Statement of Intent

2010/11 – 2012/13

Taranaki District Health Board

DHB Contact Details

Statement of Intent 2010/13

Name of DHB:	Taranaki District Health Board
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Taranaki DHB Vision

Vision: *Taranaki Together, a Healthy Community*
Taranaki Whanui He Rohe Oranga

In 10 years:

- People will be smoking less
- People will be eating more healthily
- People will be more physically active
- The impact of disease will be less
- We will have a skilled workforce and the right infrastructure with people working together

Taranaki DHB Values

We work together by:

- Treating people with trust, respect and compassion
- Communicating openly, honestly and acting with integrity
- Enabling professional and organisational standards to be met
- Supporting achievement and acknowledging successes
- Creating healthy and safe environments
- Welcoming new ideas

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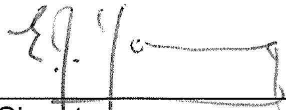
EXECUTIVE SUMMARY

This Statement of Intent has been prepared by Taranaki District Health Board (DHB) to meet the requirements of Section 39 of the New Zealand Public Health and Disability Act 2000 and Section 139(i) of the Crown Entities Act 2004. This document is intended to outline for Parliament and the general public the performance that will be delivered during 2010/11 by Taranaki DHB and contains financial and non-financial forecast information for 2011/12 and 2012/13. The agreed performance measures are in the context of the Government's strategic and service priorities for the public health and disability sector.

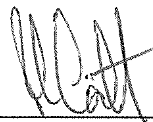
As an organisation we strive, within the resources available to us, to actively support our population towards achieving healthier and more independent lives.

Fiscal restraint is important for all public sector organisations in the current economic climate. This is even more of an imperative for Taranaki DHB as the rate of our future funding growth is projected to decline. The outcomes we aim to deliver are therefore aimed at improved efficiency and effectiveness, both as an organisation and in terms of our resource allocation. These key outcomes include reducing demand for hospital services, improving productivity and quality of hospital services, and allocation of resources on the basis of health needs of the population. Finally, we recognise that smoking is the greatest cause of ill health and early death amongst our people. Thus, we aim to reduce the number of Taranaki people who smoke.

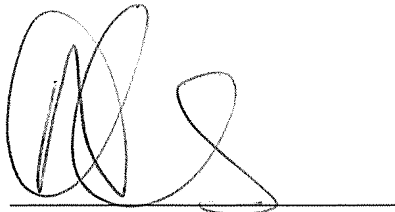
The Statement of Intent is of central importance to Taranaki DHB because the Board's collective duties are in part defined by reference to the content of this document.



Signature
E. John Young ONZM
Chairman



Signature
Peter Catt
Deputy Chairman



Signature
Tony Foulkes
Chief Executive

1. OPERATING ENVIRONMENT

1.1 Strategic Context

Taranaki DHB is one of 21 DHBs established on 1 January 2001 in accordance with Section 1a of the New Zealand Public Health and Disability Act 2000 (NZPHD Act 2000).

Taranaki DHB is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004). The CE Act 2004, section 49, states that the Board of Taranaki DHB must ensure that the DHB acts in a manner consistent with its objectives, functions and this Statement of Intent (SOI).

This SOI covers the period 2010/11 to 2012/13. It describes to Parliament and the communities of the Taranaki District what the DHB intends to achieve over the next three years in terms of promoting, enhancing and facilitating the health and wellbeing of the people in our district. This SOI incorporates the governance (Board), funder and provider (e.g. hospitals, clinics) activities of the DHB.

This SOI is aligned to and consistent with:

- NZPHD Act 2000
- CE Act 2004
- Public Finance Act 1989 (and subsequent amendment Acts)
- Taranaki DHB's Annual Plan 2010/11
- Taranaki DHB's Strategic Plan 2005-2015
- Taranaki DHB's Crown Funding Agreements (CFA)
- The New Zealand Health Strategy 2000
- The New Zealand Disability Strategy 2001
- He Korowai Oranga (Māori Health Strategy) 2002
- Te Tahuhu: Improving Mental Health 2005-2015 (2005)
- The Health of Older People Strategy 2002
- The Primary Health Care Strategy 2001

This SOI includes:

- Statement of forecasted service performance the DHB will seek to achieve during 2010/11 with non-financial performance measures and targets for each of the four output classes it delivers (i.e. public health services, primary and community services, hospital services and support services)
- Financial forecast for 2010/11, 2011/12 and 2012/15

At the end of the year, auditors working on behalf of the Office of the Auditor-General will compare the performance planned in this SOI with the actual performance achieved and described in the DHB's Annual Report.

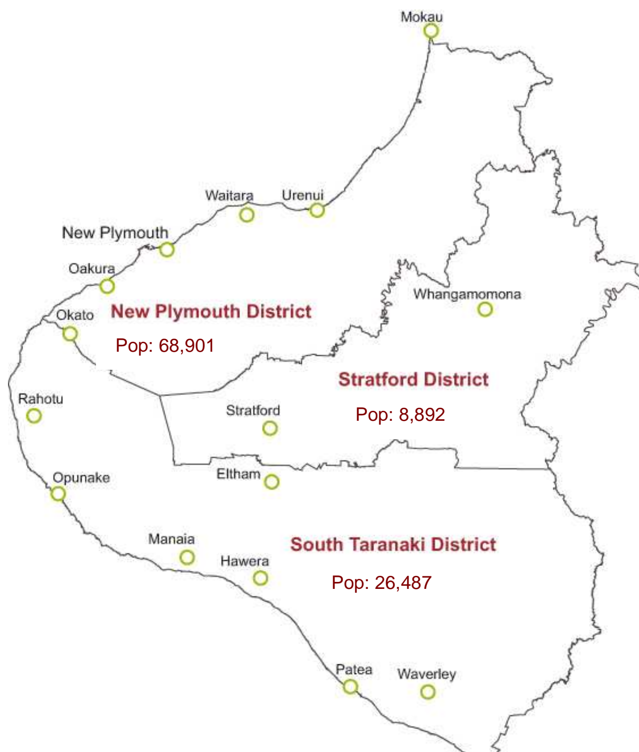
1.2 Population environment and health profile

1.2.1 Population

This section describes our DHB's external environment, including our geographical location and our population profile.

Total Population

As per the Census 2006[1] there were approximately 104,000 people living in Taranaki. The last population prediction released by Statistics New Zealand shows that in 09/10 approximately 108,000 people live in the Taranaki DHB region. The district covers a geographical area of over 7,000 square kilometres, with a few densely populated areas such as New Plymouth, Stratford and Hawera. The rest of the population is scattered in and around small rural centres. Therefore ensuring equitable access to health and disability services by our population is both a priority and a challenge for the DHB.



Boundaries

Taranaki DHB boundaries are co-terminus with those of Taranaki Regional Council and covers the three Territorial Local Authorities of New Plymouth District Council, Stratford District Council and South Taranaki District Council. This relationship enables focused and productive joint work with the Regional Council and TLA's on the wider determinants of health, particularly environmental, social and economic issues.

Ethnic Profile

In comparison to the New Zealand average, the Taranaki population has much smaller populations of Pacific and Asian people and a higher proportion of European people. The proportion of Māori people living in Taranaki is similar to the New Zealand average. There are a smaller proportion of Taranaki people who live in the most affluent and in the most socio-economically deprived areas. Within Taranaki, a higher proportion of Māori people live in the most socio-economically deprived areas in comparison to non-Māori. The DHB's approach to reducing inequalities for those people with the poorest health and highest need therefore focuses on Māori people.

Age Profile

The age profile of the Taranaki population differs from the New Zealand average in two key areas. Firstly the proportion of the population over the ages of 65 and 85 years is significantly higher. Provision of services to older people is therefore considered to be a strategic priority by the DHB. Secondly whilst the proportion of children between the ages of 5 and 14 years is higher than the national average, the proportion of young people between the ages of 15 and 24 years is significantly lower than the national average. This relative decline reflects the outward migration of young people for tertiary education and

[1] 2006 Census of Population and Dwellings, Statistics NZ

employment. Due to the direct relationship between education, employment and disposable income; which in turn has a direct relationship to health needs, young people in Taranaki could reasonably be expected to have relatively higher health needs.

Population Growth

Despite the increase in the number of births in Taranaki over the last 3 years the rate of growth of the Taranaki population is lower than the New Zealand average. This results in an ongoing projected decline in Taranaki DHB share of population based funding. The continued decline in population-based funding share, along with a higher proportion of older people and also an increasing proportion of Māori presents significant challenges for the DHB to meet the health and disability needs of the population now and into the future. The DHB is therefore planning and implementing a programme of activities to refocus and re-prioritise resource allocation across the sector, to meet the projected health and disability support service needs of our population within our projected future funding availability.

Detailed analysis of our population can be found in Taranaki DHB Health Profile 2007: http://www.tdhb.org.nz/misc/document_library.shtml

1.2.2 Health Profile

What the HNA is

Taranaki DHB's health profile is generated through a comprehensive Health Needs Assessment (HNA)[2] that describes our population, its health status and identifies key strategic priorities. It was prepared in consultation with stakeholders and published in 2005. In 2007 the HNA was reviewed and a shorter updated Health profile was published. We continue to expand the scope and quality of information as a normal part of our work.

How we use the HNA

The HNA's identification of health needs enabled us to develop a District Strategic Plan (DSP)[3] based on key priorities and containing long-term strategic outcomes to meet our population's needs. This adds a local flavour to the nationally driven requirements of the Public Health and Disability Act 2000, Ministry of Health priorities and Ministerial priorities that guide DHBs.

Key Priorities of Taranaki DHB:

Chronic Disease

Cardiovascular disease, diabetes and respiratory diseases comprise three of the five main causes of ill health and death amongst our population. The impact of these chronic diseases is significantly higher for Māori than for non-Māori. In Taranaki rates of diabetes and rates of renal failure with concurrent diabetes, in both Māori and non-Māori women are higher than the overall New Zealand picture. Māori of both sexes had significantly higher rates of hospitalisation for all cardiovascular disease than their non-Māori counterparts in Taranaki.

Cancer

Cancer is the fourth main cause of ill health and death amongst our population. Non-Māori women are more likely to have melanoma than women elsewhere in New Zealand.

[2] Taranaki DHB HNA is available on our website at http://www.tdhb.org.nz/misc/document_library.shtml#h
[3] The Taranaki District Strategic Plan can be accessed on our website www.tdhb.org.nz

Mental Health and Addictions

Mental illness and addictions are other important causes of ill health and death amongst the Taranaki population.

Oral Health

Tooth decay is the most common chronic disease affecting our population. The average number of damaged (decayed, missing or filled) teeth for 5 year olds living in areas with a fluoridated water supply is 1.7 for non-Māori and 3.4 for Māori. The number of damaged teeth for those living in non-fluoridated areas of Taranaki is higher, 2.5 for non-Māori children and 3.9 for Māori children.

1.3 DHB operating environment

Key internal operating environmental factors that impact upon Taranaki DHB's performance include:

- Reduced future funding path
- Shortages of specialists, e.g. Psychiatrists, Obstetricians, Renal Physicians
- Layout and fabric of Taranaki Base Hospital

1.4 Summary of Operating Environment

Table 1: Summary table of overall operating environment

Aspect of Operating Environment (Internal and External Factors)	Potential Impact on DHB
Economy and State Budget	
• Global economic crisis and impact on Government revenue	• Future increases in PBFF funding will be smaller than in previous years • Fiscal constraint by the Government on health infrastructure spending is likely to delay phases 2 and 3 of the DHB's Base Hospital refurbishment plan
Social environment	
• Reduced public spending due to the global economic crisis	• May reduce donations to the DHB from the public and from charitable organisations
Health Status	
• Cardiovascular disease, diabetes, respiratory disease and mental illness and additions are the main causes of chronic ill health and death amongst our population • Cancer is the other main cause of ill health and death	• A significant proportion of the DHB's overall expenditure is targeted at chronic disease • Service priorities include reducing risk of developing disease, reducing symptoms of disease, slowing the deterioration of disease and, finally, improving the quality of life for those with chronic disease

Aspect of Operating Environment (Internal and External Factors)	Potential Impact on DHB
Demographics	
• Total population numbers are slowly declining, in contrast to the country overall	• Our share of population based funding will continue to decline
• The proportion of older people is increasing	• Demand for health services will increase
Issues with Providers of Health Services	
• Shortages of General Practitioners	• Reduced access to primary health care and increased demand seen through Emergency Departments
• Shortages of Specialist medical staff	• Use of locum and increased cost of outsourced services
• A number of small primary care NGO providers	• Ongoing viability of some providers is uncertain • High proportion of resources allocated to overheads
• One GP is not aligned with a PHO	• Patients enrolled with that practice not able to benefit from e.g. Care Plus programmes
Effect of the Physical Environment	
• Parts of Taranaki Base Hospital are outdated and do not comply with seismic requirements, nor does it enable modern models of care to be delivered	• Low rates of day case surgery • New building being built and expected to open in 2012
Issues emerging from current arrangements	
• All four Primary Health Organisations operating in Taranaki are partners in one of two expressions of interest for Better, sooner, more convenience primary care	• Consolidation of providers is likely • Contractual arrangements likely to change as several DHBs will be contracting with these consolidated providers • A number of secondary services will be delivered differently in future as part of emerging new Integrated Family Health Centres and Whanau Ora Centres

2. WHAT WE DO

2.1 Performance objectives

Every DHB has the following objectives as outlined in the NZPHD Act 2000:

- to improve, promote and protect the health of people and communities;
- to promote the integration of health services, especially primary and secondary health services;
- to promote effective care or support for those in need of personal health services or disability support services;
- to promote the inclusion and participation in society and independence of people with disabilities;
- to reduce health disparities by improving health outcomes for Māori and other population groups;
- to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
- to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services;
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;
- to uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;
- to exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.

In addition, Taranaki DHB's specific performance objectives for 2010/11 are:

Table 2: Performance Targets

Code	Performance Target
HT1	95% of patients will be admitted, discharged or transferred from an Emergency Department within 6 hours
HT2	5,190 cwd and 4,105 elective surgical discharges will be delivered
HT3	100% of cancer patients in categories A, B and C will wait less than four weeks between first specialist assessment and the start of radiation oncology treatment
HT4	90% of Māori 2 year olds and 92% of 2 year olds overall will be fully immunised by 2011
HT5	80% of patients attending primary care and 90% of hospitalised smokers will be provided with advice and help to quit by July 2011

Code	Performance Target
HT6	74% of Māori people with diabetes and 83% of all people with diabetes will have satisfactory or better diabetes management 69% of Māori people with diabetes and 83% of all people with diabetes will have attended free annual checks 53% of eligible Māori people and 67% of all eligible people will have had their CVD risk assessed in the last 5 years

2.2 The Scope of our Work

Taranaki DHB regularly evaluates the health of the local population. This includes undertaking a Health Needs Assessment (HNA)[4] every three years. The information is used to plan and fund the most appropriate allocation of funding to meet the health needs of our population. The DHB receives funding from the Government based on the number of people living in our district. Other factors are also taken into account including ethnicity, socio-economic status, rurality and historic utilisation of services.

The DHB's planning and funding role is responsible for planning, promoting and undertaking service contracting with organisations, including our own hospital services at Taranaki Base Hospital in New Plymouth and Hawera Hospital in South Taranaki. The DHB also contracts services from other providers, including other DHBs who provide more specialist services. An example is the provision of cancer services at MidCentral DHB. This type of service is only offered by some hospitals.

Some services are funded and contracted directly by the Ministry, for example breast and cervical screening; as well as the disability support services for people aged less than 65 years.

Taranaki DHB is responsible for monitoring and evaluating the service delivery of all our providers, including auditing services.

The amount of funding provided to DHBs is insufficient to meet the total spectrum of health needs. All DHBs are therefore required to prioritise the allocation of funding. When considering prioritisation decisions, Taranaki DHB applies the following criteria:

- ***Effectiveness*** – the extent to which services produce improvements in health status or reduce or prevent a decline in health status. High priority is given to services which produce the greatest improvements to health status at a population level.
- ***Affordability*** – the cost of services and the impact on overall health expenditure relating to achievement of that health gain. Higher priority is given to funding services that achieve the greatest value for money.
- ***Equity of both access and outcome*** – can the service be accessed by the target population and does it improve the status of those with the worst health?
- ***Māori Health*** – the degree to which Māori people will take up and benefit from the service; and whether the service is appropriate and acceptable to Māori . Higher priority is given to services which reduce health disparities between Māori and non-Māori .
- ***Strategic Fit*** – higher priority is given to services which accord with Taranaki DHB's Strategic Plan 2005-2015 or which address gaps in the Service Coverage Schedule.

[4] Taranaki DHB HNA is available on our website at http://www.tdhb.org.nz/misc/document_library.shtml#h

- ***Timing of Benefits*** – higher priority is given to services which deliver benefits soonest.

Local allocation of funding to services is more reflective of historical service delivery than health needs. A Planning and Funding Clinical Leadership Group, encompassing clinicians from primary and secondary care, has been established to advise on the reallocation of funding to better reflect the health needs of our population.

2.3 DHB ownership interests

Table 3: Ownership interests

Description	Physical Assets	FTEs
Taranaki DHB is a Crown Entity with ownership of:	Buildings and Equipment:	People:
• Taranaki Base Hospital delivering a full range of secondary services. These are New Zealand Role Delineation Model Level 4 for Emergency Medicine, General Medicine, Maternity and Neonates, Paediatrics, Health of Older Persons and Specialist Rehabilitation; and Level 3 for Oncology and Haematology, and Surgical Services	• $68,127,592	• 780 FTE
• Hawera Hospital delivering New Zealand Role Delineation Model Level 2 services in Emergency Medicine, Medicine, Surgery, Maternity and Older Adult Services; and Level 1 Paediatrics	• $11,625,908	• 98 FTE
• Mental Health and Addiction Services with acute inpatient facilities and community facilities in New Plymouth	• $3,070,875	• 164 FTE
• Public Health Unit providing a range of health promotion, health protection and Medical Officer of Health services in New Plymouth	• $1,112,785	• 30 FTE
• HIQ – a wholly-owned subsidiary delivering operational and strategic information systems support to the DHB	• $5,067,122	• 39 FTE
• Allied Laundry Services Ltd – ownership shared with Hawke's Bay, MidCentral, and Whanganui DHBs for the provision of laundry and linen services	• $4,595,239	• 66.5 FTE
• Fulford Radiology Services Ltd – joint ownership with Taranaki Radiologists Ltd, providing a comprehensive range of imaging services to the district	• $1,711,350	• 50.75 FTE
• HealthShare – ownership shared with Bay of Plenty, Lakes, Tairawhiti, and Waikato DHBs for the provision of routine and issues-based quality audit of service providers	• $19,670	• 20 FTE
• Health Centres at Patea, Mokau, Opunake, Stratford and Waitara, delivering community and outpatient services	• $313,612	• 5 FTE
• Other FTE not aligned with any of the above services	–	• 140 FTE
• Governance	–	• 19 FTE

3. OUTCOMES AND PRIORITIES

3.1 Key outcomes and priorities for our DHB

Taranaki DHB plans to achieve three key outcomes:

- improved health of the Taranaki population
- a reduction in health inequalities for Māori people and lower socio economic groups
- future service delivery that is affordable within our expected future funding path

The first of these key objectives accords with DSP priority of "having people as healthy as they can be through promotion, prevention, early intervention and rehabilitation".

The second of these key objectives reflects the DSP priority of improving "the health of Māori and groups with poor health status".

The final key objective aligns with the DSP priority of "lead and support the health and disability sector and provide stability through change".

Taranaki DHB's District Strategic Plan 2005 – 2015 was reviewed by the Board in February 2009 and agreed as fit for purpose for the period 2009 – 2011. A recent requirement for DSPs to have a strong regional focus has led to the development of a Regional Clinical Services Plan (RCSP) by Midland region to inform the development of the next DSP.

2010/11

The Midland region is currently implementing two vulnerable services plans in the areas of obstetrics/gynaecology and rural primary care. These services were identified as initial focus areas based on work that was completed in early 2009.

An obstetrics/gynaecology clinical network has been established to support capacity to work regionally to support obstetrics/gynaecology services. Implementing the action plan will be a key focus for the obstetrics/gynaecology network commencing with the establishment of the clinical leadership network.

Rural primary care issues are less amenable to regional solutions. Rural primary care vulnerable services action plans have consequently been progressed at individual DHB level by Taranaki, Lakes, Tairawhiti and Waikato DHBs, focusing on supporting rural primary care to maintain service coverage.

A draft CSP identifying 3 – 4 vulnerable services will be prepared by 1 July 2010 with implementation progressing over the course of 2010/11.

All four local Primary Health Organisations (PHOs) were partners in two separate successful Expressions of Interest (EOI) for Better, sooner, more convenient Primary Health Care. Peak Health Taranaki PHO and Hauora Taranaki PHO, along with the Tui Ora network, are members of the Midland PHO Network. Taranaki DHB is collaborating with the Network and other affected DHBs on the implementation of the EOI business case. Key changes for 2010/11 will be the development of three local Integrated Family Health Centres and Whanau Ora Centre and new models of care for older people; those with chronic conditions; and children and young people.

Te Tihi Hauora o Taranaki PHO and Te Oranganui Iwi Health Authority PHO are members of the National Māori PHO Coalition. Taranaki DHB is collaborating with the Coalition and other affected DHBs on the implementation of the EOI business case. Whilst the key changes for Taranaki in 2010/11 have yet to be finalised, the EOI business case focuses on Whanau Ora; Māma, Pēpi and Tamariki (mothers, babies and children); and Ki Tua Oranga (long term conditions).

Both the Network and the Coalition aspire to effect change in Hawera. The Network plans include the development of an Integrated Family Health Centre in Hawera, whilst the Coalition's plans include a Whanau Ora Centre in Hawera. The DHB will work collaboratively with both the Network and the Coalition to lead an integrated approach h to developing a combined Integrated Family Health Centre/Whanau Ora Centre in Hawera, encompassing all providers.

