

# Taranaki District Health Board ANNUAL PLAN 2016/17

*Incorporating the  
Statement of Intent and  
Statement of Performance Expectations*



This document presents our Annual Plan 2016/17 (referred to as the Plan). The Plan is broken into a number of modules that can be extracted for different purposes including presentation of our Statement of Intent 2015/18. Central to understanding this Plan, is our performance story which sets out our key outcomes (what we are trying to achieve), our impacts (our shorter term contribution to an outcome), our outputs (goods and services supplied), and our inputs (resources).

This Plan should be read in conjunction with the Taranaki District Health Board Māori Health Plan and the Midland DHB Regional Services Plan.



Crown copyright ©. This copyright work is licensed under the Creative Commons Attribution 4.0 International licence. In essence, you are free to copy, distribute and adapt the work, as long as you attribute the work to the New Zealand Government and abide by the other licence terms. To view a copy of this licence, visit <http://creativecommons.org/licenses/by/4.0/>. Please note that neither the New Zealand Government emblem nor the New Zealand Government logo may be used in any way which infringes any provision of the [Flags, Emblems, and Names Protection Act 1981](#) or would infringe such provision if the relevant use occurred within New Zealand. Attribution to the New Zealand Government should be in written form and not by reproduction of any emblem or the New Zealand Government logo.

Published by Taranaki District Health Board  
Private Bag 2016, New Plymouth, 4342

This document is available on the Taranaki District Health Board website: [www.tdhb.org.nz](http://www.tdhb.org.nz)

## Table of Contents

<b>MODULE 1: INTRODUCTION AND STRATEGIC INTENTIONS .....</b>	<b>8</b>
1.1 Message from the Chair.....	8
1.2 Message from the Chief Executive Officer .....	9
1.3 Executive Summary .....	10
1.4 Minister's Letter of Approval.....	12
1.5 Context.....	15
1.5.1 Background Information and Operating Environment.....	15
1.5.2 Nature and Scope of Functions/Intended Operations.....	17
1.6 Strategic Intentions .....	19
1.6.1 Our Vision.....	19
1.6.2 Strategic outcomes in national, regional and local context.....	20
1.7 Key Risks and Opportunities.....	27
1.7.1 Achieving Health Equity.....	27
1.7.2 Living within Our Means.....	27
1.7.3 Health System Workforce Shortages.....	27
1.7.4 System Integration .....	28
1.7.5 Regional Integration .....	28
1.8 Key Measures of Performance .....	28
1.8.1 Outcome 1 – People Are Supported To Take Greater Responsibility For Their Health .....	29
1.8.2 Outcome 2 - People Stay Well in Their Homes and Communities.....	32
1.8.3 Outcome 3 - People Receive Timely and Appropriate Specialist Care .....	36
<b>MODULE 2A: IMPLEMENTATION OF THE NZ HEALTH STRATEGY .....</b>	<b>42</b>
2A.1 Context.....	42
2A.2 Themes from the Health Strategy .....	43
<b>MODULE 2B: DELIVERING ON PRIORITIES AND TARGETS .....</b>	<b>48</b>
2B.1 Priorities and Targets.....	48
2B.1.1 Implementing Government Priorities .....	48
2B.2 Actions to Deliver on Annual Plan Priorities .....	50
Child and Youth Health.....	50
2B.2.1 Reducing Unintended Teenage Pregnancy.....	50
2B.2.2 Increased Immunisation .....	51
2B.2.3 Supporting Vulnerable Children .....	56
2B.2.4 Reducing Rheumatic Fever .....	58
2B.2.5 Prime Ministers Youth Mental Health Project .....	60
2B.2.6 Child and Youth Oral Health.....	62
2B.2.7 Well Child Tamariki Ora.....	64
Long Term Conditions – Prevention, Identification and Management .....	67
2B.2.8 Obesity .....	67
2B.2.9 Living Well with Diabetes .....	72
2B.2.10 Cardiovascular Disease .....	75
2B.2.11 Tobacco .....	78
2B.2.12 Rising to the Challenge .....	81
System Integration.....	86
2B.2.13 Cancer Services/Faster Cancer Treatment.....	86
2B.2.14 Stroke Services.....	92
2B.2.15 Cardiac Services.....	93

2B.2.16	Health of Older People .....	96
2B.2.17	Service Configuration including Shifting Services.....	101
2B.2.18	System Level Outcome Measures .....	104
2B.2.19	Shorter Stays in Emergency Departments.....	105
2B.2.20	Whānau Ora.....	108
2B.2.21	Improved Access to Diagnostics.....	114
2B.2.22	Improved Access to Elective Surgery.....	115
2B.2.23	Living Within Our Means.....	117
2B.2.24	National Entity Priority Initiatives.....	119
2B.2.25	NZ Health Partnership Ltd.....	128
<i>Other .....</i>	<i>129</i>	
2B.2.26	Improving Quality.....	129
<i>Actions to Deliver on Regional Service Plan Priorities.....</i>	<i>135</i>	
2B.2.27	Spinal Cord Impairment Action Plan 2014-19.....	135
2B.2.28	Major Trauma .....	136
2B.2.29	Information Technology .....	137
2B.2.30	Hepatitis C Management.....	138

## **MODULE 3: STATEMENT OF PERFORMANCE EXPECTATIONS..... 140**

3.1	<i>Output Classes.....</i>	<i>140</i>
3.2	<i>Guide to Reading the Statement of Performance Expectations .....</i>	<i>140</i>
3.3	<i>People are Supported to Take Greater Responsibility for their Health.....</i>	<i>141</i>
3.3.1	Fewer People Smoke .....	141
3.3.2	Reduction in Vaccine Preventable Diseases.....	142
3.3.3	Improving Health Behaviours .....	142
3.4	<i>People Stay Well in their Home and Communities.....</i>	<i>144</i>
3.4.1	An Improvement in Childhood Oral Health.....	144
3.4.2	Long-Term Conditions are Detected Early and Managed Well .....	144
3.4.3	Fewer People are Admitted to Hospital for Avoidable Conditions.....	145
3.4.4	More People Maintain their Functional Independence.....	146
3.5	<i>People Receive Timely and Appropriate Care .....</i>	<i>146</i>
3.5.1	People Receive Prompt and Appropriate Acute and Arranged Care .....	146
3.5.2	People Have Appropriate Access to Elective Services.....	148
3.5.3	Improved Health Status for those with Severe Mental Illness and/or Addictions .....	148
3.5.4	More People with End Stage Conditions are Supported Appropriately.....	149
3.6	<i>Support Services.....</i>	<i>149</i>

## **MODULE 4: FINANCIAL PERFORMANCE ..... 152**

4.1	<i>Key Points from the Budgeted Financials: 2016-20.....</i>	<i>153</i>
4.2	<i>Key Risks.....</i>	<i>154</i>
4.2.1	Taranaki DHB's Funder Operations.....	154
4.2.2	Taranaki DHB's Hospital Provider Operations.....	156
4.3	<i>Key Financial Assumptions .....</i>	<i>157</i>
4.3.1	Application of Public Benefit Entity Accounting Standards.....	157
4.3.2	Equity and Borrowing.....	157
4.3.3	Operating Expenditure assumptions: .....	157
4.4	<i>Financial Assumptions and Budgetary Outlay.....</i>	<i>158</i>
4.4.1	Mental Health Services .....	158
4.4.2	Interest Rates.....	158
4.4.3	Asset Revaluation and its Impact.....	159
4.4.4	Depreciation.....	159
4.4.5	Capital Charge.....	159

4.4.6	Leasing.....	159
4.4.7	Financial Covenants and Ratios.....	159
4.4.8	Changes in Accounting Policies .....	160
4.4.9	Capital Investment .....	160
4.4.10	Capital Divestment.....	161
4.4.11	Personnel.....	161
4.5	<i>Capital Expenditure: Strategic</i> .....	163
4.5.1	Base Hospital Inpatient Facilities Development Programme .....	163
4.6	<i>Cost and Efficiency Initiatives</i> .....	164
4.7	<i>Debt and Equity</i> .....	165
4.8	<i>Sensitivity Analysis: Budgetary Risks in Plan 2016/17</i> .....	165
4.9	<i>Statement of Comprehensive Income</i> .....	167
4.10	<i>Consolidated Statement of Financial Position</i> .....	169
4.11	<i>Consolidated Statement of Cashflow</i> .....	170
4.12	<i>Consolidated Statement of Movement in Equity</i> .....	171
<b>MODULE 5: STEWARDSHIP .....</b>		<b>174</b>
5.1	<i>Managing our Business</i> .....	174
5.1.1	Our People.....	174
5.1.2	Organisational Performance Management.....	174
5.1.3	Funding and Financial Management .....	175
5.1.4	National Health Sector Agencies .....	176
5.1.5	Risk Management.....	176
5.1.6	Performance and Management of Assets .....	177
5.2	<i>Building Capability</i> .....	177
5.2.1	HealthShare Limited.....	178
5.2.2	Information Communications Technology.....	179
5.2.3	Quality Assurance and Improvement .....	180
5.2.4	Capital and Infrastructure Development.....	180
5.2.5	Cooperative Developments .....	180
5.3	<i>Workforce</i> .....	180
5.3.1	Managing Our Workforce within Fiscal Restraints.....	180
5.3.2	Strengthening Our Workforce.....	181
5.4	<i>Organisational Health</i> .....	184
5.4.1	Governance .....	184
5.4.2	Providing Health and Disability Services.....	184
5.4.3	Planning and Funding Health and Disability Services.....	185
5.5	<i>Reporting and Consultation</i> .....	186
5.5.1	Consultation with the Minister and the Ministry of Health .....	186
5.5.2	External Reporting .....	187
<b>MODULE 6: SERVICE CONFIGURATION .....</b>		<b>190</b>
6.1	<i>Service Coverage</i> .....	190
6.1.1	Service Issues.....	190
6.2	<i>Service Change</i> .....	192
<b>MODULE 7: PERFORMANCE MEASURES.....</b>		<b>194</b>
7.1	<i>Monitoring Framework Performance Measures</i> .....	194

<b>MODULE 8: APPENDICES.....</b>	<b>204</b>
8.1 Glossary Of Terms.....	204
8.2 Output Class Definitions.....	208
8.3 Output Class Revenue and Expenditure.....	214
8.4 Output Measure Rationale.....	215

# Module 1

## Introduction and Strategic Intentions

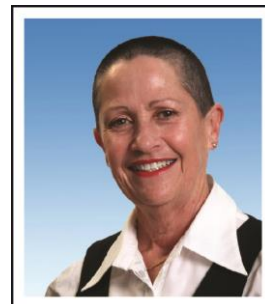


# MODULE 1: INTRODUCTION AND STRATEGIC INTENTIONS

## 1.1 Message from the Chair

The New Zealand health system faces a number of challenges – for example, an increasing number of older people are living longer, there's a growing burden of long term conditions, and we need to keep up with new technologies and expensive drugs.

We also need to address the disparities in health outcomes for some populations, notably Māori and those with mental health conditions, and people with disabilities.



The DHB (and the national health sector) is therefore faced with increasing demand for health services while living with nominal annual funding increases. Targeted changes within our operating framework (including both the hospital and the non-hospital sectors) are inevitable.

Assisting us in developing our approach, the Ministry of Health's refresh of the New Zealand Health Strategy (NZHS) has recently been released. This sets a vision that All New Zealanders live well, stay well, get well which we believe aligns well with Taranaki DHB's Shared Vision - Te Matakite

*Taranaki Together, A Healthy Community*

*Taranaki Whanui He Rohe Oranga.*

Under the five strategic themes of people-powered, closer to home, value and high performance, one team and smart system, there is an emphasis on more services in the community and a stronger push on prevention, early intervention, and new, innovative ways of reaching our most vulnerable.

While acknowledging the financial constraints we work within, in 2016/17 we will continue to apply our Integrated Healthcare Strategy, seeking opportunities to work in a whole of health system way by continuing to look at how health information can be shared safely across a wider range of health professionals, to seek opportunities for more services to be provided closer to home, to work as a health system collaboratively with other Agencies and Councils to consider the wider determinants of health.

## 1.2 Message from the Chief Executive Officer

As the new Chief Executive of the Taranaki District Health Board, I look forward to working with the Taranaki DHB staff and our Taranaki community to provide high quality health services.

In Taranaki we have an opportunity to build on a solid foundation together to improve the health of our communities. To do that well, we need to really understand what matters to our patients, to their families, and to our communities, through delivering person and family centred care.



In terms of priorities this year, we are focusing on more integrated services delivered in the community so that people can get the support and care they need away from hospitals. The health targets also continue to be a key focus. They are not just about numbers – they are about delivering better and quicker access to important health services.

It's timely that a refreshed Health Strategy, created in collaboration with people and organisations from across health and social services, has been released which considers new and emerging opportunities and provides clear directions for the future. This requires a collective change in mind set. To succeed we not only need to seek efficiencies in existing services, but we need to adapt to emerging technologies, innovations and opportunities, and work more effectively together. Regardless of what changes we may identify or propose, we must always put the patient / whānau at the centre of what we do.

With the support of strong governance, clinical and executive leadership and capability across the health sector, The Taranaki District Health Board (TDHB) remains ready to meet the significant challenges the New Zealand public health system as a whole continues to face.

## 1.3 Executive Summary

This document expresses our continued commitment to our local strategic vision of Taranaki Together, a Healthy Community – Taranaki Whanui He Rohe Oranga. It also articulates our commitment to meeting the Minister's expectations, including the Health Targets, and how we will achieve this, as well as how we will work with our partners to deliver appropriate and high quality services for our local people.

The Ministry of Health has given the New Zealand Health Strategy a refresh. The updated draft Strategy proposes a clear view of the future for the health system over the next 10 years, to ensure all New Zealanders live well, stay well, get well. The strategic direction set out in this Plan for the Taranaki DHB is aligned to this vision and the five strategic themes contained within the strategy.

The health sector is changing, presenting challenges and pressures to the way we approach our work. Challenges such as an ageing population, a changing demographic make-up of population, substantial inequalities in health status, more people living longer and more with multiple and long-term conditions and health system workforce shortages. The challenges that affect us all are global, national and local. The fiscal environment remains constrained as health consumes an ever increasing portion of total government expenditure. The public has high expectations of its health system.

With challenges, however, come opportunities to collaborate with other agencies, communities and individuals, to build trust and establish partnerships. This plan details many of the opportunities and interventions we can make to have positive impacts on the health status of our population. Strengthening integration also extends beyond health, across government to support the most vulnerable, reduce inequities and address issues outside the health and disability system that impact on health.

To respond to these drivers there will be a need to develop and support new models of service delivery, including information systems, integration of care and workforce capacity. Underpinning change there must always be a commitment to provision of quality in health care delivery and of course to sustainability. Our response to the challenges facing us requires us to work together in partnership with people and our community, as one system. This year's Annual Plan has a strong emphasis on the theme of integrated health systems and with our primary care partners, through our Taranaki Alliance Leadership Team, to make changes to the health system, for the benefit of our population.



A blue ink signature of Jonathan Coleman, written in a cursive style.

Jonathan Coleman  
Minister of Health



A blue ink signature of Pauline Lockett, written in a cursive style.

Pauline Lockett  
Chair  
2 August 2016



A blue ink signature of Sally Webb, written in a cursive style.

Sally Webb  
Deputy Chair  
2 August 2016



A blue ink signature of Rosemary Clements, written in a cursive style.

Rosemary Clements  
Chief Executive  
2 August 2016

## 1.4 Minister's Letter of Approval

---



### Office of Hon Dr Jonathan Coleman

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

30 AUG 2016

Ms Pauline Lockett  
Chairperson  
Taranaki District Health Board  
Private Bag 2016  
NEW PLYMOUTH 4342

pauline.lockett23@gmail.com

Dear Ms Lockett

#### **Taranaki District Health Board 2016/17 Annual Plan**

This letter is to advise you I have approved and signed Taranaki District Health Board's (DHB's) 2016/17 Annual Plan for one year.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional \$2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and in order to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

#### ***Living Within our Means***

In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I note that your DHB is planning a deficit for 2016/17 and a return to breakeven in 2019/20. I expect that you will work to improve this position in out years and will work closely with the Ministry to achieve this. For 2016/17, I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result.

#### **National Health Targets**

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

#### **System Integration including Shifting Services**

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Taranaki DHB has committed to develop an integrated model of care spanning primary, community and secondary services for implementation in 2017/18. I look forward to being advised of your progress with this throughout the year. If this activity triggers the service change protocols you will need to follow the normal service change process.

#### **Cross-government Initiatives and Collaboration**

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

**Annual Plan Approval**

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely



Hon Dr Jonathan Coleman  
**Minister of Health**

cc Ms Rosemary Clements  
Chief Executive  
Taranaki District Health Board  
Private Bag 2016  
NEW PLYMOUTH 4342  
  
rosemary.clements@tdhb.org.nz

## 1.5 Context

Taranaki DHB was established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000 (NZPHD) and is one of 20 DHBs in New Zealand. DHBs were established as vehicles for the public funding and provision of personal health services, public health services and disability support services for a geographically defined population. Each DHB is a Crown Entity and is accountable to the Minister of Health.

This Plan sets out the activities we will undertake in terms of national, regional and local priorities. It describes to Parliament and to the New Zealand public what we intend to achieve in 2016/17, to improve the health of the Taranaki DHB population and to reduce or eliminate health inequalities.

We are part of the Midland DHB region, and have worked together to improve regional consistency across our plans. This collaboration is reflected throughout this Plan.

### 1.5.1 Background Information and Operating Environment

Our DHB serves a population of 118,110 (2016/17 Projection – Statistics NZ) and covers a geographic area of 723,610 hectares. It stretches from Mokau River in the north to Waitotara River in the south.

Our district takes in the major population centres of New Plymouth and Hawera. A detailed breakdown of our population is presented in the following three tables:

#### Ethnic Group (using all identified ethnicities) <sup>1</sup>

##### Taranaki Region usually Resident Population Count - 2013 Census

	1 person = 1+ ethnicities	% 2016/17 population
European	99,200	84.0%
Māori	20,400	17.3%
Pacific Peoples	1,980	1.7%
Asian	4,340	3.7%
Middle Eastern/Latin American/African	540	0.5%
Total	126,410	107.1%

Source: <http://nzdotstat.stats.govt.nz> Statistics NZ, NZ.Stat - Dataset: Estimated resident population (ERP), subnational population by ethnic group, age, and sex, at 30 June 1996, 2001, 2006, and 2013

<sup>1</sup>Includes all people who stated each ethnic group, whether as their only ethnic group or as one of several. Where a person reported more than one ethnic group, they were counted in each applicable group, except if a person belongs to both the 'European' and 'Other ethnicity' groups they have only been counted once. Almost all people in the 'Other ethnicity' group belong to the 'New Zealander' sub-group.

#### Ethnic Group (using primary ethnicity only) <sup>2</sup>

##### Taranaki Region usually Resident Population Count - 2016/17 projection based on 2013 Census

	1 person = 1 ethnicity	% 2016/17 population
European	88,740	75.1%
Māori	22,370	18.9%
Pacific Peoples	1,390	1.2%
Asian	5,610	4.7%
Total	118,110	100.0%

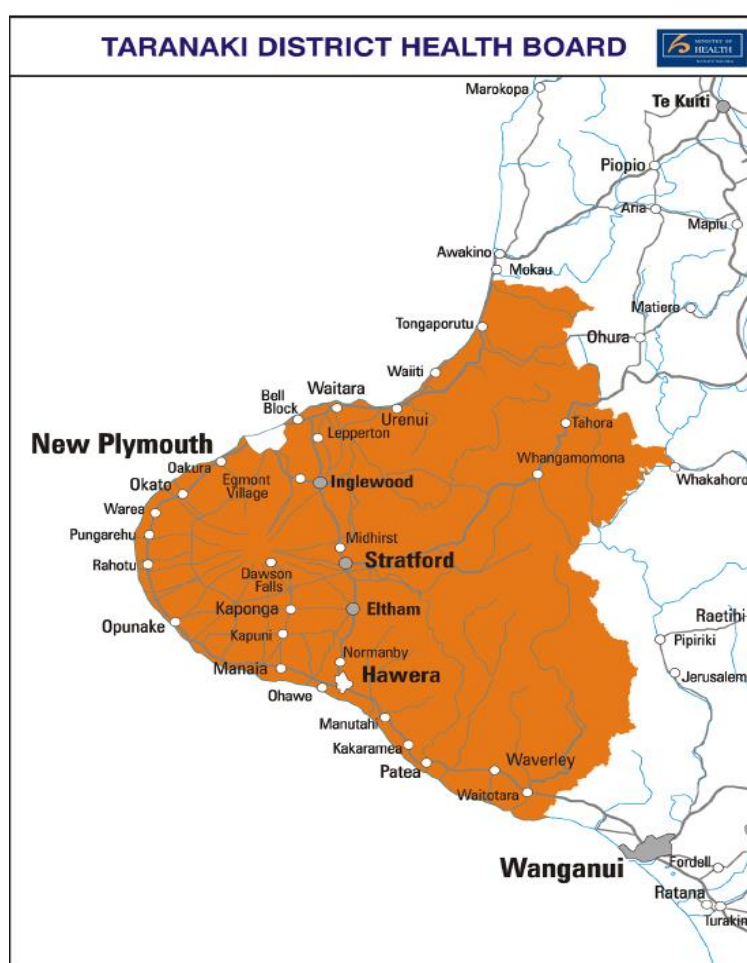
Source: Statistics NZ – 2015 Stats NZ Pop Projections - projections produced by Statistics New Zealand according to assumptions specified by the Ministry of Health

<sup>2</sup>Primary ethnicity, one person = one ethnicity, grouped by four main ethnicities

**Table: Taranaki DHB Population by Age and Ethnicity – 2016/17 Projection Statistics NZ**

Age Group	Ethnicity		
	Māori	Other	Total
00-24	11,530	26,475	38,005
25-44	5,250	23,310	28,560
45-64	4,150	27,025	31,175
65-74	940	10,415	11,355
75+	500	8,515	9,015
Total	22,370	95,740	118,110

### Taranaki DHB Map



A large proportion of our population live outside the main urban areas. Our large rural population presents diverse challenges in service delivery and ensuring access to health services.

The two main population centres are New Plymouth and Hawera. There are a large number of more rural towns and settlements including Urenui, Waitara, Inglewood, Stratford, Eltham, Opunake, Manaia, Patea and Waverley. Taranaki District Health Board areas reach from Mokau in the north to Waitotara in the south. The geographic boundaries of Taranaki District Health Board cover the council areas of Taranaki Regional Council, New Plymouth District Council, Stratford District Council and South Taranaki District Council.

### 1.5.1.1 Health Profile

Understanding our health profile plays an important part in our decision making processes. This information helps us focus on where we can make the greatest gains in terms of our strategic outcomes, as well as for planning and prioritisation of programmes at an operational level. Key points of interest in terms of the health profile of the population are:

- Around 43% of Taranaki population live in NZDEP2013 Decile 6, 7 and 8 compared to 30% nationally. Non-Māori are over-represented in the wealthiest socio-economic deciles and Māori are over-represented in the lowest socio-economic deciles.
- Within Taranaki, 32% of Māori live in the most deprived 20% of areas compared to 14% of non-Māori. In contrast, 7% of Māori live in 20% of the most affluent areas compared to 16.3% of non-Māori.
- Māori in Taranaki experience a shorter life expectancy than non-Māori. Based on the 2011/12 HNA<sup>1</sup>, Māori females have a life expectancy of 75.5 years compared to 82.5 years for non-Māori a difference of 6.9 years.
- Based on the 2011/12 HNA Māori males have a life expectancy of 72.4 years compared to 79.0 years for non-Māori, a difference of 6.6 years. This difference is less than that for the general New Zealand population at 7.7 years for females and 7.9 years for males.
- The leading causes of avoidable mortality in Taranaki DHB for non-Māori are ischaemic heart disease, cerebro-vascular disease and chronic obstructive pulmonary disease (COPD) and lung cancer. For Māori in the Taranaki District, the leading causes of avoidable mortality are ischaemic heart disease, lung cancer, diabetes and chronic obstructive pulmonary disease (COPD).

In our last Whānau Ora Health Needs Assessment on the Māori Population in the Taranaki region, the following areas were identified as priorities in terms of protective and risk factors and preventative care: smoking, alcohol and drug issues, breastfeeding, immunisation, breast screening and cervical screening. Priority health conditions identified were; diabetes, cardiovascular disease, lung cancer, breast cancer, respiratory disease (i.e. COPD and asthma), oral health, mental health and disability.

### 1.5.2 Nature and Scope of Functions/Intended Operations

We receive funding from Government to undertake our role. The amount of funding is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status characteristics. We are both a funder and provider of health services. In 2016/17 the Funder has a planned expenditure of \$334,094,117 in order to pay for services to improve the health of our community. This includes most personal health (services to improve the health of individuals), Mental Health and Addictions, Māori Health and Health of Older People services for the Taranaki DHB population.

The Hospital and Specialist Services, our Provider division (which includes Governance costs), will receive approximately \$171,945,477 (51.47%) of this funding with \$124,098,045 (37.14%) being utilised to fund services including those provided by non-government organisations (NGOs), primary care, pharmacy and laboratories. The remaining \$38,050,595 (11.39%) is allocated to fund services that are provided by other DHBs on behalf of Taranaki (inter-District Flows). The costs of providing services to people living outside of our district are met by the DHB of the patient and are referred to

---

<sup>1</sup> Taranaki DHB's Whānau Ora Health Needs Assessment† (Ratima and Jenkins, 2012)

as ‘inter-district’ services or Inter-District Flows (IDFs). Likewise, where we do not provide the service, we have funding arrangements in place enabling our district residents to travel outside the district. We also deliver against service delivery contracts with external funders, such as the Accident Compensation Commission (ACC). We closely monitor IDFs and ACC volumes to ensure our ability to provide for our own population is not adversely affected by demand from outside the district

The Ministry of Health and National Health Board also have a role in the planning and funding of some services. Some services are funded and contracted nationally, for example Public Health Services, Breast and Cervical Screening as well as the provision of Disability Support Services for people aged less than 65 years.

We are socially responsible and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. We are responsible for monitoring and evaluating service delivery, including audits of the services we fund. We are also increasingly working with other Government agencies such as the Ministry of Business Innovation and Enterprise (MBIE), Ministry of Social Development (MSD) and the Ministry of Education (MOE) to improve the services we provide in particular our most vulnerable populations.

In order to achieve the planned outputs, impacts and outcomes as outlined in this Annual Plan, we may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or vary any current agreement for the provision or procurement of any health and disability support service. These agreements (or variations) may contain any terms or conditions acceptable to the DHB.

#### 1.5.2.1 Our Role and Purpose

As a DHB we:

- **Plan**, in partnership with key stakeholders and our community (i.e. clinical leaders, Iwi, Primary Health Organisations and non-Government organisations); and in collaboration with other DHBs and the National Health Board, regional and national work. the strategic direction for health and disability services in the Taranaki;
- **Fund** the provision of the majority of the public health and disability services in our district, through the contracts we have with providers (see also *Modules 5 and 7*);
- **Provide** hospital and specialist services primarily for our population of 118,560 people; and
- **Promote, protect and improve** our population’s health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives.

We are responsible for the provision (or funding the provision) of the majority of health services in our district. These services in our district include:

- Relationship with one Primary Health Organisation
- 32 GP Practices
- 21 Dental Practices
- 26 Pharmacies.
- 19 Community Personal Health Providers
- Providers of Community Laboratory Services and Radiology Services
- 7 Community Based Mental Health, and Alcohol and Addiction Services

- 1 Māori Mental Health and Alcohol and Addictions Service Provider
- Support Services for People with Disability, including 28 Residential Facilities
- 16 Providers of Community Health for Older People Services
- Hospital Provider - facilities include Taranaki Base Hospital, Hawera Hospital and five Community Health centres in Waitara, Stratford, Opunake, Patea and Mokau.

We collaborate with other health and disability organisations (such as our primary care alliance partners), key stakeholders and our community to identify what health and disability services are needed and how best to use the funding we receive from Government. Through this collaboration, we aim to ensure that health and disability services are well coordinated and cover the full continuum of care, with the patient at the centre. We expect these collaborative partnerships to also allow the sharing of resources, reduction in duplication, variation and waste across the health system to achieve the best outcomes for our community. As a DHB we will:

- Plan in partnership with key stakeholders, the strategic direction for health and disability services
- Plan regional and national work in collaboration with the National Health Board and other DHBs
- Fund the provision of the majority of the public health and disability services in our district, through the agreements we have with providers
- Provide hospital and specialist services primarily for our population and also for people referred from other DHBs
- Promote, protect and improve our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives

## 1.6 Strategic Intentions

### 1.6.1 Our Vision

#### **Our Shared Vision – Te Matakite**

*Taranaki Together, A Healthy Community*  
*Taranaki Whanui He Rohe Oranga*

#### **Our Mission – Te Kaupapa**

Improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki

#### **Our Aims**

- To promote healthy lifestyles and self-responsibility
- To have the people and infrastructure to meet changing health needs
- To have people as healthy as they can be through promotion, prevention, early intervention and rehabilitation
- To have services that are people-centred and accessible where the health sector works as one
- To have a multi-agency approach to health
- To improve the health of Māori and groups with poor health status

- To lead and support the health and disability sector and provide stability throughout change
- To make the best use of the resources available

## **Our Values**

### **How We Work Together With Others – Ngā Tikanga**

The actions and behaviours described below are how we aim to contribute to all our relationships including those with our patients, clients, Whānau, funded agencies, staff and members of the public. Therefore, we will 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

To contribute to achieving the outcomes at a national and regional level, we have identified our local strategic intent for 2016/17. Our strategic intent represents a continuation from previous years, as the challenges we face are not short term issues easily resolved within a 12 month period. Our local strategic outcomes listed below align directly to the regional strategic outcomes outlined in the Regional services Plan (RSP).

1. To improve the health of the Taranaki DHB population
2. To reduce or eliminate health inequalities

## **1.6.2 Strategic outcomes in national, regional and local context**

### **1.6.2.1 National Context**

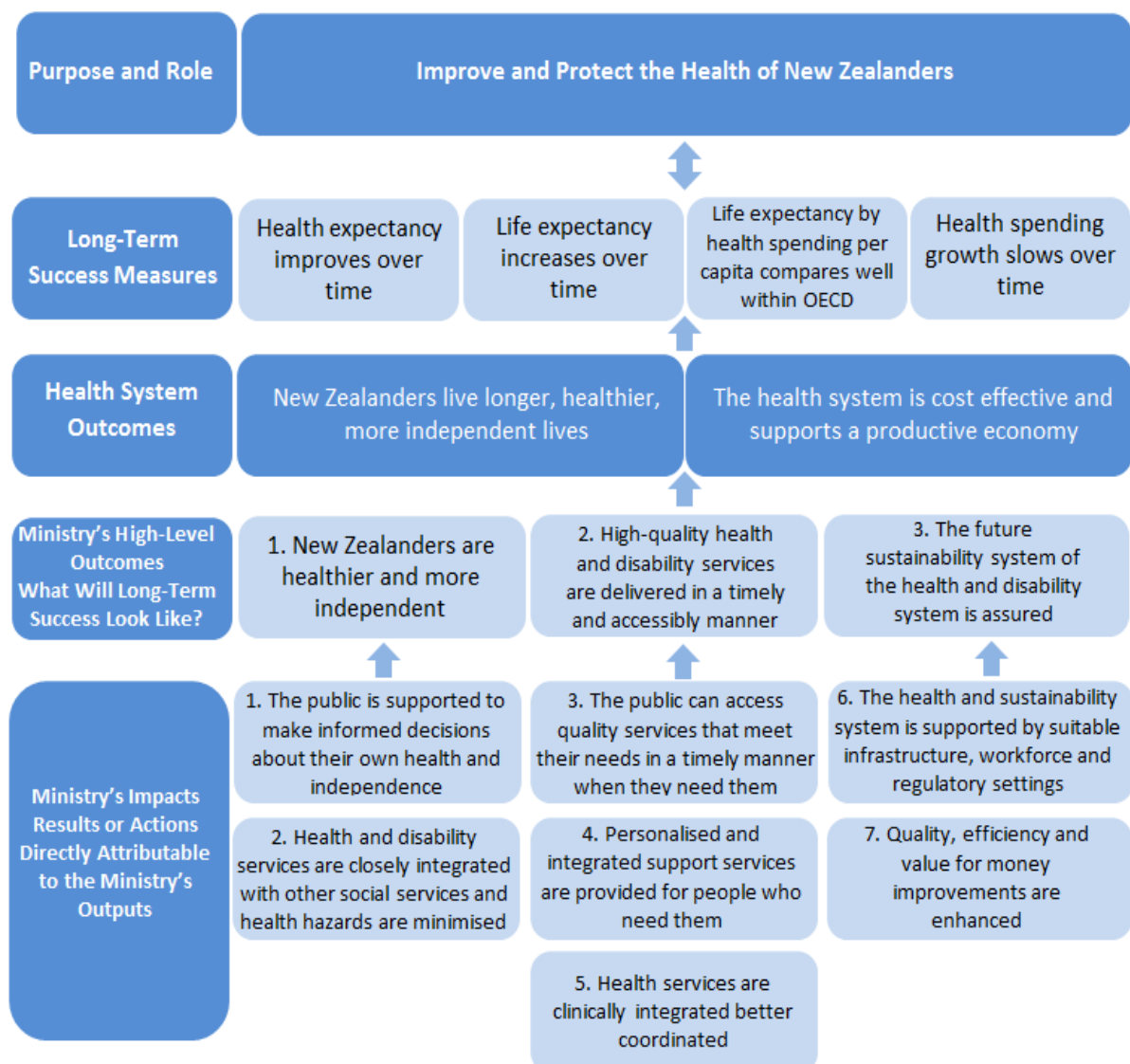
This section sets out the strategic direction by identifying the national and regional visions, outcomes and priorities and then describes in more detail the local context and how the Taranaki DHB is committed to achieving Healthy, Thriving Communities for Taranaki region.

The following framework outlines the Ministry's current purpose and outcomes for the health system. Within this framework, the Minister of Health has set out the following Government priorities for 2016/17:

- a) Refreshed NZHS – DHB's current work programmes and new initiatives need to be aligned to the five themes in the refreshed strategy – people-powered, closer to home, value and high performance, one team and smart system
- b) Living Within Our Means – DHBs need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. More specifically, the Minister's expectation is that the Taranaki DHB will improve its current financial position. This requires emphasis on Value for Money: is the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

- c) Working Across Government – DHBs are expected to continue supporting cross-agency work that delivers outcomes for children and young people, and advise the Minister and Ministry of work being undertaken with other sector agencies.
- d) National Health Targets – DHBs are to remain focused on achieving and improving performance against the health targets, particularly the Faster Cancer Treatment target. The national health targets are described below
- e) Tackling Obesity – A key focus for 2016/17 is to reduce the incidence of obesity. A key part of this package is a new childhood obesity health target. Strengthen the link between physical activity and keeping New Zealanders healthy. All DHBs are expected to be considering what they can do to help reduce the incidence of obesity in New Zealand.
- f) Shifting and Integrating Services – DHBs are to continue to move services closer to home and provide clear evidence of how they plan to do this.
- g) Health IT Programme 2015-2020, – DHBs are to be part of the co-design phase of this programme to make health information systems more productive, efficient and sustainable.

#### *Ministry of Health's National Outcomes Framework*



### 1.6.2.3 National Operating Environment

#### Health Sector Challenges and Pressures

Major, long-term systematic pressures are shaping the way health services will be delivered in the future. These pressures not only impact on New Zealand, but on a majority of health systems across the world. The following table summarises the key challenges and pressures.

*Table: Summary of health sector challenges and pressures<sup>2</sup>*

Challenge	Health Sector Pressures
Population is Changing	<ul style="list-style-type: none"><li>• Urban growth</li><li>• Rural decline</li><li>• Increasing ethnic diversity</li><li>• Evolving family structure</li><li>• Ageing population</li></ul>
Increasing Burden of Chronic Conditions	<ul style="list-style-type: none"><li>• Growth in the number of people living with chronic conditions</li><li>• Increased incidence of multiple, complex symptoms and co-morbidities</li><li>• Greater chance of chronic conditions linked to lifestyle choices</li></ul>
Rate of Funding Growth is Unsustainable	<ul style="list-style-type: none"><li>• New technologies and models of care</li><li>• A decrease in the rate of funding growth (after a recent period of increases)</li></ul>
Substantial Inequalities in Health Status Persist	<ul style="list-style-type: none"><li>• Inequalities in health status continue, with potential for disparities to worsen</li><li>• Long term and inter-generational inequalities</li></ul>
Health System Workforce Shortages are Worsening	<ul style="list-style-type: none"><li>• International demand and an ageing workforce</li><li>• Decreased hours / availability as a result of:<ul style="list-style-type: none"><li>– regulated maximum working hours</li><li>– changing lifestyle preferences</li><li>– super specialisation of some medical professions</li><li>– rural workforce shortages</li></ul></li></ul>
Multiple New Technologies are Being Developed	<ul style="list-style-type: none"><li>• Ongoing introduction of new diagnostic tools/tests and new therapeutics</li><li>• More access to information for patients and clinicians</li><li>• Increased communication options and speed for patients and clinicians</li><li>• Continued growth in research and knowledge</li><li>• Increased understanding of need and service impacts</li></ul>
Public Expectations are Rising	<ul style="list-style-type: none"><li>• Patients will be better informed</li><li>• Ongoing expectations of highly personalised services and extensive choices</li><li>• Increased diversity in service expectations as the population becomes more multi-cultural</li></ul>

<sup>2</sup> Trends in Service Design and New Models of Care: A Review (Ministry of Health New Zealand), 2010.

### 1.6.2.4 Regional Context

The diagrams presented on the following pages provide a high level summary of our performance story (intervention logic). These diagrams demonstrate flow from resources through to, ultimately our desired outcomes, as well as the links between our national, regional and local strategies.

The outputs section of the service performance diagram contains examples of measures contained in Module Three.

#### *Midland DHBs' Regional Performance Story*

Midland Vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives "Healthy Communities – Integrated Healthcare"					
Midland Outcomes	To improve the health of our population			To reduce or eliminate health inequalities		
Regional Long Term Impacts	To increase our average life expectancy		To reduce premature death rates		To improve our amenable mortality rate	
Regional Strategic Objectives	To improve Māori health outcomes	Systems integration across the continuum of care	To improve quality access across agreed regional services	To improve clinical information systems	To build the workforce	Efficiently allocate public health system resources
By focusing on these objectives we will be able to drive change that enables us to live within our means						

### 1.6.2.5 Regional Operating Environment

Taranaki DHB is one of five DHBs that make up the Midland Region. In 2016/17 all five Midland DHBs will continue to progress activities towards regional cooperation in a planned manner. Collectively the Midland DHBs have developed and agreed a Midland DHB Regional Services Plan (RSP) which is available from: [www.healthshare.health.nz](http://www.healthshare.health.nz)

Taranaki DHB is committed to being an active participant in our regional planning process. This is evidenced by both clinical and management representatives from our DHB being part of the various forums and networks that have been established to guide implementation activities from our regional services plan as well as directly funding regional work and positions. HealthShare<sup>3</sup> is tasked with co-ordinating the delivery of regional planning and implementation on behalf of the Midland DHB region.

By actively participating in planning across the Midland DHB Region, we will:

- Reduce duplication of effort
- Enable the Midland DHBs to collectively develop more sustainable solutions

<sup>3</sup> See module 5.2 for more detail

- Identify efficiencies
- Ensure that specialist skills, services and input remain available at a local level

The health sector challenges and pressures (see table in section 1.6.2.3) all have implications at the regional level. Some distinguishing features of our region include:

- High proportion of population identifying as Māori;
- Low proportion of the population identifying as Asian or Pacific peoples;
- Higher number of people living in rural areas;
- Higher proportion of people living in areas identified as higher deprivation quintiles four and five;
- Lower life expectancy than the New Zealand average;
- Higher smoking rates than the New Zealand average.

There is great need and desire to improve the health outcomes of our most vulnerable populations, in particular Māori; older people; and our children and youths.

The Midland DHBs have produced a Regional Service Plan (RSP), which describes the strategic intent for the Midland DHB Region. The strategic intent is presented in the following diagram and more detail is available in the RSP.

Our DHB is committed to being an active participant in the regional planning process. The Midland DHBs have agreed two strategic outcomes:

Strategic Outcome 1: Improve the health of the Midland populations

- Health and wellbeing is everyone's responsibility. A core function of DHBs is to promote, protect and improve our population's health and wellbeing through health promotion, health protection, health education and the provision of evidence-based public health initiatives.

Strategic Outcome 2: Eliminate health inequalities

- The DHBs in the Midland Region remain committed to working to eliminate health inequalities in its populations. This occurs in partnership with key stakeholders and our community (i.e. clinical leaders, Iwi, Primary Health Organisations and non-Government organisations) and in collaboration with other DHBs and the Ministry of Health regional and national work.

The region has agreed six regional objectives, which are:

- Regional Objective 1..... Improve Māori health outcomes
- Regional Objective 2..... Integrate across continuums of care
- Regional Objective 3..... Improve quality across all regional services
- Regional Objective 4..... Improve clinical information systems
- Regional Objective 5..... Build the workforce
- Regional Objective 6..... Efficiently allocate public health system resources

### 1.6.2.6 Local Context

#### Taranaki DHBs Performance Story

Our Vision	Vision: Taranaki Together, a healthy Community – Taranaki Whanui He Rohe Oranga					
Our Outcomes	To improve the health of our population			To reduce or eliminate health inequalities		
Our Strategic Priorities	Meeting Health Targets	Addressing Māori Health/Disparities	Supporting Older people to live well within their community	Addressing a system wide approach to integrated services	Supporting wellness and managing Chronic Conditions	

Long Term Impacts	People are supported to take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate care	
Intermediate Impacts	<ul style="list-style-type: none"><li>Fewer people smoke</li><li>Reduction in vaccine preventable diseases</li><li>Improving health behaviours</li></ul>	<ul style="list-style-type: none"><li>An improvement in childhood oral health</li><li>Long-term conditions are detected early and managed well</li><li>Fewer people are admitted to hospital for avoidable conditions</li><li>More people maintain their functional independence</li></ul>	<ul style="list-style-type: none"><li>People receive prompt and appropriate acute and arranged care</li><li>People have appropriate access to elective services</li><li>Improved health status for people with a severe mental health illness and/or addiction</li><li>More people with end-stage conditions are appropriately supported</li></ul>	
Outputs <sup>4</sup>	<ul style="list-style-type: none"><li>Percentage of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking</li><li>Percentage of eight months olds who will have their primary course of immunisation on time</li><li>Number of people referred to the Green Prescription programmes</li></ul>	<ul style="list-style-type: none"><li>Percentage of children (0-4) enrolled in DHB funded dental services</li><li>Percentage of population enrolled with a PHO</li><li>Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years</li><li>Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months</li></ul>	<ul style="list-style-type: none"><li>Percentage of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</li><li>Acute re-admission rate</li><li>Elective and arranged day surgery rate</li><li>Improving the percentage of long-term clients with up to date relapse prevention/treatment plans</li></ul>	

Output Classes	Prevention Services	Early detection and management services	Intensive treatment and assessment	Rehabilitation and support services	Module 3
----------------	---------------------	---	------------------------------------	-------------------------------------	----------

Stewardship	Workforce	Organisational Performance Management	Clinical Integration Collaboration Partnerships	Information	Module 5
-------------	-----------	---------------------------------------	---	-------------	----------

<sup>4</sup> The outputs described are examples only. See module three for a comprehensive set of outputs.

