Operational Policy Framework 2011/12

Significant changes to the OPF are included as Appendix 2

This copy of the Operational Policy Framework is released subject to endorsement by the Minister of Health in accordance with Crown Funding Agreement requirements. This document is also subject to ongoing updates resulting from Cabinet approval of the report developed by the Ministerial Review Group. Updates will include, but are not restricted to:

- Dispute Resolution
- Service Change
- Information Technology

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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 each Crown Funding Agreement (CFA) 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 the following:

- 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 SPH (00) 160 (2 November 2000) report
- the New Zealand Health Strategy
- the New Zealand Disability Strategy
- He Korowai Oranga: Māori Health Strategy.

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 National Health Board (NHB[1]) will consider such a request as part of the Annual Plan (AP) and CFA processes. Any variation or exemption will be recorded in the relevant 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 provide 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 requirement 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 the document makes

[1] The role of the NHB is to provide planning advice, funding and monitoring of DHBs, planning and funding of designated national and regional services, coordinating strategic planning and funding of future capacity planning, and facilitate the process for deciding, which services should be planned, funded and provided at national, regional and local levels, and how that should change over time.

reference 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 through its CFA to comply with the Service Coverage Schedule (SCS) which sets out, on a national basis, the minimum services in terms of range, level of access and standard, that DHBs must ensure are provided to their populations

Due to the current transitional environment, changes to this version of the OPF are likely.

1.2 Structure of the OPF

1.2.1 The OPF contains the following:

1 Purpose and Overview - an overview of the OPF as part of the policy component of the DHB planning package and as a component of the CFA as well as a list of relevant definitions.

2 DHB Governance - organisational requirements of DHBs as set down by legislation.

3 Planning and Accountability - a summary of requirements of DHBs when developing their accountability documentation

4 Service Planning and Operational Policy – highlighting service specific areas of key operational policies

5 Service Change and Public Consultation – a summary of requirements for DHBs when dealing with areas of service change

6 Relationships with Māori - a summary of requirements of DHBs in regards to their work with Māori.

7 Inter-district flows rules - a system and rules for managing inter-district flows.

8 Dispute Resolution – a summary of requirements for DHBs to follow when resolving disputes

9 Quality - a summary of requirements that apply to DHBs to follow when developing their provider quality specifications.

10 Workforce – a summary of requirements that apply to DHBs to follow

11 Information Technology – a summary of requirements for DHBs to follow when following the National Health IT Plan

12 Financial and Capital Operations – a summary of requirements regarding financial operations that deal with fixed assets and capital.

13 Monitoring and reporting - a summary of requirements that apply to DHBs in relation to monitoring and reporting as well as of the Ministry's obligations to DHBs in this area.

Appendix 1 defines a range of terms used in and relevant to this document.

1.2.2 The structure of each section is organised to cover:

- the purpose of the section
- summary of mandatory requirements
- relevant legislation, guideline, policy principle
- context
- any other information that is relevant.

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

1.2.3 Terms have been defined only where a specific or expanded meaning applies to the term in the context of a particular chapter or appendix. An explanation of commonly used abbreviations is included in the 'Defined terms' section in Appendix 1.

2 DHB Governance

2.1 Purpose of the section

2.1.1 This section sets out various general organisational requirements of DHBs relating to legislative compliance, the process of preparing accountability documents, employment responsibilities, information technology, and emergency planning and management.

Summary of mandatory requirements

Each DHB must:

- meet legislative requirements (**2.2**)
- 150–157 of the Crown Entities Act 2004 (CE Act) apply an open approach to disclosing interests and an active approach to managing conflicts of interest as they arise – see the New Zealand Public Health and Disability Act 2000 (NZPHD Act) and CAB (00) M32/2A (2) (**2.3**)
- conduct board member self-evaluation as part of board business (**2.4**)
- maintain neutrality and be able to serve successive governments which may be drawn from different political parties (**2.5**)
- provide Regional Mental Health Strategic Plans (**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 and Regulations). DHBs should seek legal advice regarding their statutory obligations and ways of achieving compliance with them.
DHBs are established under the NZPHD Act. As Crown entities, they also fall within the scope of the CE Act 2004.

2.2.2 The NZPHD Act was amended in November 2010. Changes included:

a. **A new DHB objective:** To seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs.

b. **A new DHB function:** To collaborate with relevant organisations to plan and co-ordinate at local, regional, and national levels for the most effective and efficient delivery of health services.

c. A new DHB planning framework:

- Removes the requirements for a District Strategic Plan.
- Removes the requirements for a District Annual Plan

- Repeals the section 40 requirement for consultation on proposed changes to annual plan (see Service Change, OPF Section 4).

- Introduces a legislative requirement for an annual plan and for other planning requirements to be defined in Planning Regulations (see Planning and Accountability, OPF Section 3).

d. **Directions in relation to administrative, support and procurement services:** Provides for the Minister to direct DHBs regarding how administrative, support and procurement services within the public health and disability sector should be obtained and who must provide these services. The government has identified that an improved national approach to shared services in the health and disability sector could yield significant cost savings, reduced personnel, more efficient systems, and better health services.

e. **All-of-DHB direction power:** Ability for the Minister to give a direction to all DHBs to comply with stated requirements for the purpose of supporting government policy on improving the effectiveness and efficiency of the public health and disability sector.

f. **Dispute Resolution (see Dispute Resolution, Section 8)**:

- Over the contents of plans: a new section 39 that empowers the Minister to resolve disputes between DHBs over the contents of a plan.

- Between DHBs and / or other publicly owned health and disability organisations without needing the agreement of the affected parties (section 92(2)).

g. **Establishment of the Health Quality and Safety Commission to:**

- advise the Minister on how quality and safety in health and disability support services may be improved; and

- to advise the Minister on any matter relating to: health epidemiology and quality assurance; or mortality; and

- to determine quality and safety indicators (such as, serious and sentinel events) for use in measuring the quality and safety of health and disability support services; and

- to provide public reports on the quality and safety of health and disability support services as measured against the quality and safety indicators; and any other information that HQSC considers relevant for the purpose of the report; and

- to promote and support better quality and safety in health and disability support services; and

- to disseminate information about the quality and safety of health and disability support services; and
- to perform any other function that relates to the quality and safety of health and disability support services; and HQSC is for the time being authorised to perform by the Minister by written notice to HQSC after consultation with it.

2.2.3 DHBs also should be aware of other legislation which may impact their operations. As an example, the State Services Commissioner's Standards of Integrity and Conduct are a code of conduct that came into force on 30 November 2007. The Standards were issued by the Commissioner under section 57 of the State Sector Act 1988 and apply to all DHB employees

2.3 Conflicts of interest

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

2.3.1 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.

2.3.2 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 should be disclosed rather than less. Errors in handling conflicts of interest can have major ramifications for DHB decisions.

2.3.3 Further information on conflicts of interest can be found in the Ministry publication Conflict of Interest Guidelines for District Health Boards.

Legal requirements

2.3.4 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 interests. Conflicts of interest are defined in section 6 of the NZPHD Act, and the statutory process for their management is set out in Schedules 3 and 4.

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

2.3.6 Subsection (2) of section 6 defines what it is to be interested in a transaction

2.3.7 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/whānau employment connections with the DHB should be disclosed.

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

a. if his or her interest in a transaction is so remote or insignificant that it cannot reasonably be regarded as likely to influence him or her in carrying out his or her responsibilities under the NZPHD Act or another Act, or

b. because he or she receives remuneration or other benefits authorised under the NZPHD Act or another Act unrelated to the transaction.

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

Ethical and good practice considerations

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

2.3.11 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 the nature of existing interests changes.

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

2.3.13 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 of conflicts should also be raised during meetings where it is felt another member's proper participation could be compromised by their conflicts.

2.3.14 Clause 36(4) of Schedule 3 of the NZPHD Act allows members who have disclosed interests to take part in deliberations (but not 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, extreme care is required. 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.

2.3.15 The DHB must also ensure that it declares instances where such waivers have been granted in its annual report, in accordance with section 42(4) of the NZPHD Act.

2.3.16 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. For example, where relevant, members should consider how to manage communications with DHB staff. Despite the existence of management strategies being put in place, the board must always be prepared to act further (eg, exclude board members from involvement with a transaction, or to cancel a procurement or other process where that is necessary to ensure a fair and proper process).

2.3.17 The Auditor General's Good Practice Guide Foreword — Office of the Auditor-General New Zealand (March 2007) provides further assistance in considering ethical and good practice considerations.

Duty not to disclose information

2.3.18 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.

2.3.19 In regards 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 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

2.3.20 The State Services Commissioner's *Standards of Integrity and Conduct* (the Standards) are a code of conduct that came into force on 30

November 2007. The Standards were issued by the Commissioner under section 57 of the CE Act and apply to all DHB employees. (Board member conduct is regulated by members' individual and collective duties under the CE Act.)

2.3.21 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 set out in the Standards.

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

2.3.23 A number of elements of the Standards apply to conflict of interest situations. For example, DHB employees:

a. must 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 our organisation or of the State Services Commission.

A copy of the Standards is available online at**:** Code of conduct for the State Services

Summary

2.3.24 Each DHB must ensure that they comply with the:

a. provisions of the NZPHD Act in respect of conflicts of interest, meaning that interests are properly disclosed and managed; and that appropriate disclosures are made in the DHB's annual report

b. *Standards of Integrity and Conduct* as do any state servant and state services organisation.

2.4 Board self-assessment

2.4.1 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.

2.4.2 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 Officer should participate in the process at an appropriate level.

e. The output of the process will be that the board:
    - makes a report on its overall performance, 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), assurance that the self-assessment process has been appropriately implemented (ie, by providing a brief outline of the process), and comment on any other significant issues that should be brought to the attention of the Ministry or Minister of Health
    - that the board will supply the Ministry with a copy of that report as soon as practicable after its completion, while the DHB retains the individual assessments/plans which are not shared with the Ministry[2]
    - should consider the extent to which its committees would benefit from a similar self-assessment exercise.

2.5 Political neutrality

2.5.1 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] 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.

2.5.2 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 1988. Under the *Standards*, DHB employees must:

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.

2.5.3 DHBs should be aware that it is a constitutional convention that Ministers avoid making major decisions around elections. 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.

2.5.4 Further 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 at http://www.ssc.govt.nz.

3 Planning and Accountability

3.1 Purpose of the section

3.1.1 This section sets out requirements of DHBs relating to 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.
c. The accountability requirements for DHBs under the Public Finance 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 plans under the NZPHD Act (**3.3**)
- prepare and provide DHB accountability and planning documents (**3.2**)
- prepare and provide annual accountability documents under the CE Act **(3.4)**
- provide annual reports under sections 150–157 of the CE Act (**3.7**)
- prepare and provide accountability documents under the Public Finance Act **(3.8)**
- develop, maintain and exercise a Health Emergency Plan (**3.11**)
- demonstrate the use of equity tools (see 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 (**3.12**)
- aim to reduce health disparities by improving health outcomes for Māori and other population groups, such as Pacific peoples and ethnic peoples (**3.13**)
- take account of the needs within the community to be served in order that access to services and communication in relation to such services are effective and responsive, and that services are safe and effective for all people (**3.14**)
- continue to co-ordinate and monitor the implementation of the updated evidence-based guidelines (**3.16**)
- have written and implemented policies and procedures for seeking ethical review and advice from an approved ethics committee (**3.17**)
- have service information for consumers (**3.18**)
- facilitate support from whānau, hapū, iwi, kaumātua, rongoa practitioners, spiritual advisors, Māori staff and others as appropriate for Māori accessing their services (**3.19**)
- not act inconsistently with the Pharmaceutical Schedule (**3.20**)
- adhere to the selection of service providers, particularly the Provider Selection Protocols (**3.21**)

- follow the guidelines as set out by the Nationwide Service Framework (**3.26**)
- use the standard of contract forms, which are part of the Nationwide Service Framework, and to use the services of the Information Delivery and Operations Group for all contract generation (**3.22**)
- give effect to the guidelines for contracting with non-governmental organisations developed by The Treasury, Audit New Zealand and the State Services Commission (**3.23**)

3.2 DHB accountability and planning documents

NZPHD Act - see sections 38 (Planning framework and requirements) and section 10 (Crown Funding Agreement)

3.2.1 The accountability documents inter-relate and fit in the broader accountability environment. Each DHB is required to prepare, and agree with the Minister of Health:

a. An Annual Plan (see 3.3); and

b. A Regional Service Plan (see 3.4)

3.2.2 S38(2) requires that every plan must address:

a. Local, regional and national needs for health services; and

b. How health services can be properly co-ordinated to meet those needs

c. The optimum arrangement for the most effective and efficient delivery of health services; and

3.2.3 Must demonstrate how a DHB that is party to the plan is to give effect to the purposes of the NZPHDAct; and

3.2.4 Must reflect the overall direction set out in, and not be inconsistent with, the New Zealand health strategy and the New Zealand disability strategy.

3.2.5 A DHB that is party to a plan must comply with any requirements (including any procedural requirements) relating to the plan that are stated in regulation (if any).

3.2.6 The plan is finalised once it is –

a. Approved by the Minister after he or she is satisfied that the requirements of subsections (2) and (3) have been met; and

b. Signed by the Minister and every DHB that is party to the plan.

3.2.7 A DHB that is party to the plan must give effect to it and any amendments to it.

3.2.8 The plan may be amended at any time in the same manner as it was made.

3.2.9 A DHB that is a party to the plan must ensure that the plan and any amendments to it are publicly available as soon as is reasonably practicable after that plan is finalised.

3.2.10 In making the plan (and any amendments to it) publicly available, a DHB may omit any information that may properly be withheld under the Official Information Act 1982 if a request for that information were made under the Act.

3.3 The Annual Plan (AP)

3.3.1 s38(1)(a) of the NZPHD Act Section 38(1)(a) states the Minister must direct every DHB to prepare a plan for each financial year beginning on or after 1 July 2011.

3.3.2 s92 (1) allows for the development of Planning Regulations. These Regulations were invoked on [date] and stipulate that DHB AP must contain the following requirements:

a. how performance, both as a funder and as a provider of services, will be demonstrated;

b. its stewardship, as owner, of its assets, workforce, IT/IS, and other infrastructure needed to deliver its services (I will be expecting much clearer planning, monitoring, and reporting of DHBs' separate roles of funder and provider of services and owner of Crown assets);

c. strong intervention logic across funding, key actions and outputs, expected impacts and outcomes;

d. the key actions and outputs (linked to funding) the DHB will deliver in order to meet Government priorities, Health Targets, including its performance targets for all measures within the performance monitoring framework;

e. service coverage / service change requirements, emerging policy or sector issues, Maori health or other sub-plan requirements laid out in annual planning guidance;

f. detailed outputs for which DHBs will be held to account, both as a funder of services for its population and as a provider of services;

g. detailed financial budgets;

h. the actions the DHB will lead / deliver to support delivery of regional plans and where relevant, national service plans;

3.3.3 Refer to the 11/12 planning guidelines for more detail on requirements on the 2011/12 AP

3.4 Other plans as required by Planning Regulations

3.4.1 s38(1)(b) of the NZPHD Act states that the Minister may direct a DHB to prepare or contribute to 1 or more other plans. These plans are set out in the Planning Regulations, under section 92(1) of the NZPHD Act. These Regulations were invoked on [date] and stipulate that DHBs must prepare Regional Service Plans containing both strategic and implementation sections:

3.4.2 ***Strategic component***

a. an outline of the strategic environment including Government goals, national service and infrastructure strategies and plans. This would include an outline of key regional strategic issues in health and disability service delivery, and in addressing Maori Health (in line with the legislative objectives and functions of DHBs on improving Maori Health);

b. current and future regional population characteristics including demography, socio-economic determinants, health status, and demand for health services in the region;

c. summary of current service delivery configuration and operating requirements across the region (for example service activity and access levels, operating cost, workforce requirements, capital, and IT requirements) as specified in the annual planning package;

d. an analysis of options of future models of care and service delivery configuration across the region, including quality and safety considerations, and workforce, operating cost, facility and IT needs, assessing the options' impact on the regional population;

e. long-term (5-10 years) strategic intentions

f. agreed regional actions that will be delivered in order to meet regional strategic priorities. This will need to include a strong explanation of the link between funding, key actions and outputs, and expected impacts and outcomes;

3.4.3 ***Implementation component***

a. be fully costed for the services to be implemented;
b. be clear on how patient or service user pathways will be managed to ensure smooth transition of people to services according to their needs;

c. state how the implementation of the regional service plan will be governed and managed;

d. contain collaborative performance measures and targets, and specify monitoring and evaluation processes;

e. specify the funding mechanisms and approaches for regional services and the methods that will be used to purchase the services;

f. specify how the region will manage consultation needs across any proposed major service reconfiguration or change

g. cover risk management arrangements;

h. lay out a regional dispute resolution process and how disputes between DHBs in the region will be managed.

3.4.4 Refer to the planning guidelines/templates.

3.5 The Crown Funding Agreement (CFA)

(NZPHD Act – section 10)

3.5.1 The CFA is the output agreement between the Crown and DHBs. The Crown (the Ministry) agrees to provide money in return for service provision as specified in the agreement. The CFA links the AP to the funding provided by the Minister of Health and the performance required from the DHB. Clause A.3.2 of the Operational Policy Framework (OPF) and the Service Coverage Schedule are incorporated into this agreement. For more detail on the CFA refer to section 10 of the NZPHD Act and the CFA.

3.6 Statement of Intent (SOI)

(CE Act 2004 - sections 141–143 and 146–148)

3.6.1 **The Statement of Intent** (SOI) (sections 138–149 of the CE Act): written by each DHB is the formal accountability document between the DHB and Parliament and has a three-year focus. Performance against the financial and non-financial expectations is described in the Statement of Intent and reported at the end of each year in the DHB's annual report.

3.6.2 The content of the **Statement of Intent** is set out under section 141 of the CE Act 2004. Section 142 of the CE Act requires additional information in the Statement of Intent for the first financial year to which it relates.

3.6.3 The Statement of Intent and statement of forecast service performance are also covered regarding exemption for certain outputs under section 143 of the CE Act.

3.6.4 Approval and modification of the Statement of Intent are covered under sections 146 to 148 of the CE Act.

3.7 The Annual Report

(CE Act - sections 150 – 157)

3.7.1 The Annual Report is a key public accountability document that must be presented to Parliament. It is the means by which a DHB, as a Crown entity, discharges its accountability to members of Parliament and the public they represent. It is the key resource for the financial review of the performance and current operations of each DHB that select committees conduct under the Standing Orders of the House of Representatives.

3.7.2 A DHB's annual report must provide the information that a reader would need to make an informed assessment of the DHB's operations and performance for that financial year. Such an analysis would include an assessment against the intentions, measures and standards that the DHB set out in its SOI at the beginning of the financial year.

3.7.3 A DHB's annual report must be in writing, be dated and be signed on behalf of the board by two members.

Contents of annual reports

3.7.4 The content of a DHB's annual report is stipulated in section 151 of the CE Act. A DHB's annual report must also contain information required by section 42 of the NZPHD Act:

3.7.5 In accordance with section 152 of the CE Act, a DHB must also disclose payments in respect of its board members, committee members, office holders and employees in a DHB's annual report. DHBs should comply with all elements of that section.

Statement of service performance

3.7.6 A DHB's statement of service performance must comply with section 153 of the CE Act.

Annual financial statements

3.7.7 DHBs must prepare financial statements for that financial year in accordance with section 154 and section 151(1)(c) of the CE Act.

Statements of responsibility

3.7.8 Section 151(1)(d) of the CE Act requires a DHB's annual report to contain a statement of responsibility. The required contents of statements of responsibility are set out in section 155 of the CE Act.

3.7.9 The statement of responsibility is to be dated and signed on behalf of the board by two members.

Audit and process

3.7.10 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. It is important for the effectiveness of an annual report that readers can see the links between

the audited financial statements and the other information provided on the DHB's operations and performance, as well as the links between the financial and non-financial information in the audited statement.

3.7.11 The process that a DHB must follow for the auditing of the annual report by the Auditor-General is set out in section 156 of the CE Act. Also note 'Presentation of Papers to the House', a document promulgated by the Office of the Clerk of the House of Representatives, is found online at New Zealand Parliament - Home. The required process is that the:

a. DHB must forward to the Auditor-General its annual financial statements, statement of service performance, and any other information that the Auditor-General has agreed, or is required, to audit within three months after the end of each financial year (refer section 156(1)(a) CE Act) (note: the Ministry would also appreciate a draft copy of the DHB annual report prior to submission to the DHB auditors)

b. DHB must forward its annual report to the Auditor-General in a timely manner (refer section 156(1)(b))

c. Auditor-General will review and provide an audit report to the DHB within four months after the end of each financial year

d. DHB must provide its annual report to the Minister no later than 15 working days after receiving the audit report provided under section 156 (refer section 150(1)(b))

e. Minister must present the DHB's annual report to the House of Representatives within five working days after receiving it or, if Parliament is not in session, as soon as possible after the commencement of the next session of Parliament (refer section 150(3))

f. DHB must publish its annual report as soon as practicable after it has been presented to the House of Representatives, but in any case not later than 10 working days after the annual report is received by the Minister, in a manner consistent with any instructions given by the Minister of Finance under section 174 of the CE Act (refer section 149(3)).

Publication

3.7.12 In accordance with section 174 of the CE Act, if a DHB's annual report is published in advance of its presentation to the House of Representatives (because the House is not in session); a notice is required to be published in the Gazette indicating that the annual report has been published.

3.7.13 DHBs are to publish their annual reports electronically according to the practice recommended in the New Zealand Government Web Guidelines as set out online at http://www.e-government.govt.nz/web-guidelines

3.8 Key financial information

Public Finance Act 1989 –

3.8.1 Key financial information must be provided under the Public Finance Act 1989; 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 AP.

3.9 National Service Planning

3.9.1 One of the principal functions of the Ministry via its business unit, the NHB, is to be a planner and funder of services that are national in scope.

3.9.2 The NHB will advise the Minister on services where patient care, access, and clinical and financial viability can be improved by national involvement. Two different approaches are to be adopted in during 2011/12 for development of new services at a national level.

3.9.3 National Services - services that are to be nationally planned and funded [‘purchased’] by the NHB.

3.9.4 National Service Improvement Programmes - services that require centrally coordinated planning and/or performance improvement activities, but are not currently seen as requiring the additional step of the NHB purchasing.

3.9.5 The NHB 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.

3.9.6 Five initial candidate services will be developed as National Services effective as of 1 July 2011. These services are: Clinical Genetics, Paediatric Pathology, Paediatric Metabolic Services, Paediatric Cardiology and Paediatric Cardiac Surgery. A further five services will be the recipients of National Service Improvement Programmes. These services are: Cardiac Surgery, Paediatric Oncology, Paediatric Gastroenterology, Neurosurgery and Major Trauma.

3.9.7 The appropriate planning and funding and contracting model will be implemented for each National Service.

3.9.8 Leading up to and following the release of the 2011/12 Planning Package, the NHB will work with DHBs to develop contract specifications and arrangements for the services to be planned and funded nationally; identify the funding methodology for providers; negotiate terms with selected provider(s); and develop national clinical network arrangements

for both National Services and National Service Improvement Programmes.

3.10 Devolved Services

3.10.1 The Cabinet has instructed the NHB to advise on the best location for effective and efficient planning and funding of services. A component of that is advice on the services currently purchased by the Ministry. Advice on the full range of those services will go to the Minister in 2010 for consideration. Work subsequent to Ministerial decisions may involve further detailed analysis and advice, or development of implementation paths. Close consultation with DHBs and other stakeholders will be necessary throughout that programme of work. Timing and scope will be dependent on Ministerial decision.

3.10.2 Work on previous government decisions to transfer to DHBs the planning and funding responsibility for supports for people with long-term chronic conditions (also known as the Interim Funding Pool) has been underway with Board for some time. The Minister has confirmed that this is to proceed and indicated that it should be managed regionally by Boards. Funding will transfer effective from 1 July 2011.

