
- coverage of and/or terms of access to those services
- user charges (if any)
- standards for safety and quality
- particular process requirements indicated by the Minister (such as implementation of booking systems and Second National Mental Health Strategy and Blueprint).

1.3.2 Circumstances where more service coverage information detail is required

More detail of the range of services, including their terms of access, quality and safety standards and/or method of funding, is required in the following circumstances:

- when close government interest exists and action is being taken, for example, because of:
  - significant reprioritisation, transition or policy development
  - funder or system performance shortfall
  - requirements to undertake the provision of a service in a particular manner
  - DHBs asking to have the service specified in more detail
- when there are other related developments such as:
  - changes in legislation
  - specific safety requirements to protect the health of the public or consumers
  - user charges or levels of subsidy for services.

2 Key principles underlying the funding of services

2.1 Eligibility criteria applying to publicly funded services

The Ministry and the DHBs will fund services for eligible people according to the obligations set out in this document. A full description of the eligibility criteria applying to funded health and disability services is set out in the Health and Disability Services Eligibility Direction 2011 (Eligibility Direction) issued by the Minister. The Eligibility Direction is available publicly on the Ministry's website[1] along with a range of other supporting material and tools, including an electronic guide to eligibility.

All sections of the SCS, unless specified otherwise, apply to eligible people only.

Additional purchasing criteria (such as those applying to acute treatment for ineligible people) may be found in individual CFAs.

2.2 Availability of publicly funded health and disability support services

The obligations of responsible funders outlined in this document represent population-level expectations, and generally do not confer individual entitlements to services. Levels of access to services are determined clinically, and are based on principles of levels of need and ability to benefit.

The availability of publicly funded health and disability support services and the level of services to be funded (service mix) will be determined in line with the requirements outlined below. These requirements ensure that rationing decisions are made to enable the maximum benefit from the funding available.

- Access to services will be determined on a fair and reasonable basis, and subject to generally accepted clinical protocols.
- Priority for access will be granted on the basis of need, ability to benefit and/or an improved opportunity for independence for those with a disability. The responsible funder will, where appropriate, target delivery of services to those groups with poor health status and those who are most likely to benefit.
- The responsible funder will ensure people have reasonable access to services as close as possible to where they live, taking into account the geographic location of where they live and the nature of the service to which access is required.
- When determining the availability of funded services, the responsible funder will consider and accommodate the needs of people in remote areas in the most practical, efficient and clinically safe way.

[1] www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services

- If a patient chooses to supplement the volumes of consumables prescribed and funded by the DHB, it is up to the patient to fund the additional consumables that they wish to have. There is no provision for part funding by the patient for their preferred consumable product.

2.3 Funding

Funding for services will not duplicate the services that are already funded by DHBs, the Ministry, the Accident Compensation Corporation (ACC), other accident insurers or other government agencies.

Publicly funded inpatient services, as well as day patient services and any community-referred services provided in the hospital setting, are provided to eligible people free of charge. This includes all the services and supplies associated with the hospital treatment.

Services for which co-payments have been agreed are dental, orthotic and pharmaceutical services (refer to the individual schedules for the details). Providers of services which are permitted to charge co-payments must inform the client of the co-payment prior to commencing the service.

No co-payment will be sought from service users for supplies and equipment unless permitted under current CFA and SCS for the Provision of Equipment and Modifications and other Services and Supplies (T1 Community Health, Transitional and Support Services).

If a DHB wishes to fund services that are explicitly identified as excluded from the national minimum service coverage, the DHB must request a formal exemption from service coverage requirements from the Ministry.

2.4 Prioritising the funding of services and managing service risk

Please note that this section will be updated for the final version of the SCS released in December.

2.4.1 Deciding priority for publicly funded services

The Ministry and DHBs have a set budget provided by the Government from which they fund the services that are deemed to meet the minimum needs of New Zealanders.

2.4.2 Requests for specific variation to the national minimum service coverage requirements

If the obligations are unsustainable, the responsible funder will identify the areas where reprioritisation is necessary.

A DHB or the Ministry can request a specific variation to the national minimum service coverage requirements. Such a request will be considered as part of the Annual Plan and/or CFA process. Variations or exemptions must be publicly transparent and shall be recorded in the accountability documentation with a clear reasoning for their existence and a time-bound review, resolution or improvement path.

2.4.3 Service coverage gaps must be reflected in DHB Annual Plans

All service coverage gaps affecting the DHB's population should be acknowledged in the DHB's Annual Plan. Supporting material for each service coverage gap should include either a workout plan for managing resolution of the gap identified within the period of the Annual Plan, or background material supporting an exception to service coverage for the period of the Annual Plan.

Where the gap is to be managed within the period of the Annual Plan, the DHB will be required to report on progress towards resolution of the gap through the service coverage measure in the DHB's performance measures.

New policy expectations that are agreed during the course of the year and that impact on service coverage will be implemented through a variation to the CFA.

2.4.4 The Ministry and DHBs have the responsibility to manage service risks

Strategies used to manage service risks include:

- working with clinicians and consumers (specifically Māori and Pacific peoples and users of mental health services) to develop best practice guidelines
- developing criteria governing the use of extremely high-cost treatments
- working with other government agencies to ensure co-ordination of services to identify and address policy and service risks
- collaborating with other DHBs and the Ministry nationally and, where appropriate, regionally, to ensure coordinated planning, funding and delivery of publicly funded health services and to collectively manage risks to public health
- collaborating with other DHBs to ensure the coordinated planning, funding and delivery of mental health services and services for Māori.

2.5 The Government's health priorities for Māori

He Korowai Oranga: Māori Health Strategy[2] supports the Ministry and DHBs to reduce health disparities and achieve health equity required by the New Zealand Public Health and Disability Act 2000. DHBs should consider He Korowai Oranga in their planning, and in meeting their statutory objectives and functions for Māori health.

He Korowai Oranga places an emphasis on the importance of leadership in achieving health equity and working in partnership with Māori for the future.

He Korowai Oranga sets the overarching framework to achieve the best health outcomes for Māori. Pae Ora - healthy futures is the Government's vision for Māori health that provides a platform for Māori to live with good health and wellbeing in an environment that supports a good quality of life. Pae Ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high quality, effective services. Pae ora includes three interconnected elements: Mauri Ora - healthy individuals, Whānau Ora - healthy families and Wai Ora - healthy environments.

[2] www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

The elements, directions, key threads and pathways of He Korowai Oranga are the health system's guide to improving Māori health and realising Pae Ora - healthy futures. The four pathways tell us how to implement He Korowai Oranga and include:

- supporting whānau, hapū, iwi and community development
- supporting Māori participation at all levels of the health and disability sector
- ensuring effective health service delivery
- working across sectors.

The Ministry and DHBs will ensure that mainstream services are effective for Māori and work to improve access for Māori, particularly for primary health care services. DHBs will allocate resources to reduce health disparities and achieve equity for Māori. DHBs will continue to identify and account for Māori health funding. This will involve identifying the expenditure targeted at reducing health disparities and achieving equity for Māori, which includes identifying funding for: Māori providers, Māori workforce and provider development, Māori targeted services across mainstream services, and resource allocation for intersectoral initiatives to improve Māori health.

Building Māori health providers' capacity and capability is also an important strategy for improving Māori health status. The Ministry and DHBs will continue to support accelerated development of the Māori health workforce at all levels of the health sector.

2.6 Services to meet the needs of Pacific peoples

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 sets out the Ministry's priority outcomes and actions that will contribute to achieving better health outcomes and reduce health inequalities for Pacific peoples.

To ensure systems and services are effective for Pacific peoples, DHBs with significant Pacific populations will engage Pacific communities in DHB development and planning processes in order to allocate resources to reduce inequalities and improve health outcomes for Pacific peoples.

The Ministry and DHBs will ensure that all services are responsive to and effective for Pacific peoples, taking account of the health status as well as the linguistic, cultural and social characteristics of Pacific communities.

The Ministry and DHBs will progress towards addressing the broad determinants of health through intersectoral collaboration and the co-ordination of health services for Pacific peoples. A priority of the intersectoral collaboration is to improve access to all services, particularly primary health care services, for Pacific peoples

Building both Pacific and non-Pacific health providers' capacity and capability is an important strategy for improving health equity and health status of Pacific peoples. The Ministry and DHBs will continue to support accelerated development of the Pacific health workforce at all levels of the health sector.

2.7 Health emergency coverage

DHBs are responsible for being prepared to respond to health emergencies within their region, and for supporting other DHBs when there is a local emergency.

DHBs must ensure that essential health services – such as ambulance, primary health care, hospital services, mental health, disability support, aged residential care and public health services – will continue to be delivered during health emergencies, civil defence emergencies, large casualty-causing incidents, major weather events, infrastructure failures and natural disasters.

DHBs are required to maintain adequate stocks of reserve supplies of antibiotics as agreed with the Ministry of Health.

3 Specific services with transitional issues in 2017/18 and out years

The purpose of Section Three is to summarise future key transitional issues affecting service coverage.

Public health

3.1 Public health services

The updated tier one and five new tier two service specifications for public health services are available. It is expected that providers will transition to the new service specifications.

In 2016 the Ministry introduced a core functions approach to its purchase of public health services that references each activity to a core function that can be combined to produce the public health services needed to support a high performing system. This approach is a different way to describe the public health services purchased by the Ministry, rather than a change to the services themselves. The core functions approach will also provide the Ministry with relevant data to guide future policy and investment, using an appropriate mix of public health services. The following five tier two service specifications for public health services are published on Nationwide Service Framework Library (NSFL) website[3]:

- Health assessment and surveillance
- Public health capacity development
- Health promotion
- Health protection
- Preventive interventions

3.2 Stop Smoking Services

Reducing the harm from tobacco is a high priority for the health sector. 'Better help for smokers to quit' is one of the Government's six health targets aimed at encouraging and then supporting people to stop smoking. Stop smoking services play an important role in reducing tobacco-related morbidity and mortality and can decrease tobacco-related health inequity. A range of stop smoking services (face-to-face services and Quitline) are purchased by the Ministry of Health and are able to be accessed in all areas throughout New Zealand.

Stop smoking interventions include multi-session face-to-face behavioural support, and help for people to access and use the full range of stop-smoking medicines (nicotine replacement therapy, bupropion, nortriptyline, varenicline). Behavioural support includes evidence based behaviour change techniques as outlined in the *New Zealand Guidelines for Helping People to Stop Smoking*[4] (*the Guidelines*).

Minimum requirements for all stop smoking services are outlined in the mandatory tier three *Public Health Services Preventive Interventions Stop Smoking Services* service specification, which should be read in conjunction with the tier two *Public Health Services Health Protection*

[3] www.nsfl.health.govt.nz/service-specifications/current-service-specifications/public-health-service-specifications

[4] The New Zealand Guidelines for Helping People to Stop Smoking. June 2014. Ministry of Health.

and Health Promotion and *Public Health Services Capacity Development* service specifications as well as the tier one *Public Health Services* service specification[5].

The Ministry expects that people who want to stop smoking and who engage with the health sector, are encouraged and assisted to access stop smoking services and appropriate stop smoking medicines.

3.3 Cervical Screening: HPV Primary Screening

In 2018 the National Cervical Screening Programme will change the primary test for cervical screening from a cytology test to a test for the presence of human papillomavirus (HPV), supplemented by a reflex cytology test where needed.

As part of the new programme most women will only need to be screened every five years instead of every three. The age range for the programme will change from 20–69 to 25–74 years.

3.4 Bowel Screening

A national bowel screening programme will be rolled out progressively from 2017. The programme will offer bowel screening every two years to eligible people aged 60 to 74 years.

The roll-out will begin with Hutt Valley and Wairarapa DHBs, with other DHBs following in stages. Bowel screening will continue to be offered to eligible people at Waitemata DHB, which will transition from the pilot to the national bowel screening model over the course of the roll-out. A national co-ordination centre will be established by 2018 to manage and send screening invitations and co-ordinate the processing, analysis and management of completed bowel screening test results. DHBs will be responsible for delivering colonoscopies, overseen by four bowel screening regional centres that will support clinical leadership, ensure quality, safety and effectiveness of the pathway in their region.

Child and youth

3.5 National Safe Sleep Programme

The Ministry is working to develop a National Safe Sleep Programme to ensure every infant and their family is provided with comprehensive and customised safe sleeping information and follow-up support. The objective of this initiative is to strengthen and enhance the existing Safe Sleep Programme through co-ordination of a multiagency, system-based approach. The Ministry will be guided by the evidence available and will be seeking input from a range of sources into its plans for a National Safe Sleep Programme. The Ministry expects to begin implementation of the National Safe Sleep Programme from July 2017.

3.6 Youth health services

In 2015/16 and 2016/17 national standards for youth health service delivery are being developed and agreed. It is likely there will be further significant changes to the youth sections of the SCS in 2017/18.

DHBs should support an integrated, sustainable set of youth-friendly health and social services.

While most youth access general practice services, barriers such as cost, assured confidentiality, opening hours and access to services are issues. DHBs will work with primary

[5] www.nsfl.health.govt.nz/service-specifications/current-service-specifications/public-health-service-specifications

health organisations (PHOs) and primary health care networks to make general practice youth friendly and responsive to the particular needs of young people (refer 4.16 Schedule Primary health care services).

The Ministry expects that school-based health services will be an integral part of DHB youth health plans. The continued implementation, maintenance and quality improvement of school-based health services in decile 1 to 3 secondary schools, teen parent units and alternative education facilities is a priority and a key element of improving access to health care for young people.

The Ministry expects DHBs to support interagency collaboration and long-term strategic planning for youth services. DHBs will engage with primary health care networks, and youth health and social service providers (including Youth One Stop Shops where they exist) to ensure integrated provision of youth services.

3.7 National immunisation programme

The National Immunisation Programme is an important mechanism to prevent serious vaccine-preventable diseases and improve the health of our children and adults.

The Better Public Services (BPS) target for Increased Immunisation was retired at the end of 2016/17 after achieving an increase in infant immunisation coverage of 8 percent. Immunisation will still contribute to the new BPS targets set in 2017/18 under the following results:

- Result 2: Healthy Mums and Babies. By 2021, 90 percent of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80 percent by 2019
- Result 3: Keeping Kids Healthy. By 2021, a 25 percent reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15 percent by 2019. The avoidable hospitalisations include dental conditions, respiratory conditions, skin conditions, and head injuries.

Maternal immunisation has been identified as a supporting measure for Result 2, and this measure will be further developed in 2017/18 to allow monitoring and public reporting in subsequent years.

The national health target for immunisation coverage at age 8 months remains at 95 percent for 2017/18.

In 2015/16, a DHB performance measure for immunisation coverage at age 5 years was introduced with a target of 95 percent coverage by end June 2017. The 95 percent target for immunisation at age 5 years continues as a DHB performance measure in 2017/18.

A DHB performance measure for increasing HPV immunisation coverage rates was also introduced in 2015/16. For 2017/18, the target is for 75 percent of girls born in 2004 to be fully immunised (all doses completed as per schedule) by the end of June 2018.

HPV immunisation has been funded for boys and young men (aged up to 26 years) since January 2017. At the same time, the age criteria for funding of HPV vaccine for young women was extended to age 26 years. No target will be set for HPV immunisation coverage in boys until the programme is well embedded.

Currently the Tdap (tetanus, diphtheria and pertussis) and HPV vaccines are primarily delivered through school-based immunisation programmes in school years 7 and 8, respectively. From 2017 onwards the HPV vaccine will be delivered through schools for both boys and girls in year 8. Options for providing both HPV and Tdap vaccines in school year 7 are being

considered for future years Young people can also receive HPV immunisation in general practice.

A single dose of varicella vaccine has been funded from 1 July 2017, with one dose for primary vaccination given to children at 15 months of age. A single-dose catch-up in general practice will also be funded for children aged 11 years who have not previously been vaccinated against varicella or contracted chickenpox. . Like rotavirus vaccine coverage, the varicella vaccine coverage will not be included in childhood immunisation milestone reports and health targets measures until the programme is well embedded.

Measles outbreaks in 2016 have emphasised the importance of immunisation against measles in those who did not receive two vaccine doses when younger; those aged 10 to 29 years are considered most susceptible. Anyone can get the measles-mumps-rubella (MMR) vaccine for free from their general practitioner if they were born in 1969 or later and have not had two documented doses of an MMR-containing vaccine given after 12 months of age.

3.8 Children's Action Plan

The Vulnerable Children Act 2014, contains some workforce requirements relating to child protection policies and worker safety checks, the workforce requirements are specified in the Operational Policy Framework document (OPF).

Children's Teams are a key part of how the Children's Action Plan (CAP) is being delivered locally. The CAP provides a framework for professionals from different sectors (eg. health, education and social sectors) to work better together to reduce and prevent child abuse and neglect. In 2016/17 ten children's teams will be operating in the following DHB regions: Lakes, Northland, Nelson-Marlborough, MidCentral, Waikato, Bay of Plenty, Tairawhiti, Canterbury, Whanganui and, Counties Manukau.

From 1 July 2016, DHBs with a local Children's Team are required to ensure resources and health services are provided within baseline funding to support the local Children's Team operations. (Refer Appendix 4: Vulnerable Children for further information).

Other services

3.9 Pharmacy Action Plan

The Pharmacy Action Plan 2016 – 2020 was launched on 3 June 2016.

The New Zealand Health Strategy, which includes a focus on operating as one team and making the best use of the health workforce, provides the overarching umbrella to the Pharmacy Action Plan, which sets out a programme to be implemented over the next three to five years, at national, regional and local level.

The Pharmacy Action Plan describes an integrated service delivery model that will see pharmacist services deployed differently across a broader range of settings, as part of wider health sector reconfiguration.

The Pharmacy Action Plan signals the intention to make best use of the capacity and capability of the pharmacy workforce, particularly in medicines management. Any changes to service coverage across the DHBs will be included in subsequent updates of the SCS.

3.10 Diagnostic services

DHBs are required to report waiting time information on a number of key diagnostic modalities – colonoscopy, coronary angiography, computed tomography (CT) and magnetic resource imaging (MRI). A monitoring and reporting framework supports collection and management of performance data. From 2014/15 diagnostics has continued as a priority area. Waiting time

indicators are agreed annually with performance monitored formally on a quarterly basis (data will continue to be provided monthly). There will be continued focus on providing support to clinical groups to lead the necessary service improvements.

National patient flow system

DHBs will support and contribute to the development of the National Patient Flow system, designed to capture information on end-to-end patient pathways, including diagnostic services. DHBs will collaborate with the national work programme through a phased approach, and integrate local systems as required to support regional and sector wide quality improvement opportunities.

3.11 Oral health service coverage – hospital dental services

The Oral Health Clinical Leadership Network has reviewed the provision of hospital dental services and provided a report to the Ministry highlighting significant inconsistency of access to hospital dental services between DHBs (*Improving Oral Health Services of High Needs and Vulnerable Populations*). The Network developed a service eligibility matrix to clarify which patients should have priority of access to hospital dental services. The service eligibility matrix provides a tool for DHBs to benchmark their service against, and may assist them to enter into regional arrangements to improve consistency of access to services. This information was circulated to all DHBs in October 2013.

The Ministry and the Oral Health Clinical Leadership Network would like to see the service eligibility matrix, or a variation of it, embedded within sector planning and accountability arrangements. The Ministry may seek additional information from DHBs about hospital dental service provision so that consistency of access to services can be measured.

3.12 Disability Support Services new model programmes.

The Disability Support Services (DSS) Group has developed a new model for supporting disabled people that is currently being demonstrated around the country. The elements of the new model are:

- the local area co-ordinator (LAC), who works with disabled people and their families to provide information and support them to plan and connect to their communities. LACs are available to people living in the Bay of Plenty, Lakes, Hutt Valley and Otago/Southland regions

- a new funding allocation process and tool, which the DSS Group is testing to provide people with a personal budget (rather than services) that they can use to purchase most types of support (within purchasing guidelines) through individualised funding

- a demonstration called Choice in Community Living. Under Choice in Community Living, people will be supported to move from residential services, where they live in a home owned or rented by their support provider, to a home of their own. The demonstrations are being undertaken in the Waikato and Auckland regions and the demonstration is being extended to include the Hutt Valley and Otago/Southland regions.

3.13 In-between Travel

The In-between Travel Settlement Agreement required a transition to a regularised workforce by September 2016. The Settlement parties have since agreed that regularisation be introduced by 1 April 2017. This date aligns with the introduction of the Employment Standards Amendment Act 2015.

Further details about the In Between Travel Settlement can be found on the Ministry's website: www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-

entitlements/between-travel-settlement/information-providers-and-funders-about-between-travel-payments.

3.14 Regularisation of the Workforce

Work to implement workforce regularisation in the home and community workforce support sector is ongoing. . To ensure continued progress and that all important transitional matters are fully and fairly covered, DHBs are expected to work in good faith with the Ministry of Health and other Settlement Parties to regularise the home and community sector workforce.

A regularised home and community based support workforce is described as one which has:

- the majority of workers employed on guaranteed hours
- training to enable Level 3 New Zealand Certificate qualifications within two years of commencing
- work consistent with the service needs of the population
- wages paid on the basis of the required levels of training of the worker
- a case-mix/caseload mechanism to ensure the fair and safe allocation of clients to home care
- workers at a safe staffing level.

4 Individual service coverage schedules

General operational service delivery mechanisms

Service specifications are the operational service delivery mechanism for service coverage. Where service specifications are nationally agreed, consistency of service is maintained through the NSFL website. The NSF service specifications and related information are published on the NSFL website. www.nsfl.health.govt.nz/service-specifications

Not all services funded by the Ministry have their service specifications available on the NSFL website. In particular, DSS Service Specifications are available on the Ministry's website: http://www.health.govt.nz/our-work/disability-services/contracting-and-working-disability-support-services/contracts-and-service-specifications

Services are funded and delivered according to nationwide service specifications as stated, unless variations and exceptions are explicitly agreed through DHB CFAs.

In addition, responsible funders have agreements with their service providers that describe the range of services to be funded, the outcomes desired and the quality requirements of those services.

Services and programmes impacting on or related to several schedules are described in following appendices:

Appendix One: provides information on Special High Cost Treatment Pool
Appendix Two: provides information on Requirements in relation to accident claimants
Appendix Three: provides information on Gateway Assessment Programme
Appendix Four: provides information on Vulnerable Children – Children's Action Plan
Appendix Five: provides information on Violence Intervention Programmes
Appendix Six: provides summary of changes to the 2017/18 Service Coverage Schedule.

Summary schedule: health and support services for children and young people

This summary schedule collates the range of key health and support services for children and young people that are described in detail throughout this document.

Health and support services for children and young people are delivered in a variety of settings across a DHB's district to provide for needs of its local population. The types of services funded recognise individual circumstances, cultural preferences and service configurations available within the DHB's district. The service delivery ranges across the spectrum of health promotion and prevention, primary care, community and hospital services.

Although the national picture of health is positive, there are substantial variations in outcomes for different populations, particularly for Māori and Pacific peoples. For example, rates of some illnesses (such as rheumatic fever and skin infections) are much higher among Māori and Pacific peoples. As the New Zealand population is becoming more diverse, the health system recognises the need to be flexible to meet changing needs for and expectations of services.

The Government's Better Public Services goal envisages that people will be able to access services when they need them and that those services meet the needs of different population groups. One of the key ways to deliver better public health services is through integrated care. This involves careful co-ordination of patient care between different service providers and professions, often away from hospital, in patients' homes and communities. An example is maternity and child health services working alongside or with families and whānau, and other social services where necessary, to provide a seamless, consistent, network of coordinated care for pregnant women and for children.[6]

Transition to adult care

DHBs are responsible for ensuring that eligible young people aged from 14 to 24 years who require assessment or ongoing treatment for a medical or surgical condition, or are in transition to adult services (especially those with long-term conditions or disability or who require palliative care) must be able to access developmentally appropriate services. Pathways for transition to adult care will be developed and implemented for those children who require them. Core components of such a service include:

- identification of eligible children and young people
- development of an agreed care pathway for each clinical group of young people
- identification and/or development of a clinical service for young people to transition into
- transition plans agreed between the services and the child or young person with or without their family
- monitoring of the effectiveness and acceptability of the pathway.

[6] For the funding chart on the services for children from 0–6 years, refer www.health.govt.nz/our-work/life-stages/child-health/new-zealands-maternity-and-child-health-services-preconception-6-years.

Criteria for publicly funded treatment

Refer to the Eligibility Direction[7] for detail on the eligibility of children for publicly funded health services (also refer Section 2.1).

The following services provide universal access for children. Refer to the respective sections below and the nationwide service specifications for more detail: Well Child / Tamariki Ora, immunisation, newborn screening, child and adolescent oral health services.

Access to health services for children and young people will meet the availability requirements set out in section 2.2.

Services funded by the DHBs

DHB funded child and youth health services are provided for children and young people from birth up to the age of 18 years, although it may be appropriate in some circumstances for this age to be extended to up to 25 years. DHB-funded services include a range of community and primary health care services, inpatient and community-based mental health services, hospital core paediatric services, support services and disability services for children and young people. Note: Services for young children may be delivered through their parent or guardian (eg, parenting services for children with behavioural problems).

Services funded by the Ministry

The Ministry funds additional programmes and services for children and young people, sometimes in conjunction with other government agencies. These additional programmes are listed below under 'Other programmes for children and young people'.

Accommodation of children and young people as inpatients

The appropriate placement of a child or young person should be decided by clinical staff in discussion with the child or young person and their parents/guardians in the context of their developmental stage, clinical needs and availability of appropriately trained staff. In general, children should not be placed on adult wards (and vice versa), as this is developmentally inappropriate and is likely to be psychologically unsafe. If for any reason a child cannot be accommodated in an appropriate ward, the child must have paediatric-trained staff (medical and nursing) caring for him or her, should be physically separated from adults in the ward and should be relocated to a suitable location as soon as possible.

Article 37(c) of the United Nations Convention on the Rights of the Child (UNCROC) states that "Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances."[8]

Specific mandatory requirements for some health services are detailed in the nationwide service specifications published on the NSFL website.[9] The tier one service specifications for specialist medical and surgical services, and services for children and young people summarise the generic requirements for a range of services for children and young people.

[7] www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services

[8] New Zealand ratified the United Nations Convention on the Rights of the Child in 1993. The full convention is available here: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

[9] www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/468

Range of services

Key services for children and young people are summarised below. More detailed information relating to each service is provided in the corresponding schedule in this document, or in specific service specifications, as follows.

Schedule 4.3: Disability support services

The DSS schedule details the supports provided to children and young people with disabilities and their families, whānau, aiga and carers. Generally people must be assessed by a Ministry-contracted Needs Assessment and Service Co-ordination (NASC) service or, where eligible, through a National Intellectual Disability Care Agency (NIDCA). Some children and their families may access child development services or assessment, treatment and rehabilitation services via health referrals, and as a result may access services without going through the NASC process.

Schedule 4.6: Immunisation services

All children are eligible to receive vaccinations listed on the National Immunisation Schedule.

Immunisation services include, but are not limited to, the following publicly funded immunisations:

- antenatal immunisation programme
- newborn and early childhood immunisation programme mainly delivered through general practice
- school-based immunisation programme
- influenza immunisation programme
- outreach immunisation services
- targeted immunisations programmes for some groups of children at high risk of certain diseases due to other medical conditions or high risk of exposure, including vaccination against tuberculosis, influenza and hepatitis A and hepatitis B, and the pre-post splenectomy/ functional asplenia programme.

Schedule 4.7: Support services for people with long term or chronic conditions

DHBs support the development of an ‘integrated continuum of care’ for children and young people with chronic health conditions and with long-term support needs. This requires that appropriate and effective clinical and support services are in place, which link with each other and are designed around the needs of the clients, their families, whānau, aiga and carers. Examples of such services are support packages for families caring for medically fragile children that take account of the whole family’s needs, including the needs of siblings, and Ministry - funded child development services.

Schedule 4.8: Maternity services

Maternity services are provided to women and their families throughout pregnancy and childbirth and for the first six weeks of a baby’s life.

Schedule 4.9: Mental health and addiction services continuum

For the strategy on child mental health, refer Section 5 of the Mental Health and Addiction Service Development Plan (Ministry of Health 2012b).

Mental health and addiction services for children and young people are available up to and including the age of 19 years, and adult services are available from age 18 years – this overlap is managed according to the clinical and developmental needs of the consumer. Some flexibility will be allowed to manage the transition between child and youth services and adult services through to 25 years in order to best meet the needs of the young person. Perinatal and maternal mental health services are also included.

Children and young people have access to the same range of services as the adult population. However, those services are provided in a manner and setting that are safe and developmentally appropriate; ideally, services for children and young people should be separate from services for adults unless a different arrangement is in the best interests of any particular child or young person.

Schedule 4.10: Oral health services

Preventive, educative and treatment dental and oral health services are available for all preschool and primary school aged children and a specified range of dental services for adolescents under the age of 18 years.

Schedule 4.11: Palliative care

Guidance for Integrated Paediatric Palliative Care Services in New Zealand (Ministry of Health 2012) provides guidance for delivery of palliative care service to children and young people.

Schedule 4.12: Pharmaceutical Services

For children under 13 years of age, the prescription co-payment will be $0 for fully subsidised medicines.

Schedule 4.13: Primary health care services

Assessment, diagnosis and treatment of acute and long-term conditions by primary health care services are available for children and young people. All infants should be enrolled with primary health care, Well Child / Tamariki Ora and oral health services, and be placed on the National Immunisation Register, before they are two weeks of age. All young people should have access to primary health care that is responsive to the specific needs of youth.

Children and young people (under 18 years old), regardless of their citizenship or immigration status, are eligible for publicly funded Well Child / Tamariki Ora services, immunisation services, and primary prevention, promotion and protection services from birth.

Primary health care services for children and young people funded by the DHB or Ministry include, but are not limited to:

- Well Child / Tamariki Ora services such as hearing and vision tests, and Well Child checks which include the B4 School Check service
- essential primary health care services specified in the current PHO–DHB Services Agreement
- health assessment and treatment services to support at-risk children and adolescents and their families – for example, children and young people in the care of the State – and the Family/Whānau Support Service
- preschool and school health services such as: school based health services in decile 1, 2 and 3 secondary schools, teen parent units and alternative education facilities
- sexual and reproductive health services
- primary mental health promotion, education, diagnosis and treatment.

Cost

Long-term support services and disability support services are provided at no charge for children under 16 years old or until they qualify for a supported living payment. Children with disabilities may have their own Community Services Card, giving them access to subsidised health services.

PHOs provide access to essential primary health care services at low or reduced cost to their enrolled populations according to fees that they notify to the DHB in accordance with the Fees

Framework – level policy and charges to services users included in the current PHO–DHB Services Agreement.

Children up to 13 years of age are eligible for free general practice visits and access to free after-hours visits.

Schedule 4.14: Provision of equipment, modifications and other supplies and services

The Ministry and DHBs fund equipment, modifications and other supplies and services for disabled people to promote their independence, maintain and improve levels of mobility, enable them to remain in or return to their home, and support and maintain their access to education, vocational training and employment.

Schedule 4.15: Public health services and prevention services

Public health services primarily focus on populations or specific groups of people in specific settings, such as students in a school setting. However, this boundary is blurred, and interventions arising out of a public health programme, such as throat swabbing for rheumatic fever, may still be undertaken by public health nurses if this is the most effective and efficient model of care.

Prevention services are those that aim to stop people becoming ill. For example, the National Immunisation Register contributes to the prevention of key childhood illness by supporting health professionals to share information so that the right immunisations can be delivered to the right children at the right time.

Screening in child and youth health

There are a number of screening programmes and opportunistic screening interventions offered to children and young people. Organised screening programmes include new-born screening for metabolic disease, hearing loss screening, vision and hearing screening, and strengths and difficulties screening at four years of age.

Schedule 4.16: Specialist medical and surgical services

Specialist medical and surgical services for children or young people are usually provided in, or from, a hospital following a medical emergency or an accident, or after referral from an approved specialist or primary health care referrer, or another DHB. Where medical services are delivered in a hospital setting, they are traditionally provided for children and young people up to 14 years of age, but this is not a firm cut-off, and the upper limit may be extended on clinical grounds up to age 24 if appropriate safeguards are in place.

Other programmes for children and young people

Children's Teams (refer Appendix 4)

Children's Teams work to ensure vulnerable children are kept safe before they come to harm so they thrive, achieve and belong. There is an expectation that DHBs will be active participants in the leadership, governance, design, implementation and operation of local Children's Teams in their regions.

Children's Teams represent a new and different way of working. Putting children at the centre of everything we do means that providers from across the health, education and social sectors need to work through how best to work together to achieve better results for vulnerable children and their family/whānau.

DHBs will support the operation of local Children's Teams by:

- participating in Local Governance Groups for Children's Teams

- developing effective referral pathways to/from Children's Teams and primary and secondary health services.
- providing, where appropriate, staff resource for Children's Team Panels, Child Action Networks, Lead Professionals and Service Brokers

Specific programmes for vulnerable children (refer Schedule 4.16)

DHBs deliver Violence Intervention Programmes (VIP) in acute and community health services, in particular: mental health, alcohol and drug; child health (including school and home visiting services and tertiary paediatric services); maternity; sexual health; and emergency department.

Interagency programmes – Gateway Assessments (refer Appendix 3)

The Gateway Assessment Programme is a comprehensive health and education assessment programme for children and young people engaged[10] with Child, Youth and Family (CYF), a business group within the Ministry of Social Development. The Ministry of Health, Ministry of Education and CYF have collaborated on policy to support the programme, and report at ministerial level on joint outcomes.

The overall objective is to enhance the child or young person's physical, mental, educational and social wellbeing by identifying unmet need and referring them to services to address these needs. CYF contracts with all DHBs for the service.

Youth services (refer paragraph 3.3 and Schedule 4.13)

DHBs will engage with youth service providers (including YOSS), other primary health care and community health providers, and other social services agencies, to ensure youth services are provided in an integrated and sustainable way. DHBs should support a range of sustainable youth-friendly health and social services, including:

- youth specific services as appropriate for the locality, which could include youth wellness hubs/networks, school-based health services or YOSS
- general practice that is responsive to youth.

[10] Children and young people entering care, in care, or being referred for a care and protection family group conference.

4.1 Blood services

Range of services

DHBs will ensure the provision of blood, blood products and blood services include, but are not limited to:

- blood components and plasma-derived products for health services for people
- administration and transfusion
- informed consent, including provision of systems to document that the potential recipient has been informed of the benefits and potential risks associated with administration of the blood component or plasma-derived products
- monitoring the use of blood components and plasma-derived products
- reporting untoward events and adverse outcomes associated with transfusion to the New Zealand Blood Service (NZBS) Haemovigilance office.

The National Haemophilia Management Group (NHMG) is responsible for the management oversight of the coordinated services for people with haemophilia. Each DHB will ensure that recombinant Factor VIII and/or Factor IX products ('synthetic blood products') are able to be accessed for haemophilia treatment according to NHMG guidelines on the use of recombinant products in New Zealand.

Access

Doctors decide on the use of blood components and plasma-derived products in emergencies, and for the treatment of specific conditions like haemophilia and primary immune deficiency. In circumstances where a proposed treatment approach represents a significant move away from usual practice in terms of volume of product, clinical liaison with an NZBS transfusion medicine specialist is recommended.

Cost

Irrespective of eligibility status blood components or plasma-derived products are provided at no charge to all people requiring these products in New Zealand. NZBS has a list of national charges (which is reviewed each year) to DHBs for blood services and products. As set out in supply agreements between DHBs and NZBS, DHBs must pay NZBS for services and stock ordered, on invoice by NZBS.

Time

There is no waiting period for blood components or plasma-derived products in normal circumstances.

Other information

This service is accessible only because New Zealanders volunteer to donate blood, from which blood components and plasma-derived products are manufactured. All people who meet the NZBS's eligibility criteria are encouraged to donate blood.

4.2 Diagnostic, therapeutic and support services – personal health

Diagnostic, therapeutic and support services are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided as a support service/ input into other services that are described in other schedules (eg, 4.16 Specialist Medical and Surgical services, 4.3 DSS).

Diagnostic, therapeutic and support services are usually provided by allied health professionals and nurses.

The Ministry is working closely with DHBs to develop consistent national access criteria and standards for community services, and to remove discrepancies between what is available for people eligible for DSS and people who are not eligible for DSS but have an assessed need for support that may not be available within health services.