2011/12 and beyond

The Midland region will develop a 10 year plan for regionally led, collaborative community and hospital services in the region, taking a whole-of-system approach. It will take a long-term (20 year) view of health needs across the population and will be matched to future clinical service provision and infrastructure requirements.

The plan will examine services that are currently vulnerable (or may become so) because of workforce, demand growth or funding issues. It will include an assessment of the status quo financial situation of Midland DHBs, likely cost growth and changes required to "live within our means" regionally. It will include a 5 – 10 year financial forecast.

Table 4 – Outcomes and Priorities

Key Outcome Sought	Action we will take	What are we trying to achieve?	Why is this outcome important?	What will we do to achieve this outcome?	How will we demonstrate our success in achieving this outcome?
• Improve the health of the Taranaki people	• Action on wider determinant of health, e.g. smoking • Screening, e.g. cervical • Early intervention and treatment, e.g. diabetes and cardiovascular disease	• People as healthy as they can be, living longer and having an improved quality of life	• Objective of the DHB under the NZPHD Act 2000 • Reduces demand for health services • Fewer health needs will be unmet as resources will go further	• Deliver health promotion and education services • Deliver statutory and regulatory public health services • Population based screening programmes • Immunisation services • Primary and Community services • Hospital services • Support services	By improving performance against health targets, i.e.: • Improved access to elective surgery • Shorter waits for cancer treatment radiotherapy • Increased immunisation • Better help for smokers to quit • Better diabetes and cardiovascular services
• Reduction in health inequalities for Māori people and lower socio economic groups	• Ethnicity data collection • Whanau Ora approaches • Workforce development	• Māori people and those from lower socio economic groups with the same health status as the rest of the population	• Disparities in health status are ethically unacceptable • Crown obligation to Māori under the Treaty of Waitangi	• Require providers to collect ethnicity data • Public health services • Primary and Community services • Hospital services • Support services • Monitor access, utilisation and outcomes by ethnicity	Utilising DHB performance measures which are reported on by ethnicity, i.e.: • Increased immunisation • Better diabetes and cardiovascular services • Improving health status of people with severe mental illness • Oral health DMPT score at year 8

Key Outcome Sought	Action we will take	What are we trying to achieve?	Why is this outcome important?	What will we do to achieve this outcome?	How will we demonstrate our success in achieving this outcome?
					• Children caries free at 5 years of age • Ambulatory sensitive hospital admissions • Improving breast feeding rates
• Future service delivery is affordable within our expected future funding path	• Hospital productivity • Primary – secondary integration	• Ability to live within our means	• Taranaki DHB is on a reduced future funding path due to declining population • Proportion of older people is increasing and therefore demand for services will also increase	• Increase productivity of services • Redevelopment of hospital so that effective models of care can be used • Ensure effectiveness of interventions • System integration	• DHB financial performance

3.2 How we aim to meet the Government priorities

The Minister of Health's annual **'Letter of Expectations'** is sent to all DHBs and identifies the Minister's specific expectations and priorities for the coming year. These expectations, in addition to national health and disability strategies and our strategic priorities (set out in the District Strategic Plan), enables our DHB to plan and prioritise activity for 2010/11.

Our SOI aligns with Government priorities. These priorities are closely aligned with our vision and long term strategy to improve the health and wellbeing of our community.

The Minister of Health has agreed to a set of national Health Targets to focus the efforts of DHBs and make more rapid progress against key national priorities. These Health Targets are included within the selection of performance measures and are also clearly identified in our DAP 2009/10.

Based on these Government priorities and local health needs, our DHB seeks to achieve the following outcomes:

- Shorter stays in Emergency Departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- Better diabetes and cardiovascular services

Our DHB undertakes a number of activities and performs a wide range of interventions that lead to services provided to our people. The vast majority of these are delivered consistently every year and can be considered to be 'Business as Usual'. This SOI will outline a framework to measure the benefits / impacts of these interventions as well as those newly funded which will assist in improving the quantity, quality and coverage of services funded and provided by our DHB over time.

These outcomes are consistent with the purposes of the Crown Entities Act 2004, and the New Zealand Public Health and Disability Act 2000.

3.3 Key Mechanisms for Intervention

Our DHB:

- **FUNDS** health and disability services through the contracts we have with providers
- **PROVIDES** hospital and specialist services that cover medical and surgical services, mental health, older persons' health
- **PROMOTES** community health and wellbeing through health promotion, health education and population health programmes.

To ensure our interventions are relevant to our communities, coordinated and ensure best value for money, before making funding, provider or promotion decision, we:

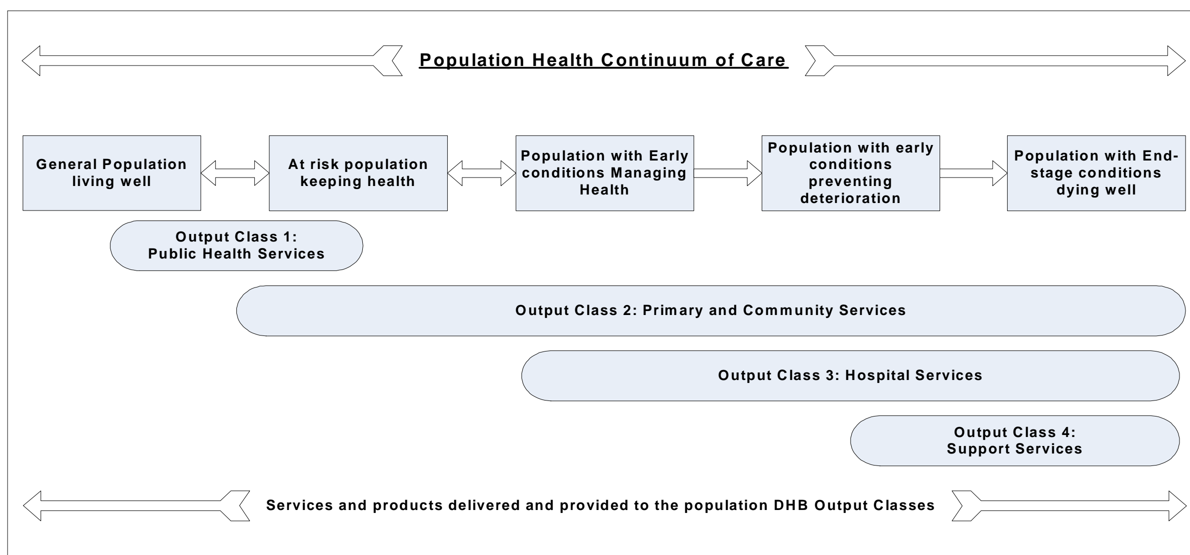
- **PLAN** in consultation with key stakeholders (Iwi, PHOs and NGOs) and our community, the strategic direction for health and disability services within our district[5]
- **PLAN** in collaboration with other DHBs, regional and national stakeholders.

[5] For more information on our strategic direction, you can view our District Strategic Plan (DSP) on our website www.tdhb.org.nz

The DHB uses four output classes to classify the wide range of services and products delivered in our population:

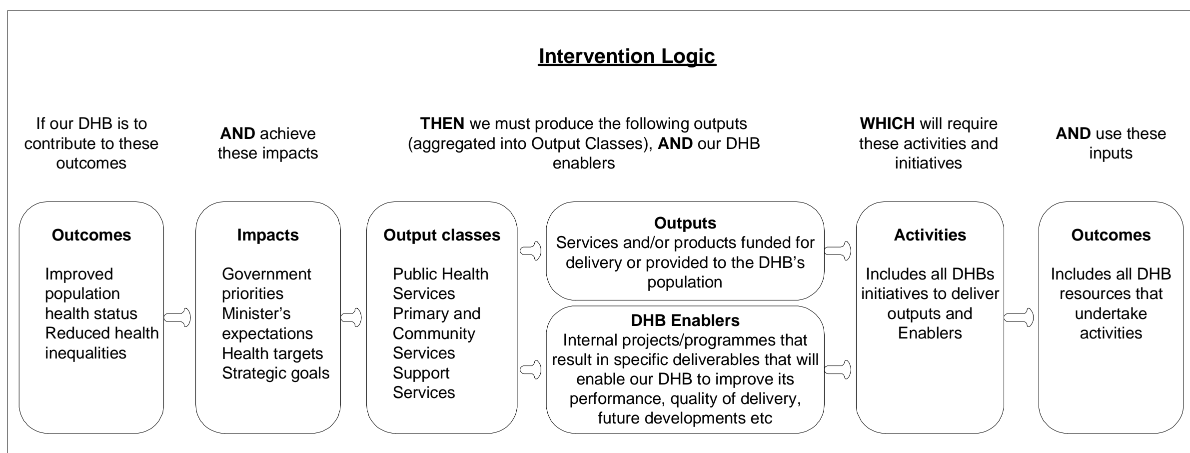
- Public Health services
- Primary and Community services
- Hospital services
- Support services

The following diagram illustrates the relationship between population health along a continuum of care and the services and products delivered and provided to the population according to output class:



3.4 How we will measure our progress – DHB main intervention logic model

The following intervention logic model shows the intended relationship between what we do and our desired outcomes:



4. OUTPUT CLASS AREAS and STATEMENT OF FORECAST SERVICE PERFORMANCE

4.1 Output Classes

Section 142 (2) CE Act 2004 requires DHBs to provide measures and forecast standards of output delivery performance against the DHBs actual delivery of classes of outputs that will be reported and audited against at the end of the financial year. DHBs must also report their outputs, that is ‘the services they provide or fund for delivery to the DHB population’, under aggregated ‘headings’ or Output Classes.

An output agreement[6] for 2010/11 has categorised the following Output Classes: **public health services, primary and community services, hospital services, support services** (see Appendix 2 for definitions). The performance measures associated with each output class relate to the outputs for 2010/13 that will contribute to the longer-term impacts described in the outcome areas found in section 3 above.

The four Output Classes are relevant for all DHBs to provide the story regarding the ‘impacts’ their PBF allocation decision, Government Priorities and national decisio9n-making has on the ‘Health of the DHB Population’ Over time, through ensuring Nationwide Service Framework Library (NSFL) and associated services’ Purchase Unit Codes (PUCs) align to one of the four output classes, it will be possible, through using this framework to demonstrate ‘shifts’ in resources from one end of the population health continuum of care to another over time.

For example, by having expert knowledge supporting the care of patients with early diabetes in the community, we can prevent people from requiring in-hospital services with increased services then being provided in Primary and Community versus Hospital.

For each output class there are agreed national performance measures and targets of the desired outcomes and objectives[7].

Within these output classes our DHB has prioritised a number of outputs. How these outputs contribute to our intermediate outcomes is detailed below on an output class by output class basis.

One of the functions of this SOI, and in particular the Statement of Forecast Service Performance is to show how the DHB will evaluate and assess what services and products we deliver to others in 2010/11.

The performance measures chosen are not a comprehensive list and do not cover all of the activity of the DHB, but they do reflect a picture of our activity against local and national strategies and priorities.

Where possible, we have included past performance (baseline data) along with each performance target to give context of what we are trying to achieve and to better evaluate our performance.

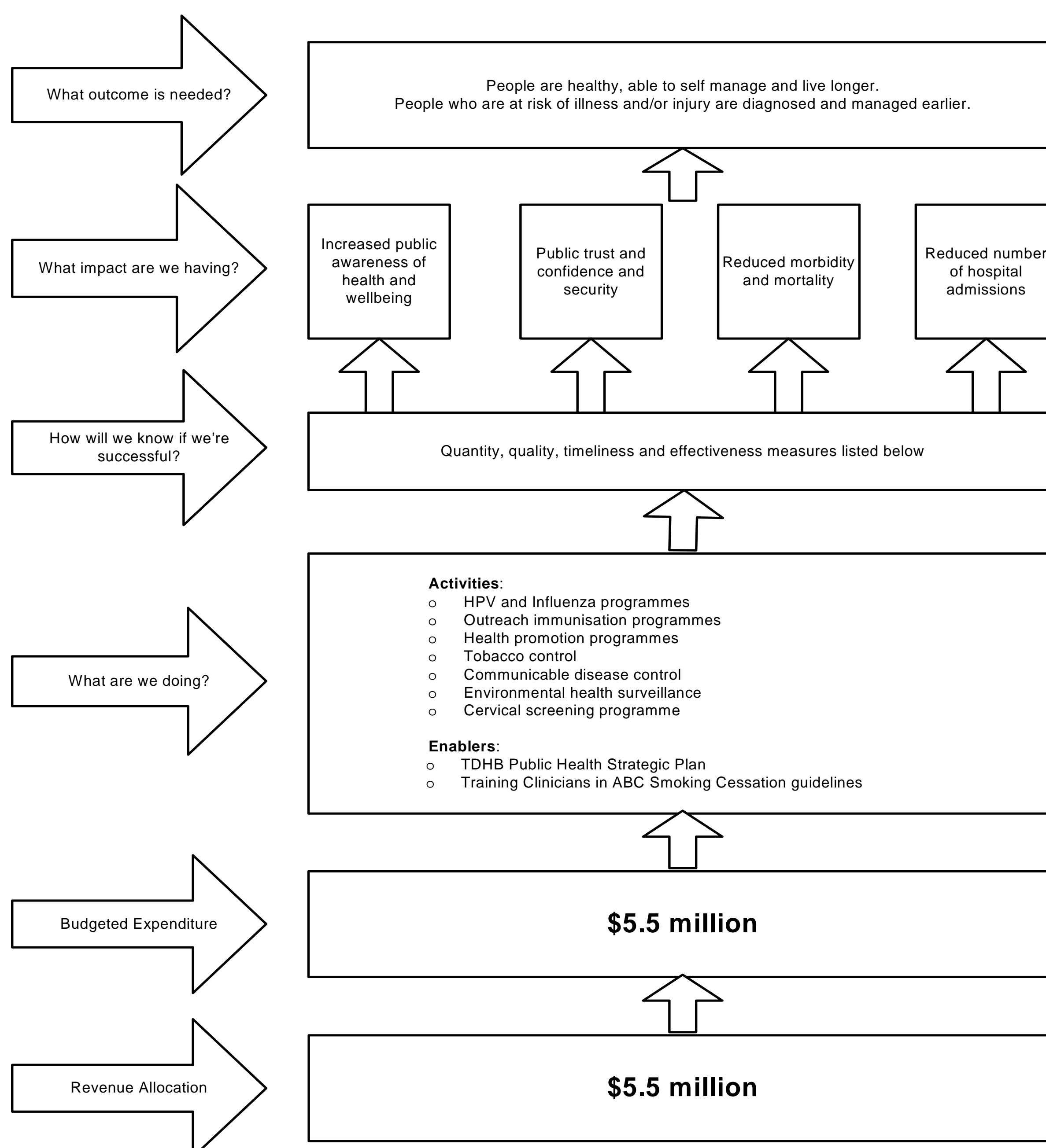
[6] In 2009-10 DHBs trialed the use of new ‘aggregate classes’ aligned to the Population Continuum of Care
[7] As stated in the CE Act 2004 (s 142 (1))

4.2 Public Health Services – Output Class #1

Public health services are the domain of many organisations across the region, including:

- Ministry of Health, principally as a funder of public health services, and also a regulator; the Ministry of Health is also a provider of services
- District Health Boards, in both funding and provision
- Primary health Organisations, mainly in the area of provision of primary health care services, but with some public health functions
- A significant array of private and non-government organisations, including Māori and Regional Sports Trusts
- Local and Regional government

Intervention Logic Model: Public Health Services



STATEMENT OF FORECAST SERVICE PERFORMANCE

Main areas of performance in Public Health Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
1. Health Promotion and Education services which include: • Social environments • Health Promoting schools • Nutrition and Physical activity • Sexual Health • Early Child Health (Well Child) • Injury Prevention • Youth Health • Integrated tobacco and alcohol plan	Numbers of health promotion and education programmes undertaken	8	8	
Smoking Cessation Programmes	% of Hospitalised smokers provided with advice and support to quit	16%	90%	
	Support to quit in Primary Care	0	80%	New target for 2010/11
2. Statutory and Regulatory Services (statutory and regulatory services may only be provided by some DHBs – e.g. those DHBs with a Regional Public Health Unit)	Number of communicable disease investigations	392	400	Excludes H1N1 flu cases
	Number of environmental health inspections	190	200	
	Number of education and compliance visits to alcohol/ tobacco premises	20	50	

Main areas of performance in Public Health Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
	Number of Controlled Purchase Operation tobacco premises	4	5	
	Number of Controlled Purchase Operation alcohol	5	7	
3. Population Based Screening Programmes including Breast Screening, Cervical Screening	% enrolled women aged 20-69 who have been provided with a cervical screen in the last 3 years % Māori enrolled women aged 20-69 who have been provided with a cervical screen in the last 3 years	86.1% 60.0%	87.0% 62.0%	Taranaki DHB performance significantly higher than national rates and exceeds programme goals. Forecast is based on maintenance of current performance
4. Immunisation Services	% enrolled population >65 years given flu vaccination	67.0%	69.0%	PMP data as at September 2009
	% high needs population >65 years given flu vaccination	65.0%	67.0%	PMP data as at September 2009
	% children fully immunised at 24 months	87.0%	92.0%	In line with Health Target

4.3 Primary and Community Services – Output Class #2

A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealanders' overall health, and to reducing health inequalities between different groups. New Zealand is experiencing an increasing prevalence rate of long-term conditions including diabetes, cardiovascular disease and depression. Some groups of New Zealanders suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. Long-term conditions require an increased focus across the primary/secondary interface to ensure that people at risk are recognised early and conditions managed effectively.

The three key goals from the national Primary Health Care Strategy are:

- **Transparent national priorities** – DHBs, Primary Health Organisations (PHO) and the Ministry focused on national health priorities and working collaboratively to improve sector performance.
- **Collective stewardship and governance** – Communities and PHOs engaged to identify population needs and target responses consistent with national priorities.
- **Enhanced delivery** – A continuum of accessible services focused on reducing the incidence and impact of chronic conditions.

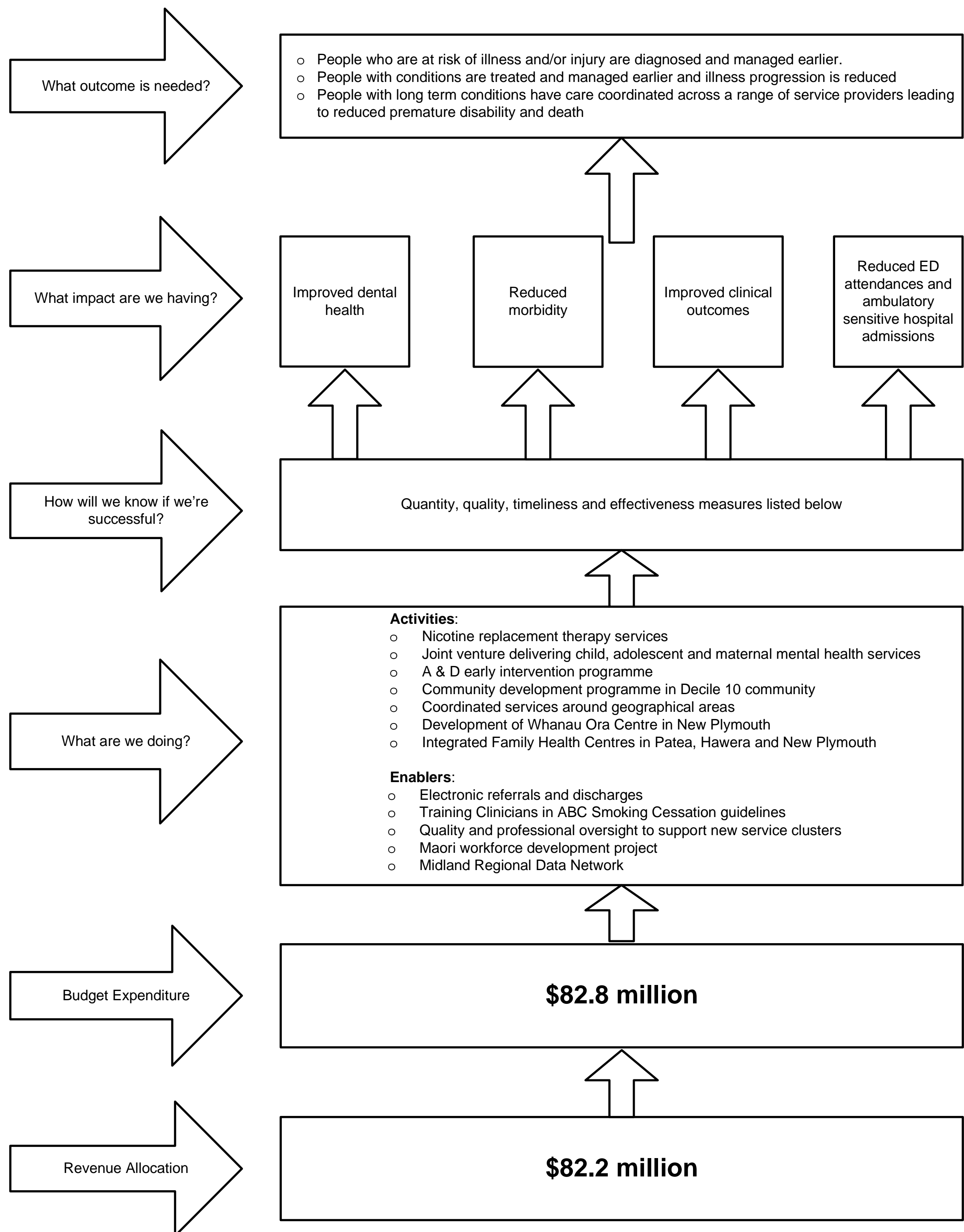
Taranaki DHB has three Primary Health Organisations(PHOs) operating across the District: Hauora Taranaki PHO, Peak Health Taranaki PHO and Te Tihi Hauora o Taranaki PHO. In addition, a Wanganui based PHO, Te Oranganui Iwi Health Authority PHO, operates a GP practice in Waverley. All four PHOs were party to expressions of interest (EOI) from groups of PHOs to deliver transformational change and rapid progression of the Primary Health Care Strategy.