### 1.6.2.7 Local Operating Environment

Strategic Priority	Description
Māori Health/Disparities	<p>Improving Māori health and enabling a Whānau Ora approach to the health and well-being of Māori living in Taranaki, are priorities for the Taranaki DHB.</p> <p>The findings and implications identified in the Whānau Ora Health Needs Assessment and also those identified as national priorities have been expressed in Taranaki DHBs Māori Health Plan (MHP) and are a focus for our activities in 2016/17.</p>
Meeting and Maintaining Health Targets	Taranaki DHB is committed to meeting the Health Targets. Improving our performance requires a 'whole of system' approach with a combination of focused attention, clinical leadership and system integration.
Financial Performance	Ensuring delivery on agreed financial forecasts and the ability to live within our means, while delivering national, regional and local initiatives.
Mama Pepi Tamariki	This is a focus on all children having the best start in life. Delivering on the Children's Action Plan, Health Beginnings and the Well Child Tamariki Ora Quality Improvement Framework are a priority for Taranaki DHB. The approach involves working closely with our agency partners, recognising the important contribution and accountability all agencies have in improving outcomes for all Taranaki children.
Youth	We will continue to implement the Taranaki Taiohi Health Strategy, Prime Ministers Youth Mental Health Project objectives and use the Social Sector Trial site as the platform to do things differently for Taranaki Taiohi.
Health of Older Persons	<p>We will continue working with primary and community care to deliver integrated services for older people to support their continued safe, independent living at home. Particularly important are avoiding hospital admission and care after a hospital discharge.</p> <p>We are also working with the Ministry to implement our commitment to improving home care, stroke services and dementia care pathways.</p>
Mental Health	We will continue with the redesign of the Mental Health and Addictions Services with an emphasis on achieving and aligning to align to the objectives of the Service Development Plan, <i>Rising to the Challenge</i> . The sector recognises the importance of robust early intervention strategies to maintain wellness for those experiencing Mental Health and Addictions issues. Service development takes into consideration a whole of life and whole of system approach. We also see our Primary Care partners as important for service integration. Work in this area will focus on Perinatal, Infant and children.
Service Integration and Redesign of Non-Acute Services	<p>This will involve many stakeholders working together to redesign the Taranaki Integrated Health System.</p> <p>A key to this will be the collective effort of local providers and communities, together with lessons from elsewhere developing new ways and potentially new locations for services to be delivered within the resources available.</p>

## 1.7 Key Risks and Opportunities

By its nature, the health sector is complex and challenging. We have identified the following risks and opportunities as being particularly relevant for 2016/17.

### 1.7.1 Achieving Health Equity

We are committed to reducing or eliminating the effects of health disparities through, firstly, identifying them and, secondly, through funding and providing universal programmes which include a focus on reducing disparities as well as specific programmes that target disparities and improve access to services. It should be noted that long term conditions, particularly those that are exacerbated by tobacco use, and maternal smoking (particularly in the third trimester) are significant contributors to health disparity. A challenge for DHBs in this region is to configure health service delivery in a way that takes account of the complex relationships between the key social determinants of health inequalities (e.g. housing quality and employment), while recognising that a number of public and private agencies influence health outcomes.

The approach we intend to take includes:

- Implementing Te Matakite 2016/17 (our Māori Health Plan)
- Promoting screening services too hard to reach groups to increase early detection of disease
- Implementing services that target communities with identified health inequalities
- Setting targets by ethnicity or by high needs
- Supporting kaupapa Māori services where appropriate
- Increasing the capability of the Māori and Pacific workforce across our district
- Using an equity lens as part of decision-making processes
- Engaging with our joint Community and Public Health Disability Support Advisory Committee to provide advice and inform decision making
- Engaging with Iwi Governance bodies to provide advice and inform decision making
- Engaging with community health forums and expert advisory groups to provide and receive advice – this will include alliance mechanisms and Service Level Alliance Teams (SLATs) representing community/primary/DHB perspectives.
- Work with our Māori Health alliance partners towards improved outcomes for Māori

### 1.7.2 Living within Our Means

The ongoing pressure of the financial environment is driving a need to improve efficiency, reduce waste and improve healthcare. This, together with the Government's goal of returning to surplus in the out-years has created a strong focus on improving fiscal management.

### 1.7.3 Health System Workforce Shortages

Workforce shortages, particularly in rural and provincial areas, are a key threat to the health system's ability to provide a full range of accessible, high-quality health services.

Between 2001 and 2021 there is a projected to be a 47% increase in demand for registered health professionals in New Zealand; over the same period it is anticipated that there will be a 12% projected increase in supply<sup>5</sup>.

We will work to strengthen the Taranaki health workforce through collaboration with:

- Health Workforce New Zealand
- Midland Regional Training Network
- Local partners, e.g. Western Institute of Technology, the Whakatipuranga Rima Rau Trust and other Government agencies

#### 1.7.4 System Integration

A growing commitment to the achievement of more effective system integration in partnership with primary care and other appropriate stakeholders is fundamental to strengthening our healthcare system. We will use clinical leadership to drive improved system integration and Better Public Services.

Evidence shows that integrating primary care with other parts of the health system is vital for better management of long term conditions, responding to the pressure of an ageing population and in managing acute demand. Hospital demand is growing at a rapid rate, and as more hospital admissions occur due to preventable causes, we need to examine what could be improved in regard to how we deliver our services.

Alliance Leadership Teams and Service Level Alliance Teams have a key role to play in the development of the 2016/17 DHB Annual Plan for Primary Care (including Rural Health) and Youth Health.

#### 1.7.5 Regional Integration

There are potentially significant gains to be made from DHBs working together in new and innovative ways, both in cost savings and better patient wellbeing. Regional services' planning is a vehicle to progress regional system integration and regional service development opportunities. It is vital that this is a whole of system approach and as such, it is vital for primary care to be engaged in developments in this arena.

### 1.8 Key Measures of Performance

The following outcomes and impacts described below set out what we expect to see occurring in response to the outputs we deliver over time. Local actions in relation to our services are recorded, along with deliverables and timing, in *Module 1 (Strategic Intentions - priorities and targets)*, *Module 3 (Statement of Performance Expectations)* and *Module 5 (Stewardship)* of this Plan.

---

<sup>5</sup> Source: Trends in Service Design and New Models of Care: A Review, Ministry of Health 2010

## 1.8.1 Outcome 1 – People Are Supported To Take Greater Responsibility For Their Health

### Expectation

Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. These programmes create health-promoting physical and social environments which support people to take more responsibility for their own health and make healthier choices.

### Why is this outcome a priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. We are more likely to develop long-term conditions as we age, and with an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

### 1.8.1.1 Fewer People Smoke

#### Why is this important?

Smoking and exposure to second-hand smoke causes 4,500 to 5,000 premature deaths annually and impacts directly on those who smoke and also through the effects of passive smoking on children and others who spend time with smokers. Tobacco smoking is a major contributor to preventable illness and long term conditions, such as cancer, respiratory disease, heart disease and strokes. Cancer is the leading cause of death in New Zealand (29.8%), and is a major cause of hospitalisation and driver of cost. Cancer also highlights continuing inequalities, with Māori experiencing a higher incidence (20% +), higher mortality and higher stage at presentation. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say “no” to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Māori.

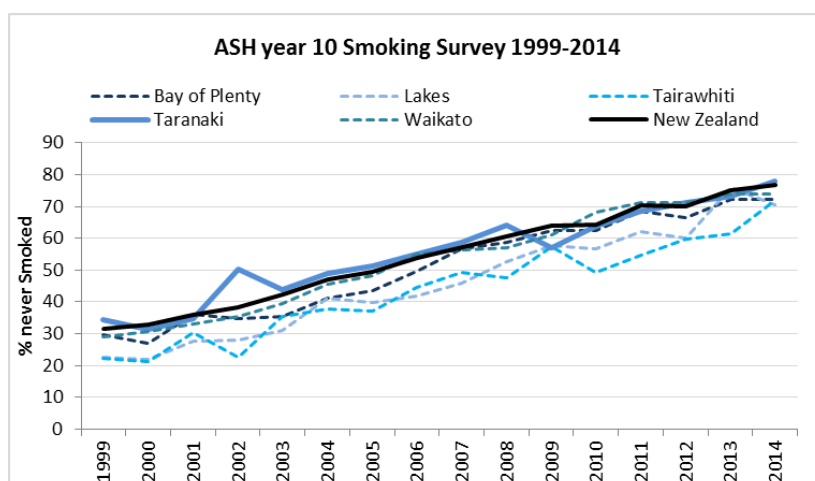


Figure 1 - Percentage of Year 10 high school students who have indicated they have never smoked, not even a puff in the annual ASH survey. ASH New Zealand 2014. Report for the Ministry of Health, Health Sponsorship Council and Action on Smoking and Health: Auckland, New Zealand

### How will we know we are succeeding?

In order to have the greatest impact we need to increase the number of people quitting smoking and utilising pharmacotherapy and specialist stop smoking support. The prevention of people taking up smoking in the first place and protecting our children and grandchildren from harm by not being exposed to second and third hand tobacco smoke (includes pregnancy) and tobacco products.

In order to have the greatest impact, we will prevent people from taking up smoking in the first place (Year 10 students), working our way through the continuum from prevention, to detection (identifying adults who smoke and offering them cessation advice – see Health Targets), and ultimately reducing the number of people who smoke.

Fewer People Smoke	Actual	Target	Target	Target
	2014	2016	2017	2018
Percentage of Year 10 Students who have never smoked	76.93%	Increase		

### 1.8.1.2 Reduction in Vaccine Preventable Diseases

#### Why is this important?

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals, but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (Whooping Cough). These diseases are entirely preventable. See Health Targets.

#### How will we know we are succeeding?

There is a direct correlation between decreasing the incidence of communicable diseases and increasing our immunisations rates. We will succeed when the number of admissions for vaccine preventable diseases is further reduced.

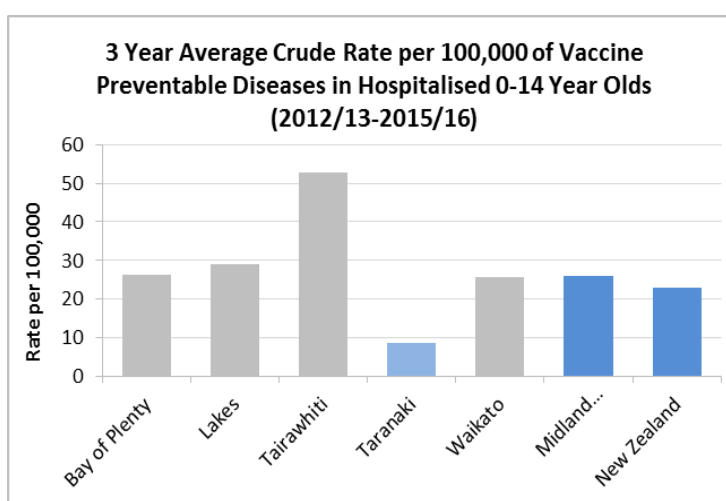


Figure 2 - Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year olds

Reduction in Vaccine Preventable Diseases	Actual	Target	Target	Target
	Ending 14/15	Ending 16/17	Ending 17/18	Ending 18/19
Three year average crude rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year old	8.81	<5.87	Decrease	

### 1.8.1.3 Improving Health Behaviours

#### Why is this important?

In 2016 Body Mass Index (BMI) is expected to overtake tobacco as the leading preventable risk to New Zealanders' health, thus in October 2015 the Ministry of Health (MoH) released the Childhood Obesity Plan which aims to prevent and manage obesity in children and young people up to 18 years of age. The focus of the Plan is on food, the environment, and being active at each life stage starting during pregnancy and early childhood bringing together government agencies, the private sector, communities, schools, and whānau across 22 initiatives.

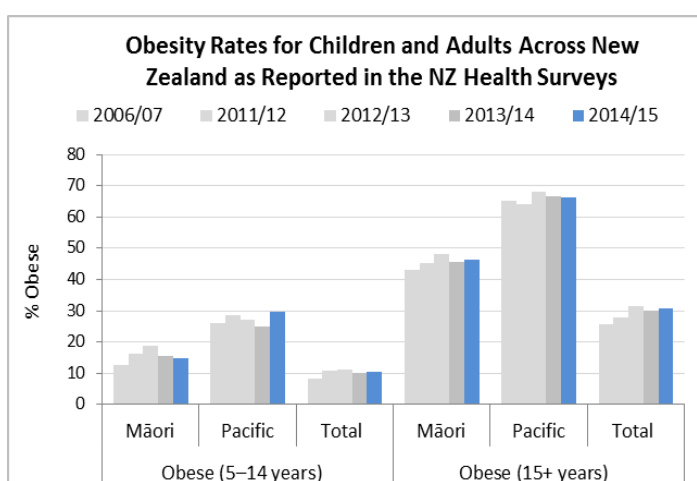


Figure 3 - 2014/15 New Zealand Health Survey.

Note - Obesity is defined as a body mass index (BMI) of 30 or more (calculated by dividing a person's weight in kilograms by the square of their height in metres). Survey interviewers measured respondents' height and weight, from which BMI could be calculated.

Development of the Plan drew on recent evidence including the World Health Organisation's (WHO) Commission for Ending Childhood Obesity and Professor Peter Gluckman's, Chief Science Advisor to the Prime Minister and co-chair of the WHO Commission, research indicating that pre-conditions for obesity are set very early and the best intervention point is maternal and infant nutrition (including breastfeeding) and physical activity.

Increased physical activity and improved nutrition will impact rates of obesity and other conditions including high cholesterol, high blood pressure, heart disease, some cancers and mobility disorders however a multi-faceted approach is needed. Obesity disproportionately affects Māori, Pacific, and low socio-economic groups across New Zealand, thus Taranaki DHB interventions will be targeted to Māori to decrease this disparity.

#### How will we know we are succeeding?

The long-term outcome will see the reduction of Childhood Obesity rates in the New Zealand Health Survey and a decrease in BMI for Taranaki 4 year olds at B4 School Checks.

These are measures of successful health promotion and engagement and a change in the social and environmental factors that influence people to make healthier choices. The outcomes can be influenced by the number of referrals to the Green Prescription programme, the number of Active Families/Whānau Pakari participants discharged as independently active (by ethnicity), and demonstrable increases to breastfeeding rates.

Obesity Rates for Children and Adults Across New Zealand	Actual	Target		
	2014/15	2016	2017	2018
% obese of New Zealand 5 -14 years population	10.3%	reduce rate of obesity		
% obese of New Zealand 15+ years population	30.7%	reduce rate of obesity		

## 1.8.2 Outcome 2 - People Stay Well in Their Homes and Communities

### Expectation

Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and better managing their illness or long-term conditions. These services assist people to detect health conditions and risk factors earlier, making treatment and interventions easier and reducing the complications of injury and illness. They also support people to regain their functionality after illness and to remain healthy and independent.

### Why is this outcome a priority?

For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and closer to home and prevent disease through education, screening, early detection and timely provision of treatment. Primary care is also vital as a point of continuity and effective coordination across the continuum of care, particularly in improving the management of care for people with long-term conditions.

Supporting primary care are a range of other health professionals including midwives, community nurses, social workers, aged residential care providers, personal health providers and pharmacists. These providers have prevention and early intervention perspectives that link people with other health and social services and support them to stay well. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

With an ageing population, the Midland Region will require a strong base of primary care and community support, including residential care, respite and home-based support. If long-term conditions are managed effectively, crises and deterioration can be reduced and health outcomes improved. Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence.

If people are well they need fewer hospital-level or long-stay interventions and, those who do, have a greater chance of returning to a state of good health or slowing the progression of disease. This is not only a better health outcome for our population, but it reduces the rate of acute and unplanned hospital admissions and frees up health resources.

### 1.8.2.1 Children and Adolescents Have Better Oral Health

#### Why is this important?

Good oral health demonstrates early contact with health promotion and prevention services and reduced risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights. Oral health is also an integral component of lifelong health and impacts a person's comfort in eating (and ability to maintain good nutrition in old age), self-esteem and quality of life.

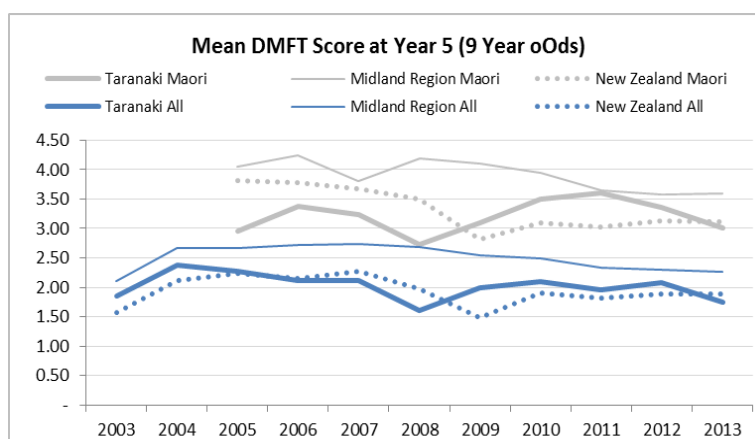


Figure 4 – Diseased, Missing and Filled Teeth (DMFT) for year 5 students in Taranaki DHB, Midland Region and New Zealand. Ministry of Health 2013 (national data only in 2003-04)

Māori children are three times more likely to have decayed, missing or filled teeth, and improved oral health is a proxy measure of equity of access and the effectiveness of mainstream services in targeting those most in need.

### How will we know we are succeeding?

With the continued decrease in the

DMFT score of year 8 children. Mean Diseased, Missing or Filled

Teeth (DMFT) for permanent teeth. DMFT is a count of Diseased, Missing or Filled Teeth in permanent dentition (permanent teeth) in a person's mouth. By Year 8, children's teeth should be their permanent teeth and any damage at this stage is life long, so the lower a child's DMFT, the more likely that their teeth will last a life time.

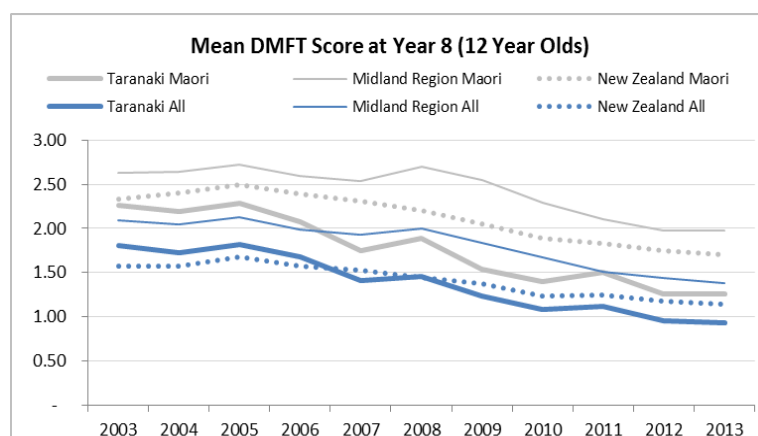


Figure 5 – Diseased, Missing and Filled Teeth (DMFT) for year 8 students in Taranaki DHB, Midland Region and New Zealand. Ministry of Health 2013

Children and Adolescents Have Better Oral Health	Actual	Target	Target	Target
	2015	2016	2017	2018
Mean DMFT Year 5	1.75	Decrease		
Mean DFMT Year 8	0.93	0.88	Decrease	

### 1.8.2.3 Long-Term Conditions are Detected Early and Managed Well

#### Why is this important?

If we are to empower people to take greater responsibility for their health, to improve the health of our population and if we are to “contain costs” we have a significant opportunity by detecting conditions early. Early detection will lead to either successful treatment, or delaying or reducing the need for secondary and specialist care,

enabling more people to stay well in their homes and communities for longer.

Our greatest opportunity to do this is to manage Cardiovascular Disease (CVD or heart disease). It is one of the largest causes of death in New Zealand, and disproportionately higher for Māori. Often by the time heart problems are detected, the underlying cause of atherosclerosis (arterial disease) is usually well advanced. Our aim is to either prevent the disease by modifying risk factors such as healthy eating, exercise and avoiding smoking, or early detection and management. See also Health Targets.

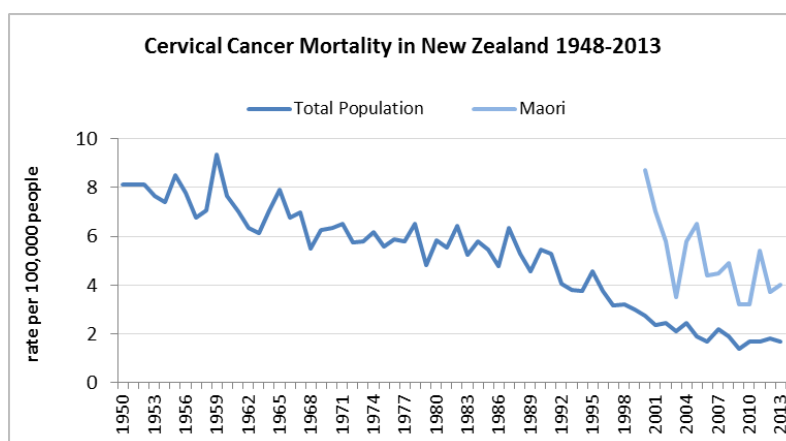


Figure 6 - Female Cervical Cancer mortality in New Zealand 1950 to 2013. Ministry of Health 2013.

## How will we know we are succeeding?

Screening is one of the most effective methods to reduce the incidence and impact of some cancers. By catching cancers when they are small screening programmes offer the best chance of success. Also by increasing the proportion of people with well managed diabetes, we will reduce avoidable complications that require hospital-level intervention, such as amputation, kidney failure and blindness, and will improve people's quality of life, allowing more people to stay well in their homes and communities for longer.

Cervical Cancer Mortality in New Zealand	Actual	Target	Target	Target
	2013	2016	2017	2018
Age standardised rate for NZ	1.70	Decrease		

### 1.8.2.4 Fewer People are admitted to Hospital for Avoidable Conditions

#### Why is this important?

There are a number of admissions to hospital for conditions which are seen as avoidable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the effectiveness of screening, early intervention and community-based care.

A reduction in these admissions will reflect better management and treatment of people across the whole system, will free up hospital resources for more complex and urgent cases and deliver on the Government's priority of "better, sooner, more convenient" healthcare.

The key factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services. Improving people's access to, and the effectiveness of, primary care will facilitate early interventions, particularly among Māori and Pacific people, which supports improving our population's health outcomes and reducing health inequalities for Māori.

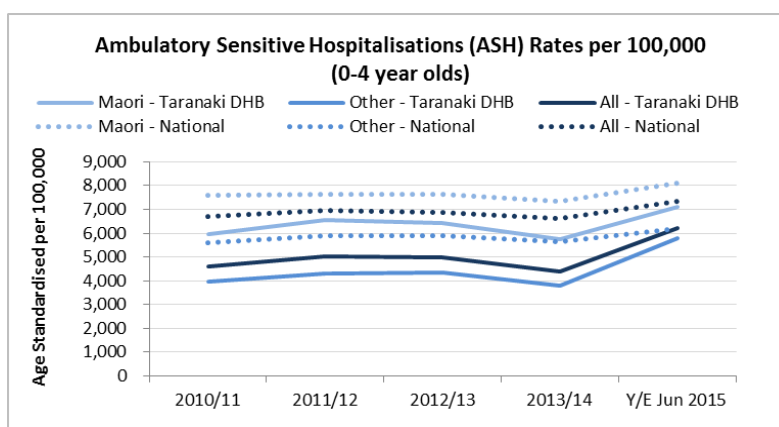


Figure 7 – Rate of Ambulatory Sensitive Hospitalisations, Ministry of Health, ASH summary by DHB, Q4 2015

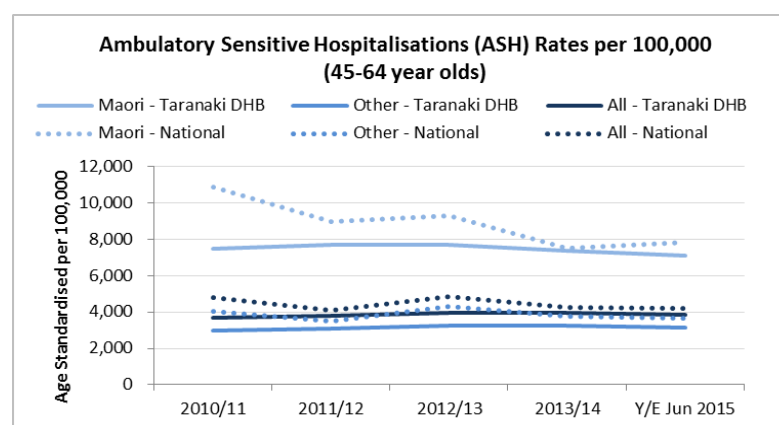


Figure 8 – Rate of Ambulatory Sensitive Hospitalisations, Ministry of Health, ASH summary by DHB, Q4 2015

### How will we know we are succeeding?

When we reduce the ratio of actual to expected avoidable hospital admissions for our population (Total and Māori)?

Fewer People are Admitted to Hospital for Avoidable Conditions	Actual	Target	Target	Target
	2015	2016	2017	2018
Taranaki DHB 0-4 year olds	6,205	Decrease		
Taranaki DHB 45-64 year olds	3,838	Decrease		

### 1.8.2.5 People Maintain Functional Independence

#### Why is this important?

If we are to deliver on our twin goals of improving health outcomes, and reducing or eliminating health inequalities, for our older population, we aim to support people to maintain functional independence. With an increasing and ageing population, as this cohort increases, so does demand on our constrained funding. Aged Residential Care (ARC) is a specialist, high cost, and scarce resource. We are looking to manage the expected growth in demand, through an ageing population, by improved models of care that support people to remain independent for as long as possible.

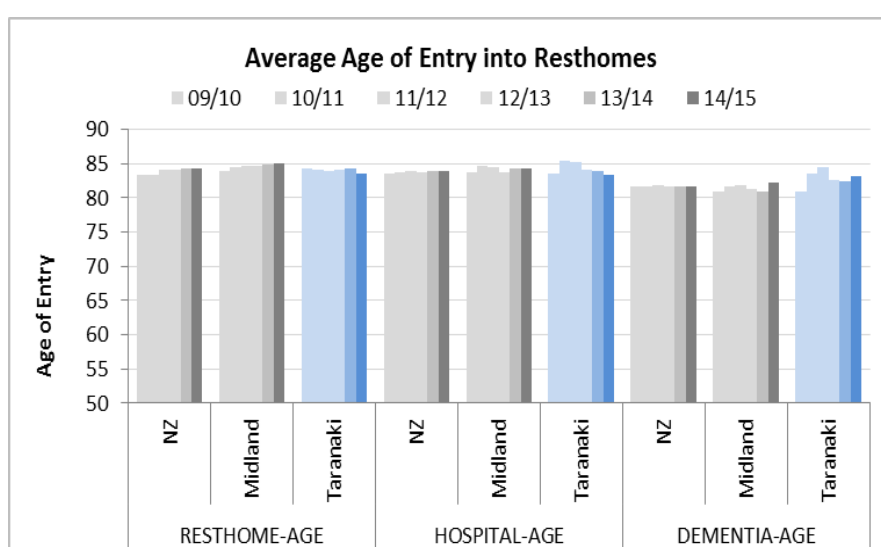


Figure 9 – Average age at entry to residential care facilities in each of the last 4 years for people under the Health of Older People funding stream. Data sourced from Client Claims Processing System (CCPS).

### How will we know we are succeeding?

Ideally, we would like to promote a model of care that reduces the proportional length of time an older person requires ARC. As we do not currently capture this information, our best proxy indicator is to increase the average age at which an older person enters ARC.

Average Age of Entry to Aged Related Residential Care	Actual	Target	Target	Target
	15/16	16/17	17/18	18/19
Rest Home	83.56	Increase		
Hospital	83.33	Increase		
Dementia	83.20	Increase		

### 1.8.3 Outcome 3 - People Receive Timely and Appropriate Specialist Care

#### Expectation

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, people's health outcomes and quality of life can be improved.

#### Why is this outcome a priority?

Clinicians, in cooperation with patients and their families, make decisions with regards to complex treatment and care. Not all decisions result in interventions to prolong life, but may focus on patient care such as pain management or palliative services to improve the quality of life. For those who do need a higher level of intervention, timely access to high quality complex care improves health outcomes by restoring functionality, slowing the progression of illness and disease and improving the quality of life.

The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter waiting lists and wait times are also indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures, and Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. The expectations around reducing waiting times, coupled with the current fiscal situation, mean DHBs need to develop innovative ways of treating more people and reducing waiting times with limited resources.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the Midland Region has the capacity to provide for the complex needs of its population now and into the future.

#### 1.8.3.1 People Receive Prompt and Appropriate Acute Care

##### Why is this important?

Long stays in Emergency Departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Less time spent waiting and receiving treatment in an ED improves the health services DHBs are able to provide.

The duration of stay in ED is influenced by services provided in the community to reduce inappropriate ED presentations, the effectiveness of services provided in ED and the hospital and community services provided following exit from ED. Reduced waiting time

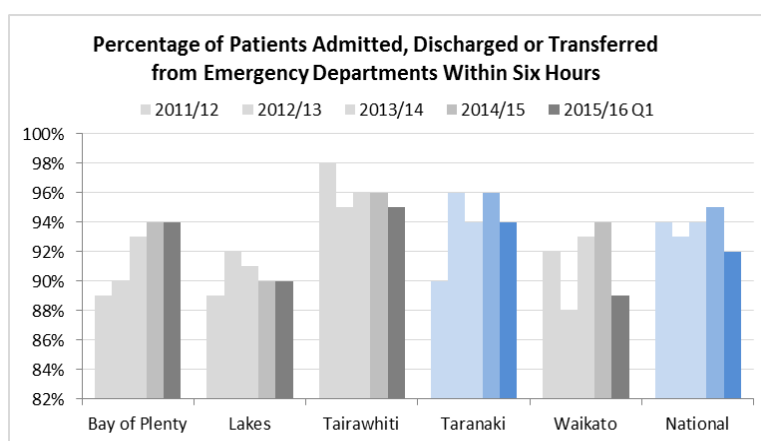


Figure 10 – Emergency Department Waiting Times

in ED is indicative of a coordinated ‘whole of system’ response to the urgent needs of the population.

### How will we know we are succeeding?

When we see an increase in the percentage of people who visit our ED are admitted, discharged or transferred within six hours. Improved performance against this measure will not only improve outcomes for our population, but will improve the public’s confidence in being able to access services when they need to.

Percentage of Patients Admitted, Discharged or Transferred from Emergency Departments Within Six Hours	Actual	Target	Target	Target
	15/16 Q1	16/17	17/18	18/19
	0.94	>90%	>95%	>95%

## 1.8.3.2 People Have Appropriate Access to Elective Services

### Why is this important?

Elective services are an important part of the health system, as they improve a patient’s quality of life by reducing pain or discomfort and improving independence and wellbeing. The Government wants more New Zealanders to have access to elective surgical services (see Health Targets). Improved performance against this measure is also indicative of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

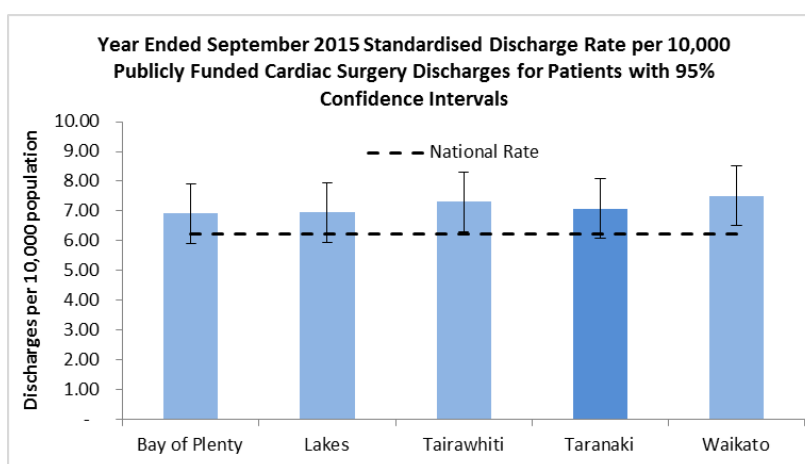
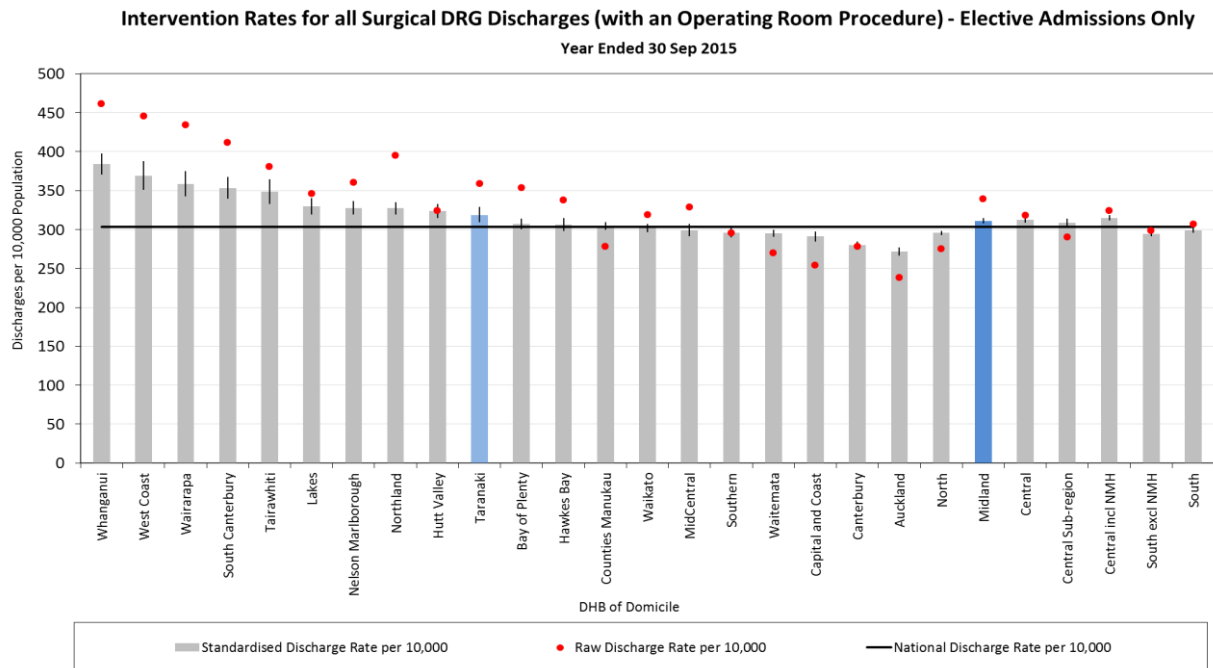


Figure 11– Ministry of Health Year Ended September 2015 Standardised Discharge Rates per 10,000 for Publicly Funded Cardiac Surgery Discharges for patients with 95% Confidence Intervals

### How will we know we are succeeding?

To meet the appropriate level of access, we want to ensure that our Standard Intervention Rates (SIRs) meet national expectations for elective procedures. The measure in figure 11 is one example of comparative intervention rates that we use. It is only one of 43 SIR measures that are currently being monitored on a regular basis. Other examples of monitoring are as follows;

Elective Service Standardised Intervention Rates (per 10,000)	Actual	Target	Target	Target
	14/15	16/17	17/18	18/19
Major joint replacement	20.61	≥21.00	Maintain	Maintain
Cataract procedures	31.09	≥27.00	Maintain	Maintain
Cardiac surgery	6.56	≥6.50	Maintain	Maintain



### 1.8.3.3 Improved Access to Mental Health Services

#### Why is this important?

It is estimated that at any one time, 20% of the New Zealand population will have a mental illness or addiction, and 3% are severely affected by mental illness. With high suicide rates in some of our communities, we are working to reduce this rate and support our communities with Whanau Ora initiatives (see Module 3). There is also a high prevalence of depression with the economic downturn and other pressures. The World Health Organisation (WHO) predicts that depression will be the second leading cause of disability by 2020. We have an ageing population, which places increased demand from people over 65 for mental health services appropriate to their life stage. The prevalence of mental illness in the population increases with age, and older people have different patterns of mental illness, often accompanied by loneliness, frailty or physical illness.

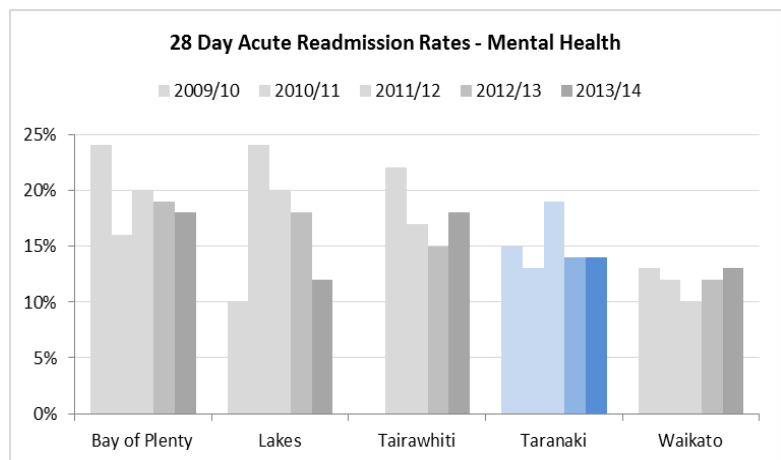


Figure 12 – Data from PRIMHD showing the per centage of mental health patient admissions who are readmitted to hospital within 28 days of a previous discharge

#### How will we know we are succeeding?

Access is the key to improving health status for people with a severe mental illness. Our goal is to build on our existing, and well established intersectoral cooperation between primary/community and secondary services, by offering programmes to individuals and groups from a broad range of ages – children and youth, adults and older people.

If we improve access, and providing we provide services to people at the right time, and in the right place, and can expect to see a reduction in our 28 day readmission rate. This will, in turn, assist in reducing pressure on our hospital services.

28 Day Acute Readmission Rates	Actual	Target	Target	Target
	14/15	16/17	17/18	18/19
	14%	≤10%	Decrease	Decrease

#### 1.8.3.4 More People with End-Stage Conditions are Appropriately Supported

##### Why is this important?

It is important that people who have life threatening illness, along with their family and whanau, receive appropriate care and support to cope with their situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition that end of life is imminent and commencement of a palliative approach to care and support will heavily influence the quality of life individuals and their family experience during the dying process. Support services during this time include palliative care, aged residential care, respite care and home based support services.

##### How will we know we are succeeding?

Palliative care is being accessed. We want to facilitate early identification of palliative care need in primary care, within aged care facilities and also within our acute hospitals in collaboration with the specialist palliative care service. On-going education for these health professionals will be an essential building block in ensuring all Taranaki people facing end-stage conditions have access to quality end of life care wherever they are located.

The Palliative Care Council in its 2010 position statement identified a lack of data on the need for palliative care for New Zealand and monitoring on the implementation of the New Zealand Palliative Care Strategy. We have commenced by monitoring numbers of palliative care clients who have ED presentations with the conjecture that people who are supported appropriately with end stage conditions will have fewer ED presentations.



## Module 2A

# Implementation of the New Zealand Health Strategy



## MODULE 2A: IMPLEMENTATION OF THE NZ HEALTH STRATEGY

### 2A.1 Context

In accordance with section 38(2)(d) of the NZPHDA, DHB's annual plans must reflect the draft refreshed NZHS's direction and detail each DHB's commitment to delivering appropriate actions in line with the Strategy's Roadmap.

The refreshed NZHS has two parts: (i) Future Direction and (ii) Roadmap of Actions. The Future Direction outlines a high-level direction for New Zealand's health and disability system over the next 10 years. The Roadmap of Actions identifies 20 work areas for the next five years to put the Strategy in place. The Strategy has been informed by the Government's four high level priorities and will support the health system's contribution to a range of cross-government strategies.

The refreshed NZHS focuses on health but is set within the wider context of the interconnections between health and other aspects of people's lives. The Government is focused on improving the lives and wellbeing of New Zealanders. Its priorities include work, across agencies, to tackle the complex and long-term problems that some New Zealand families face. Examples include putting families and whānau at the centre of service delivery through Whānau Ora, and reducing assaults on children by working closely with the Police, courts and justice sector partners and providing mental health addiction and treatment.

There are five strategic themes identified in the draft strategy as illustrated below:



In order to reduce duplication, where there is an obvious cross over with our DHB and/or regional activities identified under existing priority areas, we have captured these in the below table that references where the detailed actions can be found elsewhere in this plan.