Range of services

DHB funded diagnostic, therapeutic and support services include but are not limited to:

Diagnostic services

- allergy testing
- audiology service
- diagnostic imaging services (eg, X-rays, ultrasound scans, specifically including diagnostic mammography for people with symptoms)
- diagnostic mammography for asymptomatic women regardless of age who have any of the following:
  - a previous breast cancer
  - a mother or sister with pre-menopausal breast cancer or bilateral breast cancer
  - a breast histology demonstrating an at-risk lesion (eg, atypical hyperplasia)
- positron emission tomography (PET) scans in line with national clinical indications
- electro-diagnostic imaging (eg, electrocardiograms (ECGs) and electroencephalograms (EEGs))
- laboratory tests and services, including collecting, transporting and analysing specimens, and reporting results
- pre-implantation genetic diagnosis (PGD) as part Artificial Reproductive Technology Services.

Therapeutic Services

- community nursing – both general and specialist services
- community oxygen therapy
- dietary and nutritional counselling
- interventional radiology
- occupational therapy
- physiotherapy
- podiatry services
- speech language therapy

Support services

- assistance with daily living, including home help, personal care and meals on wheels
- continence education and consumable services
- mortuary services
- social work
- stomal therapy services
- smoking cessation services.

In relation to the above services, each DHB funds all required materials, resources and health professional services as follows:

Mortuary services

DHBs must ensure the ongoing availability of services and facilities to appropriately support the provision of coronial and medical post-mortems.

In relation to laboratory services, if changes to service provision models are made, DHBs must ensure that the availability of forensic pathology services to support coronial post-mortems is maintained.

Smoking cessation services

The Ministry currently funds the majority of smoking cessation services (eg, Quitline and Aukati KaiPaipa services). Note that some DHBs also fund local cessation services. This service may be provided by non-registered health care workers such as community workers.

Services related to diagnostic, therapeutic and support services covered in other schedules

- Support services associated with the long-term needs of people who meet the DSS definition of ‘person with a disability’ are addressed under Schedule 4.3: Disability support services.
- Support services associated with ‘health and support services for older people’ access criteria are addressed under Schedule 4.5 Health and support services for older people.
- Pharmaceuticals associated with diagnostic, therapeutic and support services are addressed under Schedule 4.12 Pharmaceutical services.
- Medical equipment and supplies associated with diagnostic, therapeutic and support services are addressed under Schedule 4.14 Provision of equipment, modifications and other supplies and services.
- Specific diagnostic modalities (CT, MRI, coronary angiography, colonoscopy) associated with the staged programme to reduce waiting times for diagnostic services are addressed under Schedule 3.7 Diagnostic Services.

Access

The referring health professional determines which services will be requested according to their clinical judgement. For some services (eg, continence services and smoking cessation services) the client may self-refer for assessment. The providers of some diagnostic services, and most therapeutic and support services will assess the referred person’s need against predetermined eligibility and health status risk criteria contained in the relevant nationwide service specifications. DHBs are expected to consider positron emission tomography (PET) scans on an exception basis for clinical indications outside of national clinical indications.

Improving equity

DHBs will work to improve the equity of access to diagnostic services. DHBs will have in place, and maintain, effective systems to support them to make decisions around the priority, order and urgency of people's access to diagnostic services.

Exclusions

Access criteria for some services vary around the country.

Time

For some diagnostic, therapeutic and support services time frames for response to referrals and commencement of services is defined in nationwide service specifications.

4.3 Disability support services

The New Zealand Disability Strategy (Minister for Disability Issues 2001) provides a framework that guides government departments towards a fully inclusive society for disabled people. It influences the way the Ministry develops and provides support for disabled people. To reflect the New Zealand Disability Strategy in its daily work, the Ministry's Disability Support Services Group, in consultation with consumers, developed a vision:

> Disabled people and their families are supported to live the lives they choose. Ministry-funded disability support services are services or products that, within available funding, assist disabled people to carry out their daily lives. This DSS service coverage schedule details the supports provided (where necessary) to disabled people and their families, whānau, aiga and carers.

Within Vote Health's agreed definition of disability,[11] the Ministry is responsible for planning and funding DSS for people who have physical, sensory or intellectual disabilities, or a combination of these, and are generally aged under 65 years. A person's disability must be likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is needed.

There are three exceptions to this general rule.

- The Ministry funds environmental support services[12] for people of all ages.
- The Ministry will continue to fund its clients, even if they are over 64 years, until they are assessed as requiring aged residential care, at which time the DHBs will take over funding responsibility.[13]
- DHBs fund services for people aged between 50 and 65 years who have been clinically assessed by a DHB and/or needs assessor as having health and support needs because of long-term conditions more commonly experienced by older people.

Services provided under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 are also funded by the Ministry.

Range of services

The Ministry funds a range of DSS. Generally, to access these services, people must be assessed by a Ministry-contracted Needs Assessment and Service Co-ordination (NASC) service or, where eligible, through a National Intellectual Disability Care Agency (NIDCA). Access to environmental support services, including equipment and modification services, is via a specialised assessment or an appropriate health professional. DSS may include, but are not limited to, the following features:

[11] In Vote Health, disability support services support a person who has a physical, psychiatric, intellectual, sensory or age-related disability, or a combination of these, where the disability is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that ongoing support is needed.

[12] Environmental support services include the provision of equipment and modifications (housing and vehicles), services and support for people with vision and/or hearing impairments, specified specialist assessment and training services, and specified subsidies and supports.

[13] This was agreed as applying when responsibility for disability support services for people aged over 65 years was devolved to district health boards on 1 October 2003.

Description of services	Service specifications / guideline documents
Inform people and their families, whānau or carers about available services and advise on access to services	Disability Information and Advisory Service Specification
Assessment of individual needs Facilitated needs assessment through NASC organisations or for those eligible for high and complex services (civil population), through the NIDCA Offenders with intellectual disabilities are subject to the court-ordered timelines and procedures for determining access to services, which the NIDCA will carry out Service co-ordination[14] to develop a package of services to meet an individual's prioritised assessed need, within available funding	NASC Service Specifications National Intellectual Disability Care Agency Service Specification Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines Operational Manual for Needs Assessment and Service Co-ordination Managers
Individualised funding to enable eligible clients with disability-related needs to independently manage their support needs and budget	Individualised Funding Guidance Good Practice and Service Specifications
Assistance with daily personal care activities (eg, dressing, bathing, eating and toileting) Assistance with household activities (eg, meal preparation, laundry, cleaning)	Home and Community Support Services Service Specification
Carer support services (eg, carer support subsidy, respite care, carer training)	Respite Care Service Specification Service Specification for carer training Service Specification for carer matching Carer support guidelines for Ministry clients
Community Day Services, primarily to assist people who have been reintegrated into community living under deinstitutionalisation agreements	Service Specification for Community Day Services
Rehabilitation and habilitation services, including: • DHB-provided assessment, treatment and rehabilitation (AT&R) services • community-based rehabilitation services • child development services	AT&R Service Specifications (assessment and planning service components) Child Development Service Specification (assessment and planning service components)
Supported living	Supported Living Guidelines and Service Specifications
Residential support services (eg, community residential services and community residential placements in aged care facilities for younger people)	Community Residential Support Service Specifications for people with physical and/ or intellectual disability Community Residential Service within aged care facilities for younger people with lifelong disabilities specifications
Autism Spectrum Disorder specific services	NZ Autism Spectrum Disorder Guidelines Service Specifications for Autism Spectrum Disorder specific services
Behaviour Support Services	Behaviour Support Services service specification
Services for people with intellectual disabilities under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003	Regional Intellectual Disability Supported Accommodation Service (RIDSAS) Service Specifications Regional Intellectual Disability Secure Care Service (RIDSS), Hospital-level Service Specifications National Intellectual Disability Secure Care Service (NIDSS, hospital high-level forensic assessment and secure beds) Specification

[14] Service coordination assists the person with a disability to have their needs met from all appropriate supports that are available in the community, including, but not limited to, liaising with other government agencies such as Housing New Zealand and the Ministry of Education. In some cases, Ministry funding may be a component of the total support package. The Ministry will ensure that there are auditable boundaries between needs assessment, service coordination and other DSS.

Description of services	Service specifications / guideline documents
Funded Family Care – funding available to eligible adults with high and complex needs who are able to employ specific family members (excluding spouses) for assistance with: • daily personal care activities (eg, dressing, bathing, eating and toileting) • household activities (eg, meal preparation, laundry, cleaning)	Relevant notice under section 88 of the NZPHD Act 2000 Home and Community Support Services Service Specification Funded Family Care Operational Policy

DSS-related services covered in other schedules

- For medical equipment and supplies, provision of equipment, modifications and other supplies and services, hearing and vision services, specialised assessment services, specialised assessor training and other support, refer Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Disabled people should have access to the same range of health services as the rest of the general population, in a manner and setting that are safe and appropriate. This level of access includes people in residential care settings. Refer to the following service coverage schedules:

- 4.9 Mental health and addiction services continuum
- 4.11 Palliative care
- 4.12 Pharmaceutical services
- 4.13 Primary health care services
- 4.15 Public health services and prevention services (particularly injury/falls prevention)
- 4.16 Specialist medical and surgical services
- 4.17 Travel and accommodation services.

Access

The Ministry funds NASC. People wishing to receive DSS for the first time will have a needs assessment facilitated by a Ministry-contracted needs assessor. If needs change, a full reassessment may be undertaken. A person may be referred or self-refer to the needs assessment service.[15] Where a person is being referred by another person, the referrer needs to make that referral, where possible, with the permission of the person being referred.

The Ministry funds NASC through NIDCA for access to high and complex services for eligible individuals. Access to high and complex services is required for people with intellectual disabilities who are subject to compulsory care orders under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. For other individuals defined as ‘civil’, referrals are made by mainstream NASC services. Eligibility and service access is determined according to the NIDCA eligibility criteria.

For people with intellectual disabilities who are convicted of imprisonable offences and are subject to compulsory care orders made by the court under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 or the Criminal Procedure (Mentally Impaired Persons) Act 2003, access is determined by court order.

[15] A list of NASC organisations is available from www.health.govt.nz/our-work/disability-services/about-disability-support-services/needs-assessment-and-service-coordination-service

Provision of equipment, modifications and other specific environmental support services must be accessed through equipment and modification services assessors or appropriate health professionals.

Some people may access child development services or Assessment, Treatment and Rehabilitation (AT&R) services via health referrals and, in this way, may access services without going through the NASC process.

Any person with a disability or member of the community can self-refer to disability information and advisory services.

Criteria for publicly funded treatment

Needs assessment and service co-ordination

A needs assessor facilitates the assessment of the support needs of disabled people and their family, whānau, aiga or carers. The needs assessor does not facilitate an assessment of the total needs of a disabled person as they do not assess, for example, mental health or a person's financial situation. The needs assessor does complete a comprehensive assessment of disability needs, which can/does identify other areas where a person may require additional support. Based on this assessment, the needs assessor will, with the person's permission, refer them to appropriate support services.

After a needs assessment has been completed, a service coordinator:

- explores all options for achieving desired outcomes with the person who requires support
- may assist the disabled person to access support from other services
- may allocate DSS funding, within available funding and using prioritisation and resource allocation tools
- ensures services are in place and that agreed outcomes are being achieved.

Note: The needs assessor and the coordinator could be the same person.

Access to equipment and modification services is through specialised assessment and recommendation. The Ministry's contracted providers for the administration of the provision of equipment, modifications and other supplies and services make decisions based on Ministry access and eligibility criteria.

Exclusions

The Ministry of Health's Disability Support Services Group does not fund support services for conditions or situations covered by other funders, including those where people:

- have conditions covered under the Accident Compensation Act 2001, require support due to their injury and do not have a co-existing disability that meets DSS eligibility criteria
- require support due to a mental health problem and/or addiction and/or damage from alcohol or other drug abuse, and do not have a co-existing disability that meets DSS eligibility criteria
- require support due to a disabling chronic health condition and do not have a co-existing disability that meets DSS eligibility criteria (some may be funded under Schedule 4.7 Long-term support services for people with chronic health conditions)
- require support due to behavioural difficulties and do not have a co-existing disability that meets DSS eligibility criteria

- present with long-term support needs at age 65 or over except for provision of equipment, modifications and other environmental support services
- are aged 50 to 64 years and have been clinically assessed as having health and support needs because of long-term conditions more commonly experienced by older people
- have short-term support needs (less than six months)
- need personal health (clinical) and palliative care services.

Cost

NASC services, contracted services, environmental support services and most assessments for equipment and modifications are provided at no charge.

DSS are provided at no charge for children under 16 years old, or until they qualify for an invalid's benefit.

Personal care services, which are delivered mostly in a person's home (eg, assistance with dressing, bathing, eating), are provided at no charge.

Household management services (eg, meal preparation) are provided at no charge to Community Services Card holders. Note that children with disabilities may have their own personal Community Services Card which gives them access to subsidised health services, but this will not give the family access to funded household management services. For the family to get such access, where household management services are assessed as necessary, the child's parents or informal carers will need a Community Services Card as well. If a person does not hold a Community Services Card, they may be charged for these services.

Carer support services for informal carers are not income and asset tested. The carer support subsidy is designed to assist informal carers with some of the costs of securing short-term relief care services. Carers may have to contribute towards the costs of short-term relief care when those costs are higher than the subsidy.

A number of arrangements apply to specific equipment and modifications services. Refer to Schedule 4.14 Provision of equipment, modifications and other supplies and services.

If Ministry-funded clients are in residential care, are beneficiaries under section 3(1) of the Social Security Act 1964 and are not subject to income and asset testing under Part 4 of that Act, they may be required to contribute some of the cost of care. These people will pay an amount no greater than the equivalent single person's benefit less any personal allowance permitted by the Ministry of Social Development. They do not have to pay any of the personal allowance portions of the benefit toward the costs of care.

Time

In a crisis, where a person's safety is at risk, they should receive, or be assessed for, DSS within 24 hours.

If a person urgently requires assessment for DSS but is not in a crisis situation, a needs assessor or health professional should contact them within two working days.

If a person is assessed to urgently require DSS but is not in a crisis situation, they should receive services within two weeks subject to availability of funding.

If the need for DSS is not urgent, a person will receive services as soon as possible. Timing of services will depend on the person's need relative to that of others, their ability to benefit

and become more independent as a result of the services provided, and the availability of funding.

For offenders with intellectual disabilities subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, timelines are determined by that Act.

Additional quality requirements

Compliance with certain standards

The Ministry and DHBs will ensure that all providers of relevant DSS are required by their service agreements to comply with the following standards and guidelines in addition to the quality and other relevant requirements within the service agreement or standard contract documentation:

- **needs assessment and service co-ordination** documents:
  - Standards for Needs Assessment, 1994
  - Guidelines for Service Co-ordination, 1995
  - Needs Assessment Standards, 1999, and Service Co-ordination Standards, 1999; Standards for NASCs, 1999
  - Support Needs Assessment and Service Co-ordination Policy, Procedure and Information Reporting Guidelines, February 2002
  - National Health and Disability Sector Standards (HDSS) (only specific parts of the HDSS are relevant to NASC providers. All Ministry-funded NASC providers are required to be compliant with the criteria identified by letters A and B in the HDSS)
- **community residential:** relevant[16] standards approved under the Health and Disability Services (Safety) Act 2001, as set out in the Health and Disability Services Standards (NZS 8134:2008)
- **Home and community support services:** Standards as set out in the Home and Community Support Sector Standards NZS8158:2012 .

[16] Not all standards or criteria within NZS 8134 are relevant to all services.

4.4 Emergency ambulance services

Emergency ambulance services are to be provided in accordance with the joint Emergency Ambulance Service Specifications of the Ministry of Health and ACC.

For the purposes of this schedule, a 'medical emergency' is defined as:

> An ambulance response to a call received and triaged by an ambulance communications centre as indicating that a person has a condition that requires urgent medical attention. The call indicates the person is triaged as requiring urgent medical attention (not caused by trauma). Emergency ambulance response does not include patient/client transfer services.

Range of services

Services funded by the Ministry

Emergency ambulance services funded by the Ministry include, but are not limited to:

- provision of land, water and air emergency ambulance services to respond to people requiring assistance as a result of a medical emergency
- emergency assessment, treatment and transportation (where necessary and appropriate) of medical patients to appropriate medical facilities, including resuscitation and stabilisation before and during transport
- transport from public hospital emergency departments to a higher-level hospital, after arriving at the first hospital within three hours by ambulance[17]
- provision of a comprehensive 24-hour communications system, including a 111 answering facility and triage service to determine the most appropriate response, or access to same through a Service Level Agreement, and a two-way connection to Healthline for calls from that service that are promoted to an emergency response or calls to the 111 service for which an emergency response is not appropriate
- capacity to respond to potential and actual major incidents.

The following are guiding principles for retrievals/ treatment/ transport in/from the community:

- Treatment delivered is necessary, appropriate and of the required quality
- Treatment is delivered by the staff with the appropriate skill level and support
- Transport to treatment is undertaken only when necessary and appropriate and is related to patient need.
- Transport to treatment for patients should be in accordance with nationally or agreed destination policies.

Note: For all individuals accepted as accident claimants by ACC, emergency transport for treatment within 24 hours of injury (or being found or diagnosed) is funded by ACC.

Services funded by the DHBs

DHBs fund inter-hospital transfers except those funded by the Ministry under the emergency ambulance services agreements. In relation to inter-hospital transfers, the DHB of domicile pays.

[17] The exception to this is for the Order of St John in the Northern Region.

Refer to the 4.8 Maternity services schedule for maternity related transport.

Access

24-hour, seven-day a week access is provided to all people, for all settings, requiring emergency ambulance services whether by road, water or air.

Criteria for publicly funded treatment

The provider determines the mode of transport (where appropriate) and type of response (crew configuration) through protocols and procedures (including consideration of severity of an injury or illness, the risks of sudden severe complications, and the availability of local medical resources).

Exclusions

No public funding from Vote Health is made available for the following services: emergency ambulance services for individuals accepted as accident claimants by ACC (these are funded by ACC), and private hire response by ambulance of less than 'emergency' status.

Cost

In a medical emergency (eg, a heart attack) there may be a patient part-charge for ambulance transport to a hospital or place of definitive care, irrespective of the distance travelled. Contracts cap the part-charge amount and providers cannot increase this amount without prior agreement with the Ministry.

Time

All calls or requests for emergency services will be dealt with immediately to determine the most appropriate response. The Ministry monitors the performance of providers of emergency ambulance services, including a range of appropriate response times (from call to arrival at the patient). Information for this monitoring is indicated in the joint Ministry–ACC Emergency Ambulance Service Specifications and sourced directly from emergency ambulance service providers.

Additional quality requirements

All emergency air and road ambulance service providers covered by contracts, service agreements or funding arrangements with the Ministry are to be members of Ambulance New Zealand and are required to be certified as compliant with NZS 8156 (Ambulance and Paramedical Services Standard). Emergency air ambulance providers are also required to meet the Ambulance New Zealand Air Ambulance/Air Search and Rescue Service Standard (AA/ASAR Standard).

It is expected that DHBs will include both these quality standards in their agreements with providers for transfer services by ambulance, including inter-hospital transfers.

DHBs will participate in an emergency care co-ordination team where one exists.

4.5 Health and support services for older people

The focus for older people's health and support services is on developing an integrated 'continuum of care' to support older people to maintain and, where feasible, improve their health and wellbeing so that they can participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life.

Integrated care is about careful co-ordination of a person's care between different service providers and professions. Greater system integration, including clinical and support services, across the health and community sectors aligns organisations and health care professionals to improve outcomes for older people and provide a better experience. System integration is a way of achieving more timely and efficient person-focused services that are more cost-effective, reduce duplication of effort (eg, for access and collection of patient information) and achieve economies of scale.

The continuum of care for older people covers the whole range of health and support services for older people, including health promotion and primary care, secondary and specialist care, home and community-based care, residential care, palliative care and end-of-life care. Within the continuum, responsive health and support services recognise the need for age-appropriate services, the importance of strong links across services and the sector, cultural and ethnic diversity, and the need for flexible and client-centred approaches.

Health and support services for older people will be delivered in a variety of settings across DHBs to provide for needs of the local population. The types of services will recognise individual circumstances, cultural preferences and service configurations available within a DHB's district.

The Government's priorities for the health of older people, include:

- a focus on improving older people's underlying health and wellbeing – particularly in the areas of minimisation of harm and injury
- building better systems – including timely access to standardised assessments and care planning, and aggregated data for monitoring and audit to improve quality across home and community support services and aged residential care
- providing new and expanded services – concentrating on dementia, and primary and community care improvements to avoid hospital admissions
- supporting family and whānau – in particular, through providing and enabling access to support for carers, respite care, day programmes and social supports
- providing integrated services closer to home with the aim of improving outcomes – in particular, chronic disease management, services for the frail elderly, and support for the Whānau Ora initiative
- collaborating regionally to maximise clinical and financial resources
- strong clinical leadership.

Range of services

Services funded by the DHBs

Services funded by DHBs will include, but will not be limited to:

- information, advice and education for older people and their families, whānau and carers about, but not limited to, available services, access to services, health promotion and self-management, and needs assessment of older people,[18] including assessment of carer needs
- interRAI Community Health Assessment and functional supplement or Home Care Assessment, which must be completed to determine need for home and community support services and aged residential care
- implementation and roll-out of interRAI into aged residential care
- service co-ordination[19]
- support to live at home, including personal care (eg, assistance with dressing, bathing, eating and toileting), household management (eg, assistance with meal preparation, laundry and cleaning) and, where appropriate, restorative and rehabilitative approaches to support older people to regain independence and remain part of their community
- support for informal carers including carer support subsidy and respite care (eg, carer training, residential respite, dementia respite care and day programmes for older people, in-home respite care)
- specialist health of older people services providing support to residential and home-based support services for older people as well as to acute hospital, primary health care and NASC services
- an organised stroke service
- AT&R services
- long-term residential care
- rest home
- hospital
- dementia
- specialised hospital (psycho-geriatric).

Older people should also have access to the same range of health services as the general population, in a manner and setting that are safe and age appropriate. Refer in particular to the following service coverage schedules:

- 4.2 Diagnostic, therapeutic and support services – personal health
- 4.9 Mental health and addiction services continuum'
- 4.11 Palliative care
- 4.12 Pharmaceutical services
- 4.13 Primary health care services
- 4.15 Public health services and prevention services (particularly injury/falls prevention)
- 4.16 Specialist medical and surgical services

[18] Comprehensive clinical assessment through interRAI Contact Assessment, Community Health Assessment or Home Care Assessments to address risk factors, if present, and to allow for the early detection, intervention and management of conditions for clients at all levels of complexity.

[19] Service coordination assists the older person to have their needs met from all appropriate supports available in the community. This may include liaising with other government agencies such as Ministry of Social Development and Housing New Zealand. Service coordination may include goal setting.

- 4.17 Travel and accommodation services.

Additional services funded by the DHB

The DHB may fund other services to support a continuum of care for older people, including:

- separate needs assessment for carers, particularly where comprehensive clinical assessments (interRAI) signal that carers are under pressure
- intermediate or transitional care (eg, planned early discharge with home support, slow stream rehabilitation, convalescent care, short-term residential care).

Services funded by the Ministry

Ministry-funded services include environmental support services – refer to Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Access

Access to support services funded by DHBs is determined through the NASC process. Older people can be referred from any source to have their needs assessed, and can self-refer. If an older person's needs change, then a full reassessment of their needs will be made. Access to support for informal carers (such as respite care and short-term relief through the carer support subsidy) is also determined through the NASC process. Access to equipment, modifications and other supplies and services is through specialist assessment and recommendations. Refer to Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Criteria for publicly funded support services

The service co-ordination process identifies the specific services that will be provided to meet the assessed needs and goals of the older person and, where appropriate, their family, whānau and carers. Service co-ordination decisions take account of individual circumstances including current supports available (informal and formal) and support needs that can be met by other services. Decision-making may also use prioritisation and resource allocation tools.

Providers of equipment, modifications and other supplies and services make decisions based on Ministry of Health access and eligibility criteria. Refer to Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Cost

Needs assessment and service co-ordination services are provided at no charge.

Personal care services, delivered primarily in a person's home (eg, assistance with dressing, bathing, eating and toileting) are provided at no charge.

Household management services (eg, assistance with meal preparation, laundry and cleaning) are income tested. If a person has a Community Services Card, household management services are provided at no charge. If a person does not have a Community Services Card, the person may be fully or partly charged for these services.

Support services for informal carers are not income or asset tested. The carer support subsidy, administered by the Ministry of Health and DHBs, is designed to assist informal carers with some of the costs of securing short-term relief care services. Carers may have to contribute

towards the costs of short-term relief care when the costs of that care are higher than the subsidy.

DHBs can decide a limit on the cost of providing support services that enable an older person to remain in their own home. If the DHB does place such a limit:

- the limit must be at least the average cost to the DHB of relevant residential care (ie, the aged residential care (ARC) price for the relevant level of care less the average contribution of residents towards the cost of their residential care). The limit can be higher than that minimum. A limit must not be based on what the individual would pay based on their individual income and asset testing.
- any limit must allow for exceptions where the DHB judges expenditure above the limit is justified eg, for short-term care or where limiting care would increase the risk of a couple both going into residential care
- DHBs can include the cost of support services other than home support if they are ongoing and provided regularly
- DHBs may allow arrangements for the older person to purchase services that are beyond the DHB limit.

Aged residential care services (contracted care services)[20]

People who have been needs assessed as requiring aged residential care indefinitely may apply to the Ministry of Social Development for a financial means assessment (income and asset test) to be completed under Part 4 of the Social Security Act 1964.

If a person's assets are under the asset threshold, then the Ministry of Social Development, through the financial means assessment, will determine how much the older person must contribute towards the cost of services up to the gazetted maximum contribution per week in their local region. If the cost of contracted care services exceeds the gazetted maximum contribution, the DHB will pay the difference between the maximum contribution and the cost of the contracted care services paid to the provider.

If a person has not had a needs assessment or has not been income and asset tested under Part 4 of the Social Security Act 1964, the person will pay the full cost of the services.

People aged 50 to 64 years who are assessed as requiring aged residential care indefinitely and who are single with no dependent children are income tested only (ie, not asset tested).

Exempt persons[21] (as defined in regulation 5 of the Social Security (Long-term Residential Care) Regulations 2005) will not be income and asset tested. The DHB will pay the cost of

[20] Contracted care services are defined in the Social Security Act 1964 as 'services that are provided by a contracted care provider' (ie, a provider that has a service agreement or accepts payment under a section 88 notice) 'to an eligible person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely' and 'the services necessary to meet the person's assessed long-term residential care needs' (s 136).

[21] An 'exempt person' is defined in regulation 5 as a resident who:

- received long-stay geriatric care in a geriatric hospital before 1 July 1993, or
- was receiving long-stay care in one of the following hospitals prior to their closure – Kimberley Hospital (Levin), Templeton Hospital (Christchurch), Mangere Hospital (Manukau City) or Braemar Hospital (Nelson), or
- has intellectual disabilities and was receiving long-stay care in a psychiatric hospital prior to closure of the hospital, or
- under the Mental Health (Compulsory Assessment and Treatment) Act 1992 is subject to a compulsory treatment order made under s 30; or, is declared a restricted patient under s 55; or, is a special patient under s50 or s 52 of the Act, or
- is subject to a compulsory care order, or
- under the Health Act 1956 is removed to any hospital or rest home under s 79, or

the contracted care services provided, but the exempt person will contribute the amount of any benefit they receive, less the amount of the personal allowance.

Elderly victims of crime (as defined in regulation 6 of the Social Security (Long-term Residential Care) Regulations 2005) will not be income and asset tested. The DHB must pay the full cost of contracted care services above the ACC level of payment of the services. The payments by the DHB are without prejudice to the Ministry or the Crown recovering from ACC the whole or part of those payments.

Time

The Social Security Act 1964 allows for an eligible person to apply at any time to a DHB for a needs assessment (s137(2)). A DHB that receives such a request must arrange for a needs assessment to be conducted as soon as practicable (s 137(4)).

- In a crisis, where a person's safety is at risk, the person should receive, or be assessed for, support services within 24 hours.
- If a person urgently requires assessment for support services but is not in a crisis situation, needs assessors or health professionals should contact the person within two working days.
- If a person is assessed as urgently requiring support services but is not in a crisis situation, the person should receive services within two weeks subject to availability of funding.
- If the need for support services is not urgent, people will receive services as soon as possible. Timing of services will depend on the older person's need relative to that of others, their ability to benefit and become more independent as a result of the services provided, and the availability of funding.

Additional quality requirements

Residential care

Residential care services for rest home care (for three or more people) or hospital-level care (for two or more people) must be provided in facilities certified under the Health and Disability Services (Safety) Act 2001.

Residential care providers must comply with quality requirements under:

- their Age-Related Residential Care Services Agreement
- Part 4 of the Social Security Act 1964
- relevant[22] standards approved under the Health and Disability Services (Safety) Act 2001, as set out in the Health and Disability Services Standards (NZS 8134:2008).

Home-based support services

DHBs should have appropriate processes in place to receive and respond to complaints from older people or their families regarding the supports they receive. Older people should also be made aware of how they can complain if they wish to. Home support providers must comply with:

- quality requirements in their home support service contracts
- Home and Community Support Sector Standard (NZS 8158:2012).

- is committed to any hospital or rest home under s 126, or
- was receiving continuing hospital care in a rest home or hospital before 1 July 1993.

[22] Not all standards or criteria within NZS 8134:2008 are relevant to all services.

4.6 Immunisation services

The National Immunisation Programme:

- aims to prevent disease through vaccination across the lifespan and to achieve coverage that prevents outbreaks and epidemics
- is accountable for achieving all agreed immunisation targets
- ensures immunisation providers deliver services that meet the needs of their population
- implements the National Immunisation Schedule
- improves information and data systems
- manages the National Immunisation Register (NIR)
- monitors DHB coverage and provides assistance to regions as required.

There is a mix of universal programmes (everyone of a particular age is eligible) and targeted programmes (only people with certain conditions are eligible).

The Pharmaceutical Schedule lists vaccines provided free to eligible populations. PHARMAC is responsible for leading vaccine changes listed on its Schedule, including determining the eligibility criteria. The National Immunisation Schedule defines how the vaccines are delivered.

Range of services

Vaccines funded by DHBs are listed on the Pharmaceutical Schedule-National Immunisation Schedule. As of 1 July 2017, the following immunisations funded by DHBs include, but are not limited to:

1. Pregnant women - Antenatal immunisation programme
    - Pertussis immunisation between 28 and 38 weeks' pregnancy
    - Influenza immunisation during the influenza season — usually late March to end of December.
2. Newborn and early childhood immunisation programme mainly delivered through general practice. Vaccines cover diphtheria, tetanus, pertussis (DTaP), polio, hepatitis B, Haemophilus influenzae type b (Hib), pneumococcal infection (PCV), rotavirus, varicella, and measles, mumps and rubella (MMR).
    - 6 weeks immunisations
    - 3 months immunisations
    - 5 months immunisations
    - 15 months immunisations
    - 4 years immunisations.
3. Outreach immunisation services
    - Children aged under 6 years who have missed vaccination events specified in the National Immunisation Schedule.
4. School-based immunisation programme
    - Year 7 school immunisation programme: Tdap
    - Year 8 school immunisation programme: human papillomavirus (HPV) vaccine for girls and boys.

Options for providing both HPV and Tdap vaccines in school year 7 are being considered for future years.

5. Adolescent/Young adult
    - From January 2017, HPV vaccine is funded for both boys and girls up to and including 26 years of age.
    - Measles vaccine for those who do not have recorded evidence of 2 doses given after 12 months of age.
6. Other adult programmes
    - Tetanus-diphtheria booster for adults at age 45 and 65 years
    - MMR for anyone born from 1 January 1969 with no documented history of 2 doses of measles-containing vaccine after age 12 months.
7. Influenza immunisation programme
    - Adults over 65 years
    - Children under the age of 5 years with significant respiratory illness
    - Children or adults with an eligible condition, including certain cardiovascular, respiratory, metabolic and other chronic diseases, down syndrome or a cochlear implant
8. Targeted immunisation programme
    - Pre-post splenectomy/functional asplenia programme
    - Additional vaccines are funded for some groups of children and adults at high risk of certain diseases due to other medical conditions or high risk of exposure, including vaccination against hepatitis A, hepatitis B, Hib, human papillomavirus, influenza, pertussis, meningococcal infection, pneumococcal infection, tuberculosis and varicella.
9. Outbreak control
    - Localised outbreaks
    - National outbreaks.

Services funded by the Ministry

- **Immunisation Co-ordination Service** (the Service) provides up-to-date, evidence-based information to assist vaccinators, non-vaccinators and the general public in their decision-making in regard to immunisation services and the immunisation of children, young people and adults. The Service establishes and maintains effective working relationships with all service providers who have an interest in immunisation activity, to reduce duplication, enhance effectiveness of services and achieve the maximum benefit within allocated resources. The Service promotes immunisation and is designed to support and work with existing networks to provide immunisation information, education, support and advice to vaccinators, non-vaccinators and the general public.
- **Immunisation Advisory Centre (IMAC)** supports delivery of immunisation programmes through providing the Ministry and local service providers with clinical and technical advice. IMAC provides training for health professionals, national immunisation co-ordination and advocacy to implement best practice and improve immunisation coverage**.**
- **National Immunisation Register** enables authorised health professionals to quickly and easily find out what vaccines a child has been given and to make sure immunisations are given at the appropriate time. Each DHB ensures that information from the National Immunisation Register forms part of its planning, targeting and monitoring of immunisation services, outreach immunisation services, primary health care and other complementary services.

Access

Publicly funded vaccines are available through general practices, school-based programmes, work environments from occupational health nurses, family planning clinics (for HPV immunisations), marae and outreach providers, as well as through hospital services where cold chain compliance allows.

Criteria for publicly funded treatment

All children (under 18 years) are eligible for publicly funded immunisations, regardless of their citizenship or immigration status. For people aged over 18 years the Health and Disability Services Eligibility Direction 2011 issued by the Minister of Health sets out the eligibility criteria for publicly funded health and disability services in New Zealand.

Exclusions

There is currently no funding provided for the administration of adult type tetanus-diphtheria vaccine (Td) boosters given at 45 and 65 years of age, although the vaccine is free.

Cost

Only vaccines given according to the Pharmaceutical Schedule- National Immunisation Schedule are available free of charge, unless there is a specific funded programme in response to a recognised need.

Time

Immunisation services are age specific and required at the age prescribed in the National Immunisation Schedule (refer to Immunisation Handbook 2014). On-time immunisation coverage is an important milestone and is required to prevent disease outbreaks.

Additional quality requirements

The DHB will maintain minimum immunisation coverage of 95 percent for two-year-olds (previously a health target), and reach and maintain minimum immunisation coverage of 95 percent for 8-month-olds (national health target).

By June 2017, a minimum of 95 percent of those aged 5 years will be fully immunised.

The DHB will maintain strategies to increase coverage rates for HPV vaccination. For 2017/18, the target is that 75 percent of girls aged 12 years will be fully immunised (all doses completed as per schedule). This will be measured at end June 2018 for the 2004 birth cohort of girls. At least 75 percent of adults aged 65 years and older are vaccinated annually against influenza, including 75 percent of Māori aged 65 years and older.

The School-based Immunisation Programme offers Tdap and HPV to all children in school Year 7 and the HPV vaccinations to girls in school Year 8. To ensure that the school-based programme is delivered in a consistent, safe and effective manner, the DHBs will plan and deliver their school-based programme as outlined in the Ministry's current school-based standards and in the Immunisation Handbook (Ministry of Health 2017).

Information for both these vaccinations is recorded on the National Immunisation Register (NIR). DHBs need to note that Patient Management Systems (PMS), such as School Based Vaccination System (SBVS), MedTech, etc, used by DHBs to record their school immunisation information need to comply with the same privacy and governance frameworks that apply to the National Immunisation Register. IT support for the PMS is the responsibility of the individual DHBs.

4.7 Support services for people with long term or chronic conditions

Long-term, or chronic conditions are defined by the World Health Organization as having one or more of the following characteristics: they are permanent, leave residual disability, are caused by non-reversible pathological alteration, require special training of the patient for rehabilitation, or may be expected to require a long period of supervision and care.[23]

This schedule covers services for people who are under the age of 65 years, have one or more chronic health conditions that is/are expected to continue for six months or more, and have an assessed need for long-term support services.