Taranaki DHB is working closely with the Midland Health Network, which includes Hauora Taranaki and Peak Health Taranaki PHOs, to deliver better care to people with long term conditions and the development of Integrated Family Health Centres in New Plymouth, Hawera and Patea, as well as a Whanau Ora Centre in New Plymouth. Similarly, the DHB is working closely with the National Māori PHO Coalition, which includes Te Tihi Hauora o Taranaki and Te Oranganui Iwi Health Authority PHOs, to deliver better care for mothers, babies and children and people with long term conditions. The Taranaki DHB's District Annual Plan 2010/11 provides more details on these developments.

Impacts for Primary and Community Services

The impacts that the DHB wants to achieve in Primary and Community service delivery are outlined in the following intervention logic diagram.

Intervention Logic Model: Primary and Community Services



STATEMENT OF FORECAST SERVICE PERFORMANCE

Main areas of performance in Primary and Community Health Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
Primary Health Care Services (capitation/first contact)	The number of people enrolled with primary care	**Peak**: Māori 5,864 Pacific 339 Other 46,699 **Total 52,902** **HTPHO** Māori 5,673 Pacific 463 Other 39,055 **Total 45,191** **TTHPHO** Māori 3,449 Pacific 90 Other 2,076 **Total 5,615** **Non-PHO Enrolled** **Total 2,535**	**Peak**: Māori 5,864 Pacific 339 Other 46,699 **Total 52,902** **HTPHO** Māori 5,673 Pacific 463 Other 39,055 **Total 45,191** **TTHPHO** Māori 3,449 Pacific 90 Other 2,076 **Total 5,615** **Non-PHO Enrolled** **Total 2,535**	The population expectations have not been updated for the non-baseline periods and are included only to provide an indication of enrolled population size. Population growth is minimal within the district. The data provided are obtained from enrolment data provided by MoH as at December 2009. Data regarding the breakdown of Non PHO enrolled population is not collected.
	Ratio of GP consultations provided to high needs people compared with non-high needs people	Peak 1.15 HTPHO 1.08 TTHPHO 0.93 **Total 1.06**	≥ 1.00 ≥ 1.00 ≥ 1.00 ≥ 1.00	PMP report. Baseline data from DHBNZ September 2009 IDP report.

Main areas of performance in Primary and Community Health Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
Oral Health Services	Level of treatment visits pre-school children	5,211	5,543	From MoH report for Q2 2009/2010
	Number of 5-12 year old children enrolled with oral health services	11,640	12,000	From MoH report for Q2 2009/2010
	Level of treatment visits for 5-12 year olds	18,129	20,000	From MoH report for Q2 2009/2010
	Number of Year 8 children examined	1,363	1,370	MoH website 2008 data for Taranaki
	Number of adolescents who receive oral health services	5,304	6,000	From MoH quarterly report for Q4 2008/2009
	Numbers of enrolled and treated (essential) low income adults	434	500	Provider Patient Totals 2008/2009
	The proportion of 5-12 year old children that are enrolled with oral health services	99%	99%	Based on estimated population and number of individuals enrolled
Primary and Community Care Programmes	Number of people that are provided with Primary Mental Health Initiative services	200	200	
	Number of patients who are enrolled in Care Plus Peak HTPHO TTHPHO **Total**	30 1,808 96 **1,934**	≥ 1,544 ≥ 1,808 ≥ 163 ≥ 3,515	As per MoH report. Baseline as at January 2010 2010/11 target aligns with business case expectations

Main areas of performance in Primary and Community Health Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
	The proportion of the eligible population that is enrolled in Care Plus Peak HTPHO TTHPHO **Total**	 1.4% 76.5% 33.4% **31.4%**	 ≥ 50.0% ≥ 76.5% ≥ 50.0% **≥ 57.0%**	As per MoH report. Baseline as at January 2010 2010/11 target aligns with business case expectations
	Diabetes annual reviews provided	3,458	4,338	Baseline as per target for 09/10
	CVD Risk Assessment, delivered in primary care: Total population Māori population	 64.8% 49.2%	 67% 53%	Targets are stated as a percentage of eligible population
	Retinal Screens delivered	1,857	>1,857	Bi-annual check for community based patients with diabetes. Demand driven service
Pharmacist Services	Numbers of dispensed items provided	1,711,363	1,814,045	From Pharmac generated pharmaceutical expenditure reports. Baseline for 12 months to September 2009. Projections are based on 6% p.a. increase.

4.4 Hospital Services – Output Class #3

Hospital services include all personal health services, specialist mental health services, Māori health services and services for older people that are provided through our hospital provider and through other hospitals via Inter District Flows (IDFs).

The following diagram clarifies the difference between primary care services and different types of hospital services.

Acute Services Outcomes

Acute hospital services are for illnesses that have an abrupt onset. They may or may not lead to an acute hospital admission. The symptoms leading to the need for acute hospital services are usually of short duration, rapidly progressive, and the need for care is urgent. While a proportion of acute services will never be prevented (for example, people who suffer from an acute episode of appendicitis) there are a number of causes that could be prevented by:

- better self-management by the individual with the problem (for example, an acute asthma attack)
- better, more convenient, Primary Care (for example, annual diabetes checks prevent episodes of diabetic complications leading to a need for acute services)
- better coordination and integration of care (for example, older people who are on multiple drugs having their medicines managed in the community by Pharmacists, GPs, home care workers and the care coordinated by PHOs, NASC and Geriatricians)
- better palliative care coordination in the community (for example, a person with a long-term condition at the end of life [within six months of death] can receive supportive care through hospice to enable better pain management and symptom control and preventing an acute admission to hospital)

Elective Services Outcomes

The Midland DHBs are working collectively to ensure equitable access to elective services that improve patients' quality of life through either early intervention (for example, removal of an obstructed gallbladder so that the patient does not have repeat attacks of abdominal pain/colic, increased risk of cancer and/or infection; or through corrective action (for example major joint replacements to relieve pain and improve activity). The Midland DHB Planning and Funding teams are working together to develop a collective regional elective services plan that links to the Midland Region Clinical Services Plan (MRCSP) that supports greater sharing and maximisation of resources, flexibility in the delivery of elective surgical services across the region and improved overall productivity in line with Government expectations and commitments.

The benefits of this collective Midland elective services approach include:

- reduction in unmet surgical health needs across the Midland population
- greater collaboration and cooperation of clinical networks
- creating value by developing and implementing processes and incentives to ensure more efficient, effective and equitable use of resources
- clinician and management partnerships in driving change forward

Elective services (booked surgery) are for patients who do not require immediate hospital treatment. "Acute-arranged" means hospital services that can be booked are classified as electives. Our DHB is committed to meeting the Government's expectations around elective services, particularly the key principles underlying the electives system:

- **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 most in need.

In managing Elective Services our DHB will focus on the following areas:

- **Patient Flow Management** – our DHB 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 and meeting the 6 month timeframe for provision of assessment and treatment.
- **Level of Service** – our DHB will ensure that the hospital(s) provide the amount of elective operations, procedures and assessments agreed to in our District Annual Plan. We will review the key operations we perform to ensure we are delivering the right level of service for the people in our region. We will demonstrate innovative strategies, or alternative delivery options aimed at increasing elective capacity, including initiatives across the primary/secondary interface.
- **Order of Service** – our DHB is committed to making sure 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.

A Non admitted

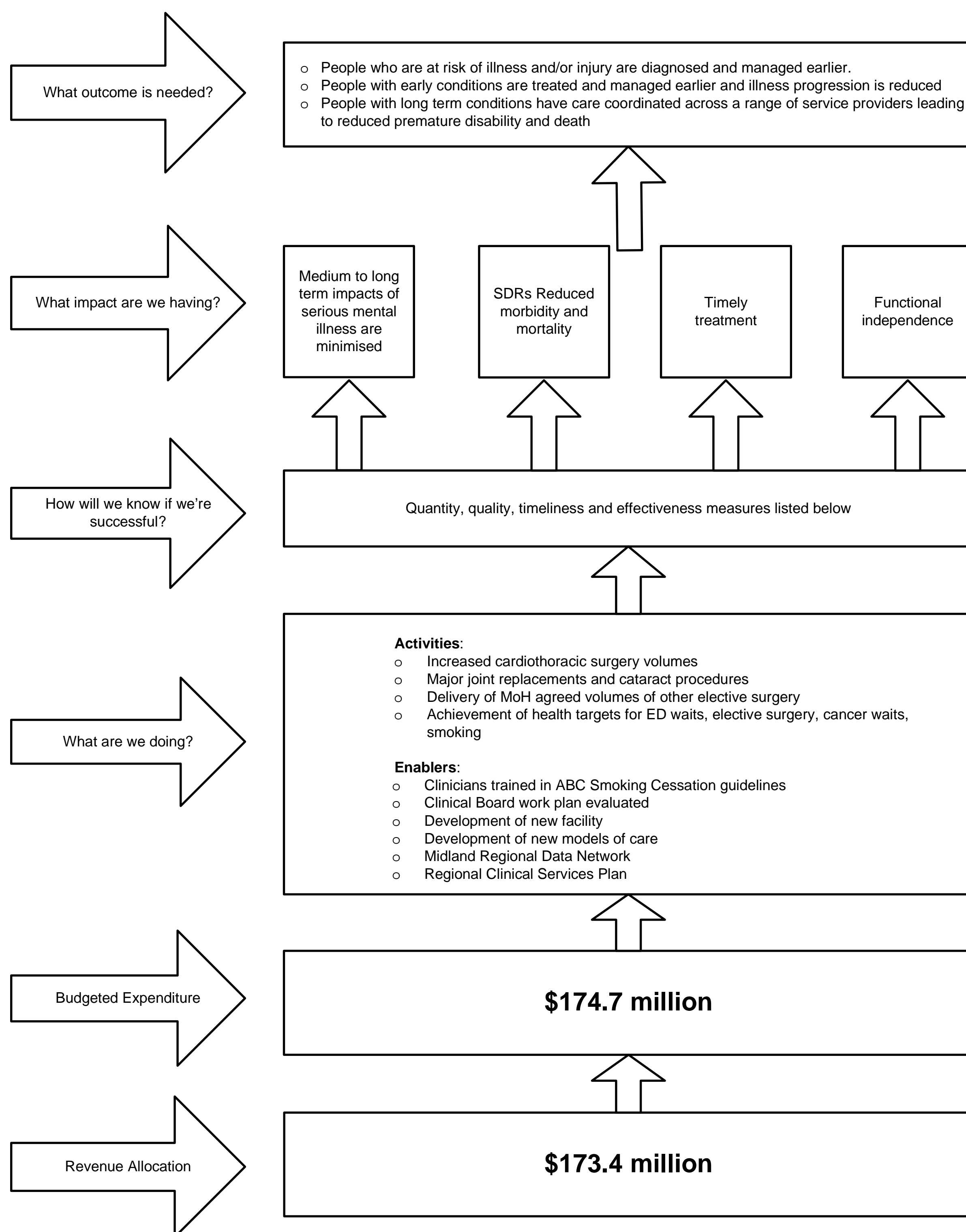
Non-admitted patients can be categorised as:

- Outpatient – First Assessment and Follow-up Assessment
- Pre-admission Assessments – completed at a clinic, usually prior to an elective procedure
- Day surgery events

B Emergency attendances

Taranaki DHB has a number of strategies to reduce waiting times for patients. These include:

- Optimising Patient Journey (Lean) initiative
- Acute pathway project looking at the pathway across primary and secondary care
- Hospital wide focus on ED target



STATEMENT OF FORECAST SERVICE PERFORMANCE

Main areas of performance in Hospital Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
Mental Health Acute and Inpatient Services	• % of population accessing services	Māori 0-19 yrs 2.27% Māori 20-64 yrs 5.34% Māori 65+ yrs 2.58% Other 0-19 yrs 3.13% Other 20-64 yrs 3.33% Other 65+ yrs 3.31% Total 0-19 yrs 2.90% Total 20-64 yrs 3.63% Total 65+ yrs 3.27%	3.1% 5.34% 3.60% 3.20% 3.50% 3.60% 3.12% 4.02% 3.60%	
	• % of Crisis prevention plans up to date	90%	95%	
	• Length of stay – Acute Inpatient Ward (TPW)	Best practice range 14-21 days (currently 17 days)	Remain within target range	
Electives Services (inpatient, outpatient)	• Total number of elective discharges	3,921	4,105	Includes additional volumes funded through MoH electives initiative
	• Total number of elective caseweights	4,329	5,190	Includes additional volumes funded through MoH electives initiative
	• Number of FSAs	10,193	10,381	Baseline target expected by MoH for Taranaki population

Main areas of performance in Hospital Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
	• ESPIs	Compliance	Compliance	MoH set a suite of targets regarding timeframes to access services
	• Admission on day of surgery as % of total Elective admissions	71%	>90%	
	• Day Surgery procedures performed as % of total Elective admissions	64%	64%	Currently meeting MoH target. Aim is to maintain level of achievement
	• Cancer treatment waiting times	100%	100%	The % of patients waiting less than six weeks between FSA and commencement of chemotherapy treatment
	• 30 Day Mortality	1.5%	1.5%	Mortality rate within 30 days of admission to hospital
Acute Services (emergency department, inpatient, outpatient)	• Shorter stays in emergency department	94%	95%	The percentage of patients either admitted, discharged or transferred within 6 hours
	• Acute readmission rate	10.4%	10.4%	
	• Percentage of total acute admissions that were treated as day-stay cases	40%	18%	This indicator shows the proportion of all acute discharges which are the same day. Decrease in the % could indicate fewer inappropriate admissions

Main areas of performance in Hospital Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
	• Reduced length of stay for acute admissions	4.03 days	4.01 days	To meet national benchmark target
Maternity Services	• Number of deliveries	1,419	1,419	Monitor activity, assists in forward projections of population demand
	• Neonatal length of stay	15.09 days	<=15.09 days	
	• Reduced caesarean section rate	25% of total births	<25%	Reduction in caesarian rate desired
Assessment Treatment and Rehabilitation Services	• Numbers of patients discharged home from Inpatient services	117	117	Monitor activity, assists in forward projections of population demand

4.5 Support Services – Output Class #4

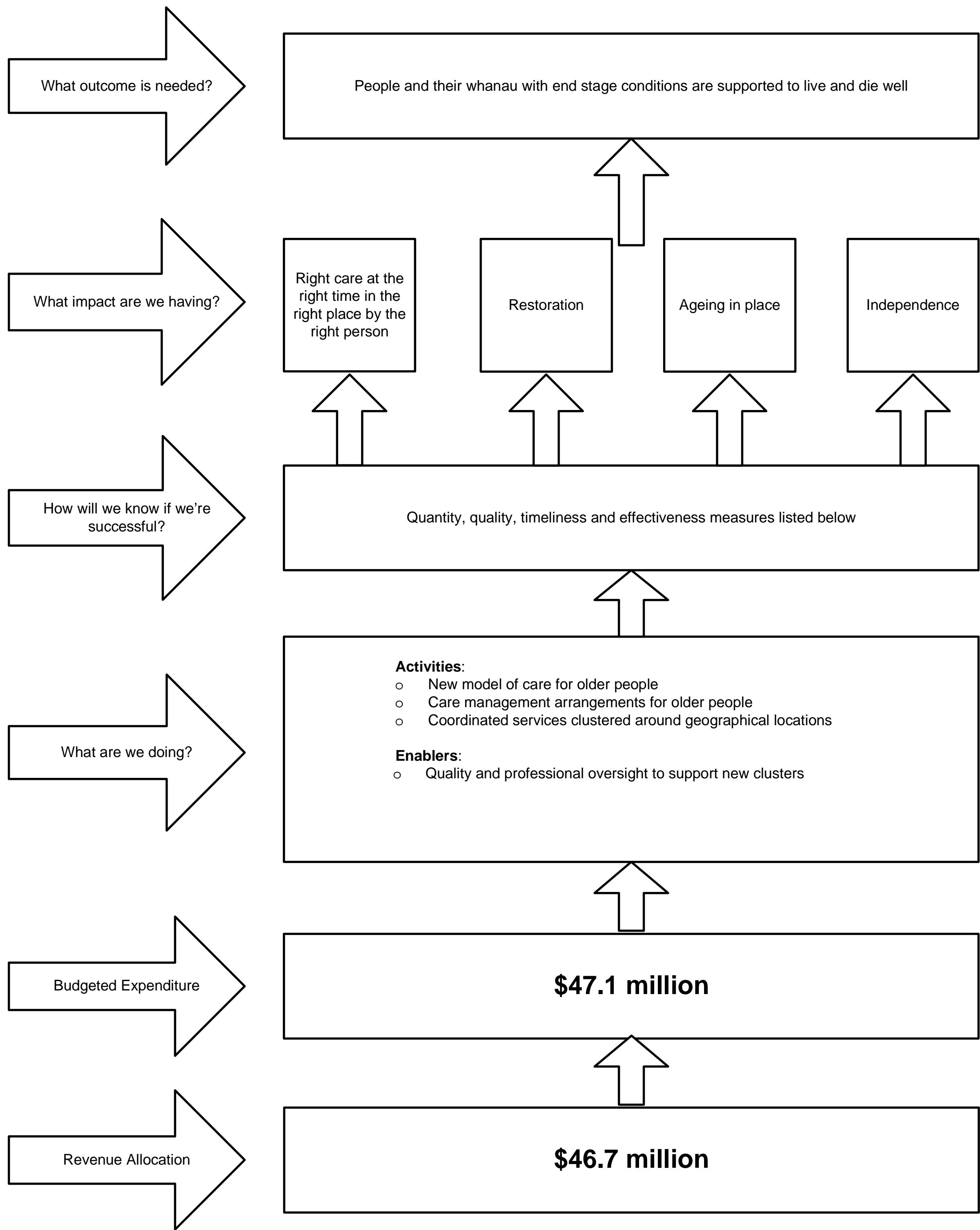
The Support Services Output Class comprises services that are delivered following a "needs assessment" process and service coordination by NASC services for people who have age related needs, short-term support requirements after hospital discharge or palliative care. Services include community home based support services, residential care services and rehabilitation services.

Taranaki DHB's aim is to have a fully inclusive community where people are supported to live with independence and can participate in their communities. The role of support services is to ensure that these needs are met through a range of integrated services coordinated into six geographical clusters around GP services.

Outcomes for Support Services

It is anticipated that these services will enable more people to live safely and independently in the community with fewer people requiring residential support. Home based support services in our DHB are provided by community NGOs delivering a range of packages of care from basic support to complex packages of support that enable people to live higher quality lives in their communities.

Intervention Logic Model: Support Services



STATEMENT OF FORECAST SERVICE PERFORMANCE

Main areas of performance in Support Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
NASC Services – Older People	Numbers of assessments completed	2,000	2,050	Project Splice proposes the development of the NASC function into care management for clients with complex needs and a referral coordination centre utilising telephone assessment for those with non complex needs. This change, together with the introduction of restorative home support services is expected to impact on planned volumes as TDHB moves to the new model. Population of over 65s increasing by around 2% per year.
Specialist Palliative Care Services	Numbers of patients assessed and supported	435	400	Hospice Taranaki is in the process of introducing the Liverpool Care Pathway in the inpatient unit and it is anticipated this will be introduced into Aged Residential Care Facilities in the future.
Rehabilitation Services – Older Peoples Service	Numbers of patients	100	100	Rehabilitation programmes provided through the ICATT (Intermediate Care Assessment and Treatment Team) service delivered according to client need either in the Rehabilitation Day Ward or at home.

Main areas of performance in Support Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
Home Based Support Services	Numbers of home based support services hours	210,000 hours per year	210,000 hours per year	These are expected to reduce as a restorative model of care is implemented, however the increasing number of older people may negate any reduction. NB: includes household management and personal care.
	No. of new clients provided with ARC p.a. Total number of clients in ARC	300 1,023	300 1,023	Numbers entering ARC are expected to reduce with the introduction of restorative home care, but reduction is anticipated to be evident into the 11/12 year as the service changes are fully implemented.
	Ratio of expenditure between Home Based Support and ARC	$1 HBSS = $4.99 ARC	$1 HBSS <= $4.99 ARC	Baseline data based on 08/09 actual accounts. Data not previously recorded – will be aiming to maintain status quo despite 2% population increase
Aged Residential Care Bed Services	Numbers of subsidised bed days: hospital, rest home, dementia, psychogeriatric	Capacity is 1,237 beds Subsidised Occupancy approx. 733	<= 2% increase in occupancy	Total Occupancy is 1,023
	Proportion of population occupying ARC beds/population over 65	6%	<= 6%	% is calculated as follows: Total occupancy/estimated population 65+ (1,023/16,630)

Main areas of performance in Support Service output class	Main Measures of performance (includes quantity, quality and effectiveness of outputs)	Volumes		Comments/Definitions
		Baseline (09/10)	2010-11 Target	
Respite Care Services – Older People	Number of bed days of respite provided to support patient care	505 bed days of allocated respite per year	1,010 bed days of allocated respite per year	Number of Older People increasing by around 2% per year – Funded through contracts for bed days
Day Services – Older People	Numbers of clients being provided with day services	310 clients	310 clients	These are expected to reduce as a restorative model of care is implemented; however, the increasing number of older people may negate any reduction

5. ORGANISATIONAL CAPABILITY

5.1 Human Resources

Human Resources (HR) is responsible for ensuring that the Taranaki District Health Board staff and culture are aligned with the DHB's vision and values: and support the achievement of the DHB's strategic objectives in the most effective, efficient and sustainable way.

HR provides organisational leadership, authoritative advice and specialist support services for managers and employees in the areas of HR strategy, policy, systems and legislative and regulatory compliance including: Employee and Industrial Relations, Learning and Development and Staff Well Being, Organisational Development, Change management and Productivity Improvement, Workforce Reform, Recruitment and Selection and Workforce Planning and Performance.

The HR service is guided by the HR and Organisation Development Strategy ("The People Plan") in all continuous improvement activities and long term projects such as the constructive engagement, consultation, regional and national collaboration, organisational reform, culture change and clinical/transformational leadership. The Plan also focuses on crucial programmes relating to the Regional Clinical Services Planning, Expressions of interest and Shared services Initiatives.