## 2A.2 Themes from the Health Strategy

People Powered	Reference
Developing understanding of users of health services	<i>References to consumer engagement are identified throughout Module 2 (e.g. 2B.2.20 Whanau Ora and 2B.2.26 Improving Quality)</i>
Encouraging and empowering people to be more involved in their health	<i>2B.2.24 Integration with National Electronic Health Record 2B.2.29 Improving Clinical Information System</i>
Partnering with people to design services to meet their needs	<i>2B.1.3 Rising to the Challenge: Cementing Gains for the Most Vulnerable 2B.2.17 Integrated Health Care 2B.2.18 System Level Outcomes</i>
Supporting people's navigation of the health system	<i>2B.12 Rising to the Challenge: Cementing Gains for the Most Vulnerable 2B.2.17 Integrated Health Care 2B.2.18 System Level Outcomes</i>
Care Closer to Home	Reference
Providing health services closer to home	<i>2B.2.3 Supporting Vulnerable Children 2B.2.5 Prime Ministers Youth Mental Health Project 2B.2.16 Health of Older Persons System Integration for Older People 2B.2.19 Shorter Waits in ED (ED Redirection)</i>
More integrated health services, including better connection with wider public services	<i>2B.2.17 Integrated Health Care 2B.2.18 System Level Outcomes</i>
An investment early in life	<i>2B.2.1 Reducing Unintended Teenage Pregnancy 2B.2.2 Increased Immunisations 2B.2.3 Supporting Vulnerable Children 2B.2.4 Reducing Rheumatic Fever 2B.2.5 Prime Ministers Youth Mental Health Project 2B.2.6 Child and Youth Oral Health 2B.2.7 Well Child Tamariki Ora 2B.2.8 Childhood Obesity 2B.2.11 Better Help for Pregnant Women to Quit</i>

<b>Care Closer to Home</b>	<b>Reference</b>
A focus on the prevention and management of chronic and long-term conditions	<i>2B.2.8 Childhood and Adult Obesity</i> <i>2B.2.9 Living Well with Diabetes</i> <i>2B.2.10 Cardiovascular Disease</i> <i>2B.2.12 Rising to the Challenge (Mental Health)</i> <i>2B.2.14 Stroke Services</i> <i>2B.2.15 Cardiac Services</i>
<b>Value and High Performance</b>	<b>Reference</b>
The transparent use of information	<i>2B.2.24 Integration with National Electronic Health Record</i> <i>2B.2.29 Improving Clinical Information System</i> <i>5.2.2 Information Communication Technology</i>
An outcome-based approach	<i>1.6 Strategic Intentions</i> <i>2B.2.17 Service Configuration</i> <i>2B.2.18 System Level Outcomes</i>
Strong performance measurement and a culture of improvement	<i>1.6 Strategic Intentions</i> <i>2B.2.25 National Entity Priorities (HQSC Programmes)</i> <i>5.1 Managing Our Business</i> <i>5.2.3 Quality Assurance &amp; Improvement</i> <i>5.3 Workforce</i> <i>5.4 Organisational Health</i>
An integrated operating model providing clarity of roles	<i>5.1 Managing our Business</i>
The use of investment approaches to address complex health and social issues	<i>4.2.1 Taranaki DHB Funder Operations</i> <i>4.2.2 Taranaki DHB Hospital Operations</i> <i>5.3.1 Managing our Workforce Within Fiscal Constraints</i>

<b>One Team</b>	<b>Reference</b>
Operating as a team in a high-trust system	<i>2B.2.17 Service Configuration 2B.2.18 System Level Outcomes</i>
The best and flexible use of our health and disability workforce	<i>5.3 Workforce</i>
Leadership and management training	<i>2B.2.25 National Entity Priorities (Capability and leadership programmes) 5.1 Managing our Business 5.2 Building Capability 5.3 Workforce 5.3.2 Strengthening our Workforce</i>
Strengthening the role for people, families and whānau and communities to support health	<i>References to consumer engagement are identified throughout Module 2 (e.g. 2B.2.20 Whanau Ora and 2B.2.26 Improving Quality)</i>
More collaboration with researchers	<i>2B.2.24 National Entity Priorities (Commitment to work with National Health Committee)</i>
<b>Smart System</b>	<b>Reference</b>
The increased use of analytics and systems to improve management reporting, planning and service delivery and clinical audit	<i>2B.2.24 Integration with National Electronic Health Record 2B.2.29 Improving Clinical Information System 5.2.2 Information Communication Technology</i>
The health system as a learning system, that continuously monitors and evaluates what it is doing, and shares it	<i>Module 6 Service Configuration (as any service coverage is considered, evaluations and learnings will be taken into account.)</i>
The availability – at the point of care – of reliable and accurate information including on-line electronic health records	<i>2B.2.24 Integration with National Electronic Health Record 2B.2.29 Improving Clinical Information System 5.2.2 Information Communication Technology</i>



## Module 2B

# **Delivering on Priorities and Targets**



## MODULE 2B: DELIVERING ON PRIORITIES AND TARGETS

### 2B.1 Priorities and Targets

#### 2B.1.1 Implementing Government Priorities

Four important policy drivers have been identified through which the health sector may best utilise resources to achieve Better, Sooner, More Convenient services.

##### **Better Public Services (including Social Sector Trials)**

Positive health outcomes are a consequence of activities across the social sectors, not just the health sector. Initiatives such as Better Public Services and Social Sector Trials are examples of where the health sector and the social sectors are working together to deliver a collective impact. New Zealand's State Sector, (which includes DHBs), faces increasing expectations for better public services in the context of prolonged financial constraints compounded by the global financial crisis. The key to doing more with less lies in productivity, innovation, and increased agility to provide services. Agencies need to change, develop new business models, work more closely with others and harness new technologies in order to meet emerging challenges.

The area that health is taking a major role in is the results around supporting vulnerable children, which are:

- Result 2: Increase participation in early childhood education
- Result 3: Increase infant immunisation rates and reduce the incidence of Rheumatic Fever
- Result 4: Reduce the number of assaults on children

##### **Regional Collaboration**

This means DHBs working together more effectively, whether regionally or sub-regionally.

##### **Integrated Care**

This includes both clinical and service integration to bring organisations and clinical professionals together, to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home.

##### **Value for Money**







This is the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

##### **Health Targets**

Overarching Government priorities are presented in the Minister's Letter of Expectations, which was sent to DHB Chairs in December 2015. The planning priorities for DHB 2016/17 Annual Plans are:

## Commitments

DHBs are expected to commit to achieving the following health targets in our Annual Plans.

Health Target	National long Term Targets
	<p>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours of presentation.</p>
	<p>The volume of elective surgery will be increased nationally by at least 4,000 discharges per year.</p>
	<p>85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by June 2017.</p>
	<p>By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.</p>
	<p>95% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.</p>
	<p>90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.</p> <p>90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.</p>

## 2B.2 Actions to Deliver on Annual Plan Priorities

### Child and Youth Health

#### 2B.2.1 Reducing Unintended Teenage Pregnancy

The consequences of adolescent pregnancy and childbearing are serious and numerous. Pregnancy teenagers are more likely than women who delay childbearing to experience maternal illness, miscarriage, stillbirth and neonatal death. Teen mothers are less likely to finish high school education and more likely than their peers who delay childbearing to live in poverty and rely on welfare, posing a substantial financial burden. Often young men are overlooked as group that plays an important role in reducing teenage pregnancy,

##### *Our Approach*

In 2014/15 the rates of births for young Māori had decreased however the rates of abortion had increased. Public Health Nurses provide a valuable sexual health services within schools and other community based clinics. We will continue to focus actions to reduce unintended teenage pregnancies with a focus on Māori and young women living in high deprivations areas.

##### *Linkages*

- Better Public Services Target
- Vulnerable Children

##### *Action Plan*

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Reducing Unintended Teenage Pregnancies</b>	<b>School Based Health Service (SBHS) Contracts.</b> Taranaki DHB will ensure that SBHS contracts negotiated with schools include explicit agreement for: <ul style="list-style-type: none"><li>• Nurses to provide contraception choice eg, discussion, referral, prescriptions or provision and have sufficient access to contraceptive supplies</li><li>• Nurses to have ECP endorsement and use standing orders</li><li>• Nurses to get appropriate professional support/supervision and remuneration e.g.:<ul style="list-style-type: none"><li>- attend workforce development in relevant youth health and sexual and reproductive health issues</li><li>- access training from DHB nursing professional development units</li><li>- attend regional networks of other school nurses and/or youth health professionals</li><li>- be able to access clinical supervision/support from appropriate health professionals eg, GPs.</li></ul></li></ul>	By March 2017 100% of PHN's trained and qualified to provide contraception advice including ECP and to operate under standing orders.  Quarter 4 – confirmation and exception report against the actions identified.	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<b>Access to Contraceptives and Termination of Pregnancy</b> <ul style="list-style-type: none"> <li>• There is affordable (low cost, no cost) locally available culturally competent, youth friendly primary care sexual health and contraceptive consultations (including the insertion of LARCs) in urban, provincial and rural towns.</li> <li>• Pro-actively offer contraceptive counselling to all vulnerable young women/teenagers following a decision to terminate a pregnancy and at appropriate points during pregnancy and post partum.</li> <li>• Provide contraception to vulnerable young women following termination of pregnancy, and post partum based on informed consent and documented choices.</li> <li>• Support youth access to safe termination of pregnancy including early medical abortion.</li> <li>• Ensure that all youth needing advice are referred to our termination service.</li> <li>• Sexual health clinic hours reviewed to support access – carry out patient and staff satisfaction survey to identify issues with accessing services.</li> <li>• That our sexual health service is accessible in terms of hours open and services provided to ensure free sexual health care is available.</li> <li>• That 100% of young women receive contraceptive advice following a termination.</li> </ul>		

## 2B.2.2 Increased Immunisation

### Our Approach

During 2016/17 we will continue to focus on increasing the immunisation uptake in Taranaki. The governance and operational group structures are embedded and continue to drive for efficiency and effectiveness of services and systems. We are implementing NCHIP (Child Health Platform) which is proven to help close the loop in children receiving more timely information. Alongside we will continue to work with our agency partners to look for opportunities to share information including education and training for agency staff to support immunisation messages. We will focus on the wider continuum of care from pregnancy to six years of age with the aim of immunisation milestones being delivered on time and reducing the gap for Māori uptake against Total population.

### Linkages

- Our Performance Story Impact: People Take Greater Responsibility For Their Health
- Better Public Health
- Minister's Letter of Expectations
- Draft NZ Health Strategy
- Māori Health Plan

- Taranaki DHB Pae Ora Framework
- Te Kawau Maro, Taranaki DHB Māori Health Strategy

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Increased Immunisation</b>	<p>95% of eight month, 24 month and five year immunisation events are on time.</p> <ul style="list-style-type: none"> <li>• Maintaining a well functioning Taranaki Immunisation Steering Group (TISG) and Operational Taskforce Group to drive the activity associated with continuous improvement in systems and service delivery.</li> <li>• Increase membership of Steering group to include other agencies.</li> <li>• Use of the monthly Dashboard to monitor immunisation activity and gaps in service provision.</li> <li>• Target activity to focus on reducing the gap between Māori and Other population uptake of immunisation. <ul style="list-style-type: none"> <li>- Utilisation of centralised NCHIP system to locate families that are not engaged. Support immunisation of all children at one appointment.</li> <li>- monthly analysis of OIS registers on the demographics of overdue children, targeting specific geographical and practice areas who are over represented and redirect resource.</li> <li>- Work with Women's Welfare League to set up pop-up clinics</li> </ul> </li> <li>• Re-orientate services and teams to meet the target coverage for Māori and children living in high deprivation by focussing on Māori babies not enrolled at 6 weeks, overdue at 7 weeks and follow them through until 5 month immunisations complete. Monitor and distribute Māori coverage. <ul style="list-style-type: none"> <li>- Continue to strengthen and</li> </ul> </li> </ul>	<p>By July 2016 refreshed action plan completed</p> <ul style="list-style-type: none"> <li>• 95% of 8 month olds are fully immunised</li> <li>• 95% of 2 year olds are fully immunised</li> <li>• 95% of 4 year olds are fully immunised by July 2016.</li> <li>• 95% of General Practice meets 95% of the target.</li> <li>• By December 2016 the gap between Māori and non-Māori is uptake immunisation rates is decreased by: <ul style="list-style-type: none"> <li>- 8 months from 7% to 2%.</li> <li>- 24 months from 4% to 2%</li> <li>- 5 years from 5% to 2%.</li> </ul> </li> </ul> <p>By June 2017 the 6 month immunisation rate gap for Māori is decreased from 18% to 5%.</p> <p>By December 2016 decrease number of OIS referrals by 10%</p>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>monitor the new born enrolment process to begin at registration with a Lead Maternity Carer (LMC) through to booking in at 28 weeks and new born enrolment booking to ensure named GP and WCTO.</p> <ul style="list-style-type: none"> <li>Continued implementation of NCHIP – continuous improvement of the functionality of the system and links with the NZ Health Strategy Smart Systems.</li> <li>Identify families not engaging with health services early.</li> <li>Continue to improve systems for opportunistic vaccinations within the DHB.</li> <li>Increase the DHB's use of social media to provide immunisation information and messages</li> <li>Assess and agree use of Apps for the Taranaki population on immunisation milestones</li> <li>Promote the use of General Practice pregnancy registers to ensure early enrolment.</li> <li>Improve the interface between Lead Maternity Carers (LMC's) and General Practice with a focus on early enrolment and information sharing.</li> <li>Refresh the Taranaki Immunisation Action Plan with an emphasis on activity for timeliness for all immunisation milestones, and mapped out as a four point action planning process, Engage (Plan), Enrol (Do), Monitor (Check), Promote (Act).</li> <li>Enabling flexibility in OIS resource to meet the demand of referrals.</li> <li>Continue to improve the interface with opportunistic vaccinations throughout the</li> </ul>	<p>Report to MoH on Immunisation Week and Communications Plan</p>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>District Health Board services.</p> <ul style="list-style-type: none"> <li>• Yearly development of a Communications plan, covering immunisation week, and opportunities for using media for key messages.</li> <li>• Identify a community champion to use to front key messages.</li> <li>• A MOU or similar is in place between relevant agencies to maximise ability to locate hard to reach families.</li> <li>• NZ Health Strategy One Team - Work with MSD providers to ensure immunisation and engagement in primary care and WCTO are part of MSD contacts with families.</li> <li>• Decrease the number of OIS referrals by focused efforts of keeping families engaged or reengaged with Primary Care</li> <li>• Monthly analysis of the demographics of those on the OIS registers.</li> <li>• Target activity to areas highlighted with higher numbers of unimmunised babies and children</li> <li>• Understanding peoples needs in accessing immunisation services</li> <li>• All newborn babies are enrolled with a PHO and registered with a GP, WCTO Provider by: <ul style="list-style-type: none"> <li>- Ensuring all babies are enrolled soon after birth</li> <li>- Education for parents to encourage enrolment</li> <li>- Continue to work with General Practice to ensure consistency in administration processes for enrolment and recall.</li> </ul> </li> <li>• NZ Health Strategy One Team and Closer to Home - Work with B4SC providers to increase the delivery of 4-year-old immunisations at the B4 School nurse check.</li> </ul>	<p>By December 2016 MOU (or similar in place)</p>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>• Work with B4SC providers to increase the delivery of 4-year-old immunisations at the B4 School nurse check.</li> <li>• Build on the relationship with Kohanga Reo and Early Childhood Education (ECE) to provide health services to high need centres.</li> </ul>		
<b>Increased Uptake Of The HPV Vaccination</b>	<ul style="list-style-type: none"> <li>• Link regional screening unit and PHO's to ensure they are aware of their enrolled population that have not participated in the school based vaccination programme.</li> <li>• Maintain an HPV immunisation champion within the school-based immunisation team to include participating in Ministry of Health (MoH) teleconferences and planning for increased coverage</li> <li>• Liaising with schools to ensure 100% of consent forms are returned.</li> <li>• Offer all schools HPV information for school representatives to use and for parents/students.</li> <li>• Support primary health care and acute inpatient services to routinely promote HPV immunisation through opportunistic events and booked appointments</li> <li>• Work with primary health care on implementing a programme to recall 14-year-old girls not fully HPV immunised</li> <li>• Consider integrating an NIR HPV status look up into the year 9 HEADSS<sup>[1]</sup> assessment and offering a catch up.</li> <li>• Promotion and use of the on-line learning tool to promote knowledge and benefits of the HPV programme</li> </ul>	70% of all 12 year old girls will have completed all doses of their HPV vaccination	

<sup>[1]</sup> Home, education (ie, school), activities/employment, drugs, suicidality, and sex assessment

## 2B.2.3 Supporting Vulnerable Children

Supporting Vulnerable Children contributes to the Government's overall priorities by improving services and reducing avoidable expenditure in the justice, health and welfare systems – helping to deliver better public services within financial constraints.

### *Our Approach*

Taranaki has not yet been notified for implementation of a children's team in the region, however Taranaki DHB and our providers have a duty of care to any child/young person at risk, suspected, witnessed, reported or disclosed abuse or neglect that has presented to a Taranaki hospital, community or primary health provider or who has been referred to and/or treated by Taranaki DHB providers. Reporting all abuse or neglect of children/young persons to Child, Youth and Family (CYFS) is mandatory and safety of the child is the paramount consideration.

Taranaki DHB has implemented the new requirements to our policies and processes so that they are aligned to the Vulnerable Children's Act. We have implemented the following:

- Recruitment policies include all aspects of vetting and screening for all new staff, contractors and volunteers
- Safety checks and three yearly reassessments of existing employees, in compliance with the requirements in the Act
- All NGO providers delivering services directly to children have child protection policies in place and a system for worker safety checks in line with the Taranaki DHB Child Protection Policy
- All DHB and NGO providers are required to have a child protection policy in place to be reviewed three yearly
- Safety checking information can be made available to the Director General

### *Linkages*

- Minister's Letter of Expectation
- The Vulnerable Children's Act (VCA) 2014
- Health Target – Increased Immunisation
- Draft NZ Health Strategy
- Better Public Services Results 4 – Reduce Assaults on Children

### *Action Plan*

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Supporting Vulnerable Children</b>	<ul style="list-style-type: none"><li>• Continued participation in regional Children's Team governance and leadership involvement by DHB and non-DHB employed health professionals through review of all Paediatric meetings related to vulnerable children</li><li>• Continued collaboration with other agencies to plan, test and monitor assessment processes to support early response systems, assessment processes and delivery of coordinated services for vulnerable</li></ul>	Governance/Leadership team maintained	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>children through improved information sharing systems and communication between agencies</p> <ul style="list-style-type: none"> <li>• Review and monitor deaths from assault neglect or maltreatment of children aged 0-14 years</li> <li>• Hospitalisations for injuries arising from the assault, neglect or maltreatment of children aged 0-14 years.</li> <li>• That Taranaki DHB works within the vulnerable children's act to ensure child protection policies are up to date.</li> <li>• That all child health workers are safety checked within the specified timeframes within the vulnerable children's act.</li> </ul>	<p>Audit of deaths resulting from assault, neglect or maltreatment</p> <p>Audit of admissions resulting from assault, neglect or maltreatment</p> <p>By July 2016, Taranaki Children Protection Policies are completed and signed off.</p> <p>Children's worker checking commences in May 2016 and is completed by June 2017.</p>	
	<p><b>Services for Pregnant Women With Complex Needs:</b></p> <ul style="list-style-type: none"> <li>• Implement the National Toolkit</li> <li>• Actions as outlined around early engagement with an LMC under Child and Maternal Health Action Plan</li> <li>• Actions as outlined as part of FVIP initiatives (e.g. Child protection alerts) and the MOU with CYF and Police for interagency coordination for child protection</li> <li>• Continue to support the work all existing providers and governance groups</li> <li>• All women who present without a midwife are allocated one on arrival</li> <li>• All women are discharged with information relating to having a GP or are enrolled with a GP.</li> </ul>	<ul style="list-style-type: none"> <li>• National Toolkit implemented by December 2016</li> </ul> <p>Audit of women arriving without a midwife during their pregnancy</p>	Quarterly
	<p><b>Services for vulnerable children and their families:</b></p> <ul style="list-style-type: none"> <li>• Alignment of policies for protecting vulnerable children across primary and secondary services</li> <li>• Review the lactation consultant service to ensure best support for vulnerable families</li> <li>• Continue to hold MDTs across services for vulnerable families</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced readmissions due to feeding problems.</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	identifying families that may need increased levels of support <ul style="list-style-type: none"> <li>Review the Paediatric Liaison Meeting to align with the Children's Team philosophy and to include support and Services for Vulnerable Pregnant Women, Infants and Families Toolkit</li> <li>Review current peri-natal mental health pathway to ensure appropriate referral and timely access – more direct access</li> <li>Service users (and their families/whanau) will be supported in their role as parents.               <ul style="list-style-type: none"> <li>Implement process for identification of service users or care-givers.</li> <li>Implementation of service provision in line with Supporting Parents – Health Children guidelines.</li> </ul> </li> <li>Taranaki DHB mental health services attending Domestic Violence Intervention Programme fortnightly meetings</li> </ul>	<ul style="list-style-type: none"> <li>Increase breastfeeding rates from 68% to 75% on discharge by Dec 2016</li> <li>Audit adherence to the perinatal MH pathway. Audit admissions and outcomes for vulnerable patients.</li> <li>Reduced wait time for peri-natal mental health services</li> </ul>	

## 2B.2.4 Reducing Rheumatic Fever

Rheumatic Fever is recognised as a significant contributor to poor child health outcomes in New Zealand. Children with Rheumatic Fever normally need to be hospitalised for several weeks. A proportion of children with Rheumatic Fever suffer permanent heart damage. There are significant health inequities with Pacific Island and Māori children having much higher incidence rates than European children.

### Our Approach

During 2013/14 we developed our Rheumatic Fever Prevention Plan. Taranaki has been defined as a “low incidence” area for Rheumatic Fever. The main outcome measure is to reduce the 2012/13 incidence of disease in Taranaki from 0.9 per 100,000 (one case per year) to below 0.3 per 100,000 (one case every three years) by 2017.

The Prevention Plan outlines a list of potential strategies which will be reviewed on an annual basis. Local epidemiology will drive the implementation of the various strategies which will be consistent with local need and consistent with available evidence of effectiveness.

### Linkages

- Our Performance Story Impact: Fewer people admitted to hospital for avoidable conditions.
- Better Public Services: Supporting vulnerable children.
- Rheumatic Fever Prevention Plan 2013-2017.

## Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Reduce the Incidence of Rheumatic Fever	<ul style="list-style-type: none"><li>Implement the Rheumatic Fever Prevention Plan consistent with local need and consistent with available evidence of effectiveness.</li></ul>	<ul style="list-style-type: none"><li>The 2016/17 target for Rheumatic Fever Hospitalisation rates is a 2/3 reduction from the baseline level.</li><li>For Taranaki this means a target of no cases.</li></ul>	Annual
	<ul style="list-style-type: none"><li>Investigate notified cases as per the 2012 Ministry of Health Communicable Disease Control guidelines, and identify and follow up known risk factors and system failure points.</li></ul>	<ul style="list-style-type: none"><li>Complete a Root Cause Analysis Report on each Rheumatic Fever case which is forwarded to the Ministry of Health each quarter.</li></ul>	Quarterly
	<ul style="list-style-type: none"><li>Ensure that all patients notified with Rheumatic Fever are entered onto the Rheumatic Fever Register and patients with a past history of Rheumatic Fever receive monthly antibiotics not more than 5 days after their due date.</li></ul>	<ul style="list-style-type: none"><li>Complete a Timely Antibiotic Prophylaxis Report which is forwarded to the Ministry of Health each quarter.</li></ul>	Quarterly

**Acute Rheumatic Fever Notification Rates by Year, Taranaki and New Zealand**

Year	Taranaki Rate	NZ Rate
1997	1.0	2.8
1998	1.0	2.0
1999	1.0	2.8
2000	0.0	3.0
2001	0.0	3.2
2002	1.0	2.5
2003	0.0	3.8
2004	0.0	2.0
2005	0.0	1.9
2006	0.9	2.8
2007	0.0	3.3
2008	0.9	3.6
2009	0.9	3.2
2010	1.8	3.8
2011	0.0	3.7
2012	1.9	4.0
2013	0.0	4.5
2014	0.0	4.7
2015	1.8	2.5

## 2B.2.5 Prime Ministers Youth Mental Health Project

The aim of the Prime Ministers Youth Mental Health Project has been to build and evidence base on what works to improve mental health, increased resilience, more supportive schools, communities and health services, access to information, earlier identification of issues and better access to treatment.

### Our Approach

Primary Care plays an important part of care for our young people. We will focus on activities that enable access to services and supports that build resiliency and prevent further development of more serious mental health and addiction issues. This means expansion of the continuum of care to more service delivery to those presenting to mild to moderate. We will also continue with our work with other agencies to ensure a multi-disciplinary approach to support young people and their families and whanau. We also see working with young people at an earlier age, e.g. Intermediate age group, is important time to mitigate issues escalating.

### Linkages

- Prime Ministers Youth Mental Health Project
- Social Sector Trial Action Plan
- On Track – Knowing Where We Are Going
- Draft – NZ Health Strategy
- Blue Print II – How Things Need To Be
- Youth Mental Health Project
- Drivers of Crime Work Programme
- Suicide Prevention Action Plan

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Prime Minister's Youth Mental Health Project</b>	<b>Initiative 1. School Based Health Services (SBHS)</b> <ul style="list-style-type: none"><li>• Maintain the SBHS in the Decile 1-3 schools, alternative education and teen parent units.</li><li>• Increase access to HEADSSS throughout the region by working with at schools with at risk registers</li><li>• Identify schools to implement the continuous quality framework and develop timeframe in 2016/17 for this to occur.</li><li>• Completion of 100% of year 9 student's psychosocial health assessment by end of November annually.</li><li>• By December 2017. We will review the clinic hours, service provision and nurse availability with an objective to ensuring the service is accessible for young people.</li></ul>	<ul style="list-style-type: none"><li>• Quarterly reporting PP25</li><li>• Number of students in Social Sector Trial site in non decile 1-3 schools who have had a HEADSSS assessment.</li><li>• Five schools implementing the quality improvement framework.</li><li>• 100% of assessments completed by end of November 2016.</li><li>• Review completed and clinic times adjusted as necessary</li><li>• Reporting through Quarterly MoH indicators</li></ul>	<p>Quarterly</p> <p>Quarterly</p>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Survey of youth and of attendance rates.</li> <li>By February 2017 Implementation of changes where identified</li> <li>By December 2017 we will review our adherence to privacy and confidentiality policy with an objective of ensuring it is maintained at all times for our youth.</li> </ul>		
	<b>Initiative 3: Youth Primary Mental Health.</b> <ul style="list-style-type: none"> <li>Work with MH&amp;A sector to shift the continuum of care to provide access to service provision for mild to moderate.</li> <li>Pilot a youth coordinator an intermediate and secondary school in North Taranaki to work in a multi-agency structure to develop one care plan for the young person and family and whanau.</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly reporting against the evaluation framework July and October 2016 and January 2017.</li> <li>Reporting against PP25 (links to PP26)</li> </ul>	Quarterly
	<b>Initiative 5: Improve the Responsiveness of Primary Care to Youth.</b> <ul style="list-style-type: none"> <li>Establish Youth PMH service across the Midlands Health Network within a consistent framework</li> <li>As part of the MH&amp;A SLAT, a review of CAMHS services has been initiated. Children and Young People Health and Wellbeing SLAT will focus on addressing the systemic issues, expand the continuum of care to include capacity and resource to deliver to those experiencing mild to moderate MH&amp;A issues.</li> </ul>	<ul style="list-style-type: none"> <li>Reporting against PP25 (links to PP26).</li> </ul> <p>By June 2017 a consistent Youth PMH service will be established across the PHO.</p>	Quarterly
	<b>Initiative 6. Review and Improve the Follow-Up Care For Those Discharged From CAMHS and Youth AOD Services:</b> <ul style="list-style-type: none"> <li>Consistently follow process of completing care plans in letters to GP to be sent within 7 days of discharge</li> <li>Improve follow-up in primary care of youth aged 12-19 years discharged from secondary mental</li> </ul>	<ul style="list-style-type: none"> <li>The percentage of care plans will increase to 95% by June 2017</li> <li>PP8 Shorter waiting times for non-urgent MH&amp;A services for 0-19 year olds 3 weeks: 80%</li> <li>8 weeks: 95%</li> <li>The percentage of care plans included in</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	health and addiction services by providing follow-up care plans to primary care providers. The follow-up care plans should be provided with the expectation that they are activated by the primary care provider within three weeks of discharge	discharge summaries to GPs from CAMHS & Youth AoD will increase to 95% by June 2017 <ul style="list-style-type: none"> <li>Implementation of audit findings               <ul style="list-style-type: none"> <li>Referral processes</li> <li>Discharge planning and documentation</li> <li>Care planning</li> </ul> </li> </ul>	
	<b>Initiative 7. Improve access to CAMHS and Youth AOD services through wait times targets and integrated case management:</b> <ul style="list-style-type: none"> <li>Implement agreed action to meet the waiting time targets that by 2017 will enable: 80% of youth to access services within three weeks; 95% to access services within eight weeks</li> <li>Taranaki DHB will change the model of service through role redesign in order to complete initial assessments within three weeks of referrals</li> </ul>	<ul style="list-style-type: none"> <li>Delivery against target</li> <li>Measured through PP7 being the MoH Measurement of MH&amp;A waiting times. Targets being to achieve by June 2017</li> <li>80% of service users to be seen within three weeks of referral and 95% within eight weeks</li> </ul>	Quarterly

## 2B.2.6 Child and Youth Oral Health

### Our Approach

Taranaki DHB is not currently meeting the Ministry of Health 85% target for rangatahi/adolescent utilisation of the publicly funded oral health service. The latest data shows Taranaki DHB provides care for 73.4% of the Taranaki rangatahi/adolescent population. The latest data shows the private Dentists are providing 3,934 or 50% of Taranaki rangatahi/adolescents with publicly funded oral health care which is funded through Combined Dental Agreements (CDA) with the DHB funder. The Community Oral Health Service (COHS) provides care for 1401 or 23% of rangatahi/adolescents.

During 2014-2015 Taranaki DHB increased preschool enrolments into the COHS by introducing enrolment from birth for all Taranaki babies. This project was established to support Hospital and Specialist Services to meet the Māori Health Plan indicator of 95% of all preschoolers enrolled in the COHS. This is an opt-off enrolment system where all babies are enrolled unless the parents/caregivers choose not to enroll their children. The project was successful resulting an additional 4000 preschool children enrolled for oral health care with the COHS. Analysis of the Titanium data received from MIU in November 2015 shows 38% Māori preschool tamariki/children and 29% of non-Māori preschool tamariki/children enrolled with the COHS are not engaged with the service and as a result are enrolled but not receiving any oral health care. This level of disengagement with the COHS has the potential to increase the disparities between Māori and other ethnicities and impact on the improved patient outcomes envisaged by increasing preschool enrolment to >95%.

The Ministry of Health Oral Health Strategy, Good Oral Health for All, for Life articulates a seamless service from 0-18 years old, the Dental Therapy workforce have a scope of practice to be able to provide oral health care for 0-18 years and potentially could provide care for those adolescents unable to access care with a Dentist.

During 2016/17 the DHB plans to review services currently delivered by Hospital and Specialists Services to identify how COHS could potentially increase capacity to enable additional adolescent oral health care to meet the MoH 85% target and to address the high percentage of preschool children currently enrolled with the COHS and not receiving care.

The funders expectation is any new service delivery model will be subject to a Health Equity Assessment Tool to ensure there are no unintended consequences that increase the current oral health disparities between Māori and other ethnicities.

The expectation is that these service reviews will be undertaken during the 2016/17 year and any changes to the model of service delivery and additional capacity required will be implemented in 2017-2018.

#### Linkages

- New Zealand Health Strategy
- Taranaki DHB Māori Health Plan
- Good Oral Health for All, for Life

#### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Increased Access for Tamariki/Children and Rangatahi/ Adolescents to Publicly Funded Oral Health Care.	Taranaki DHB Hospital and Specialists services the DHB funder and Māori Health Services to jointly undertake a review of all oral health services provided by Taranaki DHB with the aim of re-prioritising tamariki and rangatahi between the ages of 0-18 years.	Project Management Plan approved	Q1
		Project implemented	Q2
		New service delivery model agreed and implementation commencement starts in Q1 2017-2018	Q4
		Engage with Dentists to promote rangatahi/adolescent oral health care through the Combined Dental Agreement	Annually
		Progress toward 85% of all rangatahi/adolescents both Māori and non-Māori are engaged with an oral health provider and have had an annual treatment plan completed	Annually
The Taranaki DHB Community Oral Health Service has	Project undertaken to identify the barriers causing the	All Taranaki DHB oral health clinics are rangatahi/adolescent and	Q4

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Progressed Toward Increasing the Capacity to Provide Oral Health Care for 0-18 Years To Meet the MoH Targets	current oral health inequalities, rangatahi/adolescent uptake of publicly funded oral health care and the high percentage of unengaged preschool tamariki/children in the Community Oral Health Service	tamariki/child friendly spaces  Agreed model of service delivery for increased capacity in the COHS  A reduction in the gap between Māori and non-Māori caries free at age 5 years, Year 8 and adolescents  A reduction in the 38% of Māori and 29% non-Māori preschool tamariki currently enrolled but un-engaged with the Taranaki DHB Community Oral Health Service receiving oral health care	Q3  Annually  Annually

## 2B.2.7 Well Child Tamariki Ora

### Our Approach

The Well Child Tamariki Ora (WCTO) programme aims to support and promote the healthy development of children and their whānau from birth to five years. It is a universal programme, designed on the principle of providing services for all, with additional services available according to need. The current WCTO schedule involves 13 'core' contacts – four during the postnatal period provided by Lead Maternity Carers (LMCs), a six-week check by General Practice (GPs), and a further eight contacts from six weeks through to five years delivered by WCTO providers including clinical assessment, health promotion, whānau support and advice, interventions or referral as appropriate.

The WCTO programme links with a number of health programmes including the National Immunisation Programme, the Newborn Metabolic Screening Programme, and the Newborn Hearing Screening Programme. It also links with agencies and services external to the health sector. Over the last 10 years, a range of measures have been put in place to improve the WCTO programme. The WCTO Framework (a pricing framework for delivery of the WCTO National Schedule) was introduced in 2002 and was designed to improve consistency in service delivery. 2007/08 saw a major review which identified – variable clinical practice, service quality, and health outcomes. The review resulted in a range of evidence-based changes across the programme, including changes to the timing and content of core contacts. The review supported the introduction of the B4 School Check (B4SC) into the WCTO programme.

In July 2013 the Ministry of Health (MoH) published the WCTO Quality Improvement Framework drawing together 27 measures across three dimensions of access, equitable outcomes, and quality. Monitoring of this Framework will demonstrate the value of the programme in supporting whānau to maximise their children's health and developmental potential. The Framework focuses on the health and social service environment that the WCTO programme operates within, including core contacts, additional contacts and the B4SC, as well as other primary care services, referred services, and early childhood education. It places deliberate emphasis on the key intersections between the WCTO programme and other health and social services to promote the delivery of seamless and collaborative care.

Each District Health Board (DHB) was tasked, in conjunction with local stakeholders, to develop a local quality improvement implementation plan. The MoH then funded four regional Project Managers to co-ordinate the rollout of the DHB plans from a regional perspective to enhance shared learnings, consistencies, and collaboration. Each DHB's plan will focus on three indicators chosen by each DHB, initiatives will be identified for the chosen indicators and quality improvement methodology applied, the focus will be on small incremental changes. This aligns with the priority of Taranaki DHB to ensure 'all children have the best start'.

The original Taranaki DHB WCTO Quality Improvement Plan was developed following a stakeholder workshop in February 2014. Particular focus was on improving Māori health and reducing disparities between Māori and non-Māori. Taranaki DHB refreshed the Plan in 2015 to reflect current and emerging local and national priorities and activities, as a result the Child Health Service Level Alliance Team (SLAT) agreed to focus on the identified indicators in the Plan for 2015 to 2017.

### Linkages

Strong linkages exist between this work and other strategies and activities:

- Taranaki Well Child Tamariki Ora Quality Improvement Plan, Taranaki DHB: 2015
- Taranaki DHB Maternity Quality and Safety Work Plan, Taranaki DHB: 2015/16
- Midland Region Well Child Tamariki Ora Quality Improvement Project Plan, Midland District Health Boards: July 2015
- Māori Health Plan, Taranaki DHB: 2016/17
- Regional Services Plan, Midland District Health Boards: 2016-2019
- Childhood Obesity Action Plan, MoH: October 2015
- Child Health Action Group and Maternity Action Group
- Matua Mama Pepe Tamariki Programme
- Taranaki DHB Immunisation Steering Group
- Whangai U Breastfeeding Coalition

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Review the Child Health Service Level Alliance Team (SLAT)</b>	<ul style="list-style-type: none"> <li>• Review the Terms of Reference</li> <li>• Undertake the recommendations of the review</li> <li>• Implement milestones as agreed by the Child Health SLAT</li> </ul>	<ul style="list-style-type: none"> <li>• To be determined following the review</li> </ul>	Quarterly
<b>Increase Rates of Breastfeeding for Māori and non-Māori at 6 weeks, 3 months, and 6 months and Reduce Inequalities in Breastfeeding Rates Between Māori and non-Māori</b>	<ul style="list-style-type: none"> <li>• Maintain BFHI accreditation across DHB facilities</li> <li>• Continue to contract Te Kawau Maro to deliver the Mama Pepe Hauora contract via the MoH extended funding for Maternal and Child Nutrition and Physical Activity Projects <ul style="list-style-type: none"> <li>• Support 120 mothers from priority populations to initiate and maintain breastfeeding for at least 6 months via Community Lactation Consultants and</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• BFHI re-accreditation achieved</li> <li>• Exclusive and full breastfeeding rates increase towards the targets – 6 weeks 75%, 3 months 60%, and 6 months 65% (including partial)</li> <li>• Number of Community Breastfeeding Support Service referrals received</li> </ul>	Annual  6 Monthly   Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Peer Support Counselling Services</li> <li>Deliver 12 Breastfeeding Education Workshops to groups in priority communities</li> <li>Re-accredit 3 providers with BFCI</li> <li>Support Early Childhood Education (ECE) settings to complete the Oranga Mākopuna Programme (including Breastfeeding Welcome Here accreditation)</li> <li>Continue to externally evaluate the Mama Pepe Hauora Service</li> </ul>	<ul style="list-style-type: none"> <li>Number of Breastfeeding Education Workshops delivered</li> <li>Number of providers achieve BFCI accreditation</li> <li>Number of ECE settings achieve BFWH accreditation</li> </ul>	<p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p>
<b>Implement the WCTO Quality Improvement Plan for Taranaki DHB</b>	<ul style="list-style-type: none"> <li>Implement and evaluate the WCTO Increased Enrolment Project (including ongoing implementation and monitoring of NCHIP)</li> <li>To undertake initiatives outlined in the Plan via the Child Health Working Group</li> <li>To monitor and improve performance against the priority indicators outlined in the Plan</li> <li>Contribute to regional WCTO Quality Improvement Project Board</li> </ul>	<ul style="list-style-type: none"> <li>Proportion of infants enrolled with NIR/NCHIP</li> <li>Proportion of infants enrolled with a GP by 2 weeks</li> <li>Children aged 0 – 4 are enrolled with Child Oral Health services</li> <li>LMCs refer whānau to a WCTO provider</li> <li>Infants receive all WCTO core contacts in their first year of life</li> <li>Infants are exclusively or fully breastfed at 3 months</li> <li>Proportion of infants immunisations up to date by 8 months</li> <li>Four year olds receive a B4SC</li> </ul>	6 Monthly

## Long Term Conditions – Prevention, Identification and Management

### 2B.2.8 Obesity

#### *Our Approach*

This year Body Mass Index (BMI) is expected to overtake tobacco as the leading preventable risk to New Zealanders' health. New Zealand has the third highest rate of adult obesity in the OECD and rising. Data from the 2011 – 13 New Zealand Health Survey indicates that Taranaki children (2–14 years) have the second highest rates of obesity nationally (21.9%)\*. Nationally Māori, Pacific, and deprived children are most likely to be obese. Local Before School Check (B4SC) 2014/15 data showed that 21% of the 1601 four year olds who received a B4SC were considered overweight, obese, or very obese.

The Ministry of Health's (MoH) Childhood Obesity Action Plan released in October 2015 draws on national and international evidence specifically the World Health Organisation's (WHO) Commission on Ending Childhood Obesity (ECHO Report, September 2015). The Plan outlines three focus areas to prevent and manage obesity in children and young people – i) targeted interventions for those that are obese; ii) increased support for those at risk of becoming obese; and iii) broad approaches to make healthier choices easier for all New Zealanders. The MoH outlined twenty-two initiatives across the focus areas including existing or expanded initiatives as well as new initiatives which bring together government agencies, the private sector, communities, schools, and whanau to focus on food, the environment, and being active at each life stage. Central to the Plan is the new health target for the B4SC programme.

No additional obesity-related funding has been earmarked for Taranaki DHB until 2018/19 which will be for 'family-based nutrition and physical activity lifestyle interventions' thus Taranaki DHB's action on obesity for 2016/17 concentrates on implementing the new health target and maintaining existing activities. Existing activities range from community development approaches to treatment interventions but also align with activities led by the Public Health Unit including Health Promoting Schools, Breastfeeding Welcome Here, and the Healthy Eating and Physical Activity Collaborative Working Group as well as Taranaki DHB's Workplace Wellness Group who are responsible for the implementation of the Healthy Food and Beverage Environments Policy. As well as implementing new guidelines, reviewing the Advertising Standards Authority Codes for Children, and leveraging off national social marketing campaigns as advised by the MoH.