The service includes 'medically fragile children' (children with high health needs and/or multiple impairments whose health status has not yet stabilised and for whom a physical, sensory and/or intellectual disability with associated ongoing support needs has not been identified).

The aim of long-term support services is to support the development of an 'integrated continuum of care' for this client group. This requires that appropriate and effective clinical and support services are in place, which link with each other and are responsive to the needs of the clients, their families, whānau, aiga and carers.[24]

Note: Other support services for the following groups are covered in these schedules:

- older people (people aged 65 years and over and people aged between 50 and 64 years who are assessed as 'close in interest'[25] to older people) – refer Schedule 4.5 Health and support services for older people
- people with long-term support needs due to a mental illness or addiction – refer Schedule 4.9 Mental health and addiction services continuum; however, the non-mental health needs of these clients may be subject to this long-term support services schedule
- people requiring palliative care – refer Schedule 4.11 Palliative care
- people whose need for support is due to a physical, sensory or intellectual disability (or a combination of these) and who are generally aged under 65 years – refer Schedule 4.3 Disability support services.

Range of services

Long-term support services for people with chronic health conditions funded by DHBs will include, but are not limited to:

- assessment of individual needs through NASC organisations or care/service co-ordination centres
- service co-ordination to develop a customised package of services to meet individual assessed need that can be provided within available funding and incorporating prioritisation tools – this service includes strong linkages with education and employment services

[23] WHO. 2003. Adherence to Long Term Therapies Evidence for Action Eduardo Sabete.

[24] On 1 July 2011, the Government gave DHBs the responsibility for planning and funding long-term support services for people who have chronic health conditions and are under the age of 65 years. This allocation was accompanied by transfer of existing funding and contracts that had been managed by the Ministry since November 2006 as the Long-term Supports – Chronic Health Conditions (LTS-CHC, formerly known as the Interim Funding Pool) programme.

[25] People aged between 50 and 65 years who have been clinically assessed by a DHB and/or a needs assessor as having health and support needs because of long-term conditions more commonly experienced by older people.

- assistance with daily personal care activities (eg, dressing, bathing, eating and toileting)
- assistance with household activities (eg, meal preparation, laundry, cleaning)
- carer support services (eg, carer support subsidy, respite care)
- intermediate care (eg, slow-stream rehabilitation) provided as medium-term residential care or in the community
- short- and long-term residential care (community, rest home, hospital, dementia, specialised hospital)
- flexible support packages for families caring for medically fragile children that take account of the whole family's needs, including siblings
- advanced personal care for people who require invasive personal cares that cannot be provided through home-based support services.

Within the range of support services described in the nationwide Community Health, Transitional and Support Services Service Specifications, there are specific service specifications for people with chronic health conditions:

- home support services (personal care and household support) for people with chronic health conditions
- community residential services within aged care facilities for people with chronic health conditions
- community residential support services for people with chronic health conditions.

Medical equipment and supplies for long-term support are described in Schedule 4.14 Provision of equipment, modifications and other supplies and services.

Any person with a long-term condition can access disability information and advisory services.

Access

Access to long-term support services (excluding environmental support services, child development services, medically fragile children's service, and disability information and advisory services) is through a needs assessment facilitated by a DHB-funded needs assessment service. If needs change, a full reassessment will be undertaken. A person may be referred or self-refer to the needs assessment service.

Exclusions

DHBs do not fund long-term support services for people who meet the access criteria for: Ministry-funded DSS or environmental support services; or supports for which other agencies have responsibility such as ACC, Ministry of Education or Ministry of Social Development.

Cost

The following services are provided at no charge:

- needs assessment
- personal care services, which are delivered mostly in a person's home (eg, assistance with dressing, bathing, eating)
- household management services (eg, meal preparation) for Community Services Card holders only (note that children with long-term conditions may have their own personal Community Services Card, which gives them access to subsidised health services, but this will not give the family access to funded household management services)

- long-term support services for children under 16 years old, or until they qualify for a supported living payment.

Cost contributions

People receiving carer support services will not be income and asset tested for these services, but may have to contribute towards the cost of these services if the cost exceeds the carer support subsidy.

If people are in short- or long-term residential care for long-term conditions not associated with ageing, are beneficiaries under section 3(1) of the Social Security Act 1964 and are not subject to income under Part 4 of that Act, they may be required to contribute some of the cost of care. These people will pay an amount no greater than the equivalent single person's benefit less any personal allowance permitted by the Ministry of Social Development. They do not have to pay any of the personal allowance portion of the benefit toward the costs of care.

Funding by multiple funders for services may be put into place for service users, for example with DHB mental health and addiction services, Ministry of Health disability support services, and ACC.

Time

- In a **crisis**, where a person's safety is at risk, the person should receive, or be assessed for, long-term support services within 24 hours.
- If a person **urgently** requires assessment for long-term support services but is not in a crisis situation, a needs assessor or health professional should contact the person within two working days.
- If a person is assessed to **urgently** require long-term support services but is not in a crisis situation, the person should receive services within two weeks subject to availability of funding.
- If the need for long-term support services is **not urgent**, the person will receive services as soon as possible. Timing of services will depend on the person's need relative to that of others, their ability to benefit and become more independent as a result of the services provided and the availability of funding.

Additional quality requirements

In addition to the quality and other requirements within the service agreement and/or service specification, the following requirements apply.

- All NASC organisations are required to meet the standards and criteria to be identified in the Health and Disability Sector Standards.
- Home-based support providers must comply with the Health and Disability Sector Standards NZS8134:2008 mandated under the Health and Disability Services (Safety) Act 2001.

4.8 Maternity services

Maternity services are provided to women and their families throughout pregnancy, childbirth and for the first six weeks of a baby's life. These services are provided in the home and a range of maternity facilities by a range of health professionals, including midwives, GPs and obstetricians.

Maternity Service Specifications and the Primary Maternity Services Notice 2007, pursuant to section 88 of the New Zealand Public Health and Disability Act 2000, are the operational service delivery mechanism for service coverage.

Range of services

Maternity health services funded by the DHB and/or the Ministry will include, but are not limited to, the services below:

Services funded by the Ministry

The Ministry funds lead maternity care (including homebirth lead maternity care) and related primary maternity services as specified under the Primary Maternity Services Notice 2007, pursuant to section 88 of the NZPHD Act 2000.

Services funded by the DHBs

Maternity services are to be provided as specified in the following service specifications:

- DHB Funded Maternity Services (tier one)
- DHB Funded Primary Maternity Services (tier two)
- Secondary and Tertiary Maternity Services and Facilities (tier two)
- DHB Funded Primary Maternity Facility (tier two), including in urban areas or rural communities with a catchment of 200 pregnancies where the facility is 30 minutes from a secondary service, and with a catchment of 100 pregnancies where the facility is 60 minutes from a secondary service
- Pregnancy and Parenting Information and Education services. DHBs will provide pregnancy and parenting education services to a minimum of 30 per cent of pregnant women of each population group, defined as: Māori, Pacific Peoples, Asian and Other.

Maternity-related services covered in other schedules

- Medical equipment and supplies associated with maternity services are addressed under Schedule 4.14 Provision of equipment, modifications and other supplies and services.
- Pharmaceuticals associated with maternity services are addressed under Schedule 4.12 Pharmaceutical services.
- Ambulance services associated with maternity services are addressed under Schedule 4.4 Emergency ambulance services.
- Laboratory services and community referred professional services (eg, allied health) are addressed under Schedule 4.2 Diagnostic, therapeutic and support services – personal health.
- Neonatal services associated with maternity services are addressed under Schedule 4.16 Specialist medical and surgical services.

Access

All pregnant women and their babies must have access to maternity services. Women can choose to give birth at any primary maternity facility that has a contract with a DHB and where their chosen lead maternity carer (LMC) holds an access agreement.

The LMC selected by the woman retains primary responsibility for the woman's care, unless there is a transfer of clinical responsibility to a specialist as described in the *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* (Ministry of Health 2012a).[26]

DHBs will provide pregnancy and parenting education services to a minimum of 30 per cent of pregnant women of each population group, defined as: Māori, Pacific Peoples, Asian and Other.

Decision-making criteria for publicly funded treatment

The Referral Guidelines provide guidance to LMCs and other primary providers along with secondary services and specialists in regard to clinical need for secondary/specialist maternity services.

Exclusions

As per the service specifications and the Primary Maternity Services Notice 2007, pursuant to section 88 of the NZPHD Act 2000, no public funding is to be made available for non-clinically indicated elective caesarean sections.

Cost

All maternity inpatient and outpatient services received from GPs, midwives and hospitals are provided at no charge. DHBs will not charge for any maternity services provided in a public facility. DHBs will ensure that all women have access to specialist services at no charge including specialist obstetric, lactation, anaesthetic, paediatric and radiology services (including primary referred ultrasound services).

Ineligible spouses or partners of eligible people are to be provided the same access to subsidised maternity-related services as eligible women.

Public funding of preventive treatment and all care during pregnancy, birth and postnatally that is designed to limit risk of mother-to-child HIV transmission is required to be made available to HIV-infected women who are currently not eligible to receive publicly funded health care. This includes postnatal hospital visits for the child for the purpose of disease exclusion, that is, to provide medication to prevent transmission and determine the HIV status of the child.

In maternity cases the woman will not be charged a part-charge for emergency ambulance transport from home or a community primary maternity facility to a secondary or tertiary maternity service where the ambulance transfer is requested by a health professional.

Transport of women and/or babies from one DHB-run facility to another is provided at no charge to the women, where the transport is required on clinical grounds. This transport is funded by the DHB of domicile.

[26] www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines

Time

Maternity services, including emergency transportation services, are to be available when they are needed.

Additional quality requirements

In addition to the quality and other requirements within the service agreement and/or service specification, the following requirements apply.

The DHB will establish and maintain a Maternity Quality and Safety Programme to continually improve the maternity services funded for its population; and will seek the views of women about those services. Maternity facilities will promote and support breastfeeding by achieving and maintaining Baby Friendly Hospital accreditation.

4.9 Mental health and addiction services continuum

Epidemiological studies indicate that one in five New Zealanders at any one time experience a mental illness or addiction (Oakley Browne et al 2006). Mental health and addiction problems experienced range from mild to severe. The service delivery continuum ranges across the spectrum of health promotion and prevention, primary, secondary and tertiary services. It embodies the concept of early intervention intended to mitigate against the severe impacts of mental illness. This service coverage schedule covers all mental health and addiction services funded through Vote Health with the exception of services provided by the Health Promotion Agency, the Health and Disability Commission (Mental Health Commissioner) and the Health Research Council. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017* (*Rising to the Challenge*) sets the direction for the delivery of mental health and addiction services.

Broader government policies have placed improvements in the health status of Māori and approaches to whānau ora as an overall priority. *Te Puāwaiwhero –The Second Māori Mental Health and Addiction National Strategic Framework 2008-2015*[27] (Ministry of Health 2008) provides the framework for the delivery of mental health and addiction services for Māori. It is expected that all mental health and addiction services will be responsive to the needs of Māori that services will be designed to facilitate earlier access to mental health and addiction services by Māori, and that choice will be promoted by facilitating development of Kaupapa Māori services.

Responsive mental health services will recognise New Zealanders' growing ethnic diversity, and consider their cultural and ethnic needs as well as their clinical needs. (Concepts to be taken into account include spirituality, family and whānau, social inclusion, and different understandings of mental health, wellbeing and recovery.) Mental health services will not exclude eligible people on the basis of underlying disabilities or chronic health conditions where the one or more presenting issues relate to mental illness.

Specialist mental health and addiction services are funded for those people who are most severely affected by mental illness or addictions. In addition to the access expectations set out in *Rising to the Challenge*, it is expected that DHBs provide access to specialist services for a minimum of 3% of their population. A focus on early intervention strategies will mean specialist services may be delivered to people who are at risk of developing more severe mental illness or addiction.[28] A focus on early intervention strategies will mean specialist services may be delivered to people who are at risk of developing more severe mental illness or addiction.

To the extent that funding for specialist mental health and addiction services does not support coverage for all target populations, it is expected that DHBs will have criteria in place for prioritising the provision of services to people with the highest level of need. DHBs are expected to ensure the people of their district have access to regional and national mental health and addiction services.

[27] www.health.govt.nz/publication/te-puawaiwhero-second-maori-mental-health-and-addiction-national-strategic-framework-2008-2015

[28] Responsibility for planning and funding DSS for people with psychiatric disabilities devolved to DHBs in 2001 (CAB Min (01) 12/12). Residual Ministry-funded DSS for people with mental illnesses, personal health conditions and palliative care needs were devolved to DHBs on 1 October 2003 along with planning and funding of disability support services for people aged 65 years and older (CAB Min (03) 23/8).

Range of services

Services funded by the Ministry

- **Mental health promotion and prevention services**:
  - for the whole population: mental health and addictions public health education, prevention, promotion and de-stigmatisation
  - for eligible people: liaison and support for families, whānau, carers and the wider community.

Services for people with gambling problems

The following problem gambling services are funded by the Ministry of Health:

- screening and assessment
- brief interventions and other treatment including a range of psychosocial interventions
- services related to problem gambling for people with co-existing mental health or alcohol and other drug problems
- dedicated problem gambling services for priority populations involving consultation collaboration and liaison including with PHOs and other primary health care services.

Services funded by DHBs

DHBs fund **primary mental health and addiction services** that provide a general primary care response to the needs of people of any age with mild to moderate mental illness, as part of the primary health care strategy.

DHBs fund services for **people in crisis, or at risk of or having an acute episode** (especially when their own or someone else's safety is at risk) including:

- acute services provided within an inpatient setting, such as a specialist psychiatric hospital ward or mental health facility
- where clinically appropriate (and an efficient use of resources), 24-hour acute intensive home-based treatment and/or alternatives to hospitalisation
- assessment and referral from hospital-based accident and emergency departments (these services may be delivered by visiting community mental health teams or by inpatient liaison teams)
- community-based crisis respite, including a treatment component (services that provide people, including carers, with a break, so crisis can be eased)
- consultation, liaison and collaboration, including with PHOs and other primary health care services, secondary and tertiary services, for people with both addictions and mental health disorders.

DHBs fund services to **support people to recover and develop resilience** – to enable people with experience of mental illness and addiction to participate in the everyday life of their communities and whānau – including:

- assessment and brief interventions
- a comprehensive range of treatments including, but not limited to, a range of psychotherapeutic and psychosocial options
- liaison and support with education, employment and housing for service users, including service user led recovery services and peer support

- consultation, liaison and collaboration with PHOs, other primary health care services and other social service agencies
- liaison, education and support for carers, family, whānau and significant others
- mental health and addictions education, prevention and mental health promotion, and early intervention skills.

DHBs fund the following services for **people with alcohol and other drug problems**:

- assessment
- brief and early intervention
- withdrawal management
- treatment including a range of psychosocial interventions[29]
- day programmes and residential treatment
- alcohol and other drug services for people with co-existing mental health or pathological gambling problems
- opioid substitution treatment services
- rehabilitation
- peer support
- consultation, collaboration and liaison, including with PHOs, other primary health care services, secondary and tertiary services and other social service agencies.

DHBs fund services for people with mental health and/or addictions problems and/or damage from alcohol and other drug abuse and other causes needing **long term support**, including:

- services to assess a person's needs
- co-ordination services (service to ensure people get the services they need)
- Kaupapa Māori services
- social support services (eg, self-help groups)
- support for carers
- residential support (supports to live in the client's own home), including home support services
- residential care, including hospital rehabilitation
- rehabilitation
- information services
- treatment and ongoing illness management and clinical care
- planned respite
- consultation and liaison.

Note:

- Funding responsibility for long-term support services for people aged under 65 years with dementias and other disabling chronic health conditions, including damage from alcohol and other drug abuse and other causes, is inconsistent nationally and disputed in some regions. The Ministry is working with DHBs to clarify funding responsibility for these groups.

[29] Withdrawal management may be provided in a variety of environments according to assessed treatment needs.

- Mental health and addiction services will not exclude eligible people on the basis of underlying disabilities or chronic health conditions where the presenting issue is related to a mental health issue.
- The mental health and addiction treatment and support needs of this group will be funded by DHBs through mental health and addiction services.
- Mental health and addiction services will broker access to other services such as disability support services, health and support services for older people and long-term support services for people with chronic health conditions when clients receiving mental health and addiction services also present with needs that are not related to mental health and addiction and are likely to be eligible for services.[30]

Suicide Prevention

DHBs are expected to coordinate suicide prevention activities. This includes implementing a district suicide prevention plan, facilitating and enhancing cross-agency collaboration in respect of suicide prevention and, when necessary, implementing a suicide postvention plan and a coordinated response to suicide clusters/contagion.

DHB-funded services tailored to the needs of specific groups

In addition to the services described above, DHBs fund services tailored to the needs of specific groups, as follows.

Services for offenders in the criminal justice system and alleged offenders with mental illness and addictions

DHB-funded services include:

- assessment and treatment of people on remand or sentenced to prison
- inpatient treatment in secure settings
- a secure unit for people needing long-term care
- secure rehabilitation and residential facilities and services, including extended care
- monitoring and management of special patients and restricted patients as defined by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health (CAT) Act 1992)
- regionally based community forensic teams
- court liaison services and liaison with the Department of Corrections and Ministry of Justice
- consultation and liaison services to community services provided by the Department of Corrections and Ministry of Justice in each region
- community follow-up of people who may pose a risk to others by reason of mental disorder by either forensic or general mental health services
- services for people with mental illness or addictions who are unable to be managed by general mental health services because of a high and/or level of serious danger to others.

[30] The Ministry will work with DHBs to address policy and operational barriers to working collaboratively across funders and services in the context of the work outlined above and in relation to the Ministry's Mental Health of Older People/Dementia Project.

Services for children and young people

Services are available up to and including the age of 19 years, and adult services are available from 18 years; this overlap is managed according to the clinical and developmental needs of the consumer. Some flexibility will be allowed to manage the transition between child and youth services and adult services through to 25 years in order to best meet the needs of the young person.

Children and young people should have access to the same range of services as the adult population provided in a manner and setting that are safe and developmentally appropriate. Ideally, services for children and young people should be separate from services for adults unless a different arrangement is in the best interests of any particular child or youth. [31] If for any reason a child cannot be accommodated in an appropriate ward, the child must be cared for by paediatric-trained staff (medical and nursing), should be physically separated from adults in the ward and should be relocated to a suitable location as soon as possible.

In addition to generic mental health and addiction services, specialist services funded specifically for children and young people include:

- inpatient care
- provision of specialist advice to crisis services
- specialist consultation and liaison services to other professionals working with children and young people who require mental health services – including Ministry of Education, Ministry of Social Development (Child, Youth and Family), youth justice, other health services in the primary care, secondary and tertiary sectors, and other agencies
- participation in interagency processes such as Strengthening Families, Family Group Conferences, and high and complex needs case management
- education, prevention and early intervention activities for children and young people, and for families, whānau, carers and others affected
- liaison, support and respite care for families, whānau, carers and others affected
- Youth Court liaison services and liaison with the Department of Corrections, the Ministry of Justice and the Ministry of Social Development (Child, Youth and Family).

Services should promote effective engagement with both the young person and their family and whānau (when appropriate).

Primary Mental Health Services

Primary mental health and addiction services provide interventions for people presenting with mild to moderate mental health and addiction problems. In addition to the general primary care response to the needs of people of any age, access to primary mental health interventions is funded for the following specific population groups:

1. The enrolled adult population focused on Māori, Pacific and/or low income. The expected outcome is increased access to psychological and psychosocial interventions for these at-risk groups.
2. Youth primary mental health services, available to all youth in the 12 to 19 year age group (regardless of PHO enrolment) who require such a service. The expected outcomes are to enable early identification of developing mental health and/or addiction issues and better access to timely and appropriate treatment and follow up.

[31] Incidents of age-mixing in mental health inpatient facilities should be reported to the Director of Mental Health at the Ministry of Health. For guidance on interpreting 'best interest' and adhering to United Nations Convention on the Rights of the Child contact the Director of Mental Health at mentalhealth@moh.govt.nz.

Primary mental health interventions are based on a stepped care model with interventions matched to service user needs in terms of level of intensity.

Perinatal and maternal mental health

It is known that women with mental health problems – particularly women with a history of bipolar disorder, psychosis or postnatal/severe depression – are at risk of an escalation of symptoms during the pregnancy and postnatal period. Women who are identified as needing mental health services when pregnant or in the period after birth will be able to access appropriate services to meet their needs and keep themselves and their babies safe. It is expected that all women will have access to perinatal and maternal mental health services, DHBs can either directly provide specialist services, through trained staff in generic adult mental health services or provide access to specialist services.

Older people (65 plus years)

Older people should have access to the same range of mental health and addiction services as other eligible people provided in a manner and setting that are safe and age appropriate. Older people with a mental illness and/or an addiction are also eligible for the range of specific health services for older people. Current adult specialist service users over 65 years will remain with their current specialist service provider unless their needs change. They will not be excluded from specialist services due to age.

Services funded specifically for older adults include:

- specialist services for older adults with serious mental health disorders, including serious behavioural and psychological symptoms of dementia (BPSD)
- specialist consultation and liaison services from other professionals working with older people who require mental health services – including the older persons services, community-based support and advocacy services, PHOs, other primary health care services and other social agencies.

Access

Referrals to secondary mental health and alcohol and other drug services for assessment may be made from any source. This includes self-referrals, which is to ensure that referral pathways do not form a barrier to access. Access to mental health and addiction services is determined on the basis of highest level of need identified by a health professional as defined by the Health Practitioners Competency Assurance Act 2003 or an addiction worker who is a member of a recognised professional body. While access to peer support services and family support services may not necessarily be determined by a health or addiction professional, need should nonetheless be a guiding principle in the access decision.

Criteria for publicly funded treatment

On referral (including self-referral), the criteria for assessment are based on the person having a suspected, developing or identifiable mental illness, and/or an addiction problem.

Following assessment, access criteria for ongoing service delivery are based on:

- clinical judgement about diagnostic classification
- the severity of the mental illness or addiction
- the likely impact of the mental illness and/or addiction on the person's ability to participate in activities of daily living, work, education and community life

- meeting any legal requirements
- the safety of the individual or the safety of others.

Exclusions

DHBs will fund (and may provide) services to address the mental health and addiction treatment needs of people with the primary needs identified below. However, they will not fund services from Vote Health funding allocations for mental health and addiction treatment services where the service or support needs are solely oriented to:

- sexual abuse
- violence and anger
- intellectual disability (including post-head injury), with or without behavioural problems
- learning difficulties
- criminal activities (anti-social behaviours)
- parenting difficulties
- conduct disorder
- nicotine addiction
- relationship issues.

Note: Services may be funded for these people through other health funding streams or in some cases by other agencies.

Services for parenting difficulties and conduct disorder may be funded by Vote Health when delivered in collaboration with other funding agencies as an interagency funded venture. Where DHBs provide the following services, they will provide those services on a fee for service basis, reimbursing the mental health and addiction service funding allocation for the costs incurred for the:

- preparation by the mental health and addiction services of court reports ordered by Ministry of Justice, except for those under section 38(2)c of the Criminal Procedure (Mental Impaired Persons) Act 2003
- preparation of court-ordered reports or parole board reports
- assessments under section 65 of the Land Transport Act 1998
- assessments and reports under section 333 of the Children, Young Persons, and Their Families Act 1989.

The following services are not funded within Vote Health:

- mental health and addiction treatment services where they are the sole focus of the intervention
- counselling interventions that are unrelated to mental health and addictions
- psychological testing for educational requirements.

Cost

Services are provided free of charge for people who receive:

- mental health and/or addiction treatment services as an inpatient (including pharmaceuticals)
- mental health services (including pharmaceuticals) as a day patient or an outpatient, including as a patient of a community mental health team, and are receiving compulsory treatment under the Mental Health (CAT) Act 1992

- compulsory treatment under the Alcoholism and Drug Addiction Act 1966 (including pharmaceuticals).

With the exception of residential services (see below) and prescription charges for pharmaceuticals (notwithstanding the preceding statement), other mental health services funded by DHBs in the community are free.

Some residential services will require part payment by the resident. If people are in short- or long-term residential care not associated with ageing, are beneficiaries under section 3(1) of the Social Security Act 1964 and are not subject to income and asset testing under Part 4 of that Act, they will be required to contribute to the cost of care. These people will pay an amount no greater than the equivalent single person's benefit less any personal allowance permitted by the Ministry of Social Development. They do not have to pay any of the personal allowance portion of the benefit toward the costs of care.

Service providers (including mental health and addictions counsellors and private mental health and addictions residential services) who are not funded by the DHB may charge for their services.

Primary health care providers may require people to pay for mental health services on the same terms as other primary health care services, unless they are part of a specifically funded programme for primary mental health in which case there is no charge.

Problem gambling services funded by the Ministry of Health are provided free of charge.

Time

When assistance is required under the Mental Health (Compulsory Assessment and Treatment (CAT)) Act 1992, 90 percent of people presenting should be assessed within four hours. DHBs with isolated rural communities will ensure that effective arrangements are in place.

If a person is assessed as needing hospital care under the Mental Health (CAT) Act 1992, 90 percent should be admitted to a hospital within six hours of being assessed by a doctor or another health professional.

The DHB will ensure that crisis services to deal with critical or urgent mental health and/or addiction needs will be available to people (regardless of whether or not they come under the Mental Health (CAT) Act 1992) as follows:

- telephone or other remote assistance will be available at all times with minimal delay
- where telephone assistance is insufficient to meet the person's needs, direct contact with a clinician will be provided within four hours;[32] DHBs with isolated rural communities will ensure that effective arrangements are in place
- other services will be arranged when required, including acute inpatient admission and crisis respite.

People seen and assessed as needing services will receive those services as soon as possible. For some services (eg, opioid substitution programmes) there may be a wait before treatment can begin.

[32] Until a person is assessed, it will not be known whether they fall under the Mental Health (CAT) Act 1992.

4.10 Oral health services

Oral health services are provided to assist people in maintaining healthy teeth and oral tissues. Publicly funded oral health services are provided by DHB-approved, registered oral health professionals.

Range of services

The oral health services funded by DHBs will include, but are not limited to, the following.

1. **Preventive, educative and treatment oral health services for all preschool and primary school-aged children up to school year 8 (12-13 years of age).** These services are mainly delivered through the Community Oral Health Service and consist of:
   - education on appropriate oral health practices
   - preventive services
   - restorative services.

   The improved model of care for the Community Oral Health Service is oriented towards whānau/family participation, health education for self-care, prevention of ill-health, and early-intervention.

2. **Basic oral health services for adolescents up to their 18th birthday.** These services are mainly delivered by contracted dentists under the nationally standardised Combined Dental Agreement (CDA) and consist of:
   - examinations
   - radiographs
   - diagnosis and advice
   - extractions
   - restorations
   - prosthetics.

3. **Emergency dental services for some Community Services Card holders.**

   These services provide emergency dental treatment that is immediately necessary for the relief of pain or treatment of infection for low-income adults. The service can be provided from DHB dental facilities or by specifically contracted private community dentists.

4. **Hospital and community dental services.** Note that the Ministry and DHBs will continue to work to improve national equity of access in the context of an overall oral health work plan. DHBs will fund:
   - essential dental treatment for hospital inpatients
   - general and specialist dental services to all people requiring primary, secondary or tertiary services as a necessary part of other hospital treatment (eg, tooth extraction prior to radiation therapy)
   - general and specialist dental services that require inpatient, day patient or outpatient services not available from a dentist or other health professional in the community because of the person's special dental or medical condition, disability or need for special management facilities
   - outpatient general and specialist services that are not available from a dentist in private practice to all people requiring such services because of the person's special dental or health or disability problems, or the need for special management facilities for the person

- basic dental services for low-income people unable to access private care, where capacity and funding of the DHB's hospital dental service allow.

5. **Adolescent oral health co-ordination service.** This service facilitates access to and utilisation of DHB-funded dental services delivered mainly under the Combined Dental Agreement (CDA). It supports the provision of adolescent oral health services.

All services will promote dental public health, including water fluoridation.

Access

Early enrolment in the Community Oral Health Service is to be facilitated through neonatal enrolment with multiple universal core health services. Enrolment and service utilisation is also to be encouraged through the Well Child / Tamariki Ora programme. Primary health care providers, such as GPs, practice nurses and Well Child/Tamariki Ora providers, should provide information about enrolment and prevention in accordance with the national Well Child schedule.

Suitable arrangements must be available for providing dental care to children whose needs fall outside the scope of practice for dental therapy, but within the definition of basic dental services. These arrangements can include referral to hospital dental services or dentists contracted under the Combined Dental Agreement. Suitable arrangements must also be provided to ensure a seamless and effective transfer of care at the end of school year 8, from the Community Oral Health Service to adolescent dental services including dentists contracted under the CDA.

Adolescents may be referred to dentists holding an agreement with the DHB or may enrol directly with a participating dentist.

Emergency dental services for people on low incomes, particularly Community Services Card holders, are available only to people who are not receiving income support for dental services from Work and Income New Zealand.

Hospital dental services are accessed by referral from registered health professionals.

Criteria for publicly funded treatment

Dental therapists make assessments of need for children and adolescents within their scope of practice. Some therapists may also have the requisite training to allow them to undertake assessments for adults, within the terms of their scope of practice.

Dentists make assessments for all patients.

Cost

Services provided free of charge are:

- a designated range of preventive, educative and treatment oral health services for preschool, primary and intermediate school children. Funders should plan to ensure funding generally allows annual examinations, but allow for twice-yearly examination for children matching 'at risk' criteria
- basic dental care for all adolescents up to their 18th birthday
- orthodontic treatment for children and adolescents aged from 0 years up to their 18th birthday for the correction of severe congenital craniofacial abnormalities and malocclusions
- dental health services provided as part of inpatient and day patient services in hospitals.

The following services are provided with a charge.

- Community Services Card holders in some areas partly pay for dental services to relieve pain. In these areas, adult Community Services Card holders will be charged a maximum of $35.78 ($31.11 excluding GST) per visit.
- DHBs may charge co-payments for outpatient dental services (other than those described above). Charges for comparable services should not be greater than 70 percent of the applicable fee set out in the Combined Dental Agreement. Further information on charging is set out in the Hospital Dental Service Specification.

Note

- In any consecutive 12-month period, DHBs should ensure that any increases in the level of co-payments charged do not exceed the annual Forecast Funding Track (FFT) percentage adjustor currently applicable. The annual FFT percentage adjustor is advised annually to each DHB in its annual funding package. Service providers in each DHB may need to refer to the DHB's planning and funding function for details of the applicable FFT percentage adjustor.
- Any increase in user charges must be limited to the annual FFT percentage adjustor against the fees being charged by the service prior to this service specification becoming applicable.

Time

Urgent dental services (eg, pain relief, treatment of infections) will be available by the following working day or sooner if necessary.

The DHB contracts with providers of oral health services on the basis that oral health services recommended during a dental examination of a preschool, primary or intermediate school child will be provided within two months.

The frequency of dental examinations for preschool, primary and intermediate school children who are at risk will be determined according to individual need, but there should be no longer than 18 months between examinations.

Adolescents should receive at least an annual examination. Those requiring further treatment should receive services within two months of their assessment for treatment.

Elective hospital dental services should be provided according to the timeframes specified in the Elective Services National Access Criteria

Additional quality requirements

In addition to the quality and other requirements within the service agreement and/or service specification, the following requirements apply:

Qualified supervision and provision of oral health services

Providers are required to comply with current professional standards and codes of practice (refer Dental Council of New Zealand) and in accordance with the Code of Ethics (where relevant). Services will comply with specific dental infection control procedures.

Where emergency dental services are provided to Community Services Card holders (refer above), the services will be of a similar standard to the standard of services normally provided in a dental practice.

4.11 Palliative care

Palliative care is provided for people who are dying from active, progressive diseases or other conditions when curative or disease-modifying treatment has come to an end. Palliative care aims to:

- optimise a person's quality of life until death by addressing their physical, psychosocial, spiritual and cultural needs
- support a person's family, whānau and other caregivers where needed, through the illness and after death.

DHBs must ensure that all people can access palliative care services according to their need.

The *Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand* (Ministry of Health 2013) (the Framework) provides guidance to support more consistent access to and purchasing of palliative care services. The Framework is based on the concept that, for many people, the need for palliative care can be met by their existing primary are provider (eg, their general practitioner). The need for specialist palliative care services may be episodic or shared rather than required on an intensive basis. The Framework also promotes a collaborative and integrated approach to service delivery.

Guidance for Integrated Paediatric Palliative Care Services in New Zealand (Ministry of Health 2012) provides guidance for the delivery of palliative care service to children and young people.

Adult palliative care services in the last days of life will be provided in a collaborative way to improve access to the services regardless of setting, diagnosis or location. Palliative care services will be aligned with the national and regional guidelines, including: Te Ara Whakapiri - Principles and Guidance for the Last Days of Life[33]. Ministry of Health 2015. This publication provides a statement of guiding principles and components for the care of adults in their last days of life across all service settings, including the home, residential care facilities, hospitals and hospices.

Range of services

Palliative care services funded by DHBs include but are not limited to: assessment, care co-ordination, clinical care, and some support services.

Services are also available for family and whānau members of people receiving specialist palliative care, where palliative care services assess them as requiring grief and loss support services.

Palliative care services may provide additional services (eg, non-clinical patient and family support services such as biography writing and day activities). These additional services are usually provided by volunteers and/or funded through community fundraising.

Access

Access to palliative care services funded by DHBs is determined by health professionals who are responsible for making clinical decisions about when palliative care should be provided, on the basis of the level of need.

[33] www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life

Criteria for publicly funded treatment

Palliative care services are available for people, including children and adolescents, who:

- have an active, progressive and advanced disease
- are reasonably expected to die within 12 months, but in exceptional circumstances this timeframe may be longer
- have episodic specialist palliative care needs.

Exclusions

No public funding is available to the services usually provided via hospice volunteers.

Cost

Palliative care provided by hospital services, domiciliary nursing and allied health services will be provided free of charge.

Publicly funded palliative care services provided by hospices will also be provided free of charge. Additional palliative care services provided by hospices are generally provided free of charge. There may be user charges for palliative care clients accessing primary health care services and pharmaceuticals, etc. (refer service coverage requirements in Schedules 4.12 Pharmaceutical services and 4.13 Primary health care services).

Time

Palliative care telephone services will be available 24/7 and home visits may be available outside standard working hours.

4.12 Pharmaceutical services

Range of services

All DHBs must comply with the requirements of the Pharmaceutical Schedule. Pharmaceutical services funded by DHBs include all components of services listed in service specifications. These include, but are not limited to:

- provision and dispensing of medicines
- provision of therapeutic medical devices and supplies
- In accordance with the 1998 Health (Needles and Syringes) Regulations, in particular Section 9(1), the Ministry of Health expects that all DHBs fund a sharps disposal services for people using needles and syringes in the community, at no cost to the patient. Pharmacies and medical practitioners are responsible for the collection of sharps they dispense, and DHBs are responsible for their disposal.

Access

Practitioners who are able to prescribe pharmaceuticals are specified in Medicines Regulations. Pharmacists may dispense pharmaceuticals only upon presentation of a prescription from one of these practitioners, written in the appropriate format, as set out in the Medicines Act 1981, Misuse of Drugs Act 1975 and accompanying regulations.

Decision-making criteria for publicly funded treatment

- Prescriptions must be written and dispensed in accordance with current legislation and meet the requirements for subsidy and payment.
- The appropriateness of the prescribed pharmaceutical should be verified.
- The acquired medication history should be checked for consistency of treatment, interactions and evidence of non-compliance or misuse.

Exclusions

No public funding is made available for non-subsidised pharmaceuticals, except in some circumstances (refer ‘Cost’ below).

Time

DHBs will contract for pharmaceutical dispensing services to be available for prescriptions presented to a pharmacy during normal business hours, as follows:

- 90 percent of the prescribed items will be dispensed within one hour of presentation
- 99 percent of the prescribed items will be dispensed before the end of the next business day after presentation[34]
- 100 percent of the prescribed items will be dispensed within two business days after presentation.

These dispensing waiting times will not apply if the pharmaceutical is not available in New Zealand at the time the prescription is presented.

DHBs will use best endeavours to ensure a level of access to after-hours pharmacy services that meets the reasonable needs of their populations.

[34] The requirements of 90 and 99 percent are national targets, and practice may vary across regions.

Cost

The following groups may be charged a co-payment of $5 or less for pharmaceutical services.