The Clinical Board, Clinical Leadership Group, Combined Health Union Management Forum, Joint Consultative and Joint Action Committees are functioning to support engagement on a broad range of issues including Expressions of Interest, Clinical Services Planning, Reviews and District Annual Planning.

TDHB applies financial and HR performance metrics to monitor, manage and where appropriate address HR operational measures. The DHB has lower than average levels of absenteeism and turnover which augers well for its operational performance and employee satisfaction.

Skills

Taranaki DHB has developed a comprehensive Workforce Development Plan which is aligned to the District strategic Plan and DAP priorities. The Plan focuses on ensuring that the DHB has the right people with the right skills and cultural competence at the right place and time.

Consequently, active programmes are in place to support the development of the aged care workforce, build a GP capacity through GP development programmes, build skills and competence to required to deliver services and offering in the Taranaki Base hospital which is undergoing a significant redevelopment. To this end, staff and the community have been engaged in the redevelopment of the facility and the design and introduction of new models of care.

The DHB is also centralizing its training budgets and activities. Greater focus on both clinical and transformational leadership development and access to e-learning will facilitate further improved learning opportunities.

Physical assets and technology

The overall goal of asset management for TDHB is to ensure that the best performance is achieved from its assets in the most cost effective way.

Taranaki DHB has an Asset Management Plan signed off by the Board.

Basic process, procedures and policies are in place in TDHB for the three main processes involved in operational asset management: asset acquisition, asset maintenance and asset disposal.

Oracle Financials is the current Taranaki DHB financial system. A register of assets is maintained within the Oracle Fixed Assets sub-ledger. Although basic information is maintained in the financial asset register for each asset, key asset management planning information such as expected life, criticality and replacement value is not. This limits the value of the data for renewal and replacement planning. The DHB therefore uses other systems to ensure appropriate management of assets and technology.

These two smaller asset specific systems are used for asset management purposes for clinical (biomedical) equipment and for buildings, services and non-clinical equipment. Biomedical equipment data is managed through a combination of a computerised maintenance management called SmartStream and an in house developed Access database for biomedical maintenance scheduling. SmartStream provides a repository for basic asset data along with maintenance history. The in house Access database produces planned preventative maintenance schedules. Compliance and other maintenance requests and maintenance activities undertaken are captured in SmartStream, as this is a key component of electrical safety and functional compliance legislative requirements.

SmartStream is also used for the management of buildings, services and non-clinical equipment data. SmartStream provides a repository for basic asset data along with maintenance history. It also produces planned preventative maintenance schedules. Compliance and other maintenance requests and maintenance activities undertaken are captured in SmartStream, as this is a key component of electrical safety legislative requirements.

Systems, processes, structure

PLANNING *What are we planning to do?* *What are we trying to accomplish?*	**STANDARDS** *Define the standards of clinical and non-clinical practice*	**SERVICE DELIVERY** *Do the improvement*	**MONITORING** *Did we meet our standards and targets?* *Check the results and lessons learned*	**EVALUATING & REPORTING** *Do we need to take corrective action?* *Act to hold the gain*
Guidance from the TDHB Board • TDHB Strategic Plan • TDHB District Annual Plan	**Provider Quality** Specified in service contracts of all DHB funded healthcare providers	**Clinical Services** • Inpatient • Outpatient • Day-stay • Community	**Reportable Events** • Incidents/accidents/near misses • Serious and sentinel event review • ACC Treatment Injuries • Mortality and Morbidity review	**Evaluating** All activities are evaluated to ensure we are doing the 'right things' in the 'right way' at the 'right time' ie to our standards
Guidance from the TDHB Executive Team • TDHB Quality & Risk Plan	**Credentialling of clinical staff** **Competence** based practicing certificates	**Clinical Support** • Diagnostics • Infection Control • Pharmacy	**Performance Monitoring** • Performance Appraisals • Peer Reviews • Supplier contract compliance	**Reporting to agreed internal and external key stakeholders in an accurate, meaningful and timely manner.**
• **Service and Department** Plans including Quality & Risk Plans	**Policies, Procedures, Protocols and Guidelines developed to:** • Ensure compliance with legislation, external standards and internal requirements • Ensure evidence based practice • Ensure efficient and effective operational management	**Non-Clinical Support** • Facilities • Information Technology • Human Resources • Finance • Materials Management • Business Support • Continuous Quality Improvement • Risk Management • Emergency Management • Health and Safety	**Audits** • Clinical Audits • Quality & Risk Audits • Internal Audits • External Audits • Infection Control surveillance • DHB Funded Healthcare Provider Audits	**Evaluation and reporting informs the next planning round and results in changes to service/department level quality and risk plans as needed to address negative trends or adverse outcomes and to continually improve service delivery.**
Influencing external factors: • MoH strategies • MoH Improving Quality documents and programmes • MoH funding contracts	**Establishing measures and setting targets** • Key Performance Indicators • Hospital Benchmarking Indicators • Clinical Indicators • Non-clinical measures • Process and outcome measures • Benchmarking	**Quality Improvement Projects to improve service delivery**	**Patient Satisfaction** • Compliments and complaints • Satisfaction surveys **Staff Satisfaction** • Staff perception surveys	

PLANNING *What are we planning to do?* *What are we trying to accomplish?*	STANDARDS *Define the standards of clinical and non-clinical practice*	SERVICE DELIVERY *Do the improvement*	MONITORING *Did we meet our standards and targets?* *Check the results and lessons learned*	EVALUATING & REPORTING *Do we need to take corrective action?* *Act to hold the gain*
	External factors which influence our standards: • Legislation and regulations • Certification • Accreditation o Quality Health NZ o Ambulance o Baby Friendly o IANZ – Laboratory o Physiotherapy • ACC Partnership Programme • Evidence based practice	**External factors which influence our service delivery** • Information flows with patients and their families • Other providers eg referral and discharge information • Supplier contracts	**External factors which influence our monitoring and reporting:** • MoH Quality & Risk reporting requirements • Hospital Benchmarking Requirements • Labour Department requirements	

5.2 National and Regional Collaboration, and cross-sector Collaboration

Working collaboratively with others, both across the sector and with other health and social service providers is integral to the success of Taranaki DHB in achieving the goals set out in our DSP. We are committed to sharing resources with our Midland regional group as well as collaborate with NGOs[8], the National Health Board and the National Shared Services Agency, the 21 DHB Collaborative (DHBNZ[9]), the Ministry of Health and other service providers in order to achieve our outcomes.

National

Along with DHBs nationally, our DHB collectively funds services for people with haemophilia and PHARMAC for community pharmaceuticals management. Collectively, we are organising a national genetics service that will be delivered out of two centres of excellence in New Zealand and support other national services such as solid organ transplantation, paediatric sub-specialty services, some cancer services, the national burns unit and other highly specialised services.

Our DHB is part of the 21 DHB Collaborative (DHBNZ) through which we organise national funding agreements for Aged Residential Care Services, Pharmacist Services, Dental Services and the PHO Performance Management Programme.

Our DHB also works in national programmes to reduce collective costs and improve quality, such as Health Workforce, Value for Money and Productivity, Procurement and Shared Services.

Our DHB is involved in Ministry of Health initiatives such as productivity measurement Health Round Table (HRT) and reviews of the PBFF and the establishment of the national InterRAI tool for assessment of older people for services.

Regional

Along with other DHBs our DHB collectively funds HealthShare to undertake audit function. HealthShare manages the Midland Aged Residential Care (ARC) Audit Programme and the Midland Mental Health provider audit programme.

We are progressing on the collective approach to the Midland Regional Clinical Services Plan (MRCSP) which will identify three to four vulnerable services. Development in these areas will progress over the course of 2010/11. This process will review work completed in early 2009 identifying rural GP services and obstetrics as vulnerable services and determine whether or not these services still need to be considered priority vulnerable services to be addressed by the CSP. It is expected that a final Midland region CSP will be available by 30 June 2011.

Taranaki DHB is also a member of the Central Region Cancer Network. The focus of the Network in 2010/11 will be ensuring the delivery of the 4 week waiting time for cancer radiation treatment; improving reporting for medical oncology, developing lung and bowel cancer tumour streams and standardising models of care and treatment pathways.

Further detail of both Midland and Central Region collaboration is provided in our DAP.

[8] NGOs (Non-Governmental Organisations) for more information on NGOs go to http://www.moh.govt.nz/ngo
[9] DHBNZ (District Health Boards New Zealand) has the overall purpose of assisting DHBs in meeting their objectives and accountabilities to the Crown.

Cross-Sector

Future Taranaki

Taranaki DHB is an active participant of the Future Taranaki Facilitation Group (FTFG) which was formed in 2004 out of a collaborative regional partnership between a wide and varied range of agencies. The FTFG member organisations currently comprise:

- Taranaki District Health Board
- Ministry of Social Development
- Te Puni Kokiri
- Venture Taranaki Trust
- New Plymouth District Council
- Stratford District Council
- South Taranaki District Council
- Taranaki Regional Council

The purpose of the group is to provide a framework through which these and other organisations can be encouraged to collaborate to deliver the seven community outcomes identified for the Taranaki region. These outcomes are:

- Secure and Healthy: Region is a safe, healthy and friendly place to live, work or visit
- Sustainable: Region appreciates its natural environment and its physical and human resources in planning, delivery and protection
- Prosperous: Regional economy sustainable, resilient and innovative, prospering with the natural and social environment
- Together: Region is caring and inclusive, works together and enables people to have a strong and distinctive sense of identity
- Vibrant: Region provides high quality and diverse cultural and recreational experiences, and encourages independence and creativity
- Connected: Region has accessible and integrated infrastructure, transport and communication systems that meet the needs of residents, businesses and visitors
- Skilled: Region values and supports learning so all can play a full and active role in social, cultural and economic life

Three key projects are being undertaken by FTFG, all of which link to Taranaki DHB's strategic aims:

- Working Together for a Smokefree Taranaki: Taranaki DHB is the lead agency for this project, which aims for Taranaki to become the first Smokefree province in New Zealand by Smokefree Day 2009
- Safer Families, Safer Communities – Eliminating Family Violence in Taranaki: The Ministry of Social Development is the lead agency for this project, which aims to provide intervention, education and support in workplaces
- Regional Skills Strategy: This project is led by Venture Taranaki Trust, with the New Plymouth District Council. The aim is to ensure that the region's supply of labour meets its potential demand

5.3 Workforce development and organisational health

Workforce development and strong organisation health are central to Taranaki DHB to ensure that the DHB provides access to and delivery of high quality, effective services and meet the continued challenges of the health needs of our community.

Taranaki DHB aims to continue to be recognised as an employer of choice and in so doing, the DHB connects with the community through a number of forums focusing on engagement in workforce, employment and career promotion. Taranaki DHB has a clear set of values which underpins the way we work with our employees, patients, communities, business partners and stakeholders. To this end, the DHB encourages and promotes flexibility and innovation; employee engagement, organizational and clinical leadership, career, learning and skill development opportunities.

As a 'good employer' Taranaki DHB has a number of policies and programmes that promote equity, fairness and a safe and healthy work environment. These include:

- fair and transparent recruitment policies to ensure that the DHB meets current and future workforce needs and retain staff
- strong induction, health checks and on-boarding practices to support and welcome new staff
- flexible work practices are recognised and operated within the DHB. Taranaki DHB recognises the need for work-life balance and has implemented a number of initiatives to support staff
- change management and consultation processes to ensure that employees are engaged in change processes
- a zero-tolerance of all forms of harassment and bullying, supported by up-to-date policies, training, coaching and support
- equitable training and development opportunities for all employees
- a range of proactive policies and programmes focusing on health and safety. These include healthy living initiatives, exercise programmes, influenza vaccinations, Employee Assistance Programme, critical incident debriefing.
- a wide range of discounts are provided to staff with the majority sought from local gyms, exercise programmes, massage and other health related fields.
- Smokefree programmes and a program with TDHB caterers to provide healthy food choices.
- post entry surveys are conducted with new employees after 3-months service to identify and address any employment related issues
- exit interviews are offered to all departing employees to ascertain the effectiveness of employment practices and identify any areas for concern
- the management and disclosure of adverse events to ensure a safe quality working environment.
- implemented strong workforce planning programmes and has implemented a number of successful initiatives to improve service delivery and ensure continuity of staffing.

Taranaki District Health Board has developed a strong set of HR Key Performance Indicators to facilitate effective staffing. The DHB has an understanding of the needs and expectations of its workforce and engages effectively with clinical leaders and staff through a range of committees and forums. We are committed to improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki.

5.4 Building capability

Taranaki DHB recognizes that by working with others, more can be achieved . Therefore, the DHB collaborates extensively, with a range of partners in order to influence the wider determinants of health. These collaborations include

- Multi-parent and Associated Companies
- National Collaboration, through for example the ACC
- Intersectoral collaboration
- Regional Collaboration

Taranaki DHB is part of the Midland Region. The DHBs are committed to building sustainable regional services while ensuring that local services are effective and deliver the requisite health outcomes for the population. The focus on collaboration has led to the development of a 10-year Clinical services plan, which is regionally led and takes a whole-of-system approach with respect to service development and delivery. At the same time, Taranaki DHB also participates with the Central Region for cancer services, where several major projects have been initiated to improve services and health outcomes.

As an organization, Taranaki DHB has enjoyed considerable recruitment success over the last 18 months. This coupled with low staff turnover and strong engagement processes ensures the DHB is in sound staffing position and is prepared and able to address the challenges ahead. The DHB focuses on building and redesigning sustainable and affordable services, collaboration, clinical leadership, workforce development and employee engagement.

Consequently, the DHB's priorities are:

- Engagement of staff in the development of new models of care and the redevelopment of the Base Hospital, New Plymouth
- Engaging clinicians and staff in reviewing services, Expressions of Interest and national projects/strategy groups
- Increasing clinical assessment skills and professional competencies for Nurses working in Aged Care
- Increasing leadership capability of clinical leaders to deliver change and improve health outcomes in primary and secondary care settings
- Develop financial competence across the sector in Taranaki
- Participate in and provide good learning opportunities for GP's and Trainees with a rural interest
- Attract and retain the best staff and ensure continuity of services, as outlined in our DAP and workforce planning programmes.

5.5 Information services

The following major developments in the information and communication technology (ICT) field are planned to be initiated in 2010/11:

- Medicine reconciliation tool
- Clinical Portal
- Referred services information system management

Priorities in this area will ve reviewed in the first quarter of the year, together with other DHBs to develop a regional implementation plan that aligns with the new National Health IT Plan expected in July 2010.

5.6 Quality and safety

Improvements in patient and staff safety, practice service delivery and risk mitigation are supported by the Taranaki DHB, recognising that there needs to be a balance maintained between achieving the necessary improvements, mitigating risk and the costs of doing so.

The Taranaki DHB has an annual Taranaki DHB Quality and Risk Plan, located on the DHB's intranet, that is monitored through the DHB's committee structure with formal evaluation occurring at least annually. It is mainly focused on Taranaki DHB's Provider services and aims to facilitate the progressive achievement of the Taranaki DHB's vision by monitoring and continuously improving all services, processes and activities relevant to the quality of care, patient safety, risk mitigation and the service provided or funded. The plan facilitates the progressive achievement of the DHB's vision by outlining objectives and actions to be taken in relation to the 10 goals outlined in the Ministry of Health's IQ Action Plan: Supporting the Improving Quality Approach. It also links into the DHB's Strategic and District Annual Plans.

Key focus areas within the Taranaki DHB Quality and Risk Plan for the 2010-11 year include progressing our commitment to the national Quality Improvement Committee programmes, improving information and document management systems and processes, delivering root cause analysis training to key staff, formalising our patient/client participation mechanisms and ensuring delivery on the established clinical board work plan.

The Taranaki DHB is committed to the delivery and funding of quality services by all health and disability providers within the district. Quality assurance systems and procedures are in place to ensure services undergo performance measurement (usually focused on service content, delivery specifications and patient/client outcomes). Continuous quality improvement is the response to this quality activity and supports the vision of the Board – Taranaki Together, a Healthy Community.

Improvements in patient and staff safety, practice service delivery and risk mitigation are supported by the Taranaki DHB, recognising that there needs to be a balance maintained between achieving the necessary improvements, mitigating risk and the costs of doing so. The tension and challenge lies in finding this balance. We continue to broaden our quality and risk management approach from the Taranaki DHB Hospital Provider as our key point of reference, to an approach that involves the entire health and disability sector in Taranaki, particularly engaging with clinicians and clinical services.

Indicators Level 2 – Risk Management

5.7 Subsidiaries

Taranaki DHB is a Crown entity in terms of the Public Finance Act 2004, owned by the Crown and domiciled in New Zealand.

The Taranaki DHB group consists of Taranaki DHB, a 50% investment in Fulford Radiology Services Ltd, a fully owned subsidiary providing information technology services called

HIQ Ltd, a 25% investment in Allied Laundry Services Ltd and a 20% investment in HealthShare Ltd.

The financial statements of Taranaki DHB are prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Public Finance Act 2004.

HIQ Ltd

On 01 July 2009, HIQ Ltd became a fully owned subsidiary of Taranaki DHB, with the ICT operations of Capital & Coast DHB becoming an in-house operation of the DHB. Previously, Taranaki DHB and Capital and Coast DHB had a joint venture arrangement (HIQ Ltd) to provide IT services to both DHBs.

HIQ provides a full range of IT services to Taranaki DHB. HIQ does not currently provide services to private organisations, other than affiliates and organisations closely aligned to the DHB and its operations. The philosophy and social objectives of HIQ are in line with that of the shareholding DHBs.

HIQ builds on the use of existing information systems and looks to achieve enterprise wide gains from improving these systems. HIQ is focused on improving access to clinical and administrative information through both information exchange (e.g. the implementation of online ACC claiming) and providing sector stakeholders with secure and appropriate access to health information (e.g. laboratory results repository). Additionally, HIQ Ltd has a consulting and business development arm which is currently engaged in executing a number of projects at the national level for the Ministry of Health.

HIQ supports the Health Information Strategy for New Zealand. In particular, key initiatives are:

- National Network Strategy: HIQ Ltd is participating in the selection and implementation of a secure data network between regional DHBs.
- E-Labs: Implementation of a laboratory results repository accessible by multiple stakeholders in the region.
- Chronic Care and Disease Management: HIQ is actively investigating tools and decision support systems that will support chronic care initiatives.
- National Collections/Strategies: TDHB has implemented the National Non-admitted Patient Collection (NNPAC) and is actively participating in the Primary Health Care Strategy programme.

It is anticipated that HIQ's support to other DHBs will grow in the future.

Allied Laundry Services Ltd

Allied Laundry Services Ltd (ALSL) is a shared services arrangement between four District Health Boards for the provision of laundry and linen services. The participating District Health Boards are Hawkes Bay, MidCentral, Taranaki and Whanganui. This collaborative arrangement enables cost savings to be achieved in the delivery of laundry and linen services to the participating District Health Boards.

In pursuant of the provisions of Section 157 of the Crown Entities Act 2004, ALSL has received exemption to prepare an independent Statement of Intent (SOI), with an undertaking that one of the shareholding DHBs (MidCentral DHB) would provide appropriate information on ALSL's activities and operating plans in its SOI.

Fulford Radiology Services Ltd

Taranaki District Health Board has a 50% investment in Fulford Radiology Services which provides a comprehensive range of radiography imaging services to the Taranaki population.

HealthShare Limited

Each of the five Midland DHBs has a participatory interest in HealthShare Limited, a DHB joint venture company that specialises in both routine and issues-based quality-audits of service providers. The five DHB Chief Executives are Board members. The service level agreement between the five DHBs and HealthShare sets out the principles, targeted performance standards, and operational guidelines that underpin HealthShare's audit programme and framework ensuring alignment with both national and regional requirements.

HealthShare reports back to the participating DHBs throughout the year ensuring contractual obligations and standards are met by contracted providers.

HealthShare also manages the primary health regional fees review process for the Midland DHBs.

6. FINANCIAL PERFORMANCE

6.1 Financial Statements

6.1.1 Consolidated Financial Summary: 2010 – 2013

The consolidated financial summary below includes the Hospital Provider (Personal Health, Mental Health, Public Health and DSS), DHB Governance & Funding Administration, and the DHB Funder operations.

($'000)	2008/09 audited	Year 0 2009/10 Forecast		Year 1 2010/11 plan	Year 2 2011/12 plan	Year 3 2012/13 plan
Hospital Provider + Governance Funding (including other income)	165,200	165,999		167,859	172,515	178,824
Non Hospital Provider Funding (NGO)	124,039	135,360		140,016	142,815	145,672
TOTAL FUNDING	**289,239**	**301,359**		**307,875**	**315,330**	**324,495**
Hospital Provider + Governance Operating Expenses	168,684	173,948		176,583	178,932	182,856
Payments to Non Hospital Providers (NGO)	120,598	129,056		131,141	136,313	140,455
TOTAL OPERATING EXPENSES & PAYMENTS	**289,282**	**303,004**		**307,724**	**315,245**	**323,320**
Hospital Provider + Governance Operating Deficit	**(3,484)**	**(7,949)**		**(8,724)**	**(6,416)**	**(4,032)**
TDHB Funder surplus before strategic expenditure	3,441	6,304		8,875	6,502	5,217
OPERATING RESULT FOR THE FISCAL PERIOD	**(43)**	**(1,645)**		**151**	**86**	**1,185**

Notes:

A: The net consolidated financial result is AFTER recognising the:

I. expenditure on account of Workforce Development initiatives (an appropriation against retained surpluses),

II. expenditure on Mâori Health gains project (an appropriation against retained surpluses), and

III. expenditure on Strategic Hospital Provider projects (an appropriation against retained surpluses)

The consolidated operating result BEFORE the appropriations against prior period retained surpluses is a financial breakeven position, with an operating surplus of $0.15M, $0.09M and $1.18M for the plan periods 2010/11, 2011/12 and 2012/13 respectively.