3.11 Emergency planning and management

3.11.1 Emergency planning reference documents:

a. Legislation

- The Health (Burial) Regulations 1946
- The Health Act 1956
- The Health (Infectious and Notifiable Diseases) Regulations 1966
- The Medicines Act 1981
- The Health (Quarantine) Regulations 1983
- The Public Health and Disability Act 2000
- The Civil Defence Emergency Management Act 2002
- The Health Practitioners Competence Assurance Act 2003
- The International Health Regulations 2005
- The Epidemic Preparedness Act 2006
- The Public Health Bill (proposed legislation)

b. Other documents

- Paragraphs 28 to 32 of the National Civil Defence Emergency Management Plan Order, 2005
- The National Health Emergency Plan (NHEP)

- National Health Emergency Plan: Guiding Principles for Emergency Management Planning in the Health and Disability Sector, 2005
- National Health Emergency Plan: Hazardous Substances Incident Hospital Guidelines, 2005
- National Health Emergency Plan; H5N1 Pre-Pandemic Vaccine Usage Policy (latest published edition)
- National Health Emergency Plan: National Reserve Supplies Management and Usage Policies (latest published edition)
- The New Zealand Influenza Pandemic Action Plan (latest published version)
- Any other published National Health Emergency Planning documents.
- The Environmental Health Protection Manual
- Health and Disability Standards (2008) Part 4.7; 'Essential emergency and security systems.'

Intention

3.11.2 Each DHB will develop, maintain and exercise:

a. a health emergency management function and capability, led by a designated Health Emergency Manager; and
b. a Health Emergency Plan (HEP).
c. DHB Health Emergency Management

3.11.3 The purpose of DHB health emergency management is to:

a. develop, maintain, exercise and operate the DHB Health Emergency Plan; and
b. ensure essential ambulance, primary, secondary, tertiary, mental health, disability support and public health services will continue to be delivered during health emergencies, civil defence emergencies, large casualty-causing incidents, major weather events, infrastructure failures, or natural disasters.

3.11.4 DHB personnel must include:

a. a designated manager with appropriate qualifications and skills responsible for all aspects of health emergency management ; and
b. other individuals appropriately trained and skilled in emergency planning and management, sufficient in number to carry out the functions defined in this document.
c. DHB emergency management personnel will be trained and equipped to respond to DHB emergencies, national warning system alerts, Ministry code alert messages, or any event that may impact on DHB services, and

to provide a cadre of appropriately skilled staff for the management of large or extended emergencies.

d. The DHB emergency management function is to be funded by sustainable funding provided for the purpose through the Crown Funding Agreement and other Ministry contracts, plus any additional DHB funds required to ensure legislative and Ministry requirements relating to emergency planning and management can be met.

The DHB Health Emergency Plan

3.11.5 The Health Emergency Plan 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 – and 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 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.

3.11.6 The Health Emergency Plan will:

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

b. use the Co-ordinated Incident Management System (CIMS) structure and functional roles, and identify the human resources required for these roles

c. identify and document the specific roles and responsibilities of the major health agencies, units and providers involved in an emergency response[3]

d. provide for the use of communications networks, structures, data standards and formats defined in NHEP documents for all DHB (and, where appropriate, DHB provider)[4] communications with the Ministry of Health, the National Health Co-ordination Centre or National Crisis Management Centre during an emergency, threat of emergency, or exercise

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[3] Specifically including but not limited to DHB emergency management and planning and funding sections, DHB hospitals, DHB public health units, and primary health organisations.

[4] Specifically including, but not limited to public health units (PHUs).

e. 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 (EMIS), information management, decision making and emergency management), sufficient in numbers to operate the DHB HEP on a sustainable basis
f. 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
g. describe the HEP's linkages with, assumptions about, and critical dependencies on the emergency response plans of other government and/or non-government agencies which may be involved in an emergency response (such as Civil Defence, ambulance, fire, police, the defence forces, and other relevant agencies)
h. 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, these organisations' emergency response plans
i. describe the protocols and processes that provide for the transfer to other DHBs of human resources, and/or supplies maintained under national programmes (such as medications, personal protective equipment and other clinical supplies)
j. describe the protocols and processes that provide for the receipt and management of human resources and/or supplies from other DHBs, or from national stockpiles
k. provide for DHB co-ordination, direction and support of health-related community responses to a very large scale or extended emergency such as pandemic disease.

3.11.7 The DHB response to local health emergencies and/or contributions to the response to a regional or national health emergency, or threat of an emergency, will be made 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

3.11.8 Each DHB's health emergency plan is required to define, links with and critical dependencies on regional health emergency plans (ie, plans for the Northern, Midland, Central and Southern 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

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.

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

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

Provider health emergency plans

3.11.11 Each DHB will ensure that:

a. all DHB health service and other service provider5 agreements contain contractual commitments requiring a provider HEP or provider emergency service provision plan (as appropriate), relating to the services provided

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

Exercising the Health Emergency Plan

3.11.12 The HEP will describe the exercise programme planned to further develop and test all aspects of the DHB HEP. 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.

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[5] Suppliers to the DHB of goods or services other than health services, such as facility support, maintenance, laundry, catering services, fuel, transport, etc.

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

3.11.14 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 or night.

DHB health emergency plan sign-off and publication

3.11.15 The DHB HEP must be signed off by the DHB Chief Executive.

3.11.16 The HEP sign-off process must be repeated:

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

b. every third year at minimum.

3.11.17 The DHB's HEP is to be a public 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.

3.12 Reducing health inequalities

3.12.1 In order to achieve a reduction in health inequalities, in particular for Māori, Pacific peoples ethnic peoples, and low income groups, each DHB is required to demonstrate the use of equity tools (for example the Reducing Inequalities Intervention Framework and the Health Equity Assessment Tool) in all service planning. Each DHB is also required to demonstrate how this use has informed service reconfiguration and other actions.

3.13 Improving the health of Māori, Pacific peoples and ethnic people

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

3.13.1 It is one of the explicit purposes of the NZPHD Act 'to reduce health disparities by improving the health outcomes of Māori and other population groups' within the context of section 4 of the Act.

3.13.2 Each DHB (in both its funder and provider functions) must aim to reduce health disparities by improving health outcomes for Māori and other population groups, such as Pacific peoples and ethnic peoples.[6]

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

3.13.4 Each DHB must foster the development of Māori, Pacific and ethnic capacity and capability to participate in the health and disability sector, and providing for the needs of Māori, Pacific peoples and ethnic peoples (including by contributing to population -specific provider and workforce development and by improving access to, and the effectiveness of, mainstream services for Māori, Pacific and other populations).

3.14 Acceptability of services

(See Health and Disability Services Standards (H&DSS) 1.1 and H&DSS 1.2, CAB Min (02) 31/13, POL Min (03) 27/3, CAB Min (04) 42/5A.)

3.14.1 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.

3.14.2 It is expected that each DHB will:

a. deliver services in a culturally appropriate and competent manner, with acknowledgement and respect of 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

c. use reasonable endeavours to incorporate Māori principles/tikanga as part of ensuring effective service delivery processes.

[6] 'Ethnic' defined by the Office of Ethnic Affairs in *Ethnic Perspectives in Policy* as that group of people whose ethnic heritage distinguishes them from the majority of other people in New Zealand, including Māori and Pacific people.

3.14.3 Each DHB must develop and maintain links with key groups in its locality (see paragraph 3.14.2 above) in order to facilitate consultation and encourage their involvement in planning, implementing, monitoring and reviewing services. Two key objectives for He Korowai Oranga Māori Health Strategy are improving access to, and the effectiveness of, mainstream services for Māori: and the delivering services to the highest clinical and quality standards (taking into account the need for cultural as well as clinical safety) within available funding.

3.15 Prioritising health needs and services

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

3.15.1 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

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,[7] people with a disability and non-governmental organisations (NGOs), in the service planning process

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.

3.16 Implementation of evidence-based guidelines

3.16.1 In order to achieve demonstrable quality improvement, DHBs should continue to co-ordinate and monitor the implementation of the updated

[7] The Office of Ethnic Affairs in *Ethnic Perspectives in Policy* 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.

evidence-based guidelines relating to diabetes and cardiovascular disease.

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

3.17 Ethical review of research and innovative treatments

(See Operational Standard for Ethics Committees (Updated 2006) Ethical Guidelines for Observational Studies: Observational Research, Audits and Related Activities 2006 (National Ethics Advisory Committee), Guidelines for the Use of Human Tissue for Future Unspecified Research Purposes 2007 (Ministry of Health), Guidelines for Using Cells from Established Human Embryonic Guidelines 2006 (Ministry of Health) and Guidelines for Researchers on Health Research Involving Māori 2008 (Health Research Council of New Zealand).)

3.17.1 If a DHB conducts research and innovative procedures or treatments, the DHB will have written and implemented policies and procedures for seeking ethical review and advice from an approved ethics committee, in accordance with the current Operational Standard for Ethics Committees and listed Guidelines. These policies and procedures will include a requirement to ensure that the DHB has sufficient indemnity insurance to compensate participants for harm that does not qualify for compensation under the Accident Compensation Act 2001.

3.17.2 DHBs are required to consult with Māori in relation to any research, or innovative procedures or treatments, which will impact on Māori in accordance with Section 2.7 of the Operational Standard for Ethics Committees (updated 2006) and Guidelines for Researchers on Health Research Involving Māori 2008 (Health Research Council of New Zealand).

3.18 Service information for consumers

(See H&DSS 3.1.3.)

3.18.1 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).

3.18.2 Service information may be in the form of a brochure and must include at least the following:

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 Health and Disability Commissioner Code of 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 in order for people to access DHB services.

3.18.3 This information must be presented in a manner appropriate to the communication needs of consumers and communities.

3.19 The Pharmaceutical Schedule

(See sections 23(7) and 48(a–b) NZPHD Act.)

3.19.1 Section 23(7) of the NZPHD Act, 'Functions of DHBs', states that in 'performing any of its functions relating to the supply of pharmaceuticals, a DHB must not act inconsistently with the Pharmaceutical Schedule'. The purpose of this section is to clarify what DHBs must do to give effect to this requirement.

3.19.2 DHBs must support PHARMAC in its role under section 48(a) of the Act 'to maintain and manage a Pharmaceutical Schedule that applies consistently throughout New Zealand, including determining eligibility and criteria for the provision of subsidies'.

3.19.3 Each DHB is required to:

a. comply at all times with the rules of the Pharmaceutical Schedule and with any decisions made by PHARMAC in relation to the Pharmaceutical Schedule

b. ensure that, where a patient of any of its provider arm hospitals or related facilities is prescribed a pharmaceutical listed on the Pharmaceutical Schedule for use in the community (ie, off the hospital premises, such as in the patients home), it is dispensed by a community pharmacy or, where the pharmaceutical is listed in the Pharmaceutical Schedule under a hospital pharmacy restriction, by a pharmacy consistent with the applicable definition in the Pharmaceutical Schedule

c. ensure that pharmaceuticals that are not listed on the Pharmaceutical Schedule for use in the community are dispensed to patients of its provider arm hospitals or related facilities in a way that is consistent with the provisions and rules of the Pharmaceutical Schedule relating to the

exceptional circumstances scheme and/or with any directions from the Minister

d. 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

e. 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, relating to the exceptional circumstances scheme)

f. 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 Funding Agreement

g. purchase dispensing services for its resident population and for other people as specified in the Service Coverage Schedule exclusively from providers approved for the purpose under the Medicines Act (1981)

h. comply with the relevant terms of any contracts for hospital pharmaceuticals which have been negotiated by PHARMAC

i. provide PHARMAC with data in relation to hospital pharmaceuticals in accordance with the terms of the Pharmaceutical Schedule

j. ensure that transition level information on subsidised medicines dispensed in the community continues to be supplied by community pharmacies in a format that can be included in the Pharmaceutical Data Warehouse held at the Information Delivery and Operations Group

k. ensure that transition level information on pharmaceutical cancer treatments (as defined in the Pharmaceutical Schedule) dispensed in hospital pharmacies is supplied by hospital pharmacies in a format that can be included in the Pharmaceutical Data Warehouse held at the Ministry.

3.19.4 The exceptional circumstances scheme is administered by PHARMAC. Any amendments to the rules regarding the administration of this scheme will be developed by PHARMAC in consultation with DHBs. DHBs must comply with the pharmaceutical funding decisions made by the Exceptional Circumstances Panel.

3.20 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, SOC Min (09) 13/1.)

Selection of providers

3.20.1 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 disabilities sector: in some cases DHBs will be heavily dependent on private providers to deliver some publicly-funded services.

3.20.2 The following protocols were agreed by Cabinet in 2000, 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 to purchase from private providers with DHBs and managing 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.

3.20.3 The **provider selection protocols** set out the following requirements for the process of choosing a provider:

a. The choice of providers and facilities 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 needs and, 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 primary health organisations).

e. Where a DHB has a significant[8] 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).

f. Where a DHB has a significant proposal to shift services out of a public provider,[9] or to start providing services previously provided by a non-government provider, this change should be 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, etc) regardless of whether the provider is publicly owned or not.

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:
   - 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.

k. For further information refer to the Public/Private Radiotherapy Protocol and Public Capacity Sharing Protocol both of which are published on http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/300.

3.20.4 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 be the one that most effectively achieves the goals of the public health and disability sector. In considering the selection of providers, therefore, 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.

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8 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.

9 Including a service run by a number of DHBs together.

Nationwide providers

3.20.5 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.

3.20.6 In all of these situations, DHBs and the Ministry must comply with the requirements in the *Nationwide Service Framework* (see section 3.21 below). Prior to making any significant changes to service agreements with nationwide providers, a DHB must inform and discuss with the Ministry the substance of 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.

3.20.7 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. a change to the provider, or
b. a material change to the level, nature or volume of services provided, or
c. a material change to funding method or contracting arrangement.

Involvement in privately-funded service provision

3.20.8 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.

3.20.9 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.

3.20.10 **Private involvement protocols.** Each DHB must notify their 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 Funding Agreement 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

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:

a. services funded by the Accident Compensation Corporation and other accident insurers

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

3.20.11 For clarity, in respect of protocol d), DHBs cannot branch into new service lines on a purely private basis.

Sponsorship

3.20.12 The principles that guide a DHBs 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 also 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 result in:

d. directly or indirectly increasing costs for another funder, or
e. conflict with government or health policy.

3.20.13 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.

3.20.14 In all cases, of 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 and discuss with the Ministry the substance of the proposal, including 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.

3.21 The Nationwide Service Framework

(See CAB (00) 319, CAB (00) 418 and SPH (00) 160 The Nationwide Service Framework (NSF): National Service Framework Library (NSFL)

The purpose of the NSF

3.20.15 The NSF is a collection of definitions, methodologies and processes that provide a ‘common language’ necessary to achieve an agreed level of nationwide consistency of approach to funding, monitoring and analysing services. NSF information is published on the NSFL, a website maintained by the Ministry.

3.20.16 The Ministry and DHBs are expected to use the NSF to ensure:

a. consistency and clarity of what services are funded or provided, and to facilitate analysis, prioritisation and benchmarking
b. efficient information sharing and interactions between DHBs and the Ministry, in order to avoid duplication and support a focus on value-adding activities.

Components of the Nationwide Service Framework

3.21.1 The mandatory components of the NSF include:

a. nationwide service specifications published on the NSFL

b. common service agreement forms and documentation[10] (including notices issued under Schedule 88 of the NZPHD Act)

c. the Purchase Unit Data Dictionary

d. established business rules, such as wash-ups, inter-district protocols and risk management

e. current monitoring processes

f. Information Directorate services (as described in the Memorandum of Understanding (MoU) between DHBs and the Ministry)

g. clinical coding, Diagnostic Related Groups (DRGs) and cost weights

h. use of Common Chart of Accounts

i. application of both the Common Counting Technical Advisory Group and Common Costing Group Standards.

3.21.2 Use of the mandatory components of the NSF also ensures the integrity of the central processing and information services provided by the Information Directorate of the Ministry. These units in turn support the integrity of the NSF and it is mandatory for DHBs to use their services.

3.21.3 Other components include, but are not limited to:

a. tools and processes for allocation decisions

b. recommended service specifications

c. service definitions, purchase units, units of measure, data definitions and quality specifications

d. benchmark prices

e. continuous improvement processes (review and technical work)

f. demographic and volume information

g. monitoring processes.

Service and provider quality specifications

(See section 9 NZPHD Act, The Health and Disability Services (Safety) Act 2001 and Government policy.)

3.21.4 For services that are funded, each DHB and the Ministry must use the appropriate nationwide service specification that is available in the NSFL, or

[10] It has been acknowledged that some DHB service agreements are not yet entered in Information Directorate files / databases. It is recognised that these are agreements that were historically entered into by Hospital and Health Services prior to the coming into effect of the NZPHD Act 2000. DHBs will use best endeavours to enter these agreements into the Information Directorate systems at the time of their renegotiation, if not before.

the Ministry's website whenever the DHB enters into new service agreements, or when the DHB is varying or rolling over existing service agreements.

3.21.5 In addition, each DHB must comply with quality requirements in nationwide service specifications for services that it provides. Each DHB must also include non-discretionary quality requirements are included in agreements with funded providers. Where a service or new initiative is not covered by a current nationwide specification the DHB shall develop a local specification. To reduce duplication of effort, email the NSFL (nsfl@moh.govt.nz) to check if there are other local specifications already available. Local specifications may also be published in the NSFL as non-mandatory for other DHBs to use.

3.21.6 Service specifications content headings will include:

a. service definition
b. service objectives
c. service users and access criteria
d. service component descriptions
e. quality requirements
f. purchase units
g. reporting requirements.

3.21.7 All service specifications must include or reference the Māori health clause as services are expected to contribute to the reducing of health inequalities and to achieving Māori health gain objectives in areas of key need.[11]

Service contracting

3.21.8 A full description of the services provided by the Information Directorate Sector Services Business unit Agreement Administration Teams of the Ministry, and the expectations of both DHBs and the Ministry in terms of the delivery of those services, is detailed in a MoU signed by both parties. This section of the OPF is to be read in conjunction with the MoU, insofar as the application of the NSF supports the Information Directorate's effective delivery of services to DHBs.

3.21.9 DHBs must use the services of the Information Directorate of the Ministry for all service agreement management[12] (including agreement generation, payment against agreement and support in terms of monitoring against the agreement) relating to the funding of services. In using the services, DHBs

[11] 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. Health providers are expected to provide health services that will contribute to realising this aim. This may be achieved through mechanisms that facilitate Māori access to services, provision of appropriate pathways of care which might include, but are not limited to, matters such as referrals and discharge planning, ensuring that the services are culturally competent and that services are provided that meet the health needs of Māori. It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of the service.

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

are to follow the standard processes for contract administration, including by using standard contract documentation.

3.21.10 A DHB or the Ministry can request a DHB-specific variation to the mandatory parts of the NSF, including transitional requirements, (Refer to 3.21.3 The Mandatory Components of the NSF). 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 one of urgency, the Director Performance will consider any DHB request for a DHB-specific variation or exemption

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

Governance and maintenance of the NSF

3.21.11 Endorsement of nationwide service specifications and oversight of the service specification work plan are the roles of the Nationwide Service Framework Co-ordination Group (NCG), or any successor groups. The NCG comprises a 20 DHBs / District Health Boards New Zealand (DHBNZ) representative on behalf of the DHB General Managers Planning and Funding Network, the Manager Performance and Funding, National Health Board Business Unit (NHBBU), Ministry (who functions as the Chair), and another suitably experienced Ministry official (who acts as the secretariat). Nationwide service specifications for non-devolved services will be endorsed solely by the Ministry members of NCG.

3.21.12 Where consensus cannot be reached on an NSF issue, the matter will be referred to the National Director of the NHB through the Director Performance Monitoring and Accountability for decision. The National Director, NHB (as the Minister's agent) retains final decision-making rights in relation to mandatory components of the NSF.

3.21.13 NSF components excluding Information Directorate NHB service delivery will be updated on approval from the NCG, or its delegated authority, according to whether:

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

b. the final document is clear and is the result of appropriate consultation through group processes

c. the final document has been approved by the National Director NHB, or his / her delegated authority, for inclusion in the NSF Library

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

e. there are clear net benefits for health and disability, clinical and financial sustainability and/or consistency and transparency.

3.21.14 Changes to the mandatory elements of the NSF come into force upon written notification to the DHBs by the National Director NHB. In addition to direct notification, the amendment will be published on the NSFL.

Publication

3.21.15 The Ministry will make all NSF components available to DHBs through the NSFL.

3.22 Contracts with primary health care providers

(See sections 88 and 89, NZPHD Act and CAB (01) 12/12.)

3.22.1 DHBs are required to use the standard contract forms, which are part of the Nationwide Service Framework (NSF), and to use the services of the Ministry's Information Delivery and Operations Group in generating all contracts as stated in section 3.21.9 above.

3.22.2 In particular, when renewing or entering into new contracts with primary health care providers, DHBs must include the standard audit and reporting requirements set out in contracts that form part of the NSF are included. In order to ensure that standard primary health care documentation is put in place with primary health care providers, DHBs are to use the Information Delivery and Operations Group for all contract generation.

3.22.3 In respect of notices issued under section 88 of the NZPHD Act, each DHB must comply carefully with the principles of national consistency and requirements in section 89 of that Act. In accordance with section 89(3) of the NZPHD Act, a DHB may not issue a notice under section 88 without the written approval of the Minister if the proposed notice:

a. relates to services in respect of which the DHB has not previously issued a notice, or

b. sets terms and conditions in respect of particular services that depart from terms and conditions set out in an existing notice in respect of the same or substantially the same services, or

c. differentiates between persons or classes of persons accepting payment under section 88.

In almost all DHBs will be required to obtain ministerial permission for a notice under section 89(3).

3.22.4 Whether or not ministerial permission is required, before considering whether to issue a new notice or an amendment notice, a DHB must first consult with the Ministry, so that the Ministry can monitor and comment on

issues that arise in relation to national consistency. Specifically, when issuing any new notices, a DHB must consult with the Ministry about the audit and reporting requirements to be included in the notice, with a view to mitigating the risk of double payments in the primary health care area and ensuring that the services are provided and are of high quality. 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.

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

3.23 Contracting with non-governmental organisations

3.23.1 DHBs should give effect to the guidelines for contracting with NGOs developed by the Treasury in conjunction with Audit New Zealand and the State Services Commission, 'Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown version 2.2 (April 2009)'. These guidelines are aimed at encouraging better contracting practices, minimising transaction costs and strengthening relationships with NGOs.

3.23.2 In these guidelines, The Treasury notes that its guidelines 'do not contain any mandatory requirements', but that 'government agencies should think very carefully before they decide to take a different approach, and be clear about the reasons for doing so'. The guidelines are important when contracting with community and voluntary organisations. They do not apply to straightforward commercial transactions, such as buying stationery.

3.23.3 DHBs should also give effect to the Office of the Controller and Auditor General's document, 'Procurement Guidance for Public Entities' (June 2008), and the good practice guide 'Principles to underpin management by public entities of funding to non-governmental organisations' published in June 2006 (http://www.oag.govt.nz/2006/funding-ngos/default.htm).

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

4 Service Change

4.1 Purpose of the Section

This section describes how DHB service change and public consultation is managed within the new 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 / national service change and service reconfiguration and 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 other related terms **(4.6)**

(See Planning Regulations (section 92(1) of the New Zealand Public Health and Disability (NZPHD) Act and SOC Min (10) 15/2, Service Change: Rules, Principles and Protocols, DHB Consultation Guidelines (to be updated 2011).

This section is also to be read in relation to the following OPF sections where relevant:

4.18 Selection of service providers (service change)
5.20 Cooperative agreements and arrangements (service change)
5.21 Acquisition of securities, shares and other interests (consultation)
5.26 Business cases (service change)
5.27 Dealing with land (consultation)
7.8 Inter District Flows (service change).

Mandatory Requirements of this Section

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. This ensures that Ministerial noting, or prior agreement, or agreement in principle for the proposed significant service change has taken place before inclusion in the DHB's Annual Plan, Regional Service Plan or other accountability documents **(4.3)**
- adhere to the Planning Regulations section 92(1) of the NZPHD Act. Where the Minister of Health directs DHBs to make significant changes, the Minister may also require DHBs to consult on how those changes should be made **(4.5)**

4.1.1 Key service changes processes

The key service change processes are:

- when it is required, all of a DHB's service change proposals must be discussed at an early stage with the DHB's Regional Relationship Manager[13] (Relationship Manager), to clarify if the Minister of Health is to be notified, and facilitate the Minister's prior approval or approval in principle. The responsibility lies with the

[13] The Regional DHB Relationship Manager(s) National Health Board Business Unit.

DHB to ensure alignment with Government expectations and legislation when considering service change proposals as part of their annual planning documentation. Note: a DHB's plan may be amended at any time in the same manner in which it was made.

- where the Minister directs DHBs to make significant changes, the Minister may also require DHBs 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.