- Where the service user holds a valid Community Services Card or a valid High User Health Card, they will pay a maximum co-payment of $5 per prescription item.
- Where the service user or their family holds a valid Pharmaceutical (Prescription) Subsidy Card, then the co-payment will be $0.
- Where the service user is under 13 years of age, the co-payment will be $0.
- Where the service user has been prescribed contraceptives (drugs and devices that help prevent pregnancy), they will pay a maximum co-payment of $5 per item of contraceptive prescribed. This includes condoms if prescribed by a general practitioner.
- The service user will pay a maximum co-payment of $5 per prescription item where they are eligible for publicly funded services (regardless of whether they are enrolled in a PHO or not) and the provider/prescriber: is employed by a DHB; or has an access or service agreement with the Ministry or a DHB or a PHO; or is an after-hours provider that has an access or service agreement with a DHB or a PHO; or is a provider providing a fully publicly funded service under a section 88 (NZPHD Act 2000) notice alone.

Eligible providers

Prescriptions from the following additional providers are eligible for $5 co-payments on subsidised medicines if they meet the specified criteria:

- public hospital
- a midwife
- family planning clinic
- general practitioners (as long as they are part of a PHO)
- after-hours accident and medical services (as long as they have a DHB or a PHO contract)
- youth health clinics (as long as they have a DHB or a PHO contract)
- dentists (only if the prescription relates to a service being provided under a DHB contract)
- private specialists (only if the prescription relates to a service being provided under a DHB contract)
- other health professionals (as long as they have a DHB or a PHO contract)
- Health practitioners who write a prescription during normal business hours to a person who is not enrolled in the general practice, provided the person is eligible for publicly funded services and the general practice is part of a PHO
- hospices (as long as they have a DHB contract)
- providers making an ACC-related claim.

Additional prescription rules

Prescriptions for subsidised medicines are free for eligible people if:

- their prescription is written by an eligible provider/prescriber and they have a Pharmaceutical (Prescription) Subsidy Card
- they are under 13 years old, regardless of their provider’s eligibility.

Prescriptions may incur a greater co-payment in the following circumstances:

- Where a service user is aged between 13 and 17 years and does not fall into one of the other co-payment categories, then they will pay a maximum co-payment of $10 per prescription item.

- Where a service user is aged 18 years or over and does not fall into one of the other co-payment categories, then they will pay a maximum co-payment of $15 per prescription item.
- Where a service user receives a prescription from a private specialist who is not contracted with a DHB for publicly funded services, a higher co-payment (up to $15) may apply.

Product premiums

PHARMAC is responsible for setting subsidies for pharmaceuticals. If the price of the pharmaceutical charged by the supplier is more than the subsidy set by PHARMAC, the service user will pay this difference plus a mark-up charged by the pharmacy in addition to the co-payments listed above.

Other charges

- In addition to co-payments and product premiums, service users may be charged extra:
  - for other services provided to them in addition to the services funded under the Community Pharmacy Services Agreement; this includes fulfilling a request by a service user or prescriber that is in excess of the requirements of the Pharmaceutical Schedule or the Pharmacy Services Agreement
  - for pharmaceuticals provided in excess of the maximum quantity specified for the relevant pharmaceutical in the Pharmaceutical Schedule
  - for delivery of the pharmaceutical (eg, if it is delivered to a service user's home or business)
  - for the cost of unusual packaging
  - if the pharmaceutical is collected by the service user outside ordinary business hours of the pharmacy[35]
  - where the information contained in a prescription form does not include all the information it should include and where the pharmacist has to obtain this missing information from a person or organisation other than the service user so that the pharmacist can forward the script to the DHB's payment agent to obtain payment for their services.
- For the avoidance of doubt, a service user may not be charged for:
  - compliance packaging if the pharmacy is providing age-related residential care pharmacy services to the service user
  - any additional amount by way of a pharmacy charge unless a relevant circumstance listed above has arisen
  - any charge that has the effect of spreading the cost of circumstances listed above across service users more generally
  - any other pharmacy charge not expressly permitted by the Pharmacy Services Agreement.
- Where a pharmacy charge is applicable, it must be fair and reasonable, and the provider must inform the service user of the amount of and reason for the pharmacy charge, which may include providing reasonable supporting evidence if requested. The provider must also explain how this charge may be avoided or reduced.

Hospital pharmaceutical charges

- Service users will not have to pay for any pharmaceuticals needed by and dispensed to them while they are receiving treatment in a public hospital.

[35] Ordinary business hours are defined in the Pharmacy Agreement 2012 on the Nationwide Service Framework Library website (www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/165).

- Where a service user is prescribed a pharmaceutical by a staff member of a public hospital (or one of its contractors, eg, a private specialist) to be dispensed at a community pharmacy for use in the community (eg, discharge prescriptions for outpatients), then the patient charges listed above will apply.

Quality and audit

- DHBs will appoint suitably qualified auditors to undertake pharmacy quality audits against the Pharmacy Services Standards, and claiming audits against the Community Pharmacy Services Agreement.
- Audit of the Community Pharmacy Services Agreement will ensure monitoring of the provision of services by identifying good performance as well as areas of improvement, and the supply and management of pharmaceuticals
- Organisational quality standards are set out in the Health and Disability Services Pharmacy Services Standard NZS 8134.7:2010, Community Pharmacy Services Agreement, quality specifications and specific quality requirements set out in each service specification.

4.13 Primary health care services

Primary health care services are typically people's first and most frequent point of contact with the health system. These services aim to improve, maintain and restore people's health. They are offered in a local community setting and are usually provided by a primary health care team including general practitioners, registered nurses (including nurse practitioners, diabetes nurse specialists and nurse prescribers), pharmacists and other appropriately qualified health care professionals. Many primary health care services are contracted through or provided by PHOs.

Nationally consistent services are provided to the eligible and enrolled population of the PHO in accordance with the current DHB–PHO Services Agreement.

PHOs are expected to provide access to essential primary health care services at low or reduced cost to their enrolled populations in accordance with the Fees Framework – level policy and charges to services users included in the current PHO–DHB Services Agreement.

Refer also Schedule 4.15 Public health services and prevention services.

Range of services

Primary health care services funded by DHBs or the Ministry will include, but are not limited to:

- essential primary health care services specified in the current PHO–DHB Services Agreement
- Well Child / Tamariki Ora services to help children stay well (eg, hearing and vision tests, Well Child assessments)
- health assessment and treatment services (including oral health, sexual health and primary mental health) to support at-risk children and adolescents and their families (eg, children and young people in the care of the State (Child, Youth and Family, including those in Child, Youth and Family youth justice and care and protection facilities) and the Family/Whānau Support Service)
- school-based health services in decile 1, 2 and 3 secondary schools (including secondary school-aged students that attend other schools, such as composite schools), teen parent units and alternative education facilities. DHBs will implement school-based health services in new decile 1–3 secondary schools, teen parent units and alternative education facilities, or in secondary schools that become eligible by being reclassified from a higher decile into decile 1, 2 or 3. The services are to be provided in accordance with the tier three service specification 'Additional school-based health services', and with quality standards supplied by the Ministry which may be updated from time to time. Each DHB is responsible for identifying all eligible schools in its district, and for ensuring that the roll-out of school-based health services to all decile 3 secondary schools is completed by the end of 2015. Coverage requirements for these services are:
  - all decile 1–3 secondary schools, teen parent units and alternative education facilities with school-based health services
  - all Year 9 students receiving home, education/employment, eating, activities, drugs, sexuality, suicide and depression and safety (HEEADSSS) assessments from nurses in decile 1–3 schools, teen parent units and alternative education facilities
- support for local interagency co-ordination initiatives, such as Strengthening Families
- sexual and reproductive health services including family planning services, provision of counselling and birth control information and assessment, diagnosis treatment and contact tracing of sexually transmitted infections
- primary mental health promotion, education, diagnosis and treatment.

- Diabetes services focus on improving equity, with particular emphasis on preventing high-risk people from developing diabetes and on preventing diabetes-related complications.
- Multi-disciplinary diabetes services may be provided in primary or community settings.

Pharmaceuticals and devices associated with primary health care services are addressed in Schedule 4.12 Pharmaceutical services.

Diagnostic services associated with primary health care services are addressed in Schedule 4.2 Diagnostic, therapeutic and support services – personal health.

Access

Service users can access primary health care services directly – that is, they do not require a referral. PHOs are funded to provide 'services to improve access' through the Flexible Funding Pool, which may include outreach services, mobile clinics and follow-up services.

Some services are usually initiated by the health practitioner (eg, Well Child / Tamariki Ora examinations, sexual contact tracing).

Each PHO must ensure that casual users (not enrolled) have access to the same standard of care as the PHO's enrolled population. General medical services may be provided in accordance with the current DHB–PHO Services Agreement.

Criteria for publicly funded treatment

Access to first-level and urgent care services is to be provided in accordance with the current DHB–PHO Services Agreement and Minister's Eligibility Direction.

In most cases the health practitioner determines which services will be provided, and how urgently those services are required, according to their clinical judgement. Routine Well Child / Tamariki Ora services are to be provided according to the national Well Child schedule and service specification and Public Health Service Specifications.[36] Screening services are to be provided according to specific contracts (eg, DHB newborn hearing screening services), agreed national policies and guidelines (eg, cervical screening), or best evidence-based practice (eg, screening at-risk groups for diabetes and problem drinking).

Exclusions

No public health funding is available for:

- issuing of certificates (except for purposes of obtaining a government benefit)
- immunisations not on the New Zealand Immunisation Schedule.

Cost

General medical services provided through non-PHOs and casual visits

For general medical services provided outside DHB-PHO Services Agreements and for casual users under the Agreement, the government subsidises the cost of access for certain people. General practices are required to reduce any fee they would otherwise charge the patient by at least the amount of the subsidy.

[36] Previously known as the *Public Health Handbook*; refer to www.nsfl.health.govt.nz

Smear taking

Smear taking is available at no charge from a number of providers. Details of the locations of these providers must be available from the local DHB. Women may be charged a fee by their GP or other smear taker to take a cervical smear. As with other publicly funded health services, the testing, reporting and any necessary follow-up provided within secondary facilities, as a result of the smear, are free.

Well Child / Tamariki Ora services

Routine Well Child / Tamariki Ora care services, hearing and vision screening, and some support services for children who are at risk are provided at no charge.

Immunisations

All immunisation services listed in the Immunisation Schedule (contained in the *Immunisation Handbook*, Ministry of Health 2014) are provided at no charge.[37]

Sexual health services

People will have access, at no charge, to at least one provider of sexually transmitted infection services; these service locations must be available from the local DHB.

Primary mental health promotion, education, diagnosis and treatment

Refer to Schedule 4.9 Mental health and addiction services continuum.

Other primary health care services

The following primary health care services will be provided free of charge to the consumer:

- services to support at-risk children and adolescents and their families (eg, the Family/ Whānau Support Service)
- support for local interagency co-ordination initiatives (eg, Strengthening Families).

Services for under 13 years of age as per the DHB-PHO Services Agreement:

Zero-fee general practice visits and prescriptions during regular hours should be available to children up to 13 years of age. Access to free after-hours services for this age group (for general practice and pharmacy) will also be purchased by DHBs for care that could not be deferred until regular business hours. Access to free after-hours services is required for 95 percent of the population enrolled with a general practice within 60 minutes travel time. DHBs will ensure information in relation to practices providing free daytime access and free urgent after-hours arrangements is publicly available on their websites.

Additional quality requirements

The DHB will ensure 90 percent of the eligible population have had their cardiovascular risk assessed in the last five years (previously a health target).

Time

Refer to the current DHB–PHO Services Agreement.

[37] Link to Immunisation handbook 2017 http://www.health.govt.nz/publication/immunisation-handbook-2017

4.14 Provision of equipment, modifications and other supplies and services

This schedule relates to both people accessing Ministry-funded disability support services[38] and those accessing DHB-funded health and support services for older people, people with a personal health need and people with chronic health conditions. Some of these services overlap those detailed in Schedule 4.3 Disability support services, Schedule 4.5 Health and support services for older people and Schedule 4.16 Specialist medical and surgical services.

Range of services

The Ministry and DHBs fund equipment, modifications[39] and other supplies and services for disabled people to:

- promote their independence
- maintain and improve levels of mobility
- enable them to remain in or return to their home
- support and maintain access to education, vocational training and employment.

On 1 October 2003, DHBs were devolved responsibility for some long-term equipment and supplies in addition to their existing responsibilities, specifically orthotics and prosthetics services. The Ministry has retained responsibility for funding other equipment and modifications for people of all ages with a physical, sensory, intellectual or age-related disability or a combination of these, whose needs last longer than six months and people aged under 65 years with disabling chronic health conditions who have high needs.[40]

DHB funded

DHBs will fund equipment and supplies for all age groups, regardless of whether it is for a short- or long-term need. These equipment and supplies include, but are not limited to:

- orthotics services
- prosthetics services (note that in 2003 funding for prosthetic limb services was devolved from the DSS Group to Capital & Coast DHB as the lead DHB (CAB Min (03) 23/8). Capital & Coast DHB contracts with the Artificial Limb Board for the provision of this service.)
- contact lenses (Central Region)
- incontinence supplies (except where the supply of products is included in the bed day funding for the facility)
- equipment to help people manage medical conditions. (conditions include asthma, diabetes and sleep apnoea), including peak-flow meters, nebulisers and medicine dispensers for asthma, and monitoring equipment, oxygen equipment, syringes and needles for diabetes

[38] Within the Ministry's agreed definition of disability (refer the first footnote in Schedule 4.3 Disability support services), the Ministry of Health's DSS Group is responsible for planning and funding disability support services for people who have physical, sensory or intellectual disabilities, or a combination of these, and are generally aged under 65 years.

[39] Environmental support services include the provision of equipment and modifications (housing and vehicles), services and supports for people with vision and/or hearing impairments, specified specialist assessment and training services and specified subsidies and supports.

[40] The Ministry's DSS equipment and modification services support a person who has a physical, intellectual, sensory or age-related disability, or a combination of these, where the disability is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is needed.

- equipment that allows some illnesses to be managed at home instead of in hospital, where appropriate. Examples include drug delivery devices and supplies for people with cancer, renal dialysis equipment and supplies, equipment and supplies that people may need after discharge from publicly funded hospital care such as dressings, drips, ostomy and urological supplies, along with the appropriate equipment, including wheelchairs, temporary ramps, walking sticks and crutches, and hospital beds and hoists used in providing follow-up care to publicly funded secondary and tertiary medical services.[41]

Services funded by the Ministry

The Ministry funds, or contributes to the cost of, equipment and modifications where a person meets specified criteria, the Ministry's Equipment and Modification Services Prioritisation Tool has determined that funding is available, and it has been identified that the equipment or modifications are essential for the person (or with assistance from support people) to do one or more of the following:

- get around more safely in their home
- remain in or return to their home
- communicate effectively
- study full time (tertiary level) or take part in vocational training
- work full time
- work as a volunteer
- be the main carer of a dependent person.

When a person meets the Ministry's definition of disability, their disability is likely to last longer than six months and they meet agreed criteria for services, and the outcome of the Ministry's Equipment and Modification Services Prioritisation Tool is that funding is available, the Ministry will fund, or contribute to the funding of, equipment and modification services including, but not limited to:

- communication devices – equipment and resources to support a person to communicate effectively and safely, and training in the use and application of this equipment
- seating and positioning – equipment to minimise the person's physical discomfort and deterioration and to support them to carry out daily activities as independently and safely as possible
- housing modifications – including rails, level access showers, and access modifications such as ramps
- mobility – equipment such as standing frames, walking aids and wheelchairs, as well as, in some cases, adaptations to vehicles and assistance with vehicle purchase
- vision – equipment that enables a person with a vision disability to interpret visual information
- equipment for daily living – including shower stools, commodes, specialised beds and hoists
- hearing – hearing aids and hearing assistive technology to support a person to live safely in their home (eg, visual/vibrating smoke detectors).

[41] DHB provision of equipment is referred to in the Community Health, Transitional and Support Services – Allied Health Services (Non Inpatient) Service Specification, which states DHBs should provide equipment for short-term loan for people who do not need it in the long term – ie, up to three months – but should provide it for longer if necessary. Once it is clear that the person's need is not long term (ie, they do not have a disability that lasts longer than six months), short-term equipment should remain on issue to the person until they no longer require it. This could be an interim solution while the person is awaiting long-term loan equipment funded by the Ministry of Health.

Other equipment and services

Note: Refer 'Cost' below for eligibility by age and other factors.

The Ministry will contribute to the funding of:

- wigs and breast prostheses
- replacement artificial eyes
- hearing aids
- children's spectacles
- contact lenses (Northern, Midland and Southern regions)
- cochlear implant services (assessment, surgery, device, habilitation/rehabilitation, repairs for children's devices, replacement processors).

Access

DHB funded equipment and supplies

Based on assessment of need, decisions about a person's access to particular equipment or supplies are made by:

- the person's general practitioner, for items that are provided on prescription
- other health professionals, such as midwives, in some circumstances
- the specialist hospital service that is providing the person's course of treatment or an ongoing service
- appropriately skilled assessors for the provision of equipment, modifications and other supplies and services (eg, an occupational therapist or physiotherapist), to whom the person could self-refer or be referred to, and who will assess the need for access to equipment and supplies

Access by Eligible People to dialysis while on holiday

Dialysis for eligible people while on holiday in New Zealand is available free of charge in DHB-funded dialysis units. However each DHB can determine whether it is able to provide this service (if appropriate arrangements have been made in advance of the eligible person's visit and the DHB has the capacity to provide the service).[42]

Eligible people includes those people who are covered by New Zealand's reciprocal health agreements with Australia and the United Kingdom because access to dialysis for people with end stage renal disease who make a temporary visit to New Zealand is deemed to be a necessary medical treatment under these agreements.[43]

Ministry-funded equipment and modifications

Based on assessment of need, decisions about a person's access to particular equipment and modifications[44] are made by an appropriately skilled assessor (eg, an occupational therapist, physiotherapist, audiologist or speech-language therapist), who will assess the person's needs related to their disability. The Ministry's contracted providers of equipment modification services

[42] http://www.health.govt.nz/new-zealand-health-system/claims-provider-payments-and-entitlements/accessing-dialysis-while-holiday

[43] http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services/eligibility-limited-range-publicly-funded-health-services-0/australian-resident-temporary-visit-new-zealand

[44] Funding availability is subject to the outcome of the Ministry's Equipment and Modification Services Prioritisation Tool

will arrange access to equipment through an appropriate supplier, or housing modifications through appropriate contractor. The person may access an appropriately skilled assessor through:

- a referral arranged by the person's needs assessor or service coordinator
- self-referral
- referral by a DHB health professional, GP or family member.

Ministry-funded hearing aids

- Based on specific eligibility criteria, a person with hearing loss can receive funding for hearing aids. Two funding schemes are provided.
- Hearing Aid Funding Scheme[45] – eligible children and adults can be provided with a hearing aid that is suitable to meet their hearing needs.
- Hearing Aid Subsidy Scheme[46] – adults who are not eligible for the Hearing Aid Funding Scheme can receive a subsidy towards the cost of hearing aid(s).

Other equipment, supplies and services funded by the Ministry

Based on assessment of need, referrals or recommendations for a person to access particular equipment and other supplies and services are made by:

- GP or medical specialist for wigs and breast prostheses benefit
- registered medical specialists for artificial eyes
- audiologists for hearing aid(s) funding
- optometrist or ophthalmologist for children's spectacle subsidy
- optometrist or ophthalmologist for contact lens benefit (Northland, Midland and Southern regions)
- the Cochlear Implant Programme Assessment Team for cochlear implant services.

Note:

- Audiologists must be **full members** of the New Zealand Audiological Society to access hearing aid funding through the Ministry of Heath on behalf of their clients.
- Audiometrists, audiology technicians and other personnel working in an audiology clinic are **unable** to access hearing aid funding from the Ministry of Health on behalf of their clients.

Criteria for publicly funded treatment

For items available on a general practitioner's prescription

The doctor may prescribe items listed in the Pharmaceutical Schedule that are appropriate for the treatment of the diagnosed condition, such as diabetes or asthma. The doctor decides, on the basis of their diagnosis, what medicines and equipment are appropriate for the treatment of the condition.

For items relating to non-urgent medical and surgical services

Access is based on the decision of the specialist hospital service about the person's suitability for treatment and ability to benefit. Refer Schedule 4.16 Specialist medical and surgical services.

[45] www.health.govt.nz/publication/guide-getting-hearing-aids-hearing-aid-funding-scheme

[46] www.health.govt.nz/publication/guide-getting-hearing-aids-hearing-aid-subsidy-scheme

For equipment and supplies funded by Ministry and/or DHBs

Access to equipment, modifications and other supplies and services for people with disabilities is through assessment from an appropriately skilled, approved or credentialed assessor. Access to the service is based on eligibility criteria and prioritisation of need.

Exclusions

No services are specifically excluded from DHB funding. Rather, decisions about offering particular services or treatment on a publicly funded basis are made according to an assessment of each individual's specific clinical and social circumstances.

Funding from Vote: Health is not available for people who are eligible for direct funding from Veteran's Affairs New Zealand.

Cost

Limits on charges

People may not be required to pay a deposit for short-term items such as crutches, or to pay for the long-term use of some of the items listed under 'Range of services' above, if any of the following conditions applies:

- paying will cause financial hardship
- the person receives residential care
- the items are disposable and will not generally be used again
- the person receives temporary additional support under section 61G of the Social Security Act 1964, or special benefit grandparented under section 23 of the Social Security (Working for Families) Amendment Act 2004
- the full cost of the service is covered by ACC.

People may be required to make a co-payment for items provided through pharmacies as per Schedule 4.12 Pharmaceutical services.

Deposits for short-term use of some items

People may have to pay a deposit for the short-term use of some items, such as crutches, used in providing follow-up care to specialist medical and surgical services. The charge will be a **maximum** of $37.82 ($32.89 excluding GST) per item. Any deposit will be refunded in full when the item is returned in acceptable condition.

Consumables

If a patient chooses to supplement the volumes of DHB-funded consumables that have been prescribed, it is up to the patient to purchase the additional consumables that they wish to have. There is no provision for DHBs to provide part funding for a patient's preferred consumable brand.

Ministry-funded specific benefit/subsidy regimes

The Ministry will subsidise the cost of the following items.

Wigs, hair pieces and head gear (eg, turbans) benefit

- For permanent alopecia, the Ministry will pay adults (18 years and over) up to $2,330.66 ($2,026.66 excluding GST) over a nine-year period.
- For permanent alopecia, the Ministry will pay children and young people (under 17 years of age.) up to $1,226.66 ($1,066.65 excluding GST) over a three-year period.

- For temporary hair loss, the Ministry will pay up to $408.88 ($355.55 excluding GST) over a one-year period.

Breast prostheses benefit

- Unilateral – the Ministry will pay up to $613.33 ($533.33 excluding GST) over a four-year period.
- Bilateral – the Ministry will pay up to $1,226.66 ($1,066.66 excluding GST) over a four-year period.

Artificial eyes

- The Ministry will pay the full cost of a replacement eye for a child under six up to once every two years. This funding cannot be accrued from one year to the next.
- The Ministry will pay full cost of a replacement eye for children and young people aged 6 to 17 years inclusive, up to once every three years. This funding cannot be accrued from one year to the next.
- The Ministry will subsidise the cost of artificial eyes up to the cost of $150.00 ($133.33 excluding GST) per eye for those 18 years of age and over. This payment may be accumulated if not used every year. The person may have to pay the difference if the items cost more than the amount paid by the Ministry.
- Provision of the first artificial eye is the responsibility of the DHB at which the procedure was performed and cannot be claimed for under the subsidy for artificial eyes.

Hearing Aid Subsidy Scheme

The Ministry will pay a subsidy of $511.11 ($444.44 excluding GST) towards the cost of a new hearing aid no more than once every six years for people other than those eligible for the Hearing Aid Funding Scheme as noted below. For people who require bilateral hearing aids, the amount is a maximum of $1,022.22 ($888.88 excluding GST) no more than once every six years. The subsidy can be used for replacement hearing aids after the six-year period if the person's needs have changed and their current hearing aids no longer meet their needs.

Hearing Aid Funding Scheme

1. **Hearing aids for children**: The Ministry provides funding for hearing aids and frequency modulation (FM) systems for pre-schoolers, and hearing aids for children and young people aged 20 years and under who are studying at school or tertiary level.

2. **Hearing aids for adults**: The Ministry will fund the cost of hearing aids for eligible adults who have:
   - had long-term hearing loss since childhood
   - had onset of sudden and severe hearing loss during adulthood
   - a dual disability (such as being deaf and blind, or having hearing loss and an intellectual disability).

   The Ministry will fund hearing aids for eligible adults who have a Community Services Card and need hearing aids to:
   - work full time (more than 30 hours per week)
   - study at tertiary level or do vocational training leading to future employment (for adults aged over 21 years)
   - do voluntary work (more than 20 hours per week)
   - safely look after a dependent person full time.

Children's spectacles subsidy

The Ministry will pay up to a maximum of $287.50 ($250.00 excluding GST) per child per year toward the price of eye examinations (this does not cover examinations undertaken in DHB services), frames, lenses and patches prescribed for children aged 15 years or under who are holders of High Use Health Cards, community services cards or whose families hold Community Services Cards. An additional $51.11 ($44.44 excluding GST) is available for children who need adult-sized frames.

Ministry-funded equipment and modification services

Equipment

The Ministry will not pay for equipment under $50.00 ($43.48 excluding GST) except when the:

- person is living in residential care
- person is unable to pay due to hardship and is receiving either a special benefit or temporary additional support from Work and Income
- person is under 16 years old
- item is available on the Ministry of Health's Equipment Lists, which are managed by the equipment and modification service providers.

Housing modifications, and vehicle modifications and/or purchase

For housing modifications costing more than $8,076.00 ($7,022.22 excluding GST) where the person is aged 16 years and over, or for funding towards the purchase of a vehicle, a person may be income and cash asset tested by Work and Income to determine their level of contribution, if any, towards the cost.

Housing modifications costing less than $200.00 ($173.91 excluding GST) are not funded by the Ministry.

There is an upper limit on the amount of funding of $15,334.00 ($13,333.33 excluding GST) that a person can get towards access modifications to allow them to get in/out of their home, including moving between floors. This upper limit includes modifications such as ramps, platform lifts and through-floor lifts, but does not include other types of housing modifications such as door widening and level access showers.

The maximum funding available for vehicle purchase for eligible adults is $12,165.00 ($10,577.78 excluding GST). This is subject to income and cash asset testing.

The maximum funding available for vehicle modifications for eligible people is $12,165.00 ($10,577.78 excluding GST). Income and cash asset testing is not required for vehicle modifications.

4.15 Public health services and prevention services

Public health has been defined as 'the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society' (Acheson 1988). Public health services act to protect people from health threats, prevent disease, improve health and promote better health for all New Zealanders. Public health services primarily focus on populations or specific groups of people, such as children. Prevention services are those that aim to stop people becoming ill or seek to improve outcomes through the early detection of health conditions.

Some disease prevention services for individuals, which need to be delivered on a population basis (eg, organised population-based cervical screening programme), are also considered part of public health services.

Range of Services

All public health service agreements and service schedules must be consistent with the requirements outlined in the Public Health Service Specifications. Specific mandatory requirements and regulations for some services (eg, for the provision of information, notification of public health risks, and minimum standards of service coverage) are detailed in some of the service specifications. The tier one Public Health Service Specification summarises the generic requirements for all public health services.

Providers will transition from the 13 'issues-based' tier two specifications to the five new, 'functions-based' tier two specifications. The following service specifications describe the public health services funded directly by the Ministry:

Public Health Services tier one

1. Health assessment and surveillance – tier two
2. Public health capacity development – tier two
3. Health promotion – tier two
4. Health protection – tier two
5. Preventive interventions – tier two.

These five tier two specifications replace the former 'issues-based' tier two specifications. The 'functions-based' specifications outline broad approaches that can be applied to many health issues and service areas as well as more detailed elements for national consistency and meeting statutory requirements.

Service volumes are determined as part of contract negotiations and are considered in relation to local needs and priorities as well as national service planning processes.

While the high level framework is now functions-based, the overall scope of public health services remains unchanged. Providers may continue to configure their services in ways that reflect their own planning, organisational and service delivery requirements, so long as they meet the public health needs of their service users / communities.

Service planning and delivery

For most of the service categories outlined below, a 'mix' of complementary services are purchased from providers of services at national, regional and local levels.

Public health services can be categorised into the following three broad categories. A combination of services from these categories may be required to make progress in one or more public health issue or setting.

1. Public health promotion services

Some health promotion services are provided to benefit the whole population, such as national media campaigns, or the national Quitline service. Other health promotion services are provided for a particular community or group in the population according to need. The Ministry funds activities that have been outlined using the Ottawa Charter action areas (World Health Organisation, 1986). However there are examples of other established frameworks for planning health promotion services, such as Te Pae Mahutonga (Durie, 1999).

2. Public health protection and regulatory services

Most public health protection and regulatory services are provided to protect and benefit the whole population. These services include:

- monitoring public health risks
- taking action where necessary to protect public health
- providing advice on public health protection and regulatory issues
- investigating public health complaints

The Ministry funds the following categories of public health protection and regulatory services:

- **environmental and border health** – services to protect and promote healthy communities and healthy environments – for example, border health, sewerage, drinking-water, air-quality, hazardous substances, emergency planning/response and resource management planning services
- **communicable diseases** – services to help prevent and control the spread of communicable diseases such as HIV/AIDS, sexually transmitted infections, tuberculosis (TB), and hepatitis A/B/C (including needle and syringe exchange programme) and food-borne illness
- **alcohol and other drugs** – services to prevent and reduce alcohol- and/or other drug-related harm
- **tobacco** – tobacco control programmes, including monitoring smokefree workplaces, restaurants, retail sales of tobacco products/tobacco retailer education and public education programmes.

Public health protection and regulatory services available from all public health units cover:

- border health and quarantine/imported disease control
- hazardous substances
- drinking-water quality
- public health emergency planning and response
- resource management
- other environmental health regulatory issues such as:
  - contaminated land
  - recreational water quality
  - sewage treatment and disposal
  - waste management (liquid and solid waste)
  - environmental noise management
  - ionising/non-ionising radiation

  - air quality (indoor and outdoor)
  - burials and cremation
  - early childhood centres
  - solaria
  - high power laser pointers
- communicable disease control, including TB control and regulatory components of the prevention and control of sexually transmitted infections and HIV/AIDS, hepatitis A/B/C (including needle and syringe exchange programme) and various enteric illnesses.
- alcohol regulatory roles
- tobacco control regulatory roles
- psychoactive substances regulatory roles

Note: Depending on the nature or circumstances of public health issues, the public health unit may not be the lead agency and /or may share legislative responsibilities with other regulatory agencies.

3. Prevention, detection and early intervention services

A range of specific prevention, detection and early intervention services are also purchased, including the following services: national screening programmes, immunisation, stop smoking and family violence prevention (refer Appendix 5):

Breast screening

Breast screening services are provided through BreastScreen Aotearoa, a national breast screening programme for eligible asymptomatic women aged from 45 to 69 years. Services include:

- recruitment and retention services
- regional engagement and co-ordination, including with primary health care
- support to screening services in some regions
- screening mammography services, including mobile services
- assessment services for women requiring further investigation following a screening mammogram
- connecting women requiring treatment support with appropriate providers
- national and regional BreastScreen Aotearoa promotion and education services
- monitoring and evaluation services.

Cervical screening

Cervical screening services are provided through the National Cervical Screening Programme (NCSP), for eligible women aged between 20 and 70 years. Services include:

- invitation and recall services through primary health care
- support to services in some regions, including targeted free smears
- monitoring and evaluation services
- NCSP Register to support the clinical management of the women
- hospital and community-generated laboratory cervical cytology services – NCSP tests
- hospital and community-generated laboratory cervical histology services – NCSP tests
- hospital and community-generated laboratory human papilloma virus testing services – NCSP tests
- diagnostic and treatment services for women with cervical abnormalities (colposcopy)
- regional co-ordination services.

Newborn metabolic screening services

Newborn metabolic screening services are provided through the Newborn Metabolic Screening Programme, covering over 20 metabolic disorders. All newborn babies within New Zealand are eligible for this screening. Parents are offered the opportunity to have this screening for their babies. Samples are taken by lead maternity carers and tested by LabPLUS, which is part of Auckland DHB.

The National Screening Unit (NSU) is responsible for the strategic direction, monitoring and evaluation of this screening programme.

Antenatal HIV screening services

HIV testing is offered to all pregnant women at their first antenatal visit. Testing is performed by community laboratories who also provide data to DHBs for local monitoring. The NSU provides consumer resources and education and training for referring practitioners

Antenatal screening for Down syndrome and other conditions

All pregnant women should be offered antenatal screening for Down syndrome and other conditions.

Laboratory services for first trimester combined screening and second trimester serum screening will be nationally purchased.

Nuchal translucency scanning may have a part charge.

Newborn hearing screening services

The national Universal Newborn Hearing Screening and Early Intervention Programme, offers hearing screening to all eligible newborn babies within New Zealand. Its services include:

- newborn hearing screening services
- monitoring services
- diagnostic audiology and ear, nose and throat services for babies with a ‘refer’ result
- early intervention and amplification services as required for babies with hearing loss.

Other services

Other prevention, detection and early intervention services are:

- **National Poisons Centre** – a poisons advisory service providing 24-hour emergency advice
- **vaccine distribution** – buying, storing and distributing vaccines (drugs to prevent infection and disease)
- **National Immunisation Register** – supporting the prevention of key childhood illnesses through sharing information among health professionals so that the right immunisations can be distributed to the right children at the right time.

Access

Information and advice on public health promotion and public health regulatory services is available from all public health units. These are often located at the nearest public hospital.

Health protection and regulatory services

Health protection and regulatory services are available from public health units as required. In some cases, another organisation is the lead agency.

Health promotion services

While some services are available to the whole population, other programmes are targeted to specific populations where greatest need has been identified.

Services for specific populations

Breast screening

Breast screening is provided two-yearly for asymptomatic women aged 45 to 69 years. Women can access the programme in several ways:

- they can self-refer by telephoning 0800 270 200
- they may receive a direct invitation from their regional lead provider. This will only happen if their GP has provided their contact details to the provider, after seeking and receiving the woman's permission to do so
- their GP may enrol them (with the woman's consent)
- they may be assisted to enrol after attending a regionally planned and coordinated health promotion and recruitment initiative.

Cervical screening

Women aged between 20 and 70 years are automatically enrolled in the National Cervical Screening Programme when they have a smear taken, unless they choose to withdraw from the programme. The National Cervical Screening Programme provides a record of a woman's cervical screening history, sends reminder letters to women enrolled in the programme if their cervical smear is overdue and provides information to smear takers regarding women overdue for their smear test or overdue for follow up.

DHBs have a three-yearly coverage target for women aged 25–69 years under the National Cervical Screening Programme. This target is 80 percent coverage for Māori, Pacific, Asian and European/Other ethnic groups and for total women.

Newborn metabolic screening

Participation in the screening programme is voluntary. Under section 88 of the NZPHD Act 2000, lead maternity carers are required to gain informed consent from mothers and send a sample to LabPLUS, which is part of Auckland DHB.

Antenatal HIV screening

Participation in screening is voluntary. Maternity care providers must offer antenatal HIV screening to all pregnant women and gain informed consent, but there are extended specific eligibility criteria for this screening.

Antenatal screening for Down syndrome and other conditions

Participation in screening is voluntary. Maternity care providers must offer all pregnant women appropriate antenatal screening for Down syndrome and other conditions and gain informed consent.

Newborn hearing screening

Participation in the screening programme is voluntary. Newborn hearing screeners must offer screening to all newborns and are required to gain informed consent from parents. Newborns may be screened in the hospital before discharge, as an outpatient or in the community.

Criteria for publicly funded treatment

For most of the health promotion and recruitment services, and some of the health protection services, a 'mix' of complementary national, regional and local services is purchased. For example, the range of services to reduce alcohol- and other drug-related harm, purchased in a particular community, may include services to monitor and inform alcohol licensing, public education services (eg, to reduce drink-driving and community action programmes). Some services may be most efficiently provided at a regional level. Both local and regional services

are supported by national services such as training or media strategies. Most health protection and regulatory services are complemented by non-regulatory services, such as public education programmes that complement the enforcement of the Sale and Supply of Alcohol Act 2012.