B: Expenditure against prior period surpluses: These relate to short to medium term investment in strategic services and operations::

i. Workforce development ($ 0.1M) for each of the planning periods 2010-2013 (Board commitment of $2.5M over a 5 year period)
ii. Māori Health inequalities ($0.6M) for each of the planning periods 2010-2013 (Board commitment of $3.0M over a 3 year period)

These annual investments were committed by the Board, span more than one financial period, and are outside the core annual operating budget. The investment is being funded out of carried forward surpluses from prior periods.

iii. Hospital provider strategic projects to support transformational and structural service changes ($1.75M) for the plan period 2010-2011

This major outlay for 2010/11 is related to strategic projects to implement changes to service configurations across both hospitals with a targeted reduction of $4.0M in direct costs. The changes are focussed particularly around acute in-patient consolidation, reallocation of outpatient and procedural services, specific procedure consolidation, changes to allied health services and mental health service delivery. The Board is also considering the exit of ownership and provision of Ambulance services in favour of a nationally provided ambulance service as currently prevalent in other parts of the country. The resultant cost reduction is expected to be $ 0.50M.

The above service reconfigurations will be subject to approval by the Minister of Health where necessary. Further, it is recognised that timelines for the transition will perhaps span more than the 2010/11 financial period. Nonetheless, these changes are crucial for Taranaki DHB hospital services to reduce its cost structures and operating deficit. It is required to be undertaken at this strategic point in the operations of the DHB when faced with reduced future funding growth, increased demand, growth in services and operating costs, and a $80M hospital redevelopment project to be completed by June 2012.

C: It is also to be noted that expenditure ($1.44M towards capital charge and depreciation) incidental to the revaluation of assets (per FRS3 - land and buildings) carried out on 30 June 2008 continues to be charged against the hospital provider. This extraordinary expenditure has had a material impact on TDHB's financial and cash positions. No confirmation or commitment for funding this expenditure has been received (this was funded on a cost neutral basis during previous revaluation exercises). The corresponding funding if/when received will improve the hospital provider and also the consolidated financial results by approximately $1.44M each year - a significant improvement in the financial results of the DHB.

D: These financial results are to be read with the accompanying notes and assumptions.

6.1.2 Key Points from the Budgeted Financials 2010 – 2013

In principle, the Board has planned for a consolidated financial breakeven result in each year of the plan period. However, this financial breakeven goes against the emerging trend across the entire planning period 2010 - 2013, which clearly indicates that cost growth in the hospital provider operations is significantly in excess of funding received, leaving residual operating deficits. The consolidated surplus is solely on account of the surpluses generated in the Funder operations during each of the fiscal periods under consideration.

1. The Hospital Provider Arm is facing a significant budgetary cost to funding gap resulting in operating deficits in each year covered by this plan. This financial gap could increase to $11.60M in 2010/11 if other identified risks and associated costs

(estimated at $2.80M) were to materialise fully. With the residual risk estimated at $2.0M, the resultant financial gap could be in the region of $10.80M. (Please refer to the "Sensitivity Analysis" section for details).

2. In applying the stated budgetary assumptions, it is evident that current cost structures in the Hospital Provider have little to offer by way of further savings, unless there are fundamental changes in some of its services, workflows and staffing levels. In view of the increasing cost pressures and risks, the financial budget for the provider arm hinges on the implementation of some major cost reduction initiatives which have been approved by the Board, but remain provisional subject to approval by the Minister of Health. If adopted, these changes are expected to generate approximately $4.50M of reduced operating costs, of which $2.0M is expected to be realised during 2010/11. This is besides the $2.0M in efficiencies and productivity gains as noted in the "Efficiency & Productivity Improvements" section of this document.

3. Additionally, it is carrying unbudgeted financial risks in many of its cost structures that are likely to materialise in part or full during the plan period. (Please refer to the "Sensitivity Analysis" section for details).

4. The Board therefore recognises that the operating cost to funding gap in the Hospital Provider operations will need to be addressed through options that could result in significant changes to models of care, service configurations and re-alignment of services within funding available. It acknowledges these changes are essential if the hospital services arm is to remain financially viable when faced with increased costs on several fronts.

5. In context of increasing cost structures and continuing operating deficits, it is to be noted that Taranaki DHB is about to embark on a staged redevelopment of the Base Hospital inpatient facilities. There are several compelling reasons to undertake the redevelopment, but non more compelling than the fact that the current hospital layout and structures are not conducive for delivery of complex clinical pathways and modern models of care. Consolidation of specialist services and improved models of care and pathways will result in more efficient use of clinical resources and thereby reduction in core operating costs. The redevelopment will pave the way for a recovery plan for the hospital services to align itself more efficiently – both clinically and financially. The impact will be evident post redevelopment of the base hospital facilities.

6. Likewise, the DHB Funder operations is planning to reprioritise funding worth $4 million to enable the DHB Funder operations to manage its costs down and deliver the operating surplus planned for 2010/11. It is also faced with an overall exposure in its contracts estimated at around $7.0M for 2010/11, with a probability factor leaving a residual risk equating to about $3.50M. This is in addition to the financial risks carried by the Hospital Services operations. (Please refer the "Sensitivity Analysis" section for details).

7. In the final tally, though the Board is planning a financial breakeven it is faced with:
    a. a significant cost to funding gap in its Hospital provider operations for 2010/11 (and out years),
    b. additional financial exposure in its expense budgets which could materialise in part or full
    c. the need to make radical changes and re-align service configurations in its hospital service operations to manage the gap and other potential risks

d. the financial recovery for its hospital provider operations being largely dependent on cost reductions incidental to structural changes noted earlier, and the efficiencies arising from the redevelopment of the hospital facilities
e. its Funder operations having to significantly reduce investment in additional services, besides carrying financial risks.

Recognising that additional risks continue to be carried both within and outside the financial budget and its reliance on the timely outcomes from structural changes to reduce the hospital operating deficit, Taranaki District Health Board's financial risk assessment of the current District Annual Plan is potentially "medium to high" risk under the assumptions and risks as stated.

6.1.3 Key Financial Risks

6.1.3.1 Taranaki DHB's Funder

1. The 2010/11 Funding Envelope indicates an increase of $8.22 million over the 2010/11 Funding Package start point. The increase includes $3.63 million demographics and $4.59 million as a contribution to cost pressures. Whilst this increase is welcome, it amounts to only two thirds of the increase received in 2009/10 and is not as great as the general funding and expenditure pressures being experienced by the DHB.
2. Unlike previous years, the Government has made no decision on funding for 2011/12 and 2012/13. Taranaki DHB has therefore prepared the DAP on the assumption that funding increases for cost growth in out years will be of the same nominal value as 2010/11.
3. Taranaki DHB's share of population based funding for 2010/11 is 2.76% and is forecast to decline to 2.75% in 2011/12 and 2.73% in 2012/13, reflecting the slower population growth of Taranaki in comparison to other parts of the country. This lower funding for cost growth will require the DHB to reconfigure services as we strive to meet increasing demand and live within our means.
4. The Funding Envelope advice indicates that there may be some further additional funding made available to DHB's from non-devolved funding held by the Ministry of Health for 2010/11. Further advice on the level of increases is awaited. However it should be noted that any funding would already be committed to contracts currently held by the Ministry and which would be transferred to DHB's. Furthermore the Ministry has indicated that the level of contribution to cost pressures allocated to these contracts will be less than that allocated to DHB's. This could therefore result in further cost pressures for the DHB in the future.
5. The DHB has assumed that funding usually provided outside the Funding Envelope through a Crown Funding Agreement (CFA) (e.g. Care Plus, smoking cessation programmes etc) will be provided in this way in 2010/11. However confirmation has yet to be received from the Ministry of Health. The budget has not assumed any revenue or expenditure in these areas. However, there are contractual implications that will have to be considered if no payments are made.
6. The financial impact of the implementation of EOI business cases for Better, Sooner, More Convenient Primary Health Care is unknown at this time. However it has been assumed at this time that no funding other than existing primary care funding will be required for the implementation in 2010/11.
7. The proposed devolution of the Interim Funding Pool for long term conditions from the Ministry of Health to DHB's in 2010/11 has been assumed to be financially neutral.

8. General hospital and specialist services delivered by the DHB's own Provider Arm are specified in the Provider Arm Volume Schedule (Appendix B) and are paid for according to national inter-district flow (IDF) prices. Mental health services delivered by the DHB's Provider Arm are specified in the same way and paid for according to local prices. However the cost of delivering both general and mental health services exceed the funding allocated. Significant reconfiguration of the DHB's hospital and specialist services is therefore planned over the next 3 years to bring the cost of service delivery closer to the funding available.
9. In order to maintain a consolidated breakeven position the Funder is required to achieve significant surpluses over the next three years to offset planned deficits in the Provider Arm. In 2010/11 the planned Funder surplus is $6.4 million (after strategic expenditure). Delivery of these surpluses will present significant challenges for the Funder.
10. The absence of a risk reserve will severely limit the Funder's ability to fund transition costs of new models of care and respond to unexpected demands in year.
11. Close monitoring and analysis of IDFs will be undertaken, with information on referrals, cost and expenditure being fed back routinely to referring Specialists. The intention is to reduce expenditure by $1.5 million through a rigorous approach to controlling expenditure in this area.
12. The 2009/10 DAP signalled the DHB's intention to change the provision of services for older people and others with chronic health conditions. The DHB expects to have completed all consultation requirements prior to the start of the 2010/11 financial year. Implementation of the new model of care is expected to generate savings of $1 million in 2010/11 against current expenditure trends.
13. In order to deliver a net $6.4 million surplus the Funder plans to deliver further service changes signalled in section 6.2. These changes are transformation in nature and it is believed will deliver better services for less cost.

In summary, the level of funding allocation may prove insufficient to cover all risks that have been identified. Therefore robust management and monitoring of potential risks will be required and revised management proposals developed if the level of risk rises above that manageable within the funding regime.

6.1.3.2 Taranaki DHB's Hospital Provider

1. The funding for cost growth for 2010/11 is 1.73%. However, the real cost growth in hospital provider services is well in excess of this adjustor. The year on year cost movements across several expenditure lines are on an average between 3% and 5%. This gap between FFT and real cost growth has resulted in a budgetary deficit of $8.80M after considering all current efficiencies and cost savings. This growth is particularly evident in the following:
    a. wages – primarily provisions for MECA commitments.
    b. clinical staff – primarily nursing
    c. outsourced clinical staff – primarily locum doctors and psychiatrists
    d. diagnostics – primarily radiology
    e. blood costs, pharmaceuticals, air ambulance retrieval costs
    f. acute services such as renal, intensive care, mental health inpatient services, emergency services
    g. increasing cost impacts of statutory compliances, financial standards, quality and accreditation deficits and adherence to a number of legislative requirements
    h. general overhead costs – primarily utilities, travel, transport, legal, professional services, communication costs etc.

i. information and communication technology (ICT) capital investment and operating costs.

Overall, the Hospital Provider's financial plan for the three year period is highly geared and has no flexibility to accommodate unplanned cost movements. Its operating budget carries financial risks and it is highly dependent on the realisation of targeted savings within planned timelines to meet its 2010/11 financial targets.

On the basis of current trends in expenditure, the issues requiring tight management and efficiency gains are:

- **Payroll** costs make up over 65% of total operating expenditure (excluding interest and depreciation) and have increased significantly over the recent periods. The flow on impacts of MECA agreements, together with increase in base rates, are in excess of inflation adjustors and presents budgetary risks. We estimate this impact to be $0.30M, to be managed to the extent possible through strict FTE planning, attrition and deferment of staff vacancies.
- **Outsourced clinical staffing costs** – mainly locum doctors and psychiatrists. The increasing cost of locums to cover vacancies has been one of the primary contributors to recent period deficits. Whilst it is acknowledged that this is a national issue, the impact on costs at a local level is perhaps more significant. The financial exposure in the 2009/10 budget is estimated at $0.75M, with best efforts being directed towards more aggressive and extensive recruitment initiatives to fill vacancies and reduce the dependence on locums.
- **Diagnostic budget** – the financial exposure in both radiography services and pathology budgets against current year costs are estimated at $0.15M, which is expected to be managed by initiatives to contain volume growth in agreement with our service providers, reduce duplication and enforce clinical access protocols.
- The hospital **pharmaceutical** budget has not provided fully for the increasing trends in usage and introduction of expensive new drugs. This is expected to be managed through measures to reduce medication errors, inventory management and operating within dispensing guidelines.
- Costs of **clinical supplies and treatment consumables** have been steadily increasing for a variety of reasons. The budgetary risk carried for 2010/11 is expected to be managed by contract re-negotiations and pricing gains generated from the Value for Money (VFM) collective procurement projects at the local and national level.
- **General operating overheads** including travel, training, conferences, stationery, transport, general repairs and such other discretionary costs have annually been subjected to reductions in unit budgets. These expense lines are budgeted at minimum levels, with a high probability to exceed the budgetary outlay. Cost growth in most of these lines is driven by external influences. These lines are highly vulnerable to small movements in prices, rates or increase in service levels. Estimated exposure is around $0.68M, which is expected to be managed through internal cost controls, budgetary caps and contract re-negotiations.

The overall impact is a financial exposure close to $2.80M, with a probability factor leaving $2.00M as a real and potential risk. (Please refer 'Sensitivity Analysis').

2. In applying the budgetary assumptions we have recognised ongoing quality improvements and those compliance costs of which TDHB has been aware. The financial budget is vulnerable to small movements in costs over stated assumptions or increased costs resulting from unforseen clinical safety and legislative compliance expectations.

3. The Hospital Services Provider is fully dependent on sustainable revenue streams. With over 90% of its revenue derived from health funding (via Taranaki DHB and the Ministry of Health), the Hospital Provider has few alternate income streams for significant revenue growth opportunities. In the 2010/11 budget there is has been a reduced dependence on ACC revenues in view of changes in ACC referrals and claims payments. Consequently, contributions from ACC work have reduced with corresponding impact on the financial result.
4. In view of the increasing cost pressures, the financial budget for the provider arm continues to hinge on a number of efficiency gains, which are expected to generate approximately $2.0M of reduced operating costs during 2010/11. (Please refer the "Efficiency & Productivity Improvements" section for details).

In summary, the gap between funding and the realistic cost model for services has resulted in a very sensitive financial budget for the planning period 2010/11 and out years. In financial terms the budgetary gap in the draft hospital provider budget presented for the period 2010/11 is around $2.0 M. The hospital provider will have to bridge this budgetary gap + realise the efficiency gains and cost reductions targeted if it is to remain under its DAP financial deficit of $8.80M. This will involve some hard decisions around rationalisation of services and reduction in FTE levels within its hospital structures - in an urgent and time sensitive manner. A number of service changes have been proposed which have been approved by the Board, but remain provisional subject to Ministerial approval. These changes will have to be undertaken in order to exit costs and reduce the deficit in a planned manner to realistic funding levels.

6.1.4 Key Financial Strategies

a. The Hospital Provider Arm is faced with an operating deficit of $8.80M in its 2010/11 operating budget + other financial risks. The hospital provider has identified a number of key areas and is considering a framework (subject to Ministerial approval where necessary) for effecting structural change. These include, amongst others, plans for:

   - A targeted reduction of $4.50M in operating costs (with $2.0M achieved in 2010/11) through structural changes and identified service exits/reconfigurations. These strategic changes will span more than a single financial period to be fully implemented, but are the only realistic options to achieve financial sustainability in the hospital services operations.

     (Focus: Acute in-patient consolidation, exit ownership of Ambulance services, fringe clinical services, community referred diagnostics, allied health in line with inpatient consolidation, exit non PV ACC services, relocation of outpatient and procedure services)
   - Integration of Health centre services/facilities with primary care and other providers. (Focus: Stratford Health Centre, other Health centres)
   - Selective capital investment in Information Technology aimed at improving work flows and processes and releasing FTEs. (Focus: HIQ Ltd)
   - Development of regional networks to support effective local service delivery of vulnerable services. (Focus: Midland Clinical Services Plan, regional services collaboration)
   - Effective and robust clinical pathways for after hours care (Focus: Base Hospital and Hawera Hospital).
   - Focus on chronic disease management strategies (DHB Funder Strategic Plan).
   - Service reviews (Focus: Allied health services, Pharmacy, Maternity, Neonatal).

- Staffing reviews aimed at improving productivity and reduction in core FTEs (Focus: FTE and vacancy management across all DHB operations).
- Implementing processes and procurement initiatives developed by SSEB and National collective programmes.

Overall the approach will be to implement a range of practical options including re-configuration of services and facilities with the primary aim of reducing the overall cost of service delivery whilst maintaining access of core services to the people of Taranaki.

b. These options will be progressed in conjunction with the redevelopment of the inpatient facilities at the Base Hospital. The facilities redevelopment is expected to deliver greater workflow efficiencies and an overall reduction in costs in several areas of its operations. Underpinning this redevelopment is the need to configure the facilities to meet the services profile for the future and achieve maximum efficiency and effectiveness of service delivery.

c. Considering the trends in demand for health services, it is obvious that longer term sustainability, both clinical and financial, will continue to be the key focus for Taranaki DHB and in particular its hospital operations. To achieve this balance, Taranaki DHB has embarked on the development of strategies and processes that involve:

- identifying and evaluating service options to match costs with funding
- alignment towards a more sustainable clinical services model in line with funding
- internal cost controls and closer monitoring of operating budgets
- achievement of systems and process improvements, initiatives and efficiency gains
- technology driven solutions
- Sustained focus on longer term strategic plans, whilst continuing to proactively address immediate and medium term risks and issues

d. Investment and cash outlay for committed strategic initiatives such as Workforce Development, Mâori Health Gains and Hospital Provider services projects will continue to be funded below the line using prior period retained surpluses.

e. Primary sector cost pressures will be mitigated through management of demand driven services, contract delivery and integration of services with providers, while the secondary service aligns itself.

f. The hospital provider services will continue to pursue operational efficiencies and structural changes to reduce its service costs and decrease its operating deficit.

g. Greater focus on cost reduction across the hospital provider operations in growth areas such as staffing and operational overheads will continue to be aggressively pursued.

h. During the plan period 2010/13, baseline capital expenditure is expected to be contained within annual depreciation accruals, so that additional equity injection or borrowing is not required. The only exception will be funding to support the stages of the hospital redevelopment programme in line with funding approvals received.

6.1.5 Key Financial Assumptions

The following key assumptions have been employed in the preparation of the financial statements for the three-year planning period 2009/12.

6.1.5.1 Application of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS)

The DAP financial template for the plan period 2010/13 and comparative years has been prepared in accordance with NZIFRS.

6.1.5.2 Equity and Borrowing

- The District Annual Plan 2010/13 has not assumed any additional Crown equity, other than the capital funding approved to undertake the rollout of the community oral health project ($3.04M) which is being treated as equity.
- Term borrowing from the Crown Health Financing Agency (CHFA) to fund the first stage of the capital redevelopment programme proposed for the inpatient facilities at the Base Hospital has been included in the DAP 2010/13. Approval for Stage 1 (estimated cost: $80M) of the redevelopment was received in July 2008, which includes a CHFA funded borrowing of $45M.
- With the exception of the capital outlay envisaged on inpatient facilities redevelopment as noted above, base line capital expenditure outlay is expected to be contained within the level of depreciation for 2010/11 and the two years following
- Taranaki DHB is on “standard monitoring” status on the performance monitoring scale, and it is assumed that monthly funding will continue to be received in advance.

6.1.5.3 Wages and Operating Cost Growth

1. Wage costs: in principle, wage budgets for employee groups covered by national MECA settlements are essentially in accordance with the agreement (s) and in line with collective DAP assumptions agreed nationally.
2. Clinical supplies: average around 1.20% for 2010/11 + estimated on activity levels + reduced for efficiencies and value for money (vfm) gains.
4. General operating expenditure: average 2.0% for 2010/11 + confirmed outflows + reduced for efficiencies and value for money (vfm) gains.
5. Value for Money (VFM) impacts: the potential impact of efficiencies and cost reductions likely to be generated from SSEB/National VFM programmes and initiatives has been estimated and built into the relevant operating budgets and expense lines. Other potential gains from local initiatives and projects have also been considered in the relevant expense budgets.

6.1.6 Taranaki DHB Funder – “Ring Fence Principle” and Application of Surplus/Deficits

6.1.6.1 Mental Health Services

In keeping with the guidelines on treatment of “Mental Health Ring fence surplus” the amount of any under-expenditure carried forward from previous accounting periods have been reported as a surplus in Taranaki DHB’s Statement of Financial Performance in the year the surplus is generated. The ring fenced surpluses as at the beginning of FY 2009/10 has been fully applied to mental health services either in the hospital provider or community during 2009/10. Based on expenditure to date and forecasts, there is likely to be no surplus remaining on 30 June 2010. No surpluses from MH services are envisaged during the 2010-13 plan period, and if any surpluses do eventuate these will be ring fenced and expended in the year(s) following.

6.1.6.2 Mental Health Services and Strategic Initiatives Expenditure

Expenditure on strategic projects and initiatives viz. Workforce Development, Māori Health Gains and Hospital Services Strategic Projects to support transformational and structural changes are being funded from prior period retained surpluses and is in line with the strategic direction set by TDHB. In principle, this strategic spend being outside the 12 month fiscal period may result in a financial deficit for the period, however no additional funding or deficit support is being requested by Taranaki DHB to progress these long term initiatives.

6.1.6.3 Interest Rates

Interest rates have been assumed along current monetary indicators and commitments and averaged as appropriate over the mix of funding streams and options as follows:

	Overdraft	CHFA loans (existing)	CHFA loans (new)	Deposits	Equity
Year 1 (2010/11)	8.00%	6.85%	7.00%	5.50%	8.00%
Year 2 (2011/12)	8.25%	6.85%	7.50%	6.00%	8.00%
Year 3 (2012/13)	8.50%	6.85%	7.50%	7.00%	8.00%

Notes:

1. CHFA existing facility limit is $31M, with $29M drawn down. This is besides the $43M new term debt approved for Stage 1 of the base hospital redevelopment project approved by CHFA.
2. TDHB has transactional banking arrangements with ASB bank. Approved overdraft facilities are available on stand bye basis (uncommitted) with ASB. No financial covenants have been stipulated by ASB for transactional banking and stand bye overdraft arrangements.
3. TDHB currently has $29M in term deposits with Kiwi Bank and ASB Bank, which are available to bridge any shortfalls in working capital if required.