*\*as the regional sample was small this is based on synthetic estimates*

#### *Linkages*

Strong linkages exist with this work and other strategies and activities:

- Childhood Obesity Action Plan, MoH: October 2015
- ECHO Report, WHO: September 2015
- New Zealand Health Strategy, MoH: September 2015
- Living Well with Diabetes Plan, MoH: October 2015
- Community Sport Strategy, Sport NZ: March 2015
- Gestational Diabetes Guidelines, MoH
- Activity within Primary Care, the Regional Screening Unit, Paediatric Medicine, Maternity Unit, Public Health Unit, Sport Taranaki, National Heart Foundation, Local Territorial Authorities, and Māori Health Providers

## Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Implement The Before School Check (B4SC) Health Target – by December 2017, 95% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity, and lifestyle interventions</b>	<ul style="list-style-type: none"> <li>Identify and refine appropriate services to refer into</li> <li>Work with key stakeholders (including PHOs, Sport Taranaki, the Whanau Pakari and B4SC teams) to define a consistent referral pathway for B4SC team across providers</li> <li>Establish baseline data</li> <li>Record reason for Declined Referral</li> <li>Provide refresher training to B4SC team in measurement techniques</li> <li>Provide Healthy Conversation Skills training for B4SC team</li> <li>Provide advice and information in accordance with the MoH guidelines to families with overweight or obese children</li> <li>Offer referral to families of overweight, obese, or children with poor lifestyle behaviours</li> </ul>	<ul style="list-style-type: none"> <li>Complete a review of the B4SC programme as it relates to the obesity target:               <ul style="list-style-type: none"> <li>- Work with key stakeholders (via meetings and workshops) to refine the referral and intervention pathways and implement process changes</li> <li>- Understand the baseline data</li> <li>- Support staff and stakeholders to complete Healthy Conversation Skills training</li> </ul> </li> <li>Monitor and report quarterly the uptake of the B4SC programme and identification of overweight and obesity ensuring equitable rates for Māori:               <ul style="list-style-type: none"> <li>• Number of children eligible for B4SC (Māori/Non Māori)</li> <li>• Number/Percent of children received B4SC (Māori/Non-Māori)</li> </ul> </li> <li>Increase the number of referrals made for overweight and obese children towards the target ensuring equitable rates for Māori:               <ul style="list-style-type: none"> <li>• Number/Percent of obese children offered referral (Māori/Non-Māori)</li> <li>• Number/Percent of obese children who decline referral (Māori/non-Māori)</li> <li>• Number/Percent of overweight children offered referral (Māori /Non- Māori)</li> <li>• Number/Percent of overweight children who decline referral (Māori /Non-Māori)</li> </ul> </li> </ul>	30 September 2016  Quarterly  Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Continue to Contract Sport Taranaki to Deliver the Green Prescription (GRx) Adult and Active Families Programme for Adults and Children Not Achieving the Recommended Amount of Physical Activity and Wanting to Make a Change With Referral From Their Healthcare Professional</b>	<ul style="list-style-type: none"> <li>• Employ GRx staff skilled in behaviour change and exercise prescription for special populations to deliver programmes</li> <li>• Develop a Service Plan</li> <li>• Undertake the GRx Annual Patient Survey</li> <li>• Support staff to undertake annual motivational interviewing and exercise prescription refresher training</li> <li>• Develop and maintain relationships with key stakeholders particularly Primary Care, B4SC teams, Whanau Pakari, and Lead Maternity Carers</li> <li>• Promote programmes to referrers and directly to participants using a variety of methods</li> <li>• Support activity providers to deliver safe, appropriate, and accessible entry-level activities and provide links for participants</li> <li>• Support referred participants to initiate and maintain regular physical activity (30/60 minutes per day of moderate intensity) guided by the GRx Patient Support Guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• 1714 Adult referrals received annually (Māori/Non-Māori)</li> <li>• 35 Active Families referrals received annually (Māori/Non-Māori)</li> <li>• Number/Percent of Adult referrals received for diabetes (including pre-diabetes and gestational diabetes)</li> <li>• Number/Percent of new Adult and Active Families referrals received</li> <li>• Number/Percent of Adult and Active Families quarterly referrals currently participating in programme (Māori/Non-Māori)</li> <li>• Number of Adult and Active Families activity audits completed quarterly</li> <li>• Number/Percent of Adult and Active Families annual referrals Discharged – Complete/Incomplete (Māori /Non-Māori)</li> </ul>	Quarterly
		<ul style="list-style-type: none"> <li>• Percent of Adult and Active Families participants more active 6 to 8 months after receiving their GRx</li> <li>• Percent of Adult and Active Families participants that have made changes to their diet since receiving their GRx</li> <li>• Percent of Adult and Active Families participants that feel more confident about doing physical activity</li> <li>• Percent of Adult and Active Families participants that felt activity suggested was appropriate for them</li> <li>• Percent of Adult and Active Families participants motivated to get/stay physically active</li> <li>• Percent of Adult and Active Families participants that understand the benefits of physical activity</li> <li>• Percent of Adult participants that have noticed positive</li> </ul>	Annually

Objective	Actions to Deliver Improved Performance	Measure	Reporting
		health changes <ul style="list-style-type: none"> <li>• Percent of Adult Māori participants that have noticed positive health changes</li> <li>• Percent of Active Families participants that have noticed positive health and fitness changes</li> <li>• Percent of Adult participants encouraged to continue their GRx by their referrer</li> <li>• Percent of Adult and Active Families participants satisfied with the overall service and support provided</li> </ul>	
<b>Implement the Whanau Pakari Programme</b> <i>for Obese or Children At Risk Of Obesity And Their Families</i>	<ul style="list-style-type: none"> <li>• Develop a Service Plan</li> <li>• Employ/retain a Whanau Pakari Coordinator skilled in relationship building and programme management to lead the programme</li> <li>• Develop and maintain relationships with key stakeholders including a governance group with Māori representation</li> <li>• Establish a multi-disciplinary team with Paediatrician oversight to monitor and review cases and refer-on high risk participants for additional support</li> <li>• Promote programmes to referrers and directly to participants using a variety of methods</li> <li>• Deliver weekly sessions during the school term in priority communities including education, physical activity, and advice and monitoring from a Community Dietitian, Community Psychologist, and Active Families Coordinator</li> <li>• Support activity providers,</li> </ul>	<ul style="list-style-type: none"> <li>• Service plan developed and staff appointed</li> <li>• 4 governance group meetings held per annum</li> <li>• 60 referrals received per annum (Māori/Non-Māori)</li> <li>• Number of programme sessions delivered per quarter</li> <li>• Number/Percent of quarterly referrals currently participating in programme (Māori/Non-Māori)</li> <li>• Number/Percent of annual referrals Discharged (Māori/Non-Māori)               <ul style="list-style-type: none"> <li>• Number/Percent Discharged–Complete (Māori/Non-Māori)</li> <li>• Number/Percent Discharged–Incomplete (Māori/Non-Māori)</li> </ul> </li> </ul>	30 July 2016  Quarterly          Annual

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>schools, and clubs to deliver safe, appropriate, and accessible entry-level activities and provide links for participants</p> <ul style="list-style-type: none"> <li>• Support referred participants and their families for two school terms (6 months) to develop and share skills, knowledge, behaviours, and attitudes to initiate and maintain regular physical activity and positive nutrition habits</li> <li>• Follow-up participants 6 months post-discharge to assess sustained changes and other support required</li> </ul>		
<p><b>Continue to Contract Te Kawau Maro to Deliver the Mama Pepe Hauora Contract</b>  <i>via the Ministry of Health Extended Funding for Maternal and Child Nutrition and Physical Activity Projects</i></p>	<ul style="list-style-type: none"> <li>• Develop a Service Plan</li> <li>• Contract COGO to develop an evaluation plan and undertake the external evaluation</li> <li>• Maintain a stakeholder governance group to oversee the service</li> <li>• Support 10 new Early Childhood Education (ECE) providers in priority communities to undertake one or more levels of the Oranga Mokopuna Programme (including 5 Kohanga Reo) to develop and share skills, knowledge, behaviours, and attitudes that contribute to a positive nutrition and physical activity environment</li> <li>• Support and resource 10 new ECE providers implement a new physical activity and/or nutrition initiative(s)</li> <li>• Support 220 mothers from priority populations to</li> </ul>	<ul style="list-style-type: none"> <li>• Number of new ECEs completed OMP</li> <li>• Number of new initiatives implemented</li> <li>• Number of Community Breastfeeding Support Service Referrals received</li> <li>• Number of Breastfeeding Education Workshops delivered</li> <li>• Number of providers achieve BFCI accreditation</li> </ul>	<p>Quarterly</p>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	initiate and maintain breastfeeding for at least 6 months via Community Lactation Consultants and Peer Support Counselling services <ul style="list-style-type: none"> <li>• Deliver 12 Breastfeeding Education Workshops to groups in priority communities</li> <li>• (Re)accredit 5 providers with BFCI</li> </ul>		

## 2B.2.9 Living Well with Diabetes

### Our Approach

Reduce the incidence and impacts of Long Term Conditions (LTC) through prevention, early identification and integrated management of risk to ensure our patients are living well with diabetes.

People living with diabetes are regarded as leading partners in their own care within systems that ensure they are supported to self-manage.

Priorities include:

- Preventing people developing diabetes, detecting diabetes early and reducing complications
- Self-management, providing integrated quality care and meeting the needs of people with Diabetes

It is recognised that long term conditions such as diabetes account for a higher proportion of illness and deaths among Māori, people on low incomes, Pacific peoples and patients with mental illness than among the general population. The need to reduce health inequalities remains urgent and work within the living well with diabetes programme needs to focus on ensuring outcomes for these groups improve sooner and more significantly.

In Taranaki the Ministry of Health *Living Well with Diabetes – A plan for people at high risk or living with diabetes 2015-2020* document will provide the strategic framework for progressive development of local services and programmes that enhance people's ability to live well with diabetes. The focus is on enhancing care and quality of life for people with diabetes and the focal point of care remains in primary care and the community setting, this is supported by integrated primary health care teams and specialist health services.

As part of the strategy we will ensure Diabetes Management Services and Diabetes Care Improvement Programmes (DCIP) support the achievement of:

- Prevention: Limit and reduce the risk of developing diabetes
- Identify: Reduce the risk of developing complications for those New Zealanders with diabetes
- Manage: Reduce the risk from complications of diabetes where they exist
- Enable: Support and develop systems to provide high quality care for people with diabetes

The DHB will work in collaboration with Midlands Health Network and secondary care providers, and consumers to consolidate service development to date and improve performance for the people living with Diabetes and long term conditions including actions in the following areas:

- Implementation of the Quality standards for Diabetes Care (Toolkit 2014)
- Continue to progress the Diabetes Care Improvement Plans (DCIPs) packages of care approach
- Ensure clinical leadership through the Midland Health Network Alliance framework
- Support GP practice models through PHO system initiatives, including application of key clinical pathways and tools within the primary/secondary integrated health environment, to make significant contribution to a 'Whole of system' approach for patients
- The Manage My Health primary care patient portal provides patients with information to support better self-management and increased health literacy
- Proactive recall for Retinal screening
- The LTC MDT supports GP's to provide 'wrap around' services as part of LTC management programme operation
- The 'Diabetes Care Improvement Packages' (DCIP) is a dedicated strategic programme initiative that is embedded within the Integrated Care and Long-Term Condition management approach. It is designed to ensure people living with diabetes are regarded as the leading partners in their own care; within systems that support patients to manage their condition effectively, to better self-manage in the community and reduce or avoid the need for hospitalisation.

#### Linkages

- Ministry of Health Diabetes Care Improvement Packages Guidelines and Work Programme
- Ministry of Health Quality Standards for Diabetes Care Tool Kit 2014
- Ministry of Health Screening, Diagnosis and Management of Gestational Diabetes in New Zealand A Clinical Practice Guideline 2014
- Ministry of Health Target More Heart and Diabetes Health Target
- NZ Atlas of Health Care Variation: HQ & SC
- Taranaki DHB Māori Health Plan
- Midland Regional Services Plan 2016/17
- The Networks Plan 2014 – 2017 MHN Alliance
- Taranaki Alliance Leadership Team (TALT) Work Programme
- TALT Integration Project

#### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Strategy – Prevention</b>  People Living with Diabetes are Considered Partners in Their Own Care Within Systems That	<ul style="list-style-type: none"> <li>• Services in primary care to detect and prevent or delay the onset of diabetes-related complications.</li> <li>• People with diabetes have access to 'healthy lifestyle' support including referral (either internal/external) to the LTC programme for</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in proportion of patients with HbA1c above 64, 80 and 100 mmol/mol (reporting the range if not currently available needs to be a quality improvement measure and progress reported)</li> <li>• Pre diabetes advice is available to patients in the More Heart and Diabetes</li> </ul>	Quarterly: <ul style="list-style-type: none"> <li>• for progress on delivery, capacity and development</li> <li>• Report on proportion of patients with HbA1c above 64, 80 and</li> </ul>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Ensure They Manage Effectively With Appropriate Support	<p>education (improved health literacy), nutrition/dietician, exercise prescription, smoking cessation and mentoring support</p> <ul style="list-style-type: none"> <li>• Access to the MDT could include engagement of DHB staff within broader team approach</li> <li>• Kaupapa Māori approaches are supported by Te Kawau Maro provider interventions</li> </ul>	<p>Check</p> <ul style="list-style-type: none"> <li>• A high quality structured self-management education programme is tailored to their individual and cultural needs</li> <li>• Continued utilisation of the Green Prescriptions service</li> <li>• People will participate in making their own care plans, and set agreed goals/targets with their healthcare team.</li> <li>• Numbers of e-Referrals to MDT and other providers e.g. Green prescriptions, dietician, social work, podiatry and clinical pharmacy.</li> </ul>	<p>100 mml/mol by total, high needs and Māori and age bands</p> <ul style="list-style-type: none"> <li>• Quarterly achievement /progress against measures by total, high needs and Māori and age bands</li> </ul>
<b>Strategy - Identification</b>	<ul style="list-style-type: none"> <li>• Proactive recall for retinal screening, foot checks, renal function tests to ensure the early identification of diabetes related complications</li> <li>• Identification of patients eligible for Diabetes Management Services including pre diabetes</li> <li>• Contribute to reduced ED presentation for LTC patients</li> </ul>	<p>More Heart and Diabetes targets are met</p> <ul style="list-style-type: none"> <li>• MoH/IPIF Targets are achieved</li> <li>• 90% of Patients with Diabetes will have <ul style="list-style-type: none"> <li>• retinal screening in the last three years</li> <li>• annual foot checks,</li> <li>• renal function tests</li> </ul> </li> </ul> <p>ASH rates monitored by programmes for identified clients (ASH reported separately to MoH)</p>	<p>Quarterly</p> <ul style="list-style-type: none"> <li>• for progress on delivery, capacity and development</li> <li>• Quarterly achievement /progress against measures by total, high needs and Māori and age bands</li> </ul>
<b>Strategy - Management</b>	<ul style="list-style-type: none"> <li>• Implementation of the 20 Quality Standards for Diabetes Care, using the Quality Standards for Diabetes Care Toolkit 2014</li> <li>• Provision of Diabetes Management Services for people with diabetes,</li> <li>• Multi-Disciplinary Team (MDT) support is provided to patients by PHO providers at GP practice level and actions recorded within patient care plans</li> </ul>	<ul style="list-style-type: none"> <li>• Progress on the standards within each diabetes management service programme is reported</li> <li>• Access to an experienced multidisciplinary team including expertise in insulin pump therapy and Continuous Glucose Monitoring System when needed</li> <li>• Access to specialist help is available if required</li> <li>• Insulin Initiation is available within a structured programme</li> <li>• Provide easy access via e-</li> </ul>	<p>Quarterly:</p> <ul style="list-style-type: none"> <li>• for progress on delivery, capacity and development</li> <li>• Quarterly reporting achievement /progress against measures by total, high needs and Māori and age bands</li> <li>• Report on referral to</li> </ul>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>(podiatry, clinical pharmacy, social work, dietician)</p> <ul style="list-style-type: none"> <li>• Self-management support and education is included within care plans</li> <li>• Gestational diabetes (GDM) is a priority group for the LMC's</li> <li>• Support patients with access to a care co-ordinator to co-ordinate services among multiple providers including social and support providers; in particular patients without a strong relationship with their practice</li> </ul>	<p>referral to specialist advice and follow up support and type of specialist referral (podiatry, dietician physician etc)</p>	<p>MDT by total, high needs ethnicity and age bands</p>
<b>Strategy – Enablers</b>	<ul style="list-style-type: none"> <li>• PMS to show network/practice/provider data for improved diabetes management services</li> <li>• Enablers include on-going workforce development in primary care</li> <li>• IT capability is to be maintained and improved</li> </ul>	<ul style="list-style-type: none"> <li>• Monitoring framework in place for the Diabetes Management Services including DCIP programme, achievement of patient goals which can inform service development</li> <li>• Education/Workforce development in Long Term Conditions management available</li> <li>• Access to Patient Portal availability is progressed</li> </ul>	<p>Quarterly:</p> <ul style="list-style-type: none"> <li>• achievement /progress against measures</li> <li>• Report on education/workforce development activities</li> <li>• Report of patient portal usage</li> </ul>

## 2B.2.10 Cardiovascular Disease

### Our Approach

Our objective is to provide, and support a range of adaptive services to meet the increasing burden of long term conditions. These services will be people centred, delivered as 'close to home' as possible and integrate across a range of providers.

The DHB will work with our Midlands Health Network to reduce the impact of cardiovascular disease and diabetes within the Taranaki DHB population. Our primary care partners are leading the development and implementation of their long term conditions management programmes, including

more heart and diabetes checks, diabetes management services for all people with diabetes, and diabetes care improvement packages (DCIP) for complex patients with diabetes.

A range of nutrition, activity and lifestyle interventions will be provided. Access to an appropriate multidisciplinary team and support services will be provided. Services such smoking cessation, Green prescriptions (GRx), Podiatry, Dietetics, Social Work, Clinical Pharmacy all play an important role in helping people better manage their long term condition.

Primary care information systems have capacity to inform practices around the level of risk associated with their patients at a network, practice and provider level. This information can be used to enhance the care planning required to better manage individuals with a long term condition. In 2016/17 year the focus in primary care will shift towards enhancing self-management of long term conditions.

Our primary care partner's use allocated funding to support and incentivises performance of their practices, assisted by dedicated primary care clinical teams, to improve overall performance and performance for high risk and Māori populations.

This approach is intended to contribute to the achievement of our outcomes of improving the health status of our population and reducing or eliminating health inequalities.

#### Linkages

- New Zealand Primary Care Handbook (Update 2013) Cardiovascular and Diabetes Risk Assessment
- IPIF Targets
- Ministry of Health Target More Heart and Diabetes Health Target
- Taranaki DHB Māori Health Plan
- Midland Regional Services Plan 2016/17
- The Networks Plan 2014–2017 MHN Alliance
- Taranaki Alliance Leadership Team (TALT) work programme
- TALT Integration Project

#### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>More Heart and Diabetes Checks</b>  <i>Overall Objectives for PHOs/practices and NGOs</i>	<ul style="list-style-type: none"> <li>• Delivery of More Heart and Diabetes checks based on comprehensive cardiovascular risk assessment (CVDRA) assessments and diabetes checks</li> <li>• Continue to provide comprehensive patient management to support checks within five year period</li> <li>• Continue to support network/practice/provider Information Technology (IT) systems</li> </ul>	<ul style="list-style-type: none"> <li>• More Heart and Diabetes Checks Health Target / IPIF Target as defined by the MoH met – 90% <ul style="list-style-type: none"> <li>• Cardiovascular Disease (CVD) risk and HbA1c</li> </ul> </li> <li>• All MDT activity including all outreach and non-contact activity delivered will be included within Patient Management system data profile and reports</li> <li>• Patient Management</li> </ul>	Quarterly: <ul style="list-style-type: none"> <li>• Achievement/p progress against measures by total, high needs and Māori and age bands</li> <li>• Progress on specific actions</li> </ul>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>that have patient prompts, decision support and audit tools. Ensure these systems, are used to fully and accurately report performance</p> <ul style="list-style-type: none"> <li>Develop a range of network, practice and provider reports to enable the ability to monitor and benchmark performance</li> </ul>	<p>System (PMS) ensures coverage of the population enrolled including identification of the clients outstanding for CVDRA each quarter</p> <ul style="list-style-type: none"> <li>Numbers of e-Referrals to MDT and other providers e.g. Green prescriptions, dietician, social work, podiatry and clinical pharmacy.</li> </ul>	
<b>Reduce System Inequality for Māori at the Local Level Through Elimination of Disparity Evident in Health Targets</b>	<ul style="list-style-type: none"> <li>Eligible Māori men in the PHOs aged 35 – 44 years have had a CVDRA within the past five years</li> <li>Ensure accurate ethnicity data is collected and maximised for identification and improved access for Māori</li> </ul>	<ul style="list-style-type: none"> <li>Achievement of More Heart and Diabetes health Target /IPIF targets as defined by the MoH</li> <li>Reduction in CVDRA disparity gap</li> </ul>	<p>Quarterly:</p> <ul style="list-style-type: none"> <li>Achievement /progress against measures by total, high needs and Māori and age bands</li> </ul>
<b>More Heart and Diabetes (PHOs)</b>	MHN practice support arrangements incentivise achievement of health targets	<ul style="list-style-type: none"> <li>Health Target / IPIF Target achieved as defined by the MoH for eligible adult population for Taranaki DHB region</li> </ul>	<p>Quarterly:</p> <ul style="list-style-type: none"> <li>Achievement /progress against measures by total , high needs and Māori and age bands</li> </ul>
<b>More Heart and Diabetes (Long Term Conditions)</b>	Long Term Conditions Programme management includes CVDRA and Diabetes	<ul style="list-style-type: none"> <li>MDT activities reported for all Long Term Conditions</li> </ul>	<p>Quarterly:</p> <ul style="list-style-type: none"> <li>Achievement /progress against measures by total, high needs and Māori and age bands</li> </ul>

## 2B.2.11 Tobacco

### Our Approach

Our children and tamariki need to grow up free of the risk of becoming addicted to tobacco and the effects of second-hand smoke. We recognise that actions we take at a regional and local level will link and with the actions driven at a National level to contribute to the achievement of the goal of a Smokefree Aotearoa by 2015.

A renewed impetus is required in order to achieve the Government's aspirational goal of a Smokefree Aotearoa by 2025. Increased integration into all other aspects of health is essential to achieve an Auahi Kore/Tupeka Kore Taranaki by 2025. Supporting smokers to quit needs to be integrated approach across pregnancy, mental health & addiction, primary, secondary, and community setting's work streams for our priority population groups and DHBs have a leading role.

We will be implementing actions from our Tautoko I Rerenga a Tupeka Kore Taranaki Tobacco Control Strategic and Action Plan. The aim of the plan is to provide leadership, coordination and service development. Achieve the health targets; increase the number of people who attempt to quit smoking which in turn more successful quits. To prevent the initiation of smoking and protection children from harm – no exposure to second or third hand tobacco smoke.

### Linkages

- Minister's Letter of Expectations
- Government Goal: Smokefree Aotearoa by 2025
- Health Targets – Better Help for Smokers to Quit, Primary, Secondary and Maternity Care
- Taranaki DHB Tobacco Control Strategic Action Plan
- Well Child Tamariki Ora Quality Improvement Framework
- Māori Health Plan & DHB Public Health Plan
- Maternity & Quality Safety Programme

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Smokefree Aotearoa 2025 Goal</b>  By 2025, less than 5% of the DHB's population will be a current smoker	Taranaki DHB is committed to continuing to contribute towards achieving a Smokefree Taranaki by 2025 <ul style="list-style-type: none"><li>• To write a Taranaki Tobacco Control Strategic, Action Plan and Communications Plan</li><li>• To Implement the updated and refreshed Taranaki Tobacco Action Plan 2016/17 and Communication Plan</li><li>• For our priority populations to address, explore and resource to increase the range, variety and capacity of specialist stop smoking support available</li><li>• Continue engagement and communications with, Primary,</li></ul>	<ul style="list-style-type: none"><li>• Taranaki Strategic Tobacco Control Action Plan and Communications Plan completed</li><li>• Taranaki Tobacco Action Plan and Communications Plan for 2016/17 milestones completed by June 2017</li></ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>Maternal child and health and Secondary with monitoring of the target coverage - Quarterly at practice and PHO level</p> <ul style="list-style-type: none"> <li>Quarterly at LMC level</li> <li>Monthly by ward/unit level within Secondary care</li> </ul> <ul style="list-style-type: none"> <li>Continue to contractually require and support all DHB and non-DHB providers to strengthen their Smokefree/Auahi Kore policies</li> </ul>		
<b>Better Help for Smokers to Quit in Secondary Care</b>	<ul style="list-style-type: none"> <li>Taranaki DHB is committed to sustain achieving against the Secondary Care performance target</li> <li>Current unit procedures support ongoing process to ensure all patients who smoke are asked about and document their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support and referral to specialist stop smoking service to everyone who accepts the offer for hospital based services</li> </ul>	<ul style="list-style-type: none"> <li>Maintain 95% of hospitalised patients who smoke and are seen by a health practitioner are offered brief advice and support to quit smoking</li> <li>Maintain 95% of hospitalised Māori patients who smoke are seen by a health practitioner are offered brief advice and support to quit smoking</li> </ul>	Quarterly
<b>Better Help for Smokers to Quit in Primary Care (PHOs) and General Practices</b>	<ul style="list-style-type: none"> <li>Taranaki DHB is committed to working collaboratively with Midland Regional Health Network to achieve the Primary Care performance target</li> <li>To ensure all patients who smoke are asked about and document their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support/and or referral to a specialist stop smoking service</li> <li>Support for new integrated PHIS, including API level access to hospital data</li> </ul>	<ul style="list-style-type: none"> <li>Progress towards 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months</li> <li>Progress towards 90% of Māori PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Collection and provision of brief advice data provided in secondary/community settings</li> <li>Pinnacle will implement a regional stop smoking programme with a focus on general practice and community service delivery</li> <li>Develop relationships with Iwi and other community based organisations to provide Stop Smoking services to Māori and Pacific peoples</li> </ul>	<ul style="list-style-type: none"> <li>All General Practices meet 90% Brief Advice Health target</li> <li>Successful recording of smoking cessation advice given outside of general practice</li> <li>A regional Stop Smoking Programme in place</li> </ul>	
<b>Better Help for Pregnant Women to Quit</b>	<ul style="list-style-type: none"> <li>Taranaki DHB is committed to support LMCs and general practice to provide pregnant women who smoke with active support to quit as early as possible in pregnancy and sustain achieving against the Maternity performance target</li> <li>Ensure all patients who smoke are asked about and document their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support/or referral to specialist stop smoking service for hospital based maternity services</li> <li>Maternal and Child Health to develop and implement activities from the Maternity Quality Safety Plan</li> <li>Reporting against WCTO QIF Plan Outcome: Indicator 19 – Mothers are smokefree at two weeks postnatal</li> </ul>	<ul style="list-style-type: none"> <li>Progress towards 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking</li> <li>Progress towards 90% of pregnant Māori women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking</li> </ul>	Quarterly

## 2B.2.12 Rising to the Challenge

International evidence indicates that a combination of a strong primary care sector and a well-developed NGO sector is critical to demonstrating improved outcomes for people and increased system capability. Hospitable-based interventions can dislocate people from their home, family and whanau and communities. It is also acknowledged that complex social problems cannot be solved by a single organisation and continuing to strengthen a multiagency approach is paramount to improving outcomes for those with mental health and addictions issues.

### Our Approach

Through the establishment of a Taranaki Mental Health and Addictions (MH&A) Service Level Alliance Team (SLAT) we will continue to progress the Ministry of Health's strategic goals with a focus on the review of the current service provision with an aim to shift the continuum of care to be more responsive to the mild to moderate service requirements, provide services closer to home, enhance primary and secondary collaboration and integration.

The three key outcomes sought include:

1. People: Improved health, wellbeing and equity for individuals and their families and whanau
2. Service System: An integrated people-centred service system; and
3. Communities: Activated, engaged, socially cohesive communities.

We acknowledge that the MoH is working on developing a Commissioning Framework and a National Population Outcomes Framework that will be available for use from 2016. We will meet any MoH expectations in relation to its implementation.

### Linkages

- On Track – Knowing Where We Are Going
- Draft – NZ Health Strategy
- Draft – Closing the Loop (PHO Action Plan)
- Midlands Regional Services Plan
- Blue Print II – How Things Need To Be
- Youth Mental Health Project
- Drivers of Crime Work Programme
- Suicide Prevention Action Plan
- Whanau Ora Initiatives
- Māori Health Plan

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>1. Make Better Use Of Resources/ Value For Money</b>	<p>1.1 Fully functioning MH&amp;A SLAT that provides direction and programme of work for prioritised service improvement and redesign.</p> <p>1.2 Review the continuum of care in relation to mild and moderate MH&amp;A interventions.</p> <ul style="list-style-type: none"><li>• Pathways for mild to</li></ul>	<p>1.1 Quarterly reporting on work programme progress to Taranaki ALT.</p> <p>1.2 By September 2016 NGO CAMHS mild to moderate pathway completed.</p>	PP26 Service Development Plan (SDP) Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>moderate services are developed for two service areas.</p> <p>1.3 Data, KPI's and other information will continue to be used to improve performance.</p> <p>1.4 Development of a service for clients that are like in age in interest with complex issues in conjunction with Older Persons Services.</p> <p>1.5 Implementation of Real Time Feedback and loop for addressing any consistent issues that are being raised.</p> <p>1.6 Monitoring discharge planning placement to enable timely discharge</p>	<p>1.3 Discussed at MH&amp;A clinical governance monthly where required solutions put into place</p> <p>1.4 By June 2017 model of care options have been developed.</p> <p>1.5 Quarterly report on Real Time Feedback tabled at MH&amp;A clinical governance.</p> <p>1.6 By December 2016 10% reduction in delayed discharges</p> <p>1.6 Delayed discharge report discussed at Clinical Governance monthly.</p> <ul style="list-style-type: none"> <li>Improving the health status of people with severe mental illness PP6</li> <li>PP8 Waiting time for adult outpatient services meets milestone of 80% being seen &lt;= 3 weeks and 95% being seen &lt;= 8 weeks to be achieved by end December 2015</li> </ul>	
<p><b>2. Improve Primary Secondary Integration</b></p>	<p>2.1 Establishment of a Youth Coordinator role as a two year pilot to work within an intermediate and secondary school to advocate and support young people, their families/whanau and the agencies in address their needs.</p> <p>2.2 Through the SLAT development of a single point of access to services covering primary/secondary/NGO</p>	<p>2.1 By June 2016 evaluation framework in place for the service.</p> <p>2.2 By September 2016 a model of care for single point of access has been developed.</p>	<p>PP26 Service Development Plan (SDP) Quarterly</p>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>services.</p> <p>2.3 Participation in the MHN regional review of youth primary mental health services.</p> <p>2.4 Localised development and production of mental health and addictions Map Of Medicine pathways</p> <p>2.5 Developing the capability of the workforce, provide education and training for GPs:</p> <ul style="list-style-type: none"> <li>• Management of patients using Map of Medicine Pathways</li> <li>• Dementia pathways</li> <li>• Children Of Parents with Mental Illness and/or Addictions (COPMIA)</li> <li>• Addiction</li> <li>• Recovery Action Plans</li> </ul> <p>2.8 Project to transition services users from Secondary Opioid Substitution Treatment services to primary care will be implemented.</p> <p>2.9 Through the SLAT – explore and identify opportunities for co-location of specialist services into the community.</p> <p>2.10 Mental Health and Addictions service provision included in the Integration project.</p>	<p>2.2 By June 2017, single point of access has been implemented.</p> <p>2.5 100% of referrals that receive a brief PMHI intervention have a pre/post treatment score (Kessler 10) demonstrating improvement.</p> <p>2.6 Prioritised pathways will be published by December 2016</p> <p>2.7 Training content decided by September 2016 and training programme in place end June 2017</p> <p>2.8 By December 2016 Resource and pathway requirement are established in partnership with MHN.</p> <p>2.8 By June 2017 80% of non-complex clozapine service users have transitioned to Primary care management.</p> <p>2.9 By December 2016 options for co-location have been identified.</p> <p>2.10 Reporting against milestones as developed in the work programme</p>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>3. Cement and build on gains for the most vulnerable</b>	<p>3.1 Service users (and their families/whanau) will be supported in their role as parents.</p> <ul style="list-style-type: none"> <li>Implement process for identification of service users or care-givers.</li> <li>Implementation of service provision in line with Supporting Parents – Health Children guidelines.</li> </ul> <p>3.2 Equally well - identification of opportunities for routine physical health checks for those with long term secondary MH&amp;A issues</p> <p>3.3 We will build and strengthen our partnerships across the sector and with other agencies and key stakeholders –</p> <ul style="list-style-type: none"> <li>The suicide prevention and postvention advisory group will continue to be multi-agency, other organisations and community interest groups.</li> <li>The suicide prevention and postvention coordinator will hot desk around other agencies.</li> <li>We will continue to work with the social sector trial in South Taranaki,</li> <li>We will work with the multi-agency Youth on Track forum to establish the Youth Coordinator role for North Taranaki.</li> </ul> <p>3.4 Increasing number of people with Recovery Action Plans in place through review of current plan format, staff training twice yearly, raised service user awareness through plan development at 3-monthly review meetings,</p>	<p>3.1 By June 2017 the implementation of the Supporting Parents – Healthy Children guidelines will be progressing in accordance with the work plan.</p> <p>3.2 By December 2016 process for physical health checks developed.</p> <p>3.3 The Advisory Group will provide a quarterly report on progress against the Taranaki Suicide Prevention and Postvention Action Plan.</p> <p>3.4 Recovery Action plan format includes provision for the care of children during acute episodes</p> <p>3.4 80% of patients have Recovery Action Plans by June 2017. Milestone of</p>	PP26 Service Development Plan (SDP) Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>and development of community booklet</p> <p>3.5 Continue working with Police to finalise a service level agreement.</p> <p>3.6 Implementation of Police / DHB (MH&amp;A services and Emergency Department) joint working for response to crisis call outs.</p> <p>3.7 Improving Mental Health outcomes for Māori (Māori Health Plan) – reducing the number of community treatment orders.</p> <ul style="list-style-type: none"> <li>- Taranaki DHB and Māori Kaupapa NGO providers will take a whanau ora approach by interviewing whanau, tangata whaiora and relevant key works with questions related to benefits or being under or not being under the Mental Health Act.</li> <li>- Results of the survey will be discussed and actions jointly agreed at MH&amp;A services clinical governance forum.</li> </ul>	<p>75% at end December 2016</p> <p>3.5 By July 2016 draft service level agreement is complete.</p> <p>3.6 By December 2016, the parties have implemented processes for working together.</p> <p>3.7 By December 2016 questions and results have been completed.</p> <p>3.7 By June 2017 actions/solutions have been implemented.</p> <p>3.7 By June 2017 the gap between Community Treatment Orders issued under Section 29 of the Mental Health Act for Māori 89 and Non-Māori 64 – a reduction of the gap from 39 to 25.</p>	
<b>4. Deliver Increased Access for All Age Groups</b>	<p>4.1 Utilise HONOS sub-clinical data routinely to assist MDTs in decision making regarding entry and exit</p> <p>4.2 Review service entry and exit criteria for community service users against current client base – review service users with sub-clinical HONOS scores for potential discharge from service</p> <p>4.3 Maximise use of crisis and planned respite services.</p>	<p>4.1 Current sub-clinical HONOSCa = 9%. Current sub-clinical HONOS = 8.5%</p> <p>4.1 30% reduction in number of sub-clinical HONOS scores on caseload</p> <p>4.3 Quarterly reporting on occupancy discussed at Clinical Governance regarding access to</p>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>4.4 Continue to support the colocation of NGO employment specialists with DHB Specialist MH&amp;A services.</p> <p>4.5 Increase the presence of employment specialists in clinical teams across the sector.</p>	<p>services.</p> <p>4.4 by December 2016, 5% increase of referrals from clinical teams.</p>	
<b>5. Implementation of the Taranaki Suicide Prevention and Postvention Action Plan</b>	<p>5.1 Development and implementation of postvention pathway.</p> <p>5.2 By April 2016 we will have a Suicide Prevention and Postvention Coordinator in post.</p> <ul style="list-style-type: none"> <li>- Delivery of refreshed priorities and milestones will happen in accordance with the Advisory Groups agreed focus.</li> </ul>	<p>5.1 By June 2016, postvention pathway and relevant documentation completed.</p> <p>5.1 By December 2016 the postvention pathway completed.</p> <p>5.2 Reporting monthly against the activity completed against the plan.</p>	
<b>6. Ensuring NGO Sustainability</b>	<p>6.1 NGO sector will be involved in all service redesign with an expectation that sustainability of the NGO sector is important to future service delivery.</p>		

## System Integration

### 2B.2.13 Cancer Services/Faster Cancer Treatment

Better Sooner More Convenient Health Services for New Zealanders in relation to cancer means all New Zealanders can easily access the best services, in a timely way to improve overall cancer outcomes.

Cancer is the country's leading cause of death (29%) and a major cause of hospitalisation. Most New Zealanders will have some experience of cancer, either personally or through a relative or friend.

The incidence of cancer is 20% higher for Māori than for non-Māori, but cancer mortality is nearly 80% higher for Māori. Māori are also more likely than non-Māori to have their cancer detected at a later stage of disease spread.

Residents of more socioeconomically deprived areas are more likely to develop cancer, less likely to have their cancer detected early, and have poorer survival than residents of less deprived areas.

While the overall risk of developing cancer in New Zealand is decreasing, New Zealand has an increasing number of people who are developing cancer, mainly because of population growth and ageing. The total number of cancer registrations is projected to increase by approximately 21% from 2006 to 2016. In addition, once people are diagnosed with cancer they are now less likely to die from it. This means that people are surviving longer, and being treated for longer periods of time, with different treatments.

There is a large amount of work underway around the faster cancer treatment targets including the appointment of additional nursing staff to co-ordinate the patient journey. A comprehensive database designed to monitor the timelines of each patient's care, access to each of the multiple services involved in cancer care has been created. Referrals are flagged for patients with a high suspicion of cancer and the patients are actively followed up wherever they are in their journey through the hospital system. The Multidisciplinary Care Coordinators help facilitate this journey for patients.

### *Our Approach*

Taranaki DHB maintains a clinical relationship with the Central Cancer Network for care and treatment of our cancer clients. The Central Cancer Network area includes Capital and Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui, Hawkes Bay and Taranaki DHBs. Cancer is an area of high need which can only be effectively met through regional and inter-regional collaboration and cooperation. In the Central Region there are strong clinical networks which provide for essential collegial support in the provision of cancer services to mitigate the risks to a potentially vulnerable service.

A health system that functions well for cancer is one that ensures all:

- People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care)
- People have access to services that maintain good health and independence
- People receive excellent services wherever they are
- Services make the best use of available resources

Health system success is measured by five year survival rates, cancer incidence and cancer mortality data. The focus of the regional work programme covers the following areas:

- Continuing to ensure timely and improved access to radiotherapy and chemotherapy services
- Building knowledge and capacity to ensure timely and improved access to diagnosis and cancer treatment services via the Faster Cancer Treatment programme of work
- Improving colonoscopy wait times and quality of services
- Improving system integration and service collaboration

The DHB will apply the Equity of Healthcare for Māori Framework Resource to improve the timeliness and quality of patient pathways across the cancer pathways.

### *Linkages*

- Minister's Letter of Expectations
- Health Target – Faster Cancer Treatment
- National Cancer Programme Work Programme
- Midland DHBs Regional Services Plan 2016/17
- Central Cancer Network Strategic Plan
- Taranaki Palliative Care Plan 2013-16

- Hei Pā Harakeke Action Plan
- Our Performance Story Impact: People Receive Timely and Appropriate Specialist Care

## Action Plan

<b>Objective</b>	<b>Actions to Deliver Improved Performance</b>	<b>Measure</b>	<b>Reporting</b>
<b>Shorter Waits for Cancer Treatment</b>	<ul style="list-style-type: none"> <li>Maintain performance against the radiotherapy and chemotherapy wait time targets by investing in workforce and capacity as required.</li> </ul>	<ul style="list-style-type: none"> <li>100% of patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy</li> </ul>	Monthly
	<ul style="list-style-type: none"> <li>Work with CCN to continue implementation of the priority areas for each year identified in the National Medical Oncology Models of Care Implementation Plan 2012/13, including:               <ul style="list-style-type: none"> <li>Support the implementation of e-prescribing into both cancer centres ensuring process appropriate for Taranaki DHB site</li> <li>Implement SMO workforce priorities as identified by the national plan.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Implementation of agreed regional priorities identified and completed by June 2017.</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Following the successful proposal for service improvement, Taranaki DHB has commenced the project ‘Defining the Uro-Oncology Pathway’. The objectives of the project being to:               <ul style="list-style-type: none"> <li>Identify health inequities and develop strategies to address these.</li> <li>Develop clinical pathways, adopting the ERAS principles.</li> <li>Develop patient information pamphlets using the principles of patient co-design.</li> </ul> </li> <li>The new health target to be achieved by July 2016 is 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017.</li> </ul>	<ul style="list-style-type: none"> <li>Development of strategies to address inequities in cancer Services for the people of Taranaki</li> <li>Implementation of clinical pathways for patients with a Urological Cancer</li> <li>Clinical audit of the pathways</li> <li>Implementation of patient information pamphlets for patients with a Urological Cancer.</li> <li>Final report due October 2016 to Ministry of Health.</li> <li>85% of patients referred with a high suspicion of cancer and a need to be seen within two weeks receive their first treatment within 62 days.</li> </ul>	Quarterly  Monthly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p><b><i>Faster Cancer Treatment Indicators (FCT)</i></b> Work with CCN to ensure a coordinated approach to identifying and implementing actions to improve FCT data-collection systems, including:</p> <ul style="list-style-type: none"> <li>FCT trackers identify and implement processes to make FCT data collection systems/processes part of business as usual.</li> </ul>	<ul style="list-style-type: none"> <li>% of patients (by DHB and ethnicity) referred urgently with a high suspicion of cancer receive their first cancer treatments (or other management) within 62 days Target – 85%</li> <li>% of patients referred urgently with a high suspicion of cancer and need to be seen within two weeks who have their first specialist assessment within that timeframe</li> <li>% of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days</li> </ul>	Quarterly
	<p><b><i>Multi-Disciplinary Meeting Development (MDM)</i></b></p> <ul style="list-style-type: none"> <li>Taranaki is working with CCN to identify regional clinician resourcing requirements to support MDMs. Under the Cancer Health Information Strategy, the Ministry are progressing a project to deliver a standardised national MDM framework by late 2016.</li> </ul>	<ul style="list-style-type: none"> <li>Taranaki will actively participate in the MDM development project.</li> <li>Framework in place by end of 2016</li> </ul>	Quarterly
	<p><b><i>Tumour Standards</i></b> Work with CCN to undertake the following actions to support use of the tumour standards:</p> <ul style="list-style-type: none"> <li>Following the completion of three tumour standard reviews (2014/15) a further three will be undertaken (2016/17).</li> <li>Implement the service improvement recommendations following the tumour standard reviews Work with CCN to develop a coordinated approach to cancer pathway development via Map of Medicine/Health Pathways projects.</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of the service improvement recommendations identified in the tumour standard reviews.</li> <li>Reviews completed by June 2017</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Active surveillance for prostate cancer will be undertaken in accordance with implementation of Guidance on Using Active Surveillance to Manage Men with Low-Risk Prostate Cancer and the Ministry of Health Prostate Cancer Management and Referral Guidance during 2016/17.</li> <li>ERAS pathways for Prostate and Bladder Cancer are under development. This will incorporate the MoH Prostate Cancer Management and Referral Guidelines.</li> <li>As the result of the HEAT assessment to identify service inequities a project has commenced. This will involve the development of a focus group of male Māori patients post Urological cancer treatment to identify reasons for late presentation and to identify areas of service improvements.</li> </ul>		
	<p><b>Care Coordination</b></p> <ul style="list-style-type: none"> <li>Support Cancer Nurse Coordinators' professional development plan, including attendance at national and regional training and mentoring forums.</li> <li>Following the employment of the Oncology Social Worker and Psychologist, develop an amalgamated approach to patient support and care coordination. Continue to work with CCN to support active patient tracking aligned to national patient flow.</li> </ul>	<ul style="list-style-type: none"> <li>Cancer Nurse Coordinator to attend the annual National Forum.</li> <li>Number of patients referred to Cancer Nurse Coordinators and the supportive care team per quarter</li> </ul>	Quarterly
	<p><b>Health Information Strategy</b></p> <p>A review against the cancer health Information strategy will be completed once finalised with implementation of strategies where appropriate.</p>	<ul style="list-style-type: none"> <li>Review undertaken Quarter 2</li> </ul>	Quarterly
	<p><b>Primary Care</b></p> <p>Work with Midlands Cancer Network to coordinate a focus on the front end of the process in primary care identification</p>	<ul style="list-style-type: none"> <li>E-referral criteria developed in place by end of 2016</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>of high suspicion of cancer (HSC), including:</p> <ul style="list-style-type: none"> <li>Implementing nationally developed e-referral criteria for referral of patients with HSC from primary care</li> </ul>		
<b>Improved Waiting Times for Diagnostic Services (Colonoscopy)</b>	<p>Taranaki DHB will take a coordinated approach to identifying actions to improve waiting times and quality of endoscopy/colonoscopy services, including:</p> <ul style="list-style-type: none"> <li>The development of Endoscopy Governance Group (EGGs NZ)</li> <li>Identifying and implementing improvements to colonoscopy services</li> <li>Monitoring waiting times for diagnostic and surveillance/follow up colonoscopy.</li> </ul>	<p>Diagnostic Colonoscopy:</p> <ul style="list-style-type: none"> <li>a. 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) 100% within 30 days (PP29)</li> <li>b. 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 120 days (PP29)</li> </ul>	Quarterly
<b>Improving Palliative Care</b>	<ul style="list-style-type: none"> <li>Support the development of hospice innovative Fund initiatives</li> <li>Participate regional forums and initiatives to improve palliative care</li> <li>Continue consideration to implementation of National Specialist Palliative Care Service Specifications (2015)</li> </ul>	<p>Report progress and activities</p> <p>Record of participation evidenced by meeting minutes</p> <p>Report progress</p>	Quarterly
	<ul style="list-style-type: none"> <li>Consider Recommendations arising from the National Adult Palliative Care Review (due September 2016) and build into regional work programme as able;</li> <li>Work streams include: <ul style="list-style-type: none"> <li>Projected demand for palliative care services</li> <li>Quality and standards of care, including service user perspectives</li> <li>Workforce issues</li> <li>Integration of and equitable access to services</li> <li>Funding and sustainability</li> </ul> </li> </ul>	Report service improvement initiatives	Quarterly

## 2B.2.14 Stroke Services

### Our Approach

Stroke Services are identified as a priority area in our Regional Services and Annual Plan. Health Share through the Midland Stroke Action Group is leading the development and implementation of regional actions. The focus in 2016/17 is maintenance of a coordinated stroke and thrombolysis service.