4.2 Why good management of service change and consultation matters

4.2.1 Implementing health policy is complex and challenging, with a multitude of difficult and potentially contradictory policy choices for DHBs. There is also considerable public pressure to expand public spending on new medical technologies and greater levels of care and interventions.[14]

4.2.2 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 the DHB.

4.3 DHB Service Change Protocols and Requirements

4.3.1 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 it is required, the Relationship Manager will facilitate effective decision making of the proposed service change, and provide support and scrutinise funding and purchasing methods proposed.

4.3.2 If a critical situation arises that results in immediate impact on patient care and service delivery the DHB will immediately alert the Relationship Manager and affected DHBs. The NHB will agree necessary action with the DHB(s) to ensure a timely decision.

4.3.3 All proposed service change must be consistent with:

- the mandatory components of the Nationwide Service Framework, including the service coverage schedule and nationwide service specifications. (See 3.21)
- the sector's needs as a whole and not detrimentally affect:
  a. service delivery
  b. any necessary longer-term service changes
  c. the local, regional and national services objectives

[14] Ministry of Health. 2010. *Statement of Intent 2010–2013*.

d. generic service reconfiguration protocols that provide for short-term adjustments that are needed to address particular financial or service viability problems.

4.3.4 A proposed service change must also consistent with the sector's needs as a whole, and not compromise either other DHBs or other funders[15], or any necessary longer-term service reconfiguration.

4.3.5 A DHB's current arrangement for funding and/or provision of services will continue until the agreed service shift process is approved and completed.

4.3.6 DHBs will have developed a well argued case for the service change and 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.

4.3.7 The responsibility lies with the DHB to ensure alignment with the Government's expectations and legislation when considering all service change proposals as part of their annual planning processes and documentation.

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

DHB Collaboration

4.3.9 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, assist with patient loads (where appropriate) and proactively work with the DHB.

4.3.10 A DHB's service change will have effective funding mechanisms to achieve aims for planning their services collaboratively or nationally for implementation.

Note: Service Planning and New Health Intervention Assessment (SPNIA)

The SPNIA process is no longer operating. The Government has announced that the National Health Committee (NHC) will be reconfigured to focus on prioritisation of new, and a selection of existing, technology and interventions and related functions. DHBs will be informed of any changes that impact on them in advance of any changes coming into effect.

[15] Other funders in this context means funders such as Accident Compensation Corporation, Ministry of Social Development and other Government Agencies

4.4 Service Change Process

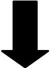
Table 4.1 Overview of the Service Change Process reflects the three stages of the process.

Joint evaluation	**A. Proposal in development** (DHBs evaluate if the proposal triggers the protocol for service change) refer to Table 4.2 Decision Tool - for NHB information only - does it meet the service change requirements?
	B. Discuss with Relationship Manager refer to Table 4.3 Information guideline for early discussion of a proposed service change. - 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. NHB triages proposal** to action as appropriate refer to Diagram 4.1 Service Change Process Flow Chart. a. No action needed by NHB- DHB to continue as business as usual, OR b. Relationship Manager facilitates analysis to support advice on proposal I. advice – not to proceed - does not meet requirements II. advice - yes (with riders if applicable) prepare information for noting for the Minister III. advice requires the Minister's prior approval c. Proposed change is sent to the Minister with all the information required to inform the decision
Decision	**D. NHB communicates the advice** and or the Minister's decision on the proposed service change to the DHB in writing.

4.4.1 Not all DHB service change requires input from the NHB 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 DHB planning service change and decision making and helps provide confidence that there are sufficient controls in place to manage potential risks of proposed service change.

Table 4.2 Decision Tool for Triggering Service Change Protocols

QA. Does this proposal meet the current Service Coverage Schedule (SCS) and / or the mandatory components of the Operational Policy Framework (OPF)?	• If YES proceed to QB. • 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



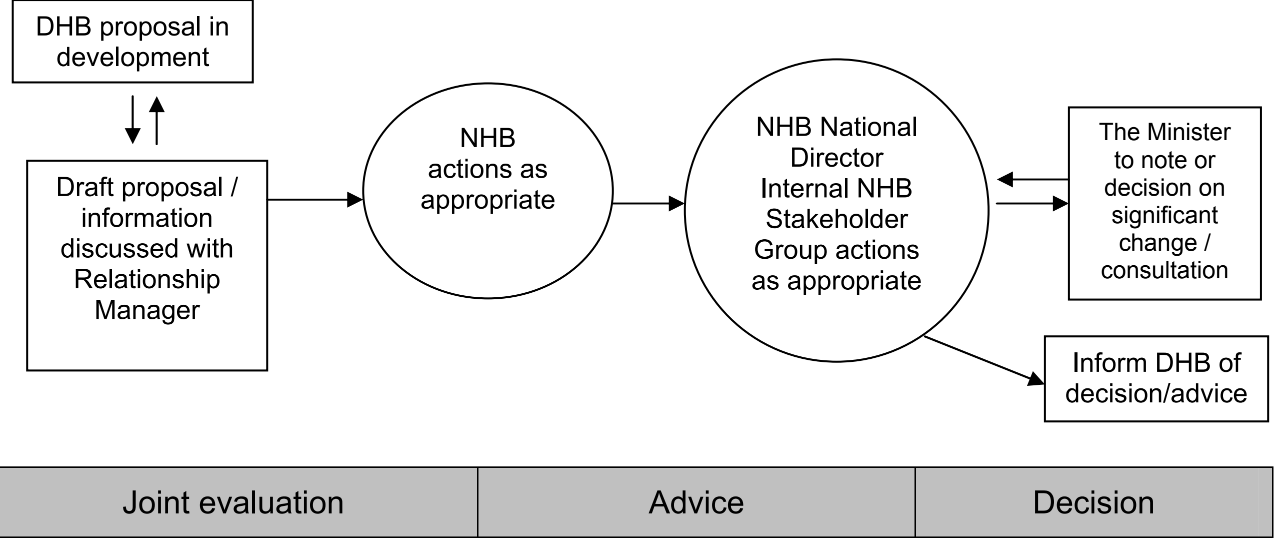
QB. Does this proposal trigger any of the existing protocols that require Ministerial approval (ie, significant service change, the capital approval process, the public / private service protocols)?	• If YES the DHB(s) discuss with the Relationship Manager(s). The NHB will use agreed criteria as to whether the Minister needs to be consulted using the service change protocols. • If NO, proceed to QC.

QC. Does this proposal: a. require public consultation under the Planning Regulations (section 92(1) of the NZPHD Amendment Act 2010 or b. is the proposal 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.

4.4.2 Early engagement with the Relationship Manager(s) to discuss the DHB(s) proposed service change and their implications / progress is an important part of the success of the service change approval process. To assist this discussion the initial key information to be considered is provided in Table 4.3. Significant service changes (See 4.5) that require the Minister's approval in principle / approval will need more in depth information to be provided to support a timely decision.

4.4.3 Service change proposals discussed with the Relationship Manager will follow the Service Change Process depicted in Diagram 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.

Diagram 4.1 Service Change Process Flow Chart for DHB Service Change Proposals



4.5 Significant service change and consultation

4.5.1 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 DHBs' population including access to services provided in other DHBs or the way that services are provided
- the financial position of DHBs proposing the change or for the other DHBs.

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

4.5.3 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[16].

4.5.4 Significant change is a specific criterion for DHB planning processes; refer to the Planning Regulations section 92(1) of the NZPHD Amendment Act 2010 and the Consultation Guidelines[17] for the Minister's decision about significance triggering consultation. The DHBs proposed service change will not be implemented until appropriate consultation has been undertaken with the affected population(s), when consultation is required.

[16] SOC Min (10) 23.

[17] Consultation Guidelines (Draft 2011) Ministry of Health http://www.moh.govt.nz/moh.nsf/pagesmh/4321?Open

Significant service change funding implications

4.5.6 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 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. Note that the current national IDF price contains an element for incremental technological service change.

4.5.7 In many cases, a new advanced clinical practice for a procedure / drug treatment will substitute for current services that may result in a saving to the DHB. In the case of the introduction of other clinical advances / procedures requiring new technology, the future funding track in a DHB's population-based funding includes money for new technology and is a component of the IDF prices.

4.5.8 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 NMDS data (or other national data sets as applicable) and be used for volume-setting for future IDF volumes.

The facilitation role of the Relationship Manager

4.5.9 The 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 which potentially override the district or regional solution
- there has been a failure to resolve a DHB or regional level issue between the parties concerned.

4.5.10 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. Further information may be requested by the Relationship Manager to facilitate timely decision making depending on the significance of the proposed change before the proposal is forwarded to the Minister for noting or decision making.

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

The Table provides a list to guide discussion of a DHB's change proposal. The level of information required to support the proposal's approval depends on the significance of the 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 • what is the scale of proposal? Is it a change to an existing or a new district / regional / national service? Confirm that the current service cover will not be diminished. • what is the community/population to be affected? • what other stakeholders will have input into this proposal • what is the consultation process that is proposed? • why the service change has been proposed ie, rational for change.
b. What collaboration has taken place in planning the service?
For example: • consider how you will demonstrate how the funding mechanisms in the proposal are effective in achieving the aims of planning services collaboratively (ie, local, regional or national services). • what agreement on the proposed service change (where it is necessary) is to be reached with other DHB(s) and the NHB on the following points: • 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 Relationship Manager)
c. What is the impact on community/population?
Such as: • 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?
Such as: • clinical impact analysis • patient impact analysis • revenue impact analysis, Nett Present Value, proposed financial impact • workforce implications • infrastructure (buildings, information systems etc)
e. What is the impact (if any) on other DHBs?
Such as: • clinical impact analysis • patient impact analysis • revenue impact analysis, Nett 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.

4.5.11 The DHB that wishes to make a service change (either as a service provider or 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.
- If the parties are unable to agree on the proposal, the affected funder will prepare a dissenting submission and send it to the Relationship Manager.

4.5.12 The final sign-off in relation to any significant service change will be facilitated by the Relationship Manager and, where applicable, the prior approval/approval in principle decision is made by the Minister. 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.

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

4.5.14 A timely response will provided to the DHB via the National Director, NHB or delegate.

4.6 Explanation of terms used in this section

National Services:	For the purposes of planning and funding, national services are defined under two areas: a. *The Ministry*: plans, funds the delivery of the national service for the catchments of all DHBs through contracts with service providers *b. A single DHB* plans, coordinates and funds the delivery of the national service through contracts with service providers when it provides 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 will be defined as the current four geographic regions.[18] A DHB is providing a regional service when it provides a specified service for all DHBs within a region. This does not preclude other collaboration arrangements such as Cancer Networks. 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 that 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:	Having or likely to have a noticeable or measurable change to a new or current service, and / or that it may have associated risks, financial impacts or consequences for service users, their caregivers or service providers.
Significant service change:	Includes 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[19], 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 A DHB must consider that a significant service change means any of a. to c. above when assessing whether a proposal is one that must be discussed with the Relationship Manager,
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:

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

[19] 2010/11 Operational Policy Framework Selection of Service Providers 4.18.7

	a. setting of the service b. transfer of service provider eg, inpatient to outpatient services, or hospital to community due to introduction of new technology or treatment methods c. moving of a hospital provided clinical activity to delivery by another organisation eg, a primary health care provider or to the private sector d. moving to national procurement of supplies and services, from individual DHB responsibility eg, pharmaceuticals or medical equipment
National IDF reference price	The price for Inter District Flow as advised by the Ministry on an annual basis; it cannot be varied without authorisation by the Ministry
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.

4.7 DHBs as providers of last resort

(See sections 22 and 23 NZPHD Act 2000.)

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.

5 Service Planning and Policy

Mandatory Requirements of this section

DHBs must:

- work with primary health organisations (PHOs) and ensure that PHOs comply with their contractual obligations (**5.2)**
- meet the National Cervical Screening Programme Operational Policy and Quality Standards for colposcopy services (**5.3**)
- have a 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' (**5.4**)
- work towards implementing the Health of Older People Strategy by 2010 and the health component of the New Zealand Positive Ageing Strategy annual action plans (**5.5**)
- illustrate they have a plan for advancing the objectives of the New Zealand Disability Strategy that includes reference to the health needs of people with disabilities (**5.6**)
- treat patients in accordance with the principles of the electives services policy (**5.7**)

5.1 Purpose of this Section

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

5.2 Primary health care

(See CAB (00) M41/6, CAB Min (02) 31/13, POL Min (03) 27/3, CAB Min (04) 42/5A.)

5.2.1 Due to the current transitional environment, changes to this section of the OPF are likely to occur.

5.2.2 All DHBs are required to work with the primary health care sector to implement the goals outlined in the Government's Better, Sooner, More Convenient (BSMC) Strategy including but not limited to:

a. Shifting services from secondary care to primary care settings;

b. The development of Integrated Family Health Centres;

c. Increased access to diagnostics for the primary health care sector;

d. The development of nurse walk in clinics;

e. Increased access to extended hours services;

f. Improved care for people with chronic conditions; and

g. Improved access to urgent care and after hour services;

h. Maintaining health promotion as a central theme of service development.

DHBs involved in BSMC business cases are required to work with their Alliance Leadership partners to implement the business cases including but not limited to the use of:

a. alliance-based agreements

i. the Flexible Funding Pool; and

j. the agreed monitoring framework

5.3 Cervical screening

(The Health Act 1956, as amended by Part 4A in 2004, (The Health (National Cervical Screening Programme) Amendment Act 2004) refers.)

5.3.1 DHB colposcopy providers must meet the relevant legislative requirements as set out in the Health Act 1956, as amended by Part 4A in 2004, (The Health (National Cervical Screening Programme) Amendment Act 2004); 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 Operational Policy and Quality Standards 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 PHOs and other primary health care providers that offer smear taking services are also required to meet the requirements of Health Act 1956 as amended by Part 4A in 2004, (The Health (National Cervical Screening Programme) Amendment Act 2004); and specifically section 112L relating to the duties of persons taking specimens for screening tests. They must also meet the NCSP Operational Policy and Quality Standards for smear takers, particularly in relation to informed consent, managing women with abnormal cervical smears and the recall of women.

5.3.4 DHBs must meet the coverage target for the National Cervical Screening Programme of 75%. Specifically, this target must be met for Maori and Pacific women.

5.4 Tobacco Control

5.4.1 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’. The health target is 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.

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 ask about smoking status, provide brief advice and offer 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.

5.4.2 All DHBs have a Tobacco Control Plan (TCP) in place. The TCP outlines the DHB’s strategic approach to Tobacco Control across their district (in line with the national strategic direction for Tobacco Control), including leading work to support smokers to quit. TCPs may cover up to 3 years. New or revised TCPs are required to be submitted to the Ministry for review and feedback before they are finalised.

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 (which may be updated).

5.5.2 Adhering to this process includes enforcing the provisions of the ARRC Service Agreement and the services that are covered under it.

5.5.3 DHBs are to ensure that there is an adequate level of provision of contracted care beds for all people eligible for the residential care subsidy (as set out in the Service Coverage Schedule under *Health and Support Services for Older People*). This provision must take into account those who qualify for the “top up subsidy for higher levels of 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 It is expected that DHBs will work towards the development 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. include 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. improve support for 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 Disability support services

(See NZPHD Act 2000.)

The New Zealand Disability Strategy (NZDS)

5.6.1 DHBs should illustrate that they have:

a. a plan for advancing the objectives of the New Zealand Disability Strategy that refers to the health needs of people with disabilities of all ages and older people's disability support needs; this will require DHBs to consider people with disabilities in their population health needs assessment in order to collect comprehensive information on the health and support needs of people with disabilities

b. an accessibility plan that addresses physical and non-physical access for people with disabilities, including an outline of how they are responding to the New Zealand Sign Language (NZSL) Act (for example, having a written New Zealand Sign Language policy that includes consideration of other forms of communication with deaf people to remove barriers to accessing information and services).

5.6.2 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.

5.6.3 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 PHOs and any associated NGOs to implement the requirements of the New Zealand Disability Strategy through developing and implementing strategies to improve services and access for disabled people

c. develop, improve and expand upon best practice guidelines in relation to the New Zealand Disability Strategy

d. promote the inclusion and independence of people with disabilities and those with mental illness

e. implement initiatives to reduce inequalities of service access and provision for Māori with disabilities

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

5.6.4 The Service Coverage Schedule sets out eligibility and access criteria relating to disability support services. However, due to the current split of funding responsibility for disability support services between DHBs and the Ministry, there is potential for some providers of disability support services to receive funding from more than one funder. It will be necessary for the funders to maintain an ongoing dialogue about their service funding intentions so that there is effective and unambiguous communication with those providers. It is particularly important that:

a. any potential change in the terms and conditions of service agreements which are funded by both the Ministry and a DHB, where that change may affect the other funder is discussed first, in good faith, with the other funder

b. the Contract Relationship Manager (Disability Support Services Group, Ministry of Health) who covers the DHB's region is contacted in the first instance for the purposes of communication according to these protocols

c. all service changes are consistent with the service change protocols set out in the section on Service Change in this document

d. the Disability Support Services Group, part of the Health and Disability National Services Directorate of the Ministry of Health, funds disability support services for people with 'long term intellectual, physical and/or sensory disabilities', largely under the age of 65

e. people between the ages of 50 and 64 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,[20] and who require access to disability support services are funded by DHBs (see CAB Min (03) 23/8 refers)

f. any dispute about access to Ministry or DHB funded services will be resolved by discussion between Needs Assessment and Service Co-ordination (NASC) agencies

g. where resolution cannot be achieved through discussion NASC agencies, the first level of escalation will be to the DHB at the funder level and the Ministry's operational management within the Disability Support Services Group

[20] The 'close in interest' group.

h. where resolution cannot be achieved through the involvement of the DHB and Disability Support Services Group, the dispute resolution processes in the Crown Funding Agreement will apply.

Transfer of clients between funders

(See CAB (03) M 23/8 refers.)

5.6.5 In respect of moving disability clients from one funder to another, the following conditions apply:

a. Ministry of Health clients can move to become DHB clients, but DHB clients cannot move to become Ministry clients.[21] A Ministry client will become a DHB client only if they are assessed as requiring aged residential care.

b. DHB clients can move from one DHB to another.

c. People aged 50–64 years require integrated health and disability support services as provided in section 4.6.3(e) of this document.

5.7 Management of elective services

Objectives for elective services

5.7.1 The key principles underlying elective services system are clarity, timeliness and fairness: clarity, where 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; 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 AP. 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.

[21] Note that 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.

DHBs will focus on meeting the commitments given to patients for specialist assessment and treatment, and reduce waiting times to a maximum of six 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 prioritisation systems as agreed with the Ministry. 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.

Clarity of access to elective services

5.7.2 First specialist assessment (including non-contact FSA) – Following a request for a specialist opinion, all referrals will be logged into the patient management system upon receipt. 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 advised in writing within 10 working days whether or not a first specialist assessment (FSA) is indicated and can be provided (within six months). 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 six months of referral, 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. notify referrers and patients of the ability or inability to provide services within the required six-month standard

c. 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.

5.7.3 Treatment - 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 10 working days of the assessment. Status regarding treatment should be within one of the following categories:

a. Certainty of treatment within six months – commitment should be given to patients with the highest priority.

b. Active review – active review is 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 – this means that the patient's condition has been assessed as currently being of low priority 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

5.7.4 The DHB is to ensure that they either:

a. meet their contractual obligations themselves, to deliver elective surgical service volumes in a timely way, or

b. implement suitable and timely alternative solutions to provide these services.

5.7.5 All patients accepted for an FSA should be provided with their assessment within six months of the date the referral was received.

5.7.6 All patients given a commitment to treatment should receive that treatment within a timeframe consistent with their relative priority and within a maximum of six months.

5.7.7 All 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 (aTT), 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

5.7.8 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.

5.7.9 All services will have in place, and maintain, effective prioritisation systems. 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.

5.7.10 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 judgment may override a particular patient's priority. Such clinical exceptions must be documented with the cause of the exception noted.

5.7.11 All services will develop and maintain a reliable commitment threshold to determine the priority level above which patients can be offered treatment within the funding levels 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 score below the commitment threshold for treatment.

Other processes for elective services

5.7.12 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.

5.7.13 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 alternate providers (eg, primary sector)

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

c. develop and agree referral processes and review mechanisms.

5.7.14 DHBs will be expected to continue to contribute to the development and review of referral information including assessment criteria for first specialist assessment (ACA).

5.7.15 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% implementation of nationally recognised tools to ensure patients are seen and treated equitably and in the order of greatest priority.

5.7.16 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

5.7.17 DHBs will participate in a continuous quality improvement (CQI) 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, ACA, CPS or 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
   - achieve or maintain ESPI compliance
   - reduce the waiting time for assessment or treatment for elective patients.

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

Provision of elective services

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

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

6 Relationships with Māori

6.1 Purpose of the section

6.1.1 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.

6.1.2 DHBs will be guided by the strategic and policy directions of the Ministry to improve health outcomes and reduce health inequalities for Māori.

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 and achievements/successes.

Summary of mandatory requirements

DHBs must:

- work with Māori at both governance and operational levels (**6.2**)
- enable Māori to contribute to decision-making on and to participate in the delivery of heath and disability services (**6.3**)
- reflect in their AP the planning set out in their Māori Health Plans for reducing health inequalities and improving health outcomes for Māori (**6.4**)
- work with the Ministry to set targets in relation to Māori health spending through the AP process that recognise the poor health status of Māori and take into account each DHB's population profile, needs assessment and services currently available (**6.5**)
- demonstrate a commitment to identifying pathways of care that focus on improving access to effective services for Māori within mainstream services (**6.6**)
- provide for the needs of Māori as set out in section 4 of the New Zealand Public Health and Disability Act 2000 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 reduce health inequalities and improve health outcomes for Māori (**6.7**).

6.1.4 This section sets out what DHBs are required to do in relation to working with 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 reducing Māori health inequalities, and providing for the needs of Māori by other means.

6.2 Working with Māori

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

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

6.2.2 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 sections 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.

6.2.3 Each DHB should be guided by the New Zealand Health Strategy, the New Zealand Disability Strategy, He Korowai Oranga: Māori Health Strategy and Building Relationships with Māori.

6.3 Engagement and participation of Māori

(See sections 22(1)(e) and 23(1)(d)–(e) NZPHD Act.)

6.3.1 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, 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 (as set out above).

6.3.2 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

d. service delivery
e. monitoring
f. evaluation of services
g. Māori Health Plans.

6.3.3 Each DHB will ensure that it has processes to involve iwi and Māori communities in monitoring progress against He Korowai Oranga: Māori Health Strategy.[22]

6.4 Māori health planning

6.4.1 The Māori Health Plan records the DHBs direction on improving Māori health and reducing Māori health outcome disparities

6.4.2 The DHB Māori Health Plan will be a stand alone plan and will be referenced in the Annual Plan.

6.4.3 A DHB's Māori Health Plan will be informed by:

- Current and future district population characteristics including demography, socio-economic determinants, health status and demand for health services in the district
- the DHB's strategic objectives from its Regional Services Plan and Annual Plan

6.4.4 The Māori Health Plan will align with those processes in 6.4.3 ensuring that strategic objectives become activities. The Māori Health Plan records the Māori health issues within their district that the DHB plans to focus on, what they are doing about those issues, and how they will measure progress.

6.4.5 All DHBs are expected to develop and submit a 2011/12 Māori Health Plan using the template provided by the Ministry (Appendix 3) to document how the DHB will improve Māori health and reduce Māori health outcome disparities.

6.4.6 The Māori Health Plan should have at the least the following components:

- Description of the health status of the Māori population in the District

[22] See Ministry of Health. 2002. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health. Te Ara Tuarua, Pathway 2, Objective 2.1.

- Priorities decided at a National level
- Priorities decided at a Regional level
- Priorities decided at a local level

6.4.7 National level priorities will be drawn from the whānau ora set of indicators developed by the Ministry. These are indicators linked to the major causes of morbidity and mortality for Māori.

6.4.8 Each DHB will decide its own Local level priorities based on the information for their population – see 6.4.3. They will also be priorities not already covered at the National level.

6.4.9 DHBs, the National Health Board and the Ministry will monitor different aspects of the Māori Health Plan. Te Kete Hauora will coordinate these processes using existing structures such as the Quarterly Reporting Database.

6.4.10 DHBs will report by exception national level priorities (in the DHB Māori Health Plan) that have not been achieved. The report will say why the priority has not been achieved, what the DHB will do to rectify it, and by when.