6.1.6.4 Asset Revaluation and its Impact

Under the provisions of FRS3, TDHB is required to undertake an asset revaluation exercise as at 30 June each year, and recognise any material increase in land and building values, and also its impact on depreciation and capital charge.

TDHB was required to revalue its land and buildings as @ 30 June 2008 and take into consideration the future carrying values of its buildings incidental to the redevelopment of its base hospital inpatient facilities. The impact of the revaluation was a net increase of $9.01M in its current land and building values, resulting in an increase in capital charge ($740K) and depreciation ($700K). The impact ($1.44M) is already being carried in the financial statements with no corresponding funding from the MOH (as was provided on a cost neutral basis for previous revaluations).

Revaluation of land and building assets was undertaken on 30 June 2009 with no material movements noted. It is assumed that any movement in the asset base as at 30 June 2010 is not likely to be material and accordingly no provision for changes in asset values and related costs have been made.

6.1.6.5 Depreciation

Depreciation has been calculated on a straight line method for all existing assets, less disposals and recognising additions.

6.1.6.6 Capital Charge

Capital charges have been calculated in line with existing methodology, adjusted for monthly movements in operating results and closing balance of shareholders fund. There are no capital charge payments outstanding, with the exception of capital charge (full year: $740K) arising from the revaluation of assets as at 30 June 2008. This fact has been communicated to MOH, the primary reason for withholding this payment being non receipt of funding or other adjustments to the capital charge regime to meet this expenditure.

6.1.6.7 Leasing

The District Annual Plan assumes certain items of plant and equipment will be leased after evaluation on a case-by-case basis. The Plan also assumes that operating leases will be explored for capital plant and equipment which have a short economic life or are prone to rapid changes in technology. Operating leases will adhere to current guidelines and tests to clearly differentiate these from finance leases.

6.1.7 Financial Covenants and Ratios

There are no specific financial covenants stipulated by the Crown Health Financing Agency (CHFA) for its term lending to TDHB. No financial covenants have been stipulated by ASB for transactional banking and stand bye overdraft arrangements.

The following are some key financial ratios as derived from the consolidated financial statements for the period 2010 to 2013.

	Financial ratios	TDHB 2009/10	TDHB 2010/11	TDHB 2011/12	TDHB 2012/13
		forecast	plan	plan	plan
1	Revenue to net funds employed	2.96	2.83	2.21	2.28
2	Operating margin to revenue	3%	3%	4%	5%
3	Operating return on net funds employed	9%	10%	8%	11%
4	Debt to debt equity ratio	29%	36%	52%	52%
5	Interest cover ratio	4.61	5.12	5.99	4.45

6.1.7.1 Changes in Accounting Policies

There have been no changes from the accounting policies adopted in the last audited financial statements other than the changes brought about by the adoption of NZIFRS in the financial statements. All policies have been applied on a basis consistent with the previous period. These are detailed in the Statement of Intent for 2009/10.

6.1.8 Capital investment

The capital investment planned during the Business Plan period and the proposed funding lines to finance the investment are as follows:

Capital Outlay	Year 1 (2010/2011)	Year 2 (2011/2012)	Year 3 (2012/2013)	Total (2010/2013)
Operating				
Clinical Equipment	1,600	2,000	2,000	5,600
Other Equipment	350	450	450	1,250
Motor Vehicles	50	50	50	150
Minor Site Redevelopment (excluding prior year WIP)	500	500	500	1,500
SUB - TOTAL	**2,500**	**3,000**	**3,000**	**8,400**
Information Technology (100% subsidiary - HIQ Ltd)	4,000	4,000	4,000	12,000
TOTAL	**6,500**	**7,000**	**7,000**	**20,500**
Strategic				
Community Oral Health Project	545	431	-	976
Base Hospital redevelopment project	13,100	55,759	11,330	80,189
TOTAL	**13,645**	**56,190**	**11,330**	**81,165**
GRAND TOTAL	**20,145**	**63,190**	**18,330**	**101,665**
Sources of Funding				
Crown Equity	545	431	0	976
Bank Borrowing	0	0	0	0
CHFA Term Loans	13,100	31,900	0	45,000
Internal Cash Accruals	6,500	30,859	18,330	55,689

Note: Effective 01 July 2009, HIQ Ltd (previously the JV between Capital & Coast DHB and Taranaki DHB for delivery of ICT services) became a fully owned subsidiary of TDHB. Capital outlay on Information and Communication Technology (ICT) is in relation to capital investment in HIQ Ltd as a 100% subsidiary of TDHB.

6.1.8.1 Capital Divestment

The disposal of surplus assets proposed during the period 2010/13 is as follows:

Asset	Book value ($)	Realisable Value ($)	Gain/(loss) On sale ($)	Timing
Miscellaneous equipment (discarded/ obsolete)	0	Not material	-	2010/11
Surplus land	0	0	-	2010-2013
Total	**0**	**0**	**-**	

Taranaki DHB will ensure that disposal of any land transferred to, or vested in it pursuant to the Health Sector (Transfers) Act 1993 will be subject to approval by the Minister of Health. Taranaki DHB will work closely with the Office of Treaty Settlements to ensure the relevant

protection mechanisms that address the Crown's obligations under the Treaty of Waitangi and any processes relating to the Crown's good governance obligations to Mâori sites of significance are addressed.

6.1.9 Personnel

A: <u>Paid / contracted / core FTEs</u>:

The movement of "contracted/worked FTE" numbers across the Annual Plan period is assumed along the following lines:

	2009/10 forecast	**2010/11 plan**	**2011/12 plan**	**2012/13 plan**
Medical	118	137	138	140
Nursing	535	497	500	500
Allied Health	247	250	245	242
Support	88	88	86	87
Management & Admin	240	240	235	234
Average worked FTE's	**1228**	**1212**	**1204**	**1203**
Subsidiary: HIQ Ltd (Category: Mgt & admin)	**36**	**39**	**40**	**42**
Oral health + other national projects	**2**	**7**	**7**	**8**

The average worked FTE numbers for the three-year plan period are expected to be managed within the core staffing numbers indicated above.

- There is an overall decrease in total worked FTE planned for 2010/11 relative to 2009/10. Medical FTE count will increase on the assumption that vacancies are likely to be filled over the coming period in lieu of locum cover (with corresponding drop in locum costs). Reduction in nursing staff is primarily due to service changes proposed, plus review of nursing support for one on one care and the use of casuals. Movements in allied health and support staff are essentially vacancies that are likely to be filled in 2010/11. Reduction in Management and Administration staff is aimed at reduction in back office and administration staff arising from efficiency reviews and reduction in staff managed through attrition. Reduction of FTEs is a primary goal to reduce operating costs and the deficit, and the service changes proposed for 2010/11 are expected to bring FTE reductions across nursing and related areas, in conjunction with closer internal monitoring of FTE movements and deferment of vacancies.
- Taranaki DHB is currently tracking below the Ministerial cap set for management and administration staff, and expected to remain below the cap over the plan period.
- HIQ Ltd (a fully owned subsidiary of Taranaki DHB) staffing is likely to increase over the plan period, mainly due to national and shared service projects undertaken by HIQ Ltd (for which separate project specific revenue is being received). Likewise, the likely FTE's related to the Community Oral Health project are likely to follow the growth as noted.
- The baseline average worked FTE count is 1,212 FTE, 1,204 FTE and 1,203 FTE for the plan periods 2010/11, 2011/12 and 2012/13 respectively.
- In principle, the personnel budget has not planned for FTE increases – rather a phased reduction in FTEs to manage the overall wage bill carried by the DHB. Though there will be movements relating to vacancies, specific increases in clinical activity and changes in service specifications, reductions planned in other staff lines

should result in net decrease in the core FTE base. There will also be likely reductions from changes to services and models of care that are planned for 2010/11 and out years. The overall strategy is to cap and reduce core FTEs; however it is acknowledged that there is likely to be demand for clinical resources due to an expected increase in normal activity levels – both acute and elective. Additionally, as the current year statistics indicate, there has been an increase in specialling patients (one on one care) in ICU and mental health inpatient admissions. Measures and initiatives are being worked through to increase productivity of existing staff and reduce the demand for locums and casual staff within the hospital and specialist services

B: Accrued FTEs:

The corresponding average "Accrued FTE" count for the three-year plan period is as below:

	2009/10 forecast	2010/11 plan	2011/12 plan	2012/13 plan
Medical	128	148	147	149
Nursing	577	546	530	525
Allied Health	266	268	257	254
Support	95	95	93	94
Management, admin & DHB P&F	259	258	254	252
Average Accrued FTE's	**1325**	**1315**	**1281**	**1274**
Subsidiary: HIQ Ltd (Category: Mgt & admin)	**39**	**42**	**43**	**45**
Oral health + other national projects	**2**	**8**	**8**	**9**

6.2 Capital Expenditure

The capital expenditure for Year 2010/11 envisages an outlay of $6.50 M. The capital expenditure movement against the outlay for 2009/10 is:

($'000)	2009/10 (Plan)	2010/11 (Plan)	Movement (+/(-))
Clinical equipment	1,600	1,600	-
Other equipment	500	350	(150)
Motor Vehicles	50	50	-
Site redevelopment (minor)	1,350	500	(850)
SUB TOTAL	**3,500**	**2,500**	**(1,000)**
Information Technology. (HIQ Ltd)	2,000	4,000	+ 2,000
TOTAL	**5,500**	**6,500**	**+ 1,000**
Contingency	**1,000**	**1,000**	**-**

- Overall capital expenditure is budgeted to increase marginally in 2010/11 vis-a-vis the current financial year, with small movements between the expenditure lines.

  Capital outlay on Information Technology will show a material increase due to ongoing projects, hardware infrastructure and Disaster Recovery planning. Expenditure in this area will be reviewed and where necessary reprioritised in line with required implementation plans for the National IT Plan.

- The capital expenditure budget ($6.50M) is prioritised to remain within the base line depreciation for 2010/11 ($10.65M), enabling it to be financed through internal cash accruals whilst leaving sufficient contingency funds for unplanned capital expenditure and improving residual cash reserves
- Minor site redevelopment activity in 2010/11 will trend down in view of the redevelopment of the inpatient facilities commencing January 2011. The plan envisions a host of minor work across the site, primarily in clinical wards to improve work flows, meet compliance deficits, roof repairs, ventilation etc. Some capital works in progress during the current year is also likely to spill over to the next financial year. The Board will continue to seek financial support from local community trusts to progress some of the redevelopment activities proposed during the plan period 2010/11.
- The proposed outlay on clinical equipment is $1.60M, mainly replacement of obsolete and unsafe clinical equipment and continuation of a phased programme for replacement of expensive theatre equipment and beds (co-ordinated with equipment planning for the new facility).
- Proposed outlay on non clinical equipment is along similar lines as the current year, albeit marginally reduced.
- Capital outlay proposed for Information Technology investment in HIQ Ltd (100% owned subsidiary) is increased to $4.0M. The major costs relate to new applications and software projects, replacement of desktop hardware, software upgrades, new applications and storage devices. Additionally, an outlay of $0.25M is earmarked specifically towards strengthening the Disaster Recovery (DR) capabilities to balance risks against loss of computing services or in the event of a natural disaster. However major investments or material changes in applications will be undertaken in line with the strategic plan and directions spelt out by the National IT Board.
- Capital outlay on motor vehicles has reduced significantly upon completion of the vehicle replacement programme (commenced in 2005/06) for the transport fleet.
- In summary, the year 2010/11 will reflect levels of capital spending within internal cash resources. In parallel, Taranaki DHB has commenced planning for the re-development of its inpatient facilities at Base Hospital in New Plymouth, with construction scheduled to commence in January 2011. This is detailed separately.

6.2.1 Capital Expenditure 2010/11 (strategic)

6.2.1.1 Community oral health project

The capital expenditure related to the rollout of the community oral health project is being separately funded by the MOH in line with an approved business case. The total capital outlay is $3.04M to be invested in fixed and mobile dental facilities, and related clinical equipment. Construction of fixed facilities has commenced, whilst orders have been placed for the mobile units. Of the total, $2.07M is expected to be spent during 2009/10, with the balance to be spent in 2010/11 ($0.55M) and 2011/12 ($0.43M).

6.2.1.2 Base Hospital Inpatient Facilities Development Programme (Project Maunga)

The business case for the redevelopment of the Base Hospital inpatient facilities was approved in July 2008. Since then the planning for the facility has been in progress, and currently has reached the detailed design phase. Construction is scheduled to commence in January 2011 and expected to be completed by June 2012.

The primary focus of this project is to generate efficiencies and improvements to prevalent models of care through consolidation of hospital services and systems into a more compact

footprint, which will lend more flexibility and efficiency to operations both in the immediate and long term. In doing so, it will also provide a more user friendly hospital and wellness environment to patients, staff and public.

Proposed Capital Outlay

This programme presents a staged redevelopment of the Base Hospital core inpatient facilities and support systems, such that it is both financially and operationally feasible over a defined timeline. The components of the programme are as follows:

Stages	Comprising	Estimated Cost	Construction Timeline	Status
1 **STAGE 1**	Theatres, Ambulatory, Inpatient wards	$80M	Start: Jan 2011 Finish: Jun 2012	Approval received in July 2008.
2 **STAGE 2**	Maternity, Neonatal, Paediatrics, ED	$37M	Tentative: Jul 2013	Supplementary business case will be progressed later
3 **STAGE 3**	OPD, Laboratory, CSD, Administration	$28M	Tentative : Jul 2015	Supplementary business case will be progressed later
TOTAL		**$145M**	**Jan 2011 – Dec 2016**	

Notes:

1. Approval and confirmation of funding has been received for Stage 1 only.
2. Stages 2 and 3 are discrete components of the overall Master Plan for the redevelopment of inpatient facilities at the Base Hospital.
3. Once Stage 1 is nearing completion it is envisaged that supplementary business cases will be developed for each of the remaining stages and forwarded to NCC for approval and funding.
4. In short, each of the stages can be visualised as stand alone projects, yet forming part of one coherent facilities redevelopment programme for the Base Hospital in New Plymouth, thus enabling affordability to both Taranaki DHB and the National health capital budget.

Financing Plan for Stage 1:

The plan for financing Stage 1 is as follows:

	($M)	Notes
* **Project capital cost**	**$80M**	QS estimate based on concept design.
* Internally generated funds	$35M	- Free cash flows + retained surpluses
* Net external borrowing	$45M	- Fresh borrowing as term debt
Source:		
Crown Health Financing Agency (CHFA)	$45M	- Un-utilised facility = $2.00M - New term debt = $43.00M
NET EXTERNAL FUNDING	**$45 M**	**- equivalent to 56% of project cost**

Notes:

Project capital cost:

1. The cost of the project is based on the concept design, with the cost estimate prepared by Rider Levett Bucknall (Quantity Surveyors) as at August 2007.
2. The project capital includes the cost of site preparations, construction, building infrastructure, design and consultant fees, project management, fit-outs and the costs associated with decanting.
3. The above costs exclude capitalised interest on $45M term loan. Interest will be capitalised at the relevant cost of borrowing up to the date of commissioning the facilities.
4. This cost estimate has been independently reviewed and revisions incorporated as appropriate.

Internally generated funds:

5. TDHB has over the recent years built up cash reserves from its annual operating surpluses. These cash reserves together with base line depreciation reserves have enabled it to be an equal partner in this development. The internal investment of $35M (44% of project capital cost) is a combination of current cash reserves +
6. future free cash flows plus donations from local community trusts and organisations. TDHB is committed and confident of generating the necessary investment by the time the project reaches the active phase. Additionally, TDHB will rationalise its annual base line capital expenditure over the immediate following financial periods with the aim of generating as much cash flow as possible to support the project.
7. Contingency cash lines are on standby in the form working capital facilities (uncommitted) with ASB Bank. Whilst, it is acknowledged that this line of credit is not permitted for capital purposes, it nonetheless provides backup liquidity should it be required.

Net external borrowing and source:

8. It is TDHB's intention to borrow $45M in the form of debt financing. Financial analysis indicates that with the current CHFA financed debt ($ 29M) + fresh borrowing ($ 45M); the debt equity ratio (currently 29%) is able to be maintained within an acceptable range.
9. CHFA has advised TDHB that the term loan of $43m (with the balance $ 2M to come from the unutilised limit with CHFA) has been approved by their Board and draft loan facility and related documents have been completed by TDHB. Tentative timelines for draw down of the approved facility has been drawn up, which subject to final peer review and approval of the detailed design is expected to be activated around January 2011. The lending quantity surveyor (LQS) appointed by CHFA has completed site visits and has communicated his satisfaction of the progress to date.

Key dates and timelines

Project planning and related activities are progressing satisfactorily. The tentative dateline for construction to commence is January 2011.

Asset Management Plan (AMP)

The first AMP for Taranaki DHB was completed and forwarded for review in October 2005, with subsequent reviews and updates. An inpatient facilities redevelopment programme has been developed to support the planned clinical and health services by the secondary services and linkages with primary services. Stage 1 of the programme has been given approval to proceed, with allocation of funding to support the redevelopment. Whilst the AMP is an evolving document and strategic in content, it will be matched against the projected financial capability of the DHB to support the development programme, besides

integration and co-ordination with the capital investment plans of regional and neighbouring DHBs. An updated AMP will be provided in 2010 in line with the national timetable.

6.2.2 Efficiency and Productivity Improvements

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope. In addition, it has to balance its long-term strategies with short-term objectives while continuing to provide a clinically safe and quality service. The DHB will also be faced with managing the redevelopment of its base hospital facilities scheduled to commence in the 2010/11 fiscal year. Under this capped environment, with increasing operating costs and demand for services, the hospital provider arm will need to achieve sustainability – both clinical and financial. Taranaki DHB recognises the need for continuous service improvements and efficiency gains while it attempts to re-position itself continually to meet the challenge.

The strategy is to continuously progress short term initiatives and service reviews to provide immediate gains, while progressing a series of more strategic and fundamental structural changes to achieve longer term sustainability. The latter is needed to rationalise the growth in demand for services and operating costs, besides the need to arrest and reduce the financial deficit.

The following key initiatives are planned during 2010/11 within the hospital provider operations to generate efficiency gains and reduce operating costs:

	Initiative	Proposal	Potential ($)	Impact
1	Reduction of outsourced services costs	Bringing in-house services currently outsourced	$ 650K	Reduce service cost
2	Manage Clinical supply costs.	Efficiency reviews + contract negotiations + VFM initiatives	$ 250K	Contain cost growth
3	Staffing reviews and alignment of services to funding + FTE's.	Efficiency & process reviews + reduction of FTE's	$ 600K	Contain cost growth + FTE reduction
4	Reduce General Operating overheads	Internal cost controls + capped budgets	$ 300K	Contain cost growth
5	Management of FTE's through vacancies and attrition.	Active review and FTE reduction by attrition.	$ 200K	Contain cost growth + FTE reduction
	TOTAL		**$ 2.0 Million**	

The DAP 2010/11 has recognised the efficiency and reduced cost impacts of the above initiatives in the financial budget. The gains from these initiatives are also expected to flow into future periods and have been recognised in the out years.

In parallel, the focus is on the redevelopment of the facilities. A significant aim of this project is to generate efficiencies and improvements to prevalent models of care through consolidation of hospital services and systems into a more compact footprint. This will in turn lend more flexibility and efficiency to operations. Overall, the project should generate more permanent and sustainable results.

Faced with a cost to funding gap in its operating budget, the hospital provider arm will continue to further explore all practical options with the aim of reducing its overall cost of services delivery, whilst improving productivity and efficiency of operations. This will involve some hard decisions on changing the models of care and service delivery across the two hospitals and health centres – this being the only option to reduce operating costs. This financial recovery plan is an ongoing process, will involve partnering with primary sector

providers and is expected to span more than one fiscal year in view of their strategic components and broader implications.

6.2.3 Debt and Equity

The current debt profile of Taranaki DHB is four term loans totalling $29M with the Crown Health Financing Agency (CHFA), drawn down against an approved loan limit of $31M. The primary assumptions carried in the financial plan 2010/11 are:

a. No overdraft borrowing for working capital requirements is envisaged (though a backup facility with ASB is available if required – financial covenants will be stipulated only upon commitment and utilisation of this facility), on the assumption that TDHB will remain under “standard monitoring” and continue to receive it’s funding in advance.

b. The draft DAP 2010/11has not budgeted for any additional equity (other than capital funding of $ 3.04M in total for the community oral health project which is being treated as equity injection) or debt. It is expected that base line capital expenditure will be contained within the level of depreciation for 2010/11. Additional borrowing from CHFA ($ 45M) to partially finance the first stage of the Base Hospital redevelopment has been approved, and subject to final reviews and costings of the final design is planned to be drawn down over the 2010/11 and 2011/12 plan periods.

c. The operating budget of the Board for 2010/11 has planned for a consolidated financial breakeven, before recognising the impact of expenditure against prior period surpluses in workforce development and strategic projects. The financial breakeven is assumed in context of the financial risks and sensitivity indices highlighted in the plan, and exploration of options to manage the financial risks carried primarily in the Hospital provider and the DHB Funder operations.

d. It is assumed that from an operational perspective, realistically the timing for realisation of all the cost reductions contemplated in the hospital services operations may extend beyond a 12 month financial planning framework. Any residual operating deficit (in addition to the deficit arising from expenditure on strategic projects and initiatives) arising from a timing perspective will be managed from internal cash reserves. No additional equity or deficit support is envisaged.