The mix of services purchased will depend on:

- the needs of the particular community
- what available services are in accordance with the national strategy
- what complementary regional and national services are available in the particular service area.

Public health protection and regulatory services are available from 12 DHB-based public health units (PHUs) across the country, which are funded to provide a 24-hour, seven-day-a-week response capacity on the issues listed in 'Range of services' above (note: the PHU is not always the lead agency).

Cost

Most public health services are funded from Vote Health with no direct cost to users. See also the Eligibility Direction and Tier One Public Health Service Specification for further details.

To safeguard the public's health, these services are expected to contribute to the investigation of suspected TB and treatment of active TB, regardless of the patient's usual eligibility for publicly funded services and ability to pay. For patients not usually eligible for publicly funded services, the services must still be provided and cost recovery must be attempted. Cost recovery may be directly from the person or from their insurance company. It is important to remember that treatment to protect the public health may not necessarily equate with the benefit of the infected individual; for example, treatment to render a person non-infectious may be for a period of two to four weeks to enable a non-eligible person to safely depart from New Zealand.

Screening services

Two-yearly breast screening is provided at no charge for asymptomatic women aged 45 to 69 years through BreastScreen Aotearoa. Cervical screening diagnostic and treatment services (within public hospitals) and laboratory services (community and public hospital laboratories) are provided at no charge. However, women will be charged a fee by their GP or other smear taker to take a cervical smear (refer Schedule 4.13 Primary health care services for further details).

The Newborn Metabolic Screening Programme screens for over 20 metabolic disorders in New Zealand. It is provided at no charge as it is fully publicly funded. Samples are sent to LabPLUS, which is part of Auckland DHB. A limited pool of money ($760,000) is available nationally for free smears for priority group women[47].

The blood test for antenatal HIV screening is provided at no charge.

For antenatal screening for Down syndrome and other conditions, the blood test is provided at no charge. Women may be charged a co-payment for ultrasound scans.

Newborn hearing screening is free for all babies, however, some babies may not be eligible for free audiology services. Refer to www.moh.govt.nz/eligibility for more eligibility information.

[47] 'Priority women' in the National Cervical Screening Programme are Māori, Pacific and Asian women, within the eligible age range for screening, and any woman over 30 years who is unscreened or under-screened.

Time

Public health protection response capacity services are available 24 hours, seven days a week in order to respond to public health emergencies.

Information and advice on public health promotion and regulatory services are available during normal business hours from public health units at:

- Northland DHB
- Auckland Regional Public Health Service (provider for Auckland, Waitemata and Counties Manukau DHBs)
- Waikato DHB
- Toi Te Ora Public Health (provider for Bay of Plenty and Lakes DHBs)
- Hauora Tairawhiti DHB
- Taranaki DHB
- Hawke's Bay DHB
- MidCentral DHB (provider for MidCentral and Whanganui DHBs)
- Regional Public Health (provider for Capital & Coast, Hutt Valley and Wairarapa DHBs)
- Nelson Marlborough DHB
- Community and Public Health (provider for Canterbury, South Canterbury and West Coast DHBs)
- Public Health South (provider for Southern DHB).

Breast screening

BreastScreen Aotearoa provides breast screening for eligible women every two years. There are screening sites that can be accessed by women in urban centres. In rural and some urban areas, mobile services are available.

Cervical screening

Screening services such as laboratory and diagnostic services, the NCSP Register, the promotion of screening, monitoring, audit and evaluation services are planned and funded by the Ministry on an ongoing basis. However, women need to access (and fund) the actual taking of cervical smears by individual health practitioners through general practice or other smear taking services.

Newborn Metabolic Screening Programme

The programme screens for over 20 metabolic disorders in New Zealand neonates. Screening is offered when the baby is 48 to 72 hours old.

Antenatal HIV screening

Screening is offered as part of an antenatal visit in the first trimester with the other first antenatal bloods. It may be offered later in pregnancy if not offered at this time.

Antenatal screening for Down syndrome and other conditions

Screening will be offered to pregnant women when they first present for maternity care.

Newborn hearing screening

Screening is offered within one month of the birth of the child.

Additional quality requirements

Public health services require coordinated planning and delivery of services at national, regional and local levels and a collaborative approach between DHBs, NGOs and the Ministry, to identify and fund services to address emergent public health issues. The Ministry and DHBs, as well as NGO providers, need to collaborate to ensure quality planning and provision.

Public health protection and regulatory services must meet the requirements of: public health legislation; the relevant sections of the Public Health services specifications tier one and tier two (Health Protection); Ministry of Health manuals, guidelines, directions and advice; and the Provider Quality Specifications v1.1 attached to all new contracts.

Breast screening

BreastScreen Aotearoa providers must meet the requirements of the *BreastScreen Aotearoa National Policy and Quality Standards*.[48]

National Cervical Screening Programme

NCSP providers must meet the requirements of Part 4A Health Act 1956 and the *National Cervical Screening Programme Policies and Standards*.[49] The *Guidelines for Cervical Screening in New Zealand* define the requirements for health professionals providing services for the prevention of cervical cancer.

Newborn Metabolic Screening Programme

The Newborn Metabolic Screening Programme Policy Framework (NSU 2011) provides guidance for all providers within the screening programme. The *Guidelines for Practitioners Providing Services within the Newborn Metabolic Screening Programme in New Zealand*[50] (NSU 2010) define the requirements for practitioners.

Antenatal HIV screening

The *Guidelines for Health Practitioners Offering Antenatal HIV Screening in New Zealand*[51] (NSU 2015) support health practitioners to provide consistent information and appropriate services when offering HIV testing to pregnant women.

Newborn hearing screening

Universal Newborn Hearing Screening providers must meet the requirements of the *Universal Newborn Hearing Screening and Early Intervention Programme National Policy and Quality Standards*.[52] Newborn hearing screening must be completed by one month of age. Audiology assessment diagnosis must be completed by three months of age. Early intervention services must commence by six months of age.

[48] www.nsu.govt.nz/health-professionals/breastscreen-aotearoa/policies-and-standards

[49] www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/policies-and-standards

[50] www.nsu.govt.nz/health-professionals/newborn-metabolic-screening-programme/procedures-guidelines-and-reports

[51] www.nsu.govt.nz/system/files/page/guidelines-health-practitioners-offering-antenatal-hiv-screening-in-nz-jun15.pdf

[52] www.nsu.govt.nz/health-professionals/universal-newborn-hearing-screening-programme/procedures-guidelines-and-repor-0

4.16 Specialist medical and surgical services

DHBs fund specialist medical and surgical services. These specialist services are usually provided in or from a hospital following a medical emergency or an accident, or after referral from an approved specialist or primary health care referrer, or another DHB.

DHBs also fund a range of diagnostic, therapeutic and support services that are related to the specialist medical and surgical services described below. For more information, refer Schedule 4.2 Diagnostic, therapeutic and support services – personal health.

Specific mandatory requirements for some services are detailed in the nationwide service specifications. The tier one service specifications for specialist medical and surgical services and services for children and young people summarise the generic requirements for the range of services listed below.

Range of services

Specialist medical and surgical services funded by DHBs include, but are not limited to:

- anaesthesiology (including pain management services)
- assisted reproductive technology, including fertility preservation
- audiology
- cardiology
- cardiothoracic surgery
- clinical haematology, including services for haemophiliacs
- dermatology
- diabetes
- emergency services
- endocrinology
- gastroenterology
- general medicine
- general surgery
- gynaecology, including secondary-level infertility services, termination of pregnancy, sterilisation services
- genetics services
- hyperbaric service decompression illness
- immunology
- maxillofacial surgery
- medical and radiation oncology
- metabolic services (linked to genetics)
- neurology
- neurosurgery
- neonatology
- ophthalmology
- oral health services

- organ transplants
- otorhinolaryngology
- orthopaedics
- paediatric
- plastic and reconstructive surgery, including burns
- pulsed laser dye
- pulmonary medicine
- renal medicine
- respiratory medicine
- rheumatology
- sexual health services
- spinal cord services
- tolerisation
- urology
- vascular surgery.

For each of the services above, the following service components and related services are also included in the funding:

- assessment, diagnosis and treatment
- specialist diagnostic services (eg, endoscopies and clinical post-mortems)
- nursing and other clinical support services
- discharge planning or onward referral to other services
- consultative services
- health education and promotion and disease prevention as part of a treatment programme
- meals, cleaning and other non-treatment services related to an inpatient stay
- pharmaceuticals associated with these services, as addressed in Schedule 4.12 Pharmaceutical services
- medical equipment and supplies associated with these services, as addressed in Schedule 4.14 Provision of equipment, modifications and other supplies and services
- other associated diagnostic, therapeutic and support services, as addressed in Schedule 4.2 Diagnostic, therapeutic and support services – personal health
- rehabilitation including community-based care and support, as addressed in Schedules 4.2 Diagnostic, therapeutic and support services – personal health, 4.3 Disability support services and 4.5 Health and support services for older people
- communication with linked services, such as health and support services for older people, DSS, ACC and primary health care providers.

Services provided at tertiary hospital centres

While most of the specialist medical and surgical services are available through public hospitals, some more highly specialised, lower-volume services are provided only at the larger ‘tertiary’ hospital centres.

The hospitals providing regional or national services are required to have systems in place to ensure that access is available according to the agreed criteria with the Ministry.

Cancer services

Cancer treatment services will be provided in line with agreed standards.

- Medical oncology services should be administered under the direction/supervision of a medical oncologist. Haematology services should be administered under the direction/supervision of a haematologist. DHBs are required to ensure that multidisciplinary meetings (MDMs) are supported and coordinated to provide best-practice treatment and care for patients with cancer.
- Radiation oncology services are provided by the following responsible DHBs: Auckland, Waikato, Bay of Plenty, MidCentral, Capital & Coast, Canterbury and Southern. Southern DHB is responsible for providing the national stereotactic radiosurgery/therapy service.
- Paediatric oncology services are provided by the following responsible DHBs: Auckland and Canterbury DHBs.

In line with regionally agreed activities, DHBs are required to ensure that multidisciplinary meetings (MDMs) are supported and coordinated to provide best-practice treatment and care for patients with cancer.

Co-ordination of Adolescent and Young People Oncology and Haematology Services

Six DHB regional cancer centres provide the co-ordination of Adolescent and Young People Oncology and Haematology Services in Auckland, Waikato, MidCentral, Capital & Coast, Canterbury and Southern DHBs. This service applies to adolescents and young adults from the ages of 12 to 24 years inclusive.

Services funded by the Ministry

Transplant co-ordination services

The Ministry funds national co-ordination of organ transplant services and donor co-ordination services through a lead DHB. Organ Donation New Zealand provides a range of services, both to support the process of organ donation and to educate staff about deceased donation and includes some support for Intensive Care Units ICUs staff time for activities relating to organ donation in ICUs.

Special high cost treatments

The special high cost treatment pool is funding set aside by the Ministry of Health for one-off treatments not otherwise funded by the public health system. Only people who are New Zealand citizens or permanent residents may be considered for treatment funded under the Special High Cost Treatment Pool[53].

DHBs specialists apply to the Ministry of Health for funding on a patient's behalf. DHBs are required to ensure funding is made available for follow-up treatment for services funded via the Special High Cost Treatment Pool as clinically required.

Simultaneous pancreas kidney transplants are now fully casemix funded and are therefore not accessible through the Special High Cost Treatment Pool.

[53] www.health.govt.nz/our-work/hospitals-and-specialist-care/high-cost-treatment-pool

Criteria for publicly funded treatment

Assisted reproductive technology and fertility preservation

Access to these services will be guided by the relevant prioritisation tool[54]. Further detail is provided in the tier two Assisted Reproductive Technology Service Specification.

- Access to in vitro fertilisation (IVF) is for one full IVF/intracytoplasmic sperm injection (ICSI) treatment, including subsequent transfer of any thawed embryo or four AIH/DI (hyperstimulation, donor insemination) cycles. If the first cycle does not result in a live birth, the couple may access a second cycle provided they still meet the (CPAC) access threshold.
- Access to fertility preservation services for the retrieval, freezing and long term storage of gametes (specifically sperm and eggs or embryos if that is appropriate) is for post-pubertal people who are undergoing gender transition or for post-pubertal people whose fertility may be permanently impaired by treatment for medical conditions such as cancer, where the treatment is accepted as a standard treatment in New Zealand. The referral for fertility preservation services needs to be made by an appropriate specialist.

Emergency and acute services

Approved referrers may refer people to hospital services based on their assessment of the urgency of the situation. Where people present for emergency treatment, triage and other guidelines will be used to determine appropriate levels and timeframes for treatment.

Electives

New Zealand's publicly funded health care system has a limit to the amount of elective treatment that taxpayer funding can support. Where demand for elective services cannot be met within existing capacity, the explicit requirement is that resources are allocated based on need and ability to benefit. Where a service is offered to patients, they wait no longer than four months.

The key principles underlying the elective system are:

- clarity – patients know whether or not they will receive publicly funded services
- timeliness – where services can be delivered within the available capacity, patients receive them in a timely manner
- fairness – ensuring that the resources available are directed to those most in need.

To manage elective services, DHBs must focus on improving access to elective surgery and reducing waiting times.

Improving access

DHBs will ensure that the hospital(s) provide the amount of elective operations, procedures and assessments agreed to in their Annual Plan. They will review the key operations performed to ensure the right level of service is delivered for the people in the region.
DHBs will demonstrate innovative strategies to improve elective capacity, or alternative delivery options aimed at increasing productivity and efficiency, particularly theatre efficiency, and workforce development. Innovation and efficiency should be within the DHB and across the primary–secondary interface.

Managing waiting times

DHBs will comply with required standards on Elective Services Patient Flow Indicators, which demonstrate that the DHB is managing patients in accordance with the three principles (clarity, timeliness and fairness) and matching its commitments to capacity. DHBs will focus on meeting

[54] The prioritisation tool for assisted reproductive technology is published on the National prioritisation web service website: www.npi.1000minds.com/

the commitments given to patients for first specialist assessment and treatment and ensure patients wait no longer than four months.

Improving quality

There is to be ethical and equitable access to elective services. Patients with similar need are to have similar access to elective services, regardless of where they live. DHBs will have in place, and maintain, effective prioritisation systems as agreed with the Ministry of Health. Patients are to be prioritised using the appropriate assessment tools and processes. DHBs will ensure that patients are assessed and prioritised for surgery on a consistent basis, and that they then receive surgery according to the priority they were given.

Diagnostic Services

Diagnostics are a vital step in the pathway to access appropriate treatment. Very few diagnostic procedures have specific targets set for increases in delivery or service quality. Consequently the wait for diagnostics can result in significant delays to a patient's episode of care. Reducing waiting times for diagnostics will improve access and patient outcomes in a range of areas including cancer pathways, emergency department waiting times, and access to elective surgery. The programme to reduce waiting times for diagnostics is addressed in Section 3.8: Diagnostic services.

Termination of pregnancy

Termination of pregnancy services are provided for those women who meet the criteria provided by the Crimes Act 1961 and the Contraception, Sterilisation, and Abortion Act 1977.

Exclusions

Except where explicitly stated, no services are specifically excluded from DHB funding. Rather, decisions about offering particular services or treatment on a publicly funded basis are made according to an assessment of each individual's specific clinical and social circumstances. In particular, consideration is given to the likely benefits of the service for the individual, relative to the costs of that service, and to the potential benefits of directing those resources to a different service or another individual's treatment.

DHB-specific exclusions from nationwide service specifications are outlined in CFAs, on application to, and agreement with, the Ministry.

Excluded cardiac interventions

No public funding is made available for the following cardiac interventions excluded from the national minimum service coverage requirements:

- Renal artery denervation for patients with refractory hypertension
- Percutaneous interventions for mitral regurgitation
- Percutaneous left atrial appendage occlusion for the treatment of atrial fibrillation.

Cost

Publicly funded inpatient services, as well as day patient, outpatient and any community-referred services provided in the hospital setting, are provided to eligible people free of charge. This includes all the services and supplies associated with the hospital treatment. Organs for transplant are provided to eligible people at no charge.

Refer to Schedules 4.2 Diagnostic, therapeutic and support services – personal health, 4.10 Oral health services, 4.12 Pharmaceutical services, 4.14 Provision of equipment, modifications

and other supplies and services and 4.17 Travel and accommodation services, for details associated with each of these services.

To safeguard the public's health and to protect individuals who may have infectious diseases, these services are expected to contribute to the investigation and treatment of suspected cases of notifiable infectious diseases, regardless of the patient's usual eligibility for publicly funded services and ability to pay. If it is suspected that a patient has a notifiable infectious disease and may be infectious and so pose a risk to others, they have access to publicly funded diagnostic, treatment and follow-up services (for further details of the services, see the Ministry's website).[55]http://www.moh.govt.nz/eligibility Where a patient is not eligible for publicly funded services, these services should be provided and cost recovery should not be attempted.

Note: Treatment to protect public health may not necessarily equate to the benefit of the infected individual. For example, treatment to render a person non-infectious may be for a period of two to four weeks to enable a non-eligible person to safely depart from New Zealand.

Time

Electives

People have direct and immediate access to hospital emergency department services and will move through those services to the most appropriate level for care and/or treatment. For elective services, booking system timeframes are as follows:

- timely and efficient access to specialist advice and assistance
- 100 percent of people accepted for assessment receive their first specialist assessment within four months
- 100 percent of people offered publicly funded treatment receive that treatment within four months of the offer to treat
- 100 percent of people placed in active review receive a review of their condition and eligibility status at least every six months.

Diagnostics waiting times

Waiting time measures have been agreed for a number of diagnostic modalities – colonoscopy, coronary angiography, computed tomography (CT) and magnetic resonance imaging (MRI). Performance monitoring against these waiting time measures will continue during 2016/17. The timeframes for the diagnostic modalities are:

- urgent colonoscopies should be performed within 14 days
- non-urgent colonoscopies should be performed within 42 days
- surveillance colonoscopies should be performed within 84 days
- coronary angiographies should be performed within 90 days
- CT and MRIs should be performed within 42 days.

Radiation oncology waiting times

Facilities should be provided to ensure that patients who require radiation treatment can be treated within appropriate timeframes. The timeframes for treatment priorities are:

- urgent patients should be treated within 24 hours of referral
- curative category (radical primary radiotherapy) patients should be treated within two weeks of the radiation oncology assessment and decision to treat

[55] www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services

- palliative and other radical patients should be treated within four weeks of radiation oncology assessment and decision to treat
- sequential chemotherapy and radiation treatment should start on a date scheduled according to the chemotherapy protocol requirements.

Medical oncology waiting times

Capacity should be provided to ensure that patients who require chemotherapy treatment can be assessed and treated in accordance with the timeframes outlined in the medical oncology prioritisation criteria. The timeframes for treatment priorities are:

- immediate category patients should be treated within 48 hours of decision to treat
- semi-urgent patients should be treated within two weeks of a decision to treat
- routine patients should be treated within four weeks of a decision to treat
- concurrent chemotherapy and radiation treatment should start within four weeks of the decision to treat.

Additional quality requirements

- DHBs must deliver high-quality secondary preventative care for fragility fracture sufferers (through identification, investigation and intervention) to prevent future fractures.
- All DHBs have been contracted through Vote Health since 2007 to deliver violence intervention programmes in acute and community health services, in particular: mental health, alcohol and drug, child health (including school and home visiting services and tertiary paediatric services), maternity, sexual health and emergency department.
- Funding is provided through public health service contracts to deliver violence intervention programmes aligned with the Ministry's *Family Violence Intervention Guidelines: Child and partner abuse* (Ministry of Health 2002) and *Family Violence Intervention Guidelines: Elder abuse and neglect* (Ministry of Health 2007). DHBs are expected to achieve audit scores of 70/100 for each of the child and partner abuse components of their violence intervention programme. Contract performance and accountability against national service specifications are managed by the Public Health Group, Service Commissioning, Ministry of Health
- Services to support and care for people with Diabetes must deliver against and meet the 20 Diabetes Quality Standards.

4.17 Travel and accommodation services

This schedule describes service coverage requirements implemented on 1 January 2006, when the new National Travel Assistance (NTA) Policy 2005 was introduced.

Range of services

All DHBs must provide assistance for patient travel and accommodation as specified in the National Travel Assistance Policy 2005. The *Guide to the National Travel Assistance (NTA) Policy 2005*[56] (Ministry of Health 2009b) sets out the minimum requirements; DHBs may have additional arrangements in recognition of local needs.

The aim of the policy is to provide targeted financial assistance towards the travel and accommodation costs for those for whom transportation is a significant barrier, as identified in the policy, to accessing specialist services. For patients who are eligible for NTA funding, the policy provides assistance for transport from the patient's home to the location of the patient's specialist health and/or disability service provider and for accommodation if the patient is required to stay closer to the specialist service or meet certain travel distance criteria. In addition, some assistance is available for transport and accommodation for eligible patients' supporters.

Access

Eligibility is based on combinations of factors such as age, financial need (Community Services Card), frequency of service use, and distance from services. The NTA Policy 2005 can only consider referrals from publicly funded health and disability specialists when people are referred to publicly funded specialist health and disability services.

To ensure their patients in need are informed, DHBs are required to advertise their policies at key points in their facilities, to provide access to NTA registration and claims forms and to train key staff for helping patients to fill in forms if needed.

The Ministry provides details of eligibility criteria, registration and claims forms and other information on its website.[57] To ensure national consistency, the Ministry (NTA payments team, Sector Operations Group) administers NTA registration and claims processing on behalf of DHBs. Eligible patients can register for NTA through their DHB health or disability specialist. Once registered, patients can obtain claims forms from their DHB or the Ministry's NTA payments team, or download them.[58] Registration and claim forms need to be completed and forwarded to the Ministry's NTA payments team, with all the specified information attached.

Criteria for publicly funded treatment

NTA registrations are approved or declined by the Ministry's NTA payments team according to the eligibility criteria set out in the policy. Patients must usually meet all the criteria under at least one eligibility category (long distance travel, high frequency travel, frequent travel, Community Services Card holder and additional categories addressed in the NTA Policy). Assistance with travel and accommodation costs for a support person of an eligible patient may be granted if the

[56] www.health.govt.nz/system/files/documents/publications/nta-policy-guide-v2-1-aug-2009.pdf

[57] www.health.govt.nz/your-health/services-and-support/health-care-services/hospitals-and-specialist-services/travel-assistance

[58] www.health.govt.nz/your-health/services-and-support/health-care-services/hospitals-and-specialist-services/travel-assistance/how-claim-travel-assistance

patient is a child or the specialist deems that a support person is necessary. Claims must be received within 12 months of the last date of treatment to be eligible for assistance.

Claims that are approved will usually be processed within 10 working days and paid to the nominated bank account or to the transport and/or accommodation provider.

Exclusion

Travel and accommodation services are not available under the current National Travel Assistance Policy for the following purposes, unless otherwise advised by the patient's DHB of domicile:

- access to primary health care services
- referral from a primary provider to a first specialist assessment (eg, GP referral)
- self-referrals (which includes emergency room visits)
- private referrals or treatments
- emergency transportation
- when travel assistance is funded by other parties (eg, ACC, Work and Income)
- patients returning to their residential home following an unplanned acute admission to a treatment facility that is not the closest one to their home while they were voluntarily travelling out of their DHB district (eg, on holiday or travelling for work)
- inter-hospital transfers – note: inter-hospital transfers discharged to their residential home from a treatment facility must meet the usual NTA criteria to qualify for NTA funding
- overseas travel
- transfers from home to airport or public transport terminals (or vice versa)
- travel between client accommodation (NTA paid) and the treatment centre or any about-town travel
- when the client is an inpatient, travel between a support person's accommodation (NTA paid) and the treatment centre or any about-town travel.

Cost

Travel and accommodation costs are reimbursed at the rates specified in the policy. These may include:

- 28 cents per kilometre for private mileage, which is always calculated from the patient's address.
- actual costs for air transport if clinically required (travel insurance excluded)
- actual costs of public transport
- assistance with accommodation costs if required and approved by a specialist, up to the maximum amount specified in the policy. This maximum is usually $100 per night for motel accommodation, or $25 per night for private accommodation
- some assistance with travel and accommodation costs for a support person.

The above reimbursement rates are subject to review and change with the approval of the 20 DHBs and the Minister of Health.

References

ACC and Ministry of Health. 2014. *Accident Services: A guide for DHB and ACC staff*. Wellington: Accident Compensation Corporation and Ministry of Health.

Acheson D. 1988. *Independent Inquiry into Inequalities in Health: Report.* London: Her Majesty's Stationery Office.

Associate Minister of Health. 2006. *New Zealand Suicide Prevention Strategy 2006–2016*. Wellington: Ministry of Health.

CYF. 2011. *Interagency Guide to Gateway Assessments*. Wellington: Child, Youth and Family.

Minister for Disability Issues. 2001. *New Zealand Disability Strategy: Making a world of difference – Whakanui Oranga*. Wellington: Ministry of Health.

Minister of Health. 2011. *Health and Disability Services Eligibility Direction 2011*.

Minister of Health and Associate Minister of Health. 2002. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.

Minister of Health and Minister of Pacific Island Affairs. 2010. *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010–2014.* Wellington: Ministry of Health.

Ministry of Health. 2002. *Family Violence Intervention Guidelines: Child and partner abuse*. Wellington: Ministry of Health.

Minister of Health. 2005. *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan.* Wellington: Ministry of Health.

Ministry of Health. 2007. *Family Violence Intervention Guidelines: Elder abuse and neglect*. Wellington: Ministry of Health.

Ministry of Health. 2008. *Te Puāwaiwhero – The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015*. Wellington. Ministry of Health.

Ministry of Health. 2008. *School-based Programme Professional Standards for Service Delivery*. Wellington: Ministry of Health.

Ministry of Health. 2009a. *Evaluation of Youth One Stop Shops*. Wellington: Ministry of Health.

Ministry of Health. 2009b. *Guide to the National Travel Assistance (NTA) Policy 2005.* Wellington: Ministry of Health.

Ministry of Health. 2012a. *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines).* Wellington: Ministry of Health.

Ministry of Health. 2012b. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health.

Ministry of Health. 2013a. *New Zealand Suicide Prevention Action Plan 2013–2016*. Wellington: Ministry of Health.

Ministry of Health. 2013b. *Resource and Capability Framework for Integrated Adult Palliative Care Services in New Zealand*. Wellington: Ministry of Health.

Ministry of Health. 2014. *Immunisation Handbook 2014*. Wellington: Ministry of Health.

Ministry of Health 2015.*Te Ara Whakapiri - Principles and Guidance for the Last Days of life* (, currently in the process of being published)

Ministry of Health and 1000Minds Ltd. 2015. Treatment priority *tool for assisted reproductive technology*. URL: https://npi.1000minds.com/

NSU. 2008. *Guidelines for Maternity Providers Offering Antenatal HIV Screening in New Zealand*. Wellington: National Screening Unit.

NSU. 2010. *Guidelines for Practitioners Providing Services within the Newborn Metabolic Screening Programme in New Zealand*. Wellington: National Screening Unit.

Oakley Browne MA, Wells JE, Scott KM, et al. 2006. Lifetime prevalence and projected lifetime risk of DSM-IV disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry* 40(10): 865–74.

Oral Health Clinical Leadership Network. *Improving Oral Health Services of High Needs and Vulnerable Populations.*

Split Ridge Associates Ltd. 2012. *Report on the Provision and Funding of Specialist Behaviour Support Services.* Motueka: Split Ridge Associates Ltd.

Appendix 1: Special high cost treatment

1. Definitions

The following definitions apply to this appendix.

- **Chief Advisor** means the Ministry's Chief Advisor (Special High Cost Treatment).
- **Complex case** means a case that may require case management due to its rarity and high cost that is not adequately compensated for by weighted inlier equivalent separations (WIES) methodology, and where there is a significant financial risk that neither DHBs nor the Ministry can control.
- **Special High Cost Treatment** includes the following treatments:
  - medical treatments overseas
  - complex cases
  - treatments currently available generally only outside public hospitals.
- **Special High Cost Treatment Pool** means the central fund for special high cost treatment, which will be administered and managed by the Ministry.

2. Purpose of Special High Cost Treatment Pool

The purpose of the Special High Cost Treatment Pool is to:

- ensure equitable access for eligible people throughout New Zealand to special high cost treatments
- manage the financial risk for certain highly specialised procedures that pose a risk due to their unknown, high or fluctuating costs
- promote the use of cost-effective procedures in the public health care system.

3. Business rules for special high cost treatment

The Ministry will determine funding for Special High Cost Treatment individually, but intends to standardise such prices wherever possible. For unusual cases, the Ministry will establish funding on a case-by-case basis.

4. Access to the Special High Cost Treatment Pool

Access to the Special High Cost Treatment Pool will be determined by the Ministry. All applications for funding through the Special High Cost Treatment Pool will be subject to the eligibility criteria set out below.

5. General eligibility criteria for special high cost treatments

For special high cost treatment, the general eligibility criteria (which must normally all be satisfied) are listed below. Some types of special high cost treatment have additional specific criteria, which are listed below under the appropriate subheadings. The general eligibility criteria are:

- the person for whom access to the pool is sought to fund treatment must be an eligible person
- the treatment must have proven efficacy through appropriate clinical trials, and preferably also have been established as effective through regular application
- failure to receive the treatment would be likely to result in serious irreversible deterioration in the patient's condition, or an inability to recover lost function, or significant impairment to normal development of a child
- failure to receive the treatment could deny an adult with a lifelong disability access to treatment which would lead to a marked improvement in their quality of life
- treatment would lead to reasonable prospects of survival and to an improved quality of life after treatment
- the treatment is well established and not an experimental form of treatment
- the treatment is cost-effective, which means that the:
  - expected long-term savings to the health care system outweigh the initial costs of the treatment, and/or
  - dollar costs for the expected benefit are acceptable when evaluated against other Ministry and DHB priorities.

6. Where all the criteria are not met

Consideration will be given to individual circumstances.

7. Additional criteria for medical treatment overseas

For the approval of special high cost treatment to be provided overseas, the appropriate treatment must also not be available in New Zealand.

Where medical treatment overseas requires multiple trips over a long period of time, or in the case of, for example, a transplant and the date of the procedure being funded is unknown, the Ministry of Health and DHB of domicile will share:

- accommodation costs for the duration of the period spent overseas
- treatment costs leading up to the actual procedure.

8. Additional criteria for complex cases

For complex cases, the Ministry may agree to an arrangement where the cost of the complex case is shared between the DHB and the Ministry. The Ministry's share of such cost will be met from the Special High Cost Treatment Pool. The Ministry will determine the extent to which the Ministry and DHB respectively contribute to the cost of the complex case and, in doing so, will take into account a number of factors, including (without limitation):

- the variability of the cost profile for the complex cases in question
- whether the DHB is in a position to balance the cost variation across other services provided by the DHB

- the extent to which severity/complexity is already covered in the DHB's appropriation.

9. Additional criteria for treatments available only outside public hospitals

A person will not be eligible for special high cost treatment unless the treatment is not currently available from any public hospital in New Zealand or under any existing contractual arrangement with the private sector that the Ministry and a DHB may have entered into.

10. Application and approval process to use the Special High Cost Treatment Pool

The following application and approval process applies:

- All applications for funding must be made prior to the commencement of treatment. Retrospective funding will not be made available. The exception to this is urgent cases where DHBs must send completed applications for consideration by the Chief Advisor on the day that the person is identified as possibly meeting the criteria, except that where that day is not a working day, the application must be forwarded on the next working day. The Chief Advisor will communicate an indicative decision within 48 hours of receipt of the completed application.
- All applications for funding through the Special High Cost Treatments Pool will be received by the Chief Advisor, High Cost Treatment Pool, Office of the Chief Medical Officer, and will be considered on a case-by-case basis.
- The Ministry will only accept applications from DHB specialists with supporting documentation and recommendations for treatment.
- All applications must use the standard application form (which is available from the Office of the Chief Medical Officer) and must be accompanied by supporting evidence and costing information. Forms must be sent to the Chief Advisor.
- The Ministry will ensure that the Chief Advisor acknowledges receipt of all applications in writing, and informs all applicants of the approval process (including the likely timeframe for approval) within seven days of receipt of an application. Applicants will be informed of the Ministry's decision (or reasons for any delay in the decision-making process) in writing, within 21 days of receipt of application. In urgent cases, the Chief Advisor may give a verbal approval followed by written approval within the timeframe specified above.
- For urgent treatments, the DHB must negotiate with the Chief Advisor for approval of funding as soon as the case is identified as possibly being a special high cost treatment case and before any costs are incurred.
- All payments for approved treatments will be administered by the Ministry and paid by the Ministry through National Contracted Services – or directly to the contracted providers on receipt of one aggregated invoice.
- Any decision made on any application for funding from the Special High Cost Treatment Pool does not set a precedent for decisions on any future application or applications.

Appendix 2: Requirements in relation to accident claimants

1. ACC – public health acute services

The Accident Compensation Act 2001 is the principal Act under which ACC operates. While this Act came into force on 1 April 2002, the main impact on the purchasing of public health acute services[59] occurred from 1 July 2002, when ACC began purchasing these services through the Minister of Health under a service agreement between the Minister for ACC and the Minister of Health. Services included in 'Public health acute services' (PHAS) are the services specified in the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002. These regulations came into force on 1 July 2002.

2. Purchase objectives – outputs to be delivered by each DHB providing services for ACC claimants

Each DHB will provide public health acute services under its Annual Plan and Crown Funding Agreement in relation to the treatment of an eligible person for a personal injury for which that eligible person has cover under the Accident Compensation Act 2001.

DHBs will provide for the same performance standards, in so far as they are relevant to the delivery of public health acute services to ACC claimants as to the delivery of those services to eligible people in general.

[59] As defined in clause 4 of the Injury Prevention, Rehabilitation, and Compensation (Public Health Acute Services) Regulations 2002:

1. For the purposes of the Act, public health acute services, in relation to treatment of a claimant for a personal injury for which he or she has cover, means any of the following personal health services:
   - (a) services provided as part of an acute admission:
   - (b) services provided as part of an emergency department presentation, and any subsequent services provided by the emergency department within 7 days after that presentation:
   - (c) outpatient services that are provided by a registered medical practitioner and associated with services described in paragraph (a) if those outpatient services are provided within 6 weeks after the day of discharge:
   - (d) outpatient services that are provided by a registered medical practitioner and associated with services described in paragraph (b) if those outpatient services are provided within 6 weeks after the day of treatment:
   - (e) services that are provided by a registered medical practitioner less than 7 days after the date on which the claimant is referred for those services by another registered medical practitioner, other than:
     - (i) services associated with services described in paragraph (a) or paragraph (b); and
     - (ii) referrals to a radiologist by a registered medical practitioner who is providing treatment for which a payment or contribution is to be made under section 73 of the Act or under clause 1 of Schedule 1 of the Act:
   - (f) services that are ancillary to any of the services described in paragraphs (a) to (e), including non-emergency travel and accommodation for the claimant and an escort or support person for the claimant, but excluding emergency transport:
   - (g) services that relate to the provision of treatment described in paragraphs (a) to (f), including, for example, the provision of consumables, diagnostic imaging, and equipment.
2. To avoid doubt, subclause 1 applies only to services that are purchased through the Minister of Health and provided by a publicly funded provider.

Accident Services: A guide for DHB and ACC staff[60] (ACC and Ministry of Health 2014) provides a guide for providers of public health acute services to assist in determining which agency is responsible for purchasing treatment rehabilitation and related services required by an injured person.

The information in the guide is intended to serve as a general guide to purchasing arrangements under the Accident Compensation Act 2001 and the public health acute services regulations. For legal or financial purposes, the Accident Compensation Act 2001 and contractual arrangements between funders and providers take precedence over the contents of the guide.

Where there is a dispute over whether a service is included or excluded from public health acute services, services to individuals will be maintained by whichever agency is currently providing the treatment until the issue is resolved.

3. Ownership objectives: access of ACC's representative

Each DHB will grant such access by ACC as is reasonable in the circumstances to any patient who is receiving public health acute services for a personal injury covered by the Accident Compensation Act 2001, and to their medical records. This includes access to any relevant health professional who is necessary for arranging post-discharge treatment, rehabilitation or other services.

4. Ownership objectives: dispute resolution

Each DHB will work together with ACC and other appropriate agencies to clarify and resolve interface issues relating to the provision of public health acute services.