6.4.11 The timeframe for reviewing DHB Māori Health Plans will align with the review of respective Regional Services Plans/DHB Annual Plans. The DHB Māori Health Plans are to be submitted at the same time as the DHB Annual Plans.

6.5 Māori Health Funding

6.5.1 DHBs are expected to work with the Ministry to set targets in relation to Māori health spending through the AP process that recognise the poor health status of Māori and take into account the DHB's population profiles, needs assessments and the services currently available.

6.5.2 The establishment of targets for spending on Māori health must:

a. be consistent with the goals of He Korowai Oranga: Māori Health Strategy

b. recognise the poor health status of Māori and the contribution that Māori provider development and targeted initiatives can make to reducing inequalities.

6.5.3 Targets for spending on the health of Māori will:

a. be included in DHB's AP as agreed in the AP sign-off process

b. cover three financial years (the year of the plan and the two subsequent years

c. address capacity development (workforce and development), service provision by Māori providers and service provision by mainstream providers targeted explicitly at Māori, also taking account of the DHB's population profiles, needs assessments and the services currently available.

6.5.4 DHB performance against the targets published in APs will be reported in the DHB's routine financial reports.

6.5.5 Each year, the Ministry will provide DHBs with guidance to support target-setting in the context of its advice to DHBs on target-setting for the Performance Measures.

6.6 Supporting Māori access to services

(See H&DSS 1.2.)

6.6.1 Each DHB will facilitate Māori access to services and appropriate quality of care by engagement with whānau, hapū, iwi, kaumātua, rongoa practitioners, spiritual advisors, Māori staff and others as appropriate for Māori accessing its services.

6.6.2 The relevant service specification will identify whether this support is a key service component or not. For the purposes of this section, *facilitating support* means the DHB is only required to fund support where the relevant service specification identifies such support as being a key service component.

6.7 Improving the effectiveness of mainstream services

6.7.1 It is expected that DHBs will demonstrate a commitment to identifying pathways of care that focus on improving access to effective services for Māori, in line with He Korowai Oranga: Māori Health Strategy, to reduce health inequalities for Māori within mainstream services. Although the pathways of care are easily identified within Māori specific services, the challenge is to focus on all mainstream services within DHBs.

6.8 Other means of providing for the needs of Māori

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

6.8.1 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 co-ordination 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[23]

d. include complete and high-quality ethnicity information, where relevant, in health information that is provided to Māori communities.[24] This information enables Māori to participate in the health sector and in the development of strategies to improve health outcomes for Māori.

6.8.2 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.

[23] Clause 43 in Schedule 3 to the NZPHD ActClause 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.

[24] In accordance with the Crown Māori Relationship Instruments Guidelines: May 2006.

7 Inter-District Flows (IDFs)

Summary of Mandatory requirements

Each DHB must

- comply with generally accepted accounting practice and applicable legislative requirements, in particular the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004
- follow the key principles governing the referral and management of IDFs (**7.2**)
- adhere to the setting and management of IDF volumes (**7.3**)
- follow guidelines in managing exceptional situations (**7.4**)
- reimburse each other for IDFs from their appropriations, with systems in place to facilitate such reimbursement (**7.5**)
- follow a set dispute resolutions process
- adhere to the guidelines regarding service change
- be aware of and meet the obligations relating to privacy of patient information (**7.6**)
- adhere to the definition of inter-district flow rules (**7.7**)

7.1 Purpose of the section

7.1.1 This section sets out a system and rules for managing inter-district flows (IDFs)

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:

a) an eligible person receives treatment

and

b) the DHB of Service is not the DHB of Domicile for that person.

7.1.4 Eligibility is determined by the 2003 Direction of the Minister of Health Relating to Eligibility for Publicly Funded Personal Health and Disability Services in New Zealand (www.moh.govt.nz/eligibility), or any other Direction of the Minister in force from time to time.

Principles Guiding the IDF Rules

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

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

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

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

d. 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 individuals clinical circumstances within the constraints of available resources and capacity.

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

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

7.1.7 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

7.1.8 DHBs may expressly enter into agreements with each other that override the rules outlined below. When two DHBs have a Service Level Agreement (SLA) between them governing the management of IDFs across one or more service categories, these IDF rules apply to that SLA (including where the SLA is silent on an issue covered by these rules), except to the extent that the SLA expressly provides otherwise.

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

a. People not eligible for service in New Zealand, as set out in the 2003 Direction of the Minister of Health Relating to Eligibility for Publicly Funded Personal Health and Disability Services in New Zealand, or other Direction of the Minister in force from time to time.

b. People living in the areas of Ross Dependency, Cook Islands, Niue or the Tokelau Islands, 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 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, eg, Accident Compensation Corporation.

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

Summary of mandatory requirements

Each DHB must:

- comply with generally accepted accounting practice and applicable legislative requirements, in particular the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004
- adhere to the definition of inter-district flow rules
- follow the key principles governing the referral and management of IDFs
- adhere to the setting and management of IDF volumes
- follow guidelines in managing exceptional situations
- reimburse each other for IDFs from their appropriations, with systems in place to facilitate such reimbursement
- follow a set dispute resolutions process
- adhere to the guidelines regarding service change
- be aware of and meet their obligations relating to privacy of patient information

Residence criteria for the purposes of the IDF rules

7.1.10 The 'resident population' of a DHB is defined in section 6 of the New Zealand Public Health and Disability Act 2000 section 6 of the New Zealand Public Health and Disability Act 2000 (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.

7.1.11 Residence is self-defined and does not include a time criterion. An exception is for aged residential care IDFs (see paragraph 7.1.12 (d) below).

7.1.12 DHBs should use the following guidelines should be used 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 equal amounts 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 where a person is in institutional treatment or in receipt of support services 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. (Note: this rule may be amended when the outcome of wider sector work on prisoners' health is known.)

g. where a person has no fixed abode, the DoD will be the DoS for the event.

7.1.13 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, eg, alcohol and drug rehabilitation then the DHB of domicile at admission pays for the cost of treatment.

c. When the patient moves into non-health of older people residential care for an open ended duration then the DHB of service becomes the DHB of domicile.

d. In relation to people in aged residential care services, the DoD for the purposes of identifying aged residential care services IDFs is based on their last residential 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).

7.1.14 These guidelines are consistent with the Statistics New Zealand Census definitions of residence[25] that are used in the distribution of funding via the population-based funding formula (PBFF).

[25] Statistics New Zealand. 2001 *Census of population and dwellings: definitions and questionnaires*. Wellington: Statistics New Zealand. URLhttp://www.stats.co.nz

7.2 Referral and management of inter-district flows

General IDF referral and management principles

7.2.1 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 paragraphs 7.3.2–7.3.13 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 AP process.

c. SLAs or other 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 the HIN report and discuss material variations from plan.

Referral and management of IDFs for inpatient elective services

7.2.2 DHBs must ensure equity of access to services on the basis of need, within the scope of each DoS's capacity Therefore, a DHB should not prioritise access based on where a patient lives..

7.2.3 Unless exceptional situations apply (see section 7.5), all referrals for inpatient elective IDF services under this section must be in accordance with the following criteria:

a. the required treatment is not available from the DoD

b. there is an Service Level Agreement between the DoS and DoD providing for the service to be funded and the referral is within the scope of the agreed volumes in the Service Level Agreement.

c. Note that, in the case of a referral under 1 and 2, the cost of the IDF is covered by the DoS's IDF inflow and the DoS is not permitted to invoice separately.

Referral and management of IDFs for acute/arranged services

7.2.4 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.

Referral and management of national services

7.2.5 For personal health, the following national services are purchased from a single lead DHB (the DoS) on behalf of all other DHBs (DoDs):

a. heart transplants
b. heart-lung transplants
c. lung transplants
d. donor co-ordination and retrieval
e. liver transplants.

7.2.6 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.

7.2.7 The DoS will agree volumes for national services with the Ministry by the date at which the DoS's AP is finalised. The revenue for these services has been top-sliced, based on levels determined in the Crown Funding Agreement.

7.2.8 The DoS will manage national services within the agreed funding, which includes a risk pool for these services.

Referral and management of IDFs for aged residential care services

7.2.9 Patients must be assessed by a Needs Assessment and Service Co-ordination (NASC) agency 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 NASC transfer protocols must be followed.

Referral and management of IDF's for other services

7.2.10 General practitioners, nurse practitioners or medical specialists refer patients to outpatient departments and most other non-DRG provider arm services (except emergency departments), in accordance with applicable referral protocols in place from time to time.

7.2.11 Patients self-refer to general or nurse practitioner services or receive services from laboratories, pharmacies, etc, according to GP or nurse practitioner requests.

7.2.12 **All other** referrals occur under agreed protocols and criteria as specified in the relevant regional agreements.

7.2.13 In situations in which a DoS wants to actively manage referrals for aged-residential care services and 'other' services IDFs from neighbouring

DHBs, a separate SLA will be required, managing the risk for both the DoD and the DoS.

7.3 Setting and management of IDF volumes

7.3.1 In consultation with the IDF National Co-ordinating Group, 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 National Co-ordinating Group 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' APs. These volumes can only be changed by formal agreement between affected DHBs.

7.3.2 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 Quickplace site.

7.3.3 Regions may agree to implement their own methodology for IDFs between their DHBs.

7.3.4 If DHBs cannot agree on a technical issue, the IDF NCG will have authority to resolve the issue.

7.3.5 If DHBs cannot agree on a non-technical issues, the disputes mediation process (8.3) should be followed .

7.3.6 From time to time two DHBs may agree on a Service Level Agreement between themselves, covering additional services. Such an arrangement may modify IDF revenue/volume schedules.

7.3.7 IDF wash-ups occur for personal health case-weighted, maternity case-weighted, Health of Older People AT&R and pharmaceutical cancer treatments. The details of the standard calculation process for these IDF wash ups is contained with the IDF methodology notes. DHBs may opt out of the wash-up arrangement with the agreement of all other DHBs.

Special arrangements for residential mental health services

7.3.8 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.

Travel, accommodation and inter-hospital transfers

7.3.9 No IDFs are required in relation to travel and accommodation as the DoD pays directly through Sector Services of the Ministry. If there is a DHB-held contract for inter-hospital transfers (either road or air), the DoD will pay.

7.3.10 In relation to inter-hospital transfers, the DoD pays. Local arrangements may vary as to how this is given effect (eg IDFs, invoicing etc).

7.4 Management of exceptional situations

7.4.1 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 paragraphs 7.3.3.[26]

7.4.2 In the interests of continuity of care, the minimum expectation of the Ministry (based on sector custom and practice) is that a DoS will provide services for an eligible person from a DoD in the following exceptional circumstances:

a. The eligible person meets the following two criteria:
   - there are compelling social reasons to refer the person to the DoS, eg, the eligible person's immediate family, who have agreed to provide support, live in the area of the proposed treatment DHB
   - there is agreed appropriate capacity at the DoS and the DoS can accommodate the referral within its annual agreed IDF volumes, as specified in the revenue/volume schedules set out in its AP as applicable. **OR**

b. All of the conditions in sub-paragraphs below are met:
   - 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
   - the service cannot be provided by the DoD within seven days, but the delay is not expected to be longer than 21 days
   - both the DoD and the DoS agree to the transfer
   - the DoS has agreed appropriate capacity and can accommodate the referral within its Category 1 IDF volumes, as specified in the revenue/volume schedules set out in the DoS's AP as applicable.

   OR

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

[26] There will be some other custom and practice situations, involving procedures being undertaken by a DoS that are in IDF volume allocations.

the DoS clinicians) and elects to travel to that DoS to maintain continuity of care.

OR

d. The patient has been a resident within a DoS's district at the time of being given six-month certainty of having an elective procedure.

7.5 Payments and 'wash-ups'

Payments

7.5.1 The Ministry will pay each DoD annual appropriations for its population according to 'Schedule B: Funding and Payments' in each DHB's Crown Funding Agreement. The Ministry will not provide any additional funding for IDFs.

7.5.2 As DHBs are funded for their resident population funding for IDFs is included in DHBs' appropriations, DHBs are required to reimburse each other for IDFs from their appropriations. Systems are in place to ensure that this can occur. Sector Services manages payments on behalf of DHBs.

7.5.3 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 5th day of every month. If the fifth day is a non-working day, the payment will be made on the Friday prior. Sector Services will make the IDF transfers.

7.5.4 The Capital and Operating Team will change IDF payments based on written agreement of the DHBs involved. Reasonable notice of changes is required.

7.5.5 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

7.5.6 When 'wash-ups' against actual volumes are necessary, they will be carried out as follows, unless agreed otherwise:

a. Sector Services will provide a download of National Minimum Data Set data[27] for the applicable 'wash-up' period six weeks following the end of the relevant period. Note for PCT wash ups, the claim data from Sector Services will be used.

b. 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

[27] NMDS data will be based on the filters advised annually by the Ministry to the IDF National Co-ordinating Groups.

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.

c. 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.

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7.6 Privacy of patient information

7.6.1 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 (HIPR).

7.6.2 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 (encrypted or unencrypted)

b. high-level location information that confirms the DoD, but does not contain a person's full residential address

c. case-weight information that confirms the fact of service provision and the type of service provided.

7.6.3 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.

7.6.4 DHBs should be aware of their obligations under rule 3 of the HIPR, ensuring that individuals are aware of the purpose for which identifying information is being collected and the intended recipients of that information. Existing HIPR 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.

7.7 Inter-district flow definitions

7.7.1 The following definitions apply to Section 7.

Term	Definition
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
CWD services	all medical, surgical and neonatal intensive care unit services that are funded using Weighted Inlier Equivalent Separation (WIES)
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
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
DRG	(Australian) Diagnostic Related Groups, current version
Elective services	services covered by the data clarification WN (booking list), as defined by the Sector Services data definitions
FST	Financially Sustainable Threshold
Medical services	services with an 'M' service health specialty code in the volume schedules
NMDS	National Minimum Data Set
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 AP 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 APs 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 coverage	the service coverage described in the Service Coverage Schedule

Service Coverage Schedule	the document setting out the services that a DHB must ensure are delivered to its population that has been endorsed most recently by the Minister; before endorsing and signing the document, the Minister will ensure that the Ministry consults with 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

Summary of mandatory requirements Each DHB must:

8.1 Purpose of the section

8.1.1 The NZPHD Act includes provisions to ensure the resolution of disputes:

a. over contents of plans (as defined by section 38 of the NZPHD Act 2000);

b. between DHBs and / or other publicly owned health and disability organisations.

8.1.2 This section includes information regarding*:*

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.

8.2 Legislative provisions for resolving disputes

8.2.1 Section 39 of the NZPHD Act - Disputes over contents of plans

8.2.2 The Minister may act if, after the Minister directs one or more DHBs to prepare or contribute to a plan under section 38 –

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 resolution 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;

c. A DHB that is a party to the dispute must give effect to the Minister’s decision.

8.2.5 Section 92(2) 39 of the NZPHD Act - Disputes over contents of plans

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.

8.2.7 [On date, these regulations were invoked [DN: subject to leg and regs being passed] and lay out the following process (to confirm wording when Regs are finalised].

8.2.8 The dispute resolution regulations apply to any disputes between DHBs and / or other publicly owned health and disability organisations and deal with issues such as disputes over the implementation of plans and contractual disputes between DHBs.

8.2.9 The regulated dispute resolution process, under section 92(2), will be triggered by a DHB involved in a dispute, or the Minister becoming aware of a disagreement between the DHBs.

8.2.10 The dispute resolution regulations cover two types of dispute resolution process:

a. Mediation

b. Arbitration

8.3 Mediation

8.3.1 In the event of a dispute between DHBs (or other publicly owned health and disability organisations) which they cannot resolve themselves, assisted negotiation or mediation may be required. While the mediation process will be left to the parties to agree where possible, the following actions will be taken to ensure the timely resolution of disputes:

a. Entering mediation: Mediation may be initiated by either party to the dispute or by the Minister;

b. Choice of mediator: A third party nominates a mediator if the parties to the dispute cannot agree on one within 10 days. This shall be the President of the New Zealand Arbitrators and Mediators Society.

c. Completing mediation in a timely way: The time allowed for mediation to run its course will be limited to 30 days. If agreement is not reached in this time, the process moves automatically to arbitration.

8.4 Arbitration

8.4.1 The dispute resolution regulations establish the Director-General of Health as the arbitrator. The Director-General is required to establish an advisory panel, with at least three members to provide advice on the dispute before a determination is made. The Chair of the National Health Board will

nominate suitable members either from within the Board, or from elsewhere if it is necessary to get other expertise or avoid conflicts of interest.

8.5 Dispute Resolution Regulations

8.5.1 The dispute resolution regulations prescribe:

a. Advisory panel: The selection of panel members shall support the objectives of the dispute resolution process and its outcomes. The Director-General shall appoint the panel members from nominations from the Chair of the National Health Board and should ensure the required expertise; members of the panel shall notify the Director-General and the parties to the dispute of any potential conflict of interest.

b. The process the advisory panel is to follow: The regulations are to include the Government's objectives that will guide the panel's analysis [Note: to agree with Cabinet as the Regs are finalised], the objectives of the dispute resolution process [Note: to agree with Cabinet as the Regs are finalised], the need to respect confidentiality; and the information that the panel must or may use in reaching its conclusions [Note: to agree with Cabinet as the Regs are finalised], including the views of relevant stakeholders and specialist clinical or economic advice.

c. Determination: The Director-General will make a determination on the dispute, following the provision of the advisory panel's advice and that decision will be final. The Director-General may seek additional advice if he/she wishes. There will remain a right of appeal on grounds of due process, through judicial review. The Director-General will also be able to determine costs, namely how remuneration, travelling allowances and expenses for the advisory panel and other costs of the process are to be met. These costs will be met from Ministry Departmental Expenditure. The parties to the dispute are to meet their own costs of participating in the process.

d. Publication of findings: The advice of the advisory panel will be published to ensure transparency.

8.6 The national dispute resolution process

8.6.1 Acceptance criteria

8.6.2 For a dispute to be accepted by the Minister of Health (section 39) or the Director-General of Health (section 92(2) disputes must meet the following acceptance criteria:

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. For instance, attempts should first be made to resolve disputes involving the contents of plans through the dispute resolution processes as agreed under the

governance arrangements operating within the regions (refer planning guidelines);

c. The dispute must not be trivial, vexatious or an abuse of procedure;

d. The dispute must not prejudice any other processes that are underway (including arbitration initiated under the Arbitration Act 1996).

8.7 Mediations Stages and Deadlines

Mediation may be initiated by parties to the dispute or by the Minister of Health (subject to meeting acceptance criteria). Where the dispute is initiated by either of the parties, the Minister of Health must be notified of the dispute [via what channel, relationship managers?, see notification of / submitting a dispute below]..	Day 0
If parties cannot agree on a mediator within ten days, the President of the New Zealand Arbitrators and Mediators Society will nominate a mediator.	Day 10
Mediation between the parties must be completed within 30 days. [Parties to notify the Minister of Health of the result]. Where agreement is not reached in this time, the process will move automatically to arbitration. [Note need to tighten this when the draft Regs go to Cabinet].	Day 30

8.8 Arbitration Stages and Deadlines

Notice to parties of the dispute moving to arbitration. At a minimum, notification will outline: The expected process and timescale for panel advice The panel members who will advise on the case Any information requirements from the parties including the need to meet with the panel Any experts to be called and other evidence to be sought	Within 10 days
Panel advice to the Minister of Health (section 39) or the Director-General (section 92(2)). Panel advice to be published on the NHBs website. Panel advice to include: A description of the process the panel has followed A description of the information provided to the panel and the analysis undertaken by the panel The panel's advice and the reasons for that advice; and Recommendations by the panel as to the action, if any, that should be taken by the relevant adjudicator (Minister of the Director-General)	
Adjudicator's decision to be published (Minister or the Director-General) along with required actions of parties	Within 10 days following panel advice

8.9 Notification of / submitting a dispute

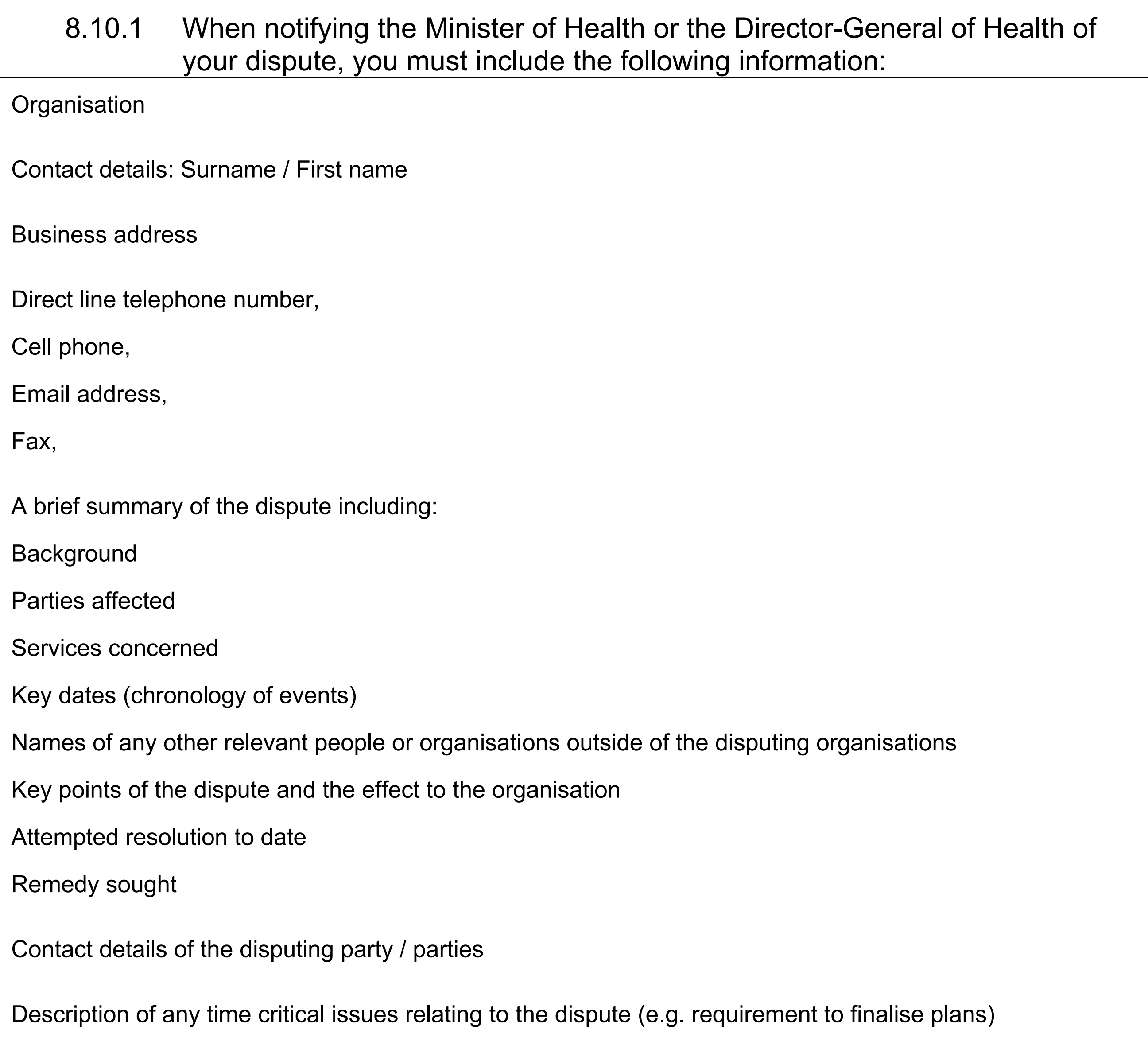
8.9.1 By submitting a dispute, the party confirms consent to the resolution of the issue by an advisory panel and a decision by the Director-General of Health or the Minister of Health. Parties are encouraged to raise all disputes within a reasonable timescale in order that the advisory panel can contemporaneously investigate the matter and the DG or Minster can make a timely decision. The National Health Board will send a version of this submission to the parties named in your dispute.