6.2.4 Sensitivity Analysis

The District Annual Plan has outlined some key financial risks and while it is difficult to quantify all these risks with accuracy, the likely impacts on the bottom line if these were to materialise is factored below:

DHB Hospital Provider operations:

Unbudgeted financial risk	Est. risk ($M)	75% risk ($M)	50% risk ($M)	25% risk ($M)	Probability factor (% risk)
General Wages + MECA impacts	0.40	**0.30**	0.20	0.10	75%
Outsourced locum costs	1.00	**0.75**	0.50	0.25	75%
Diagnostic costs	0.20	**0.15**	0.10	0.05	75%
Clinical supplies	0.30	0.22	**0.15**	0.08	50%
General overheads	0.90	**0.68**	0.45	0.22	75%
Likely impact on 2010/11 planned financial result	**$2.80M**	**$2.10M**	**$1.40M**	**$0.70M**	**$2.03M**

The analysis estimates an overall exposure of circa **$2.80M** for 2010/11, which could arise from a combination of cost drivers as identified above. The overall probability factor is estimated to be around 75% leaving a residual risk equating to about **$2.0M.** The risk is expected to be managed through a mix of:

- Internal cost controls,
- Management of FTEs,
- Operational savings in discretionary expense lines through capped budgets,
- Gains from SSEB/National cost reduction programmes and initiatives
- Achievement of internal efficiency projects and service reviews,
- Other strategic options (under consideration by the TDHB Board).

DHB Funder operations:

Unbudgeted financial risk	Est. risk ($'M)	75% risk ($'M)	50% risk ($'M)	25% risk ($'M)	Probability factor (% risk)
IDF Outflows	0.5	0.375	**0.25**	0.125	50%
CFA funding (not confirmed)	4.0	3.0	**2.00**	1.00	50%
Delay in implementation of planned service changes	2.5	1.875	**1.25**	0.625	50%
Likely impact on 2010/11 planned financial result	**7.00M**	**5.25M**	**3.50M**	**1.75M**	**3.50M**

The overall exposure is estimated at around **$7.0 million** for 2010/11, while the probability factor is estimated to be around 50% leaving a residual risk equating to about **$3.50 million**.

These risks are expected to be managed through contract monitoring and efficiency gains from current NGO contracts.

APPENDIX 1 –List of Acronyms

CE	Crown Entities Act
CFA	Crown Funding Agreement
DAP	District Annual Plan
DHB	District Health Board
DSP	District Strategic Plan
GAAP	Generally accepted accounting principles
HNA	Health Needs Assessment
IQ	Improving Quality
LTSF	Long Term System Framework
MoH	Ministry of Health
NZPHD	New Zealand Public Health and Disability Act
OAG	Office of the Auditor General
SCS	Service Coverage Schedule
SFSP	Statement of Forecast Service Performance
SOI	Statement of Intent
SSC	State Services Commission

APPENDIX 2 – Sector Led Definitions: Output Classes

Hospital Services

Comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialized equipment. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services

Emergency Department services including triage, diagnostic, therapeutic and disposition services

Primary and Community Healthcare Services

Comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

Public Health Services

Are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from the curative services which repair/support health and disability dysfunction.

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public Health services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protections services such as immunisation and screening services.

Support Services

Comprise services that are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services.

APPENDIX 3 – Glossary of Terms

Activity	What an agency does to convert inputs to Outputs.
Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government's goals.
Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister. One of the three types of statutory entities (see also Crown entity; autonomous Crown entity and independent Crown entity)
Crown entity	A generic term for a diverse range of entities within 1 of the 5 categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
Effectiveness	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. E.g. The change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989)
Impact measures	Impact measures are attributed to agency (DHBs) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can be measured after delivery, promoting timely decisions; reveal specific ways in which managers can remedy performance shortfalls. (http://www.ssc.govt.nz/upload/downloadable_files/performance-measurement.pdf)
Input	The resources such as labour, materials, money, people, information technology used by departments to produce outputs, that will achieve the Government's stated outcomes. (http://www.ssc.govt.nz/glossary/)

Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group. (refer (http://www.ssc.govt.nz/glossary/)
Intervention logic model	A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes (refer State Services Commission 'Performance Measurement – Advice and examples on how to develop effective frameworks: www.ssc.govt.nz)
Intermediate outcome	See Outcomes
Management systems	Are the supporting systems and policies used by the DHB in conducting its business.
Measure	A measure identifies the focus for measurement: it specifies what is to be measured
Objectives	is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve "outputs" . E.g. Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving relationships; improving Governance…etc are 'internal to the organisation and enable the achievement of 'outputs'.
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to a end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. (Refer http://www.ssc.govt.nz/glossary/) A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989)
Output agreement	Output agreement/output plan - See Purchase Agreement (refer to http://www.ssc.govt.nz/glossary/) An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs (see s170 (2) CE Act 2004

Output classes

are an aggregation of outputs. (Public Finance Act 1989)

Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) CE Act 2004). are groups of similar outputs (Public Finance Act 1989)

Outputs

are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004)

Ownership

The Crown's core interests as 'owner' can be thought of as:

Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown;

Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future;

Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively.

(refer http://www.ssc.govt.nz/glossary/)

Performance measures

Selected measures must align with the DHBs DSP and DAP. The use four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2010/11) and show intended results for the two subsequent financial years.

(refer to www.ssc.govt.nz/performance-info-measures)

Priorities

Statements of medium term policy priorities

Purchase agreement

A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs. Some departments piloting new accountability and reporting arrangements now prepare an output agreement. An output agreement extends a purchase agreement to include any outputs paid for by third parties where the Minister still has some responsibility for setting fee levels or service specifications. The Review of the Centre has recommended the development of output plans to replace departmental purchase and output agreements. (refer http://www.ssc.govt.nz/glossary/)

Results

Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once.

(http://www.ssc.govt.nz/glossary/)

Term	Definition
SMART	S.M.A.R.T refers to the acronym that describes the key characteristics of meaningful objectives, which are **S**pecific (concrete, detailed, well defined), **M**easureable (numbers, quantity, comparison), **A**chievable (feasible, actionable), **R**ealistic (considering resources) and **T**ime-Bound (a defined time line). Lets look at these characteristics in more detail. SMART objective then are the stepping stones to the achievement of our goals
Standards of Service Measures	Measures of the quality of service to clients focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.
Statement of Intent	A document that identifies, for the medium term, the main features of intentions regarding strategy, capability and performance. SOIs are developed after discussion between an entity and its Minister(s). Crown entities on the Sixth Schedule to the Public Finance Act prepare an SOI that covers medium term financial and performance intentions. After being finalised, the SOI is tabled in Parliament. (http://www.ssc.govt.nz/glossary/)
Statement of service performance (SSP)	Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. (http://www.ssc.govt.nz/glossary/)
Strategy	See Ownership (http://www.ssc.govt.nz/glossary/)
Targets	Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.
Values	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. (http://www.ssc.govt.nz/glossary/)

APPENDIX 4 – Financial Statements

TARANAKI DISTRICT HEALTH BOARD
STATEMENT OF COMPREHENSIVE INCOME
DISTRICT ANNUAL PLAN : 2010/13

($'000)

	Year -1	*FORECAST*		Year 0					Year 1
	Consolidated	Hosp+Gov	Funder	Consolidated	Provider	Governan:	Hosp+Gov	Funder	Consolidated
	Audited	Forecast	Forecast	Forecast	Plan	Plan	Plan	Plan	Plan
	2008/09	2009/10	2009/10	2009/10	2010/11	2010/11	2010/11	2010/11	2010/11
REVENUE									
* MOH funding	143403	147567		147567	150714	0	150714		150714
	124039		131260	131260				135302	135302
* Funding & Governance	2163	2230		2230	0	2370	2370		2370
* ACC Revenue	8268	8593		8593	7009	0	7009		7009
* CTA revenue	1619	2075		2075	2255	0	2255		2255
* Other revenue	9747	5534	4100	9634	5511	0	5511	4714	10225
TOTAL REVENUE	289239	165999	135360	301359	165489	2370	**167859**	140016	307875
EXPENDITURE									
Personnel costs									
- medical	22110	23588		23588	26436	0	26436		26436
- nursing	37191	39211		39211	39236	0	39236		39236
- allied health	15444	15314		15314	16998	0	16998		16998
- support	3883	3767		3767	4120	0	4120		4120
- mgt & admin	14023	16620		16620	16543	1187	17730		17730
total	92651	98500	0	98500	103333	1187	**104520**	0	104520

	Year -1	*FORECAST*		Year 0					Year 1
	Consolidated Audited 2008/09	**Hosp+Gov Forecast 2009/10**	**Funder Forecast 2009/10**	**Consolidated Forecast 2009/10**	**Provider Plan 2010/11**	**Governan: Plan 2010/11**	**Hosp+Gov Plan 2010/11**	**Funder Plan 2010/11**	**Consolidated Plan 2010/11**
Outsourced services									
- clinical services	19416	19882		19882	17990	0	17990		17990
- other outsourced	3546	4419		4419	2277	175	2452		2452
total	22962	24301	0	24301	20267	175	**20442**	0	20442
Clinical supplies									
- treatment disposables	7670	8066		8066	8073	0	8073		8073
- diagnostic supplies	1248	1255		1255	1277	0	1277		1277
- instruments & equip	567	884		884	826	0	826		826
- patient appliances	1069	1056		1056	1068	0	1068		1068
- implants & prostheses	2730	2599		2599	2429	0	2429		2429
- pharmaceuticals	4169	4051		4051	4230	0	4230		4230
- other clinical & client costs	2649	2716		2716	2814	0	2814		2814
total	20102	20627	0	20627	20717	0	**20717**	0	20717
Infrastructure & other op.costs									
- hotel services & laundry	3054	3302		3302	3292	1	3293		3293
- facilities	3154	3090		3090	3398	0	3398		3398
- transport	1017	1105		1105	971	34	1005		1005
- IT systems & telecom	6598	1101		1101	825	0	825		825
- professional fees	1475	1963		1963	1686	126	1812		1812
- other op.expenses	1188	1167		1167	1087	414	1501		1501
- democracy	249	281		281	1	352	353		353
- depreciation	8343	10328		10328	10650	0	10650		10650
- interest	2054	2048		2048	2029	0	2029		2029

	Year -1	FORECAST		Year 0					Year 1
	Consolidated Audited 2008/09	**Hosp+Gov Forecast 2009/10**	**Funder Forecast 2009/10**	**Consolidated Forecast 2009/10**	**Provider Plan 2010/11**	**Governan: Plan 2010/11**	**Hosp+Gov Plan 2010/11**	**Funder Plan 2010/11**	**Consolidated Plan 2010/11**
- Payment to - NGO providers									
- personal health	79095		85612	85612				86767	86767
- mental health	9052		8264	8264				9393	9393
- disability support services	31004		33177	33177				33584	33584
- public health	242		333	333				21	21
- Māori health	1205		1670	1670				1376	1376
total	147730	24385	129056	153441	23939	927	**24866**	131141	156007
TOTAL OPERATING EXPENSES	**283445**	**167813**	**129056**	**296869**	168256	2289	**170545**	131141	301686
SURPLUS before capital charge	**5794**	**1814**	**6304**	**4490**	**-2767**	**81**	**-2686**	**8875**	**6189**
- Capital charge	5715	5934		5934	6038	0	6038		6038
SURPLUS (before strategic exp)	**79**	**-7748**	**6304**	**-1444**	**-8805**	**81**	**-8724**	**8875**	**151**
<u>STRATEGIC EXPENDITURE</u>									
Mental health Ring-fenced surplus	**112**		**843**	**843**				**0**	**0**
Workforce Development	**337**		**394**	**394**				**100**	**100**
Māori Health Gains Project	**162**		**60**	**60**				**600**	**600**
Hospital Provider Strategic Projects	**0**		**0**	**0**				**1750**	**1750**
NET SURPLUS/(DEFICIT) (after strategic expenditure)	**-532**	**-7948**	**5007**	**-2741**	**-8805**	**81**	**-8724**	**6425**	**-2299**
<u>OTHER COMPREHENSIVE INCOME</u>									
*Gain/(Loss) on asset revaluation	0	0		0	0				0
*Gain/(Loss) on sale of assets	1	-201		-201	0				0

	Year -1	*FORECAST*		Year 0					Year 1
	Consolidated	Hosp+Gov	Funder	Consolidated	Provider	Governan:	Hosp+Gov	Funder	Consolidated
	Audited	Forecast	Forecast	Forecast	Plan	Plan	Plan	Plan	Plan
	2008/09	2009/10	2009/10	2009/10	2010/11	2010/11	2010/11	2010/11	2010/11
*Share of surplus/(loss) from associates	-123	0		0	0				0
Total other Comprehensive Income	**-122**	**-201**	**0**	**-201**	**0**	**0**	**0**	**0**	**0**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**-654**	**-7949**	**5007**	**-2942**	**-8805**	**81**	**-8724**	**6425**	**-2299**
Interest Cover ratio	**4.74**			**4.61**					**5.12**
Revenue to Net Funds employed	**2.79**	**1.63**		**2.96**	**1.52**				**2.83**
Operating margin to Revenue ratio	**3%**	**3%**		**3%**	**2%**				**3%**
Op. return on Net Funds employed	**9%**	**4%**		**9%**	**4%**				**10%**

TARANAKI DISTRICT HEALTH BOARD

DISTRICT ANNUAL PLAN : 2010/13 ($'000)

	Provider Plan 2011/12	Governan: Plan 2011/12	Funder Plan 2011/12	Year 2 Consolidated Plan 2011/12	Provider Plan 2012/13	Governan: Plan 2012/13	Funder Plan 2012/13	Year 3 Consolidated Plan 2012/13
REVENUE								
* MOH funding	153728			153728	156803			156803
			138007	138007			140767	140767
* Funding & Governance		2417		2417		2466		2466
* ACC Revenue	7149			7149	7292			7292
* CTA revenue	2300			2300	2373			2373
* Other revenue	6920		4808	11728	9890		4904	14794
TOTAL REVENUE	170097	2417	142815	315330	176358	2466	145672	324495
EXPENDITURE								
Personnel costs								
- medical	26919			26919	27261			27261
- nursing	39884			39884	40102			40102
- allied health	17287			17287	17415			17415
- support	4202			4202	4286			4286
- mgt & admin	16875	1211		18086	17213	1235		18448
total	105167	1211	0	106377	106278	1235	0	107513

	Year 2				Year 3			
	Provider	Governan:	Funder	Consolidated	Provider	Governan:	Funder	Consolidated
	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	2011/12	2011/12	2011/12	2011/12	2012/13	2012/13	2012/13	2012/13
Outsourced services								
- clinical services	18168			18168	17759			17759
- other outsourced	2323	179		2501	2369	182		2551
total	20490	179	0	20668	20128	182	0	20310
Clinical supplies								
- treatment disposables	8199			8199	8213			8213
- diagnostic supplies	1303			1303	1329			1329
- instruments & equip	843			843	860			860
- patient appliances	1089			1089	1111			1111
- implants & prostheses	2478			2478	2528			2528
- pharmaceuticals	4315			4315	4401			4401
- other clinical & client costs	2868			2868	2925			2925
total	21094	0	0	21094	21367	0	0	21367
Infrastructure & other op.costs								
- hotel services & laundry	3358	1		3359	3425			3426
- facilities	3466			3466	3535			3535
- transport	990	35		1025	1010	36		1047
- IT systems & telecom	842			842	859			859
- professional fees	1720	129		1848	1754	132		1886
- other op.expenses	951	424		1375	833	427		1260
- democracy	1	359		360	1	366		367
- depreciation	10650			10650	11894			11894
- interest	2012			2012	3587			3587

	Year 2				Year 3			
	Provider	Governan:	Funder	Consolidated	Provider	Governan:	Funder	Consolidated
	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	2011/12	2011/12	2011/12	2011/12	2012/13	2012/13	2012/13	2012/13
- Payment to - NGO providers								
- personal health			91039	91039			94264	94264
- mental health			9581	9581			9772	9772
- disability support services			34256	34256			34941	34941
- public health			21	21			22	22
- Māori health			1416	1416			1456	1456
total	23989	948	136313	161250	26898	962	140455	168316
TOTAL OPERATING EXPENSES	170741	2337	136313	309390	174672	2379	140455	317506
SURPLUS before capital charge	**-643**	**81**	**6503**	**5940**	**1686**	**86**	**5217**	**6989**
- Capital charge	5854	0		5854	5804	0	0	5804
SURPLUS (before strategic exp)	**-6497**	**81**	**6503**	**86**	**-4118**	**86**	**5217**	**1185**
STRATEGIC EXPENDITURE								
Mental health Ring-fenced surplus			**0**	**0**			**0**	**0**
Workforce Development			**100**	**100**			**100**	**100**
Māori Health Gains Project			**600**	**600**			**600**	**600**
Hospital Provider Strategic Projects			**0**	**0**			**0**	**0**
NET SURPLUS/(DEFICIT) (after strategic expenditure)	**-6497**	**81**	**5803**	**-614**	**-4118**	**86**	**4517**	**485**
OTHER COMPREHENSIVE INCOME								
*Gain/(Loss) on asset revaluation	0			0	0			0
*Gain/(Loss) on sale of assets	0			0	0			0

	Year 2				Year 3			
	Provider	Governan:	Funder	Consolidated	Provider	Governan:	Funder	Consolidated
	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	2011/12	2011/12	2011/12	2011/12	2012/13	2012/13	2012/13	2012/13
*Share of surplus/(loss) from associates	0			0	0			0
Total other Comprehensive Income	**0**			**0**	**0**			**0**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	**-6497**	**81**	**5803**	**-614**	**-4118**	**86**	**4517**	**485**
Interest Cover ratio				**5.99**				**4.45**
Revenue to Net Funds employed	**1.19**			**2.21**	**1.24**			**2.28**
Operating margin to Revenue ratio	**4%**			**4%**	**7%**			**5%**
Op. return on Net Funds employed	**4%**			**8%**	**8%**			**11%**

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2010-11

CONSOLIDATED STATEMENT OF FINANCIAL POSITION

($'000)

	2008/09 audited	2009/10 forecast		2010/11 plan	2011/12 plan	2012/13 plan
CURRENT ASSETS						
* Bank Account	3321	3504		3229	3214	3199
* Prepayments +ST investments	31162	29050		29050	6550	50
* Debtors (net of provision)	7432	6450		6810	6910	7010
* Inventory	2527	2465		2465	2465	2465
	44442	41469		41554	19139	12724
CURRENT LIABILITIES						
* Creditors & other payables	20167	19066		20447	16372	16455
* Term Loans (current portion)	244	273		189	90	37
* Provisions	18262	19435		20535	21035	21535
	38673	38774		41171	37497	38027
WORKING CAPITAL	5769	2695		383	-18358	-25303
NON CURRENT ASSETS						
* Net Fixed Assets	91059	97202		106693	159232	165671
* Investments	6089	1132		1089	1079	1079
* Trust funds	723	723		723	723	723
	97871	99057		108505	161034	167473
NET FUNDS EMPLOYED	**103640**	**101752**		**108888**	**142676**	**142170**

	2008/09 audited	2009/10 forecast		2010/11 plan	2011/12 plan	2012/13 plan
NON CURRENT LIABILITIES						
* Provisions - non current	670	750		750	750	750
* Finance Leases (Term portion)	386	253		102	32	0
* Term Loans	29000	29000		39000	74000	74000
	30056	30003		39852	74782	74750
CROWN EQUITY						
* Crown Equity	23191	24298		23884	23356	22397
* Reserves	52628	52628		52628	52628	52628
* Retained earnings	-2235	-5177		-7476	-8090	-7605
	73584	71749		69036	67894	67420
NET FUNDS EMPLOYED	**103640**	**101752**		**108888**	**142676**	**142170**
Debt: Debt equity ratio	29%	29%		36%	52%	52%

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2009-13

CONSOLIDATED STATEMENT OF CASHFLOWS

($'000)

	2008/09 audited	2009/10 forecast		2010/11 plan	2011/12 plan	2012/13 plan
OPERATING ACTIVITIES						
* MOH funding	274638	284154		290281	296353	302309
* Other revenue	15299	16343		15159	17462	21771
total receipts	289937	300497		305440	313815	324080
* Payment of salaries & operating exp.	159133	161640		164800	167725	170426
* Payment to providers & DHB's	121286	132153		132243	141144	141107
total payments	280419	293793		297043	308869	311533
NET CASHFLOW FROM OPERATIONS	**9518**	**6704**		**8397**	**4946**	**12547**
INVESTING ACTIVITIES						
* Interest Received	2716	1884		2075	1415	315
* Sale of fixed assets etc	18	0		0	0	0
* (Increase) / decrease in investments	-9458	6957		43	22510	6500
* Capital expenditure	-4671	-16365		-20141	-63189	-18333
NET CASHFLOW FROM INVESTING	**-11395**	**-7524**		**-18023**	**-39264**	**-11518**

($'000)

	2008/09 audited	2009/10 forecast		2010/11 Plan	2011/12 plan	2012/13 plan
FINANCING ACTIVITIES						
* Equity injections / repayments	-707	1107		-414	-528	-959
* Borrowings	114	0		10000	35000	0
* Payment of debts	-180	-104		-235	-169	-85
NET CASHFLOW FROM FINANCING	**-773**	**1003**		**9351**	**34303**	**-1044**
Total cash in	289164	301500		314791	348118	323036
Total cashout	-291814	-301317		-315066	-348133	-323051
NET CASHFLOW	**-2650**	**183**		**-275**	**-15**	**-15**
Add: Cash (opening)	5971	3321		3504	3229	3214
CASH (CLOSING)	**3321**	**3504**		**3229**	**3214**	**3199**

TARANAKI DISTRICT HEALT BOARD
DISTRICT ANNUAL PLAN : 2010-13

CONSOLIDATED STATEMENT OF MOVEMENT IN EQUITY

	2009/10 forecast		2010/11 plan	2011/12 plan	2012/13 plan
EQUITY AT THE BEGINNING OF PERIOD	**73584**		**71749**	**69036**	**67894**
* Net results for the period	-2942		-2299	-614	485
* Revaluation of Fixed assets	0		0	0	0
* Equity Injections / (repayments)	1107		-414	-528	-959
* Other	0		0	0	0
EQUITY AT THE END OF THE PERIOD	**71749**		**69036**	**67894**	**67420**