### Linkages

- Our Performance Story Impact: People receive timely and appropriate specialist care
- Our Performance Story Impact: People stay well in their homes and communities
- Midland DHBs Regional Services Plan 2016/17
- Midland Stroke Network

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Maintenance of Stroke Services</b>	Organised Stroke Services		
	Maintenance of dedicated stroke beds for management of people with stroke, thrombolysis and TIA.	<ul style="list-style-type: none"> <li>• 80% of people admitted with stroke will be managed in the stroke unit with demonstrated pathway</li> </ul>	Quarterly
	Continued provision of designated lead clinician for stroke & TIA	<ul style="list-style-type: none"> <li>• Lead stroke clinicians available Monday - Friday (Geriatrician and CNS )</li> <li>• Patients that are assessed as TIA are seen in the TIA clinic - following Taranaki DHBs TIA pathway.</li> </ul>	Quarterly
	Ensure people with stroke receive active rehabilitation by an interdisciplinary stroke team	80 % patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	Quarterly
	Improve use of the FIM Assessment tool for all stroke patients that receive stroke rehabilitation	Use of FIM to on admission, discharge and during inpatient stay to measure self-care transfers <ul style="list-style-type: none"> <li>• mobility</li> <li>• Cognitive items ie communication, social interaction</li> </ul>	Quarterly
	Ensure ongoing access to intermediate care/community stroke services	Evaluate effectiveness of referral pathway to access intermediate care/community stroke services.	Quarterly
	Ensure consistent delivery of rehabilitation on a 7 day basis		

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	Stroke Service education	Ongoing discussion of 7 day per week allied health input	Quarterly
	Review stroke policy	Stroke team to provide variety of topics this year to relevant nursing and allied staff	Bi Monthly
	Taranaki DHB will continue to be an active member of AROC (Australasian Rehabilitation Outcome Measure Centre) to support treatment, planning and rehabilitation of affected patient.	Stroke policy is reviewed by December 2016	December 2016
		FIM scores are completed and entered into AROC	Quarterly
	<u>Thrombolysis service</u>		
	All eligible people have access to thrombolysis service 24/7	<ul style="list-style-type: none"> <li>6% of potentially eligible stroke patients thrombolysed</li> </ul>	Quarterly
	Stroke thrombolysis quality assurance activities continue <ul style="list-style-type: none"> <li>Stroke thrombolysis register maintained in line with the National guidelines.</li> <li>Code Stroke in place</li> <li>Ongoing workforce training to support thrombolysis</li> </ul>	Evidence of actions in place/taken <ul style="list-style-type: none"> <li>Three education sessions per year by the lead stroke clinician or stroke CNS that includes Stroke pathway, Stroke Care/management of stroke thrombolysis</li> <li>Complete yearly registrar training</li> </ul>	Quarterly
	Regional and National Participation <ul style="list-style-type: none"> <li>Participation in national and regional clinical stroke networks to support implementation and maintenance of stroke and thrombolysis services</li> </ul>	<ul style="list-style-type: none"> <li>Monthly teleconference with Midland Regional Stroke Network and face to face meetings.</li> <li>Attend yearly quality meeting for stroke thrombolysis</li> </ul>	Quarterly

### 2B.2.15 Cardiac Services

Cardiac services are a national priority service area in our Regional Services Plan. Disparate access issues and workforce vulnerabilities exist, but an opportunity exists to make a difference to population health outcomes and inequalities through a cardiology pathway that is strongly entrenched across the continuum of care from prevention through to specialist care, and cardiac rehabilitation. The affordability of ever-emerging new technologies will require focused attention to prioritisation in the future. Development of an integrated regional cardiology service is a major focus area for the network as is the ongoing management of Acute Coronary Syndrome (ACS).

### Our Approach

HealthShare through the Midland Action Group are leading the development and implementation of regional actions.

In 2016/17 we will be continuing the work around the ACS service delivery working with the regional group to deliver a timely service to our patients throughout the care pathway. We will continue to engage with our primary care partners in the planning and implementation activities that occur in this area.

### Linkages

- Minister's Letter of Expectations
- Midland DHBs Regional Services Plan 2016/17
- Our Performance Story Impact: People receive timely and appropriate specialist care

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Cardiac Services	<ul style="list-style-type: none"><li>• Intervention rate for cardiac surgery is set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access.</li></ul>	<ul style="list-style-type: none"><li>• Agreement to and provision of a minimum of 88 total cardiac surgery discharges for local population in 2016/17</li></ul>	Quarterly
	<ul style="list-style-type: none"><li>• Improve access to cardiac diagnostics to facilitate appropriate treatment referrals, including angiography, echocardiograms, exercise tolerance tests, etc</li><li>• Midland Regionally Integrated Cardiac Services develop a forecasting methodology to plan what facilities and Cardiac FTE will be required to MoH population projections.</li><li>• Development of a regional production plan to meet quantities of procedures required to meet SIR.</li></ul>	<ul style="list-style-type: none"><li>• Refer PP29: Improved access to diagnostics. 95% of people will receive elective coronary angiograms within 90 days</li></ul>	Quarterly
	<ul style="list-style-type: none"><li>• Enhanced patient referral pathways to support improved and timely access to all cardiac services</li></ul>	<ul style="list-style-type: none"><li>• ESPI compliance</li></ul>	Quarterly
	<ul style="list-style-type: none"><li>• Manage waiting times for cardiac services, so that no patient waits longer than four months for first specialist assessment or treatment.</li></ul>	<ul style="list-style-type: none"><li>• Elective Services Patient Flow Indicators: all patients wait four months or less for first specialist assessment and treatment</li></ul>	Monthly
	<ul style="list-style-type: none"><li>• Undertake initiatives locally to ensure population access to cardiac services is not</li></ul>	<ul style="list-style-type: none"><li>• Refer SI4: Standardised Intervention Rates</li><li>• Cardiac surgery: 6.5 per</li></ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	significantly below the agreed rates. This includes cardiac surgery, percutaneous revascularisation and coronary angiography	10,000 of population <ul style="list-style-type: none"> <li>Percutaneous revascularisation: 12.5 per 10,000 of population</li> </ul>	
	<ul style="list-style-type: none"> <li>Participation in regional cardiology network activities</li> </ul>	Maintenance of regional collaboration and working groups	Quarterly
	<ul style="list-style-type: none"> <li>Embedding of ACCP pathway (implemented in Taranaki in 2014/15) has become business as usual</li> </ul>	Audit and Review of pathway to be completed Q2	Quarterly
	<ul style="list-style-type: none"> <li>Implement regionally agreed protocols and systems to optimise management of patients with heart failure</li> </ul>	<ul style="list-style-type: none"> <li>Reduced HF admissions, base line to be determined Q1</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Implementation of local cardiology project recommendations</li> </ul>	<ul style="list-style-type: none"> <li>Coronary angiography: 34.7 per 10,000 of population</li> </ul>	Quarterly
<b>Acute Coronary Syndrome</b>	<ul style="list-style-type: none"> <li>Taranaki DHB will Implement the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention</li> <li>Taranaki DHB and the Midland Region continue to enhance pathways for patients to ensure high risk ACS patients accepted for coronary angiography having it within 3 days of admission</li> <li>Midlands Integrated Cardiac Services capacity plan to facilitate increased use of BOP Cath Lab to minimise Waikato bed block.</li> <li>Increased local provision of angiography from Q3 for appropriate high risk ACS patients.</li> <li>Nurse led initiative to ensure early referrals for angiography are actioned</li> </ul>	<ul style="list-style-type: none"> <li>Indicator 1. &gt;70% of high risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission=Day 0)</li> <li>Reduce the door to referral time for angiography from current level of 1.2 days to 1.0 or less</li> </ul>	<p>Performance reported against health target</p> <p>Quarterly</p>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Taranaki DHB will develop processes, protocols and systems to enable local risk stratification and transfer of appropriate high risk ACS patients</li> </ul>	<ul style="list-style-type: none"> <li>Indicator 2 &gt;95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS Q1 ACS and Cath/PCI registry data collection within 30 days</li> </ul>	Performance reported against health target
	<ul style="list-style-type: none"> <li>Commission new angiography suite</li> <li>Embed processes to increase number of acute angiograms completed locally</li> </ul>	<ul style="list-style-type: none"> <li>New suite will open mid 2016</li> <li>Indicator 1. &gt;70% of high risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission=Day 0)</li> </ul>	Performance reported against health target
	<ul style="list-style-type: none"> <li>Taranaki DHB Cardiologists continue to meet with regional group to develop regional guidelines</li> </ul>		Performance reported against health target

## 2B.2.16 Health of Older People

### *Our Approach*

During 2016/17 we will continue to work with our primary care partners and regional DHBs to develop and refine integrated services that will address the needs of older people through early intervention, closer to home, wherever possible reducing need for hospitalisation. This will include a comprehensive review of processes to ensure effective and timely communication between health providers, aged residential care and families/carers.

Our focus will be to build on service developments commenced in 2015/16, with particular emphasis on increasing initiatives that will reduce the risk of falls and fractures, supporting early intervention for people with dementia and appropriately supporting caregivers of people with dementia. We will also continue supporting our primary and community care partners with specialist input from our specialist health services for older people.

During 2016/17 we will continue to support national development work aimed at improving to the delivery and sustainability of Home and Community Support Services. The Midland DHB region will continue to participate in the development of the national Health of Older People Steering Group's national framework. Where applicable we will use the framework to inform decision-making about the implementation of a Midland DHB regional approach. We will also continue to use interRAI data to maximise opportunities to inform clinical practice and improve health outcomes for older people.

New local pieces of work for 2016/17 include:

- Development of a Five-Year Taranaki Health of Older People Strategy aligned to the New Zealand Health of Older People Strategy which will inform future annual planning for older people's health.
- Implementation of a Yellow Envelope document transfer process to improve communication between aged residential care and hospital services during admission/discharge of older people.
- Completion of an Options Appraisal for development of a residential service for older people with chronic and enduring mental health conditions and physical health decline requiring long term residential support.

### Linkages

- Our Performance Story Impact: People Receive Timely and Appropriate Specialist Care.
- Midland District Health Boards Regional Services Plan 2016/17.
- Midlands Health of Older People Clinical Action Network Action Plan.

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>System Integration for Older People (PP23)</b>	<p>Taranaki DHB will review processes to ensure the right health information (including medication chart, prescriptions, discharge summary, Advanced Care Plans) are communicated between health providers (including Aged Residential Care, Home and Community Support Services, General Practice, Pharmacy and Secondary Care), and with families.</p> <ul style="list-style-type: none"> <li>• Review of information sharing processes between aged residential care services and health providers (NASC, general practice, pharmacy and general practice to be completed).</li> <li>• Pilot the use of the 'Yellow Envelope' scheme to manage transfer of documentation between ED and Ward 2A (Older Peoples Health) and aged residential care for aged care residents.</li> </ul> <p>Taranaki DHB will complete an Options Appraisal to inform the development of a residential service for older with chronic and</p>	<p>DHBs to provide evidence that integrated systems and processes are in place to support information flow and improve outcomes.</p> <ul style="list-style-type: none"> <li>• Review completed by March 2017 and recommendations communicated to relevant health providers.</li> <li>• Yellow Envelope scheme piloted and reviewed with aged care providers, ED and Ward 2A by 31 March 2017 and recommendations developed to guide future use (including expansion) of the scheme by 30 June 2017.</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>enduring mental health conditions and physical health decline who require long term residential support but for whom aged residential care services are not appropriate.</p> <p>Development of a Five-Year Taranaki Health of Older Strategy aligned to the National Health of Older People Strategy.</p>	<ul style="list-style-type: none"> <li>Options Appraisal completed and any recommendations presented for approval by 31 January 2017.</li> <li>Taranaki Health of Older People Strategy completed and endorsed by Taranaki DHB Board.</li> </ul>	
<b>Integrated Falls and Fracture (PP23)</b>	<p>Taranaki DHB will work in conjunction with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services. This includes, but is not limited to, identifying:</p> <ul style="list-style-type: none"> <li>Older people at risk of falls.</li> <li>The number of older people referred from primary and secondary care into the fracture liaison services.</li> <li>The number of older people referred to, and seen by, a strength and balance retaining service.</li> <li>The number of older people referred to osteoporosis management programmes.</li> </ul>	<ul style="list-style-type: none"> <li>Narrative on how older people are being assessed on their risk of falls.</li> <li>Number of older people referred from primary and secondary care into the fracture liaison services (specifying the proportion referred from each).</li> <li>Number of older people referred to the Green Prescription service by the fracture liaison service.</li> <li>Number of older people that have received appropriate osteoporosis treatment.</li> </ul>	Quarterly
<b>interRAI: Comprehensive Clinical Assessment in residential care and in home and community support settings (PP23)</b>	<p>Ensure all older people receiving long term home and community support services have had an interRAI Home Care or a Contact assessment and completed care plan.</p> <p>Ensure older people in aged residential care have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.</p>	<ul style="list-style-type: none"> <li>Evidence of the number of older people who received long term support services for home and community supports in the last 3 months and percentage who have had an interRAI Home Care or a Contact</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>Ensure all older people admitted to an aged residential care facility have been assessed using an interRAI Home Care assessment tool in the six months prior to that first LTCF assessment.</p> <p>Older people referred for an interRAI assessment to access publicly funded care services will undergo the assessment and have a service allocated/declined in a timely manner.</p> <p>Use interRAI measures provided by the national data analysis and reporting service to benchmark and compare performance with other DHBs and DHB regions to improve outcomes for older people.</p>	<p>Assessment and completed care plan.</p> <ul style="list-style-type: none"> <li>• The percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI LTCF Assessment completed within 230 days of the previous assessment.</li> <li>• The percentage of LTCF clients admitted to an aged residential care facility that had been assessed using an interRAI Home Care Assessment tool in the six months prior to that first LTCF assessment.</li> <li>• Show time taken from any referral from any source to complete (not triage) an interRAI Assessment (ie, Contact, MDS-HC, LTFC assessment). The number and percentage of clients referred from any source to complete an interRAI Assessment (Contact or Home Care) will be in line with national timeframes for crisis, high, medium and low risk clients as follows: <ul style="list-style-type: none"> <li>- Crisis – within 24-48 hours.</li> <li>- High risk – 1-5 days for assessment and maximum 5 days to service co-ordination.</li> <li>- Medium risk – 1-10 days for assessment and maximum 10 days to service co-ordination.</li> <li>- Low risk – 1.15 days for assessment and maximum 15 days to service co-ordination.</li> </ul> </li> </ul>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
		<ul style="list-style-type: none"> <li>Narrative report showing evidence that Taranaki DHB are using interRAI measures to benchmark and compare performance with other DHBs in the Midlands region and are using this data to improve outcomes for older people.</li> </ul>	
<b>Home and Community Support Services for Older People (PP23)</b>	Taranaki DHB will support the In Between Settlement agreement outcomes.	<ul style="list-style-type: none"> <li>In Between Settlement agreement outcomes are fully implemented in line with Ministry of Health guidance.</li> </ul>	Quarterly
<b>Dementia Care Pathways (PP23)</b>	<p>Taranaki DHB will demonstrate that there is continued development of the dementia care pathway, which is proactive and co-ordinated and builds on previous work.</p> <p>Actions to support early diagnosis include:</p> <ul style="list-style-type: none"> <li>Provision of support and education for primary care staff regarding dementia care.</li> <li>Survey of staff trained pre and post training.</li> </ul> <p>Actions to support patients and their families on diagnosis include:</p> <ul style="list-style-type: none"> <li>Continue to deliver Living Well Groups aimed at people recently diagnosed with dementia and their carers.</li> </ul> <p>Local Dementia Pathway initiatives:</p> <ul style="list-style-type: none"> <li>Continue to meet locally to maintain the Taranaki Map of Medicine Pathway dementia pathway.</li> </ul> <p>Taranaki DHB will demonstrate support for a regional approach to dementia services by providing detailed information of dementia education and support</p>	<ul style="list-style-type: none"> <li>50% of all GP Practices have training provided.</li> <li>Delivery of two Living Well Groups by June 2017.</li> <li>Dementia care pathway localisation meetings every six months.</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>programmes in operation to support informal carers and people living with dementia.</p> <ul style="list-style-type: none"> <li>Regional Health of Older People Action Group will complete an analysis of the current state of educational programmes and support groups to support family/whānau carers in operation in the region.</li> <li>Taranaki DHB will support the Regional Health of Older People Group with the development of a regional response to reduce variability of education and support programmes available to support family/whānau carers and people living with dementia.</li> </ul>	<ul style="list-style-type: none"> <li>Narrative report outlining outcome of regional mapping process and activities undertaken to reduce variability in education and support programme options.</li> </ul>	

## 2B.2.17 Service Configuration including Shifting Services

### Integrated Health Care

#### Our Approach

The Taranaki Alliance Leadership Team (TALT) has been established to provide a governance and business ownership role for a number of Taranaki specific initiatives that have been agreed to be of high priority for both Taranaki DHB and Midlands Health Network. Members of TALT will be responsible for driving progress toward the vision *Taranaki Together, a Healthy Community - Taranaki Whanui He Rohe Oranga*. The respective organisations have agreed to ensure the work programmes are aligned with the vision and the organisational work programmes and project implementation plans are adequately resourced.

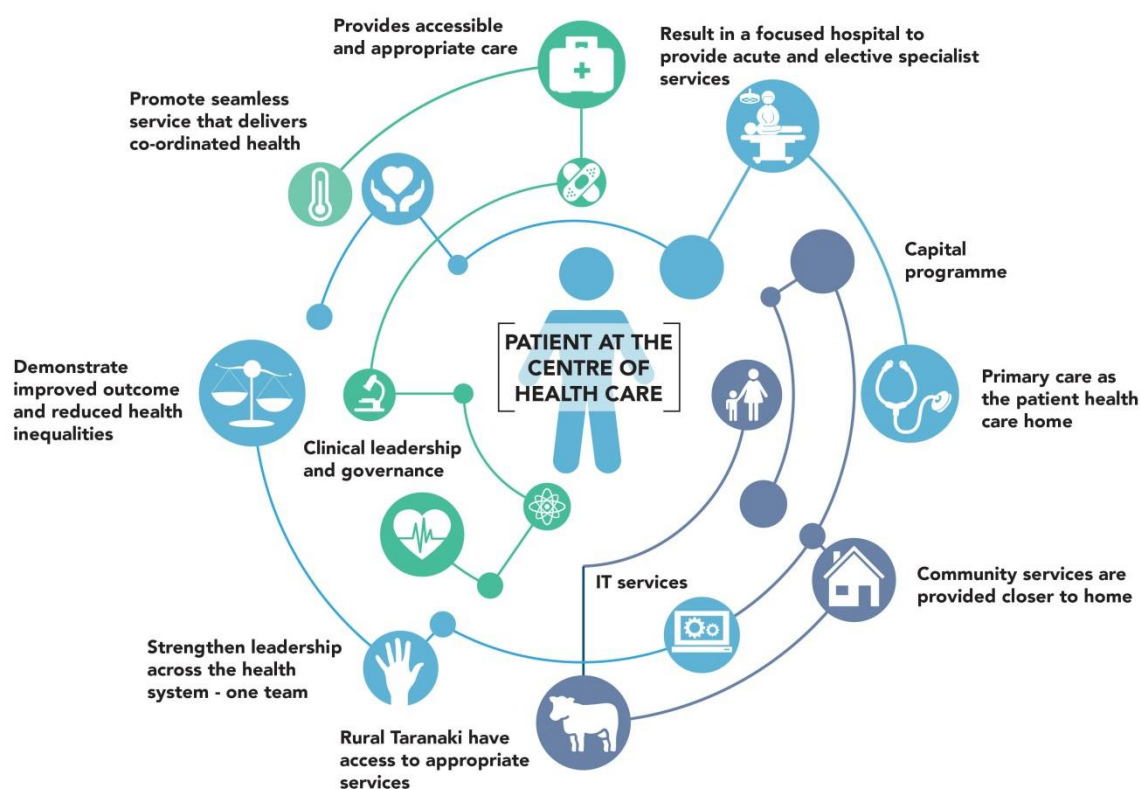
This work programme moves the Taranaki health sector towards its vision and builds on the projects that have been implemented so far. To date the TALT has focused on developing a framework for health services in Taranaki to operate as a single integrated system. This requires an agreed vision and guiding principles for a whole of systems integration approach.

#### Strategic Case for Change

A strategic approach is required in the context of real and urgent challenges around sustainability of the Taranaki Health System. This is required to allow us to continue to deliver high performing health system, reducing health inequalities and improved health outcomes and building on the strengths of our system while having an opportunity to respond to the challenges ahead of us. Taranaki DHB cannot do this in isolation. Taranaki DHB is part of “one team” with our Primary partners the Midlands Health Network and seeks to adopt a whole of system lens to our approach.

### Future Vision

The future vision for Taranaki health services places the patient/person at the centre of the system with the aim of services being co-ordinated, accessible and appropriate with Primary Care considered the patient health care home and community services provided as close to home as possible. The approach means the model must consider capital, information technology, service development, workforce and leadership through a 'one team' system lens.



Taranaki DHB and our primary and community partners are currently exploring the feasibility of community services in the context of health care home and the cost benefit of this approach.

Work will continue on a service delivery model developed through engagement with stakeholders, staff, clinicians and must take into consideration a rural population that is significantly distanced from other key centres and the current health disparities between Māori and other ethnicities in Taranaki. Other significant considerations are a population that is not predicted to grow significantly over time and a constrained fiscal environment.

### Linkages

- Taranaki Alliance Leadership Team (TALT) work programme
- Taranaki DHB Māori Health Plan
- The Networks Plan 2014 – 2017 MHN Alliance
- Draft NZ Health Strategy
- Pharmacy Action Plan

## Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
All new services and service delivery models reduce health inequality and any unintended consequences are identified.	<ul style="list-style-type: none"> <li>Engage trainers in Health Equity Tools to deliver information and tools to planners and service managers</li> </ul>	<ul style="list-style-type: none"> <li>Health Equity training delivered to DHB staff working in service planning and the management of service delivery</li> </ul>	Q3
Develop an Integrated patient centric Model of Care that spans Primary, Community and Secondary Health services in Taranaki	<ul style="list-style-type: none"> <li>Design a detailed model of integrated care for primary care and DHB community health services</li> <li>Engage local practices, clinicians, consumers, Māori Health, and Service Managers in the project leadership, development and agreement of the new integrated model</li> <li>Assess the costs and benefits of this model of care</li> <li>Consider options for, contracting, funding and governance arrangements</li> <li>Complete the associated Business Case, including economic analysis on the likely impact of the new model of integrated care</li> <li>Document the model and Business Case, and report to the Taranaki DHB and Pinnacle-MHN Boards by November 2016 with options, implications and recommendations, including an outline Implementation Plan.</li> </ul>	<ul style="list-style-type: none"> <li>Submit a Business Case to the joint boards for consideration that includes options, implications and recommendations including an outline implementation plan</li> </ul>	Q1 and Q2
Implementation Planning for Integrated seamless patient centric Model of Care that spans Primary, Community and Secondary Health services in Taranaki	<ul style="list-style-type: none"> <li>Initiate Implementation planning subject to the joint board decision and with reference to service change protocols.</li> </ul>	<ul style="list-style-type: none"> <li>Implementation plans are finalised</li> <li>All stakeholders are informed and engaged in the implementation plans</li> </ul>	Q4

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Pharmacy Action Plan	<ul style="list-style-type: none"> <li>Participate in the national development and implementation of medicines adherence and optimisation of services of high quality. This includes reviewing the current service provision across the country and building the framework for the rollout of these services within the Community Pharmacy Services Agreement.</li> <li>Participate in the national development and implementation of an efficient medicines supply chain.</li> <li>As part of the national development work plan, we will undertake, by December 2016, a stocktake of the current community pharmacy resources component of the one-team alignment across Taranaki, including rural settings, and benchmark these against national figures and analysis of population need.</li> <li>As part of the Community Pharmacy Service Agreement development, Taranaki will look to commission services to best meet the identified demand.</li> </ul>	<p>Update report identifying progress made during the Quarter against the actions to deliver improved performance. The report will include:</p> <ul style="list-style-type: none"> <li>Whether the DHB is on track meeting each deliverable by the end of Quarter 4, including comment on specific actions delivered in the Quarter.</li> <li>Where deliverables are not on track, the report must include mitigation strategies and new timeframes for delivery.</li> <li>Where quantitative measures are reported – reports must include baseline, target and quarterly performance progress.</li> </ul>	

## 2B.2.18 System Level Outcome Measures

### Our Approach

The Ministry of Health worked closely with the sector to co-develop new System Level Measures. They are:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (i.e. keeping children out of hospital)
- Acute hospital bed days per capita (i.e. using health resources effectively)
- Patient experience of care (i.e. person-centred care)
- Amenable mortality rates (i.e. prevention and early detection).

System Level Measures are high-level goals of the health system that help show the outcomes of the system. That is, how it is performing and the value the country is receiving from it.

System Level Measures are defined nationally by the Ministry of Health, working with the sector. They are the organising principles for contributory measures.

Taranaki DHB and our Primary Care partners will drive implementation of the System Level Measures.

### Linkages

- Taranaki Alliance Leadership Team (TALT) work programme
- Taranaki DHB Māori Health Plan
- The Networks Plan 2014 – 2017 Midlands Health Network Alliance
- Draft NZ Health Strategy
- Our Performance Story Impact: People receive timely and appropriate specialist care
- 2016-2019 Midland Regional Services Plan
- Midlands Alliance Leadership Team

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Implementation of System Level Measures	Taranaki DHB will work with partners to jointly develop and agree an Improvement Plan by 20 October 2016.	PP22: Improving system integration and System Level Measures (SLM) SI1: Ambulatory sensitive hospitalisations (ASH) SI7: SLM total acute hospital bed days per capita SI8: SLM patient experience of care SI9: SLM amenable mortality rate DV6: SLM youth access to and utilisation of youth appropriate health services DV7: SLM number of babies who live in a smoke-free household at six weeks post-natal	Quarterly

## 2B.2.19 Shorter Stays in Emergency Departments

### Our Approach

Better Sooner More Convenient Health Services for New Zealanders in relation to Emergency Departments means all New Zealanders can easily access the best services, in a timely way to improve overall health outcomes. A health system that functions well for people with acute care needs is one that:

- Delivers and coordinates acute care services in the hospital and community
- Improves the public's confidence in being able to access services when they need to
- Sees less time spent waiting and receiving treatment in the ED
- Moves patients efficiently between phase of care
- Makes the best use of available resources

In a constrained system with limited capacity, our approach to managing patient flow becomes even more important. If we are to continue to deliver care, we will need to ensure that our capacity is matched to demand and the right care is delivered rapidly and responsively to reduce the risk of Emergency Department attendance and avoidable hospital admission.

Increasing Emergency Department presentations and unplanned (acute) admissions to our hospitals consume resources and place pressure on clinical care, diminishing the effectiveness of hospital activity.

Activities that will contribute to achieving our target include:

- Working with primary care services to reduce demand for unplanned care
- Integrated and improved long term health conditions care and management across the health system
- An effective functioning Emergency Department
- Ensuring hospital flow, reducing gridlock and improving community based discharge services and rehabilitation

Also the Midland Regional Trauma System is a clinical programme outlined in our Regional Services Plan, as a regional activity that links multiple services across the region with a common goal; to provide the best care leading to the best outcomes for trauma patients and their families.

#### Linkages

- Minister's Letter of Expectations
- Health Target – Shorter Stays in Emergency Departments
- Midland DHBs Regional Services Plan 2016/17
- Our Performance Story Impact: People Receive Timely and Appropriate Specialist Care

#### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Shorter Stays in Emergency Departments:</b> Support the education campaign with Midlands Regional Health Network Charitable Trust (MHN) to ensure only those who need E.D. care present there, and that General	<ul style="list-style-type: none"> <li>• Complete analysis of ED patients with a focus of those with extended length of stay and to identify the main factors impacting on Emergency Department (ED) length of stay</li> <li>• Utilise this analysis for future service planning and development</li> <li>• All health targets reports broken down by Māori and Pacific ethnicity</li> </ul>	<ul style="list-style-type: none"> <li>• Analysis completed by 31 December 2016</li> <li>• 95% of patients will be admitted, discharged, or transferred from the Emergency Departments within six hours via KPI monitoring report.</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>• Care Capacity Demand Management roll out across acute inpatient wards to optimise patient flow through appropriate resourcing.</li> <li>• Work with senior clinicians and</li> </ul>	<ul style="list-style-type: none"> <li>• 95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.</li> <li>• Completion of CCDM roll</li> </ul>	Quarterly Performance against the health target

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Practices and others offer care as appropriate that enables patients to avoid the need to attend ED.	managers to focus on early discharges from inpatient areas to meet flow demands	out by end of Quarter 3 <ul style="list-style-type: none"> <li>Monitoring of time of discharge in place by 30 Sept 2016 ( Q1)</li> <li>By 30 June 2017 40% of inpatients will be discharged by 12pm</li> </ul>	
	<ul style="list-style-type: none"> <li>Development of the ED Clinical Governance Committee to ensure quality targets are monitored and measured</li> <li>Three non-mandatory measures will be identified in Q1 for implementation by end of Q3.</li> <li>Further identification of future non-mandatory measures to monitor will be undertaken.</li> <li>Complete implementation of the ED Quality framework</li> </ul>	<ul style="list-style-type: none"> <li>Committee established by end of Q1</li> <li>Monitoring of Quality Framework in place by end Quarter 2</li> <li>All mandatory measures will be audited and reported as per guidelines in Quarter 1</li> <li>KPI report developed to monitor compliance - by Quarter 2</li> <li>Further Non-mandatory measures will be included as identified and implemented Quarter 3</li> <li>Capability to monitor all mandatory measures and non mandatory measures by Q4 30 June 2017</li> </ul>	Quarterly Performance against the health target
	Key activities include: <ul style="list-style-type: none"> <li>Work collaboratively with MHN to develop across sector processes to manage growth in the ED via monthly 'Meeting Acute Demand Meetings'</li> <li>Focus on non-urgent ED presentations including analysis of why patients are attending the ED for non-emergency reasons</li> <li>Emergency Department medical and nursing resource aligns with the presentation patterns</li> <li>ED electronic touch screen whiteboard aligned with the Capacity at a Glance Screen</li> </ul>	<ul style="list-style-type: none"> <li>Shorter stays health target: 95% of patients are admitted, transferred or discharged within 6 hours</li> <li>0% growth rate for ED presentations across all triage codes - Base line analysis completed by end Quarter 2</li> <li>Following baseline analysis, targeted interventions to be developed by end of Quarter 3</li> <li>2% of ED patients will be</li> </ul>	Quarterly re progress on specific actions  Quarterly  Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	displayed hospital wide with automatic alerting to management of variance response requirement	redirected to primary care <ul style="list-style-type: none"> <li>Roll out by end of Quarter 2</li> </ul>	
<b>Sustainable Services for Unplanned and Acute Care</b>	<ul style="list-style-type: none"> <li>Funding has been allocated to enhance access to GP service for under thirteens' after hours</li> </ul>	<ul style="list-style-type: none"> <li>PHOs to report utilisation of services provided to under thirteens' after hours to measure effectiveness in reducing demand for ED services</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Midlands Health Network and the Taranaki DHB will continue to implement a programme to manage overflow at ED across Taranaki. This includes implementation of further Primary Options and redirection services in Taranaki</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly Reports showing a reduction in Primary Health Care ED presentations in both Hawera and New Plymouth</li> </ul>	Quarterly

## 2B.2.20 Whānau Ora

### Our Approach

In May 2015 the joint Taranaki DHB and Te Whare Punanga Korero Trust (Iwi Relationship Board) formally adopted a Pae Ora Framework to guide the Taranaki DHB in its quest for health equity for its population as articulated in He Korowai Oranga strategy Refresh, 2014. "Pae Ora – healthy futures for whanau" is the aspirational state of wellbeing, attainable through collective action on three key elements - Mauri Ora – healthy lives, Whānau Ora – healthy families, and Wai Ora – healthy environments.

The Pae Ora framework for Taranaki draws heavily on the Whanau Ora principles identified by the Whānau Ora Taskforce (2010)<sup>6</sup>, and is underpinned by:

- A Whānau Ora philosophy that gives Whānau Ora definition and distinctiveness as it relates to health and has at its core a concern for whānau ownership of their own health development;
- A conceptual foundation based on the Treaty of Waitangi and the determinants of ethnic inequalities in health;
- A life-course orientation;
- An overall aim of Pae Ora which builds on progress made and shifts the focus towards the determinants of health.

The Whānau Ora philosophy articulated by the Taskforce (2010) provides the philosophical base for the TDHBs approach to Whānau Ora and includes:

<sup>6</sup> Whanau Ora: Report of the Taskforce on Whanau-Centred Initiatives, to Hon Tariana Turia, Minister for the Community and Voluntary Sector, 2010, Mason Durie (Chair) et al

- Recognition of whānau as a collective entity;
- Endorses a group capacity for self-management and self-determination;
- An intergenerational dynamic which recognises ongoing intergenerational transfers of knowledge towards the goal of increasing sustainability of improved health outcomes;
- Is built on a Māori cultural foundation;
- Asserts a positive role for whānau within society;
- Can be applied across a wide range of social and economic sectors.

The Taranaki DHB has adopted the following summary statement to highlight its Whanau Ora approach:

*Every service offered or funded by the Taranaki DHB should contribute knowledge and skills that empower whānau to understand and manage their own health conditions. The transfer of knowledge and skills in a way that enables integration into routine whānau practices is a key function of Whānau Ora health service provision.*

In November 2015 the Whānau Ora Partnership Group (WOPG) agreed to a set of indicators to support Whanau Ora. Within the framework sit five key areas for DHB's to focus the health system on to accelerate progress towards health equity for Maori in the next four years. The five areas are: **Mental health, Asthma, Oral Health, Obesity and Tobacco**. The Taranaki DHB is committed to focussing on these areas, as described below, as its contribution to achieving Whanau Ora. In addressing these priorities we will give prominence to the *transfer of knowledge and skills that empower whānau to understand and manage these health conditions*.

### Linkages

Delivery of this measure supports the overarching outcomes for the health and disability system of:

- New Zealanders living longer, healthier and more independent lives, and
- The health system is cost effective and supports a productive economy

supports the following sector outcomes:

- Improved health and equity for all populations
- Best value for public health system resources
- Improved quality, safety and experience of care

and supports the following government priorities:

- Whanau Ora Outcomes Framework
- Child and Youth Health
- Long Term Conditions – Prevention, Identification and Management
- System Integration
- Living Within our Means
- Regional Services Priorities
- Better Public Services
- Health Targets

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Whanau Ora</b>	The Taranaki DHB will accelerate progress towards health equity in the five priority areas implementing and monitoring the following activity.	The Iwi Relationship Board Te Whare Punanga Korero and the Taranaki DHB Board monitor the performance against the Māori Health Plan at quarterly intervals. The	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>Māori Health Plan Steering Group also monitors performance quarterly. This group comprises senior representatives from across the Taranaki DHB (Planning &amp; Funding, Hospital Services, Clinical governance, Public Health, Māori Health) and organisations that contribute to delivery against the Plan including Pinnacle Midland Health Network and Te Kāwau Māori health provider alliance.</p> <p>The Whanau Ora indicators identified in this section of the Plan will be monitored by these groups at quarterly intervals.</p> <p><b>1. <i>Reduced rate of Māori committed to compulsory treatment relative to non-Māori.</i></b>  <b>Taranaki DHB Māori Health Plan Indicator 9: Mental Health</b>  Appropriate rates of use of Section 29 of the Mental Health Act (community treatment order).</p> <ul style="list-style-type: none"> <li>Taranaki DHB will undertake a survey of Tangata Whaiora, whanau and keyworkers to identify key issues for use of S29 MHA.</li> <li>Taranaki DHB Mental Health &amp; Addiction Service Clinical Governance Forum will discuss solutions and jointly agree implementation activity that reduces the rate of community treatment orders by 30 June 2017.</li> </ul> <p><b>2. <i>Increase in the number of children who are caries free at age 5</i></b>  <b>Taranaki DHB Māori Health Plan Indicator 8: Oral health</b>  Improved oral health outcomes for</p>	<p>The Mental Health Target is to be set in collaboration with the Ministry of Health</p>	<p>6 monthly Q2 and Q4</p>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>Māori children.</p> <ul style="list-style-type: none"> <li>Taranaki DHB will continue to ensure that all children are enrolled at birth with the dental service.</li> <li>Taranaki DHB will work alongside Māori health workers and community Māori health teams to locate enrolled children and their whanau to engage with community dental wellness strategies.</li> <li>Taranaki DHB will monitor indicator performance on a quarterly basis through the Māori Health Plan Steering Group</li> <li>Taranaki DHB will work with the midland team to support the introduction of IT systems that will facilitate better engagement with families eg NCHIP</li> </ul>	Percentage of children enrolled in the Community Oral Health Service.	Quarterly
	<p><b>3. 95% of all pregnant Māori women smoke-free at two weeks post-natal.</b></p> <p><b>Taranaki DHB Māori Health Plan Indicator 5: Tobacco</b></p> <ul style="list-style-type: none"> <li>Taranaki DHB's Maternal &amp; Child Health team will develop and implement activities from the Maternity Quality Safety Plan focusing on pregnant Māori women</li> <li>Taranaki DHB will implement Auahi Kore / Smoke Free Pregnancy work stream activities from the Taranaki Tobacco Action Plan</li> </ul>	Smoke free rates at two weeks post-natal.	6 monthly Q2 and Q4
	<p><b>4. Reduced asthma and wheeze admission rates for Māori children (ASH 0-4 years)</b></p> <p><b>Taranaki DHB Māori Health Plan Indicator 2.2 ASH 0-4</b></p> <p>Reduce the number of tamariki admitted to hospital for asthma.</p> <ul style="list-style-type: none"> <li>Maintain or improve B4 School</li> </ul>		

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>Check coverage for tamariki Māori, on-going.</p> <ul style="list-style-type: none"> <li>• Work with the Te Kawau Maro Māori Health Services Alliance (TKM) to ensure all children identified with asthma have an asthma management plan in place.</li> <li>• Work with the Midland Health Network to ensure tamariki under thirteen years have access to free after hours primary care, on-going.</li> <li>• With the introduction of the Health Care Home model of care in Taranaki, PHO peer groups will be looking at the ASH rates by General Practice and address issues at a practice level.</li> <li>• Continue to promote the increased use of the Map of Medicine Pathways by General Practitioners to reduce ASH rates.</li> <li>• The MHN Network Plan 2014-2017 objectives include <ul style="list-style-type: none"> <li>• Tackling the health status inequity faced by Māori is a priority issue for the network.</li> <li>• The underlying objective is NO GAPS. This means no gaps in health status between Māori and the wider population.</li> </ul> </li> </ul> <p><b>5. Childhood Obesity</b></p> <ul style="list-style-type: none"> <li>• By 30 June 2017, 95% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.</li> <li>• Taranaki DHB Public Health Unit will support the development of healthy and sustainable policy and practices to reduce the</li> </ul>	<p>ASH rates (O-4) will be monitored on a quarterly basis through the Māori Health Plan Steering Group. Monitoring through the routine B4SC reporting mechanism.</p> <p>Monitoring Te Kawau Maro Alliance quarterly RBA report card</p> <p>All of the activities above will be reported quarterly through the Taranaki Alliance Leadership Team (Midland Health Network) by ethnicity to track progress in eliminating the current Gaps.</p> <p>Monitoring through the routine B4SC reporting mechanism.</p>	<p>6 monthly Q2 and Q4</p> <p>6 monthly Q2 and Q4</p>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>consumption of sugar sweetened beverages (SSB) in Taranaki children. It will identify and work with 2 schools to implement healthy settings approaches including:</p> <ul style="list-style-type: none"> <li>• adopt SSB free policies, and</li> <li>• raise awareness of workers within the schools of the SSB policy and its implications</li> </ul>	<p>Number and percentage of schools that have adopted healthy policies and practices as a result of PHU intervention and are 100% SSB-free (BC,CC, O)</p>	<p>6 monthly Q2 and Q4</p>
	<p><b>6. Engagement with Te Pou Matakana Whanau Ora Commissioning Agency</b></p> <ul style="list-style-type: none"> <li>• Taranaki DHB will engage with Te Pou Matakana to explore opportunities for joint ventures, co-funding and investment for improved Māori health outcomes under the Whanau Ora Outcomes Framework.</li> <li>• Taranaki DHB will encourage engagement between Te Pou Matakana and Te Kawanui Maro Alliance to explore opportunities to work collaboratively on development and implementation of improved pathways for whānau to access a wide range of services.</li> <li>• Taranaki DHB will encourage and facilitate engagement between Te Pou Matakana and Te Kawanui Maro Alliance (Tui Ora Ltd, Ruanui Health Services and Nga Ruahine Iwi Health Service) to explore opportunities to work collaboratively on development and implementation of improved pathways for whānau to access a wide range of services</li> </ul>	<p>Two meetings attended with Te Pou Matakana to explore opportunities for joint ventures, co-funding and investment for improved Māori health outcomes under the Whanau Ora Outcomes Framework</p> <p>Two meetings attended with Te Pou Matakana and Te Kawanui Maro Alliance (Tui Ora Ltd, Ruanui Health Services, Nga Ruahine Iwi Health Service) to explore collaborative opportunities.</p> <p>A meeting with Pacifica</p>	<p>Six-monthly</p>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<b>7. Pacific Population</b> <ul style="list-style-type: none"> <li>TDHB will engage with Pacifica Futures to explore opportunities for investment for improved outcomes for Pacifica communities of Taranaki</li> </ul>	Futures to explore opportunities for investment for improved outcomes for Pacifica communities in Taranaki.	Annually

## 2B.2.21 Improved Access to Diagnostics

### Our Approach

Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management.