The following principles are to be used to reach agreement on boundary issues on services:

- disputes should be resolved at the lowest possible level of management that is appropriate given the nature of the dispute concerned
- where responsibility for payment is disputed, services to individuals will be maintained by whichever agency is currently providing the treatment, until the issue is resolved.

ACC is responsible for paying (either directly or through the Crown) for services for patients if these are required as a result of personal injury covered under the Accident Compensation Act 2001. Otherwise it is an illness or disability and the responsibility for determining the funding rests with the DHB and/or the Ministry.

If ACC receives a request to pay for a service that ACC considers is part of the public health acute services or is illness-related and this issue cannot be resolved at a local level, the Ministry will work with ACC and the Ministry of Business Innovation and Employment to determine whether a particular service is considered part of the public health acute services or not. ACC can seek a judicial review of any decision or determination by the Ministry with respect to whether ACC funds a particular service.

Each DHB will continue to provide public health acute services to eligible people while any dispute as to responsibility for payment is being resolved.

[60] www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/guide/wpc120337.pdf

5. Ownership objectives: consultation

Each DHB is to consult with ACC on any material issue related to the purchase of 'public health acute services' (PHAS) under the PHAS Agreement that may affect ACC or ACC claimants.

6. Non-residents

Non-resident accident patients who require public health acute services are to be included in acute volumes, and are not to be charged directly by a hospital that is covered under the definition of 'publicly funded provider' in the Accident Compensation Act 2001.

7. Invoicing for non-Public Health Acute Services

DHBs must invoice ACC within 12 months from the date of service for non-acute services provided to ACC claimants. Claims such as treatment injury will be excluded from this 12-month timeframe where a cover decision by ACC prohibits the DHB from invoicing within the 12-month period. In such instances the DHB must invoice ACC within 12 months of the claim being accepted. Where this is not possible, ACC will consider cases on an individual basis.

8. Physiotherapy services to ACC clients

On 15 November 2009 ACC stopped funding free treatment to people needing physiotherapy after accidents and reduced the amount paid to providers.

On 16 November 2009 private providers began charging patients a co-payment. Until further notice DHBs with an ACC physiotherapy contract are not to institute co-payments for physiotherapy services to ACC clients.

Appendix 3: Gateway Assessment Programme

The Gateway Assessment Programme is a comprehensive health and education assessment programme for children and young people engaged[61] with Child, Youth and Family (CYF), a business group within the Ministry of Social Development. The Ministry of Health, Ministry of Education and CYF have collaborated on policy to support the programme, and report at ministerial level on joint outcomes.

The overall objective is to enhance the child or young person's physical, mental, educational and social wellbeing by identifying unmet need and referring them to services to address these needs.

CYF contracts with all DHBs for the service. DHBs are required to employ a Gateway Assessment Coordinator and will ensure the Gateway Assessment Coordinator and any other DHB staff involved in the Gateway Assessment Programme follow the specified process, as outlined in the service specification. The *Interagency Guide to Gateway Assessments*[62] (CYF 2011) provides the detail and tools needed to implement and provide the service.

The health assessment component is delivered by a registered health practitioner who is experienced in child and/or youth physical and/or mental health assessment.

Within the education sector, teachers, resource teachers learning and behaviour (RTLBs) or early childhood education providers provide a profile of the child or young person's educational engagement and achievement, which is an integral component of the Gateway Assessment.

CYF social workers provide the context and history of the care and protection issues of the child or young person. The Gateway Assessment Coordinator collates this information along with any information received from ACC, Plunket, primary health care services and the New Zealand Health Information Service (as appropriate) and books the health assessment with the appropriate health practitioner.

Once the Gateway health assessment has been completed, the Gateway Assessment Coordinator combines the information, writes a health report and creates an Interagency Services Agreement that is forwarded on to the child or young person's CYF social worker. The CYF social worker discusses the recommendations in the report with the child or young person and their family and whānau, and the report contributes to the broader plan for the child or young person. The Gateway Assessment Coordinator reviews the Interagency Services Agreement three months after the health assessment with the CYF social worker and the relevant education sector representative.

[61] Children and young people entering care, in care, or being referred for a care and protection Family Group Conference.

[62] www.cyf.govt.nz/keeping-kids-safe/ways-we-work-with-families/gateway-health-and-education-assessments.html

Appendix 4 Vulnerable Children

The Vulnerable Children Act 2014 and the Children's Action Plan rest on the belief that no single agency alone can protect vulnerable children. The chief executives of five government agencies (Ministries of Health, Education, Justice, Social Development and New Zealand Police) are acting together to develop, fund and implement plans to protect vulnerable children from harm, working with families/whānau and communities.

This work programme contributes to the Government's Better Public Services: Supporting vulnerable children, result 4: to reduce the number of assaults on children.

DHBs will ensure they:

- deliver and coordinate services that meet the needs of vulnerable children and their family/whānau
- collaborate with other agencies to plan, test and monitor assessment processes to support early response systems, assessment processes and service co-ordination for vulnerable children
- Implement the Ministry's Family Violence Intervention Guidelines (Partner Abuse and Child Abuse and Neglect) through VIP Programmes and associated activities (including the National Child Protection Alerts (NCPAS), MOU between CYF, Police and District Health Boards, the Shaken Baby Prevention Programme and regional Maternity Care, Child Wellbeing and Protection working groups for pregnant women with complex needs).
- Comply with the safety checking and child protection policy requirements of the Vulnerable Children Act 2014, and ensure that all contracted providers also comply.

Children's Teams

Children's Teams represent a new and different way of working. Putting children at the centre of everything we do means that providers from across the health, education and social sectors need to work through how best to work together to achieve better results for vulnerable children and their family/whānau.

From 1 July 2016 DHBs with a local Children's Team will be required to ensure resources and health services are provided within baseline funding to support the local Children's Team operations.

Each Children's Team has a Local Governance Group (LGG). The LGG will provide overall sector leadership and ensure cross-community, Iwi and agency participation and decision-making to support effective management of resources for the local Children's Team. Core members of the LGG will be local decision makers from Education, Health (local DHB representation), Social Development, Te Puni Kokiri, and the New Zealand Police. These core members should be at the right level to make decisions regarding systems, services and resources at the local level.

Information about the Children's Action Plan is available at www.health.govt.nz/our-work/life-stages/child-health/childrens-action-plan-programme

Appendix 5: Violence Intervention Programme

The Ministry of Health's (MOH) **Violence Intervention Programme** (VIP) seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to District Health Board (DHB) services.

The VIP provides the infrastructure for the health sector response, which is one component of the multi-agency approach to reduce family violence in New Zealand led by Government's Taskforce for Action on Violence within Families. The Violence Intervention Programme is strategically aligned with the Children's Action Plan, 2012, Vulnerable Children's Act 2014 and government priorities to reduce the number of physical assaults on children (Better Public Services Key Result Action Area, 2013).

The VIP is premised on a standardised, comprehensive systems approach and the initial target areas for implementation within DHBs are the designated services of the Emergency Department, Child Health, Maternity, Sexual Health, Alcohol and Drug and Mental Health

The Ministry of Health funds the national systems that support VIP including:

1. District Health Board Family Violence Intervention Coordinators (FVIC).
2. Ministry of Health Family Violence Assessment and Intervention Guideline: Child abuse and Intimate Partner Violence (2002, 2016).
3. Resources that include a Ministry Family Violence website, a VIP section on the Health Improvement and Innovation Resource Centre (HIIRC) website, posters, cue cards, pamphlets and the VIP Quality Improvement Toolkit.
4. Technical advice and support provided by a National VIP Manager for DHBs, National VIP Trainer and National and Regional Family Violence Intervention Coordinator networking meetings.
5. National training contracts for DHB staff, midwives and primary care providers.
6. Monitoring and evaluation of DHB

Appendix 6: 2017/18 Service Coverage Schedule Summary of changes

The service coverage document has been updated to reflect policy changes and to clarify some areas. Key changes to the following sections of service coverage are summarised below.

3 Specific services with transitional issues in 2017/18 and out years

3.4 Bowel Screening New - The national bowel screening programme will be rolled out progressively from 2017.

3.5 National Safe Sleep Programme New - National Safe Sleep Programme implementation is expected to start from July 2017

3.7 National immunisation programme Updated funding information, immunisation targets and performance measures (July 2017)

3.12 Regularisation of the Workforce - New

3.13 In Between Travel - New

4 General operational service delivery mechanisms

4.2 Diagnostic, therapeutic and support services – personal health

Minor edit - deletion of hyperbaric services (Jan 2017)

4.6 Immunisation section rewritten. (July 2017)

4.10 Oral Health Summarised requirements of the oral health specifications, updated terminology

4.15 Public health services and prevention services Minor edits –public health, screening, Public health promotion services, Public health protection and regulatory services and Prevention, detection and early intervention services. (Jan 2017)

Additional quality requirements – information on key quality documents related to screening programmes.

Criteria for publicly funded treatment – minor edits throughout section.

4.16 Specialist medical and surgical services

Range of Services – addition of hyperbaric (Jan 2017)

Co-ordination of Services – edited information pertaining mostly to Cancer services. (July 2017)

Diagnostic waiting times - Minor Update

Additional Quality Requirements (Jan 2017) - Services to support and care for people with Diabetes must deliver against and meet the 20 Diabetes Quality Standards.

Range of services – addition hyperbaric (Jan 2017)

2017/18
Annual Plan Guidelines

WITH STATEMENT OF PERFORMANCE EXPECTATIONS

This document is for District Health Board (DHB) staff to use when developing their 2017/18 Annual Plan including Statement of Performance Expectations.

The Annual Plan Guidelines is a reference document to enable DHBs to meet their minimum legislative and Ministerial obligations when drafting their Annual Plans. Note that these Guidelines include references to additional guidance and resources that also need to be referred to when developing Annual Plans.

Amendments to the Annual Plan Guidelines (*note that minor editorial amendments have not been recorded in the following table*)

Page	Description
9	- PP7: Improving mental health services using wellness and transition (discharge) planning has been updated to more clearly show that there are two components associated with this measure.

Table of Contents

Overview of the Annual Plan Structure....3

SECTION 1: OVERVIEW OF STRATEGIC PRIORITIES....4

1.1 Strategic Intentions/Priorities....4

1.2 Message from the Chair and Chief Executive....4

1.3 Signature Page....4

SECTION 2: DELIVERING ON PRIORITIES....5

2.1 Government Planning Priorities....5

2.2 Financial Performance Summary....5

2.3 Local and Regional Enablers....6

SECTION 3: SERVICE CONFIGURATION....7

3.1 Service Coverage....7

3.2 Service Change....7

SECTION 4: STEWARDSHIP....8

4.1 Managing our Business....8

4.2 Building Capability....8

SECTION 5: PERFORMANCE MEASURES....9

5.1 2017/18 Performance Measures....9

APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS including FINANCIAL PERFORMANCE (for tabling as SPE)....13

Statement of Performance Expectations (SPE)....13

Output classes....13

Financial Performance....13

APPENDIX B: SYSTEM LEVEL MEASURES IMPROVEMENT PLAN....15

Additional Information....16

Glossary of Terms....16

Financial Checklist for 2017/18 Financial Statements (and supporting templates)....19

Output Class Recommendations....22

Overview of the Annual Plan Structure

SECTION 1: OVERVIEW OF STRATEGIC PRIORITIES *(suggested three pages long)*
1.1 Strategic Intentions/Priorities **1.2 Message from the Chair and Chief Executive** **1.3 Signature Page**
SECTION 2: DELIVERING ON PRIORITIES *(suggested ten to twelve pages long)*
2.1 Government Planning Priorities
SECTION 3 : SERVICE CONFIGURATION *(suggested two pages long)*
3.1 Service Coverage **3.2 Service Change**
SECTION 4: STEWARDSHIP *(suggested two pages long)*
4.1 Managing our Business **4.2 Building Capability**
SECTION 5: PERFORMANCE MEASURES *(suggested four pages long)*
5.1 2017/18 Performance Measures
APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS including FINANCIAL PERFORMANCE *(for tabling as SPE)*
Statement of Performance Expectations (SPE) Output classes **Financial Performance**
APPENDIX B: SYSTEM LEVEL MEASURES IMPROVEMENT PLAN
Guidance TBC.

Further guidance for the 2017/18 Annual Plans (APs) is outlined in the Planning Priorities Guidance and in the mock streamlined plan that has been developed to assist DHBs.

For further information regarding the Annual Plan Guidelines please contact:
Stasha Mason
Service Commissioning
Ministry of Health
stasha_mason@moh.govt.nz
(04) 496 2265.

SECTION 1: OVERVIEW OF STRATEGIC PRIORITIES

This section should include a brief explanation of the DHB's strategic intentions/priorities, key messages from the Chair and Chief Executive and the signature page, and therefore should be kept short (it is suggested that this section should be no longer than three pages).

1.1 Strategic Intentions/Priorities

This must include a brief outline of the key strategic outcomes or objectives for the DHB to enable it to deliver on local, regional and national health needs, and include brief commitment statements to:

- the Treaty of Waitangi
- the New Zealand Health Strategy
- the Healthy Ageing Strategy
- the UN convention on the Rights of Persons with Disabilities
- Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018**.**

1.2 Message from the Chair and Chief Executive

1.3 Signature Page

SECTION 2: DELIVERING ON PRIORITIES

This section should include DHB commitments to each of the Government priorities outlined in the Minister's Letter of Expectations. Please note that it is suggested that this section should be no longer than ten to twelve pages.

DHBs need to engage with relevant stakeholders, including their primary care partners, when developing their 2017/18 APs.

2.1 Government Planning Priorities

Overarching Government priorities are presented in the Minister's Letter of Expectations, which will be sent to DHB Chairs in December 2016. The planning priorities for DHB 2017/18 APs are:

Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target
Supporting Vulnerable Children Better Public Service Target
Healthy Mums and Babies Better Public Service Target
Keeping Kids Healthy Better Public Service Target
Increased Immunisation Health Target
Shorter Stays in Emergency Departments Health Target
Improved Access to Elective Surgery Health Target
Faster Cancer Treatment Health Target
Better Help for Smokers to Quit Health Target
Raising Healthy Kids Health Target
Bowel Screening
Mental Health
Healthy Ageing
Living Well with Diabetes
Childhood Obesity Plan
Child Health
Disability Support Services
Primary Care Integration
Pharmacy Action Plan
Improving Quality
Living Within our Means.

In addition, DHBs should also identify any significant individual DHB actions to deliver on the Regional Service Plan priorities. These should be identified within the annual plan priority where the priorities overlap (such as 'Mental Health') or in the separate 'Delivery of Regional Service Plan' section of the planning priorities template within the Planning Priorities Guidance for those priorities that do not overlap.

The full detail of expectations within each priority is outlined in the Planning Priorities Guidance and inclusion of the templates within that guide are mandatory.

Detailed guidance on for the 2017/18 RSPs is available in the Regional Service Plan Guidelines.

2.2 Financial Performance Summary

This needs to include the consolidated statement of comprehensive income (previous year's actual, current year's forecast and three years plan), and the prospective summary of revenue and expenses by output class for the next three years.

2.3 Local and Regional Enablers

This component will outline the DHB specific actions to deliver on the following local and regional enablers:

Information Technology
Workforce.

More detail of expectations within each enabler is outlined in the Planning Priorities Guidance and inclusion of the templates within that guide are mandatory.

SECTION 3: SERVICE CONFIGURATION

Inclusion of the below service change template is mandatory within this section, if there are service changes to include. Please note that it is suggested that this section is no longer than two pages.

3.1 Service Coverage

In this section DHBs need to:

- describe all service coverage exceptions that have been approved for the 2017/18 year
- provide a high-level explanation setting out why the exceptions have been required and the process followed for approval.

**It is also suggested that DHBs include an express empowering provision for service agreements in the AP to avoid any doubt in relation to section 25(2) of the New Zealand Public Health and Disability Act 2000. DHBs are encouraged to seek independent legal advice on appropriate wording for this.*

3.2 Service Change

DHBs are to describe all service changes that have been approved for implementation in the 2017/18 year. For each change, DHBs must explain how the changes will deliver benefits (see the below example).

Service coverage exceptions and service changes must be formally approved before they are included in APs. As in previous years DHBs are expected to provide early signals of proposed service changes to the Ministry. These are required by Friday 3 February 2017.

The template (with example) below must be included within this section, if there are service changes to include. The template should include a summary of the proposed service change information provided to the Ministry on Friday 3 February 2017.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Renal Services	We will explore how the DHB might better meet the renal needs of its community with a specific focus on the southern part of the population.	Improved access, reduced cost, earlier intervention, improvement of long term outcomes.	Local

SECTION 4: STEWARDSHIP

This section will outline the DHB's stewardship of its assets, workforce, IT/IS and other infrastructure needed to deliver planned services. Please note that it is suggested that this section only be up to two pages.

4.1 Managing our Business

Reflect the scale and scope of the DHB's services and show the extent of resources required to provide these services. Consider briefly commenting on:

- organisational performance management
- funding and financial management (key high-level figures/assumptions)
- investment and asset management
- shared service arrangements and ownership interests
- risk management
- quality assurance and improvement.

4.2 Building Capability

Briefly outline the capabilities the DHB will need over the next three to five years and reference any sub-plans the DHB uses to support improvements in capability. Link to national or regional plans (including comment on the New Zealand Health Strategy) where relevant, and include high-level comments on:

- capital and infrastructure development
- information technology and communications systems
- workforce (including organisational culture, leadership and workforce development)
- co-operative developments (working with other organisations eg, education and training providers).

SECTION 5: PERFORMANCE MEASURES

Please note that it is suggested that this section is no longer than four pages.

5.1 2017/18 Performance Measures

Inclusion of a summary of the performance measures and performance expectations is required in this section. The below performance measures template is not mandatory but is an example of what could be included. Note: the full detail of the monitoring framework for 2017/18 forms a separate component part of the planning package.

Include the full set of performance measures in the template and ensure accuracy across any other use of this information in other parts of the document (eg, Health Target figures shown here match those used in Section 2 and Appendix A) and other plans.

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- achieving Government's priority goals/objectives and targets or 'Policy priorities'
- meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- providing quality services efficiently or 'Ownership'
- purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

Each performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
HS	Health Strategy
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – Establishment of baseline (no target/performance expectation is set)

Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.

Performance measure	Performance expectation	
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes.	
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	
	Age 20-64	
	Age 65+	
PP7: Improving mental health services using wellness and transition (discharge) planning		95% of clients discharged will have a quality transition or wellness plan.
		95% of audited files meet accepted good practice.
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds		80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.
PP10: Oral Health- Mean DMFT score at Year 8	Year 1	
	Year 2	
PP11: Children caries-free at five years of age	Year 1	
	Year 2	
PP12: Utilisation of DHB-funded dental services by	Year 1	

adolescents (School Year 9 up to and including age 17 years)	Year 2	
PP13: Improving the number of children enrolled in DHB funded dental services	Year 1	
	Year 2	
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)		
Focus Area 1: Long term conditions	Report on activities in the Annual Plan.	
Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.	
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).	
Focus Area 3: Cardiovascular health	90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.	
	Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years.	
Focus Area 4: Acute heart service	70% of high-risk patients receive an angiogram within 3 days of admission.	
	Over 95% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	
	Over 95% of patients undergoing cardiac surgery at the regional cardiac centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge.	
Focus Area 5: Stroke services	8% or more of potentially eligible stroke patients thrombolysed 24/7.	
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	
PP21: Immunisation coverage	95% of two year olds fully immunised	
	95% of four year olds fully immunised	
	75% of girls fully immunised – HPV vaccine	
	75% of 65+ year olds immunised – flu vaccine	
PP22: Delivery of actions to improve system integration including SLMs		Report on activities in the Annual Plan.
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan.	
	Percentage of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.	95%
PP25: Prime Minister's youth mental health project	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.	
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).	
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.	
PP27: Supporting Vulnerable Children		Report on activities in the Annual Plan.
PP28: Reducing Rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever	
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	
	95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	
	90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within	

	two weeks (14 calendar days, inclusive), 100% within 30 days.	
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.	
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.	
PP30: Faster cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	
PP32:Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).	
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.	
PP34: Improving the percentage of households who are smoke free at six weeks postnatal		
PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
PP37: Improving breastfeeding rates	60% of infants are exclusively or fully breastfed at three months.	
PP38:Delivery of response actions agreed in annual plan	Report on activities in the Annual Plan.	
SI1: Ambulatory sensitive hospitalisations	0-4	See System Level Measure Improvement Plan included as Appendix B.
	45-64	
SI2: Delivery of Regional Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population.	
	Cataract procedures - a target intervention rate of 27 per 10,000 of population.	
	Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population.	
	Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population.	
	Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.	
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.	
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI10: Improving cervical screening coverage	80% coverage for all ethnic groups and overall.	
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall.	
OS3: Inpatient Average Length of Stay (LOS)	Elective LOS suggested target is 1.47 days, which represents the 75th centile of national performance.	
	Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.	
OS8: Reducing Acute Readmissions to Hospital	TBA – indicator definition currently under review.	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	Group A >2% and <= 4% Group B >1% and <=3% Group C >1.5% and <= 6%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% and <= 2%
	Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and <= 2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and <= 85%

	Invalid NHI data updates	TBA
Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	>= 97% and <99.5%
	National Collections File load Success	>= 98% and <99.5%
	Assessment of data reported to NMDS	>= 75%
	Timeliness of NNPAC data	>= 95% and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified about data quality audits.	
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	
DV4: Improving patient experience		No performance expectation/target set.
DV6: SLM youth access to and utilisation of youth appropriate health services		No performance expectation/target set.
DV7: SLM number of babies who live in a smoke-free household at six weeks post natal		No performance expectation/target set.

APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS including FINANCIAL PERFORMANCE (for tabling as SPE)

This section must be tabled in Parliament. All components of this section are mandatory (section 149C of the Crown Entities Act 2004[1]) and relate to a reporting timeframe of five years minimum (prior year audited actual, current year forecast and three years' plan) (section 149G(2)(b) of the CE Act).

Statement of Performance Expectations (SPE)
(section 149B-G of the CE Act)

To ensure that the SPE meaningfully supports the key strategic outcomes and priorities of the DHB's planned activities (as outlined in the previous Sections) and performance, clear intervention logic is expected to explain the link between the selected outputs and how they will contribute to impacts, and outcomes. **Refer to definitions provided in the glossary under Additional Information to ensure consistency of terms.*

The SPE is to provide specific measures/targets for the coming year, with comparative prior year and current year forecast (at a minimum). The Ministry encourages DHBs to provide both historic and future trends in their SPEs so far as it is meaningful and practical to do so.

Output classes
(section 149E of the CE Act)

Four Output Classes are to be used by all DHBs to reflect the nature of services provided. There is a close correlation between these descriptions and the logic applied when mapping Purchase Unit Codes (PUCs) to each output class. **Refer to the output class definitions included under Additional Information.* The Output Class categories are:

- Prevention
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support.

DHBs must describe services they plan, fund, provide, and promote within each Output Class. Include at least total expected revenue and proposed expenses for each Output Class that in total agree to your financial statements (section 149E of the CE Act).

Financial Performance
(section 149B-G of the CE Act)

Please note that financial templates submitted to the Ministry in support of financial statements must be completed in accordance with the 'Requirement and Guidelines for using Financial Templates', which are issued to DHBs in conjunction with the blank templates. **Refer to the checklist for financial templates included under Additional Information.*

Each SPE must, in relation to a Crown entity and a financial year, contain forecast financial statements that comply with section 149G of the CE Act (section 149E(1)(d) of the CE Act), be prepared in accordance with generally accepted accounting practice, and for each reportable class of outputs identify the expected revenue and proposed expenses (section 149(E)(2)(b) of the CE Act). The forecast financial statements must include:

- a statement of all significant assumptions underlying the forecast financial statements (section 149G(2)(a) of the CE Act)

[1] Henceforth, 'CE Act' will be used when referring to the Crown Entities Act 2004.

- any additional information and explanations to fairly reflect the forecast financial operations and financial position of the DHB (section 149G(2)(b) of the CE Act).

APPENDIX B: SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

Please see the System Level Measures Annual Plan Guidance for 2017/18.

Additional Information

(NOT to be included in final plans – for reference in developing documents only)

Glossary of Terms

Term	Meaning
Activity	What an agency does to convert inputs to Outputs.
Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government's goals.
Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister. One of the three types of statutory entities (the other two are autonomous Crown entities and independent Crown entities).
Crown entity	A generic term for a diverse range of entities within one of the five categories referred to in section 7 of the CE Act, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions.
Crown entity subsidiary	Companies incorporated under the Companies Act 1993 that are controlled by Crown entities, and that are: (a) a subsidiary of another Crown entity under sections 5–8 of the Companies Act; or (b) a multi-parent subsidiary of two or more Crown entities (section 7(1)(c) of the CE Act).
Cost containment	Reducing costs or cost growth in general, whether through improved efficiency, or other means, such as contract negotiation/consolidation, changes to budget management, changes in structure etc.
Efficiency	Reducing the cost of inputs relative to the value of outputs.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an outcome, and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Financial Statements	AP financial statements are forecast financial statements required to cover five years: prior year audited actual, current year forecast and three years' plan.
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. For example, the change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations.
Impact measures	Impact measures are attributed to agency (DHB) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can often be measured soon after delivery, promoting timely decisions; and may reveal specific ways in which managers can remedy performance shortfalls (refer to State Services Commission *Performance Measurement – Advice and examples on how to develop effective frameworks* page 13).
Input	The resources such as labour, materials, money, people, and information technology used by departments to produce outputs, that will achieve the Government's stated outcomes.
Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes (refer to State Services Commission *Performance Measurement – Advice and examples on how to develop effective frameworks*).
Intermediate outcome	See Outcome

'Living within our means'	Providing the expected level of outputs within a break-even budget or Ministry agreed deficit step toward break even by a specific time.
Management systems	The supporting systems and policies used by the DHB in conducting its business.
Multi-parent subsidiary	A company (incorporated under the Act) is a **multi-parent subsidiary** if, under sections 5 to 8 of the Companies Act,— • (a) the company is not a subsidiary of any one Crown entity; but • (b) if two or more Crown entities were treated as one entity (a **combined entity**), with their rights, entitlements, and interests in relation to the company taken together, the company would be a subsidiary of the combined entity (section 7(1 & 2) of the CE Act).
Measure	A measure identifies the focus for measurement: it specifies what is to be measured.
Objectives	The use of this term recognises that not all outputs and activities are intended to achieve 'outputs'. For example, increasing the take-up of programmes, improving the retention of key staff, improving performance, improving Governance, etc. are 'internal to the organisation and enable the achievement of outputs'.
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome, or several outputs may contribute to a single end outcome.
Output agreement	Output agreement/output plan - See Purchase Agreement. An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs. A responsible Minister may set standards, terms, and conditions in respect of certain classes of outputs (section 170 of the CE Act).
Output classes	An aggregation of outputs, or groups of similar outputs. Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures.
Outputs	Final goods and services, that is, they are supplied to someone outside a Crown entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (section 136(1)(a–c) of the CE Act).
Ownership	The Crown's core interests as 'owner' can be thought of as: **Strategy** – the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown. **Capability** – the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future. **Performance** – the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively.
Performance measures	Selected measures must align with the DHB's RSP and AP. Four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2017/18) and show intended results for the three subsequent financial years.
Priorities	Statements of medium-term policy priorities.

Productivity	Increasing outputs relative to inputs (eg, either more outputs produced with the same inputs, or the same output produced using fewer inputs).
Purchase agreement	A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs.
Regional integration	Regional integration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist. • Northern: Northland, Auckland, Waitemata and Counties Manukau DHBs • Midland: Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato DHBs • Central: Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui DHBs • Southern: Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs. A region for some clinical networks may vary slightly to the four regional groupings described above. For example, Central Cancer Network contains seven DHBs, with Taranaki DHB in addition to the Central Region DHBs.
Results	Sometimes used as a synonym for 'Outcomes', sometimes to denote the degree to which an organisation successfully delivers its outputs, and sometimes with both meanings at once.
Standards of Service Measures	Measures of the quality of service to clients that focus on aspects such as client satisfaction with the way they are treated, comparison of current standards of service with past standards, and appropriateness of the standard of service to client needs.
Statement of Performance Expectations (SPE)	Government departments and Crown entities are required to include audited statements of objectives and statements of performance expectations with their financial statements. These statements report whether the organisation has met its service objectives for the year.
Strategy	See Ownership.
Sub-regional collaboration	Sub-regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping, typically in groupings of two or three DHBs and may be formalised with an agreement (eg, a Memorandum of Understanding). Examples of sub-regional collaboration include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (CentralAlliance), Capital & Coast, Hutt Valley and Wairarapa DHBs (3 DHBs) and Canterbury and West Coast DHBs.
Targets	Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost-effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.
Values	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values, which, in turn, tend to be drawn from social norms, democratic principles and professional ethos.
Value for money	The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

Financial Checklist for 2017/18 Financial Statements (and supporting templates)

1. Financial Statements		
Requirements		**Interpretation**
1	Does the AP contain a complete set of consolidated financial statements that comply with applicable legislation, generally accepted accounting principles (GAAP) and Crown accounting policies?	AP financial statements prepared under GAAP are forecast financial statements required to cover five years: prior year audited actual, current year forecast and three years' plan. As a minimum, AP financial statements must include: • a full set of consolidated financial statements including: - financial performance showing 1 revenue as Ministry of Health Sourced, Other Government sourced, and other, and Inter-DHB and Internal Revenue 2 expenses as the major services of Personal, Mental, Disability Support, Public and Māori plus Personnel costs, Outsourced services costs, Clinical supplies costs, and Infrastructure, Non Clinical supplies and Other costs - financial position showing Current and Non-current Assets, Current and Non-current Liabilities and Equity - cash flows detailing Cash in and Cash out for Operating, Investing and Financing Activities - movements in equity showing Opening Balance, Net results, Revaluation of Fixed Assets, Equity Injections/ Repayments, and Other (section 149G(1) of the CE Act) • Summary **statements of financial performance for each arm** (Provider, Funder and Governance) showing 1 revenue from Ministry of Health, other Government, Non-Government and Other, and Inter-DHB and Internal Revenue 2 Provider arm expenses – split by Personnel, Outsourced services, Clinical supplies, and Infrastructure and Non Clinical supplies and Other 3 Funder arm expenses – split by major service areas, eg, Personal, Mental, Disability support, Māori, Public and Other 4 Governance arm expenses split by Personnel, Outsourced services, Clinical Supplies, and Infrastructure and Non Clinical supplies and Other.
2	Does the AP explain the nature, reasons for, and effects on the AP financial statements of any significant change in accounting policies?	Statement of accounting policies (section 149G(1) of the CE Act). Accounting policies applied in the AP financial statements should be consistent with prior years unless a change of policy has been noted.
3	Does the AP contain a statement of all significant assumptions underlying the financial statements?	The AP must include a statement of all significant assumptions underlying the financial statements (section 149G(2) of the CE Act).
4	Do the financial statements align with the text of the document?	The financial statements and any related narrative information should be consistent with any general or narrative information presented with them.
5	Has the DHB supplied complete AP financial templates that agree to the AP financial statements?	AP templates for 2017/18 are: 1. AP Financial Template 2. Mental Health Financial Plan Template 3. Revenue Reconciliation 4. Production Plan Financial information in the Mental Health financial plan template, revenue reconciliation and Production Plan must agree back to the AP Financial Template.
6	Does the DHB include mention of any subsidiaries in which it has an interest?	If a DHB subsidiary is a single-parent subsidiary, then it is not required to produce a separate SOI/SPE if it is covered in the parent DHB's SOI/SPE (section 156A(1) of the CE Act). If a DHB's subsidiary is a multi-parent subsidiary, then it is not required to prepare a SOI/SPE (section 157A(2) of

		the CE Act). A multi-parent subsidiary may, however, be directed to prepare an SOI/SPE by the Minister of Finance (section 157A(3) of the CE Act). These may include the condition that the SOI of one of the parents must cover the multi-parent subsidiary.
2. Planned Net Results		
Requirements		**Assumptions**
1	Are the DHB's planned net results acceptable?	• The Ministry will assess this section against the following criteria: - Do the planned net results meet the Minister of Health's expectations for the four plan years of the AP?[2] - If there is a planned deficit caused by Mental Health deficits, is there a genuine DHB surplus available to carry forward to cover the deficit? - If there is a planned deficit (other than for Mental Health), is there a genuine DHB surplus available to carry forward to cover the deficit? - If the DHB plans consolidated deficit(s), is there appropriate approval to submit an AP including deficit(s)? - Does the AP include sound realistic and quantifiable action plans or efficiency projects to address planned deficits or to ensure breakeven is achieved?[3] - Significant savings anticipated from action plans of efficiency projects should be explained and justified in the AP, or in a confidential document sent separately to the Ministry.
2	Are the DHB's planned productivity improvement initiatives appropriate and achievable?	
3. Revenue Assumptions		
Requirements		**Assumptions**
1	Does total devolved revenue (including Inter-District Flows) agree with the latest Funding Envelope? If not, are variances appropriate and explained?	All devolved revenue received from the Ministry that is disclosed in the AP will be confirmed against what has been advised in the latest Funding Envelope. Variances from the latest Funding Envelope should be explained in the Revenue Reconciliation[4].
2	Does revenue for non-devolved service contracts materially agree with what has been advised by the Ministry?	All non-devolved revenue sourced from the Ministry will be confirmed directly with the responsible Ministry directorates.
3	Out-year revenue assumptions consistent with Ministry advice?	Indicative out-year revenue increases are advised in the latest Funding Envelope.
4. Cost and Volume Assumptions		
Requirements		**Interpretation**
1	Are the assumptions for personnel costs, outsourced services costs and Full Time Equivalent (FTE) movements appropriate and adequately explained?	Assessment of whether cost assumptions are 'appropriate' and 'adequately explained' will be based on whether cost changes are consistent with: 1. financial information disclosed in the AP and AP financial templates 2. estimated revenue growth advised in the latest Funding Envelope 3. the percentage ranges estimated in CPI and salary indices 4. changes in volumes, practices, service delivery, etc 5. Production Plan aligned with FTEs, Expenditure and Productivity, and supported by historical trends and performance. Significant variation from the latest Funding Envelope or indices should be explained and justified in the AP, or in a confidential document sent
2	Are planned interest, depreciation, capital charge costs and assumptions appropriate and adequately explained?	
3	Are all other cost assumptions (eg, clinical supplies costs) appropriate and adequately explained?	

[2] The Minister's expectations for net results will either be expressly stated in correspondence to the DHB or be the approved net results in the previous year's AP for the second and third plan years.
[3] Sound action plans and efficiency projects means plans and projects that have quantifiable savings or cost reductions, are time-bound and can be realistically achieved.
[4] Funding Envelope' refers to the most recent Funding Envelope advice letter for 2017/18.

4	Is the productivity gain and associated risk inherent in the plan clearly explained?	separately to the Ministry. Expenditure planned for out years should reflect a realistic assessment of requirements to support the projected revenue stream in those years. It should not be derived simply by applying the same preliminary increase as for revenues to each expenditure line.
5. Fixed Assets		
Requirements		**Interpretation**
1	Does the AP include a statement about: a) when assets were last revalued b) in what year the next revaluation will take place as required by relevant accounting standards.	No interpretation required.
2	Does the AP include (if known) the asset impacts and additional costs resulting from re-evaluation?	No interpretation required.
3	Does the DHB note its strategy for actively disposing of assets that are surplus to requirements?	No interpretation required.
4	Does the AP include a statement about procedure for disposing of any land transferred to, or vested in the DHB under the Health Sector (Transfers) Act 1993?	Section 42(2) of the New Zealand Public Health and Disability Act requires the inclusion of a statement about a DHB's procedure for disposing of land transferred to or vested to it under the Health Sector (Transfers) Act, irrespective of whether land disposals are planned.
6. Capital Expenditure		
Requirements		**Interpretation**
1	Is the capital expenditure section of the AP consistent with the DHB's Long Term Investment Plan, Capital Intentions and the relevant RSP?	No interpretation required.
2	Does the capital expenditure section of the AP narrative reflect major capital projects, clearly distinguishing between approved and unapproved projects and whether they are baseline or strategic?	An 'approved' capital project means that the DHB has a letter from the Minister of Health approving that capital project.
3	Are sources of planned capital financing for both baseline and strategic capital expenditure clearly identified?	Sources of planned financing may include: 1. DHB contribution 2. New Crown debt (approved/unapproved) 3. Crown equity (approved/unapproved) 4. Finance leases 5. Community donations/funding.
4	Is capital expenditure and financing correctly reflected in all sections of the AP financial template including the cash flow statement?	The AP financial template should reflect only approved capital expenditure (even if included in baseline capital expenditure) and financing. The only exception is for the capital plan worksheet, which should also include unapproved capital projects and anticipated sources of funding.
7. Debt and Equity		
Requirement		**Interpretation**
1	Does the AP include a schedule of key lenders, borrowing arrangements (including rates and limits) that distinguish between new and existing borrowing facilities?	The schedule of key lenders should cover working capital, short-term and long-term borrowing and finance leases.