8.9.2 [NHB contact details, name, email address, telephone]

8.9.3 How expected to submit it… electronically, written

8.10 Information requirements

8.10.1 When notifying the Minister of Health or the Director-General of Health of your dispute, you must include the following information:



Organisation

Contact details: Surname / First name

Business address

Direct line telephone number,

Cell phone,

Email address,

Fax,

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 and the effect to the organisation

Attempted resolution to date

Remedy sought

Contact details of the disputing party / parties

Description of any time critical issues relating to the dispute (e.g. requirement to finalise plans)

Summary of any supporting documentation submitted

8.11 Expectations of DHBs and other publicly owned health and disability organisations engaged in disputes

8.11.1 While engaged in disputes, District Health Boards must:

a. Act in good faith
b. Continue to ensure continuity of services to patients
c. Align their actions with the Public sector code of conduct

9 Quality

9.1 Purpose of the section

9.1.1 This section 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 in both 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 the Nationwide Systems Framework (**9.2**)
- encourage an organisation-wide commitment to quality improvement as well as quality improvement across the wider sector (**9.3**)
- develop, document, implement and evaluate a transparent system for managing and improving the quality of services to achieve the best outcomes for consumers (**9.4**)
- comply with all aspects of the Code of Health and Disability Services Consumers' Rights in the Health and Disability Commissioner Act 1994 and amendments (**9.5**)
- safeguard consumers, staff and visitors from infection as far as is reasonably practicable (**9.6**)
- implement quality processes that demonstrate the effectiveness of their services (**9.7**)
- have a process that enables consumers, their families and whānau and other people to make complaints (**9.8**)
- ensure effectiveness of services (**9.9**)
- continue to maintain systems to manage financial and non-financial risks effectively (**9.10**)
- safeguard consumers, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment, or neglect, as far as is reasonably practicable (**9.11**)
- provide services from safe, well-designed, well-equipped hygienic and well-maintained premises, so far as is reasonably practicable (**9.12**)
- comply with the legislative requirements following the death of a consumer (**9.13**).

9.2 Provider quality specifications (PQS)

9.2.1 All services funded, provided or sub-contracted by a DHB must comply with the provider quality specifications set out in the Crown Funding Agreement.

9.2.2 Where services are funded by the DHB, the DHB will ensure that standard contract forms covering all the requirements of the PQS are used. Compliance with the requirement to use the services of the Information Delivery and Operations Group for all contract generation will assist in ensuring that the DHB meets its obligations in this regard.

9.2.3 Each DHB will also ensure that:

a. the requirements of the PQS are covered in all service specifications for services delivered by the DHB, as well as services sub-contracted by the DHB

b. employees and sub-contractors are aware of the DHB's and their own responsibilities for implementing the requirements of the PQS as they relate to services provided.

9.2.4 The Ministry will discuss and agree with appropriate DHBs which ones may fund or provide services to differing standards. The DHB must provide evidence that the safety and treatment of consumers, visitors and staff will not be materially adversely affected or materially compromised by the application of such different standards. The Ministry will also agree with the DHB a reasonable timeframe for the DHB to reach compliance with the PQS.

9.2.5 Providers must comply with the Health and Disability Services (Safety) Act 2001 that requires all hospital, rest home and disability residential care services to be audited by a designated audit agency and to be certified by the Director General of Health.

9.2.6 Providers will be audited against the applicable standards in the Health and Disability Sector Standards NZS 8134:2008.

9.3 Quality improvement

9.3.1 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.

9.4 Improving the quality of services

(See Health & Disability Services (Core) Standards 2.3.)

9.4.1 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.

9.4.2 'Improving Quality (IQ): A systems approach for the New Zealand health and disability sector', and the associated document 'IQ Action Plan: Supporting the improving quality approach' were released in September 2003. They represent a strategic approach to quality improvement that includes the identification of 11 goals to support the commitment to continuous quality improvement.

9.4.3 The Cabinet agreed to establish a Health Quality and Safety Commission (HQSC) in December 2009. An interim Board was appointed by the Minister and started meeting in June 2010. HQSC provides advice to the Minister any health epidemiology and quality improvement matters; leads and coordinates work to improve quality and safety across the health and disability system including sponsoring, monitoring and evaluating national quality improvement programmes and public reporting of quality and safety indicators. DHBs are expected to engage in these.

9.4.4 The HQSC will be developing a work programme for approval by the Minister. DHBs will be engaged in the development of the programme and should anticipate that activities within this programme will impact on individual or all DHBs.

9.4.5 The HQSC has inherited oversight of the National Quality Improvement Programmes (NQIP) from the former Quality Improvement Committee. DHBs are required to implement two priority medication safety initiatives:

a) the new national adult inpatient medications chart (which is not designed for use in special or intensive care units, paediatrics or long term aged care) by 1 January 2012 and

b) a system of medicine reconciliation that meets the Medication Reconciliation Standards published by the Safe Medication Management Programme throughout their inpatient services by 1 January 2012.

9.4.6 DHBs are required to survey patients' satisfaction (see 9.5.3) and to participate in a national review process facilitated by the HQSC to assess current surveys and make recommendations for future surveys.

9.4.7 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 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. consumer input into services and into development of the quality plan and consumer information

g. processes for improving ethnicity data collection

h. processes for the development and implementation of culturally effective services.

9.4.8 Each DHB provider arm is required to maintain certification as set out in the Health and Disability Services (Safety) Act 2001 and associated standards within the required timeframes.

9.5 Consumer rights

(See Health and Disability Commissioner. Health and Disability Services (Core) Standards Consumer Rights 1.1.)

9.5.1 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.

9.5.2 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.

9.5.3 All DHBs will carry out a patient satisfaction survey in accordance with the Crown Company Monitoring Advisory Unit (CCMAU) 2000 guidelines 'New Zealand Public Hospitals and Health Services Patient Satisfaction Survey'. The quantitative results of the survey should be reported to the Ministry quarterly.

9.5.4 A National Mental Health Satisfaction Survey (NCSS) and accompanying guidance have been developed alongside the New Zealand Public Hospitals and Health Services Patient Satisfaction Survey. DHBs should report NCSS data annually [in the second quarter, that is, December].

9.5.5 In addition to the patient satisfaction survey, DHBs will offer consumers/families/whānau the opportunity to provide feedback as a means of improving the services provided and the outcomes achieved. When requested, DHBs will make this feedback available to the Ministry. Any feedback will also be passed on to the relevant staff and used to maintain and/or improve the quality of service, for the individual consumer and across the service as a whole. DHBs will actively seek feedback from Māori and use this to improve responsiveness to Māori.

9.6 Infection control

(See Health and Disability Services (Infection Prevention and Control) Standards 3.1, 3.2, 3.3, 3.4, 3.5, 3.6.)

9.6.1 Each provider will safeguard consumers, staff and visitors from infection as far as is reasonably practicable.

9.6.2 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.

9.7 Clinical effectiveness

(See Health and Disability Services (Core) Standards 2.3.)

9.7.1 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.

9.7.2 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.

9.7.3 Each DHB is expected to implement quality processes dedicated to reducing mortality and morbidity generally. The Child and Youth Mortality Review Committee, the National Perinatal and Maternal Mortality Review Committee and the Perioperative Mortality Review Committee have developed review processes. These processes provide a good base for undertaking systematic mortality review, and each DHB is expected to work with and contribute to the national process.

9.7.4 The Family Violence Death Review Committee is developing review processes specifically for family violence deaths and commenced local reviews in 2010 these processes may provide a good base for undertaking systematic death review.

9.7.5 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 and sentinel clinical events
e. clinical audits.

9.8 Complaints procedures

(See Health and Disability Services (Core) Standards 1.13.)

9.8.1 Each provider will have a process that enables consumers/families/whānau and other people to make complaints.

9.8.2 Providers' complaints procedures will be in accordance with the Health and Disability Commissioner Act 1994 part 4 and the Code of Health and Disability Services Consumers' Rights Right 10. Providers will also ensure that:

a. their complaints procedures are made known to, and easily understandable by, consumers and their families and whānau
b. people handling complaints maintain impartiality and act fairly
c. complaints are handled at levels appropriate to their complexity or gravity
d. any corrective actions required, following complaints, are undertaken within reasonable timeframes

e. consumers and their families and whānau are aware of the various organisations to whom complaints may be made, and the processes for making complaints; consumers/families/whānau will further be advised of their right to direct complaints to the Health and Disability Commissioner or to the Ministry, particularly in the event of the non-resolution of a complaint
f. complaints are handled sensitively, with due consideration of cultural or other values
g. Māori consumers and their whānau will have access to a Māori advocate to support them during the complaints process, if they wish to have one, and there will be co-operation between the advocate and person handling the complaint
h. consumers who complain, or on whose behalf families/whānau complain, shall continue to receive services that meet all the requirements of the AP
i. complaints are regularly monitored by the management of the service and trends identified in order to improve service delivery
j. their complaints procedures are consistent with any existing, relevant Ministry health policy.

9.8.3 For requirements regarding the acceptability of services (see section 3.14).

9.9 Effectiveness of services

(See Health and Disability Services (Core) Standards 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9, 3.10, 3.11, 3.12, 3.13.)

9.9.1 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 / service plan and/or record of treatment
c. deliver to consumers services that meet its individual assessed needs, reflect current good practice and are co-ordinated 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.

Service delivery

9.9.2 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, 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 co-ordination with other medical services, and links with communities, iwi, Māori and other services as necessary.

Planning discharge from the service or transfer between services

9.9.3 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.

9.9.4 Providers will have policies and procedures for planning discharge/exit/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 plan of care/service plan, where appropriate, from or before admission
c. full involvement of consumers in planning their discharge
d. involvement of family/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.

9.9.5 Each providers 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/whānau and the wider community. These 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/whānau of appropriate alternative services
d. where appropriate, advising the family/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

9.9.6 Effective information transfer between primary, secondary and tertiary providers will occur when the provider will advise the patient's GP and the referrer (where the referrer is not the GP) of the following:

a. acknowledgement of receipt of the referral

b. the outcome of the first assessment when completed.

9.9.7 Where a referral is made by a hospital-based clinician to another secondary or tertiary provider:

a. the patient's GP contact information will be included to enable communication with the patient's GP (as above)

b. the DHB will have a system in place to ensure that the referral sent has been received

c. the DHB will have a system in place to ensure that each stage of the appointment process has been completed.

9.10 Risk management

See Health and Disability Services (Core) Standards 2.3, 2.4.

9.10.1 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 *Guidelines for managing risk in the Australian and New Zealand public sector SAA/NZS HB 143:1999*. This document can be purchased from Standards New Zealand via its website at http://www.standards.co.nz.

9.10.2 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 to 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, adhere, implement and comply with the proposed reportable events project recommendations called the sentinel events reporting system.

9.10.3 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 which have responsibility for co-ordinating 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.

9.10.4 Providers must have policies, processes and procedures that will include definitions of incidents and accidents. They 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.

9.11 Prevention of abuse and neglect

(See section 51 Crown Entities Act and Health and Disability Services (Core) Standards 1.3.7.)

9.11.1 Each provider must safeguard consumers, staff and visitors from abuse, including physical, mental, emotional, financial and sexual maltreatment, or neglect, as far as is reasonably practicable.

9.11.2 Providers will have policies and procedures on preventing, detecting and removing abuse and/or neglect. These will include definitions of abuse and neglect, and will 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.

9.11.3 For information on the registration and continuing education of DHB employees (see section 10.4).

9.12 Facilities

See Health and Disability Services (Core) Standards 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8.

9.12.1 Each provider must provide services from safe, well-designed, well-equipped, hygienic and well-maintained premises, so far as is reasonably practicable.

9.12.2 Providers' 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.

9.12.3 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 people who are deaf through the provision of interpreters and devices to assist communication.

9.13 Death

See Health and Disability Services (Core) Standards 2.4.

9.13.1 Subject to the Coroners Act 2006 and the Births, Deaths and Marriages and Relationships Registration Act 1995, each DHB is to comply with legislative requirements following the death of a consumer. (***Note*** new requirements in section 13(1)(d) of the Coroners Act 2006 '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'.)

9.13.2 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 this section

10.1.1 This section is to ensure that DHBs are fully engaged with workforce development and planning. Full engagement will assist with recruitment and retention of workers.

10.1.2 Strengthening the workforce should be a high priority for DHBs. Workforce accounts for 68 percent of public health expenditure. This section of the OPF is to ensure quality and timely delivery of health services through a sufficient and sustainable supply of skilled workers. Workforce shortages threaten the sustainability of some services and these shortages require increased flexibility in the way health professionals work to address these shortages. 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.

10.1.3 Employment Relations monitors the development of bargaining strategies for DHBs and other Crown entities and ensures compliance with the consultation and good employer requirements of the New Zealand Public Health and Disability Act 2000 and the establishment and maintenance of employment equity requirements. In addition, 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.

10.1.4 **Establishment of Health Workforce New Zealand**

10.1.5 The Government recognises the need for national oversight of workforce development in the health sector. To oversee workforce development the Government established Health Workforce New Zealand within the National Health Board Business Unit (NHBBU) [CAB Min (10)7/5 confirmed SOC Min (10) 2/2.]

10.1.6 The Ministry administers the Health Practitioners Competence Assurance Act 2003 (HPCAA) 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. The maintenance of competency is part of the HPCAA and DHBs have a role in supporting their employees to maintain competence under its requirements.

10.1.7 **Employment relations**

The Employment Relations sections set out the various organisational requirements of DHBs relating to employment responsibilities including bargaining. Each DHB must comply with section 22 of the New Zealand Public Health and Disability Act 2000 and section 118 of the Crown Entities Act 2004 to be good employers; operate collaboratively on matters concerning employment industrial relations and management of bargaining and ensure that pay and employment equity requirements are established and ongoing.

10.1.8 The 2010 Ministers letter of expectations laid out the need for clinical leadership in DHBs as it is internationally recognised as a driver to improved patient care. The Minister expects that DHB strengthen clinical leadership.

10.1.9 The NZPHD Act will be (has been) amended to change the reporting requirements of DHBs to the National Health Board (NHB). The purpose of this section is to outline to DHB their requirements for workforce development to ensure that New Zealand has a high quality workforce to deliver health services.

Section summary of mandatory requirements

Each DHB must:

- comply with section 22 of the New Zealand Public Health and Disability Act 2000 and section 118 of the Crown Entities Act 2004 to be good employers (**10.2**) comply with section 22 of the New Zealand Public Health
- ensure access of employees to professional registration and continued education (**10.3**)
- provide plans to address local workforce needs (**10.4**)
- operate collaboratively on matters concerning employment industrial relations and management of bargaining (**10.5**)
- participate in implementing the agreed recommendations of the national response plan and ensure that pay and employment equity requirements are established and ongoing (**10.6**)
- establish and publish internal procedures for receiving and dealing with information about serious wrongdoing in accordance with the requirements set out in the Protected Disclosures Act 2000 (**10.7**)

10.2 DHBs as good employers

(See section 22(1)(k) NZPHD Act and section 118 Crown Entities Act.)

10.2.1 Each DHB is required to be a good employer as indicated by section 22(1)(k) of the NZPHD Act, and as defined under section 6(1) of the NZPHD Act 2000 and under section 118(2) of the Crown Entities 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 and 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 Crown Entities Act and section 22(1)(k) NZPHD Act. Such policies should include an equal employment opportunities (EEO) programme.

10.3 Registration and continuing education of DHB employees

(See Health and Disability Services Standard (H&DSS) 2.6, H&DSS 2.7, H&DSS 1.1, Health Practitioner's Competence Assurance (HPCA) Act 2003 and Ministry Planning Signal to DHBs 2000.)

10.3.1 Each DHB is required to implement systems for the maintenance of competency of all clinical staff and the credentialing of 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 maintenance of professional registration and enhancement of 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 sub-contractors undertaking or observing service delivery are to identify themselves, including their name and role/position, to all consumers and family/whānau.

10.4 Workforce

10.4.1 The Government established Health Workforce New Zealand (HWNZ) to lead and co-ordinate the planning and development of 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. HWNZ advises the Minister on all aspects of health workforce

and works in collaboration with training providers, professional bodies and employers so that the development of the health and disability workforce is informed by those providing services. HWNZ has a role in purchasing, workforce innovation and workforce intelligence and planning.

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, cooperation and involvement in training is critical to successful planning and development of the New Zealand health workforce. The key areas for DHB collaboration include clinical leadership; data collection; and the role in training including career planning and career pathways.

10.4.3 Each DHB is required to describe in their district and regional service plans (as defined in section 3.9) how clinical leadership will be fostered in the following areas:

a. Contributing to regional clinical leadership through networks
    - Investing in the development of clinical leaders
    - Involving the wider health sector (Including primary and community care)
    - Demonstrating clinical influence in service planning
    - Investing in professional development
    - Influencing clinical input at board level and throughout the DHB

b. Maintaining up-to-date collection of workforce data[28] by the DHB and the organisations that the DHB funds

c. Making workforce data available to HWNZ on request for its workforce intelligence and planning work.

d. Demonstrating their role in training and career development:
    - Requiring support, fostering and providing training including clinical placements in their DHB region
    - Working in partnership with educators, and other relevant bodies such as professional colleges, in training and career development
    - Working in partnership with employees for training and development including their career planning
    - Demonstrating their role in training and career development
    - Developing active career plans for all trainees in receipt of HWFNZ funding

[28] (This can be defined more clearly as required)

10.5 Employment relations and management of bargaining

(See Schedule 3, clause 44(2), NZPHD Act, and Schedule 1B, Employment Relations Act 2000.)

10.5.1 Each DHB is accountable for its employment relations processes and outcomes. The NZPHD Act requires DHB Chief Executives (CEs) to consult with the Director-General of Health before finalising collective employment agreements with any or all groups of employees.

10.5.2 DHBs are expected to 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 (MECAs). DHBs should ensure that effective strategy development and negotiation processes are followed, and that their negotiation teams are adequately resourced.

10.5.3 It is expected that DHBs will have durable and robust contingency plans in place for dealing with a range of situations, including staff taking industrial action, and that these plans can be called upon in such an event. During industrial action contingency planning must include provisions for Life Preserving Services (LPS) and LPS agreements must be in place, where appropriate, for each notice of industrial action. A clinical adjudicator must be agreed in the Bargaining Process Agreement (BPA) for each set of negotiations.

10.5.4 To meet their obligation to consult with the Director-General, DHB CEs are expected to provide the NHBBU of the Ministry with details of their employment relations and specific bargaining strategies, and progress with negotiations. Bargaining strategies, and subsequent updates, should incorporate the elements of the Government Expectations for Pay and Employment Conditions in the State Sector (the Expectations), cover effective risk identification, mitigation and management and include full costings and approvals. The Ministry needs to be kept fully informed so it can provide Ministers with timely advice and information on employment relations activity in the health sector (including potential flow-on effects from bargaining) and with assurances that any risks are being appropriately managed.

10.5.5 DHB CEs are expected to fulfil their obligations by:

a. formally consulting the Ministry during the development and any subsequent review of overarching employment relations strategy

b. formally consulting the Ministry during any review of the DHBs' generic and detailed employment relations processes document (February 2008)

c. formally consulting the Ministry during 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

d. regular, free and frank sharing of 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

e. 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.

10.5.6 Schedule (1B) of the Employment Relations Act 2000 provides a Code of Good Faith for Public Health Sector (the Code) 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 will apply to them, before entering into agreements or arrangements for the provision of services.

10.5.7 DHBs should have regard to the Government's Expectations for Pay and Employment Conditions for the State Sector (May 2010).

10.6 Pay and employment equity

CAB Min (05) 42/5 dated 19 December 2005, CAB Min (07) 16/2 dated 14 May 2007 and CAB Min (09) 5/5A dated 16 February 2009 and EGI Min (09) 16/12 refer

10.6.1 Following the reviews conducted in the DHBs in 2008 each DHB is required to participate in implementing the agreed recommendations of the national response plan, and to include pay and employment equity requirements are included in already established, ongoing, internal review processes, such as internal audit plans.

10.6.2 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.

10.6.3 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.

10.7 Protected disclosures

(See Protected Disclosures Act 2000.)

10.7.1 The Protected Disclosures Act 2000 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.

10.7.2 The 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. where the 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
    - is essential to prevent serious risk to public health or public safety or the environment, or
    - is essential having regard to the principles of natural justice.

10.7.3 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 2000. A DHB must ensure that every employee is aware that it is every employee's responsibility to report suspected wrongdoing in the DHB.

11 Information Technology

11.1 Purpose of the section

11.1.1 This section sets out the requirements and expectations on DHBs to achieve the deliverables set out in the National Health IT Plan. The section addresses both the ongoing operation of DHB internal ICT systems and the work necessary to establish and implement a Regional IT Plan. Specific requirements for reporting and adherence to standards are listed.

Summary of mandatory requirements

Each DHB must:

- work to identify, install and undertake the ongoing management of appropriate information technology systems solutions within the guidelines of the National Health IT Plan (**11.2**)

11.2 eHealth Systems Development Strategy

11.2.1 Each DHB is expected to actively support the National Health IT Plan by developing and maintaining appropriate information and communication technology (ICT) system solutions in accordance with its Regional Service Plan and Annual Plan[29]. Statement of Intent.

11.2.2 To deliver on the National Health IT Plan, DHBs are to:

- work with other DHBs in the region to develop, maintain and execute a Regional IT Plan which aligns to the National Health IT Plan and Regional Service Plan
- follow guidelines and advice provided by the National Health IT Board[30]
- work with the Information Strategy Group in the development of significant ICT systems business cases for amounts greater than $500k (as outlined in this OPF – section 12.27)
- actively support and where appropriate, participate in, other sector led projects under other leadership and accountability groups[31].

[29] For Shared Support Agencies read Statement of Intent.

[30] for example: increasing IT spend from 2% to 4% of revenue; the emphasis of Regional above Local initiatives

[31] for example: Patients First, National Programmes and other Ministry of Health initiatives

In undertaking this work, each DHB must:

a. update and maintain a list of their applications and projects using the Information Strategy Group reporting tool (HICTAR – the Health ICT Applications Register). Updates should be ongoing but not less than quarterly and provide:
    - notification of new projects where the work entails capital expenditure with a total value of $50,000 or greater or $100,000 or greater for large DHBs
    - high-level status reporting against projects with a total value of $50,000 or greater 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.
b. report back to the Information Strategy Group on at least a quarterly basis, recording progress made as a Region against the Regional IT Plan, including progress made by each individual DHB. Status reports are to include comment on at least: progress made, key issues, risks and their mitigations; and planned activities for next quarter including any significant adjustments to the Regional IT Plan
c. in respect of Health Information Standards Organisation [HISO (2010)] standards activity:
    - adhere to and meet the requirements of, all published HISO standards
    - proactively report identify needs or opportunities for new standards
    - participate in the development of standards.

12 Financial and Capital Operations

12.1 Purpose of the section

12.1.1 This section sets out various financial operating rules and requirements, including in relation to fixed assets and capital.

Summary of mandatory requirements in this section

Each DHB must:

- comply with all applicable legislation governing DHB financial operations (**12.2**)
- produce a Statement of Intent (within the Annual Plan) that contains forecast financial statements, including output class statements, each financial year (**12.3**)
- prepare an AP and provide regular performance reports, including monthly financial and quarterly performance reports, against that plan (**12.4**)
- ensure accounting policies and financial statements comply with the Crown Entities Act 2004, generally accepted accounting practice, Crown accounting policies and Ministry accounting policies (**12.5**)
- operate in a financially responsible manner (**12.6**)
- procure goods and service appropriately as part of its internal financial controls (**12.7**)
- establish, maintain and operate one or more bank accounts at a registered bank or a registered building society in New Zealand (**12.8**)
- have a formal written Treasury Policy to address key financial risks it faces, and gain approval for that policy from the board (**12.9**)
- arrange working capital facilities for its provider arm with a registered bank or building society (**12.10**)
- use its Deficit Support appropriation to fund any cash requirements caused by operating deficits and capital expenditure up to the level of depreciation (**12.11**)
- make sure all new long-term debt must be issued or re-financed by the Crown Health Financing Agency (**12.12**)
- be aware that it is permitted under joint ministerial authority to enter into finance lease, or group of finance leases for similar or related assets (**12.13**)
- 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 (**12.14**)
- follow required processes regarding retention of surpluses by DHBs (**12.15**)
- pay capital charge instalments into the Ministry's Crown Receipt Account at the notified rate based on monthly invoices from the Ministry (**12.16**)
- abide by restrictions on the use of funding supplied for mental health purposes (**12.17**)

- refer to the Funding Package and the Minister's letter of expectation for requirements relating to technology improvements and efficiency gains (**12.18**)
- operate in a financially responsible manner including by prudently managing the giving of guarantees and indemnities (**12.19**)
- actively investigate, facilitate, sponsor and develop co-operative and collective arrangements with people in the health and disability sector or in any other sector to provide and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities (**12.20**)
- adhere to section 28 of the New Zealand Public Health and Disability Act 2000 relating to the acquisition of shares and interests by DHBs (**12.21**)
- ensure that its subsidiaries prepare Statements of Intent, annual financial statements and annual reports, and comply with sections 161–164 (financial provisions) of the Crown Entities Act 2004 (12**.22**)
- use the full-time equivalent (FTE) definition for all financial planning and reporting (**12.23**)
- revalue property, plant and equipment in accordance with New Zealand International Accounting Standard (NZ IAS) 16 Property, Plant and Equipment as interpreted in the Crown accounting policies (**12.24**)
- undertake formal asset management planning (**12.25**)
- present a business case fully supported by its board and the Regional Capital Committee (**12.26**)
- comply with clause 43 of Schedule 3 and sections 22 and 42(2) of the New Zealand Public Health and Disability Act 2000 Act, and sections 40–42 Public Works Act 1981 under which no DHB may sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health (**12.27**).