APPENDIX 5 – An example of mapping Purchase Unit Codes to Output Classes

Clean PU	PF Purchase Unit Code Description	Purchase Unit Definition	Unit of Measure Definition	Category	GL Code	Output Class
ADJ101	Severity/Complexity Adjuster - Medical/Surgical	Severity and Complexity pricing adjuster for National Medical & Surgical Purchase units.	Price adjustment for cost elements not funded adequately under national purchase unit base prices.	Adjuster	6288	Hospital
ADJ102	Severity/Complexity Adjuster - Neonatal	Severity and Complexity pricing adjuster for National Neonatal Purchase units.	Price adjustment for cost elements not funded adequately under national purchase unit base prices.	Adjuster	6288	Hospital
ADJ103	Rural Premium	Price adjuster for costs related to rurality (sparsity) and provincialism for RDL 1-4 facilities, not covered by base national purchase units.	Price adjustment for cost elements not funded adequately under national purchase unit base prices.	Adjuster	6288	Hospital
ADJ104	Diseconomies of Scale Premium (3 & 4)	Price adjuster for costs related to diseconomies of scale for RDL 3 & 4 facilities, not covered by base national purchase units.	Price adjustment for cost elements not funded adequately under national purchase unit base prices.	Adjuster	6288	Hospital
ADJ105	Diseconomies of Scale Premium (1 & 2)	Price adjuster for costs related to diseconomies of scale for RDL 3 & 4 facilities, not covered by base national purchase units.	Price adjustment for cost elements not funded adequately under national purchase unit base prices.	Adjuster	6288	Hospital
ADJ106	Māori Health Adjuster	Price adjuster for costs related to providing culturally appropriate services, in facilities that provide health services to areas with high Māori populations, not covered by base national purchase units	Price adjustment for cost elements not funded adequately under national purchase unit base prices.	Adjuster	6288	Hospital
ADJ107	Cost of Capital Adjustment	Adjustment to reflect re-allocation of cost of capital calculation by applying sector weighted average cost of capital on the basis of DHB specific debt and equity.	Price adjustment for cost elements not funded adequately under national purchase unit base prices.	Adjuster	6288	Hospital

Clean PU	PF Purchase Unit Code Description	Purchase Unit Definition	Unit of Measure Definition	Category	GL Code	Output Class
ADJ109	Acute and Demographic Adjuster	Adjustment to reflect allocation of dollars for risk management of acute demand and development of programmes to alleviate increasing demand	Increment to recognise local pressures on demand for acute services	Adjuster	6288	Hospital
ADJ110	Price Adjuster for Blood	Adjustment to reflect additional price increase by NZBS after 2000 prices were calculated. Inpatient portion will be absorbed into the current specifications for WIESNZ as published on the NZHIS website/NSFL. Adjustment for outpatient services will need to be kept until those prices are also adjusted.	Price adjustment for increased blood costs	Adjuster	6288	Hospital
ADJ111	Offer Adjuster	Price adjustment for reconciling item with Funding Envelope	Price adjustment for cost elements not funded adequately under national purchase unit base prices. E.g. Non Resident ACC and CFA Adjustments.	Adjuster	6288	Overheads to be manually allocated
ADJ115	Out reach clinic adjuster	Price adjustment for providing outreach clinics	Price adjustment for providing outreach clinics	Adjuster	6228	Overheads to be manually allocated
ADJ113	Non Resident Bad Debts	Government funding for bad debts associated with non-residents (non -eligible people) to DHBs for personal health services.	Agreed lump sum amount. Service purchased in a block arrangement.	Adjuster	6288	Hospital
ADJ114	Paediatric Cardiac Inpatient	Paediatric Cardiac Inpatient Price Adjustment	Provision of additional funding to cover the additional costs of inpatient Paediatric Cardiac cases	Adjuster	6288	Hospital

Clean PU	PF Purchase Unit Code Description	Purchase Unit Definition	Unit of Measure Definition	Category	GL Code	Output Class
ADJ112	PICU Retrieval/Boarders	Retrieval of paediatric (med/surg) cases requiring PICU specialist services at Starship Hospital. Purchase unit includes the retrieval of boarders to accommodate other tertiary DHB ICU units that are at capacity for accommodating paediatric cases needing intensive care				Hospital
S60006	Extreme complex burns severity payment	This is a top up payment on a case-by case basis on application and approval by ACC				Hospital
AH01001	Dietetics	Dietician services provided in an outpatient or domiciliary setting to DSS,HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Number of contacts with a client in a clinic/department/assessment unit or domiciliary.	Allied Health	6264	Primary & Community
AH01003	Occupational Therapy	Occupational Therapy services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Number of contacts with a client in a clinic/department/assessment unit or domiciliary.	Allied Health	6264	Primary & Community
AH01004	Orthoptist	Orthoptist services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Number of contacts with a client in a clinic/department/assessment unit or domiciliary.	Allied Health	6264	Primary & Community

Clean PU	PF Purchase Unit Code Description	Purchase Unit Definition	Unit of Measure Definition	Category	GL Code	Output Class
AH01005	Physiotherapy	Physiotherapy services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients..	Number of attendances to a clinic, day ward, department, or acute assessment unit.	Allied Health	6264	Primary & Community
AH01006	Podiatry	Podiatry services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients.	Number of contacts with a client in a clinic/department/assessment unit or domiciliary.	Allied Health	6264	Primary & Community
AH01007	Social Work	Social work services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients..	Number of contacts with a client in a clinic/department/assessment unit or domiciliary.	Allied Health	6264	Support
AH01008	Speech Therapy	Speech therapy services provided in an Outpatient or domiciliary setting to DSS, HOP and personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients..	Number of contacts with a client in a clinic/department/assessment unit or domiciliary.	Allied Health	6264	Primary & Community
AH01009	Prosthetic Eyes	Assessment and treatment service to individuals who require prosthetic eyes. Includes manufacture, fitting and monitoring.	Building and fitting of a prosthetic when done in an outpatient setting.	Allied Health	6264	Support

Clean PU	PF Purchase Unit Code Description	Purchase Unit Definition	Unit of Measure Definition	Category	GL Code	Output Class
AH01010	Psychologist Services - Non Mental Health	Psychology services provided by Psychologists in an Outpatient or domiciliary setting to personal health clients. Includes post discharge services and other DHB referrals as well as community-referred clients. Excludes services provided for Mental Health. See also COOC0074	Number of attendances to a clinic, day ward, department, or acute assessment unit.	Allied Health	6264	Primary & Community
C01008	Children & Young Peoples Death Register/Review	Sudden Infant Death Syndrome and Sudden Unexplained Death Syndrome	Agreed lump sum amount. Service purchased in a block arrangement.	Child & Youth	6111	Overheads to be manually allocated
C01010	**New** Well Child Framework	Being replaced by Well Child framework C01010, Client in this setting is enrolled child	Number of clients	Child & Youth	6111	Public Health

APPENDIX 6 – Trigger questions for developing a Statement of Forecast Service Performance

Trigger questions to aid DHBs in articulating their own SFSP's

What is the overarching aim of the DHB in providing services to your community? (This can be gained from your DSP).

Do the DHB specific outcomes relate to national/government priority areas identified in section 3?

Are the links between DHB outcomes and national/government priorities clearly defined?

How will this service area or priority area contributes to the outcomes identified in section 3?

What considerations/assumptions/evidence were used to establish this outcome is important?

Is the intervention logic clearly demonstrated so the reader is able to see the link between the key services (outputs) and strategic priorities?

Does the DHB have control over these outputs and therefore can actively pursue the desired outcomes?

Does the intervention logic demonstrate justification, based on evidence of effectiveness, of the outputs chosen?

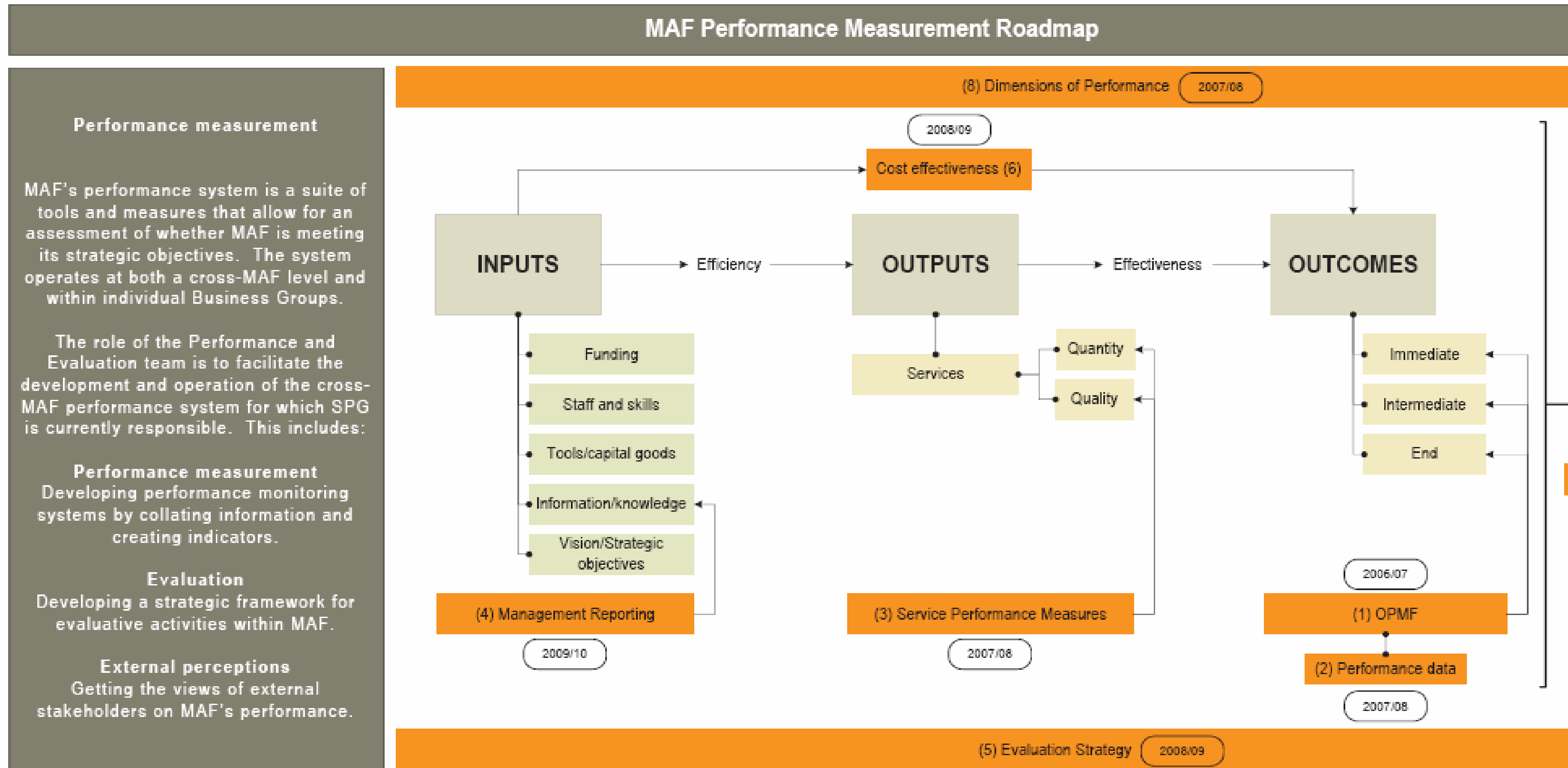
Would a diagram aid the reader's understanding?

Will graphs or tables that pictorially demonstrate the information portrayed in the targets or measures improve the readers understanding of the output? If so can these be included?

Will the graphs OR tables enhance a readers understanding?

<table>
<tr><th rowspan="2">Output Class</th><th rowspan="2">Measure</th><th colspan="3">Targets</th></tr>
<tr><th>Baseline 2008/09</th><th>Current 2009/10</th><th>Out years</th></tr>
<tr><td colspan="5">Output class if appropriate - Is there an output class or multiple classes appropriate for the grouping of all the key services? Keep in mind that the output classes used in the non-financial section will need to have expected revenue and expenses mapped against them in the financial section.</td></tr>
<tr><td>Outputs
• Is the output a good or service produced for a third party by the DHB that the DHB is accountable for? Should cover main service areas, including A&E and acutes
• NOTE: Most of the health targets are not output focused so are not appropriate for inclusion in this section. However, the DHB can include the specific activities and services it will deliver that will contribute to the achievement of a health target. Further, inputs, outcomes, management systems, internal outputs and processes are not outputs and should not be described as such in this section.
• Does the output, a good or service produced, clearly contribute to an outcome and is the intervention logic clear?</td><td>Name of the Measure
• What is an appropriate measure of the intervention? The measure should consider the components of quality, quantity, timeliness, and cost.
• Does the measure selected measure the output directly?
• Can the measure be understood by varied audiences? If not a more detailed description is required.
• Is there an appropriate measure of the cost of the intervention? Can this be used to highlight the cost-effectiveness of the intervention?</td><td>Is a baseline value available? This is useful to provide context for the reader as the current state of service.
Can you compare to a national average?</td><td>What is the standard the DHB aims to reach?</td><td>If out year targets are available, include these. Legislative requirement is only for the first financial year of the period covered by the SOI (s 142).</td></tr>
</table>

APPENDIX 7 – Example of Performance Measurement Flow Chart



APPENDIX 8 – Forecast non-financial performance information reports: Guidance for entities

Possible Issues	Why important?
1. Performance framework/story	
a) The document should provide the reader with a clear picture of what the entity is trying to achieve and how it believes it contributes to this.	In order for the document to be used to hold an entity to account, it is important that the reader is able to understand what the entity is trying to achieve and how its activities contribute to this.
b) Outcomes should be identified at an appropriate level. Where high-level outcomes are identified, these should be supported by lower-level outcomes and impacts as appropriate.	Outcomes need to be specified at a level that the entity can reasonably claim to contribute to or influence.
c) The document should provide the reader with a clear picture of the outputs (services) that the entity is accountable for.	The outputs of the entity help the reader to understand what the entity actually delivers through the application of its resources.
d) The relationship between the outputs of the entity, the impact it is intended to have, and the outcomes that it is seeking to contribute to or influence should be clearly explained to the reader. This may require a number of layers in the intervention logic to be stated.	Clearly explaining the intervention logic helps the reader to understand how the entity believes that the goods and services it is accountable for will ultimately result in improved outcomes.
e) The SOI and the Forecast SSP/ISE should reflect the entity's performance management arrangements.	In order to fairly reflect the entity's service performance for the year, the SSP must be consistent with the internal performance management arrangements. Given that the SSP also needs to be consistent with the forecast SSP, it follows that the Forecast SSP and SOI must also reflect an entity's performance management arrangements.
2. Outcomes	
a) Outcomes, which should relate to a state or condition of society, the economy, or the environment, and including a change in that state or condition, should be identified in the document.	The SOI is required to identify the outcomes that the entity is aiming to contribute to or influence.
b) Outcomes should not include objectives for organisational improvement.	It is clearly important for entities to look to improve their organisational capacity and capability and to specify objectives in relation to these. However, "outcomes" should relate to why the entity exists – that is, the end to which any organisational improvement is to be used.
c) Outcomes should be immediately clear to the reader.	The outcomes should not be "lost" in the document among priorities, goals, strategic aims, objectives, and other material.
d) Outcomes should be phrased appropriately.	Outcomes should relate to a state or condition of society, the economy, or the environment; ***and include a change*** in that state or condition.
e) Outcomes should be supported by measures.	Without measures, it will be difficult for the entity and reader to know that progress is being made towards outcomes.
f) Targets for outcome measures (covering the full period of the SOI) should be included in the document.	Clear targets for outcomes, which must cover the full period to which the SOI relates, will allow the entity and reader to understand what the entity is seeking to achieve and reach a view about whether sufficient progress is being made.

Possible Issues	Why important?
g) The inclusion of current/historical performance for outcome (main) measures provides helpful context to the reader in relation to outcomes.	Current/historical performance information provides useful context which can be used to help understand targets and future performance.
h) The inclusion of comparative data from other organisations and / or countries provides helpful context to the reader in relation to outcomes.	Comparative information from other organisations or countries helps the reader to understand the level of outcomes which the entity is seeking to influence.
3. Output classes	
a) The output classes used for financial and non-financial information should be consistent, or a reconciliation of the two sets of information should be provided.	In order to allow the reader to reach a view about an entity's planned performance, it needs to be possible to reconcile the non-financial performance forecasts with the financial forecasts.
b) The output classes referred to in the medium-term component of the document should be consistent with those used in the forecast SSP to group outputs.	Consistent use of output classes allows the entity to more easily set out its performance framework and demonstrate the links between outputs, impacts, and outcomes.
c) Output classes, and the number of them, should be appropriate to the entity.	The use of output classes allows the entity to aggregate its services in such a way that the reader is provided with sufficient information about the activities of the whole entity without being burdened with too much detail.
4. Outputs	
a) Outputs, which should relate to the goods and services provided to third parties which the entity is accountable for, should be included in the document.	The Forecast SSP is required to include the outputs which the entity is accountable for delivering.
b) The outputs included in the document should cover all "significant" services of the entity and a significant proportion of the entity's budget.	The SOI should provide the reader with a comprehensive picture of an entity's activities. In order to do this, it is important that the all of the major goods and services provided are covered by outputs in the Forecast SSP. This can be demonstrated by ensuring that the outputs represented in the Forecast SSP cover a significant proportion of the entity's budget.
c) Output performance measures should not relate to internal processes, events, milestones, and other deliverables.	Internal processes, events, milestones, and other deliverables represent important information that may need to be communicated to the reader. However, they do not represent outputs.
d) The outputs included in the document should include those goods and services that are contracted out by the entity. These should relate to the end service provided and not to the contract management process.	Outputs and the associated measures of output performance should cover those end services for which the entity is accountable, even if does not deliver them directly itself.
e) Performance measures should cover sufficient dimensions of performance.	Measures for each output should cover an appropriate range of dimensions (such as quality, quantity and timeliness,) of an output so that a balanced and rounded picture of performance can be obtained.
f) As a minimum, targets for output measures should be included for 2009/10.	Without clear targets being set and included in the Forecast SSP, it is difficult for the reader to form a view about planned performance, and for actual performance to be compared to forecast. The inclusion of targets for more than one year helps the reader to understand planned changes in the services provided over time.
g)Targets included in the document should be reasonable, and should represent best estimates.	Targets should reflect the priorities of the entity, its resources, choices, and historical performance.

Possible Issues	Why important?
h) Where the documents contain demand-driven measures, these need to be clearly identified as such and the reason for their inclusion needs to be explained.	Demand-driven measures provide useful information and context in relation to an entity's performance. However, they are not under the control of the entity and therefore need to be clearly identified as such and supported by "true" outputs.
i) Management commentary should help to explain how and why targets have been set at a particular level.	Without appropriate explanation, it is difficult for the reader to understand why particular targets have been set at particular levels. This is particularly true when targets are set at the same or a lower level than in previous years, although increased targets may also require explanation.
j) Performance measures and targets should be supported by current/historical levels of performance where this is available or by an explanation of when it will be available.	Current/historical performance information provides the context for future performance targets.
k) The inclusion of comparative data from other organisations or countries provides helpful context to the reader in relation to outputs.	Comparative information from other organisations helps the reader to understand the level of output performance that the entity is seeking to achieve.
l) It should be clear to the reader which output performance measures will be reported against in the Annual Report / SSP.	The Annual Report / SSP should reflect the content of the SOI /Forecast SSP.
5. Other document issues	
a) The document should be easy to read, concise, and include diagrams where this will aid the reader's understanding.	It is important that, as a key accountability document to Parliament and the public, the SOI is clearly written and accessible.
b) The document should contain information about how the entity will ensure that it has sufficient capacity and resources to deliver its outputs and achieve the outcomes sought.	It is important that the reader is able to see that the entity's plans in terms of its non financial performance are supported by the resources, capacity, and capability it has available.
c) The document should provide sufficient information to allow the reader to assess cost-effectiveness. Sufficient information could include cost-effectiveness measures for major outputs or logical demonstration of linkages between expenditures, outputs, intermediate outcomes, and end outcomes, with the emphasis being on the attribution of outcomes to spending.	The SOI is required to provide information on the cost-effectiveness of its interventions.
d) There should be consistency between the SOI and the ISE (government departments only).	The use of different terminology and the inclusion of different outcomes/impacts in the SOI and the ISE can make it extremely difficult for the reader to understand the relationship between financial appropriations, the delivery of outputs, and the achievement of outcomes.
e) Appropriate references are made to the ISE in the SOI and vice versa (government departments only).	In order to allow the reader to obtain a complete overview of an entity's planned performance, it is important that they are able to understand how the SOI and ISE fit together.
f) The SOI and the Forecast SSP/ISE should be "stand alone" documents.	The SOI should provide a concise overview of an entity's planned activities, how these will contribute to outcomes, and the measures and targets that will be used to demonstrate progress, without the need to refer to other documents.
g) The SOI and the Forecast SSP/ISE should contain information about all significant aspects of the entity, including recent/planned developments.	The accountability documents should provide the reader with a high-level overview of the entity and its activities.

Possible Issues	Why important?
6. Supporting Systems and Controls	
a) The forecast performance information in the SOI and Forecast SSP / ISE should be supported by robust systems and controls that are integrated into the entity's overall performance management arrangements.	The absence of robust systems and controls which can be relied upon to produce forecast and historic performance information is likely to: • reduce the ability of the entity to produce it (and therefore monitor performance) on a regular basis; and • reduce the reliability of the information produced.

APPENDIX 9 – Performance Improvement Actions

DHBs are required to develop Performance Improvement Actions. The aim of these is to identify those few vital actions which will have a material impact over the next one to five years on efficiency, effectiveness and alignment with Government Priorities.

PIA Number	Performance Improvement Action	Savings Impact
9.1	Achieve Financial Security – by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings	Operations $2.515M Capital $270K Other $175k
9.2	Improve Productivity and Quality – with a focus on hospital wards, theatre utilisation, increasing day surgery and emergency departments	$2.87M
9.3	Enhance Regional Cooperation – through development of Clinical Regional Service Plans and greater regionalisation of shared services and back-office functions	$10K