2	Does the AP show the related banking covenants, and is the DHB planning to meet them?	No interpretation required.

Output Class Recommendations

Output Class Definitions

It is expected that all DHBs will use the following output class definitions:

Prevention

- Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.
- Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing.
- Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services.
- On a continuum of care these services are public wide preventative services.

Early Detection and Management

- Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.
- These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.
- On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Intensive Assessment and Treatment Services

- Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together.
- They include:
    - Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
    - Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
    - Emergency Department services including triage, diagnostic, therapeutic and disposition services
- On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Rehabilitation and Support

- Rehabilitation and support services are delivered following a 'needs assessment' process and co-ordination input by NASC Services for a range of services including palliative care, home-based support and residential care services.
- On a continuum of care these services will provide support for individuals

Recommended outputs that may be useful for describing bundles of services within each output class are included in the following table.

PREVENTION
Health Promotion and Education Statutory Regulation Population Based Screening Immunisation Well Child Services
EARLY DETECTION & MANAGEMENT
Primary Health Care Oral Health Primary Community Care Programmes Pharmacist Community Referred Testing & Diagnostics Mental Health
INTENSIVE ASSESSMENT & TREATMENT
Mental Health Elective (Inpatient/Outpatient) Acute (Emergency Department/Inpatient/Outpatient) Maternity Assessment Treatment & Rehabilitation
REHABILITATION & SUPPORT
Needs Assessment & Service Co-ordination Palliative Care Rehabilitation Age Related Residential Care Beds Home Based Support Life Long Disability Respite Care Day Services

2017/18
Planning Priorities for Annual Plans

This document contains detailed guidance on the expectations for each planning priority. The Planning Priorities are provided to assist district health board (DHB) staff to meet Ministerial expectations for DHB 2017/18 Annual Plans.

Amendments to the Planning Priorities for Annual Plans (*note that minor editorial amendments have not been recorded in the following table*)

Page	Description
4 and multiple	- An explanation of the changes made to measure *PP38 Delivery of response actions agreed in annual plan* is included. These relate to separating the measure into two sections. Where PP38 is identified as a measure against a planning priority this has been updated to reflect whether it is captured under section 1 or section 2 of the measure.
Multiple	- Healthy Mums and Babies and Keeping Kids Healthy Better Public Service Targets have been included as government planning priorities in line with the updates to the Better Public Service Result Areas announced on 3 May 2017. PLEASE NOTE: at least one of the activities you identify to support each of these targets must be an equity activity.
Multiple	- The Reducing Rheumatic Fever Better Public Service Target has been removed as a government planning priority, but will continue as a DHB performance measure. DHBs may wish to continue to identify Reducing Rheumatic Fever as a local planning priority within their plans.
Multiple	- Increased Immunisation remains as a planning priority following the announcements of Better Public Service changes, but is now identified solely as a Health Target.
Multiple	- The Childhood Obesity Plan guidance has been updated to ask for additional information for all DHBs.
Multiple	- SI5: Delivery of Whānau Ora has been added as a measure linkage to the Raising Healthy Kids guidance.
7, 105, 119, and 126	- SI5: Delivery of Whānau Ora has been added as a measure linkage to those DHBs that had mental health guidance relating to reducing the rate of Māori under community treatment orders (Auckland, Taranaki, Wairarapa and Waitemata DHBs).

Table of Contents

Overview of the Planning Priorities *3*
Health Equity in DHB Annual Plans 3
Responding to the Guidance 4
2017/18 Planning Priorities for APs *5*
Planning Priorities Guidance for Auckland DHB 5
Enablers Guidance for Auckland DHB 11
Planning Priorities Guidance for Bay of Plenty DHB 12
Enablers Guidance for Bay of Plenty DHB 18
Planning Priorities Guidance for Canterbury DHB 19
Enablers Guidance for Canterbury DHB 25
Planning Priorities Guidance for Capital & Coast DHB 26
Enablers Guidance for Capital & Coast DHB 32
Planning Priorities Guidance for Counties Manukau DHB 33
Enablers Guidance for Counties Manukau DHB 39
Planning Priorities Guidance for Hawke's Bay DHB 40
Enablers Guidance for Hawke's Bay DHB 46
Planning Priorities Guidance for Hutt Valley DHB 47
Enablers Guidance for Hutt Valley DHB 53
Planning Priorities Guidance for Lakes DHB 54
Enablers Guidance for Lakes DHB 60
Planning Priorities Guidance for MidCentral DHB 61
Enablers Guidance for MidCentral DHB 67
Planning Priorities Guidance for Nelson Marlborough DHB 68
Enablers Guidance for Nelson Marlborough DHB 74
Planning Priorities Guidance for Northland DHB 75
Enablers Guidance for Northland DHB 81
Planning Priorities Guidance for South Canterbury DHB 82
Enablers Guidance for South Canterbury DHB 88
Planning Priorities Guidance for Southern DHB 89
Enablers Guidance for Southern DHB 95
Planning Priorities Guidance for Tairawhiti DHB 96
Enablers Guidance for Tairawhiti DHB 102
Planning Priorities Guidance for Taranaki DHB 103
Enablers Guidance for Taranaki DHB 109
Planning Priorities Guidance for Waikato DHB 110
Enablers Guidance for Waikato DHB 115
Planning Priorities Guidance for Wairarapa DHB 116
Enablers Guidance for Wairarapa DHB 122
Planning Priorities Guidance for Waitemata DHB 123
Enablers Guidance for Waitemata DHB 129
Planning Priorities Guidance for West Coast DHB 130
Enablers Guidance for West Coast DHB 136
Planning Priorities Guidance for Whanganui DHB 137
Enablers Guidance for Whanganui DHB 143

Overview of the Planning Priorities

Overarching Government priorities are presented in the Minister's Letter of Expectations, which was sent to DHB Chairs in December 2016. The planning priorities for DHB 2017/18 annual plans (APs) are:

Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target
Supporting Vulnerable Children Better Public Service Target
Healthy Mums and Babies Better Public Service Target
Keeping Kids Healthy Better Public Service Target
~~Reducing Rheumatic Fever Better Public Service Target~~
Increased Immunisation ~~Better Public Service and~~ Health Target
Shorter Stays in Emergency Departments Health Target
Improved Access to Elective Surgery Health Target
Faster Cancer Treatment Health Target
Better Help for Smokers to Quit Health Target
Raising Healthy Kids Health Target
Bowel Screening
Mental Health
Healthy Ageing
Living Well with Diabetes
Childhood Obesity Plan
Child Health
Disability Support Services
Primary Care Integration
Pharmacy Action Plan
Improving Quality
Living Within our Means.

In addition, DHBs should also identify any significant individual DHB actions to deliver on the Regional Service Plan (RSP) priorities. These should be identified within the annual plan priority where the priorities overlap (such as 'Mental Health') or in the separate 'Delivery of Regional Service Plan' section of the planning priorities template for those priorities that do not overlap. More detail of expectations within each priority area and enabler is outlined in the templates below and structural guidance and guidelines for the 2017/18 Annual Plans is outlined in the Annual Plan Guidelines. Detailed guidance on for the 2017/18 RSPs is available in the Regional Service Plan Guidelines.

DHBs are also expected to outline DHB specific actions to deliver on the following local and regional enablers:

Information Technology
Workforce.

For further information regarding the Planning Priorities Guidance please contact:
Stasha Mason
Service Commissioning
Ministry of Health
stasha_mason@moh.govt.nz
(04) 496 2265.

Health Equity in DHB Annual Plans

Please note that the 2017/18 Regional Service Plan Guidelines include the Health Equity expectations for RSPs.

DHBs are expected to consider and include actions in their APs that will help them to achieve health equity for all of their populations, including Māori. Specific actions to achieve health equity will vary by DHB and by area of

health focus. This may include condition specific activity, but should also include actions to resolve inequities of access to and utilisation of health services more generally. Effective, patient-centred, universal services, as well as tailored or targeted interventions, will be required to achieve health equity.

DHBs should consider the characteristics of the current and future population of the district, including demography, socioeconomic determinants, health status and demand for health services within their district, when identifying areas of focus for health equity. To support this outcome ensure you consider appropriate equity activities for Māori where appropriate.

Equity actions need to be clearly identified within the AP. Therefore, please include the code "EOA" for "equitable outcomes action" immediately following any action that is specifically designed to help reduce health equity gaps. It is expected that there will be an equity focus for every priority area.

Responding to the Guidance

At the request of the Minister the 2017/18 DHB APs will be streamlined and focussed on the key activities that reflect the specific planning priorities the Minister has identified for individual DHBs for delivery in the 2017/18 year. DHBs will have the opportunity to reflect more of their local strategic content in their Regional Service Plans, SOIs and SPEs. DHBs need to engage with relevant stakeholders, including their primary care partners, when developing their 2017/18 APs.

The AP guidance has been developed to support DHBs to deliver streamlined APs (no longer than 30 pages) that emphasise equity, respond to the Minister's expectations and align to the New Zealand Health Strategy. To support DHBs to deliver 30 page APs, a consistent approach to the presentation of information within the plans needs to be taken. Therefore, the templates included within this document must be used within the AP to reflect DHB responses to the Minister's expectations. The templates also include alignment information between the Minister's expectations and the Health Strategy themes.

DHBs need to clearly identify the key activities they are undertaking in each priority area. A mock streamlined plan has been developed to assist DHBs, which includes an example of the type of response (and maximum length of response) expected by DHBs for any priority area where DHBs are asked to identify activities.

PLEASE NOTE that PP38: *Delivery of response actions agreed in annual plan*, is designed to capture progress against planned activity, where the response actions identified within the plan are not captured by existing performance measures. This measure has been updated to include a section 1 and section 2. Those planning priorities captured under section 1 of the measure (BPS related activity not already captured through an existing performance measure) will require quarterly progress reports (where activity has been identified for the quarter) and those planning priorities captured under section 2 of the measure will require six-monthly progress reports.

2017/18 Planning Priorities for APs

Planning Priorities Guidance for Auckland DHB

Government Planning Priority	Focus Expected for Auckland DHB	Link to NZ Health Strategy	Auckland DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)

Government Planning Priority	Focus Expected for Auckland DHB	Link to NZ	Auckland DHB Key Response Actions to Deliver Improved Performance		Measures
~~Reducing Rheumatic Fever BPS Target~~	~~Reduce rheumatic fever rates among Pacific communities.~~	~~People powered~~			~~PP28: Reducing Rheumatic Fever~~
Increased Immunisation ~~BPS and~~ Health Target	Partner with communities, NGOs and other agencies to deliver immunisation services *when* and *where* best meets local needs, in particular those of Māori, Pacific and high-deprivation populations.	People powered			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Identify the quality improvement activities you will undertake in 2017/18 in response to your 2016/17 ED Quality Framework results.	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals

Government Planning Priority	Focus Expected for Auckland DHB	Link to NZ	Auckland DHB Key Response Actions to Deliver Improved Performance		Measures
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	People powered			PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities. SI5: Delivery of Whānau Ora
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Auckland DHB	Link to NZ	Auckland DHB Key Response Actions to Deliver Improved Performance		Measures
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~ Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these.	Closer to home			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Auckland DHB	Link to NZ	Auckland DHB Key Response Actions to Deliver Improved Performance		Measures
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Auckland DHB	Link to NZ	Auckland DHB Key Response Actions to Deliver Improved Performance		Measures
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	**Value and high performance**			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Auckland DHB

Local and Regional Enabler	Focus Expected for Auckland DHB	Link to NZ Health Strategy	Auckland DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. Continue the rollout EMRAM Stage 3 & 4 capabilities throughout the hospital. Replacement of the legacy PAS.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Bay of Plenty DHB

Government Planning Priority	Focus Expected for Bay of Plenty DHB	Link to NZ Health Strategy	Bay of Plenty DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)

Government Planning Priority	Focus Expected for Bay of Plenty DHB	Link to NZ	Bay of Plenty DHB Key Response Actions to Deliver Improved Performance		Measures
~~Reducing Rheumatic Fever BPS Target~~	~~Sustain reduction in rheumatic fever through the delivery of the rheumatic fever prevention plan.~~	~~Value and high performance~~			~~PP28: Reducing Rheumatic Fever~~
Increased Immunisation ~~BPS and~~ Health Target	Provide robust governance to ensure that the DHB, PHOs and practices work as one team to increase immunisation coverage rates to target levels and improve outcomes for children not enrolled with a PHO.	One team			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals

Government Planning Priority	Focus Expected for Bay of Plenty DHB	Link to NZ	Bay of Plenty DHB Key Response Actions to Deliver Improved Performance		Measures
Raising Healthy Kids Health Target	Identify what actions you will take to ensure that the clinical referral pathway and processes established in 2016/17 achieves the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan (section 2)
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to	Closer to home			PP23: Improving Wrap Around Services – Health of Older People

Government Planning Priority	Focus Expected for Bay of Plenty DHB	Link to NZ	Bay of Plenty DHB Key Response Actions to Deliver Improved Performance		Measures
	develop future models of care.				
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	**Closer to home**			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Bay of Plenty DHB	Link to NZ	Bay of Plenty DHB Key Response Actions to Deliver Improved Performance		Measures
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Bay of Plenty DHB	Link to NZ	Bay of Plenty DHB Key Response Actions to Deliver Improved Performance		Measures
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	**Value and high performance**			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Bay of Plenty DHB

Local and Regional Enabler	Focus Expected for Bay of Plenty DHB	Link to NZ Health Strategy	Bay of Plenty DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when Order Entry, ePA, Nursing Documentation and CPOE will be implemented (not all expected in 2017/18). Complete regional Clinical Portal	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Canterbury DHB

Government Planning Priority	Focus Expected for Canterbury DHB	Link to NZ Health Strategy	Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Canterbury DHB	Link to NZ	Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Identify the quality improvement activities you will undertake in 2017/18 in response to your 2016/17 ED Quality Framework results.	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Provide an integrated approach to delivery of ABC between primary care services.	One team			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the	and high perf orm			PP29: Improving waiting times for

Government Planning Priority	Focus Expected for Canterbury DHB	Link to NZ	Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
	national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing child and youth waiting times.	One team			PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Canterbury DHB	Link to NZ	Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Canterbury DHB	Link to NZ	Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Canterbury DHB	Link to NZ	Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Canterbury DHB

Local and Regional Enabler	Focus Expected for Canterbury DHB	Link to NZ Health Strategy	Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. Continue the rollout EMRAM Stage 3 & 4 capabilities throughout the hospital. Deploy PICS to other Canterbury DHB sites.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Capital & Coast DHB

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Improve community awareness of rheumatic fever and sore throat management services.~~	~~Closer to home~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Provide an integrated approach to delivery of ABC between primary care services.	One team			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify what actions you will take to ensure that the clinical referral pathway and processes established in 2016/17 achieves the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including improving the rate of child and youth with transition plans.	One team			PP7: Improving mental health services using transition (discharge) planning
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	Closer to home			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	**Value and high performance**			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Capital & Coast DHB

Local and Regional Enabler	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when ePA, Nursing Documentation and CPOE will be implemented (not all expected in 2017/18). Complete ePharmacy and Nursing documentation implementations.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Counties Manukau DHB

Government Planning Priority	Focus Expected for Counties Manukau DHB	Link to NZ Health Strategy	Counties Manukau DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Implement a healthy homes initiative for eligible families at risk of rheumatic fever.~~	~~Closer to home~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Counties Manukau DHB	Link to NZ	Counties Manukau DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Partner with communities, NGOs and other agencies to deliver immunisation services *when* and *where* best meets local needs, in particular those of Māori, Pacific and high-deprivation populations.	People powered			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Identify the quality improvement activities you will undertake in 2017/18 in response to your 2016/17 ED Quality Framework results.	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme,	and high perfo rman			PP29: Improving waiting times for diagnostic services – Colonoscopy

Government Planning Priority	Focus Expected for Counties Manukau DHB	Link to NZ	Counties Manukau DHB Key Response Actions to Deliver Improved Performance		Measures
	including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including improving the rate of child and youth with transition plans.	One team			PP7: Improving mental health services using transition (discharge) planning
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Counties Manukau DHB	Link to NZ	Counties Manukau DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Counties Manukau DHB	Link to NZ	Counties Manukau DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Counties Manukau DHB	Link to NZ	Counties Manukau DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Counties Manukau DHB

Local and Regional Enabler	Focus Expected for Counties Manukau DHB	Link to NZ Health Strategy	Counties Manukau DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. Continue the rollout EMRAM Stage 3 & 4 capabilities throughout the hospital. Complete activity of the Healthy Together technology platform.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Hawke's Bay DHB

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Sustain reduction in rheumatic fever through the delivery of the rheumatic fever prevention plan.~~	~~Value and high performance~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Strengthening the DHB smoking cessation plan with input from primary care and smoking cessation providers.	Value and high performance			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including improving the rate of child and youth with transition plans.	One team			PP7: Improving mental health services using transition (discharge) planning
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	Closer to home			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	NA.			NA.

Enablers Guidance for Hawke's Bay DHB

Local and Regional Enabler	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when CPOE will be implemented. Complete ePA and nursing documentation implementations.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Hutt Valley DHB

Government Planning Priority	Focus Expected for Hutt Valley DHB	Link to NZ Health Strategy	Hutt Valley DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)

Government Planning Priority	Focus Expected for Hutt Valley DHB	Link to NZ	Hutt Valley DHB Key Response Actions to Deliver Improved Performance		Measures
~~Reducing Rheumatic Fever BPS Target~~	~~Improve utilisation of sore throat management services.~~	~~Value and high performance~~			~~PP28: Reducing Rheumatic Fever~~
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals

Government Planning Priority	Focus Expected for Hutt Valley DHB	Link to NZ	Hutt Valley DHB Key Response Actions to Deliver Improved Performance		Measures
Raising Healthy Kids Health Target	Identify what actions you will take to ensure that the clinical referral pathway and processes established in 2016/17 achieves the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Implement requirements for Tranche 1 of the national bowel screening programme, incorporating quality, equity and timeliness expectations and IT integration activity, while ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing child and youth waiting times.	One team			PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Hutt Valley DHB	Link to NZ	Hutt Valley DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Hutt Valley DHB	Link to NZ	Hutt Valley DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Hutt Valley DHB	Link to NZ	Hutt Valley DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Hutt Valley DHB

Local and Regional Enabler	Focus Expected for Hutt Valley DHB	Link to NZ Health Strategy	Hutt Valley DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when ePA, Nursing Documentation and CPOE will be implemented (not all expected in 2017/18). Complete ePharmacy and Nursing documentation implementations.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Lakes DHB

Government Planning Priority	Focus Expected for Lakes DHB	Link to NZ Health Strategy	Lakes DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)

Government Planning Priority	Focus Expected for Lakes DHB	Link to NZ	Lakes DHB Key Response Actions to Deliver Improved Performance		Measures
~~Reducing Rheumatic Fever BPS Target~~	~~Sustain reduction in rheumatic fever through the delivery of the rheumatic fever prevention plan.~~	~~Value and high performance~~			~~PP28: Reducing Rheumatic Fever~~
Increased Immunisation ~~BPS and~~ Health Target	Partner with communities, NGOs and other agencies to deliver immunisation services *when* and *where* best meets local needs.	People powered			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Provide an integrated approach to delivery of ABC between primary care services.	One team			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals

Government Planning Priority	Focus Expected for Lakes DHB	Link to NZ	Lakes DHB Key Response Actions to Deliver Improved Performance		Measures
Raising Healthy Kids Health Target	Identify what actions you will take to ensure that the clinical referral pathway and processes established in 2016/17 achieves the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including improving the rate of child and youth with transition plans.	One team			PP7: Improving mental health services using transition (discharge) planning
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People

Government Planning Priority	Focus Expected for Lakes DHB	Link to NZ	Lakes DHB Key Response Actions to Deliver Improved Performance		Measures
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	Closer to home			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Lakes DHB	Link to NZ	Lakes DHB Key Response Actions to Deliver Improved Performance		Measures
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Lakes DHB	Link to NZ	Lakes DHB Key Response Actions to Deliver Improved Performance		Measures
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	**Value and high performance**			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Lakes DHB

Local and Regional Enabler	Focus Expected for Lakes DHB	Link to NZ Health Strategy	Lakes DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when ePA, and Nursing Documentation will be implemented (not all expected in 2017/18). Complete regional Clinical Portal.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for MidCentral DHB

Government Planning Priority	Focus Expected for MidCentral DHB	Link to NZ Health Strategy	MidCentral DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for MidCentral DHB	Link to NZ	MidCentral DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme,	and high perfo rman			PP29: Improving waiting times for diagnostic services – Colonoscopy

Government Planning Priority	Focus Expected for MidCentral DHB	Link to NZ	MidCentral DHB Key Response Actions to Deliver Improved Performance		Measures
	including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan (section 2)
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for MidCentral DHB	Link to NZ	MidCentral DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for MidCentral DHB	Link to NZ	MidCentral DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for MidCentral DHB	Link to NZ	MidCentral DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for MidCentral DHB

Local and Regional Enabler	Focus Expected for MidCentral DHB	Link to NZ Health Strategy	MidCentral DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when Order Entry, ePA, Nursing Documentation and CPOE will be implemented (not all expected in 2017/18). Complete ePharmacy Implementation.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Nelson Marlborough DHB

Government Planning Priority	Focus Expected for Nelson Marlborough DHB	Link to NZ Health Strategy	Nelson Marlborough DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Nelson Marlborough DHB	Link to NZ	Nelson Marlborough DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Implement the Revitalising the *National HPV Immunisation Programme* strategy to increase HPV immunisation rates to target levels by engaging communities and partnering between providers.	One team			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Identify the quality improvement activities you will undertake in 2017/18 in response to your 2016/17 ED Quality Framework results.	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Provide an integrated approach to delivery of ABC between primary care services.	One team			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the	and high perf orm			PP29: Improving waiting times for

Government Planning Priority	Focus Expected for Nelson Marlborough DHB	Link to NZ	Nelson Marlborough DHB Key Response Actions to Deliver Improved Performance		Measures
	national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan (section 2)
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Nelson Marlborough DHB	Link to NZ	Nelson Marlborough DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Nelson Marlborough DHB	Link to NZ	Nelson Marlborough DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Nelson Marlborough DHB	Link to NZ	Nelson Marlborough DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Nelson Marlborough DHB

Local and Regional Enabler	Focus Expected for Nelson Marlborough DHB	Link to NZ Health Strategy	Nelson Marlborough DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when Order Entry will be implemented. Start the implementation of ePA and eOrders as per the regional programme. Implementation of PICS.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Northland DHB

Government Planning Priority	Focus Expected for Northland DHB	Link to NZ Health Strategy	Northland DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Sustain reduction in rheumatic fever through the delivery of the rheumatic fever prevention plan.~~	~~Value and high performance~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Northland DHB	Link to NZ	Northland DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Take actions to increase immunisation rates at age 5 years to target levels, including partnering with early childhood centres, Well Child, B4 School Checks and other relevant agencies and child services.	Closer to home			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the	and high perf orm			PP29: Improving waiting times for

Government Planning Priority	Focus Expected for Northland DHB	Link to NZ	Northland DHB Key Response Actions to Deliver Improved Performance		Measures
	national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including improving the rate of child and youth with transition plans.	One team			PP7: Improving mental health services using transition (discharge) planning
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Northland DHB	Link to NZ	Northland DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Northland DHB	Link to NZ	Northland DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Northland DHB	Link to NZ	Northland DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Northland DHB

Local and Regional Enabler	Focus Expected for Northland DHB	Link to NZ Health Strategy	Northland DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. Leverage implementation of Order Entry & Nursing Documentation via healthAlliance. Start work on eOrders for Radiology and ePA rollout.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for South Canterbury DHB

Government Planning Priority	Focus Expected for South Canterbury DHB	Link to NZ Health Strategy	South Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for South Canterbury DHB	Link to NZ	South Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Implement the Revitalising the *National HPV Immunisation Programme* strategy to increase HPV immunisation rates to target levels by engaging communities and partnering between providers.	One team			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Identify the quality improvement activities you will undertake in 2017/18 in response to your 2016/17 ED Quality Framework results.	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Continue to support strategies that enable achievement of the health target.	Value and high performance			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora

Government Planning Priority	Focus Expected for South Canterbury DHB	Link to NZ	South Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan (section 2)
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People

Government Planning Priority	Focus Expected for South Canterbury DHB	Link to NZ	South Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	Closer to home			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for South Canterbury DHB	Link to NZ	South Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for South Canterbury DHB	Link to NZ	South Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	**Value and high performance**			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for South Canterbury DHB

Local and Regional Enabler	Focus Expected for South Canterbury DHB	Link to NZ Health Strategy	South Canterbury DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State plans when Order Entry and Nursing Documentation will be implemented. Start the implementation of eOrders as per the regional programme.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Southern DHB

Government Planning Priority	Focus Expected for Southern DHB	Link to NZ Health Strategy	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Southern DHB	Link to NZ	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme,	and high perfo rman			PP29: Improving waiting times for diagnostic services – Colonoscopy

Government Planning Priority	Focus Expected for Southern DHB	Link to NZ	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
	including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan (section 2)
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Southern DHB	Link to NZ	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Southern DHB	Link to NZ	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Southern DHB	Link to NZ	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Southern DHB

Local and Regional Enabler	Focus Expected for Southern DHB	Link to NZ Health Strategy	Southern DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. Continue the rollout EMRAM Stage 3 & 4 capabilities throughout the hospital. Investigate accelerating migration onto PICS.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Tairawhiti DHB

Government Planning Priority	Focus Expected for Tairawhiti DHB	Link to NZ Health Strategy	Tairawhiti DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Sustain reduction in rheumatic fever through the delivery of the rheumatic fever prevention plan.~~	~~Value and high performance~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Tairawhiti DHB	Link to NZ	Tairawhiti DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Strengthen relationships with other child health services, government agencies and NGOs to locate and follow-up children overdue for immunisation and improve outcomes for children not enrolled with a PHO.	One team			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Identify the quality improvement activities you will undertake in 2017/18 in response to your 2016/17 ED Quality Framework results.	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Continue to support strategies that enable achievement of the health target.	Value and high performance			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the	and high perf orm			PP29: Improving waiting times for

Government Planning Priority	Focus Expected for Tairawhiti DHB	Link to NZ	Tairawhiti DHB Key Response Actions to Deliver Improved Performance		Measures
	national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan (section 2)
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Tairawhiti DHB	Link to NZ	Tairawhiti DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Tairawhiti DHB	Link to NZ	Tairawhiti DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Tairawhiti DHB	Link to NZ	Tairawhiti DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Tairawhiti DHB

Local and Regional Enabler	Focus Expected for Tairawhiti DHB	Link to NZ Health Strategy	Tairawhiti DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State plans when ePA, and Nursing Documentation will be implemented (not all expected in 2017/18). Complete regional Clinical Portal.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Taranaki DHB

Government Planning Priority	Focus Expected for Taranaki DHB	Link to NZ Health Strategy	Taranaki DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Taranaki DHB	Link to NZ	Taranaki DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Strengthen relationships with other child health services, government agencies and NGOs to locate and follow-up children overdue for immunisation and improve outcomes for children not enrolled with a PHO.	One team			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Provide an integrated approach to delivery of ABC between primary care services.	One team			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the	and high perf orm			PP29: Improving waiting times for

Government Planning Priority	Focus Expected for Taranaki DHB	Link to NZ	Taranaki DHB Key Response Actions to Deliver Improved Performance		Measures
	national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	People powered			PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities. SI5: Delivery of Whānau Ora
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People

Government Planning Priority	Focus Expected for Taranaki DHB	Link to NZ	Taranaki DHB Key Response Actions to Deliver Improved Performance		Measures
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	Closer to home			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Taranaki DHB	Link to NZ	Taranaki DHB Key Response Actions to Deliver Improved Performance		Measures
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Taranaki DHB	Link to NZ	Taranaki DHB Key Response Actions to Deliver Improved Performance		Measures
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	NA.			NA.

Enablers Guidance for Taranaki DHB

Local and Regional Enabler	Focus Expected for Taranaki DHB	Link to NZ Health Strategy	Taranaki DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. Continue the rollout EMRAM Stage 3 & 4 capabilities throughout the hospital. Complete regional Clinical Portal.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Waikato DHB

Government Planning Priority	Focus Expected for Waikato DHB	Link to NZ Health Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Reducing Rheumatic Fever BPS Target	Sustain reduction in rheumatic fever through the delivery of the rheumatic fever prevention plan.	Value and high performance			PP28: Reducing Rheumatic Fever
Increased Immunisation BPS and Health Target	Provide robust governance to ensure that the DHB, PHOs and practices work as one team to increase immunisation coverage rates to target levels and improve outcomes for children not enrolled with a PHO.	One team			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target

Government Planning Priority	Focus Expected for Waikato DHB	Link to NZ	Waikato DHB Key Response Actions to Deliver Improved Performance		Measures
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify what actions you will take to ensure that the clinical referral pathway and processes established in 2016/17 achieves the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators

Government Planning Priority	Focus Expected for Waikato DHB	Link to NZ	Waikato DHB Key Response Actions to Deliver Improved Performance		Measures
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*~~.	Closer to home			PP38: Delivery of response actions agreed in annual plan

Government Planning Priority	Focus Expected for Waikato DHB	Link to NZ	Waikato DHB Key Response Actions to Deliver Improved Performance		Measures
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs

Government Planning Priority	Focus Expected for Waikato DHB	Link to NZ	Waikato DHB Key Response Actions to Deliver Improved Performance		Measures
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	NA.			NA.

Enablers Guidance for Waikato DHB

Local and Regional Enabler	Focus Expected for Waikato DHB	Link to NZ Health Strategy	Waikato DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when you plan to implement ePA, leveraging from other DHBs where possible. Complete regional Clinical Portal.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Wairarapa DHB

Government Planning Priority	Focus Expected for Wairarapa DHB	Link to NZ Health Strategy	Wairarapa DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Wairarapa DHB	Link to NZ	Wairarapa DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Provide an integrated approach to delivery of ABC between primary care services.	One team			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify what actions you will take to ensure that the clinical referral pathway and processes established in 2016/17 achieves the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Implement requirements for Tranche 1 of the national bowel screening programme,	e and high perf			PP29: Improving waiting times for

Government Planning Priority	Focus Expected for Wairarapa DHB	Link to NZ	Wairarapa DHB Key Response Actions to Deliver Improved Performance		Measures
	incorporating quality, equity and timeliness expectations and IT integration activity, while ensuring appropriate access across all endoscopy services.				diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	People powered			PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities. SI5: Delivery of Whānau Ora
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Wairarapa DHB	Link to NZ	Wairarapa DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Wairarapa DHB	Link to NZ	Wairarapa DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Wairarapa DHB	Link to NZ	Wairarapa DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Wairarapa DHB

Local and Regional Enabler	Focus Expected for Wairarapa DHB	Link to NZ Health Strategy	Wairarapa DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. Add to their plans when Order Entry, ePA and CPOE will be implemented (not all expected in 2017/18). Complete ePharmacy and Nursing documentation implementations.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Waitemata DHB

Government Planning Priority	Focus Expected for Waitemata DHB	Link to NZ Health Strategy	Waitemata DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Reduce rheumatic fever rates among Pacific communities.~~	~~People powered~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Waitemata DHB	Link to NZ	Waitemata DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Take actions to increase immunisation rates at age 5 years to target levels, including partnering with early childhood centres, Well Child, B4 School Checks and other relevant agencies and child services.	Closer to home			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Identify the quality improvement activities you will undertake in 2017/18 in response to your 2016/17 ED Quality Framework results.	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Continue to support strategies that enable achievement of the health target.	Value and high performance			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora

Government Planning Priority	Focus Expected for Waitemata DHB	Link to NZ	Waitemata DHB Key Response Actions to Deliver Improved Performance		Measures
Bowel Screening	Transition existing Bowel Screening Pilot in line with requirements for Tranche 1 of the national programme, incorporating quality, equity and timeliness expectations and IT integration activity, while ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	People powered			PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities. SI5: Delivery of Whānau Ora
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Waitemata DHB	Link to NZ	Waitemata DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Waitemata DHB	Link to NZ	Waitemata DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Waitemata DHB	Link to NZ	Waitemata DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Waitemata DHB

Local and Regional Enabler	Focus Expected for Waitemata DHB	Link to NZ Health Strategy	Waitemata DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. Continue the rollout EMRAM Stage 3 & 4 capabilities throughout the hospital. Continue the work with Ministry of Health and HIMSS Analytics on Stage six, closed looped medication.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for West Coast DHB

Government Planning Priority	Focus Expected for West Coast DHB	Link to NZ Health Strategy	West Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for West Coast DHB	Link to NZ	West Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to immunise all available children.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Identify the quality improvement activities you will undertake in 2017/18 in response to your 2016/17 ED Quality Framework results.	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Support use of IT tools in patient data management.	Smart system			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora

Government Planning Priority	Focus Expected for West Coast DHB	Link to NZ	West Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan (section 2)
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People

Government Planning Priority	Focus Expected for West Coast DHB	Link to NZ	West Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	Closer to home			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for West Coast DHB	Link to NZ	West Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for West Coast DHB	Link to NZ	West Coast DHB Key Response Actions to Deliver Improved Performance		Measures
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	NA.			NA.

Enablers Guidance for West Coast DHB

Local and Regional Enabler	Focus Expected for West Coast DHB	Link to NZ Health Strategy	West Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when Order entry & Nursing Documentation will be implemented. Start the implementation of ePA and eOrders as per the regional programme.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

Planning Priorities Guidance for Whanganui DHB

Government Planning Priority	Focus Expected for Whanganui DHB	Link to NZ Health Strategy	Whanganui DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance			PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered			PP38: Delivery of response actions agreed in annual plan (section 1)
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team			PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team			PP38: Delivery of response actions agreed in annual plan (section 1)
~~Reducing Rheumatic Fever BPS Target~~	~~Ensure systems are in place to effectively follow-up rheumatic fever cases.~~	~~Smart system~~			~~PP28: Reducing Rheumatic Fever~~

Government Planning Priority	Focus Expected for Whanganui DHB	Link to NZ	Whanganui DHB Key Response Actions to Deliver Improved Performance		Measures
Increased Immunisation ~~BPS and~~ Health Target	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance			Immunisation Health Target PP21: Immunisation Services
Shorter Stays in Emergency Departments Health Target	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance			ED Health Target
Improved Access to Elective Surgery Health Target	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance			Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team			Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target	Provide an integrated approach to delivery of ABC between primary care services.	One team			Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
Raising Healthy Kids Health Target	Identify what actions you will take to ensure that the clinical referral pathway and processes established in 2016/17 achieves the Raising Healthy Kids target by December 2017.	Closer to home			Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the	and high perf orm			PP29: Improving waiting times for

Government Planning Priority	Focus Expected for Whanganui DHB	Link to NZ	Whanganui DHB Key Response Actions to Deliver Improved Performance		Measures
	national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.				diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the use of seclusion.	People powered			PP38: Delivery of response actions agreed in annual plan (section 2)
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards for Diabetes Care.	Closer to home			PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Focus Expected for Whanganui DHB	Link to NZ	Whanganui DHB Key Response Actions to Deliver Improved Performance		Measures
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these. ~~Commit to progress DHB-led initiatives from the *childhood obesity plan*.~~	**Closer to home**			PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**			PP38: Delivery of response actions agreed in annual plan (section 2)
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances). These could include: - communication tools (particularly for those with an intellectual disability or sensory impairment) - training for ward staff in individual specific personal care - clarification of the role of the persons support workers/caregivers during a hospital appointment or inpatient stay (both formal and informal) - other issues you have addressed (informed consent, supported decision making etc).	**One team**			PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Whanganui DHB	Link to NZ	Whanganui DHB Key Response Actions to Deliver Improved Performance		Measures
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, ambulance services).	Closer to home			PP22: Delivery of actions to improve system integration including SLMs
	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance			PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team			PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance			PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance			Agreed financial templates.