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. New Zealand Public Health and Disability Act 2000 (NZPHD)

b. Crown Entities (CE) Act 2004

c. Public Finance (PF) Act 1989 – as amended by the Public Finance Amendment Act 2004.

12.2.3 DHBs should especially note the requirements of section 42 of the NZPHD Act 2000 and Part 4 of the CE Act 2004 in relation to their reporting and financial obligations.

12.2.4 DHBs must prepare Statements of Intent, annual financial statements and annual reports in accordance with Part 4 of the CE Act 2004, regulations made under the NZPHD Act 2000 and generally accepted accounting practice (GAAP) (defined in section 5.5 below).

12.2.5 Every DHB, or subsidiary of a DHB, is a Crown entity (specifically a Crown Agent) as defined in section 7 of the CE Act.

12.2.6 Default financial powers provisions of the CE Act 2004 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 Entity (Financial Powers) Regulations 2005 promulgated in March 2005 and amended in 2006 (SR 2006/294).

12.2.7 The OPF reflects regulations, ministerial authorisations and policy decisions concerning DHBs in relation to the CE Act 2004.

12.2.8 Some provisions of the PF Act 1989 (as amended by the Public Finance Amendment Act 2004) 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. 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 of Health
c. section 27 (annual financial statements of government) – as it relates to DHB financial information consolidated into the Crown financial statements
d. 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
e. 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 6 years from the date it was payable to the entitled person must be deposited with the Treasury
f. section 80 (Treasury instructions) – as it relates to consistency of DHB accounting policies with Crown reporting requirements.

12.3 SOIs – forecast financial statements

(See sections 139, 141 and 142 CE Act 2004, section 42(1) and (2) NZPHD Act, New Zealand International Accounting Standard (NZ IAS) 8 'Accounting Policies, Changes in Accounting Estimates and Errors' and NZ IAS 1 'Presentation of Financial Statements', and FRS-42 'Prospective Financial Information'.)

12.3.1 The SOI is the primary accountability document with Parliament. Each DHB must prepare an SOI each financial year (see section 2.3 for more information). Each DHB's SOI must contain forecast financial statements as defined in section 2(1) of the PF Act 1989 that are prepared in accordance with GAAP (as defined in section 5.5 below).

12.3.2 Section 141 of the CE Act 2004 is discussed in section 2.3 of this document. Section 142 (1) of the CE Act 2004 requires that each DHB's SOI must include the following forecast financial statements for the first year of the plan:

a. full statements of forecast financial performance, financial position, cash flows and movements in equity at a consolidated level

b. any other measures or standards necessary to assess the DHB's performance at the end of the financial year (at output class level)

c. a statement of all significant assumptions underlying the forecast financial statements

d. Any additional information and explanation need to fairly reflect the forecast financial operations and financial position of the entity.

12.3.3 Section 142 (2) of the CE Act 2004 requires that each DHB SOI must include the statement of forecast service performance must describe the classes of outputs that are proposed to be supplied, and:

a. Identify the expected revenue to be earned, and proposed expenses to be incurred for each class of output, and

b. Comply with GAAP

12.3.4 Each SOI must also include (as a minimum) summary statements of forecast financial performance for each of the governance, provider and funder arms (CAB (00) M 15/10).

12.3.5 DHBs are to include forecast financial statements in the SOI to cover the prior year, current year and three plan years. The prior year should be based on the audited financial statements and the current year should be based on forecast year-end results.

12.3.6 The forecast financial statements should agree with the forecast financial statements in the AP approved by the Minister.

12.3.7 It is useful, but not mandatory, for a DHB to provide statements of forecast commitments and contingent liabilities in its SOI.

12.4 Financial statements

See sections 39 and 42(1), (3) and (4) NZPHD Act 2000, section 27 PF Act 1989, sections 150, 151 and 154 CE Act 2004 and CAB (00) M 15/10.

12.4.1 Each DHB must prepare a AP and provide regular performance reports, including monthly financial and quarterly performance reports against its AP, to the Minister of Health (CAB (00) M 15/10) (see section 2.3 for more information about APs).

12.4.2 DHBs must submit to the Ministry financial templates supporting the AP that comply with monthly/quarterly financial reporting requirements. DHBs must provide all necessary information in the financial templates to meet Crown Financial Information Systems (CFIS) reporting requirements.

12.4.3 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 Price Volume Schedule

d. comply with the 'Requirements and Guidelines for using Templates' issued each year by the Ministry, available on website www.nsfl.health.govt.nz.

12.4.4 Financial templates, AP financial statements, and monthly/quarterly financial reports must:

a. comply with GAAP, Crown accounting policies and Ministry accounting policies

b. clearly and separately detail each of the dimensions of DHB performance, that is, by governance, funder and provider arms (CAB (00) M 15/10).

12.4.5 Each DHB must prepare an annual report and provide it to the Minister, who is required to present it to Parliament (see section 2.4 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.

12.4.6 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 for comparison with the actual financial statements (section 154 CE Act 2004).

12.5 Accounting policies

(See sections 136 and 154 CE Act 2004.)

12.6 Good financial management

(See section 41 NZPHD Act 2000 and section 51 CE Act 2004.)

12.6.1 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.

12.6.2 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 AP 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. It should be noted that applications for equity for deficit support take approximately four weeks to process

c. report to the Ministry within required timeframes

d. ensure that it is not over committing 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 section 4 of the PF Act 1989, it will follow the process in relation to 'Withholding of Money from DHBs' set out in section 5.14 below

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:

i. the DHB is able to fund additional services purchased
ii. the Crown will provide the DHB with additional funding
iii. there will be any negative effects on the DHB's baseline services.

(See section 41 NZPHD Act 2000 and section 51 CE Act 2004.)

12.7 Internal financial controls

12.7.1 The term 'internal financial control' means the set of policies, systems and procedures an organisation uses to safeguard its resources. Procurement policies and practices are an important element of each DHB's internal financial controls.

12.7.2 The procurement of goods and services (including capital items) represents a risk to any organisation. DHBs must procure goods and services appropriately. The responsibility for having procurement policies and practices that reflect good practice lies with each DHB.

12.7.3 There is a wealth of good practice information available within the pubic sector in relation to procurement policies and practices. DHBs should be aware of the following two key guidelines in this area, as follows:

a. 'Procurement Guidance for Public Entities' (June 2008)
b. 'New Zealand Government Procurement Policy', Ministry of Economic Development (MED) (June 2006).

12.8 Bank accounts

(See section 158 CE Act 2004 and regulations 5 to 8 of Crown Entities (Financial Powers) Regulations 2005.)

12.8.1 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:

a. the registered bank or registered building society satisfies a credit-rating test prescribed in regulations (section 158(1)(a) Crown Entities Act)
b. the bank accounts are denominated in New Zealand dollars (section 158(6) CE Act 2004).

12.8.2 A DHB must properly authorise the withdrawal or payment of money from a bank account of the DHB (section 158(7) CE Act 2004).

12.8.3 The credit-rating test is satisfied only if the credit of a registered bank or registered building society is rated by:

a. Standard & Poor's Ratings Group (Standard and Poor's) at not less than A–, or A–1 if the credit is short term (regulation 7(2)(a) Crown Entities (Financial Powers))

b. Moody's Investor Service Inc (Moody's) at not less than A3, or Prime–1 if the credit is short-term (regulation 7(2) (b) Crown Entities (Financial Powers)).

Note: The credit rating needs to meet both of the above if it is listed with both or one if it is only listed with that one. If listed with both and one rating is lower than the above then it would not meet the test.

12.8.4 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 (section 158(1) CE Act 2004).

12.8.5 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 for registered banks are available on the Reserve Bank website at http://www.rbnz.govt.nz/nzbanks/0091622.html.

12.8.6 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:

a. 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

b. request approval from the Minister of Finance to maintain the bank account.

12.8.7 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 to cover circumstances where:

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.

12.8.8 DHBs are authorised under regulation 8(1) to hold bank accounts at banks outside New Zealand if:

a. the bank account comprises debt owed and payable in New Zealand dollars

b. the credit of the bank satisfies the credit-rating test applied to registered banks and registered building societies

c. the 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. the central bank of the jurisdiction in which the bank operates the bank account is a shareholder in the Bank for International Settlements.

12.8.9 Prior authority in writing from the Minister of Finance is required for any other bank accounts at banks outside New Zealand.

12.9 Financial risk management

Treasury Policy

(See section 41 NZPHD Act 2000 and section 51 CE Act 2004.)

12.9.1 Each DHB is expected to have a formal written Treasury Policy that is approved by the Board.

12.9.2 A DHB's board has a duty to ensure that DHBs operate in a financially responsible manner, including prudently managing assets and liabilities (section 51 CE Act 2004): 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.

12.9.3 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.

12.9.4 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.

12.9.5 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.

12.9.6 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).

12.9.7 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 whilst controlling the giving of guarantees and indemnities which are irregular, or which 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 5.20 for more information about guarantees and indemnities).

12.9.8 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 rated by:

a. Standard and Poor's as "A-"or higher, or "A-1" if short-term, or
b. Moody's as "A3" or higher, or "Prime-1" if short-term, or
c. as authorised and gazetted by the Minister of Finance.

12.9.9 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.

12.9.10 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).

12.9.11 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.

Derivative transactions

(See sections 160 and 164 CE Act 2004, regulation 15 of Crown Entities (Financial Powers) Regulations 2005 and New Zealand Gazette, 21/7/2005, no. 110, p. 2644.)

12.9.12 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).

12.9.13 Regulation 15 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:

- 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
- procuring foreign exchange in order to discharge a liability arising under any of the classes of contract or instrument referred to in regulation 14
- procuring foreign exchange in order to:

3.16.1.a.i..1. deposit funds into a bank account

3.16.1.a.i..2. invest in debt securities

3.16.1.a.i..3. repay borrowing
3.16.1.a.i..4. 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 2004 and, if applicable, regulation 9, where delivery must take place in the future.

12.9.14 A Crown entity may procure foreign exchange for the purposes set out in paragraph 5.9.13(1)(c) above only if the bank account, investment, borrowing, guarantee or indemnity is:

a. in a currency other than New Zealand currency; and

b. authorised by:

- the CE Act 2004; or
- the Minister of Finance (either individually or jointly with a responsible Minister).

12.9.15 Permitted derivative instruments, transactions and limits should be covered in the Board-approved Treasury Policy.

12.9.16 DHBs should enter into prudent foreign exchange transactions, recognising that the Crown will not provide additional funding to cover foreign exchange rate losses (refer section 164 CE Act 2004).

12.9.17 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.

Insurance

12.9.18 Each DHB must ensure it has appropriate insurance to cover risks.

12.9.19 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 Crown Funding Agreement.

12.9.20 It is expected that DHBs will, where appropriate, work together to secure a prudent level of insurance that represents good value for money.

12.9.21 Each DHB should inform the Ministry, on request, of the insurance cover that it has in place.

12.9.22 The insurance provisions included in sections 120 to 126 of the CE Act 2004 do not apply to DHBs (section 21 NZPHD Act 2000).

12.10 Working capital financing

(See sections 160 and 162, of the CE Act 2004 and regulations 7(1) and 13(1)(b) Crown Entities (Financial Powers) Regulations 2005.)

12.10.1 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.

12.10.2 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 12.10.3 below.

12.10.3 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 funds arm to the provider arm as denoted in the most recently agreed AP, less net IDFs and inclusive of GST.

12.10.4 DHBs must not borrow to fund deficits.

12.10.5 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 funds arm.

12.10.6 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, ie, 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.

12.10.7 Working capital facilities should be included under liquidity management policies in a DHB's Treasury Policy (refer to section 5.9 above).

Early payment

12.10.8 If the Ministry agrees to provide a DHB with its Crown funding in advance and the DHB chooses to use its early payment funds for purposes other than repayment of working capital financing (eg, repayment of debt or equity, or purchase of fixed assets), the DHB needs to ensure that it has sufficient confirmed undrawn working capital facilities in the event that the early payment benefit is withdrawn.

12.10.9 Early payment benefit is derived from the payment to a DHB in a month for that current month's one-12th of the annual planned revenue paid by the funds arm to the provider arm as denoted in the most recently agreed AP, less IDF inflows included in the transfer and exclusive of GST.

12.10.10 A DHB will also have to ensure it is able to continue to meet its banking covenants at the time it needs to re-draw down on retained facilities.

12.10.11 When a DHB is paid deficit support consideration will be given to possibility of withdrawal of their early payment status.

12.11 Deficit support

12.11.1 DHB deficit support appropriation is available to fund financial deficits that result in cash shortfalls. This appropriation must be used to fund any cash requirements caused by operating deficits with capital expenditure limited to the level of depreciation planned in the most recently agreed AP. 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.

12.11.2 The need and amount of equity should be signalled in an AP. The AP should detail separately equity planned for cash flow support (cash shortfalls on operations), capital spending up to the value of depreciation detailed in the AP 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 should be rare.

12.11.3 By signalling the need for equity in the AP this does not imply that an equity request will be approved. No matter whether the request has been signalled in the AP or otherwise, the application will still be subject to the same rigorous approval process.

12.11.4 DHBs should not expect approval of equity if any capital charge payments are overdue.

12.11.5 When requesting deficit support, DHBs must provide Treasury and the Ministry with sufficient information to enable a clear identification of:

a. the financial position, including cashflow
b. whether there are alternatives to the provision of an equity injection.

12.11.6 The formal request for equity support should be in the following form:

a. a letter from the DHB Chair
b. addressed to the Ministers of Health and Finance
c. supported by a board resolution

Requests should be provided in electronic format, and hard copies provided of the letter from the Chair and the board resolution.

12.11.7 The approval process from the time a formal request is received is generally four weeks, or more if additional information is required, inadequate information is provided, or if it is a complex request. Requests for deficit support involve at least five parties: the DHB, the National Health Board, Treasury, and the Ministers of Health and Finance.

12.11.8 Once Ministerial approval is given distribution of the funds will be arranged between the National Health Board, the Ministry and the DHB, in general it takes 10 working days for deficit support to become available for distribution.

12.11.9 Where deficit support is released in instalments, DHBs must for each instalment provide a request which 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.

12.12 Non-working capital financing

(See sections 160 and 164 of the CE Act 2004 and regulations 13(1)(a) and (c) of the Crown Entities (Financial Powers) Regulations 2005.)

Long-term debt

12.12.1 All new long-term debt must be issued or re-financed by the Crown Health Financing Agency (CHFA).

12.12.2 Prior approval from the Ministers of Health and Finance is required if a DHB, or any subsidiary of a DHB, wishes to raise new private sector finance for long term capital requirements (sections 160 and 162 CE Act 2004).

12.12.3 Some DHBs may have access to private debt facilities that were acquired before this policy was adopted.

12.12.4 Cabinet approved that each DHB has the option of either to transferring existing private sector debt to the CHFA, or to leaving this debt in place until existing arrangements mature, expire or roll over (CAB (00) M 36/1B).

12.12.5 A DHB must give reasonable notice if it wishes to refinance with CHFA in order to meet the Crown's appropriation cycle. Cabinet noted that DHBs will be responsible for any repayment penalties it may incur, arising from the decision of the DHB to refinance early with CHFA (CAB (00) M 36/1 B).

Long term painting contracts

12.12.6 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.

12.12.7 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 are outside the normal terms of trade.

Energy Efficiency and Conservation Authority (EECA) loans

(See sections 160 and 164 of the CE Act 2004 and Regulation 13(1)(c) Crown Entities (Financial Powers) Regulations 2005 (taking effect from 26 October 2006).)

12.13 Finance leases

(See sections 160 and 164 CE Act 2004, New Zealand Gazette, 21/7/2005, No. 110, p. 2644, and Regulations 11(b) and 13 Crown Entities (Financial Powers) Regulations 2005, Ministry Guidelines for Capital Investment 2003.)

12.13.1 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% 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.

12.13.2 DHBs are permitted under joint Ministerial authority to enter into finance leases from sources other than, and including, the Crown.

12.13.3 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' (refer to section 5.26)

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 APs.

12.13.4 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.

See sections 160 and 164 CE Act 2004, New Zealand Gazette, 21/7/2005, No. 110, p. 2644, and Regulations 11(b) and 13 Crown Entities (Financial Powers) Regulations 2005, Ministry of Health Guidelines for Capital Investment 2003.)

12.14 Withholding of money from DHBs

See section 4 PF Act 1989.

12.14.1 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 4(1)). Expense does not include an expense that results from:

a. re-measuring an asset or a liability; or

b. an operating loss incurred by a Crown entity or other entities the financial statements of which are consolidated into the financial statements of the Government (section 4(2)).

12.14.2 The Ministry will follow the process for withholding money set out in paragraph 5.14.5 (1–9) 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 of the PF Act 1989.

12.14.3 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.

12.14.4 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 Crown Funding Agreement, until such time as the Ministry is satisfied that the Ministry would not be in breach of the PF Act 1989 by supplying such money.

12.14.5 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. Upon 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, whilst minimising disruption to the DHB's operations.

f. Either party may seek dispute resolution (in accordance with the Crown Funding Agreement (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.

12.15 Retention of surpluses by DHBs

(See section 165 CE Act 2004.)

12.15.1 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.

12.15.2 Subject to a DHB's agreed AP, the mental health ring-fence provisions (refer to section 5.17) and elective service provisions (refer to section 4.20), surpluses or deficits from each service area are to be aggregated. Surpluses may be retained by the DHB.

12.15.3 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.

(See section 165 CE Act 2004.)

12.16 Capital charges

(See CAB (00) M20/3.)

12.16.1 Capital charge is an annual charge based on year end audited accounts. DHBs will pay capital charge instalments into the Ministry's Crown Receipt Account, at the notified rate, based on monthly invoices from the Ministry. The annual charge will be calculated on receipt of audited accounts and wash-up invoices / credit notes issued for payment. Refer to www.nsfl.health.govt.nz for the current capital charge calculation policy.

12.16.2 DHBs are expected to accrue capital charges monthly, but pay either monthly or quarterly depending on their individual standing on the Monitoring and Intervention Framework (MIF) (see section 8.7). DHBs on "Standard Monitoring" will pay at least quarterly by the 28th of the month following the quarter end. On all other levels of the Monitoring and Intervention Framework, DHBs will pay monthly by the 28th of the month following.

12.16.3 Assets donated to DHBs since 1 December 2003 are eligible for exemption from capital charge.

12.16.4 A donation will only be eligible for an exemption from capital charge if it meets the following criteria:

a. the donation relates to specifically identifiable non-current assets

b. the donation is not from the Crown or an entity described in section 27(3) of the PF Act 1989, which includes:

- all Ministers of the Crown and all departments
- all Crown entities named or described in the CE Act 2004
- organisations named or described in Schedule 4 to the PF Act 1989 (including Crown companies, trusts and councils)
- State Owned Enterprises
- Offices of Parliament
- The Reserve Bank of New Zealand

- any other entity whose financial statements are consolidated into the financial statements of the Government.

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.

12.16.5 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.

12.16.6 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 re-valued amount, is excluded from consideration for exemption.

12.16.7 Donated assets must be recorded individually in each DHB's fixed asset register and adequate records must be maintained.

12.16.8 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 the National Health Board that has authority to settle all such disputes.

12.17 Mental health

(See CAB (00) M 42/5B)

12.17.1 The mental health ring-fence to protect specialist mental health and addiction service development remains in place in 2011/12.

Mental health funding

12.17.2 The imperatives relating to funding for specialist mental health and addiction services in 2011/12 are:

a. mental health funding, as agreed by the Minister in the AP, 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. 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, for example, the provision of consultation and liaison services, co-ordination of shared care arrangements and training, advice and supervision

c. DHBs' plans for changes in mental health and addiction services in their Annual Plans are subject to the service change provisions outlined in section 4.17.

d. DHBs which have accepted new Blueprint funding must demonstrate in their plans that this funding has been applied to services that are additional to the previous year's baseline services.

e. DHBs that seek to reduce their ring-fence level because of changes to inter-district flows 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 APs for spending the surpluses on specialist mental health and addiction services. The Ministry will consult with the DHB over the feasibility of their plans to utilise the accumulated funding during the AP process and may request that the DHB repays the surplus in whole or part to the Crown.

12.17.3 Total mental health funding for the Funder arm for any year comprises:

a. prior year baseline funding

b. plus incremental funding, e.g. Demographics, Blueprint and Future Funding Track (FFT)

c. plus prior year carried forward unspent funding

Financial reporting of specialist mental health and addiction services

12.17.4

a. DHBs must be able to demonstrate fair pricing over time to provider arm and non-government (NGO) providers of mental health and addiction services that is affordable to the DHB

b. DHBs must plan to eliminate accumulated deficits in the Funder arm

c. Mental health services funded should be recorded in the Funder arm

d. 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

e. 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

f. 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

g. DHBs must identify the proposed application of any accumulated Funder arm surpluses in current year and out-year planning assumptions

h. If there is a Provider arm surplus that is not related 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.

i. DHBs must plan to eliminate Provider arm deficits

j. Demographic adjustments should support service expansion in the priority areas identified in the DHB's plan, whether provided by the DHB or the NGO sector

Mental health planning

12.17.5 DHBs are required to give effect to the mental health ring-fence in their planning documents; in the mental health section of their APs, 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 any new Blueprint allocation

d. set out new mental health funding devolutions

e. show the reinvestment of prior year Funder arm carry-forwards

f. match forecast revenue to expectations

g. match figures, where appropriate, across the AP text, and the mental health Funder and Eliminations worksheets of the main AP financial template and the mental health plan template

h. match the PVS values to the Provider arm's internal revenue figures, as well as to values in the AP Eliminations worksheet

i. match the sum of the total $ amounts in the Provider and Funder PVS to the Funder revenue

j. show phased financial and service growth figures for new funding/application of surpluses to new services, which match the proposed timeframes in the AP text.

12.18 Technology improvements and efficiency gains

(See funding package.)

12.18.1 Refer to the current funding package and the Minister's letter of expectation for requirements relating to technology improvements and efficiency gains.

12.19 Guarantees and indemnities

See Financial Powers Provisions of the Crown Entities Act 2004; Guidance for Crown Entities, March 2006 v1.1.

Obligation

12.19.1 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 5.6).

12.19.2 Each DHB must maintain, as part of their 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, whilst controlling the giving of guarantees and indemnities which are irregular, or which invert normal commercial practice, at a board level.

12.19.3 Each DHB must keep a register of any indemnities or guarantees that they give, and insure for them accordingly. As a minimum the register is suggested to include the following information:

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. DHB Insurer notified of indemnity issued.

Statutory background to giving guarantees and indemnities

(See clause 45A of Schedule 3 of the NZPHD Act 2000, sections 160 and 163 of the CE Act 2004, and regulation 14 of the Crown Entities (Financial Powers) Regulations 2005.)

12.19.4 Regulation 14(3) provides that an indemnity given by a DHB that relates to a class of contract outlined under points (d) to (h) above 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.

12.19.5 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 2004 (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 2000

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 this Part 4 of the CE Act 2004.

12.20 Co-operative agreements and arrangements

(See sections 22, 23(1)(b) and 24 NZPHD Act 2000)

12.20.1 As one of its functions, a DHB must "actively investigate, facilitate, sponsor and develop co-operative and collective arrangements with persons in the health and disability sector or in any other sector to improve, promote and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities" (section 23(1)(b), NZPHD Act 2000).

12.20.2 To fulfil this function, a DHB may enter into co-operative agreements and arrangements with any person (whether or not that person is involved in the health sector) to:

a. assist the DHB to meet its objectives set out in section 22 of the NZPHD Act 2000, or

b. enhance health or disability outcomes for people, or

c. enhance efficiencies in the health sector.