We have a number of initiatives underway in terms of diagnostic services. It is planned that these initiatives will enable an improvement in waiting times.

### Linkages

- Our Performance Story Impact: People receive timely and appropriate care
- Health Target – Improved Access to Elective Services
- Midland DHBs Regional Services Plan 2016/17

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Improved Access to Diagnostics - Radiology</b>	Taranaki DHB Radiology Service - Fulford Radiology will continue to fully participate in initiatives to improve access to this service. The Evolve Project Team continues to work to improve access, reduce wait times, improve flow and increase quality of care with a focus on: <ul style="list-style-type: none"> <li>More efficient use of existing resources</li> <li>Making improvements to referral management.</li> <li>Assist in making improvements to patient pathways.</li> </ul>	<ul style="list-style-type: none"> <li>95% of accepted referrals for CT scans will receive their scan within six weeks (42 days)</li> <li>85% of accepted referrals for MRI scans will receive their scan within six weeks (42 days)</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Continue to work with the Midland Radiology Advisory Group to contribute to the development of</li> </ul>	<ul style="list-style-type: none"> <li>Representation, attendance and participation in national and regional clinical group activities</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	improvement programmes.	<ul style="list-style-type: none"> <li>Agreed system changes are implemented.</li> </ul>	
	<ul style="list-style-type: none"> <li>Participate in activity relating to the implementation of National Patient Flow</li> </ul>	<ul style="list-style-type: none"> <li>Progress is made towards the implementation of NPF system</li> </ul>	Quarterly
<b>Improved Waiting Times for Diagnostic Services - Colonoscopy</b>	<p>Taranaki DHB is committed to meeting the National Wait Time Indicators. It will take a coordinated approach to identifying actions to improve waiting times and quality of endoscopy/colonoscopy services, including:</p> <ul style="list-style-type: none"> <li>Implementing the Endoscopy Quality Improvement (EQI) programme</li> <li>Identifying and implementing improvements to colonoscopy services</li> <li>Monitoring waiting times for diagnostic and surveillance/follow up colonoscopy</li> </ul>	<p>Diagnostic Colonoscopy:</p> <ul style="list-style-type: none"> <li>85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) 100% within 30 days</li> <li>70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days</li> </ul> <p>Surveillance Colonoscopy</p> <ul style="list-style-type: none"> <li>70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days</li> </ul>	<p>Quarterly</p> <p>Quarterly</p>

## 2B.2.22 Improved Access to Elective Surgery

Better Sooner More Convenient Health Services in relation to electives means improved and timelier access to elective services for our population. There is an increasing demand for elective services. It is important for wellbeing of our population that we meet as much of this elective demand as possible, ensure our population receives equitable access to services and minimises the demand for unplanned (acute) care.

### *Our Approach*

Managing patient length of stay is important to sustaining our elective service in terms of capacity. Reducing length of stay is critical to providing an efficient optimal use of our health budget. We will continue to focus on enhanced recovery models which are having a positive effect on our length of stay. We have significantly improved our day procedure rate for relevant DRGs, we will continue to enhance and monitor this progress.

We are working regionally with other Midland DHBs and moving towards greater integration of each DHB's elective services. Service improvement will be supported by regional referral pathways, clinical networks and consistently applied access criteria.

### *Linkages*

- Minister's Letter of Expectation
- Health Target – Improved Access to Elective Services
- Midland DHBs Regional Services Plan 2016/17
- Our Performance Story Impact: People Receive Timely and Appropriate Specialist Care

#### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Improved Access to Elective Surgery	<ul style="list-style-type: none"> <li>• Delivery against Taranaki DHB agreed volume schedule, including elective surgical discharges, to deliver the Electives Health Target</li> </ul>	<ul style="list-style-type: none"> <li>• Delivery against agreed volume schedule, including a minimum of <b>5,479</b> elective surgical discharges in 2016/17 towards the Electives Health Target (will be provided in electives funding advice)</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>• Standardised intervention rates and/or other mechanisms (such as demand analysis) will be used to assess areas of need for improved equity of access</li> </ul>	<ul style="list-style-type: none"> <li>• Reported against non-financial reporting to MoH (Please see SI4): Elective services standardised intervention rates</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>• Patient flow management will be improved to achieve further reductions in waiting times for electives. No patient will wait longer than four months for First Specialist Assessment and/or treatment.</li> </ul>	<ul style="list-style-type: none"> <li>• Elective Services Patient Flow Indicators expectations are met, and all patients wait four months or less for first specialist assessment and treatment</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>• Implementation of the National Patient Flow Project</li> </ul>	<ul style="list-style-type: none"> <li>• Compliance awarded for Phase Three</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>• Initiatives to support improvements in electives access, quality of care, patient flow management, or that maximise available capacity and resources to include:               <ul style="list-style-type: none"> <li>• Redesign of the internal referral process for elective services</li> <li>• Improve management of follow up patients, including early referral back to primary care, in conjunction with clinicians – focussing initially on General Surgery</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Achieved status in non-financial reporting framework - Ownership Dimension performance measures for Inpatient Length of Stay (OS3)</li> <li>• Internal referral redesign complete by December 2016</li> <li>• Appropriate follow up patients are referred back to their GPs with a plan of care; patients requiring secondary follow up are seen within timeframes.</li> </ul>	Monthly
	<ul style="list-style-type: none"> <li>• Participate in regional planning with regard to Elective Surgery delivery ensuring equity of access across the region</li> </ul>	<ul style="list-style-type: none"> <li>• Increased uptake of latest national CPAC tools to improve consistency in prioritisation decisions</li> <li>• Participation and</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
		collaboration in regional activities	
	<ul style="list-style-type: none"> <li>Patients will be prioritised for treatment using national, or nationally recognised, tools, and treatment will be in accordance with assigned priority and waiting time</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of all new scoring tools as they are introduced</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Participate in all aspects of National Patient Flow</li> </ul>	<ul style="list-style-type: none"> <li>Patient level data is accurately reported into the national databases</li> </ul>	Quarterly

### 2B.2.23 Living Within Our Means

Current and projected constraints on government funds mean the health and disability system must focus strongly on maximizing value from a limited set of resources. If we live within our means we won't be distracted by short-term cost reduction measures when we want to be focused on the delivery of better, sooner, more convenient health care, improving the health status of the local and regional population and reducing or eliminating health inequalities

#### Our Approach

Taranaki DHB recognises it faces significant challenges in delivering services within available resources. We have outlined in Module 4 our financial forecast to 2016-20. In order to achieve those targets this Annual Plan contains cost containment strategies that align with our plan targets. It is to be noted that with decreased quantum of funding for 2016/17 and decreasing forecast funding in out years, the DHB is forecast to carry deficits for the plan period 2016-20, albeit decreasing.

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope. There is a growing financial gap. In addition, it has to balance its long-term strategies with short-term objectives while continuing to provide a clinically safe and quality service. Under this capped environment, with increasing operating costs and demand for services, Taranaki DHB recognises the need for continuous service improvements and efficiency gains while it attempts to re-position itself continually to meet the challenge.

Faced with a gap in its operating budget, the Hospital Provider Arm will continue to explore all practical options with the aim of reducing its overall cost of services delivery, whilst improving productivity and efficiency of operations. 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.

This Annual Plan 2016/17 has identified a range of saving initiatives and cost reduction plans. The services initiatives commenced in prior years will also generate cost savings in future periods, and have been recognised in out years. Other miscellaneous gains from local initiatives and cost reduction measures have been built into the relevant expense budgets.

More details are provided in Module 4: Financial Performance.

#### Linkages

- Stewardship Module
- Midland District Health Boards Regional Services Plan 2016/17

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Living Within Our Means</b>	<ul style="list-style-type: none"> <li>• Operate within agreed financial plans (and fund capital investment from internal sources)</li> </ul>	<ul style="list-style-type: none"> <li>• System Integration 3: Ensuring delivery of Service Coverage</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>• Appropriate clinical and executive leadership</li> </ul>		
	<ul style="list-style-type: none"> <li>• Review clinical pathways with the objectives of: reducing LOS, reducing readmission rates, increased theatre utilisation, increasing day case rates</li> </ul>	<ul style="list-style-type: none"> <li>• Ownership OS3: Inpatient Length of Stay</li> <li>• Ownership OS8: Reducing Acute Readmissions to Hospital</li> <li>• Output 1: Output Delivery Against Plan</li> <li>• Reduction in number of presentations to ED</li> <li>• Day surgery rates to increase to 85% of appropriate cases</li> </ul>	
	<ul style="list-style-type: none"> <li>• Continue collaboration with primary/community providers with a view to integrating appropriate services and reducing avoidable admissions</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in number of presentations to ED</li> </ul>	
	<ul style="list-style-type: none"> <li>• IDF flow will be monitored with the aim of reducing outflow by bringing appropriately trained clinicians to Taranaki DHB to complete procedures within the hospital</li> </ul>	<ul style="list-style-type: none"> <li>• IDF outflow rates to reduce</li> </ul>	
	<ul style="list-style-type: none"> <li>• The Paediatric model of care will continue to be reviewed in order to ensure patients are treated appropriately across the primary-secondary care continuum</li> </ul>		
	<ul style="list-style-type: none"> <li>• Taranaki DHB will continue to run initiatives such as Releasing Time To Care and a Theatre User Group to realise operational efficiencies in measures such as LOS, readmission rate, and theatre utilisation</li> </ul>		
	<ul style="list-style-type: none"> <li>• Taranaki DHB will review the opportunity for further efficiencies from diagnostic</li> </ul>		

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	services		

## 2B.2.24 National Entity Priority Initiatives

### Our Approach

We are expected to align our planning with the planning intentions key national agencies. Each of these national agencies has initiatives for the 2016/17 year, which could impact on our DHB. The following table outlines the initiatives each agency has identified as a priority and the DHB has signalled its level of commitment in the last column.

### Linkages

- Midland District Health Boards Regional Services Plan 2016/17
- Module 4 – Financial Performance

### Action Plan

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
Health Promotion Agency	Campaign Support for Health Targets	HPA is often requested to undertake national health promotion activities to support the achievement of Government priority areas, including health targets. Potential areas include oral health, patient portals, food front of pack labelling, and Healthy Families NZ. For example: (1) To deliver a Rheumatic Fever public awareness campaign targeted at Pacific and Māori parents of at risk children and young people from April 2015 to August 2015. The main objectives are to raise awareness about: 1. the link between sore throats and Rheumatic Fever 2. the importance of getting sore throats in at risk children checked by a	This aligns to Government health priorities, health outcome impacts, and health system enabler.	The DHB will support national health promotion activities around the health targets.

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
		health professional 3. the importance of completing the full antibiotics course for children who have Group A streptococcal bacteria 4. how people at-risk of Rheumatic Fever can keep their children safe in their own homes.		
		(2) Immunisation is one of the most effective and cost-effective medical interventions to prevent disease. The Ministry of Health has contracted the Health Promotion Agency to promote immunisation in New Zealand, through various work streams. The Health Promotion Agency also supports the Ministry of Health by developing new resources of providing reprints as the need is identified. The programme provides critical information for parents of infants, school aged children, teens and adults. The information provided helps parents make informed health choices for their babies and children, and alerts and prompts New Zealanders to get themselves or their families vaccinated at the appropriate times.	<p>The Immunisation Programme supports the meeting of the following health targets:</p> <ol style="list-style-type: none"> <li>1. Infant immunisations (target of 95% of eight month olds will have their primary course of immunisations - 6 weeks, 3 months and 5 months; on time by Dec 2014 and maintained until 2017,</li> <li>2. 95% of all two year olds are fully immunised).</li> <li>3. HPV Immunisation (target of 60% of young girls will receive the three doses of HPV reducing the burden of cervical cancer in New Zealand.</li> </ol>	
	Alcohol Pregnancy and Alcohol Screening and Brief Intervention	The Alcohol and Pregnancy work programme is to contribute towards a reduction in harms related to prenatal alcohol exposure by:	<p>Aligns with government and non-government initiatives and calls for action in this area, including:</p> <ol style="list-style-type: none"> <li>1. Government's response to the Health Select</li> </ol>	DHB will support alcohol screening and brief intervention

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
		<p>1. reducing the number of women consuming alcohol while they are pregnant</p> <p>2. increasing public awareness of the risk associated with alcohol consumption during pregnancy</p> <p>3. supporting health professionals (particularly primary care providers) to provide advice in a routine, effective and consistent way to women about alcohol and pregnancy.</p>	<p>Committee's inquiry into improving child health outcomes</p> <p>2. Expectation from industry that the Government will undertake other activities to promote alcohol and pregnancy messages, to support their voluntary pregnancy warning labelling efforts</p> <p>3. Ministry of Health's work to develop a FASD action plan. Harmful alcohol use was estimated to cost New Zealand \$4.9 billion in 2005/06 (Berl 2009). However, previous estimates have ranged from \$735 million to \$16.1 billion (Law Commission, 2009, p168)</p>	
		<p>HPA also has a programme of work to support Alcohol Screening and Brief Intervention in primary settings. This aligns with DHB work in this area.</p>	<p>This aligns to Government health priorities, health outcome impacts, and health system enablers. There is also evidence that if delivered across the population, SBI can reduce alcohol-harm in the community.</p>	<p>DHB will support the provision of routine and consistent advice to women of child bearing age about alcohol and pregnancy</p>
HQSC	Surgical Site Infection Programme (SSIP) National Infection Surveillance Data Warehouse	Continued DHB support for ongoing hosting costs of the national surveillance data warehouse with CDHB (\$0.27m p.a.).	Goal – Removal/reduction in preventable patient harm resulting from surgical site infections throughout the New Zealand health and disability sector. An ability to deliver a consistent approach to the monitoring of SSIs. An ability to provide accurate	The DHB commits to meeting infection control expectations in accordance with Operational

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
			outcome measures for SSI. Measurement of reduction in SSI rates. Financial benefits will vary by DHB. Additional cost of treating patients with an SSI has been conservatively estimated at \$21,000 per SSI.	Policy Framework - Section 9.8.
	Surgical Site Infection Programme (SSIP) - DHB Infections Management Systems	DHB adoption of Infections Prevention and Control Systems investment and implementation including local integrations. Both Hospital and Community with National hosting. Costs are dependent on DHBs' decision to take up the system. Overall sector costs estimated at \$1.5m capital and \$2.5m ongoing operating.	National and local surgical site infection surveillance system to generate verifiable information that drives practice change and improvement. Financial benefits will vary by DHB. Additional cost of treating patients with an SSI has been conservatively estimated at \$21,000 per SSI.	The DHB will continue development of infection management systems at local DHB level.
	National Inpatient Patient Experience Survey and Reporting System - Patient Experience Indicators	National in-patient survey to be used by all DHBs quarterly that can be incorporated in existing local patient experience surveys that provides a nationally consistent model of patient experience indicators	Patient experience indicators help measure and report how consumers and patients actually experience the health system. E.g. what happened to them and how did it make them feel? By capturing this consistently and coherently across New Zealand's health system, this information can be used to make substantial improvements to both the experience and the actual quality of care received. Efficiencies are achieved with one nationally consistent system and contract, compared to individual, and/or non compatible systems.	The DHB commits to surveying patient experience of the care they received using the national core survey, at least quarterly.
	Capability and	Programmes to support	Building sector capability and	The DHB will

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
	Leadership	improvement science and increased clinical leadership.	clinical leadership and a culture of quality and safety improvement. Uptake of increased sector leadership, good practice and transfer of improvements skills and expertise. Outcome measures still under development. Financial benefits will vary by DHB. No major DHB outlay other than releasing staff (and the associated operating costs of this). Commission fund and sponsor DHB placements.	meet expectations in accordance with Operational Policy Framework Section 9.3 & 9.4.6.
	Primary Care - Patient Experience Survey and Reporting System	Similar proposal to the national in-patient experience survey to be used by PHOs	Help measure and report how consumers and patients actually experience the health system from a primary care perspective.	DHBs hold contract with PHOs but this initiative funded directly by MoH for 3 year period no DHB financial implications
Health Workforce NZ	Increasing The Number of Sonographers	The sonographer workforce needs to grow by 300 full time equivalent (FTE) employees over the period to 2023, more than double the current FTE numbers, to enable more timely delivery of healthcare services, and meet the faster cancer health target, increased demand from demographic change and growth of sonography as a diagnostic tool. In 2013, HWNZ funded 33.2 FTEs in 2014, 46.2 FTEs and in 30.3 in 2015.	Increasing the sonographer workforce will enable more timely delivery of healthcare services, meet faster cancer health targets and meet increased demand for sonography as a diagnostic tool. HWNZ is contributing \$27,000 per trainee per annum to employers for their trainees over the 3 year training programme	The DHB supports the regional approach being undertaken to address key workforce requirements with respect to the sonography workforce.

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
	Expanding The Role of Nurse Practitioners, Clinical Nurse Specialists and Palliative Care Nurses	A Government policy 2014 health workforce commitment is to expand the role and number of nurse practitioners, clinical nurse specialists and palliative care nurses.	Nurse practitioners can, amongst other services, assess, diagnose and prescribe medicines for specific groups. Clinical nurse specialists cover a wide range of specialties including diabetes, cardiology, respite care, wound care, care of the elderly, mental health and addiction. Expansion of the nurse practitioner and clinical nurse specialist role, especially the palliative care nurse role will enable medical staff to undertake more complex procedures and improve service delivery. HWNZ is already funding the training component of these roles.	The DHB supports the regional approach to reviewing the roles of nurse practitioners, clinical nurse specialists and palliative care nurses.
	Create New Nurse Specialist Palliative Care Educator and Support Roles	A Government policy 2014 health workforce commitment is to create 60 nurse specialist palliative care educator and support roles at hospices.	Palliative care nurse specialist will provide training, mentoring and hands on support for staff across aged residential care, GP practices and home-based support services. The investment will be consistent with HWNZ's current investment in postgraduate nurse training. Government policy commitment September 2014: \$7m to create 60 nurse specialist palliative care educators and support roles at hospices	The DHB has demonstrated within the plan the steps it is taking to support the approach to implementing nurse specialist palliative care educator and support roles.

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
	Expanding The Role of Specialist Nurses to Perform Colonoscopies	A Government policy 2014 health workforce commitment is to expand the role of nurses and train specialist nurses to perform colonoscopies. The Ministry of Health is developing and implementing an advanced nursing role in endoscopy for senior nurses with relevant post-graduate education and experience.	Nurse endoscopists will make a direct contribution and an indirect contribution to service delivery, including enabling release of medical staff to undertake more complex procedures. Development of the nurse Endoscopist role is critical to the delivery of bowel screening in New Zealand. Government policy commitment September 2014: \$8m over 4 years to increase the number of colonoscopies performed	The DHB supports the regional approach to expanding the role of specialist nurses to perform colonoscopies
	Increasing The Number of Medical Physicists	There is a low retention rate of graduates from the Medical Physics programme and a low number of postgraduate positions available to graduates, despite reported staff shortages. The number of medical physicists needs to grow to address the vulnerability of a small workforce and to enable more timely delivery of health care services and meet the faster cancer health target.	Radiation therapy is reliant on an adequate supply of medical physicists to plan and implement patient treatment programmes. Increasing the number of medical physicists will allow succession planning of a small workforce, vital to DHB workforce and service planning. HWNZ is already funding the training of medical physicists	The DHB supports the regional/ national approach to address the key workforce requirements with regard to the Medical Physics workforce
	Increasing The Number of Medical Community Based Training Places and Providing Access To Primary Care/ Community Settings for Prevocational	As part of the revised New Zealand Curriculum Framework for Prevocational Medical Training, the Medical Council will require PGY1 and PGY2 interns to undertake one clinical attachment in a community-based setting by the end of 2020. HWNZ is working with the Medical Council, the	More medical trainees are exposed to quality community-based training experiences, and will have increased experience of integrated care and choose to vocationally train in general practice. An increase in the number and availability of prevocational clinical attachments across DHBs will support RMO career	The DHB supports the regional approach to providing access to community-based placements

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
	Trainees	Royal New Zealand College of General Practitioners and district health boards to ensure employment and funding arrangements support these requirements.	progression. Long term financial benefits are anticipated through early intervention and better integration between primary and secondary services	
National Health IT Board	National Maternity Information System Platform (MISP–NZ)	Implementation of the national Maternity Clinical Information System platform with the maternity module live. The platform also supports neonatal care, patient portals and Newborn Hearing Screening.	<p><i>A single platform to record births across the sector, will enable</i></p> <ul style="list-style-type: none"> <li><i>the care received by a pregnant woman and her baby to be safer and of higher quality, because health professionals will have timely access to information about a woman's clinical/medical and maternity history before making care decisions.</i></li> <li><i>bring together relevant information collected about a woman and her baby in the community.</i></li> </ul>	DHBs will identify appropriate actions and milestones to support MISP–NZ implementation.
	Electronic Prescribing and Administration (ePA)	Implementation of hospital based ePA Using the NZULM as the medicines data source and integrated with: <ul style="list-style-type: none"> <li>ePharmacy</li> <li>eMR</li> </ul> where implemented	<i>Studies have shown that there is up to a 50% error rate in the patient's drug chart. ePA reduces this rate and enhances both patient safety, the quality of clinical decision-making and the efficiency of managing the patient's drug chart.</i>	The DHB commits to support regional work toward ePA implementation.
	Regional CWS (Including MedMan) Regional CDR Regional PAS  Capability:	<p>A common platform providing DHB clinicians access to and interaction with common clinical information across patients in the region.</p> <p>It includes the capture all sources of hospital information, including ED &amp; Theatres, nursing observations and eReferrals</p>	<i>Clinical Workstation and Clinical Data Repository allow a patient centric view of clinical information from a hospital (or community) setting. It is the basis for a regional electronic health record and is the essential platform enabling support of other high value functionality like eMR, electronic orders,</i>	The DHB commits to support regional work toward completion of the implementation of the regional applications.

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
		<p>triage. It will complement and provide data to the national Electronic Health Record (EHR).</p> <p>Each region has a major programme in train:</p> <p>Northern: Northern Electronic Health Record (NEHR)</p> <p>Midland: eSPACE</p> <p>Central: Regional Health Informatics Programme (RHIP)</p> <p>South Island: Patient Information Care System (PICS)</p>	<p><i>results sign-off. It will also support a person's on-line access to their own health record.</i></p> <p><i>Hospital based patient administration systems are a fundamental enabler to support other high value functionality, like Clinical Workstation and National Patient Flow. 8 DHB's need to replace their obsolete systems.</i></p>	We commit to work regionally to support our region in developing a roadmap for delivery of each capability.
	<p>Health IT Programme 2015-2020</p> <p>(1) single EHR</p> <p>(2) digital hospital blueprint</p> <p>(3) preventative health IT platform</p> <p>(4) data for health/social investment</p>	<p>During the design phase of the Health IT Programme, regions will engage with the national programme to establish sector requirements.</p> <p>During the implementation phase the regions will continue to support the national programme and integrate their systems with national systems based on agreed interoperability standards.</p>	<p><i>A single longitudinal EHR and other national system platforms will enable access to high-value patient information to support (a) accurate, high quality information available at the point of care, (b) better care coordination (c) clinical decision support. This initiative supports the NZ Health Strategy, in particular, allowing people to access their own information, supporting virtual teams of clinicians, and overall enabling a smarter health system to operate.</i></p>	The DHB Commits to work regionally to ensure participation on advisory groups
	National Patient Flow	National Patient Flow provides a view of wait times, health events and outcomes in a patient's journey through secondary and tertiary care.	National Patient Flow aligns with the vision of better integrating care so that patients can receive the appropriate services, in the right setting and in a timely way to improve overall health outcomes. Patients, referrers and providers need to better	The DHB will collect and provide the full mandate of Phase 3 data

ENTITY	INITIATIVE	DESCRIPTION	SUMMARY OF BENEFITS	EXPECTED NARRATIVE FOR INCLUSION IN DHB ANNUAL PLANS
			understand demand for services and waiting times.	
Previous National Health Committee	Taranaki DHB commits to engage with the Ministry of Health on the work programme of the former National Health Committee once this programme is confirmed.			

### 2B.2.25 NZ Health Partnership Ltd

Objectives	Actions to Deliver Improved Performance	Measured by
NZ Health Partnerships Ltd	<p>The Taranaki DHB will work in partnership with NZ Health Partnerships to progress the following initiatives:</p> <p><b>National Oracle Solution</b> (<i>formerly Finance, Procurement and Supply Chain</i>)</p> <ul style="list-style-type: none"> <li>The National Oracle Solution will design and build a single financial management information system ready for DHB implementation. The designing of the processes and the system of the National Oracle Solution programme will be done through a co-creation approach with the sector, leveraging existing DHB expertise.</li> <li>DHBs will commit resources to the implementation of Oracle system, and will fully factor in expected budget benefit impacts.</li> </ul> <p><b>Food Services</b></p> <ul style="list-style-type: none"> <li>NZ Health Partnerships will support the DHBs in considering the Food Services business case. If the DHB chooses to proceed with the business case, the DHB will commit the appropriate resources to implement the services.</li> </ul> <p><b>Linen and Laundry Services</b></p> <ul style="list-style-type: none"> <li>NZ Health Partnerships will continue to work with the DHBs that are open to considering a collective arrangement for outsourced Linen and Laundry Services.</li> </ul>	<p>Taranaki DHB will work with NZPL to support the business cases and programmes as appropriate, and endeavour to meet the timelines for implementation in relation to the programmes.</p> <p>Further, Taranaki DHB will commit resources as may be required to achieve the benefits and outcomes of the programmes.</p>

Objectives	Actions to Deliver Improved Performance	Measured by
	<p><b>National Infrastructure Platform</b></p> <ul style="list-style-type: none"> <li>The National Infrastructure Platform programme aims to achieve qualitative, clinical and financial benefits for DHBs through a national approach to IS infrastructure consumption. The national approach is driven by converging 40 infrastructure facilities into a single infrastructure platform delivered from two data centre facilities. It will also align the health sector's infrastructure services with the Government's overall Information Communications Technology goal of harnessing technology to deliver better, trusted public services.</li> <li>DHBs will commit to working collaboratively with NZ Health Partnerships to progress the National Infrastructure Platform. DHBs will commit resources to the decision reached in relation to the implementation of the programme.</li> </ul>	

## Other

### 2B.2.26 Improving Quality

#### *Our Approach*

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

Our Strategic Quality and Risk Plan facilitates the progressive achievement of the DHB's vision by assisting us to meet the challenge of continuously improving service provision and quality of care by ensuring patient safety and robust systems and processes. The Strategic Plan outlines the Taranaki DHB's:

- Quality and risk framework
- Strategic objectives
- Dimensions of quality and our associated goals
- Clinical Governance
- Quality and risk committee structure
- Staff responsibilities

- Links into the Health Quality and Safety Commission's areas of focus identified in their Statement of Intent

We are committed to sustaining the initiatives implemented by the DHB as part of the Health Quality and Safety Commission's National Patient Safety 'Open for Better Care' Campaign which commenced in May 2013.

### Linkages

- Taranaki DHB Strategic Quality & Risk Plan
- Quality & Safety Markers
- Adverse Event processes including reporting, review, corrective action implementation and evaluation
- Patient/Client satisfaction including the Inpatient Experience Survey
- Taranaki DHB Patient and Family/Whanau Centred Care Framework
- Taranaki DHB annual Quality Accounts document
- Reporting to the Clinical Board and the Taranaki DHB

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Falls Related Quality & Safety Markers			
To Reduce the Number of Falls and Those That Result in Serious Harm	Continue with our commitment to: <ul style="list-style-type: none"> <li>• Raising staff awareness.</li> <li>• Real time auditing and feedback.</li> <li>• Improving our post falls review process.</li> <li>• Analysing all contributing factors via the new Datix e-Q&amp;R system and therefore better enabling improvement identification and implementation.</li> <li>• Working with all partners, including local ACC representatives and the work produced by the Ministry of Health's Older People Team to ensure a systematic, integrated approach that enables data analysis and most importantly improvement.</li> </ul>	<ul style="list-style-type: none"> <li>• At least 90% of older inpatients are given a falls risk assessment.</li> <li>• At least 98% of older inpatients assessed as at risk of falling receive an individualised care plan addressing these risks.</li> <li>• Decrease in the number of inpatient falls (year on year) and harm from falls by 30 June 2017.</li> <li>• Define, agree and implement measurements that reflect the collaborative preventative/improvement work undertaken by all partner agencies.</li> </ul>	Quarterly to the: Health Quality & Safety Commission, Clinical Board, DHB Board and via the DHB's annual Quality Account document
Hand Hygiene Related Quality & Safety Marker			
To Reduce Hospital Acquired Infections	Continue with our commitment to: <ul style="list-style-type: none"> <li>• Ongoing staff education, including the promotion</li> </ul>	<ul style="list-style-type: none"> <li>• At least 80% compliance with good hand hygiene practice.</li> <li>• At least 800 hand hygiene</li> </ul>	Quarterly to the: Health Quality & Safety Commission, Infection, Prevention & Control

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>of frontline ownership, and the utilisation of focused sessions for occupational groups/units where compliance has decreased.</p> <ul style="list-style-type: none"> <li>Regular organisation wide good hand hygiene awareness activities, including a promotion week with occupational group specific activities.</li> <li>Ensuring we have a sustainable pool of Gold Auditors to enable audit activity to the required levels.</li> <li>Expanding auditing activity as auditing resource is realised and sustained.</li> <li>Monitoring results and taking action via the PDSA cycle to enable improvement.</li> </ul>	<p>moments are observed each reporting period.</p> <ul style="list-style-type: none"> <li>At least five trained Gold Auditors are available for auditing at any given time.</li> </ul>	Committee, Clinical Board, DHB Board and via the DHB's annual Quality Account document
Surgery Related Quality & Safety Markers			
To Prevent Surgery Related Harm.	<p>Continue with our commitment to:</p> <ul style="list-style-type: none"> <li>Sustaining the use of all three parts of the WHO surgical safety checklist (sign in, time out and sign out) for all operations.</li> <li>Ensuring the checklist is a paperless, teamwork and communication tool.</li> <li>Sustaining briefing and debriefing processes for each theatre list.</li> <li>Monitoring results and taking action via the PDSA cycle to enable improvement.</li> <li>Working with the Commission to implement the new safe surgery marker from 1 July 2016.</li> </ul>	<ul style="list-style-type: none"> <li>All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100% of surgical procedures, with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale, 95% of the time.</li> <li>Commitment to sustain achievement at or about the old QSM threshold of all three parts of the WHO surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90% of operations.</li> <li>Commitment to ensure that the checklist is being used in paperless form, as a teamwork and communication tool rather than an audit tool.</li> </ul>	Quarterly to the: Health Quality & Safety Commission, Clinical Board, DHB Board and via the DHB's annual Quality Account document
Surgical Site Infection Related Quality & Safety Markers			
To Prevent	Continue with our	<ul style="list-style-type: none"> <li>At least 95% or more of</li> </ul>	Quarterly to the:

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Surgical Site Infections.	commitment to: <ul style="list-style-type: none"> <li>Increasing antibiotic prophylaxis compliance (Cefazolin <math>\geq 2g</math> or Cefuroxime <math>\geq 1.5g</math>) for all hip and knee replacement patients to meet or exceed the 95% quality and safety marker target.</li> <li>Sustaining our compliance of 100% of hip and knee replacement patients receive their prophylactic antibiotics 0-60 minutes before incision.</li> <li>Monitoring results and taking action via the PDSA cycle to enable improvement. This will also include root cause analysis processes and individual performance monitoring.</li> </ul>	patients undergoing hip and knee replacement operations receive appropriate prophylactic antibiotics. <ul style="list-style-type: none"> <li>100% of patients having hip and knee replacement operations have their prophylactic antibiotics within 0-60 minutes of incision.</li> </ul>	Health Quality & Safety Commission, Infection Prevention & Control Committee, Clinical Board, DHB Board and via the DHB's annual Quality Account document
Medication Related Quality & Safety Marker			
To Prevent Medication Related Harm	Continue with our commitment to: <ul style="list-style-type: none"> <li>Enabling, expanding and ensuring the sustainability of our electronic medicine reconciliation programme.</li> <li>Ensuring appropriately trained staff are available to undertake reconciliation activities.</li> <li>Undertaking reconciliation (paper and electronic) at admission, transfer and discharge.</li> <li>Monitoring results and taking action via the PDSA cycle to enable improvement.</li> </ul>	<ul style="list-style-type: none"> <li>Meeting or exceeding the targets as outlined in our e-Medicine Reconciliation project/sustainability documents.</li> </ul>	Quarterly to the: Health Quality & Safety Commission, Clinical Board, DHB Board and via the DHB's annual Quality Account document
Consumer Engagement			
To Promote Consumer Engagement	Continue with our commitment to the DHB's Patient and Family/Whanau Centred Care Framework including: <ul style="list-style-type: none"> <li>Formalisation of the DHB's Consumer Council.</li> <li>An agreed to action plan along with an accountability framework</li> </ul>	<ul style="list-style-type: none"> <li>An effective Taranaki DHB Consumer Council is implemented along with an endorsed action plan.</li> </ul>	Quarterly to the: Clinical Board, DHB Board and via the DHB's annual Quality Account document

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	to be completed during the 2016/17 year.		
Building Quality Improvement Capability and Clinical Leadership			
To Build Quality Improvement Capability and Clinical Leadership Within the DHB.	<p>Continue with our commitment to maintain and strengthen, if required, the infrastructure to support local patient safety initiatives including:</p> <ul style="list-style-type: none"> <li>Building quality improvement and patient safety capability within the DHB.</li> <li>Promoting online quality improvement tools and methodologies to staff.</li> <li>Demonstrating a distributive clinical leadership model via a clinical leadership programme, and report on this in our annual Quality Accounts document.</li> <li>Promoting key messages and the theme of Patient Safety Week 2016.</li> </ul>	<ul style="list-style-type: none"> <li>The Strategic Quality &amp; Risk Plan for the DHB is reviewed, consulted on, approved and implemented along with an endorsed action plan.</li> <li>Progress is evidenced through reporting to the Clinical Board and to the Taranaki DHB.</li> <li>Successful Patient Safety Week.</li> </ul>	Quarterly to the: Clinical Board, DHB Board and via the DHB's annual Quality Account document
Quality Accounts			
To Publish an Annual Quality Accounts Document	<p>Continue with our commitment to:</p> <ul style="list-style-type: none"> <li>Implement the Health Quality &amp; Safety Commission's quality accounts guidance.</li> <li>Report on how the DHB is building capability for quality improvement and patient safety.</li> <li>Account for quality at every DHB Board meeting.</li> </ul>	<ul style="list-style-type: none"> <li>Produce our Quality Accounts document by December 2016.</li> <li>DHB Board minutes evidence quality as an agenda item.</li> </ul>	Quarterly to the: Clinical Board, DHB Board and Health Quality & Safety Commission
Regional Services Plan			
To Support and Maintain Regional Patient Safety and Quality Improvement Governance and Working Arrangements	<p>Continue with our commitment to maintaining and participating in the Midland regional Quality Steering Group including:</p> <ul style="list-style-type: none"> <li>Ensuring regional and local leadership of the Patient Safety Campaign and patient safety and quality improvement in general.</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of effective regional and local leadership and participation in relation to: <ul style="list-style-type: none"> <li>Patient Safety Campaign.</li> <li>General patient safety and quality improvement activities/ initiatives.</li> </ul> </li> </ul>	Quarterly to the: Clinical Board, DHB Board and Health Quality & Safety Commission and via the DHB's annual Quality Account document

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Involving consumers (patients and their family/whanau.</li> <li>Developing and maintaining regional leadership and networks to support quality and safety and build capability for improvement.</li> </ul>	<ul style="list-style-type: none"> <li>Consumer engagement.</li> <li>Building and sustaining capability for improvement.</li> </ul>	
Pressure Injury Prevention			
To prevent pressure injuries	<p>Commitment to working with contract providers, Ministry of Health, ACC and HQSC to:</p> <ul style="list-style-type: none"> <li>Encourage clinicians to complete ACC 45 and ACC 2152 (Treatment Injury Claim) forms for all grades of pressure injury except grade one, in order to provide a more accurate picture of the incidence of pressure injuries occurring while patients are in our care.</li> <li>Report to HQSC all pressure injuries grade three and above as serious adverse events</li> <li>Measure and report injury prevalence regularly and consistently.</li> <li>Improve classification and documentation of pressure injuries by grade in the patient record and ensure they are coded.</li> <li>Implement structured risk assessment to support clinical judgement and evidence-based prevention approaches.</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of effective working relationships with identified stakeholders.</li> <li>Evidence of improved compliance with the completion of ACC 45 and ACC 2152 forms for all grades of pressure injury except grade one.</li> <li>100% of all grade three and above pressure injuries are reported to the HQSC as serious adverse events.</li> <li>Evidence that pressure injury prevalence is reported regularly and consistently, including to the DHB's Clinical Board.</li> <li>Audit indicates that all pressure injuries are being classified, documented in the patient's record therefore coded.</li> <li>Risk assessment to support clinical judgement and evidence-based prevention approaches is implemented.</li> </ul>	Quarterly to the: Clinical Board, DHB Board and via the DHB's annual Quality Account document

## Actions to Deliver on Regional Service Plan Priorities

### Our Approach

During 2016/17 we will continue to participate as part of the Midland DHB Region. Within the Midland Regional Plan, we aim to develop the principles of culture, capability, capacity and change leadership. In 2016/17 the overarching imperative for Taranaki DHB in order to meet our goals, is collaboration and development of productive partnerships locally, regionally and nationally.

Throughout this Annual Plan there are a number of activities we have planned to undertake which will support delivery of the regional priorities identified in our regional service plan. This section includes only those areas not covered elsewhere such as national/regional spinal Impairment action plan, the regional trauma services and regional information technology. The focus on regional collaboration will continue and be a foundation of service delivery for the foreseeable future.

### 2B.2.27 Spinal Cord Impairment Action Plan 2014-19

The New Zealand Spinal Cord Impairment Action Plan 2014-2019 outlines a vision, purpose, priorities and eight overarching objectives to help ensure the best possible health and wellbeing outcomes for people with spinal cord impairment (SCI), enhancing their quality of life and ability to participate in society.

In March 2012, ACC and the Ministry of Health jointly led a project to review New Zealand's SCI services and develop a national implementation plan for improving them. Waikato DHB (our usual tertiary provider) worked closely with the team that developed the guidelines ensuring provision of services for multi-trauma victims and transferred on to either Middlemore or Canterbury when it was clinically safe to do so. Taranaki DHB will in future send all multi-trauma patients with spinal cord injury to Canterbury DHB but for the isolated spinal cord injury patients we will endeavour early diagnosis, stabilisation and referral to the Spinal Cord Injury Unit in Christchurch, to prevent secondary injury or extension of injury level. This is in line with the guidelines.

### Linkages

- Midland District Health Boards Regional Services Plan 2016/17
- Our Performance Story Impact: People receive timely and appropriate specialist care

### Action Plan

Objective	Actions to Deliver Improved Performance	Measured by	Reporting
<b>Spinal Cord Impairment Action Plan</b>	<ul style="list-style-type: none"><li>• We will ensure information and actions outlined in the plan are disseminated to clinicians via its clinical governance mechanism and will ensure pathways that explicitly outline process and align with the action plan are developed.</li><li>• Taranaki DHB will continue to engage with ambulance and other providers to ensure the SCI pre-hospital destination</li></ul>	<ul style="list-style-type: none"><li>• Audit of spinal cord impairment patient journey, ensuring that correct pathways are followed</li></ul>	6 monthly

	and referral pathway is followed. There are appropriate pathways in place for all other trauma patients.		
--	--	--	--

## 2B.2.28 Major Trauma

### *Our Approach*

Trauma continues to have a major impact on midland communities. The cost is estimated at over 55 million dollars. The Midland region aims to deliver the highest quality trauma care that is focussed on patient needs and provides a collaborative approach amongst the 5 DHBs.

### *Linkages*

- Taranaki DHB Māori Health Plan
- Midland Regional Services Plan

### *Action Plan*

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Collection of Data on Trauma Patients and Entry Into Database</b>	<ul style="list-style-type: none"> <li>• Taranaki DHB will participate with the Midland region to ensure data is complete and accurate and contributes to the regional database</li> <li>• Trauma data entry backlog resolved</li> </ul>	<ul style="list-style-type: none"> <li>• Up to date data entry. Currently collection is up to date.</li> <li>• Install Qiksense to allow our data to be used locally for improvements to care</li> <li>• Audit changes to Traumatic Brain injuries.</li> </ul>	Quarterly
<b>Trauma Workforce is Optimal, Well Trained and Sustainable</b>	<ul style="list-style-type: none"> <li>• Support local trauma committee ensuring appropriate resources to optimise training and education to Taranaki DHB staff</li> <li>• Support trauma team to have a governance role in the organisation</li> </ul>	<ul style="list-style-type: none"> <li>• Regularly review capacity within the trauma service for teaching</li> <li>• Trauma team report through to the clinical board on an annual basis</li> <li>• Cultivate relationships to ABI in Auckland and wider network of Trauma services in New Zealand.</li> </ul>	6 monthly  Yearly
<b>To: Maintain Clinical Interface</b>	<ul style="list-style-type: none"> <li>• All trauma staff exposed to current trauma best practice</li> <li>• MTS to lead annual trauma symposium</li> <li>• Trauma to committee to lead roll out of best</li> </ul>	<ul style="list-style-type: none"> <li>• Support and encourage attendance at local and national forums</li> </ul> Regular audit of Westmead usage in ED	6 monthly  6 monthly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>practice e.g. abbreviated Westmead into ED</p> <ul style="list-style-type: none"> <li>Trauma Committee to lead planning for Mass casualty event</li> <li>Trauma committee to act as interface between Taranaki DHB and St John Ambulance Service</li> <li>Trauma committee to continue to review major trauma cases, and report to Mortality and Morbidity Committee as required.</li> <li>Review Destination for major Trauma patients in Trauma committee.</li> </ul>	<p>Successful mass casualty event delivered</p> <p>Evidence of review documented and reported</p> <p>Evidence of review documented and recorded in minutes</p>	<p>As per DHB plan</p> <p>6 monthly</p> <p>6 monthly</p>
<b>Case Management</b>	<ul style="list-style-type: none"> <li>Review role of case managers for major Trauma cases.</li> </ul>	<ul style="list-style-type: none"> <li>Impending changes in case manager workforce may cause a re-evaluation of the trauma nurse role for case management.</li> </ul>	ongoing

## 2B.2.29 Information Technology

### Our Approach

The Midland Regional IS Service will implement the Midland Region Information Services Plan (MRISP); advance National Health IT Board (NHITB) priorities, specifically the critical priorities for 2016/17 financial year, and support the delivery of the IS enablers required to implement this Regional Services Plan (RSP).