Government Planning Priority	Focus Expected for Whanganui DHB	Link to NZ	Whanganui DHB Key Response Actions to Deliver Improved Performance		Measures
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C. Note: you do not necessarily need to include an action for each priority, only where there is significant activity.	**NA.**			NA.

Enablers Guidance for Whanganui DHB

Local and Regional Enabler	Focus Expected for Whanganui DHB	Link to NZ Health Strategy	Whanganui DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when Order Entry, ePA, and CPOE will be implemented (not all expected in 2017/18). Complete ePharmacy implementation.	Smart system			Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team			NA.
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One Team			PP23: Improving Wrap Around Services – Health of Older People

2017/18
DHB Health Targets

This document outlines the health target definitions that apply in 2016/17. As health targets form part of wider DHB monitoring framework and accountability arrangements, these definitions should be read in conjunction with further information about DHB planning, monitoring and reporting arrangements, available at www.nsfl.govt.nz.

Health target	Target goal	Page reference
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	2
Improved access to elective surgery	The volume of elective surgery will be increased by an average of 4,000 discharges per year.	5
Faster cancer treatment	90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	8
Increased immunisation	95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	10
Better help for smokers to quit	• 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months • 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	13
Raising healthy kids	By December 2017, 95 percent of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	16

Last updated June 2017 – to include technical adjustments to the Faster Cancer Treatment health target definition.

Health Target: Shorter stays in Emergency Departments

Target Champion – Angela Pitchford Clinical Director Emergency Department

Summary information			
Indicator: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.			
Measures		***Reporting***	
Type:	**Output**	Type:	Data and exception
Target:	95%	Reporting frequency:	Quarterly
Source data/template for reporting provided by:		*Data provided by DHBs, template on NSFL*	

Link to outcomes

Delivery against this measure supports the health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives'. Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in the emergency department therefore improves the health services DHBs are able to provide. It also impacts on the Ministerial priority of improved hospital productivity by ensuring resources are used effectively and efficiently. Reducing ED length of stay will improve the public's confidence in being able to access services when they need to, increasing their level of trust in health services, as well as improving the outcomes from those services.

Increasing performance on this measure will also result in a more unified health and disability system, because a coordinated, whole of system response is needed to address the factors across the whole system that influence ED length of stay. Through the intermediate outcomes the target contributes to the high level outcome of New Zealanders living longer, healthier and more independent lives

The following actions and activities are examples of initiatives that have a proven impact on this measure:

1. Good diagnostic work to identify the main factors impacting on ED length of stay, therefore ensuring that the main bottlenecks and constraints are addressed first.
2. Implementing programmes such as *The Productive Ward – Releasing Time to Care* or *Optimising the Patient Journey* which, among other things, help to improve the flow from ED through the hospital by freeing up resources.
3. Organising services differently so that non urgent cases can be treated more quickly.
4. Improving the pathways that patients take through the community, ED and hospital when getting treated for common conditions.
5. Improving hospital processes, like the discharging of patients, to help free up hospital beds that patients can move into after their ED treatment.
6.

Deliverables

Each DHB will be required to submit the following data to the Ministry on a quarterly basis for each of their ED facilities of level 3 and above, and some agreed level 2 facilities:

1. *Numerator:* number of patient presentations to the ED with an ED length of stay less than six hours, and
2. *Denominator:* number of patient presentations to the ED.

A reporting template will be supplied by the Ministry for the reporting of this data. **Information is to be reported for total DHB population, Māori and Pacific.**

Those DHBs that do not meet the 95 percent target for the quarter must also provide narrative comment on:

- the activities undertaken during the quarter to meet the target and improve the quality of acute care
- any difficulties encountered during the quarter
- the activities planned for the coming quarter to meet the target and improve the quality of acute care
- their progress with implementing the ED Quality Framework.

National Non-Admitted Patient Collection (NNPAC)

Since 1 July 2009 the National Non-Admitted Patient Collection (NNPAC) database has included fields for the recording of data relating to the Shorter Stays in ED Health Target. The Ministry will continue to compare the numerator and denominator data provided each quarter by DHBs with the corresponding data obtained from NNPAC. The Ministry will then engage as needed with DHBs outside of the reporting process to examine and rectify any differences between these data sources.

Definitions

Explanation of terms:

1. *ED length of stay* for a patient equals the time period from *time of presentation*, to *time of admission*, *discharge* or *transfer*.
2. *Time of presentation* is the time of first contact between the patient and the triage nurse or clerical staff, whichever comes first.
3. *Time of admission* is the time at which the patient is physically moved from ED to an *inpatient ward,* or the time at which a patient begins a period of *formal observation*. The physical move will follow, or be concurrent with, a formal admission protocol, but it is the patient movement that stops the clock, not associated administrative decisions or tasks.
4. *Inpatient wards* include ED Observation Units or Inpatient Assessment Units (or units with a similar function)[1]. Under certain circumstances, a 'decant' ward designed to deal with surge capacity will qualify as an inpatient ward. Key criteria are that patients should be in beds rather than on trolleys, and be under the care of appropriate clinical staff.
5. *Formal observation* means that patients are in an ED observation bed, an observation unit, or similar. Key criteria are that the area or unit should have dedicated staffing, have patients in beds rather than on trolleys, and be located in a dedicated space. Limited exceptions to these criteria, to allow patients to be 'observed' in a monitored environment, should be formally approved by the Clinical Director of the ED and discussed with the National Clinical Director of ED Services.
6. *Time of discharge* is the time at which a patient being discharged from the ED to the community physically leaves the ED. For the avoidance of confusion, if a patient's treatment is finished and they are waiting in the ED facilities only as a consequence of their personal transport arrangements for pickup, they can be treated as discharged for the purposes of this measure.
7. *Time of transfer* is the time at which a patient being transferred to another facility physically leaves the ED. While a patient is still in the ED, either receiving ongoing care, or awaiting transport, ED length of stay continues. Time of transfer can only be recorded when the patient physically leaves the ED.

Inclusions and exclusions:

1. Data provided to the Ministry will be provided at facility level for all EDs of level 3 and above, and those agreed level 2, within each DHB, according to the role delineation model as elaborated in the

[1] For further information please refer to the *Guidance Statement: ED Observation and ED Assessment Units* on http://www.hiirc.org.nz/page/18737/guidance-statement-ed-obervation-and-inpatient/?section=9088&contentType=451&tab=822

ED service specification. Where a DHB has more than one facility, the overall percentage calculated for the DHB will be a weighted result, not a simple average of the results of individual facilities. The performance of individual facilities has been reported from Quarter 1, 2013/14.

2. All presentations between 00:00 hours on the first day of the quarter, and 00:00 hours on the first day of the next quarter, are included except:
    - Patients who do not wait for treatment; these will be removed from both the denominator and the numerator.
    - GP referrals that are assessed at the ED triage desk (using the Australasian Triage Scale), but are then directed to an Admission and Planning Unit or similar unit without further ED intervention. Here the term 'ED intervention, sufficient for inclusion in the measure, can encompass more detailed nursing assessment (over and above triage) and minor procedures such as analgesia or administration of intravenous fluids, for instance.
    - Patients that present to the ED for pre-arranged outpatient-style treatment.
3. No exceptions from measurement are made for particular clinical conditions.

In certain situations it may be that good clinical practice or a particular service model will compromise the ability to meet Health Target expectations. Where this situation arises, the Ministry will discuss this with the DHB affected and the definition can be re-interpreted on a case-by-case basis where relevant.

Expectations

All DHBs are expected to achieve the target percentage for this Health Target.

The following achievement scale will be applied during quarters one to three:

Rating:	
Achieved	The DHB has met the target percentage for the quarter
Partially Achieved	The DHB has not met the target percentage but the narrative comments provided satisfy the assessor that the DHB is on track to compliance.
Not Achieved	The DHB has not met the target percentage for the quarter and the narrative comments provided do not satisfy the assessor that the DHB is on track to compliance.

Only *Achieved* or *Not Achieved* ratings will be awarded in quarter four based on whether the DHB has achieved or not achieved the target.

Additional performance measures to be monitored internally

In addition to the target, each DHB is expected to collect and internally monitor their performance against a range of more specific quality measures. The monitoring of additional performance measures is intended to complement the Short Stays in ED health target by providing a concrete and comparable measure of the quality and outcomes of acute care. As the purpose is to inform internal DHB improvement and quality, DHB performance against these measures is not required to be routinely reported to the Ministry. However, the Ministry may request to review them if there are concerns about performance or quality. The selected measures should span the spectrum of acute care – from primary care, through secondary services (including ED), to post-hospital primary and community care.

Health Target: Improved access to elective surgery

Target Champion – Jess Smaling, Manager for Electives and National Services

Summary information			
Indicator: The volume of elective surgery will be increased by an average of 4,000 discharges per year.			
Measures		***Reporting***	
Type:	Output	Type:	Exception
Target:	Targets set in APs	Reporting frequency:	Quarterly
Source data/template for reporting provided by:		*Data supplied by DHB to National Minimum Dataset, and report provided by Ministry. Report will be loaded on Quickr*	

Link to outcomes

Delivery against this measure supports the health and disability system outcome of *'New Zealanders living longer, healthier and more independent lives'*. The primary intermediate outcome is that *'people receive better health and disability services'*. An additional intermediate outcome is that *'the health and disability system and services are trusted and can be used with confidence'*. This measure will also support delivery of the Minister of Health's priority of *'improving hospital productivity'*.

Elective services are an important part of the health care system for the treatment, diagnosis and management of health problems. Increasing elective surgery by an average of 4000 discharges year on year will result in better access to health and disability services for New Zealanders. Timely access to elective services is considered a measure of the effectiveness of the health system. Increasing delivery will improve access and reduce waiting times will increase public confidence that the health system will meet their needs.

Elective surgery is important to New Zealanders as these are essential services to improve quality of life by reducing pain or discomfort, and improving independence and wellbeing. Improved hospital productivity will be required to ensure the most effective use of resources so that year on year growth in electives can be achieved.

The continuing increase in delivery requires improvement in DHB-wide productivity and efficiency initiatives, development of regional services where appropriate, and collaboration between DHBs to improve patient access, reduce waiting times, and make better use of resources. It also requires shared clinical input to national service prioritisation tools and referral guidance.

The following actions and activities are examples of initiatives that have a proven impact on this measure:

1. The Electives Initiative which provides ring fenced funding to improve access to elective surgery.
2. The Ambulatory Initiative, which supports improving access to diagnostics and specialist assessment and which is reducing waiting times for people requiring elective surgery.
3. Improved production planning and monitoring frameworks to ensure targets are achieved, or appropriate remedial plans in place to ensure people have access to promised services.
4. Improving theatre productivity and ward efficiency, including increasing day surgery and day of surgery admission rates will increase capacity for elective surgery.

5. Adoption of new approaches for assessment and treatment such as non-contact First Specialist Assessments and primary care options for direct access to treatment lists

Deliverables definitions

The number of elective surgical discharges provided nationally will increase by an average of 4,000 discharges per annum.

DHBs will be required to report on progress quarterly on an exception basis against the target agreed in their Annual Plan. This level of reporting will provide early warnings of any DHB that may be experiencing difficulty in achieving their annual target and provide the opportunity for corrective actions to be undertaken.

Reporting period

Quarterly reporting. ***Note*** reporting for this measure operates on a delayed timetable – not as per the Operational Policy Framework – as the hospital activity needed for reporting is not available until one month after the quarter ends. Data will be made available to DHBs via the Electives Services Quickr website. Electives Services Managers, and General Managers Funding and Planning will be notified via email that the data is available.

Expectations

At a national level DHBs will deliver an increase in the volume of elective surgery by an average of 4,000 per year. Each DHB will identify a minimum level of elective surgery to be provided to the people living in its regions in the 2016/17 Annual Plan. The level of surgery to be provided should be determined by the DHB's actual level of service in the previous financial year - 2014/15 (previous year at the time of issue of planning advice), the level of service planned and projected in the current financial year - 2015/16 (current year at the time of issue of planning advice), and the achievement of equitable access to elective surgery relative to other DHBs.

There will be three levels of achievement for this indicator; Achieved, Partially Achieved and Not Achieved. A rating will be determined for each indicator.

Quantitative measures

DHBs will set a target number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region. Performance will be measured using data from the National Minimum Data Set (NMDS). The following discharges are included: Elective and Arranged discharges from a surgical purchase unit; Elective and Arranged discharges with a surgical DRG from a non-surgical purchase unit (excluding maternity); and skin lesion or intraocular injections, where these are reported to the NMDS.

Achievement Levels

Rating	Full Year	Quarterly (year to date)
Achieved	DHB delivers their agreed target number of elective surgical discharges.	DHB delivers their agreed target number of elective surgical discharges.
Partially Achieved	DHB does not deliver their agreed target but delivers more elective surgical discharges than the previous year, or is within 1% of plan.	DHB is within 1% of plan **OR** DHB delivers less than their agreed quarterly target but submits a report that meets Ministry approval by providing the reasons for under-delivery and an action plan as to how it will address the under-delivery and achieve the full year target.

Not Achieved	DHB delivers less than the number of elective surgical discharges required for partially achieved (above).	DHB delivers less than their agreed quarterly target and either does not submit a report or does not submit a report that meets Ministry approval.

Health Target: Faster cancer treatment

Target Champion – Dr Suzanne Beuker, National Clinical Lead, Cancer Services

Summary information			
Indicator: 90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.			
Measures		***Reporting***	
Type:	**Output**	Type:	Data and exception report
Target	Targets set in DHB Annual Plans	Reporting frequency:	Quarterly (monthly data submission via secure FTP)
Source data/template for reporting provided by:		Data to be supplied by DHBs. For detailed information on the reporting process refer to *Faster Cancer Treatment Indicators: Business Rules and Data Definitions* on the NSFL	

Link to outcomes

Delivery of this measure supports the overarching outcomes for the health and disability system of *'New Zealanders living longer, healthier and more independent lives'*, and *'the health system is cost effective and supports a productive economy'*.

The Faster cancer treatment health target takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. DHBs working towards achievement of this target supports public trust in the health and disability system; and that these services can be used with confidence. Implementation of the Faster cancer treatment health target requires existing capacity and resources to be maximised, this results in effective and efficient use of resources and supports the key planning consideration of value for money.

Implementing the overall Faster cancer treatment programme supports the overarching goal that all New Zealanders live well, stay well, get well. Cancer treatment is provided across all DHBs, although not all DHBs provide all services. This requires DHBs to collaborate across boundaries to ensure services are integrated and patients receive a seamless service.

Actions to deliver improved performance in this focus area include:

- use of the *Faster Cancer Treatment Indicators: Business Rules and Data Definitions* and *High suspicion of cancer definitions* to ensure consistency of reporting
- improve the quality of data (volume of patients, number of tumour types, types of first treatment) captured
- analysis of the data to identify areas for system and process improvement along the patient pathway, and any differences in access or timeliness by ethnicity or geography
- review and re-design of the booking and scheduling of appointments for patients with a high suspicion of cancer, including use of single point of referral to streamline referral route
- implement fast-track access to all necessary diagnostic scans and investigations
- develop rapid reporting and communication of results of diagnostic scans and investigations

- review and re-design of the coordination of treatment processes and booking processes to ensure optimal use of capacity.

Deliverables

DHBs will be required to supply data monthly (within 20 days of the end of the month) via secure file transfer protocol on the length of time taken for patients referred with a high-suspicion of cancer *and* a need to be seen within two weeks to receive their first cancer treatment (or other management).

Detailed information on the definitions, inclusions and process for submitting data to the Ministry of Health is outlined in *Faster Cancer Treatment Indicators: Business Rules and Data Definitions* available from: http://nsfl.health.govt.nz/accountability/performance-and-monitoring/business-rules-and-templates-reporting/faster-cancer.

The DHB of domicile is responsible for collecting and reporting information on their domiciled population even if it is not the DHB of:

- receipt of referral
- service.

No further quantitative reporting is required as part of the quarterly reporting process.

DHBs are required to submit a quarterly qualitative report through the quarterly reporting database outlining:

- the activities being undertaken to ensure data quality and volumes
- delays identified along the cancer pathway and challenges with implementing Faster cancer treatment
- breaches of the 62 day indicator, and analysis of reasons that contributed to the delay
- actions taken and planned in response to the delays and challenges identified.

Inclusions and exclusions

Data provided to the Ministry will include a delay code for all patients breaching the 62 day timeframe:

- Patient reason (chosen to delay)
- Clinical consideration (co-morbidities)
- Capacity Constraint (resulting from lack of resources (theatre, equipment, facilities or workforce) or process constraint including administrative errors).

All patient data submitted by DHBs is included in the Health Target result, except:

- Patients with a patient reason delay code; these will be removed from the denominator
- Patients with a clinical consideration delay code; these will be removed from the denominator

Reporting period

DHB achievement of the Faster cancer treatment health target will be calculated based on six months rolling data as outlined in the table below:

Reporting quarter	Achievement based on patients receiving their first cancer treatment between:
Quarter 1	1 April – 30 September
Quarter 2	1 July – 31 December
Quarter 3	1 October - 31 March
Quarter 4	1 January – 30 June

Expectations:

The following achievement scale will be applied:

Rating:	
Achieved	will apply where the DHB has met the target percentage.
Partially Achieved	will apply where the DHB has not met the target percentage but achievement has improved compared to the previous quarter and the narrative comment satisfies the assessor that the DHB is on track to meet the target.
Not Achieved	will apply where the DHB has not met the target percentage and achievement has decreased compared to the previous quarter and/or the narrative comment does not satisfy the assessor that the DHB is on track to meet the target.

Health Target: Increased Immunisation

Target Champion – Dr Pat Tuohy, Chief Advisor, Child and Youth Health

<table>
<tr><th colspan="4">Summary information</th></tr>
<tr><td colspan="4">Indicator: 95 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five month events) on time.</td></tr>
<tr><td colspan="2">Measures</td><td colspan="2">Reporting</td></tr>
<tr><td>Type:</td><td>Outcome</td><td>Type:</td><td>Mandatory</td></tr>
<tr><td>Target:</td><td>Targets set in APs</td><td>Reporting frequency:</td><td>Quarterly</td></tr>
<tr><td colspan="2">Source data/template for reporting provided by:</td><td colspan="2">Data is supplied by the Ministry from the National Immunisation Register Data Mart and through the DHB quarterly reporting website</td></tr>
<tr><td colspan="2">Quarterly reporting - standard timeline applies</td><td colspan="2"><table>
<tr><td>DHB Reports Due</td><td>20th of the month following the end of the quarter</td></tr>
<tr><td>Ministry Initial rating & feedback</td><td>8-10 working days from receiving reports</td></tr>
<tr><td>DHB Response due</td><td>5 working days from receiving initial ratings</td></tr>
<tr><td>Confirmed rating and feedback</td><td>4-5 working days from receiving DHB feedback</td></tr>
</table></td></tr>
</table>

Link to outcomes

Delivery against this measure supports the health and disability system outcome of *'New Zealanders living longer, healthier and more independent lives'* and the primary intermediate outcome of *'Good health and independence are protected and promoted'.* Additional intermediate outcomes are '*A more unified and improved health and disability system', 'People receive better health and disability services' and 'The health and disability system and services are trusted and can be used with confidence'.* This measure will also support delivery of the Minister of Health's priorities of '*Strengthening the health workforce' and 'Speeding up the implementation of the Primary Health Care Strategy'.*

Improved immunisation coverage leads directly to reduced rates of vaccine-preventable disease, and consequently better health and independence for children, particularly for the most vulnerable groups. This equates to longer and healthier lives. Increasing immunisation is a pro-equity strategy, producing greater improvement for those with initially the worst coverage, including Māori infants.

The changes which are required to reach the target immunisation coverage levels will lead to more efficient health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better co-ordinated. These actions are leading to improved implementation of the Primary Health

Care Strategy, and ensuring that the primary care workforce including maternity providers, are better equipped to address the needs of antenatal women, children and families.

Training in immunisation provision, health education for parents, knowledge about vaccine-preventable diseases and how to identify and provide services to high-needs populations will generalise to a range of other child and family service areas.

Deliverable

Percentage of eligible children fully immunised at eight months of age – total DHB population, Māori and Pacific

Immunisation coverage for 8-month olds will be measured quarterly using National Immunisation Register (NIR) Data Mart Milestone Ages reports for the previous 3-month reporting period. The report includes all infants turning 8 months of age during the reporting period. Coverage will be reported for Total, Māori, and (where relevant) Pacific.

Fully immunised at age 8 months is defined as having received all measured immunisations scheduled for 6 weeks, 3 months and 5 months and 15 months of age. To be measured as fully immunised, the child must have received all age-appropriate doses of diphtheria, tetanus, whooping cough, polio, hepatitis B, *Haemophilus influenzae* type B and pneumococcal vaccines. Although rotavirus is included in the National immunisation Schedule, it is not currently included in performance measures or health targets. It is anticipated that rotavirus vaccines will be included in performance measures in the future.

Assessment of coverage

Coverage is measured by the following NIR Data Mart reports:

- NIR BC CI Overview - Milestone Ages DHB
- NIR BC CI Overview - Milestone Ages National

Numerator:

The numerator is the number of eligible children enrolled on the NIR who have turned the milestone age (8 months of age) during the three-month reporting period and who are recorded as fully immunised on the day that they turn the milestone age.

Denominator:

The numerator is the number of eligible children enrolled on the NIR who have turned the milestone age (8 months of age) during the three-month reporting period.

The quarterly coverage report will be run after the weekly data update (“refresh”) of the NIR Data Mart reports after the end of the quarter; reports are generally run on the Tuesday closest to the 10th of the month after the end of the quarter to ensure timeliness while also allowing the complete quarter's data to have been loaded on to the NIR Data Mart.

Current performance reports can be accessed directly from NIR Data Mart Milestone Ages reports. The reports at both National and DHB level will also be available to DHBs in Excel and PDF format in the toolkit section of the Quarterly Reporting Database. DHBs are expected to use these reports to provide exception qualitative reports and/or use this mechanism to raise issues with the Ministry.

Immunisation coverage reports will be provided quarterly as follows:

Quarter	For the time period
Quarter 1	Data to cover the period 1 July to 30 September
Quarter 2	Data to cover the period 1 October to 31 December
Quarter 3	Data to cover the period 1 January to 31 March
Quarter 4	Data to cover the period 1 April to 30 June

Expectations

The national target is 95 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time, measured at age 8 months. DHBs are expected to set targets to meet these goals. Achieving the target will require different rates of improvement for different populations. All ethnic targets will be the same as the total population target. DHBs are expected to set targets with the aim of eliminating inequalities..

If DHBs do not reach target coverage in any quarter they are expected to provide an exception qualitative report at the end of each quarter advising how they will track towards higher coverage. If the target has been reached, only a confirmation statement is required.

The assessment requirements for each quarter are set out below:

Table 1: Quarters 1, 2 & 3 assessment

Rating	Explanation
Achieved	The DHB has reached the "Total population" immunisation coverage target for children at 8 months of age**.** This score requires that the DHB has met the target agreed in the Annual Plan **and** has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group.
Partially Achieved	The DHB's immunisation coverage is progressing towards the target and coverage is acceptable relative to national coverage.
Not Achieved	The DHB's immunisation coverage has failed to substantially progress towards the target and/or coverage is unacceptable relative to national coverage.

Table 2: Quarter 4 assessment

Rating	Explanation
Outstanding Performer	The DHB has met the "Total population" immunisation coverage target for children at 8 months of age **and** • the DHB has substantially exceeded the coverage target *and/or* • the DHB has met the coverage target for: o the total population, and o the Māori population group, and (where applicable) o the Pacific population. This score requires that the DHB has met the target agreed in the Annual Plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group. o
Achieved	The DHB has reached the "Total population" immunisation coverage target for children at 8 months of age**.** This score requires that the DHB has met the target agreed in the Annual Plan **and** has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group.
Partially Achieved	The DHB's immunisation coverage is progressing towards the target and coverage is acceptable relative to national coverage.
Not Achieved	The DHB's immunisation coverage has failed to substantially progress towards the target and/or coverage is unacceptable relative to national coverage.

Health Target: Better help for smokers to quit

Target Champion – Dr John McMenamin, Clinical Advisor on Smoking in Primary Care

Summary information			
• 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months • 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking			
Measures		***Reporting***	
Target:	Target agreed in Annual Plans	Type:	Data & report
		Reporting frequency:	Quarterly
Source data/template for reporting provided by:		• Primary care target data – supplied to the Ministry of Health through the PHO performance programme (PPP) system • Maternity target data –supplied to the Ministry by Midwifery and Maternity Provider Organisation (MMPO and DHBs All reporting templates will be supplied by the Ministry.	

Link to outcomes

Delivery against this measure supports the health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives', as well as the intermediate outcome of 'a more unified and improved health and disability system'. The measure also supports the Government's aspirational goal of a Smokefree New Zealand by 2025. Achieving a Smokefree New Zealand will mean that:

- our children and grandchildren will be free from exposure to tobacco and tobacco use
- the prevalence of smoking across all populations will be less than 5 percent
- tobacco will be difficult to sell and supply.

At present, tobacco smoking places a significant burden on the health of New Zealander's and on the New Zealand health system. Tobacco smoking is related to a number of life-threatening diseases, including cardiovascular disease, chronic obstructive pulmonary disease and lung cancer. It also increases pregnant smokers' risk of miscarriage, premature birth and low birth weight, as well as their children's risk of Asthma and Sudden Unexplained Death in Infants (SUDI).

Stopping smoking confers immediate health benefits on all people, and is the only way to reduce smokers' risk of developing a smoking-related disease. Providing smokers with brief advice to quit increases their chances of making a quit attempt. The chance of that quit attempt being successful is increased if medication and/or cessation support are also provided. Most medications roughly double a smoker's chance of quitting, but using medication in conjunction with a cessation support service (such as the Quitline or an Aukati KaiPaipa service) can increase a smoker's chance of quitting by as much as four times.

By ensuring that all health professionals are routinely providing their patients with advice and support to quit, DHBs, PHOs and midwives are helping to ensure that people receive better health and disability services, and live longer and healthier lives.

The following actions and activities are examples of initiatives that have had an impact on this measure in both hospital, maternity and primary care settings:

- Mechanisms for capturing data are accessible and easy to use.
- Methods for referring patients to cessation support services are simple and succinct.
- Services are able to monitor their progress towards the target on a regular basis.
- Smokefree champions are in place within each ward, practice or service to provide motivation, education and support for the target.

Deliverables

Primary care target:

Each quarter, DHBs, in collaboration with their local PHOs, will be required to complete the template supplied by the Ministry. The Ministry will provide DHBs with their region's primary care result once it has received the data from the PPP system.

Maternity target:

The Ministry will start online reporting of the maternity target from quarter one 2015/16. Each quarter, DHBs will be required to complete the two template supplied by the Ministry. The Ministry will provide DHBs with their region's result once it has received the data from MMPO and DHBs.

Eligible populations

Primary care target:

All adults who are:

- aged between 15 to 75 years
- enrolled in a PHO; and
- identified as a current smoker.

Maternity target:

All pregnant women who are:

- aged 15 years and over; and
- identified as a current smoker upon registration with a DHB-employed midwife or Lead Maternity Carer.

Explanation of terms

For the purpose of the primary care target and the maternity target a current smoker is someone who has smoked more than 100 cigarettes in their lifetime and has smoked tobacco in the last 28 days.

Reporting period

Quarterly reports must be submitted to the Ministry by the 20th of the month following the relevant quarter.

Expectations

All DHBs are expected to meet the 90 percent primary care target and 90 percent maternity target. The achievement scale below will be applied to each of the target areas individually every quarter.

Table 2: Health target achievement Scale

Rating	Definition
Achieved*	The DHB has met the percentage target for the quarter 90 percent for the primary care target and 90 percent for the maternity target).
Partial Achievement	The DHB has not met the percentage target, but has improved on its result from the previous quarter.
Not Achieved	The DHB has not met the percentage target, and its result has dropped since the previous quarter.

*From 2014/15 for all performance measures included in the Maori health plan this rating is applied when the DHB has met the target agreed in its Annual Plan **and** has achieved significant progress for the Maori population group, and the Pacific population group.

Health Target: Raising healthy kids

Target Champion – Professor Hayden McRobbie, Raising Healthy Kids Clinical Practice Champion Childhood Obesity.

Summary information			
Indicator: By December 2017, 95 percent of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.			
Measures		***Reporting***	
Type:	Output	Type:	Provide update
Target:	95 per cent	Reporting frequency:	Quarterly
Source data/template for reporting provided by:	*Data provided by Ministry of Health from B4SC database*		
Linkages: The performance of this indicator is also reported in System Integration SI5: Delivery of Whānau Ora. It requires a heightened focus to achieve accelerated progress towards Whānau Ora and health equity, as agreed by the Whānau Ora Partnership Group.			

Link to outcomes

Delivery of this measure supports the overarching outcomes for the health and disability system of ***'New Zealanders living longer, healthier and more independent lives',*** *and* ***'the health system is cost effective and supports a productive economy',***

Delivery of this measure most strongly supports the following sector outcomes and government priorities:

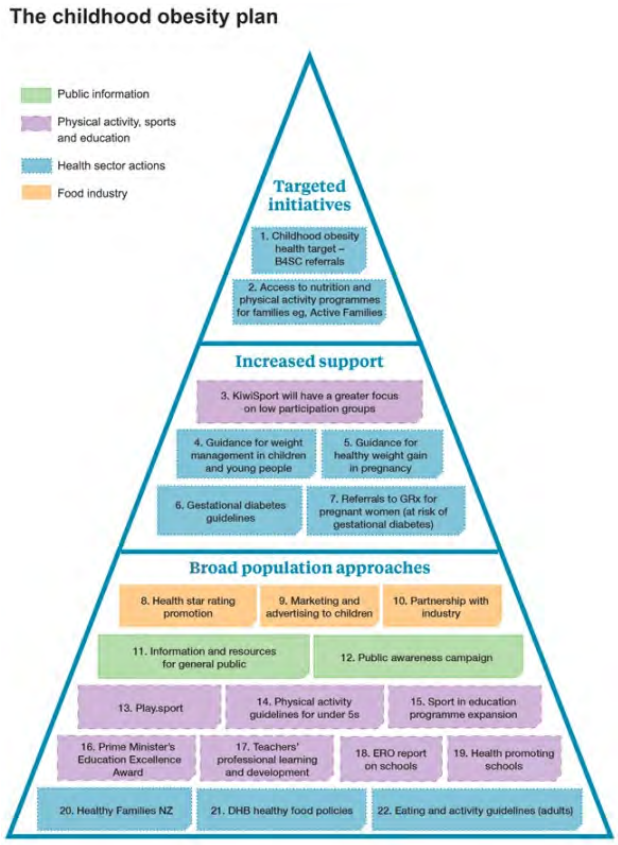
- Prevention and management of obesity in children and young people up to 18 years of age
- Health equity for Māori and Pacific, and Whānau Ora

The Government has put in place a Childhood Obesity Plan. This package of initiatives within the plan aims to prevent and manage obesity in children and young people up to 18 years of age.

It has three focus areas made up of 22 initiatives which are either new or an expansion of existing initiatives:

1. Targeted interventions for those who are obese
2. Increased support for those at risk of becoming obese
3. Broad approaches to make healthier choices easier for all New Zealanders.

The focus is on food, the environment and being active at each life stage, starting during pregnancy and early childhood. The package brings together initiatives across government agencies, the private sector, communities, schools, families and whanau.



Target Definition
The target is: By December 2017, 95 per cent of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

The target was selected as the B4SC focuses on intervening in the early stages to ensure positive, sustained effects on health. Children receive a comprehensive check before they start school and are referred to the services they need to support healthy eating and activity.

Deliverables definition
Each DHB will be required to review the following data provided by the Ministry on a quarterly basis:

1. *Denominator: the number of children identified as obese (BMI>98th percentile) from all completed checks processed in a six month period*
2. *Numerator: a subset of the group of children identified in the denominator. The numerator is the number of children where their referral was acknowledged within 60 days (30 days applies from 1 July 2016) or who are already under care or the referral was declined by the parent/caregiver*

Information will be provided for total DHB population, Māori and Pacific (for 8 DHBs with high Pacific populations), and deprivation (Dep Index 5).

DHBs must provide a progress update on:

- Target performance to date and rate of progress based on data provided.
- Your activity to support the achievement of the target and initiatives to realise a reduction in childhood obesity, as reflected in your commitments in your Annual Plan, including:

  - progress with getting referrals acknowledged from the B4SC
  - progress with the development of referrals pathways from the B4SC for assessment and family based nutrition, activity and lifestyle interventions
  - activity to ensure DHBs, PHOs and other primary care and community partners work together to ensure families experience seamless transition and support post referral from the B4SC
  - activity to support primary care and community partners having the conversation with families.
- Barriers to achieving the target and mitigation strategies over the next quarter by DHB and the PHOs.
- Collective action and link to broader approach to reducing childhood obesity across government agencies, the private sector, communities, schools, families and whānau.
- What the DHB is doing to build in evaluation, measure effectiveness, and monitor outcomes over time.

Explanation of terms:

1. Obese children are children with a BMI > 98th percentile.
2. Only *completed B4SC* checks are included as part of the denominator where all the components of the B4SC have been completed and all necessary referrals made and entered into the B4SC system
3. *Referred* is based on available data from the B4SC database and uses the 'Date referral acknowledged' field in the database. Where there is more than one referral the first referral is reported on.
4. *Referral acknowledged* is where the referral to a registered health professional[1] is accepted or declined within 30 consecutive days of the referral sent. The 30 (or 60 days) includes weekends and holidays.
5. *Undercare* is already under care of a service so not referred.
6. *Parent/caregiver declined* is the parent/caregiver declined the referral.

The Ministry accepts the following registered health professionals as valid referrals for the purposes of the health target

- general practitioner
- practice nurse
- community dietician
- public health nurse
- multi-disciplinary team that includes a registered primary health care professional in attendance

These practitioners need to have the requisite skills to conduct a clinical assessment and be able to ensure the child's growth is routinely monitored.

A child may simultaneously be referred to a family based nutrition, activity and lifestyle intervention. However this alone would not count as referred for the purposes of the health target.

Exclusions

The following data has been excluded to account for errors:

Checks which were declined

Checks with probable data quality issues:

- BMI less than 5, or over 60

Children aged outside the target range (aged less than 48 months, or more than 60 months)

Referrals which were not acknowledged by the service provider within 30 consecutive days

[1] This would be a registered health professional working in a primary care health care or community setting as part of their role in the ongoing care of a child, and to ensure clinical assessment has occurred following referral from the B4SC. This could also be a referral into a multi-disciplinary team that includes at least one registered health care professional in attendance, although we would expect a clinical assessment to occur from this referral. The referral pathway from the B4SC for a child may simultaneously include a referral to a family based nutrition, activity and lifestyle intervention, however this alone would not count as referred for the purposes of the health target. The B4SC itself cannot count as a referral

Referrals to Community Development Service, Mental Health Services, Paediatrician, Other

Reporting period

DHB achievement of the Childhood obesity health target will be calculated based on six months rolling data as outlined in the table below:

Reporting quarter	**Achievement based on** obese children identified in the Before School Check offered a referral and referral acknowledged between**:**
Quarter 1	1 March to 31August 2016
Quarter 2	1 June to 30 November 2016
Quarter 3	1 Septemberto 28 February 2017
Quarter 4	1 December to 31 May 2017

Expectations
The following achievement scale will be applied to the health target indicator:

Table 1: Quarters 1, 2 & 3 assessment

Rating:	**Definition**
Outstanding Performer	DHB shares their broader intent and activity around childhood obesity and has met the target percentage.
Achieved	The DHB has met the target percentage.
Partially Achieved	The DHB has not met the target percentage but the narrative comments provided satisfy the assessor that the DHB is on track to compliance.
Not Achieved	The DHB has not met the target percentage and the narrative comments provided do not satisfy the assessor that the DHB is on track to compliance.

Table 2: Quarter 4 assessment

Rating	**Explanation**
Outstanding Performer	• The DHB has substantially exceeded the target; **and/or** • The DHB has reached the target for: o the total population, **and** o the Māori population group, **and** where applicable o the Pacific population.
Achieved	The DHB has reached the target and made progress towards closing the equity gap.
Partially Achieved	The DHB's progress towards target has improved from the start of the year and has made significant progress towards the target.
Not Achieved	The DHB's progress towards target has not improved from the start of the year and has not significantly progressed towards the target.