12.20.3 A DHB may not enter into a co-operative agreement or arrangement unless:

a. if consent of the Minister or authority by regulations is required for that agreement or arrangement by section 28 of the NZPHD Act 2000, that consent or authority exists

b. in any other case, the DHB is authorised to enter into the agreement or arrangement by its Regional Strategic Plan, Annual Plan or by the Minister.

Ministerial authority given to enter into a co-operative agreement or arrangement may be given subject to any conditions the Minister specifies.

12.20.4 Further guidance about the process for obtaining Ministerial consent under section 24 of the NZPHD Act 2000, including a copy of the Minister's guidelines, is available from the, Governance and Crown Entities Monitoring Section of the Strategy and Performance Monitoring Unit of the Ministry. DHBs are advised to contact the Governance and Crown Entities Section early in the process of developing arrangements that may require ministerial consent.

12.20.5 Section 3.20 contains additional protocols pertaining to relationships and arrangements with the private sector.

12.21 Acquisition of securities, shares and other interests

(Section 28 of the NZPHD Act 2000 and sections 160 and 161 CE Act 2004.)

12.21.1 Sections 160 and 161 of the CE Act 2004 restrict the acquisition of securities by DHBs except:

a. those covered by Section 28 of the NZPHD Act 2000 (see paragraphs 5.20.2–5.20.4 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 2004 (note: there are none in place at this time).

12.21.2 Section 28 of the NZPHD Act 2000 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 2004 do not apply to DHBs (sections 21(3) and 28(4) of NZPHD Act 2000).

12.21.3 Unless it has the consent of the Minister of Health or is acting in accordance with the regulations made under the NZPHD Act, no DHB may:

a. hold any shares or interests in a body corporate or in a partnership, joint venture or other association of persons, or

b. settle, or be a trust or appoint a trustee of a trust (section 28(1) NZPHD Act 2000).

12.21.4 The Minister's consent for either of the above may be given subject to any conditions the Minister specifies (section 28(2) NZPHD Act 2000).

12.21.5 Debt securities are defined in section 2(1) of the Securities Act 1978 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.

12.21.6 Further guidance about the process for obtaining consent under section 28 of the NZPHD Act 2000, including a copy of the Minister's guidelines, is available from the Governance and Crown Entities Monitoring section of the Strategy and System Performance Unit of the Ministry. DHBs are advised to contact the Governance and Crown Entities Monitoring Section early in the process of developing proposals involving interests in other legal entities under section 28.

12.22 DHB subsidiaries

(See sections 7(c), 8, 139 and 157 CE Act 2004.)

12.22.1 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) (section 8 CE Act 2004). DHB subsidiaries come within this definition and are generally covered by the same requirements that govern their controlling DHB.

12.22.2 In particular, DHB subsidiaries must prepare Statements of Intent, annual financial statements and annual reports, and must comply with sections 161 to 164 (financial powers provisions) of the CE Act 2004.

12.22.3 It is the responsibility of the parent to include mention in its SOI 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 if it is covered in the parent DHB's SOI (section 139(2) CE Act 2004).

12.22.4 If a DHB subsidiary is a multi-parent subsidiary then it is the responsibility of the subsidiary to comply with the requirements to which paragraph 5.23.2 refers (section 157(1) CE Act 2004). A multi-parent subsidiary may, however, apply to the Minister of

Finance for an exemption from those requirements (section 157(2) CE Act 2004), subject to any conditions the Minister may deem fit (section 157(3) CE Act 2004). These may include the condition that the SOI or annual report of one of the parents must cover the multi-parent subsidiary.

12.22.5 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 (section 97 CE Act 2004). Sections 97 to 99 also set out other restrictions and rules relating to DHB subsidiaries.

12.23 Full-time equivalent definition

12.23.1 Full-time equivalents (FTEs) are defined in the 'Requirements and Guidelines for Using Templates' document published each year by the Ministry (available at http://www.nsfl.health.govt.nz).

12.23.2 The FTE definition introduced in 2006/07 relates to only personnel employed by DHBs and must be used for all financial planning and reporting. The definition is based on 'accrued' FTEs and represents staff resources employed by a DHB measured in hours.

12.23.3 Management/ administration FTE are to be represented based on 'establishment' FTE. This method differs from the 'accrued' FTE. This must be used for all financial planning and reporting and is defined in the 'Requirements and Guidelines for Using Templates' document.

12.24 Asset valuation

(See NZ International Accounting Standards (NZIAS) 16 Property, Plant and Equipment, NZ IAS 38 Intangible Assets and Crown accounting policies.)

12.24.1 DHBs must revalue property, plant and equipment (PPE) in accordance with NZ IAS 16 'Property, Plant and Equipment', as interpreted in the Crown accounting policies.

12.24.2 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 (NZ IAS 23 Borrowing costs).

12.24.3 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).

12.24.4 Other PPE (eg, motor vehicles, office equipment) and intangible assets are recorded at cost less accumulated depreciation/amortisation and accumulated impairment losses.

12.24.5 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, therefore it may be necessary to revalue only every three or five years.

12.25 Asset management planning

(See Ministry Guidelines for Capital Investment (2003) and Cabinet Capital Asset Management (CAMs) policy.)

12.25.1 DHBs must undertake formal asset management planning.

12.25.2 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.

12.25.3 Asset management plans must address the following areas:

a. strategic asset management
b. strategic asset financing
c. facilities and major equipment
d. Information Services Strategic Plan (ISSP).

12.25.4 The purpose and content of each of these plans are defined in the 'Guidelines for Capital Investment' and the 'Business Case Guidelines for Investment in Information Technology' and in specific guidance on asset management developed by DHBs and available from the Ministry.

12.25.5 Asset management plans must be maintained as a 'live document' and kept regularly up to date. The filing of asset management plans will be as advised by the Ministry.

12.26 Business cases

(See Guidelines for Capital Investment 2003, Business Case Guidelines for Investment in Information Technology (2005) and CAB (00) M 20/4.)

12.26.1 Joint approval from the Ministers of Health and Finance is required for the following:

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% of total assets, whichever is the lesser

c. investments that have the potential to strategically affect the performance of DHBs, or investments which have been identified in by the State Services Commission as being of high risk.

12.26.2 The above criteria also apply to joint ventures.

12.26.3 Lower approval thresholds applying to investments in information systems and communications technology are:

a. Minister of Health approval for investments over $3.0 million

b. Director-General of Health approval for investments between $0.5 million and $3.0 million.

12.26.4 For all projects, including minor capital projects, a DHB must complete a Risk Profile Assessment and submit it to the State Services Commission, Gateway Team, for verification of the risk rating. This must be completed and submitted to the Gateway team in a timely manner before the submission of the Strategic Assessment (Stage 0) business case in 31 August, in case a Gateway Review or a Strategic Assessment (Stage 0) business case are required. For information on Gateway Reviews and Risk Profile Assessment see the State Service Commission website www.ssc.govt.nz.

12.26.5 For all capital investments fitting into the criteria listed in 12.26.1 and 12.26.3, a DHB must present a business case, fully supported by its Board and the Regional Capital Committee, that:

a. demonstrates that the service model proposed is the most clinically and financially viable service option from a regional, or if appropriate, national perspective

b. shows how the proposed investment will meet the DHB's and the government's health priorities.

12.26.6 Some DHB's as a requirement of Letter of comfort, issued by the Minister of Health and Minister of Treasury, may not enter into a commitment for capital project greater than $1 million, without first obtaining Minister of Health approval. These DHB's must present a business case fully supported by its Board.

12.26.7 Strategic Assessment (Stage 0) business cases of major capital proposals are to be filed by 31 August of each year. Indicative (Stage 1) business cases are due to the Ministry by 30 September of the year following the filing of the Strategic Assessment (Stage 0) business case. The Crown considers funding priorities for major capital projects in November. Ministers will make decisions about each capital investment proposal based on a detailed assessment of the supporting business case and each proposal's relative priority against the funds available.

12.26.8 DHB capital projects can be financed from the following sources:

a. DHB contribution

b. Crown equity (from the Health capital budget)

c. long-term debt from the Crown Health Financing Agency (CHFA) – from the Health capital budget

d. finance leases (refer to section 5.13 above)

e. private debt with the prior approval of the Ministers of Finance and Health

f. donations from the community

g. public private partnerships.

12.26.9 Once crown equity or new debt has been approved by the Minister 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.

12.26.10 All Crown equity or new debt must be drawn by the DHB within 12 months of the completion of the project or will be returned to the Health Capital Envelope.

12.26.11 Detailed guidance about the capital approval process and developing business cases is provided in the 'Guidelines for Capital Investment' available from the Ministry. It is recommended that DHBs contact the NHB early in the process of developing a business case.

12.27 Dealings with land

(See NZPHD Act, sections 22 and 42(2) NZPHD Act, and sections 40 to 42 Public Works Act 1981.)

12.27.1 No DHB may sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health.

12.27.2 Applications to the Minister for approval to dispose of property 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 NZPHD Act.

12.27.3 DHBs must comply with the offer-back provisions of Public Works Act 1981, which includes requirements relating to the Māori protection mechanism and the sites of significance process when disposing of surplus properties.

12.27.4 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.

12.27.5 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.

12.27.6 Approvals under clause 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 the clause must, as soon as practicable, table the approval at a DHB board meeting.

13 Monitoring and Reporting

13.1 Purpose of the section

13.1.1 This section sets out requirements of DHBs in relation to monitoring and reporting, encompassing reporting to the Minister of Health and the Director-General of Health, national health information management and reporting requirements, national collections requirements, and requirements relating to the Accident Compensation Corporation and the Mental Health Commission. It also sets out the Ministry 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 Health or any other Minister under any statutory provision (**13.2**)
- deliver its quarterly report information by the 20th day of the month following the end of the quarter (**13.3**)
- report DHB risk management and reporting systems to manage DHB risks to its board (**13.4**)
- submit its monthly financial report (**13.5**)
- monitor, evaluate and report on the delivery of Personal Health Services and Mental Health Services set out in its AP price volume schedule (**13.6**)
- adhere to the Monitoring and Intervention Framework principles (**13.7**)
- comply with the requirement to supply at a specified time or times any information that the Minister or the Ministry requires that relates to any aspect of the operations of the DHB or its subsidiaries (**13.8**)
- conduct day-to-day relationships with the Ministry in an environment of consultation and collaboration (**13.9**)
- be good corporate citizens in respect of the information it provides (**13.10**)
- provide information of the highest possible quality, standards and completeness (**13.11**)
- make documentation available on request for audits of data collection and reporting processes (**13.12**)
- follow privacy and security rules (**13.13**)
- collect, report, store and output accurate and complete ethnicity data (**13.14**)
- ensure that all of its providers publicly funded health services submit data to National Collections Systems (**13.15**)
- follow processes attached to the National Health Index (**13.16**)
- supply the correct Health Practitioner Index data (**13.17**)
- adhere to the guidelines concerning Medical Warning Systems (**13.18**)

- 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 (**13.19**)
- adhere to the rules relating to the national Booking Reporting System (**13.20**)
- by 30 August of each financial year, provide data under its contracts with providers for the Programme for the Integration of Mental Health Data (**13.21**)
- supply data to the National Immunisation Register (**13.22**)
- supply data on Before School Checks (**13.23**)
- supply data to the National Non-admitted Patients Collection (**13.24**)
- complete medical certificates and forms for individual claimants as required by the Accident Compensation Corporation (**13.25**)
- provide all reasonable assistance to the Mental Health Commission and/or the Ministry to provide information (**13.26**).

The Ministry must:

- provide each DHB with a report on any planned reviews of the DHB (**13.27**)
- administer provision of services to DHBs via the Information Delivery and Operations Group, Information Strategy and Architecture business unit (**13.28**).

13.2 DHB annual reporting

(See sections 150–157 Crown Entities (CE) Act 2004.)

13.3 DHB quarterly reports (non-financial)

13.3.1 (See section Crown Entities Act and CAB 00 M15/10.)

13.3.2 Each DHB will deliver its quarterly report information by the 20th day of the month following the end of a quarter.

13.3.3 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 APs, and any additional reporting requirements as detailed on the Quarterly Reporting website. Where targets are either not achieved or progress is delayed, a resolution plan must be forwarded with the report.

13.3.4 Where poor performance is assessed as significant against an indicator, the DHB will be required to be reported again in subsequent quarters until the issues is satisfactorily resolved.

13.3.5 The Ministry will provide a quarterly Health Report to the Minister of Health on the performance of the DHB funder and governance arms. The report will be a consolidated assessment of the Health Targets and

Performance Measure quarterly reporting information and a summary of financial performance for the quarter.

13.3.6 DHBs are required to post reports on their designated websites. Initial Ministry feedback will also be posted on the DHB website providing acknowledgement, seeking clarification or requesting supplementary information. The Ministry will ensure that DHBs have a minimum of five working days in which to respond to the Ministry's feedback.

13.4 DHB risk management

(See section 44(1) and (2), NZPHD Act 2000 and CAB 00 M15/10.)

13.4.1 Each DHB must report a:

a. formal risk management and reporting system to manage DHB risks and report them to its Board

b. system that meets current Australia / New Zealand Standard requirements (including 'AS/NZS 4360:2004' and 'HB 228:2001') relating to risk management.

13.4.2 It is expected that, where any non-compliance exists (with either or both of the first two bullet points of 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 National Director, NHBBU 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

b. the DHB's mitigation strategy for managing such a risk.

The above notification will be copied to the DHB's Ministry Account Manager.

13.5 DHB monthly financial reports

(See section 44(1), NZPHD 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 Templates’.

13.6 Monitoring the delivery of personal health services and mental health services

(See section 133 Crown Entities Act and CAB 00 M15/10.)

13.6.1 Each DHB must monitor and evaluate the delivery of personal health services and mental health services set out in its DHB AP price-volume schedule.

Mental health financial reports

13.6.2 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.

13.7 Monitoring and intervention framework (MIF)

13.7.1 The MIF framework is in two parts:

a. the part administered by the Ministry (Table 8.1)

b. the part setting out Ministerial decisions (Table 8.2).

13.7.2 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 the table below, has been developed to give DHBs clarity in:

a. triggers for moving up and down the Ministry’s MIF monitoring and intervention levels

b. actions required by the Ministry and DHBs at each of these levels of the MIF

c. potential consequences of being at each level of the Ministry’s monitoring and intervention levels of the MIF.

13.7.3 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 monitoring and intervention is undertaken in a consistent and transparent manner.

13.7.4 The Ministry receives monthly DHB financial data, as well as quarterly non-financial reporting. Where the identified triggers (Table 8.1) indicate that review of a DHB's MIF status is necessary, the Ministry will:

a. validate the information with the DHB
b. having validated the information, review the level of monitoring and intervention, unless the DHB can demonstrate that it has robust and convincing action underway to address the situation.

13.7.5 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.[32]

13.7.6 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).

13.7.7 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. These 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 the diagram below:

Ministry MIF levels	Ministerial MIF levels
Standard monitoring	Intermediate governance action
Performance watch	Direct governance action
Intensive monitoring	

13.7.8 Intermediate governance action indicates the Minister has appointed one or more Crown monitors to a DHB's Board (section 30, 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.

[32] Refer to section 23(1)(i) of the NZPHD Act 2000.

13.7.9 Direct governance action sees the Minister dismissing a DHB's Board and replacing it with a commissioner (section 31, NZPHD Act). The Minister is entitled to do this if the Minister is seriously dissatisfied with the performance of a DHB board.

Table 8.1: 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 (RSP, AP, CFA, SOI). The DHB is performing to all key areas of its supported AP (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 Non-compliance with standard monitoring requirements, and/or • an emerging deterioration in the DHB's performance against its AP, and/or • supported AP has substantial risks that are not yet fully managed.	**Actions** As per Standard Monitoring actions, and Board-funded and approved report to Ministry identifying trends, causes, and corrective actions to be taken by DHB. Ministry to monitor DHB's progress towards implementation of corrective actions signalled in 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 CEO meetings with Ministry to discuss Board report. Ability to commit capital limited to levels agreed with Ministry. Likely trigger for Minister of Finance's interest in DHB. Appoint an expert team to engage in a 'turnaround' process (with DHB agreement).

Level and requirements (triggers)	Actions and potential additional consequences
Intensive monitoring A DHB is unable to achieve Minister's support for its AP within agreed timeframes set by the Ministry, or • continuing non-compliance and/or deterioration in either standard monitoring requirements and/or performance watch requirements, or • a single event that seriously affects planned performance or creates material risk.	**Actions** As per standard monitoring actions and Board-funded indepth review, for which the Ministry selects reviewer, and sets the terms of reference in consultation with the DHB. DHB provides Board-funded and approved report to Ministry identifying trends, causes, and corrective actions to be taken by DHB. Ministry to monitor DHB's progress towards implementation of 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. As per performance watch, potential additional consequences, and Minister may require meeting with Chair to discuss performance.

Table 8.2: Minister of Health MIF levels

Level and requirements (triggers)	Actions and potential additional consequences
Intermediate governance action At the Minister's discretion.	**Actions** The Minister appoints one or more Crown monitors (S30 NZPHD Act) either as a governance response to issues facing a DHB, or in an organisational improvement role, and to address particular issues facing a DHB.
Direct governance action At the Minister's discretion.	**Actions** The Minister replaces all the Board with a Commissioner and terms of reference.

13.8 Information for the Minister

(See sections 133 and 134 CE Act, sections 28 and 41 State Sector Act 1988, and CAB 00 M15/10.)

13.8.1 The Minister, as per section 133 CE Act 2004 may, by written notice, require any DHB to supply, at a specified time or times or at specified intervals, any information that the Minister or the Ministry requires that relates to any aspect of the operations of the DHB or any or all of its subsidiaries (this authority has been delegated to the Ministry). DHBs

must comply with this requirement, unless there are good reasons for refusing to supply the Minister with the requested information (see section 134 CE Act).

13.8.2 Each DHB is required 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 will be provided in writing and, where practicable, in an agreed format (normally within the timeframe agreed by the briefing writer, but always not 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 and respond to oral Parliamentary questions on the same day by 11:30am
   - respond to Ministerial correspondence within three working days or to meet the timeline the Minister has requested.

13.8.3 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.

13.8.4 The grounds for withholding information are set out in section 134 of the CE Act.

13.9 Ministry / DHB relationship protocol

13.9.1 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 Ministry Regional DHB Relationship Manager or other equivalent Ministry contact and the appropriate and relevant DHB contact.

13.9.2 To deal with situations where it has not been possible to reach an accommodation and to ensure the timely resolution of the outstanding issues, all parties are to abide by the Ministry/DHB relationship protocol detailed in Table 8.3 below.

Table 8.3: The Ministry / DHB relationship protocol

	Condition	Responsibility		Action by Ministry	Suggested timeframe
		MoH	DHB		
0	Either: Seeking to resolve an outstanding issue, or non-compliance of an already agreed deadline. Lack of compliance may includes only partial completion of the total requirement	Regional DHB 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.	ASAP
1	If no satisfactory resolution	DHB Relations Manager Group Manager	GM/CEO	Manager initially seeks to resolve problem with appropriate DHB Manager If timeline involved, agree a new timeline Manager to secure a resolution plan in writing and formal reporting is to be supplied via the DHB Quarterly Reporting in the next quarterly report.; OR 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	DDG/DG/ NHB Director	CEO	Letter prepared by responsible manager/ relationship manager for DDG including options that are available to the Ministry and/or DHB DDG to either speak to or forward letter to CEO DDG to decide whether or not DG to release letter CEO should be given sufficient time to reply in writing	DDG/DG/ NHB Director decision
3	If DDG unable to reach resolution with DHB CEO	Minister	Chair	Brief prepared by responsible manager/AM 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 DDG should formally advise the appropriate CEO of this action prior to the Chair's receipt of the Minister's letter	Minister's decision

13.10 The provision of quality information

13.10.1 The following section sets 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.

13.11 Quality, standards and completeness

(See section 23(1)(k) NZPHD Act, sections 133 and 134 CE Act and CAB(00) M 22/11.)

13.11.1 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:

- giving due consideration to the effect any proposed system change may have on data quality
- providing appropriate training to staff involved in the collection, dissemination and storage of health information
- undertaking consultation with the Ministry on a timely basis.

c. Apply sufficient resources are applied to meet the provider quality specifications.

See section 23(1) NZPHD Act, section 133 CE Act and CAB (00) M 22/11.

13.11.2 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 Health Information Standards Organisation (HISO) or other duly mandated sector-wide reference groups and notified to DHBs.

13.12 Audit of data collection and reporting

13.12.1 Each DHB must ensure that clinical coded data submitted to any of the National Health Collections complies with ICD-10-AM classification standards and the New Zealand coding conventions by:

a. advising the Ministry on activities and actions taken in relation to reports generated by PICQ (Performance Indicators for Coding Quality) and other relevant DHB data quality reports

b. correcting errors in NMDS data that are identified by the Ministry

c. ensuring processes are in place to continually evaluate and improve the quality of coding

d. providing an opportunity for clinical coders to participate in continuing education, both internal and external to the DHB

e. producing an annual report on completed and planned education development for individual clinical coders, and providing the report to the Ministry on request

13.13 Privacy and Security

(See section 23(1) NZPHD Act, section 134 CE Act, CAB (00) M 22/11 and the Health Information Privacy Code 1994.)

13.13.1 DHBs are to ensure that:

a. personally identifiable information about individuals is treated with the utmost care and that all privacy legislation and security policies are complied with

b. a formal written authorisation is established before their agents access personal information from the National Collection 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 clause b) above] are established or changed, this is immediately reported to the Team Leader, Analytical Services, National Health Board, Ministry of Health

d. both information and IT systems managed by the DHB are protected to prevent unauthorised access, damage to or disclosure of information held; be it by either individuals, malware or viruses.

13.14 Ethnicity reporting

(See section 23(1)(k) NZPHD Act, 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:

a. collect, record, store and output accurate and complete ethnicity data, based on the Ethnicity Data Collection Protocols. 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 that there is effective follow-up where these requirements are not met
- they work with the Ministry to educate providers and health and disability sector organisations regarding ethnicity information
- they can demonstrate that effective processes are in place to monitor and improve the quality of ethnicity data collected

b. ensure that appropriate ethnicity information is included in:
   - reports to the Ministry to aid the monitoring of Māori health issues and improving policy advice
   - reports to both its Māori, Pacific Island and ethnic communities for the purposes of NZPHD Act, the monitoring Pacific and ethnic health issues

13.14.2 DHBs must include appropriate ethnicity information in:

a. the Ethnicity Data Collection Protocols are based on the Statistics New Zealand Census question and existing Ministry National Minimum Data Set 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 and 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 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 Systems (NCS)

(See sections 23(1) and 44 NZPHD Act and CAB (00) M 22/11.)

13.15.1 To meet the sector's information needs, each DHB must:

a. ensure that it and all of its providers of publicly funded health services including any bulk funding and contract delegations, submit data to NCS 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 corresponds with the national standard data definitions issued by the Information Delivery and Operations Group this includes requiring all DHB providers to adhere to such national standards as are endorsed by the Health Information Standards Organisation (HISO), 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 of data format and quality of data.

b. provide the Ministry with the requisite data for the following National Collections Systems (NCS):

- National Health Index (NHI)
- Health Practitioner Index (HPI)
- Medical Warning System (MWS)
- National Minimum Data Set (NMDS)
- National Booking Reporting System (NBRS)
- Programme for the Integration of Mental Health data (PRIMHD)
- National Immunisation Register (NIR)
- Before School Checks (B4SC)
- National Non-Admitted Patients Collection (NNPAC)

c. 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, 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

d. ensure that all changes to the systems that support NCS reporting or reporting requirements are subject to appropriate compliance testing as determined by the Ministry.

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 NCS on the Ministry 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 using the current approved version ICD-10-AM of the International Classification of Diseases and Related Health Problems. The DSM-IV is also appropriate for reporting to the Programme for the Integration of Mental Health Data (PRIMHD).

13.15.3 Costs for providing information to national systems are to be paid by the entity generating the information.

13.15.4 To meet the sector's information needs, the Ministry will:

a. consult with sector stewardship groups, including the DHB-led project groups co-ordinated by DHBNZ, when changes are proposed to the data collected in the national collections

b. communicate with software vendors when changes to national collections are approved

c. provide DHBs with:
   - a point of contact for communication
   - feedback on their performance by publishing data on the Health Information Network (HIN)

- 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 time frames and levels of accuracy as outlined in the file specification for each collection

e. ensure that processing of all National Health Information Batch Systems are complete within two working days of receipt of data from a provider, 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 NCS:
    - 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.