In many cases the 2016/17 activities will be a continuation of the previous year's plan. The successful delivery of the identified initiatives (see below) will require ongoing review and prioritisation of current activities at both a local and regional level to enable appropriate resources to be made available.

### Linkages

- Midland Region Information Services Plan
- National Health IT Board Priorities

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Improve Clinical Information</b>	<ul style="list-style-type: none"> <li>Regional deployment of clinical workstation and</li> </ul>	<ul style="list-style-type: none"> <li>DHB's go-live with CWS/CDR as per agreed</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Systems</b>	clinical data repository. <ul style="list-style-type: none"> <li>Implementing true electronic referral management.</li> <li>Further development of a Midland Regional Telehealth Strategy</li> </ul>	plan. <ul style="list-style-type: none"> <li>Referrals are managed electronically end-to-end.</li> <li>Additional Telehealth services are established within the agreed timeframes.</li> </ul>	

## 2B.2.30 Hepatitis C Management

### Our Approach

#### Supporting development of an integrated Hepatitis C service across the Midland Region

The Midland DHBs are tasked with implementing a single clinical pathway for hepatitis C care across the region in order to provide consistent services, which maximise the wellbeing of all New Zealanders living with hepatitis C. A second objective is to implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region.

### Linkages

- Our Performance Story Impact: People receive timely and appropriate specialist care
- Our Performance Story Impact: People stay well in their homes and communities
- Midland DHBs Regional Services Plan 2016/17

### Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Development of an integrated Hepatitis C services across the Midland Region</b>	Support other Midland DHBs in the development and implementation of an integrated Hepatitis C service across the wider Midland DHB's group  Implement the clinical pathway as identified  Assess impact and plan for implementation of new pharmaceuticals  Support HealthShare agency in the implementation of regional Hep C services in Midland DHBs <ul style="list-style-type: none"> <li>Support implementation of reporting and measuring requirements</li> </ul>	Pathway identified Q1 2016/17   Q2 2016/17 Pharmaceutical plan developed  Q2-4 2016/17	Quarterly

## Module 3: Statement of Performance Expectations



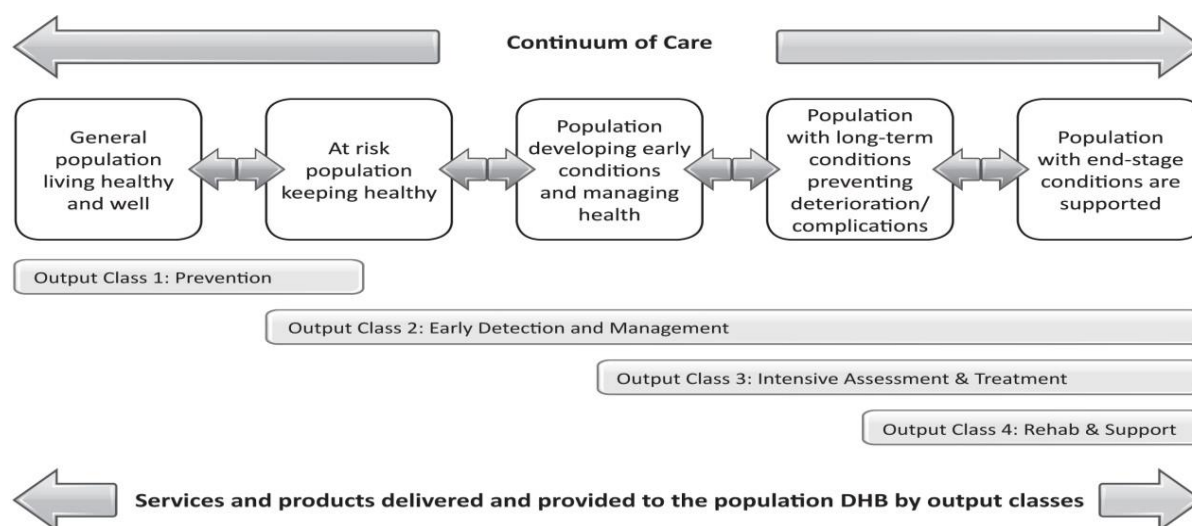
## MODULE 3: STATEMENT OF PERFORMANCE EXPECTATIONS

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop this Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2016/17. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the full range of outputs that we fund and/or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes (see modules 1 and 2). Where possible, we have included with each measure past performance as baseline data.

Activity not mentioned in this module will continue to be planned, funded and/or provided to a high standard. We do report quarterly to the Ministry of Health and/or our Board on our performance related to this activity.

### 3.1 Output Classes

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of forecast service performance are also reflected in our financial measures and are described in Module 8.3. The four output classes that have been agreed nationally are defined in Module 8.2. They represent a continuum of care, as follows:



### 3.2 Guide to Reading the Statement of Performance Expectations

The following points provided should be kept in mind when reading the rest of this module:

- Further detail of the performance story logic and rationale is contained in Module 1
- Baseline and National/Regional Result figures for the output performance measures are for the 2012/13 financial year unless otherwise stated

- In the performance measures table and where available the average column presents the national or regional average for the output performance measure
- Most measures have been adopted regionally
- Some measures fall across more than one impact. Where this is the case they have only been included once
- Measurement type key: qn = Quantity t = Timeliness ql = Quality
- There are some services we provide that support the rest of the health system so we have included these in a “Support Services” section of our performance story
- Detailed information about various programme definitions and rationale for each output measure is provided in Module 8.4
- National data collections will be occurring during 2016/17 through the Quality and Safety Commission’s National patient Safety Campaign. Taranaki DHBs Quality Programme Outcomes will be presented in our 2016/17 Quality Account Report

### 3.3 People are Supported to Take Greater Responsibility for their Health

Long Term Impact	People are supported to take greater responsibility for their health		
Intermediate Impacts	<ul style="list-style-type: none"> <li>• Fewer people smoke</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in vaccine preventable diseases</li> </ul>	<ul style="list-style-type: none"> <li>• Improving health behaviours</li> </ul>

#### 3.3.1 Fewer People Smoke

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of hospitalised smokers offered advice to quit	Māori	1	qn/t	99%		95%	95%	96%	n/a
	Non-Māori	1	qn/t	99%		95%	95%	96%	n/a
	Total	1	qn/t	98%		95%	95%	96%	95%
Percentage of Primary Health Organisations enrolled smokers offered advice to quit	Māori	1	qn/t	93%	2014/15	93%	90%	92%	n/a
	Non-Māori	1	qn/t	86%	2014/15	86%	90%	90%	n/a
	Total	1	qn/t	88%	2014/15	88%	90%	90%	92%

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit	Māori	1	qn/t	90%	2013/14	89%	90%	n/a	n/a
	Non-Māori	1	qn/t	79%	2013/14	91%	90%	n/a	n/a
	Total	1	qn/t	83%	2013/14	90%	90%	n/a	n/a

### 3.3.2 Reduction in Vaccine Preventable Diseases

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of eight month olds fully immunised	Māori	1	qn/t	81%		89%	95%	90%	90%
	Non-Māori	1	qn/t	92%		93%	95%	93%	93%
	Total	1	qn/t	89%		91%	95%	93%	92%
Percentage of the population >65 years who have received the seasonal influenza immunisation (high needs)	Māori	1	qn/t	64%	2014/15	68%	75%	n/a	n/a
	Non-Māori	1	qn/t	67%	2014/15	67%	75%	n/a	n/a
	Total	1	qn/t	66%	2014/15	69%	75%	n/a	n/a

### 3.3.3 Improving Health Behaviours

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of infants who are fully, exclusively or partially breastfed at 6 months	Māori	1	qn/t	53%	2014/15	53%	65%	55%	n/a
	Non-Māori	1	qn/t	66%	2014/15	63%	65%	66%	n/a
	Total	1	qn/t	63%	2014/15	66%	65%	66%	n/a

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Reduce the rate of teenage terminations of pregnancy per 10,000	Māori	1	qn/t	163		179	<163		
	Non-Māori	1	qn/t	120		106	<106		
	Total	1	qn/t	131		125	<125		
Reduce the teen birth rate per 10,000	Māori	1	qn/t	350		276	<276		
	Non-Māori	1	qn/t	144		117	<117		
	Total	1	qn/t	195		159	<159		
The number of referrals to the GRx (Green Prescription) programmes	Adult	1	qn/t	1132		1281	1648	n/a	1,987 (avg)
	Children	1	qn/t	96		80	60	n/a	67 (avg)
Percentage of Adult quarterly referrals currently participating in programme	Total	1	qn	51%	Q3 2015/16		>35%		
Percentage of Active Families quarterly referrals currently participating in programme	Total	1	qn	35%	Q3 2015/16		>35%		
Of Adult total discharged YTD, the percentage discharged as complete	Total	1	qn	25%	Q3 2015/16		>25%		
Of Active Families annual referrals, the percentage discharged as complete	Total	1	qn	13%	Q3 2015/16		>25%		
Number of new Early Childhood Education (ECE) providers completed the Oranga Mōkōpuna Programme (OMP)	Total	1	qn	New measure			6		
Number of Community Breastfeeding Support Service referrals received	Total	1	qn	New measure			120		

## 3.4 People Stay Well in their Home and Communities

Long Term Impact	People Stay Well in Their Homes and Communities			
Intermediate Impacts	<ul style="list-style-type: none"> <li>An improvement in childhood oral health</li> </ul>	<ul style="list-style-type: none"> <li>Long-term conditions are detected early and managed well</li> </ul>	<ul style="list-style-type: none"> <li>Fewer people are admitted to hospital for avoidable conditions</li> </ul>	<ul style="list-style-type: none"> <li>More people maintain their functional independence</li> </ul>

### 3.4.1 An Improvement in Childhood Oral Health

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of adolescent utilisation of DHB funded dental services	Total	2	qn	77%		73%	85%	72%	70%
Percentage of children (0-4) enrolled in DHB funded dental services	Māori	2	qn	59%		59%	95%		
	Non-Māori	2	qn	82%		81%	95%		
	Total	2	qn	75%		74%	95%	76%	
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Total	2	qn/t	9%		2%	6%	13%	10%

### 3.4.2 Long-Term Conditions are Detected Early and Managed Well

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of eligible women (25-69) have a cervical cancer screen every 3 years	Māori	1	qn/t	73%		65%	80%	72%	65%
	Non-Māori	1	qn/t	88%		82%	80%	82%	80%
	Total	1	qn/t	86%		80%	80%	77%	77%

Percentage of eligible women (50-69) have a breast screen in the last 2 years	Māori	1	qn/t	63%		61%	70%	70%	61%
	Non-Māori	1	qn/t	77%		75%	70%	73%	72%
	Total	1	qn/t	76%		74%	70%	72%	70%
Percentage of population enrolled with a PHO	Māori	2	qn	88%		84%	97%	91%	94%
	Non-Māori	2	qn	99%		95%	97%	97%	97%
	Total	2	qn	97%		95%	97%	96%	96%
Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Māori	2	qn	63%		81%	90%	85%	87%
	Non-Māori	2	qn	75%		92%	90%	90%	91%
	Total	2	qn	73%		91%	90%	89%	90%

### 3.4.3 Fewer People are Admitted to Hospital for Avoidable Conditions

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of eligible population who have had their B4 school checks completed	High Needs	1	qn/t	86%		87%	90%	92%	
	Total	1	qn/t	88%		91%	90%	92%	
Triage level 4 & 5s presenting to the Emergency Department as a percentage of the total population	Māori	2&3	qn	25%		23%	<23%	46%	51%

### 3.4.4 More People Maintain their Functional Independence

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months	Total	4	qn/t	41%		98%	95%	n/a	n/a
Percentage of patients aged 75 and over (Māori and Pacific Islanders 55 and over) that are given a falls risk assessment	Total	3	ql	92%	2013/14	85%	100%	n/a	n/a

## 3.5 People Receive Timely and Appropriate Care

Long Term Impact	People receive timely and appropriate care			
Intermediate Impacts	<ul style="list-style-type: none"> <li>People receive prompt and appropriate acute and arranged care</li> </ul>	<ul style="list-style-type: none"> <li>People have appropriate access to elective services</li> </ul>	<ul style="list-style-type: none"> <li>Improved health status for people with a severe mental health illness and/or addiction</li> </ul>	<ul style="list-style-type: none"> <li>More people with end-stage conditions are appropriately supported</li> </ul>

### 3.5.1 People Receive Prompt and Appropriate Acute and Arranged Care

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Acute inpatient average length of stay	Total	3	ql/t	2.61 days	2015/16	3.93 days	2.35 days	3.89 days	3.81 days
Acute Re-admission rate	Total	3	ql/t	5.22%		7.2%	≤6.9%	7.9%	7.4%

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Acute Re-admission rate 75+ years	Total	3	ql/t	8.66%		10.5%	≤10.9%	10.7%	9.8%
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total primary and secondary deliveries	Total	3	ql	20%		20%	<18%	19%	17%
Faster cancer treatment (62 day indicator)	Total	3	ql/t	77%	2014/15	77%	85%	68%	64%
Percentage of patients who require chemotherapy are treated with 4 weeks	Total	3	qn/t	100%	2015/16	Redefined locally	100%	n/a	n/a
Percentage of patients who require radiation are treated with 4 weeks	Total	3	qn/t	100%	2015/16	Redefined locally	100%	n/a	n/a
Percentage of patients with a confirmed diagnosis of cancer who receive their first cancer treatment with 31 days of diagnosis	Total	3	qn/t	Redefined locally		Redefined locally	85%	83%	81%

### 3.5.2 People Have Appropriate Access to Elective Services

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Did-not-attend percentage for outpatient services	Māori	3	qn/t	19%		19%	5%	16%	
	Non-Māori	3	qn/t	7%		7%	5%	8%	
	Total	3	qn/t	9%		9%	5%	10%	
Number of surgical discharges under the elective initiative	Total	3	qn	4569		5,293	5,479	167,104	36,630
Percentage of patients waiting longer than four months for their first specialist assessment	Total	3	qn/t	0.11%		0.0%	0.0%	0.2%	0.0%
Elective inpatient length of stay	Total	3	ql/t	1.52 days	2015/16	2.96 days	1.52 days	3.19 days	3.83 days

### 3.5.3 Improved Health Status for those with Severe Mental Illness and/or Addictions

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Average length of acute inpatient stays	Māori	3	qn/t/ql	17 days		15 days	14-21 days	17 days	17 days
	Total	3	qn/t/ql	16 days		16 days	14-21 days	18 days	18 days
Percentage of Child and Youth clients discharged with a transition (discharge) plan.	Total	3	qn/t/ql	12%	2014/15	12%	95%	n/a	n/a
Percentage of people referred for addiction services are seen within 3 weeks	0-19 yrs	3	qn/t	62%		71%	80%	85%	83%
	20-64 yrs	3	qn/t	65%		77%	80%	83%	76%
	65+ yrs	3	qn/t	57%		100%	80%	84%	83%

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Percentage of people referred for non-urgent mental health are seen within 3 weeks	0-19 yrs	3	qn/t	56%		71%	80%	69%	72%
	20-64 yrs	3	qn/t	84%		69%	80%	82%	73%
	65+ yrs	3	qn/t	89%		91%	80%	82%	83%
Rates of post-discharge community care	Māori	3	qn/t/ql	52%		35.3%	90%	54%	56%
	Total	3	qn/t/ql	52%		55%	90%	61%	61%

### 3.5.4 More People with End Stage Conditions are Supported Appropriately

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
A reduction in the percentage of palliative care clients who have had an Emergency Department presentation	Total	3	qn/t	12%		9%	≤11.0%	n/a	n/a

## 3.6 Support Services

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Improved wait times for diagnostic services - accepted referrals receive their CT scan within 42 days	CT	2	qn/t	66%	2013/14	86%	95%	85%	89%
Improved wait times for diagnostic services - accepted referrals receive their MRI scan within 42 days	MRI	2	qn/t	51%	2013/14	45%	85%	54%	62%

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2014/15	Target 2016/17	National Result	Midland Result
Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Cat 1 within 24 hours	2	qn/t	93%	2013/14	100%	90%	n/a	n/a
	Cat 2 within 96 hours	2	qn/t	95%	2013/14	100%	90%	n/a	n/a
	Cat 3 within 72 hours	2	qn/t	90%	2013/14	90%	90%	n/a	n/a

## Module 4: **FINANCIAL PERFORMANCE**



## MODULE 4: FINANCIAL PERFORMANCE

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)	2014/15 audited	Year 0 2015/16 forecast		Year 1 2016/17 plan	Year 2 2017/18 plan	Year3 2018/19 plan	Year4 2019/20 plan
Hospital Provider + Governance Funding (including other income)	187,420	184,923		190,085	192,990	196,803	200,228
Non Hospital Provider Funding (NGO)	155,800	170,182		174,949	177,621	180,297	182,976
<b>TOTAL FUNDING</b>	<b>343,220</b>	<b>355,105</b>		<b>365,034</b>	<b>370,611</b>	<b>377,100</b>	<b>383,204</b>
Hospital Provider + Governance Operating Expenses	198,272	203,003		204,885	207,315	210,153	213,088
Payments to Non Hospital Providers (NGO)	148,735	155,682		162,149	164,796	167,447	170,101
<b>TOTAL OPERATING EXPENSES &amp; PAYMENTS</b>	<b>347,007</b>	<b>358,685</b>		<b>367,034</b>	<b>372,111</b>	<b>377,600</b>	<b>383,189</b>
<b>Hospital Provider + Governance Operating Deficit</b>	<b>(10,852)</b>	<b>(18,080)</b>		<b>(14,800)</b>	<b>(14,325)</b>	<b>(13,350)</b>	<b>12,860</b>
<b>TDHB Funder surplus</b>	<b>7,065</b>	<b>14,500</b>		<b>12,800</b>	<b>12,825</b>	<b>12,850</b>	<b>12,875</b>
<b>CONSOLIDATED FINANCIAL RESULT</b>	<b>(3,787)</b>	<b>(3,580)</b>		<b>(2,000)</b>	<b>(1,500)</b>	<b>(500)</b>	<b>15</b>

The net consolidated financial projections for the planning period 2016-20 are:

- 2016/17: Deficit \$2.00M
- 2017/18: Deficit \$1.50M
- 2018/19: Deficit \$0.50M
- 2019/20: Financial Breakeven

These financial projections are to be read with the accompanying notes and assumptions.

## 4.1 Key Points from the Budgeted Financials: 2016-20

- ***Taranaki DHB's PBFF share has reduced from 2.79% to 2.67%, with the longer term forecast that its share will continue to reduce. The DHB will receive minimum growth funding in 2016/17 of 2.2% - which is \$6.90M. This funding is circa \$5.30M lower than that received in 2015/16. This quantum drop in funding over a 12 month period is material in the context of increasing operating costs. An increased financial deficit is inevitable.***
- Against this backdrop, the Board has planned for a consolidated financial deficit, albeit reducing, for each of the fiscal periods covered by the planning period 2016-20.
- These financial projections reflect a common trend across the entire planning period 2016-20, clearly indicating that cost growth in the hospital provider operations is growing year on year and is significantly in excess of its funding, leaving operating deficits in its wake. The consolidated financial result is improved on account of surpluses generated in the Funder operations during each of the fiscal periods under consideration. This is not sustainable, nor ideal for strategic health services planning for the local community.
- The Hospital Provider Arm is facing a significant cost to funding gap resulting in operating deficits in each year covered by this plan. The hospital provider budget for Year 1 is *after* targeted cost reductions and budget trimming – primarily in wages, clinical supplies and diagnostic costs (Please refer Sec: 4.8 - Sensitivity Analysis for details). In addition, there is a cost to funding gap of \$5.20M which is required to be bridged through savings and initiatives. (Please refer to the Section 4.6: “Cost & efficiency initiatives” section for details).
- The Hospital Provider (and consolidated) financial result in Year 1 (2016/17) and out years is materially influenced by the cost impacts of Project Maunga – depreciation, cost of borrowing and loss of interest income on deposits (circa \$6.0M).
- The DHB Funder operations is planning to reprioritise funding and drive strategic initiatives to enable the DHB Funder operations to manage its costs down and deliver the operating result planned for 2016/17 and years following. Like the hospital provider, the DHB funder is carrying risks in its budget which will present challenges for it to deliver to plan (Please refer Sec: 4.8 - Sensitivity Analysis for details).
- Collectively, the total cost budgeted in 2016/17 for Taranaki DHB to support national and regional agencies (NZHPL, Health Share, other National Agencies) is circa \$1.90M – and increasing year on year. The operating budget is severely limited to absorb these new (and increasing) costs arising on different fronts – noting that benefits, if any, are likely to accrue only in future periods.

### **In the final analysis, the Board is faced with:**

1. A continuing core deficit in the Hospital Provider operations in each of the plan years.
2. Additional financial exposure in its expense budgets which could materialise in part or full.
3. The need to make radical changes and re-align service configurations in its hospital service operations to reduce the current deficit. There has to be change.

4. The financial recovery for its Hospital Provider operations being largely dependent on cost reductions incidental to services rationalisation, capacity and work force management.
5. Its Funder operations having to significantly reduce investment in community services during the period the hospital operation is going through this transition.

**The Board notes:**

- a) that the DHB (and the national health sector) is faced with increasing demand for health services and nominal annual funding increases, therefore targeted changes within its operating framework (including the non-hospital sector) are inevitable.*
- b) the operating cost to funding gap in the Hospital Provider operations cannot be bridged by changes along the margins and by employing short term measures, and*
- c) that structural and service changes will have to be pursued if the Hospital Services arm is to remain financially viable and sustainable when faced with increased costs on several fronts, and*
- d) that these changes will take time, will need to transcend political sensitivities and communal expectations in a collaborative (and time challenged) manner, and*
- e) consequently, a 12 month annual plan time line is impracticable for capturing the financial impacts of structural reforms - a longer timeframe spanning 1 to 5 years (as a minimum) is required to bring about change.*

**Financial risk profile:**

Recognising that additional risks continue to be carried both within and outside the financial budget, with reliance on timely outcomes from service changes and initiatives, Taranaki District Health Board's financial risk assessment of the current District Annual Plan is rated "medium to high" risk under the assumptions and risks stated.

## 4.2 Key Risks

### 4.2.1 Taranaki DHB's Funder Operations

**Population Based Funding Share (PBFF)**

DHB funding is largely based on a Population Based Funding Formula (PBFF) which allocates the total Vote Health funding to DHB's on the basis of the total resident population, with adjustments applied for ethnicity, rurality, age profile, socio-economic deprivation and number of overseas visitors.

- Population estimates indicate a reduction in the Taranaki population to 118,100, a decrease of 450 people or 0.38%. Overall the National population is showing an increase of 2.33%. Consequently, Taranaki DHB's PBFF share has reduced from 2.79% in 2015-16 to 2.67% in 2016/17, a change of 0.12%. Small changes to PBFF percentages result in significant change to funding allocations – overall a drop of \$5.30M in relation to 2015-16.

- The DHB will receive growth in 2016/17 of 2.2%.
- The longer term forecast is that Taranaki DHB PBFF share will continue to reduce. The Government has made no decision on out-year funding. To ensure consistency across all DHBs, Taranaki DHB has prepared the Annual Plan using the planning guidance provided that funding increases in out-years will be of the same nominal value as 2016/17.

#### Taranaki District Health Board forecast PBFF share

	2014-15	2015-16	2016/17	2017-18	2018-19	2019-20	2020-21
Actual	2.72%	2.79%	2.67%				
Forecast			2.67%	2.67%	2.66%	2.65%	2.64%

Source: Funding Advice - Dec 2015

- Whilst the level of funding for Taranaki DHB is equitable when compared to the proposed increases for other DHBs, the level and quantum of increase is considerably lower than the cost and service pressures faced by the DHB Funder and Provider Arm. The quantum of funding for 2016/17 will require the Board to actively work to restrain costs growth and also requires potential service changes, for which appropriate service change processes will need to be adopted. *This is inevitable if the financial deficit is to be contained – in the first instance.*
- The range of pressures that the Taranaki Health System is experiencing is a range of interdependent categories as noted below:
  - ✓ Cost Pressures in Hospital and Specialist Services
  - ✓ Cost Pressures in NGO Sector
  - ✓ Strategic Investment to progress a Strategic Case for change/Integrated System Approach
  - ✓ Investment for Improved Outcomes in Specific Population Groups e.g. Child and Youth, Māori or Mental Health Service Clients

#### Resource Allocation

The allocation of resources is a pragmatic approach to investment given the information available at this time and reflects prioritisation in line with DHB funding responsibilities and the Minister's Letter of Expectation. Taranaki DHB is committed as far as possible to the allocation of funding according to health need. Nonetheless, historical allocation and existing contractual commitments have to be taken into account if the stability of the sector is to be managed.

In order to offset planned deficits in the Provider Arm, and whilst service reconfiguration is undertaken to a lower cost base, the Funder is required to achieve significant surpluses. For 2016/17 the planned Funder surplus is \$12.80 million. This presents a significant challenge for the Funder – at the cost of strategic investment in the non hospital sector.

## 4.2.2 Taranaki DHB's Hospital Provider Operations

1. The Hospital Provider Arm is facing a significant and increasing cost to funding gap. This gap between funding and real cost growth has resulted in a budgetary deficit of \$14.80M after considering all current efficiencies and cost savings, and carries other financial risks as noted earlier.
2. Cost pressures are particularly evident in the following areas:
  - a) Clinical staff costs – primarily nursing.
  - b) Outsourced clinical staff – primarily locum doctors and psychiatrists.
  - c) Diagnostics.
  - d) Acute services such as cardiology, mental health inpatient services and emergency services.
  - e) Increasing cost impacts of statutory compliances, quality and accreditation deficits and numerous legislative requirements.
  - f) Information and communication technology (ICT) capital investment and increased operating costs for network infrastructure and software licences.
  - g) Operating cost contributions, capital investment and participation in national and regional initiatives and business cases.

Overall, the Hospital Provider's financial plan for the planning 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 2016/17 and out year financial targets.

3. It is difficult to estimate with certainty the likely costs and benefits to this DHB from NZHPL (New Zealand Health Partnerships Limited – the successor to HBL) absorbed business cases as these are in various stages of delivery. Outgoings in capital investment and contribution to NZHPL operating expenditure have been recognised based on information available.
4. Indicative savings through reduced pricing from collective procurement projects, All of Government (AOG) initiatives and other collaborative efforts have been factored into clinical supply and consumable costs over the plan period. Likewise, operating expenditure outflow to support these national initiatives have been provided.
5. Taranaki DHB's share in supporting the Midland regional projects and contribution to HealthShare (the regional shared services entity) has been provided.
6. In applying the budgetary assumptions we have recognised ongoing quality improvements and those compliance costs of which Taranaki DHB has been aware. The financial budget is vulnerable to small movements in costs over stated assumptions or increased costs resulting from clinical compliance expectations and legislative changes.
7. The Hospital Services Provider is dependent on sustainable revenue streams. With about 93% of its revenue derived from health funding (via DHB Funder and the Ministry of Health), the Hospital Provider has few alternate income streams for revenue growth. There is a marginal increase in ACC revenues planned for 2016/17, whilst miscellaneous income assumes \$2.00M to be raised through community donations (potential risk of falling short).

8. During the plan period 2016-20, baseline capital expenditure will be contained within depreciation provisions, so that additional equity injection or borrowing is not required despite continuing operating deficits. This is not sustainable in the medium term.

In the final analysis, the gap between funding and the realistic cost model for services plus the cost impact of Project Maunga has resulted in a very sensitive financial budget for the planning period 2016/17 and out years. From a realistic view point and timeframes, the quantum of cost savings required from the hospital services will likely span a 1 to 5 year planning horizon.

## **4.3 Key Financial Assumptions**

The following key assumptions have been employed in the preparation of the financial statements for the four year planning period 2016-20.

### **4.3.1 Application of Public Benefit Entity Accounting Standards**

The Annual Plan financial template for the plan period 2016-20 and comparative years has been prepared in accordance with NZ GAAP. They comply with Public Benefit Entity Standards which include the Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS).

### **4.3.2 Equity and Borrowing**

- a) The District Annual Plan 2016-20 has not assumed any additional Crown equity.
- b) Base line capital expenditure is expected to be contained within the level of depreciation for 2016/17 and the three years following.
- c) Taranaki DHB is currently under “performance watch - remedial” status on the performance monitoring scale.

### **4.3.3 Operating Expenditure assumptions:**

- a) Wage costs: in principle, wage budgets for employee groups covered by national MECA settlements are essentially in accordance with current agreement(s) and in line with collective planning assumptions. MECA's which are yet to be settled have a budgetary provision for wage increases - and presents a risk should final settlement exceed the provision.
- b) Clinical supplies: a decrease has been assumed in 2016/17 based on estimated activity levels, reduced for local efficiencies and procurement gains. There is a potential risk in this line.
- c) General operating expenditure (excluding depreciation and interest): no increase assumed, with local efficiencies and cost controls to balance inflationary impacts.
- d) Value for Money (VFM) impacts: Cost reductions and gains likely to ensue from the collective procurement contracts undertaken by NZHPL/Health Alliance HBL programmes have been recognised in this Annual Plan. Gains from local initiatives and projects have been built into the relevant expense budgets.
- e) Other expenditure reductions: the 2016/17 expense budget assumes efficiencies and cost reductions arising from the following:
  - Prioritised service levels
  - Length of stay and patient throughput

- FTE management + reduced staffing costs
- Contract tracking + renegotiation + monitoring.
- Demand and capacity management

## 4.4 Financial Assumptions and Budgetary Outlay

### 4.4.1 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 has 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 2016/17 have been fully applied to Mental Health Services either in the Hospital Provider or community during the year. Based on expenditure to date and forecasts, no surplus is likely to remain on 30 June 2016. No surpluses from Mental Health services are envisaged during the 2016-20 plan period and, if any surpluses do eventuate, these will be ring fenced and expended in the year(s) following.

### 4.4.2 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. Interests on DMO/MoH loans are as per the loan drawdown schedule.

	Overdraft	DMO/MoH Loans (Average)	DMO/MoH Loans (new)	Deposits	Equity
Year 1 (2016/17)	4.00%	3.30%	-	3.50%	8.00%
Year 2 (2017/18)	4.00%	3.30%	-	3.50%	8.00%
Year 3 (2018/19)	4.50%	3.30%	-	4.00%	8.00%
Year 4 (2019/20)	4.75%	4.25%	-	4.25%	8.00%

#### Notes:

1. DMO/MoH total approved facility is \$74M, with the full limit having been drawn down with the completion of Project Maunga in early 2015.
2. Taranaki DHB is in the DHB collective banking & transactional arrangement with Westpac. Monthly closing cash balances are dipping into over draft during most month ends – primarily the impact of the ongoing deficit position.
3. There is a proposal to shift capital financing from Crown debt to Crown equity. The potential impact of the shift is to be determined. We are advised that the intention is that the sector will be compensated for the difference in cost through an increase in revenue which the DHBs will initially receive via a Top Slice arrangement. No change to the financial result for 2016/17 has been effected as it is assumed there will be no impact to the bottom line for 2016/17.

### 4.4.3 Asset Revaluation and its Impact

Under the provisions of PBE IPSAS 17, Taranaki DHB 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.

No provision has been made in the 2016/17 financials arising from any impacts of asset revaluation as on 30 June 2016. A detailed revaluation exercise was completed on 30 June 2013, and updated upon completion of the new build (Project Maunga) in June 2015. It is therefore assumed that there will be no material movements requiring an adjustment to the current asset base. The impact of the new hospital redevelopment on current building values has been factored in the recent revaluations and treated appropriately. Conversely, should there be a material movement, it is assumed that any related capital charge increase will be funded and base line adjusted in accordance with current Treasury guidelines.

### 4.4.4 Depreciation

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

### 4.4.5 Capital Charge

Capital charge has been calculated in line with existing methodology, adjusted for donations and closing balance of shareholders funds.

### 4.4.6 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.

### 4.4.7 Financial Covenants and Ratios

There are no specific financial covenants stipulated by the DMO/MoH for its term lending to Taranaki DHB. No financial covenants have been stipulated by Westpac for transactional banking.

The following are some key financial ratios as derived from the consolidated financial statements for the period 2016-20.

Financial ratios	TDHB 2015-16	Year1 2016/17	Year2 2017-18	Year3 2018-19	Year4 2019-20
	forecast	plan	plan	plan	plan
1 Revenue to net funds employed	2.35	2.46	2.54	2.61	2.67
2 Operating margin to revenue	4%	5%	5%	5%	5%
3 Operating return on net funds employed	10%	12%	13%	14%	13%
4 Interest cover ratio	5.35	7.42	8.00	8.43	8.22
5 Debt to debt equity ratio	49%	50%	51%	52%	52%

#### 4.4.8 Changes in Accounting Policies

There have been no changes from the accounting policies adopted in the last audited financial statements other than any changes brought about by the adoption of Public Benefit Entity Standards, including Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS).

#### 4.4.9 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 (\$'000)	Year 1 (2016/17)	Year 2 (2017-18)	Year 3 (2018-19)	Year 4 (2019-20)	Total (2016-20)
<b><u>Operating</u></b>					
Clinical Equipment	3,000	3,000	3,000	3,000	12,000
Other Equipment	500	500	500	500	2,000
Motor Vehicles	700	1000	200	200	2,250
Minor Site Redevelopment (including prior year WIP)	5,000	2,000	2,500	2,500	12,000
Information Technology	6,000	6,000	6,000	6,000	24,000
<b>TOTAL</b>	<b>15,200</b>	<b>12,500</b>	<b>12,200</b>	<b>12,200</b>	<b>52,100</b>
<b><u>Strategic</u></b>					
Base Hospital redevelopment project – Stage 2	Scoping phase	Development of BC	Development of BC	Development of BC	
<b>TOTAL</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>GRAND TOTAL</b>	<b>15,200</b>	<b>12,500</b>	<b>12,200</b>	<b>12,200</b>	<b>52,100</b>
<b><u>Sources of Funding</u></b>					
Crown Equity	0	0	0	0	0
Bank Borrowing	0	0	0	0	0
DMO/MoH Term Loans	0	0	0	0	0
Internal Cash Accruals	<b>15,200</b>	<b>12,500</b>	<b>12,200</b>	<b>12,200</b>	<b>52,100</b>

#### 4.4.10 Capital Divestment

A: The disposal of surplus assets proposed during the period 2016-20 is as follows:

Asset	Book value (\$)	Realisable Value (\$)	Gain/(loss) On sale (\$)	Timing
* Miscellaneous equipment (discarded/obsolete)	0	Not material	0	2016-20
* Surplus land	0	0	0	n/a
* Vehicles	0	Not Material	0	2016-20
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	

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 Māori sites of significance are addressed.

#### 4.4.11 Personnel

##### a) Paid/Contracted/Core FTEs

The movement of "contracted/worked FTE" numbers across the Annual Plan period is assumed along the following lines. To be noted is that Radiology Services FTE's have been included incidental to the full ownership of Fulford Radiology Services Ltd since 11 January 2016 – details below table.

##### CONTRACTED

	Forecast 2015-16	Yr 1 2016/17	Yr 2 2016/17	Yr 3 2017-18	Yr 4 2018-19
<b>PROVIDER</b>					
Medical Personnel	152	162	162	164	164
Nursing Personnel	587	565	568	573	573
Allied Health Personnel	230	281	280	280	279
Support Personnel	96	92	92	92	90
Management & Administration	252	271	271	271	269
<b>GOVERNANCE</b>	17	18	18	18	18
<b>TOTAL</b>	<b>1,334</b>	<b>1,389</b>	<b>1,391</b>	<b>1,398</b>	<b>1393</b>

*Note: includes Radiology Services FTEs incidental to full ownership of Fulford Radiology Services Ltd (100% owned by TDHB since 11 Jan 2016).*

*The distribution of Radiology Services FTEs across the categories (Year 1 to Year 4) is as follows:*

- Medical : + 8 FTE
- Nursing : + 3 FTE
- Allied: + 29 FTE
- Mgt & Admin: + 11 FTE

*Total FTE Increase: 51 FTES*

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

- 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). Nursing staff are expected to stabilise over the 4 year plan period due to more efficient management of staffing and efficiencies from services reconfigurations and changing models of care within the hospital and mental health services. Movements in Allied Health and support staff are likely to be contained and reviewed for efficiencies and optimum service delivery. Management and Administration staff are expected to remain at current levels, with any increases solely driven by new funded projects. Capping FTE growth with improved productivity and more efficient and smarter workflows is a key goal for Taranaki DHB to manage the cost growth and the deficit.
- Taranaki DHB is currently tracking within the Ministerial cap set for Management and Administration staff having made significant reductions over the recent period through internal reviews and restructures, and is expected to remain below the cap over the plan period. However, resourcing constraints are now becoming acute and will need addressing.
- In principle, the personnel budget has not planned for core FTE increases – other than FTEs required to deliver acute demand, vacancies filled, new projects and nationally driven initiatives. Additionally, there will be impacts from changes to services and models of care incidental to the hospital redevelopment project. The overall strategy is to cap FTE growth, however it is acknowledged that there will be demand for clinical resources due to increase in activity levels – both acute and elective. Additionally, as recent trends indicate, there has been an increase in specialising patients (one-on-one care) in ICU and Mental Health inpatient admissions. With introduction of management tools, Taranaki DHB will continue to aggressively pursue measures and initiatives 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 four year plan period is as below:

<b>ACCRUED</b>	<b>Forecast</b>	<b>Yr 1</b>	<b>Yr 2</b>	<b>Yr 3</b>	<b>Yr 4</b>
	2015/16	2016/17	2017/18	2018/19	2019/20
<b>PROVIDER</b>					
Medical Personnel	155	165	165	167	167
Nursing Personnel	613	590	593	598	598
Allied Health Personnel	230	281	280	280	279
Support Personnel	98	94	94	94	92
Management & Administration	256	276	276	276	274
<b>GOVERNANCE</b>	17	18	18	18	18
<b>TOTAL</b>	<b>1,370</b>	<b>1,424</b>	<b>1,426</b>	<b>1,434</b>	<b>1428</b>

*Note: Includes Radiology Services FTE’s absorbed by TDHB : Yr. 1 through Yr. 4. Total: 51 FTE’s*

## 4.5 Capital Expenditure: Strategic

### 4.5.1 Base Hospital Inpatient Facilities Development Programme

Project Maunga – the Stage 1 of the redevelopment of the Base Hospital inpatient facilities with theatres and inpatient wards has been delivered within budget and on time.

The primary focus of this project was 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.

The Base hospital Master Plan envisages a 3 Stage 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
<b>STAGE 1</b>	Theatres, Ambulatory, Inpatient wards	\$80M	Start: Aug 2011 Finish: June 2014	Completed.
<b>STAGE 2</b>	Maternity, Neonatal, ED	\$37M	Tentative: 2020-2021	Supplementary business case to be progressed.
<b>STAGE 3</b>	OPD, Laboratory, Administration	\$28M	Tentative : 2024-2025	Supplementary business case to be progressed.
<b>TOTAL</b>		<b>\$145M</b>	<b>2011 – 2025</b>	

Notes:

1. Stages 2 and 3 are discrete components of the overall Master Plan for the redevelopment of inpatient facilities at the Base Hospital.
2. As Stage 1 is now complete, it is envisaged that supplementary business cases will be developed for each of the remaining stages and forwarded to the national Capital Investment Committee for approval and funding.
3. In short, each of the stages can be visualised as standalone 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.

An updated Schedule of Capital Intentions has been submitted.

## 4.6 Cost and Efficiency Initiatives

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope. There is growing financial gap. In addition, it has to balance its long-term strategies with short-term objectives while continuing to provide a clinically safe and quality service. 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 following key initiatives are being considered within the Hospital Provider operations to generate efficiency gains, and contain or reduce operating costs. *And more importantly – to bridge its cost to funding gap if it has to meet its plan target for 2016/17 and contain its growing operating deficit.*

Initiatives	Proposal	Potential Est. (\$)	Impact
<b>Internal cost controls:</b> Campus wide cost management strategies to reduce discretionary costs	Target specific areas of cost for efficiency gains including review of service delivery and demand.	\$0.702M	Reduce operating costs
<b>Diagnostic Initiatives:</b> Review of referral processes and patterns in diagnostic services – radiology and pathology.	Review and re-structure of diagnostic service frameworks and processes.	\$0.774M	Reduce diagnostic costs.
<b>Demand Management:</b> e-referrals, i-procurement and review of internal systems	Reviews of service delivery against targets and contracts.	\$1.552M	Reduce service costs
<b>Project Cost management:</b> Review and re-negotiation of service contracts against delivery and measurable outcomes	Ongoing review of contracts in the DHB Funder and Hospital services.	\$0.576M	Reduce operating costs
<b>Staff strategies:</b> FTE vacancy management + other staffing initiatives	Range of FTE management initiatives across the organisation.	\$0.396M	Reduce operating costs
<b>Additional savings initiatives:</b>	Additional savings initiatives to be identified and evaluated.	\$1.20M	Reduce operating deficit
<b>TOTAL</b>		<b>\$5.20M</b>	

This Annual Plan 2016/17 has identified a cost to funding gap of \$ 5.20M, which has to be bridged by a range of saving initiatives and cost reduction plans as outlined. The services initiatives commenced in prior years will also generate cost savings in future periods, and have been recognised in out years.

Other miscellaneous gains from local initiatives and cost reduction measures have been built into the relevant expense budgets.

Faced with a gap in its operating budget, the Hospital Provider Arm will continue to explore all practical options with the aim of reducing its overall cost of services delivery, whilst improving productivity and efficiency of operations. 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.

## 4.7 Debt and Equity

The debt profile of Taranaki DHB as at 01 July 2016 will be term loans of \$74M with the Debt Management Office (DMO)/MoH, fully drawn down against the approved loan limit of \$74M. The primary assumptions carried in the financial plan 2016/17 are:

- Overdraft facilities (as per OPF guidelines) are assumed to be available under the DHB collective treasury banking arrangement with Westpac.
- No additional equity or deficit support is envisaged. It is expected that base line capital expenditure will be contained within the level of depreciation for 2016/17 and out years.
- There is a proposal to shift capital financing from Crown debt to Crown equity. The potential impact of the shift is to be determined. We are advised that the intention is that the sector will be compensated for the difference in cost through an increase in revenue which the DHBs will initially receive via a Top Slice arrangement. No change to the financial result for 2016/17 has been effected as it is assumed there will be no impact to the bottom line for 2016/17.