13.15.5 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 NCS. Once agreement is reached, DHBs will require providers to deliver against this timetable.

13.15.6 The Ministry and DHBs may identify ways to develop and improve information. Each DHB will assist the Ministry to develop a joint approach through the Information Liaison Group (or similar group) and contribute resources as able for this work.

13.16 National Health Index (NHI)

(See sections 23(1) and 44(2) NZPHD Act and CAB (00) M 22/1.)

13.16.1 In order for National Health Index information to be complete and accurate, each DHB is required to:

b. ensure that processes are maintained to attach the correct NHI number to all transactions relating to services for an individual patient provided either by the DHB or via its contracted suppliers. Where health information is shared with general practitioners to facilitate implementation of co-ordinated care (such as in the case of immunisation), the correct NHI number and complete, accurate NHI data are required

c. 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

d. 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.

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. demonstrate that processes are in place to monitor and reduce the number of NHI duplicates being created.

13.16.2 DHBs, in conjunction with primary health care providers, are responsible for the collection and updating of NHI data. They must, as far as possible, ensure completeness and accuracy of NHI data as a result of their direct contact with patients. To assist DHBs with this task, the Ministry (specifically the Information Delivery and Operations Group) will monitor and report back to the DHBs regarding the quality of NHI data that each DHB has submitted (for example, completeness and number of duplicate entries). DHBs and the Information Delivery and Operations Group will work together to continuously improve the accuracy of information on the NHI register.

13.17 Health Practitioner Index (HPI)

(See sections 23(1) and 44, NZPHD Act and CAB (00) M 22/11.)

13.17.1 Each DHB must:

g. supply the correct HPI data to each of the national collections as specified in the requirements for that collection
h. ensure that all HPI related data is provided to the national collections using the accurate practitioner identifier
i. engage with the Information Delivery and Operations Group in the;
    - mapping of local provider identifiers to unique HPI identifiers, and
    - integration of HPI identifiers into DHB systems and business architectures

13.18 Medical Warning System (MWS)

(See sections 23(1) and 44 NZPHD Act and CAB (00) M 22/11.)

13.18.1 Each DHB and private hospitals accessing the MWS must be able to connect to the MWS to allow appropriate staff to add, update or delete existing warnings and dangers.

13.18.2 Each DHB must require providers to submit appropriate medical warnings to the MWS in a timely manner.

13.18.3 The Information Delivery and Operations Group will ensure that the appropriate infrastructure is maintained, and that the MWS system is available to mutually agreed service levels.

13.19 National Minimum Data Set (NMDS)

(See sections 23(1) and 44, NZPHD Act and CAB (00) M 22/11.)

13.19.1 DHBs will require that all providers that are contracted to provide hospital inpatient and day-case services report that data to the NMDS, or else the DHBs 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 their discharge from, or attendance at, hospital, or the cessation of the provision of health care to that patient.

13.19.2 Each DHB is required to:

a. submit data to the NMDS only for patients who are admitted to a hospital (refer to the data dictionary appendices for definitions)

b. engage with the Information Delivery and Operations Group in the development and ongoing management of the NMDS, as required. The Information Delivery and Operations Group will ensure that the development and ongoing management of the NMDS meets the needs of DHBs. Feedback regarding DHB requirements will be sought via the National Health Board and other interested sector stewardship groups, such as the DHB-led project groups coordinated by DHBNZ. Recommended changes will be submitted to the Information Liaison Group for sign-off. Recommended changes will be agreed with the sector before being included in the national collections

c. ensure that all NMDS data is provided using the health care user's accurate 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 ACC45 form number is reported for all NMDS records that fit within ACC criteria for claims and funding.

13.20 National Booking Reporting System (NBRS)

(See sections 23(1) and 44, NZPHD Act and CAB (00) M 22/11.)

13.20.1 Each DHB is to require all providers that are contracted to provide publicly funded elective services to supply data to the NBRS, or will undertake to

submit the data themselves. Data will be supplied according to the National Booking Reporting System File Specification and the Business Rules posted on the New Zealand Health Information website.

13.20.2 Providers must submit records to NBRS at least monthly. Individual NBRS records must be submitted to the Information Delivery and Operations Group by 4pm on the third to last working day of the month following the month to which the record relates.

13.20.3 Each DHB will continue to engage with the Information Delivery and Operations Group and the Ministry's Elective Services Team in the development and ongoing management of the NBRS as required.

13.20.4 DHBs will require providers to meet mutually agreed deadlines for all new NBRS compliance requirements.

13.21 Programme for the Integration of Mental Health Data (PRIMHD)

(See sections 23(1) and 44, NZPHD Act and CAB (00) M 22/11.)

13.21.1 To support reporting to the Minister, each DHB must by 30 August for each financial year, provide data:

a. under its contracts with providers, require that PRIMHD (as identified in the PRIMHD File Specification) relating to purchased services is available to the Information Delivery and Operations Group 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 accurate NHI number and in accordance with the PRIMHD codeset and dataset documentation

c. continue to engage with the Information Delivery and Operations Group in the ongoing management and support of the PRIMHD, as required

d. ensure that NGOs and hospitals meet deadlines agreed with Information Delivery and Operations Group for all new compliance requirements. Compliance should be undertaken when there are any changes a the DHB or NGO that affects the PRIMHD data extract or as part of the NCAMP project where there are changes to the PRIMHD reporting requirements.

13.22 National Immunisation Register (NIR)

(See sections 23(1) and 44, NZPHD Act and CAB (00) M 22/11.)

13.22.1 Each DHB must:

a. supply maternity registration data to the NIR for all new registrations

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 accurate NHI number

d. be responsible, in conjunction with primary health care providers, for the collection and updating of vaccination data into the NIR

e. ensure that all vaccinations given to an individual, is 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 SBVS sourced data having 70% within two working days and 98% within five working days.

13.23 Before School Checks (B4SC)

(See sections 23(1) and 44, NZPHD Act and CAB (00) M 22/11.)

13.23.1 Each DHB must:

a. supply B4SC data to the Ministry for all B4SC funded by the DHB

b. ensure that all B4SC information is provided using the health care user's accurate NHI number

c. continue to engage with the Ministry in the development and ongoing management of the B4SCs, as required

d. require providers to meet mutually agreed deadlines for all new compliance requirements.

13.24 National Non-admitted Patients Data Collection (NNPAC)

(See sections 23(1) and 44, NZPHD Act and CAB (00) M 22/11.)

13.24.1 Each DHB must:

a. ensure all providers that are contracted to provide publicly funded services supply NNPAC data to the Information Delivery and Operations Group of the Ministry for all mandatory purchase units and may supply data for optional purchase units. These lists are published on the New Zealand Health Information Service website (http://www.nzhis.govt.nz)

b. ensure that the health care user's accurate NHI number is used with all NNPAC information provided

c. continue to engage with the Information Delivery and Operations Group 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 that the service delivery occurred in

f. provide at least one file every calendar month.

13.25 ACC (Accident Compensation Corporation)

(See Accident Compensation Act 2001 and CAB(00) M 22/11.)

13.25.1 Where a patient is covered by the ACC Act, 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 Information Delivery and Operations Group for inclusion in the NMDS data collection as set out in this document for all inpatients and day patients receiving public health acute services.

b. Emergency and outpatients – each DHB is to submit data to the Information Delivery and Operations Group for inclusion in the NNPAC data collection as set out in this document for all emergency and outpatients receiving public health acute services.

c. Within six weeks of the end of the quarter, copies of relevant audit or monitoring reports relating to public health acute services will be provided to the Ministry by each DHB.

13.25.4 Each DHB is to ensure that ACC has access to relevant parts of DHB service agreements.

13.26 Mental Health Commission (MHC)

(See Mental Health Commission Act 1998.)

13.26.1 Under the Mental Health Commission Amendment Act 2007, the MHC has a statutory obligation to monitor, and to report to and advise the Minister on, any matter relating to the implementation of the national mental health strategy. Wherever possible, this monitoring is based on data which is

readily available through Ministry national systems. Where any additional information is needed by the MHC to meet its statutory obligations, DHBs will provide all reasonable assistance to the MHC and/or the Ministry to provide the information.

13.27 Ministry reports to DHBs

13.27.1 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 for unanticipated reviews.

13.27.2 In addition to the above, the Ministry will:

a. alert each DHB to any emerging factors of which the Minister is aware that could preclude the DHB from meeting any Crown Funding Agreement obligation that relates to purchase or ownership performance

b. inform the DHB of any issue likely to be of significance to the board.

13.28 Provision of services to DHBs

13.28.1 The Information Delivery and Operations Group, Sector Services Business Unit of the Ministry, provides services to DHBs.

13.28.2 A Memorandum of Understanding (MoU) signed by both parties, contains a full description of the services provided and expectations of both the Ministry and DHBs in terms of the delivery of those services. This also covers payment for non-standard reporting.

Appendix 1: Abbreviations and Definitions

Defined terms

Unless otherwise stated, all terms and phrases used throughout the OPF use the definitions and meanings set out in the New Zealand Public Health and Disability Act (NZPHD) 2000 and/or the Crown Funding Agreement.

Term	Meaning in the OPF unless otherwise stated
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
CWD	Case weighted discharge
AP	An Annual Plan of a DHB agreed with the Minister of Health under section 9 of the NZPHD Act
DHB	District Health Board, an organisation established as a DHB by or under section 19 of the NZPHD Act
DHBNZ	District Health Boards New Zealand, a national umbrella organisation formed by DHBs to co-ordinate DHB initiatives and to communicate with the government and the Ministry over matters that affect all DHBs
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
ESPIs	Elective services patient flow indicators
H&DSS	Health and Disability Services Standard, made under sections 13–25 of the Health and Disability Services (Safety) Act 2001
IDF	Inter-district flows
NCG	Nationwide Service Framework Co-ordination Group
NGO	Non-governmental organisation
NHEP	National Health Emergency Plan
NSF	Nationwide Service Framework
NZPHD Act	New Zealand Public Health and Disability Act 2000
OPF	Operational Policy Framework
PBFF	Population Based Funding Formula
PQS	Provider quality specification
SCS	Service coverage schedule
Services	Health services and disability support services
SLA	Service Level Agreement
SOI	A Statement of Intent of a DHB to be prepared in accordance with section 139 of the Crown Entities Act 2004
s	section (of an Act)
ss	sections (of an Act)
the Minister	The Minister of Health
the Ministry	The department of the public service referred to as the Ministry of Health

Term	Meaning
Audit protocols	The protocols that apply to an audit of the quality of services
Baseline volumes	All surgical services set out in the volume schedules of a DHB’s approved AP during the current funding period, including IDF volumes incorporated into the volume schedule
Catch-up volumes	Volumes of services a DHB agreed to deliver in its AP, but that were undelivered during the previous funding period, that a 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
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 and circumstances in which disclosure occurred
Current funding period	The current financial year from 1 July to 30 June
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
Phasing plan	The phasing plan for the delivery of catch-up and baseline volumes agreed by a DHB
Price Volume Schedule	The Price Volume Schedule supplied with a DHB’s AP, showing planned services the DHB provider will supply for devolved funding from DHB funds
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	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
Services	The services to be provided in accordance with the CFA and AP.
Service users	Users of any of the services
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

Explanation of Māori principles/tikanga		
Term	**Meaning**	**Implications for services**
Aroha	Compassionate love	The unconditional acceptance that is the heart of care and support
Hapū	Subtribe of an iwi	Recognise that the Māori social structure extends to whānau, hapū and iwi
Iwi	A set of people bound together by descent from a common ancestor or ancestors	Recognise that the Māori social structure extends to the whanau, hapū and iwi
Kaumātua	Māori elders of either gender	Services should recognise the mana of the kaumātua and show respect for Māori values and traditions
Kawa	Protocol of the marae, whenua (land), iwi	Determines how things are done in various circumstances. Respect for kawa is very important. If the kawa is not known the tangata whenua should be consulted
Mana	Authority, standing	Services should recognise the mana of Māori consumers
Manaaki	To care for and show respect to	Services show respect for Māori values, traditions and aspirations
Rongoa	Rakau rongoā (native fauna, herbal preparations), mirimiri (massage) and karakia (prayer)	Rongoā Māori traditional healing is formulated in a Māori cultural context, in which the understanding of events leading to ill health and its impacts are addressed through a range of culturally bounded responses
Tapu/noa	Sacred/profane	The recognition of the cultural means of social control envisaged in tapu and noa including its implications for practices in working with Māori consumers
Tūrangawaewae	A place to stand	The place the person calls home, where their origins are
Wairua	Spirit or spirituality	Recognition that the Māori view of spirituality is inextricably related to the wellbeing of the Māori consumer
Whānau	Immediate family as well as the extended family	The unit that takes responsibility for its members and has the right to be informed of where a given member is
Whanau ora	A concept about families being supported to achieve their maximum health and wellbeing	Facilitating positive and adaptive relationships within whānau and recognising the interconnectedness of health, education, housing, justice, welfare, employment and lifestyle as elements of whānau well-being.
Whanaungatanga	The process of getting to know each other, establishing kinship ties	Which takes responsibility for its members and has the right to be informed of where a given member is

Appendix 2: Amendments to the 2010/11 Operational Policy Framework

The Operational Policy Framework (OPF) document has been reviewed and updated to reflect changes to policy, legislation and general accepted accounting practices (GAAP). Key changes are summarised below.

Significant changes

There have been several changes to both the content and structure of the OPF in this version. The changes are laid out in the table below. To decrease the size of the document, verbatim references to legislation have been replaced with hyperlinks to the section of the legislation in question. Consequently, the document has a greater functionality in the web-based environment.

Section	Amendment
2	**DHB Governance**: a. Section 2 has had the areas detailing Employment Relations and Workforce development removed and placed in a new created section (Section 10) b. Description of legislative changes under the NZPHD Act 2010 and Planning Regulations c. Removal of Regional Mental Health Services planning.
3	**Planning and Accountability** There have been major changes to this section resulting in an amalgamation of parts of the old *Organisation* and *Planning, Funding and Development of Services* sections. a. Changes reflecting the NZPHD Act 2010 and Planning Regulations. This especially impacts the section on the Annual Plan (**3.3**) b. Subsections have been included on: National Service Planning (**3.9**), Regional Service Planning (**3.4**) and Devolved Services (**3.10**) and significant changes have been made to the section on Emergency planning and management (**3.11**) c. Subsections have been removed (Diabetes) and moved to other areas of the OPF (See part 5 Service Planning and Operational Policy).

Section	Amendment
4	There is a new section on **Service Change** that describes the process to manage significant service change and public consultation within the new District Health Boards (DHB) planning framework and the requirements of the New Zealand Public Health and Disability (NZPHD) Act 2010 and Planning Regulations.
5	**Service Planning and Operational Policy** This is a new section dedicated to the Service specific areas of the OPF. This section is constituted from subsections taken from other areas of the previous versions of the OPF. a. Primary Health Care has had the balance of it's content moved to the Service Coverage Schedule document (**5.2**) b. Cervical screening has been moved to this section but remains unchanged (**5.3**) c. As above with Better help for Smokers to Quit (**5.4**) d. As above with Health of Older People (**5.5**) e. As above with Disability Support Services (**5.6**) f. Elective Services has been moved to this section. The section has been updated to reflect the objectives of improving access to elective surgery and reducing waiting times. The underlying principles remain unchanged. The section has been reduced in length by including references to supporting policies and guidelines rather than duplicating information. (**5.7**)
6	**Relationships with Māori** **Māori Health Plans**: a DHB Māori Health Plan template has been developed and incorporated in the 2011/12 OPF. The Māori Health Plan includes a description of the health status of the Māori population in the district; national priorities; regional priorities and local priorities.

Section	Amendment
7	**Inter-District Flows** The IDF business rules have been changed as follows: a. The rules have been rewritten in a shorter format with more emphasis on key points b. The service change and dispute resolution sections have been removed as these are now covered in separate chapters c. Some of the more technical calculation details have been removed and will be covered in the annual methodology notes d. The rules now make a clear distinction between the process of producing annual IDF forecasts and the setting of an IDF position in the case of a dispute. In the past there has been some confusion that the IDF forecast would be the automatic default in case of a dispute.
8	**Dispute Resolution** This is a new section that has not appeared in any previous versions of the OPF. The areas that are of particular importance to DHBs are a. Changes made to the Dispute Resolution Process to describe the new legislative / regulatory environment (section 39 of the NZPHD Amendment Bill and section 92(2) DRP regulations). b. This new section changes and broadens the previous DRP process described in the OPF, which originally focused solely on IDF disputes. The IDF chapter has been updated accordingly. There is still more work to be done on this section.
9	**Quality** The changes to the Quality Improvement section of the OPF relate to: a. the establishment of the Health Quality and Safety Commission (**9.4.3**) b. the requirement arising from the Safe Medication Management National Quality Improvement Programme for DHBs to implement the new national inpatient medication chart and a system of medication reconciliation.

Section	Amendment
10	**Workforce** This is a new section that has not appeared in any previous versions of the OPF. The section contains subsections on Employment Relations and Workforce taken from the *Organisation* section of the old version of the OPF. The subsections in regards to Employment relations are the same as in previous versions of the OPF. There have been some changes to the workforce subsections. The major changes HWNZ has made to the OPF as follows: a. provided DHBs with the reasons for the formation and functions of health Workforce New Zealand (HWNZ). HWNZ have also supplied the context for where HWNZ fits related to the National Health Board Business Unit and its work. (**10.1.4**) b. provided reasons why DHBs need to be actively involved with workforce planning and development at both district and regional levels to ensure quality health service delivery to New Zealanders; (**10.1.4**) c. outlined the HWNZ requirement that DHBs are actively engaged with three areas related to workforce. these areas are: • clinical leadership (as for the last few years), (**10.4.3**) • data collection relating to workforce and provision of this data to HWNZ as required) and (**10.4.3**) • active involvement with career planning (with evidence for this where staff are in receipt of HWNZ funding). (**10.4.3**)

Section	Amendment
11	**Information and Communications Technology** This is a new section that has not previously appeared in versions of the OPF. While there are a number of changes in the approach to Information and Communications Technology for the 2011/12 OPF - three are particularly significant: a. The incorporation of the requirement to follow the National Health IT Plan. In particular, DHBs are to collaborate within their respective region to develop and report on progress with Regional IT plans that focus on the regional aspect of systems development in favour of local activity. (**11.2**) b. DHBs are to update and maintain information on their applications and projects using the Ministry's online Health IT Applications Register (HICTAR). This activity is required not less than quarterly; covers projects where total capital expenditure is $50,000 or more; and incorporates information on project progress and completion reports. (**11.2**) c. The requirement for submission of ISSPs has been dropped.
12	**Financial and Capital Operations** The main changes in the financial section of the OPF relate to: a. clarification of process for the release of funds for deficit support, b. definition of the management/ administration cap in the area of FTE definitions. This is due to a change in the methodology for the recording of this category of staff which has been collected since April 2010 c. under the business cases a linking of the revised capital investment process with the SSC process d. requirement for Ministerial approval of all projects over $1M for DHBs with a letter of comfort e. requirement for all reimbursements of capital funds to be claimed within a 12 month completion date.
13	**Monitoring and Reporting** There have been no substantial changes to this section.

Appendix 3: Māori Health Plan DHB Template

Background

On 30 June 2010 the Cabinet Social Policy Committee decided that DHBs will be required to complete a Regional Service Plan (RSP) and a DHB Annual Plan (AP) - SOC Min (10) 15/2.

The RSP replaces the District Strategic Plan and the AP replaces the District Annual Plan. Both will take effect for the 2011/12 year.

Māori Health Plans (MHP) are documents produced by DHBs to describe how they are going to improve the health of Māori and to reduce inequalities in their district. The MHP will be informed by the DHB's Māori population and their health needs and the DHB's strategic objectives from its RSP and AP.

The existence of MHPs is empowered by Section 6.4 of the 2011/12 Operational Policy Framework, which states that APs are to be informed by MHPs. Clause 21.5 of SOC Min (10) 15/2 also states that APs are to include MHPs.

Content of MHPs

The MHPs should be no more than 15 pages and have the following sections:

1. **Summary of the DHB's Māori population and their health needs**
2. **National Māori Health priorities**
3. **Regional Māori Health priorities**
4. **Local Māori Health priorities**

Summary of the DHB's Māori population and their health needs in the district

Instruction: This section should describe the DHB's Māori population and their health needs.

National Priorities

Instructions: The purpose behind having priorities, for national, regional and local is so DHBs can show the Māori health issues that are of concern. What they are doing about those issues and how they will measure progress. Ministers are particularly interested in measuring performance over time and measuring the impact of a DHB in terms of Māori health improvement.

At this point National priority measures include Health Targets and DHB Performance Measures shown in DHB Annual Plans (APs) that have either Māori measures or are of significance to Māori health. These targets and indicators will be agreed on as part of the AP process. As targets and measures for national priorities are the same as for the AP, the reporting mechanism for these priorities is via the quarterly reporting process. Data for national priorities that aren't Health Targets or Performance Measures will be provided by the Ministry and reported by DHBs via the quarterly reporting database as well.

Each priority should have an action (or list of actions) that clearly show what the DHB is doing/planning to do to address that health issue. The action(s) should have a clear rationale as to how they will help the DHB achieve the indicator targets set.

National Level Indicators (All indicators are reported by exception unless otherwise stated).

Health Issue	**Indicator(s)Target**
Data Quality	Accuracy of ethnicity reporting in PHO registers (y)
Access to care	(1) Percentage of Māori enrolled in PHOs (y) (2) Ambulatory Sensitive Hospitalisations rates per 100,000 for the 0-4, 45-64, and 0-74 age groups (y)
Maternal health	Exclusive breastfeeding at 6 months (y)
Cardiovascular disease	(1) Percentage of the eligible population who have had their CVD risk assessed within the past three years (q) (ht) (2) Number of tertiary cardiac interventions (y) (no target, information only)
Diabetes	3.16.2 (1) Percentage of people who attend their diabetes annual review (DAR) (q) (ht) 3.16.3 (2) Percentage of people with diabetes who complete a DAR and have a HbA1c level less than 8% (q) (ht) 3.16.4
Cancer	(1) Breast Screening (6) (2) Cervical Screening (6)

Smoking	(1) Hospitalised smokers provided with advice and help to quit (ht) (y) (2) Current smokers enrolled in a PHO and provided with advice and help to quit (ht) (y)
Immunisation	(1) Percentage of two year olds fully immunised (y) (ht) (2) Seasonal influenza immunisation rates in the eligible population (65 years and over) (6)
Workforce	Percentage of Māori staff in DHBs by occupation class.(y) (no target, information only) Management Clinical Administrative

List of DHB activities/action(s) that address each of the above health issues.

Each action should have a brief rationale stating how that action will address the specific issue and help the DHB reach the indicator target.

Source: Indicators for Measuring Progress towards Whānau Ora, a Ministry of Health Review Group.

Notes: All measures will be reported by: Māori, non-Māori, Total Population, DHB and Nationally.
(q) Reported quarterly, (6) reported six monthly, (y) reported yearly, (ht) Health Target.

Regional Priorities

Instruction: DHBs will be able to put in indicators of importance at a regional level from their Regional Services Plan. They should be consistent with the purposes and goals expressed in the first part of the MHP and also not already covered in the National priorities. The format for regional priorities should be the same as for national priorities.
Each priority should have an action (or list of actions) that clearly show what the DHB is doing/planning to do to address that health issue. The action(s) should have a clear rationale as to how they will help the DHB achieve the indicator targets set.

Regional Health Issue	Indicator(s) Target

DHB action(s) that address the above health issue. Each action should have a brief rationale stating how that action will address the issue and help the DHB reach the indicator target.

Local Priorities

Instruction: DHBs will also have the flexibility to develop their own local indicator set which reflects the specific needs of the Māori population in their district. They should be consistent with the purposes and goals expressed in the first part of the MHP and also not already covered in the National priorities. The format for Local priorities should be the same as for National priorities.

The Ministry has also provided priorities that are significant to some but not all DHBs. Affected DHBs should include these as part of their local priorities.
Each priority should have an action (or list of actions) that clearly show what the DHB is doing/planning to do to address that health issue. The action(s) should have a clear rationale as to how they will help the DHB achieve the indicator targets set.

Local Health Issue 1	**Indicator(s) Target**

DHB action(s) that address the above health issue. Each action should have a brief rationale stating how that action will address the issue and help the DHB reach the indicator target.

Priorities for Affected DHBs

Local Health Issue	**Indicator(s) Target**
Rheumatic Fever	
Sudden Infant Death Syndrome	

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