## 4.8 Sensitivity Analysis: Budgetary Risks in Plan 2016/17

The District Annual Plan carries some key financial risks – *besides the \$5.20M cost to funding gap (see Sec: 4.6 – cost & efficiency initiatives)*. 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 – Key Risks in 2016/17

Unbudgeted financial risk	Est. risk (\$M)	75% risk (\$M)	50% risk (\$M)	25% risk (\$M)	Probability factor (% risk)
FTE + wage budget	1.00	<b>0.75</b>	0.50	0.25	<b>75%</b>
Timing of gains from initiatives	1.00	<b>0.75</b>	0.50	0.25	<b>75%</b>
Clinical supplies	0.80	<b>0.60</b>	0.40	0.20	<b>75%</b>
General overheads	0.40	0.30	0.20	<b>0.10</b>	<b>25%</b>
<b>Likely impact on 2016/17 planned financial result</b>	<b>\$3.20M</b>	<b>\$2.40M</b>	<b>\$1.60M</b>	<b>\$0.80M</b>	<b>\$2.20M</b>

The overall risk is expected to be **\$3.20M** for 2016/17, while the probability factor is estimated to be around **70%** leaving a residual risk equating to about **\$2.20M**. The risk is expected to be managed through a mix of:

- Internal cost controls
- Management of FTEs and vacancies
- Operational savings in discretionary expense lines through capped budgets
- Gains from National procurement programmes and initiatives
- Fast tracking efficiency projects and service reviews

### DHB Funder Operations – Key Risks in 2016/17

Unbudgeted financial risk	Est. risk (\$'M)	75% risk (\$'M)	50% risk (\$'M)	25% risk (\$'M)	Probability factor (% risk)
IDF Above Plan	1.50	1.13	<b>0.75</b>	0.38	50%
National Contracts	0.60	<b>0.45</b>	0.30	0.15	75%
Pharmaceuticals	0.30	0.23	<b>0.15</b>	0.08	50%
Health of Older People	0.75	0.56	<b>0.38</b>	0.19	50%
Personal Health/Primary Care Growth	0.80	0.60	<b>0.40</b>	0.20	50%
<b>Potential impact on 2016/17 planned financial result</b>	<b>3.95M</b>	<b>2.96M</b>	<b>1.98M</b>	<b>0.99M</b>	<b>2.13M</b>

The overall exposure is estimated at around **\$3.95M** for 2016/17, while the probability factor is estimated to be around **55%** leaving a residual risk equating to about **\$2.13M**.

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

## 4.9 Statement of Comprehensive Income

	FORECAST			Year 0		(\$'000)			Year 1
	Hosp+Gov Forecast 2015/16	Funder Forecast 2015/16	Consolidated Forecast 2015/16		Provider Plan 2016/17	Governan: Plan 2016/17	Hosp+Gov Plan 2016/17	Funder Plan 2016/17	Consolidated Plan 2016/17
<b>REVENUE</b>									
* MOH funding	171896		171896		175988	0	175988		175988
		166078	166078					170544	170544
* Funding & Governance	2576		2576		0	2584	2584		2584
* ACC Revenue	5005	78	5083		5086	0	5086	85	5171
* Other revenue	5446	4026	9472		6427	0	6427	4320	10747
<b>TOTAL REVENUE</b>	<b>184923</b>	<b>170182</b>	<b>355105</b>		<b>187501</b>	<b>2584</b>	<b>190085</b>	<b>174949</b>	<b>365034</b>
<b>EXPENDITURE</b>									
<b>Personnel costs</b>									
- medical	33283		33283		36603	0	36603		36603
- nursing	47097		47097		46503	0	46503		46503
- allied health	16545		16545		21691	0	21691		21691
- support	4624		4624		3941	0	3941		3941
- mgt & admin	18751		18751		20730	1568	22298		22298
<b>total</b>	<b>120300</b>	<b>0</b>	<b>120300</b>		<b>129468</b>	<b>1568</b>	<b>131036</b>	<b>0</b>	<b>131036</b>
<b>Outsourced services</b>									
- clinical services	18100		18100		10827	0	10827		10827
- other outsourced	1400		1400		1541	0	1541		1541
<b>total</b>	<b>19500</b>	<b>0</b>	<b>19500</b>		<b>12368</b>	<b>0</b>	<b>12368</b>	<b>0</b>	<b>12368</b>
<b>Clinical supplies</b>									
- treatment disposables	9321		9321		9460	0	9460		9460
- diagnostic supplies	1996		1996		1560	0	1560		1560
- instruments & equip	1660		1660		2137	0	2137		2137
- patient appliances	1434		1434		1272	0	1272		1272
- implants & prostheses	2873		2873		2775	0	2775		2775
- pharmaceuticals	4807		4807		4536	0	4536		4536
- other clinical & client costs	4021		4021		4197	0	4197		4197
							0		
<b>total</b>	<b>26112</b>	<b>0</b>	<b>26112</b>		<b>25937</b>	<b>0</b>	<b>25937</b>	<b>0</b>	<b>25937</b>
<b>Infrastructure &amp; other op.costs</b>									
- hotel services & laundry	3178		3178		3498	1	3499		3499
- facilities	3698		3698		3939	0	3939		3939
- transport	687		687		685	20	705		705
- IT systems & telecom	3821		3821		5789	0	5789		5789
- professional fees	2629		2629		2782	396	3178		3178
- other op.expenses	-1696		-1696		-1721	192	-1529		-1529
- democracy	279		279		1	407	408		408
- depreciation	15730		15730		17011	0	17011		17011
- interest	2794		2794		2337	0	2337		2337
- cost & efficiency initiatives	0		0		-5200	0	-5200		-5200
- <b>Payment to - NGO providers</b>									
- personal health		64340	64340					69024	69024
- mental health		10885	10885					11008	11008
- disability support services		38408	38408					40428	40428
- public health		890	890					801	801
- maori health		2829	2829					2836	2836
- IDF's		38330	38330					38052	38052
<b>total</b>	<b>31120</b>	<b>155682</b>	<b>186802</b>		<b>29121</b>	<b>1016</b>	<b>30137</b>	<b>162149</b>	<b>192286</b>
<b>TOTAL OPERATING EXPENSES</b>	<b>197032</b>	<b>155682</b>	<b>352714</b>		<b>196894</b>	<b>2584</b>	<b>199478</b>	<b>162149</b>	<b>361627</b>
<b>SURPLUS before capital charge</b>	<b>-12109</b>	<b>14500</b>	<b>2391</b>		<b>-9393</b>	<b>0</b>	<b>-9393</b>	<b>12800</b>	<b>3407</b>
- Capital charge	5971		5971		5407	0	5407		5407
<b>NET SURPLUS/(DEFICIT)</b>	<b>-18080</b>	<b>14500</b>	<b>-3580</b>		<b>-14800</b>	<b>0</b>	<b>-14800</b>	<b>12800</b>	<b>-2000</b>

Year 2					Year 3					Year 4				
	Provider	Governan:	Funder	Consolidated	Provider	Governan:	Funder	Consolidated		Provider	Governan:	Funder	Consolidated	
	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan		Plan	Plan	Plan	Plan	
	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19		2019/20	2019/20	2019/20	2019/20	0
<b>REVENUE</b>														
* MOH funding	178794		173089	178794 173089	181600		175636	181600 175636		184406		178182	184406 178182	
* Funding & Governance		2627		2627		2670		2670			2713			2713
* ACC Revenue	5137		86	5223	6088		87	6175		6649		88	6737	
* Other revenue	6432		4446	10878	6445		4574	11019		6460		4706	11166	
<b>TOTAL REVENUE</b>	<b>190363</b>	<b>2627</b>	<b>177621</b>	<b>370611</b>	<b>194133</b>	<b>2670</b>	<b>180297</b>	<b>377100</b>		<b>197515</b>	<b>2713</b>	<b>182976</b>	<b>383204</b>	
<b>EXPENDITURE</b>														
<b>Personnel costs</b>														
- medical	37335			37335	38081			38081		38842			38842	
- nursing	47433			47433	48382			48382		49349			49349	
- allied health	22125			22125	22568			22568		23020			23020	
- support	4020			4020	4100			4100		4181			4181	
- mgt & admin	21144	1599		22743	21566	1631		23197		21996	1663		23659	
<b>total</b>	<b>132057</b>	<b>1599</b>	<b>0</b>	<b>133656</b>	<b>134697</b>	<b>1631</b>	<b>0</b>	<b>136328</b>		<b>137388</b>	<b>1663</b>	<b>0</b>	<b>139051</b>	
<b>Outsourced services</b>														
- clinical services	10935			10935	11044			11044		11154			11154	
- other outsourced	1557			1557	1573			1573		1589			1589	
<b>total</b>	<b>12492</b>	<b>0</b>	<b>0</b>	<b>12492</b>	<b>12617</b>	<b>0</b>	<b>0</b>	<b>12617</b>		<b>12743</b>	<b>0</b>	<b>0</b>	<b>12743</b>	
<b>Clinical supplies</b>														
- treatment disposables	9555			9555	9651			9651		9748			9748	
- diagnostic supplies	1576			1576	1592			1592		1608			1608	
- instruments & equip	2158			2158	2180			2180		2202			2202	
- patient appliances	1285			1285	1298			1298		1311			1311	
- implants & prostheses	2803			2803	2831			2831		2859			2859	
- pharmaceuticals	4581			4581	4627			4627		4673			4673	
- other clinical & client costs	4239			4239	4281			4281		4324			4324	
<b>total</b>	<b>26197</b>	<b>0</b>	<b>0</b>	<b>26197</b>	<b>26460</b>	<b>0</b>	<b>0</b>	<b>26460</b>		<b>26725</b>	<b>0</b>	<b>0</b>	<b>26725</b>	
<b>Infrastructure &amp; other op.costs</b>														
- hotel services & laundry	3533	1		3534	3568	1		3569		3603	1		3604	
- facilities	3978			3978	4018			4018		4058			4058	
- transport	692	20		712	699	20		719		706	20		726	
- IT systems & telecom	5847			5847	5905			5905		5464			5464	
- professional fees	2810	400		3210	2838	404		3242		2866	408		3274	
- other op.expenses	-3101	314		-2787	-2180	320		-1860		-894	211		-683	
- democracy	1	293		294	1	294		295		1	410		411	
- depreciation	17856			17856	17856			17856		16856			16856	
- interest	2337			2337	2337			2337		2337			2337	
- cost & efficiency initiatives	-5000			-5000	-6000			-6000		-6000			-6000	
- <b>Payment to - NGO providers</b>														
- personal health			70104	70104			71182	71182				72254	72254	
- mental health			11192	11192			11376	11376				11560	11560	
- disability support services			41103	41103			41774	41774				42443	42443	
- public health			815	815			828	828				841	841	
- maori health			2884	2884			2931	2931				2978	2978	
- IDF's			38698	38698			39356	39356				40025	40025	
<b>total</b>	<b>28953</b>	<b>1028</b>	<b>164796</b>	<b>194777</b>	<b>29042</b>	<b>1039</b>	<b>167447</b>	<b>197528</b>		<b>28997</b>	<b>1050</b>	<b>170101</b>	<b>200148</b>	
<b>TOTAL OPERATING EXPENSES</b>	<b>199699</b>	<b>2627</b>	<b>164796</b>	<b>367122</b>	<b>202816</b>	<b>2670</b>	<b>167447</b>	<b>372933</b>		<b>205853</b>	<b>2713</b>	<b>170101</b>	<b>378667</b>	
<b>SURPLUS before capital charge</b>	<b>-9336</b>	<b>0</b>	<b>12825</b>	<b>3489</b>	<b>-8683</b>	<b>0</b>	<b>12850</b>	<b>4167</b>		<b>-8338</b>	<b>0</b>	<b>12875</b>	<b>4537</b>	
- Capital charge	4989			4989	4667			4667		4522			4522	
<b>NET SURPLUS/(DEFICIT)</b>	<b>-14325</b>	<b>0</b>	<b>12825</b>	<b>-1500</b>	<b>-13350</b>	<b>0</b>	<b>12850</b>	<b>-500</b>		<b>-12860</b>	<b>0</b>	<b>12875</b>	<b>15</b>	

## 4.10 Consolidated Statement of Financial Position

			2014/15 audited	2015/16 forecast		2016/17 plan	2017/18 plan	2018/19 plan	2019/20 plan
<b>CURRENT ASSETS</b>									
* Bank Account			69	105		105	105	105	681
* ST investments			2890	2890		2890	0	0	0
* Prepayments			1411	1750		1800	1825	1850	1875
* Debtors (net of provision)			13240	13450		13650	13800	13950	14100
* Inventory			2588	2600		2650	2675	2700	2725
			20198	20795		21095	18405	18605	19381
<b>CURRENT LIABILITIES</b>									
* Bank Account			8334	12495		6182	2609	103	0
* Creditors & other payables			18267	14610		21616	19207	17321	14093
* Term Loans (current portion)			0	0		0	0	0	0
* Provisions			24244	25110		25830	26200	26570	26940
			50845	52215		53628	48016	43994	41033
<b>WORKING CAPITAL</b>			-30647	-31420		-32533	-29611	-25389	-21652
<b>NON CURRENT ASSETS</b>									
* Net Fixed Assets			182484	178104		176293	170937	165281	160625
* Investments			3158	3747		3747	3747	3747	3747
* Trust funds			800	800		800	800	800	800
			186442	182651		180840	175484	169828	165172
<b>NET FUNDS EMPLOYED</b>			<b>155795</b>	<b>151231</b>		<b>148307</b>	<b>145873</b>	<b>144439</b>	<b>143520</b>
<b>NON CURRENT LIABILITIES</b>									
* Provisions - non current			1045	1020		1055	1080	1105	1130
* Term Loans			74000	74000		74000	74000	74000	74000
			75045	75020		75055	75080	75105	75130
<b>CROWN EQUITY</b>									
* Crown Equity			23164	22205		21246	20287	19328	18369
* Reserves			68249	68249		68249	68249	68249	68249
* Retained earnings			-10663	-14243		-16243	-17743	-18243	-18228
			80750	76211		73252	70793	69334	68390
<b>NET FUNDS EMPLOYED</b>			<b>155795</b>	<b>151231</b>		<b>148307</b>	<b>145873</b>	<b>144439</b>	<b>143520</b>

#### 4.11 Consolidated Statement of Cashflow

(\$'000)									
			2014/15 audited	2015/16 forecast		2016/17 plan	2017/18 plan	2018/19 plan	2019/20 plan
<b>OPERATING ACTIVITIES</b>									
* MOH funding			322939	340388		348916	354361	359756	365151
* Other revenue			15709	14021		15626	15838	16956	17687
<b>total receipts</b>			338648	354409		364542	370199	376712	382838
* Payment of salaries & operating exp.			182120	187023		187069	188989	191827	195762
* Payment to providers & DHB's			154406	159149		155293	167330	169458	173454
<b>total payments</b>			336526	346172		342362	356319	361285	369216
<b>NET CASHFLOW FROM OPERATIONS</b>			<b>2122</b>	<b>8237</b>		<b>22180</b>	<b>13880</b>	<b>15427</b>	<b>13622</b>
<b>INVESTING ACTIVITIES</b>									
* Interest & Dividends Received			517	526		292	262	238	216
* Sale of fixed assets etc			0	0		0	0	0	0
* (Increase) / decrease in investments			-292	-579		0	2890	0	0
* Capital expenditure			-8558	-11350		-15200	-12500	-12200	-12200
<b>NET CASHFLOW FROM INVESTING</b>			<b>-8333</b>	<b>-11403</b>		<b>-14908</b>	<b>-9348</b>	<b>-11962</b>	<b>-11984</b>
<b>FINANCING ACTIVITIES</b>									
* Equity injections / repayments			-959	-959		-959	-959	-959	-959
* Borrowings			0	0		0	0	0	0
* Payment of debts			0	0		0	0	0	0
<b>NET CASHFLOW FROM FINANCING</b>			<b>-959</b>	<b>-959</b>		<b>-959</b>	<b>-959</b>	<b>-959</b>	<b>-959</b>
Total cash in			337689	353450		363583	369240	375753	381879
Total cashout			-344859	-357575		-357270	-365667	-373247	-381200
<b>NET CASHFLOW</b>			<b>-7170</b>	<b>-4125</b>		<b>6313</b>	<b>3573</b>	<b>2506</b>	<b>679</b>
Add: Cash (opening)			-1095	-8265		-12390	-6077	-2504	2
<b>CASH (CLOSING)</b>			<b>-8265</b>	<b>-12390</b>		<b>-6077</b>	<b>-2504</b>	<b>2</b>	<b>681</b>

## 4.12 Consolidated Statement of Movement in Equity

					2015/16 forecast	2016/17 plan	2017/18 plan	2018/19 plan	2019/20 plan
<b>EQUITY AT THE BEGINNING OF PERIOD</b>					<b>80750</b>	<b>76211</b>	<b>73252</b>	<b>70793</b>	<b>69334</b>
* Net results for the period					-3580	-2000	-1500	-500	15
* Revaluation of Fixed assets					0	0	0	0	0
* Equity Injections / (repayments)					-959	-959	-959	-959	-959
* Other					0	0	0	0	0
<b>EQUITY AT THE END OF THE PERIOD</b>					<b>76211</b>	<b>73252</b>	<b>70793</b>	<b>69334</b>	<b>68390</b>



## Module 5: **Stewardship**



## MODULE 5: STEWARDSHIP

### 5.1 Managing our Business

#### 5.1.1 Our People

The central part of our capability is our people. Providing health and disability services now and into the future depends on having a workforce that is well matched to the health needs of the community and appropriately skilled and located.

Key points of note about our workforce (as at 31 December 2015) are:

- We employed 1,257.31 FTE of staff
- 81% of staff were female
- We have a multi-cultural workforce with 40 different ethnicities working together to provide health services in many settings
- The Māori workforce made up around 8.58% of the overall staffing numbers with 31% in support roles (non-health support, administration, management) and 69% in clinical roles (medical, nursing, allied)
- The Pacific workforce made up around 0.70% of the overall staffing numbers with 42% in support roles (non-health support, administration, management) and 58% in clinical roles (medical, nursing, allied)
- New Zealand non-Māori make up the largest single ethnic group of employees (67%)
- 57% of our workforce is over the age of 45 years

As at 31 December 2015, Taranaki DHB's workforce was broken down as follows:

Workforce	Subgroup	FTE
Medical	SMO	86.77
	RMO	67.70
Nursing		527.03
Allied		233.23
Non Health Support		82.31
Management/ Administration		260.26
<b>Total</b>		<b>1,257.31</b>

#### 5.1.2 Organisational Performance Management

Our performance is assessed on both non-financial and financial measures. The table in Section 5.5.2 of this module provides an overview of the external reporting. Our overall planned performance as a funder and provider of health services for 2016/17 is outlined in this plan and will be reported to our senior management, Board and the Ministry of Health on a regular basis.

##### 5.1.2.1 Non-financial Performance Reporting

Non-financial performance, which relates to volume and performance expectations for health service provision (by Taranaki DHB Provider Arm, PHOs and the NGO's we fund), is monitored regularly. It is one of the tools we use to identify issues and inform decision-making to improve our performance.

As a funder we monitor the agreements we have with providers through effective portfolio management which includes regular performance reports and data analysis. We also monitor the quality of services provided through reporting of adverse incidents, routine audits, service reviews and issues-based audits.

We report quarterly to the Ministry of Health on the required measures in the DHB Non-Financial Monitoring Framework and regularly feed into benchmarking and quality programmes to compare our performance with other providers. We support the national expectation that the public should be informed about health system performance by publishing our performance against the national health targets.

We report to our Board through our regular narrative reporting process on performance against this Annual Plan. These reports are provided and discussed in Board Meetings and are available to the public as part of the relevant Board agenda.

### 5.1.2.2 Financial Performance Reporting

As part of our annual planning process we submit a set of financial templates to the Ministry of Health. The templates inform the tables and narrative presented in Module 4. We report monthly to the Ministry of Health against the financial templates. We report on our financial performance monthly to our Board. This report includes commentary and financials as well as actions planned to improve financial performance.

As part of our financial reporting we include full time equivalent (FTE) reporting. This covers areas like:

- Accrued FTE
- Management/Administration FTE Cap
- Clinical FTE
- Out Sourced Services FTE

The information on our financial performance is one of the tools used by the organisation to identify issues and inform decision-making to improve our performance.

### 5.1.3 Funding and Financial Management

The following table sets out our key financial indicators:

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	\$M	\$M	\$M	\$M	\$M	\$M
	ACTUAL	FORECAST	PLANNED	PLANNED	PLANNED	PLANNED
<b>Revenue</b>	343.220	355.105	365.034	370.611	377.100	383.204
<b>Net Surplus/(Deficit)</b>	(3.787)	(3.580)	(2.000)	(1.500)	(0.500)	0.015
<b>Total Fixed Assets</b>	182.484	178.104	176.293	170.937	165.281	160.625
<b>Crown Equity</b>	80.750	76.211	73.252	70.793	69.334	68.390
<b>Term Borrowings and Provisions</b>	75.045	75.020	75.055	75.080	75.105	75.130

Non-financial performance, which relates to volume and performance expectations for health service provision (by Taranaki DHB Provider Arm, PHOs and the NGO's we fund), is monitored regularly. It is one of the tools we use to identify issues and inform decision-making to improve our performance.

As a funder we monitor the agreements we have with providers through effective portfolio management which includes regular performance reports and data analysis. We also monitor the quality of services provided through reporting of adverse incidents, routine audits, service reviews and issues-based audits.

We report quarterly to the Ministry of Health on the required measures in the DHB Non-Financial Monitoring Framework and regularly feed into benchmarking and quality programmes to compare our performance with other providers. We support the national expectation that the public should be informed about health system performance by publishing our performance against the national health targets.

We report to our Board through our regular narrative reporting process on performance against this Annual Plan. These reports are provided and discussed in Board Meetings and are available to the public as part of the relevant Board agenda.

#### **5.1.4 National Health Sector Agencies**

We are expected to align our planning with the planning intentions key national agencies. Each of these national agencies has initiatives for the 2015/16 year, which will impact on our DHB. The national agencies are:

- National Health Information Technology Board
- Health Workforce New Zealand
- Health Promotion Agency
- Health Quality and Safety Commission
- National Health Committee

See section 2B.1.5.2 for activities we will undertake to support the work of these National Agencies. We also are required to work with the newly created NZ Health Partnership Ltd. We have identified these activities under section 2B.1.5.3.

#### **5.1.5 Risk Management**

Taranaki DHB manages risk using AS/NZS ISO 31000:2009, a nationally accepted standard. We utilise a top down, bottom up enterprise-wise risk management process that is co-ordinated through the Quality and Risk team. The Executive Team own the Emergent Risk Register which is updated and reported to the Board on a monthly basis. Risk information is utilised to inform and drive organisation wide and service improvement and auditing activities.

A subcommittee of the Board – The Audit, Finance and Compliance Committee review risks on a regular basis. Internal and external mechanisms are in place for evaluation of contracted providers; these are done on a planned and on an ad-hoc basis as required.

Sector Services also provide a range of routine and special audits on behalf of Taranaki DHB with respect to primary care services and Fee for Service Agreements (including pharmacy, dental, home-based support services and aged care).

All DHBs face pressure to meet additional expenditure which must be managed within allocated funding. There is pressure to devolve services to the primary area seen as a “lower cost platform” and to increased tertiary level interventions such as cardio-thoracic surgery and cardiology

procedures. This creates increasing challenges for the viability of secondary services, particularly for provincial DHBs.

In employment negotiations there will be a focus on increased workforce flexibility, increased productivity and wage increases that are affordable. The DHB will have to manage staff numbers to appropriate levels and may implement changes to service configuration. These efforts will have to be prioritised within the DHB's service priorities and demographics.

### 5.1.6 Performance and Management of Assets

**Local:** Taranaki DHB has a significant investment in fixed assets which are essential to enabling the DHB to deliver sustainable health services. The DHB is committed to the effective planning and management of its assets for efficient and effective use. The strategic planning for assets is undertaken through an asset management planning process which encapsulates future demand for assets flowing out of regional and local clinical services plans. The asset management process also covers the long term maintenance and refurbishment of assets.

The DHB ensures capital expenditure is prioritised and affordable through a rigorous approval process. Business cases are produced for new asset purchases and performance indicators such as return on investment analysed to ensure the asset contributes positively to the organisation.

**Regional:** In line with national expectations we will participate in the provision of a regional commentary to sit alongside the midland DHB region Asset Management Plans. The regional commentary will take into account the long term direction on service delivery settings and clinical and economic sustainability.

## 5.2 Building Capability

Taranaki DHB will continue to work towards supporting and building the capacity and capability of the wider health system. Many of the initiatives are being progressed through collaboration and co-operative developments between the DHB and its community including other agencies. We believe these other agencies and sectors can help address complex problems involving the social determinants of health, and improving the capability of family/whanau, through health literacy, to self-manage their health and well-being.

Taranaki DHB works through its established formal alliances, including the Midland Health Network Alliance, the Taranaki Alliance Leadership Team, and the Whakatuhonotanga Alliance for the Te Kawai Māro Results Based Accountability Agreement in addition to other work programmes.

The Whakatipuranga Rima Rau Trust (WRR) is an inter-agency trust established by Taranaki District Health Board, Ministry of Social Development, Te Puni Kokiri and Te Whare Punanga Korero. WRR was created to build an integrated approach focusing on the common objective of up-skilling and developing the Māori Health and Disability workforce in Taranaki. This is an innovative multi agency and multi funder model which introduces a range of initiatives to address Māori workforce development through collaboration.

Other examples of intersectoral collaboration include:

- Whānau Ora Integrated Contracts
- Long-term Community Council Plans
- Strengthening Families

- Accident Compensation Corporation and DHB relationship

### 5.2.1 HealthShare Limited

HealthShare (HSL), established in 2001, is a regional Shared Services Agency jointly owned by Waikato, Bay of Plenty, Lakes, Taranaki, and Tairāwhiti District Health Boards. HSL has continued to take on an expanded role as a regional provider of non-clinical service and now provides operational support in a number of areas identified as benefiting from a regional solution.

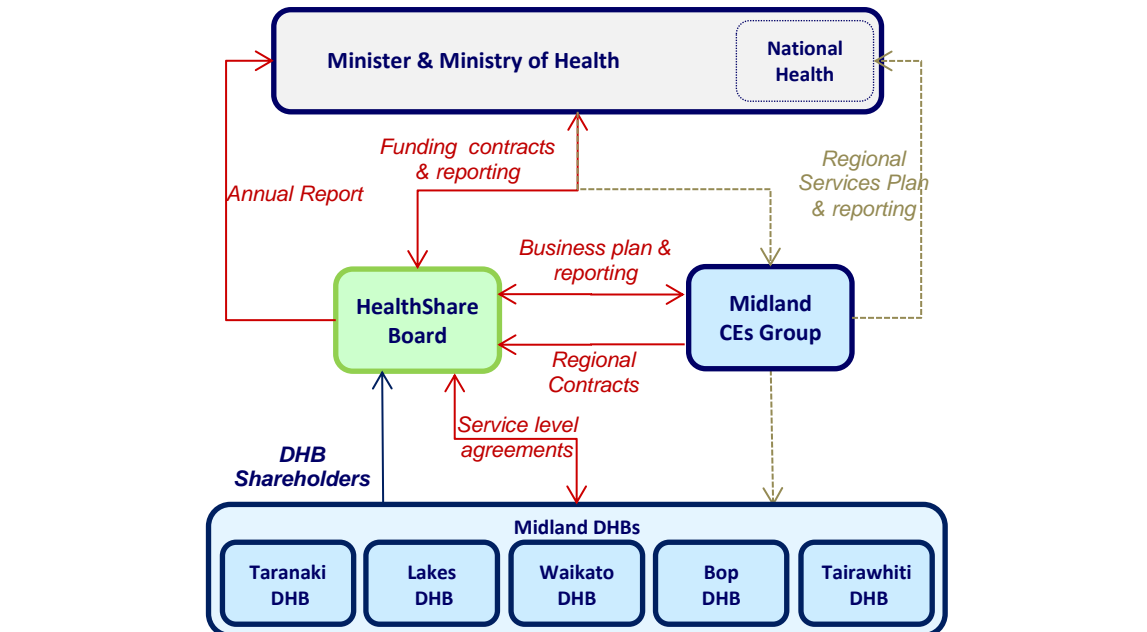
The Midland region DHBs determine the services that HSL will provide, and the level of these services, on an annual basis. These determinations are made through the Regional Services Plan (RSP) and regional business case processes.

Categories of possible regional service delivery include:

- Activities that support future regional direction and change through the development of regional plans
- Facilitating the development of clinical service initiatives undertaken by regional clinical networks and regional action groups that support clinical service change
- Key functions that support and enable change through the ongoing development of the region's workforce and information systems
- Back office service provision that can drive efficiencies at a regional level, alongside new national back office shared services.

The annually agreed regional services form the basis for HSL's Business Plan which specifies the company's performance framework; the services to be provided; and the associated performance measures. HealthShare's Business Plan also details, at a service level, the activities that have been purchased by the shareholding DHBs.

HSL has multiple planning and reporting relationships within the Midland region and to national agencies as depicted in the diagram:



## 5.2.2 Information Communications Technology

The Midland Regional IS service will implement the Midland Region Information Services Plan and advance the National Health IT Board priorities. Work in this area is done within the context of the affordability envelope of the Midland DHBs.

Taranaki DHB will use national ICT service delivery solutions where available via NZ Health Partnerships Ltd work streams and the Department of Internal Affairs' All of Government initiatives. This will occur as existing in-house solutions reach end of life. Expectations of delivery on national and regional priorities requires Taranaki DHB to migrate from an in-house model of ICT delivery to one of consuming a combination of nationally and regionally delivered ICT services supported by local capability. Taranaki DHB is committed to successfully making this transition and to actively participating in these national and regional initiatives.

Taranaki continues to be an active and committed participant in national initiatives. As part of its e-Prescribing and Administration rollout, plans are underway to migrate the existing three Wards using the MedChart solution from the MIMS drug database to NZULM. Once this task is completed, work is planned to further rollout e-PA to the two surgical Wards. The timing for the rollout to the surgical wards is likely to be early 2017.

The National Maternity Information System programme has recently re-engaged with Taranaki DHB after a pause to the national programme. Taranaki DHB is planning to commence its implementation of the National Maternity Information System some time in the second half of the 2016 calendar year. This system is a pre-requisite to support the successful rollout of the NCHIP programme for Taranaki, so is of significant importance to the DHB.

The major programme currently underway is Midland eSpace, which is the establishment and deployment of a Clinical Workstation and Clinical Data Repository across the five Midland DHBs. Over the life of the programme so far, Taranaki DHB has made a significant resource contribution to shape the requirements and design phases. As Taranaki DHB already has mature versions of the solutions running in-house that will be deployed within Midland, Taranaki DHB input will continue to be key as this solution is progressed.

Further information is available in the Midland DHBs Regional Services Plan for 2016/17.

### **5.2.3 Quality Assurance and Improvement**

Our expectation is that the Taranaki DHB health system functions as one system and that we support quality improvement across the hospital and community. More and more people across the whole system are learning about quality improvement, supported by the Service Improvement Programme Office, in collaboration with Governance and our Quality Team. We also have Clinical advisors and who work closely with the Aged Residential Care providers to improve Certification Audit results.

### **5.2.4 Capital and Infrastructure Development**

The DHB plans and implements capital upgrades and replacements in accordance with its current Asset Management Plan and its underlying Capital Intentions.

We are engaging with our local community services about future health service provision through more efficient use of existing facilities and infrastructure.

### **5.2.5 Cooperative Developments**

Taranaki DHB will work with the Midland region to have a consistent approach to certification audit corrective actions and shared improvement programmes to ensure compliance to the HDSS Act.

The Midland Region Integrated Quality and Risk system known as Datix will have a regional approach to bench marking and trending and the development of regional quality improvement projects.

A shared Midland E-learning platform has been developed with the Midland DHBs to provide consistency, efficiency gains and 24/7 access to online modules throughout the region. This is continually being developed and updated with new modules.

## **5.3 Workforce**

### **5.3.1 Managing Our Workforce within Fiscal Restraints**

To meet the Government Expectations for Pay and Employment Conditions in the State Sector, the Taranaki DHB has addressed the following:

- Recent settlements for both national and DHB-specific collective agreements have been successfully achieved within government parameters and the Taranaki DHB's budget plan with the aims of:
  - a. Delivering organisational and sector performance improvement
  - b. Fostering continuous improvement and productivity enhancement
- Identified business imperatives (such as improved performance and demonstrable recruitment and retention difficulties) have been considered to ensure:

- a. Specific attention to those areas where there are difficulties in recruitment and retention
  - b. An overall stable workforce with a relatively low turnover rate.
- Pay structures and other conditions for employees necessary to support the Taranaki DHB's business and workforce objectives continue to be the subject of ongoing review. These include:
  - a. Alignment of rates and conditions across occupational groups where this is appropriate
  - b. Application of merit pay steps to enable employee's contributions to be recognised consistently across the organisation.

Underpinning the Taranaki DHB approach to managing our workforce is the:

- Implementation of a strategic structural and operational change programme that seeks to develop organisational readiness for change. Fundamental to this programme is the concept that employees understand their role in the organisation and their contribution to the delivery of health services in Taranaki, and our people have the skills, knowledge, information and data to perform effectively in their roles.
- Engagement with employees to ensure the provision of high quality and effective services, organisational and continuous improvement, and productivity enhancements, and embed the concept of one team.
- Regional and national collaboration and connectedness to ensure we attract and retain people to Taranaki to meet needs in areas with demonstrable recruitment and retention difficulties.
- Fostering and valuing a culture of high performance to meet the key performance indicators of the organisation.

### 5.3.2 Strengthening Our Workforce

#### Context

Health Workforce New Zealand (HWNZ) was established to provide guidance and leadership in the health sector to the workforce challenges facing New Zealand in 2009. Their goal is to ensure that the workforce is appropriately trained and configured to meet current and future needs. To meet these needs HWNZ:

- Set up six taskforces with specific work programmes that focus on their designated professions – doctors, nurses, allied health, midwifery, non-regulated/kaiawhina and leadership and managerial roles.
- Strengthening the health workforce intelligence and data that ensures smart systems are used to create a one source of the truth for reporting and forecasting.

The Taranaki DHB will continue to use programmes promoted through HWNZ to meet needs in areas with demonstrable recruitment and retention difficulties:

- Voluntary Bonding Scheme
- Nurse Entry To Practice
- Midwifery First Year of Practice

The Regional Services Plan (RSP) embeds the collaboration between the Taranaki DHB, HWNZ and Regional Directors - Workforce (RDoW) to align the national workforce priorities. The collaboration with the RDoW in conjunction with HWNZ enables Taranaki DHB to achieve agreed regionally-based solutions for:

- Implementation of community based attachments for prevocational trainees
- Increased participation of Māori and Pacific in the health workforce

- Building on the 2016/17 RSP, demonstrating further progress on actions to meet milestones
- Development of vulnerable workforces
- Introduction of 'new models of care' planning and development
- Establishment of specialist roles, such as palliative care specialist's nurses and educators, nurse practitioners, clinical nurse specialists, nurses performing endoscopies, and medical physicists.

### *Leadership*

To enable a consistent approach to leadership, the national DHB General Managers Human Resources (GMsHR) group, DHB Shared Services and Health Workforce New Zealand developed a national leadership domains Framework, which was approved by DHB Chief Executives in October 2015. The Taranaki DHB will use the framework to help develop leadership capability and embed the domains in leadership development activity and information.

### *Workforce Intelligence and Data*

To enable a consistent approach to workforce planning, the national DHB General Managers Human Resources (GMHRs) Group and Health Workforce New Zealand have collaborated in the development of a Workforce Intelligence and Planning Framework. The framework aims to assist DHBs when undertaking workforce planning at the individual DHB, regional and national level for the immediate planning horizons – up to three years. The Taranaki DHB will use the framework to help with workforce planning.

Business intelligence, reporting, access to data and information, and integration of that data are a key enablers to support the ongoing financial and optimal performance of Taranaki DHB. There is a need for a strategic approach that consolidates resources and functions to cultivate a cohesive team that takes an organisational-wide view of priorities to support the achievement of goals and objectives.

### *Talent Management*

We will work on implementing a range of work streams that support talent management at Taranaki DHB to ensure that we have the right people in the right roles with the right skills at the right time. This work will focus on developing the key people management functions that support talent in the organisation, including performance management, recruitment and retention, succession planning, leadership development and employee engagement.

### *Action Plan*

Objective	Deliverables	Measure	Reporting
Ensure the Taranaki DHB has a safe and competent children's workforce	Obligations required of the Vulnerable Children's Act will be met	<ul style="list-style-type: none"> <li>• Checking of the existing children's workforce commences and is completed within legislative requirements</li> </ul>	Quarter 1
Align employees to organisational values and expectations that informs performance appraisals	Complete a organisational mapping and alignment pilot	<ul style="list-style-type: none"> <li>• Pilot commences</li> <li>• Pilot is evaluated</li> <li>• Learning is applied to the organisation</li> </ul>	Quarter 1 Quarter 2 Quarter 4
Increase the vocational capacity of New Zealand	Ability to attract and retain vocationally registered Emergency	<ul style="list-style-type: none"> <li>• Fully establish an accredited vocational training site at Base Hospital</li> </ul>	Quarter 1

Objective	Deliverables	Measure	Reporting
trained emergency medicine specialists	Medicine specialists		
Increase the vocational capacity for rural hospital medicine specialists	Attract and retain vocationally registered rural hospital medicine specialists for the Hawera Hospital	<ul style="list-style-type: none"> <li>Establish a post for an advanced trainee on the vocational training programme</li> </ul>	Quarter 2
Provide care closer to the patients home or primary care setting	Transferring paediatric care to primary care professionals	<ul style="list-style-type: none"> <li>Introduce new clinical nurse specialist role of Community / CACC / Respiratory</li> </ul>	Quarter 2
Establish on-going community based attachments	Negotiate and confirm community based attachments for PGY2s	<ul style="list-style-type: none"> <li>Availability of at least one community based attachment in the 2017-18</li> </ul>	Quarter 2
Implement a multi disciplinary team approach to manage the deteriorating patient	Promote the early warning score (EWS) system for use by clinical staff	<ul style="list-style-type: none"> <li>Creation of e-Learning module</li> <li>In service training of key nursing and medical groups is achieved</li> <li>The proportion of patients at risk of deterioration that have an EWS score</li> </ul>	Quarter 3
Develop the partnership with the University of Auckland Medical School to host 5th year medical students	Confirmation that a cohort of 5 <sup>th</sup> year medical students will be hosted by Taranaki DHB in 2018	<ul style="list-style-type: none"> <li>Agreement confirmed to host students</li> </ul>	Quarter 4
Achieve workforce equity for Māori	<p>All positions at Taranaki DHB will be assessed for their impact and influence on Māori health outcomes resulting in compulsory participation of Māori in the recruitment and selection process</p> <p>Increase the number of rangatahi Māori who enrol for tertiary studies from the WhyOra Programme</p>	<ul style="list-style-type: none"> <li>Māori participation in the hospital workforce increases to 13%</li> </ul>	Quarter 4

## 5.4 Organisational Health

We need to make sure that we have the people, relationships, and processes that will enable us to achieve our outcomes, impacts, and outputs. We cannot be successful without well-qualified and motivated staff, sound management of resources and an effective working relationship between staff and stakeholders.

### 5.4.1 Governance

We have an established governance structure based on the requirements of the NZPHD Act 2000, through which the DHB functions. Governance plays a key role in determining what we need to do to maximise the impact on our outcomes.

Our Board assumes the governance role and is responsible to the Minister of Health for the overall performance and management of the DHB. Its core responsibilities are to set the strategic direction for the DHB and to develop policy that is consistent with Government objectives and improves health outcomes for our population. The Board ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and our community. The normal composition of the board is 11 members, seven elected and four appointed by the Minister of Health.

Taranaki DHB has two statutory (mandatory) advisory committees; the Hospital Advisory committee (HAC) and the Community and Public Health Advisory Committee (CPHAC). These committees have been established to assist the Board to meet its responsibilities and membership of these committees is comprised of a mix of Board members and community representatives who meet regularly throughout the year. Membership includes both clinical and Māori members who contribute clinical and cultural experience and understanding to decision making.

The public is welcome to attend meetings of the Board and its statutory committees. However, for some items during a meeting the Board or committee may exclude the public. The Official Information Act states the grounds on which the public may be excluded. Such items are clearly noted on the agenda in question. Details of the meetings are publicly available on our website: [www.tdhb.org.nz](http://www.tdhb.org.nz)

While responsibility for our DHB's overall performance rests with the Board, operational and management matters have been delegated to the chief executive. This delegation is made on such terms and conditions as the Board thinks fit. The Chief Executive is supported by direct reports, who are:

- General Manager Finance and Corporate Services
- General Manager, Planning, Funding and Population Health
- Chief Operating Officer & Chief Nursing Advisor
- Quality and Risk Manager
- Chief Advisor Māori Health
- Chief Medical Advisor

### 5.4.2 Providing Health and Disability Services

As well as being responsible for planning and funding the health and disability services that will be delivered in the Taranaki region, we also provide a significant share of those services as the 'owner' of hospital and specialist services. These services are provided through our Provider Arm Division

from two key facilities being New Plymouth and Hawera Hospitals, supported by various clinics and facilities across the province.

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 specialised 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.

Taranaki DHB provides Hospital Services in New Plymouth and Hawera. New Plymouth Base Hospital is generally a Level 4 facility, providing a full range of services - medical, surgical, paediatrics, obstetrics, gynaecology and mental health. It is also a base for a range of associated clinical support services and allied health such as rehabilitation, speech therapy, physiotherapy, stroke and cardiac support, district nursing and drug and alcohol programmes.

Hawera Hospital is a Level 2 facility providing emergency, medical and obstetric services. Hawera Hospital delivers a range of associated outpatient, allied and community clinical support services such as rehabilitation, physiotherapy, stroke and cardiac support and district nursing.

Taranaki DHB has completed the first stage of facility redevelopment (Project Maunga) to better enable the DHB to provide health services to match population demand and expectations.

The primary focus of this project was 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 now provides a more user friendly hospital and wellness environment for patients, staff and public.

Taranaki DHB will ensure that both Hospitals provide the amount of elective operations, procedures and assessments agreed to with the Ministry of Health. 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.

### **5.4.3 Planning and Funding Health and Disability Services**

The Planning and Funding Division of our DHB is responsible for planning and funding health and disability services across our district. The core responsibilities are:

- Assessing our population's current and future health needs
- Determining the best mix and range of services to be purchased
- Building partnerships with service providers, Government agencies and other DHBs
- Engaging with our stakeholders and community through participatory consultation
- Leading the development of new service plans and strategies in health priority areas

- Prioritising and implementing national health and disability policies and strategies in relation to local need
- Undertaking and managing contractual agreements with service providers
- Monitoring, auditing and evaluating service delivery

The Planning and Funding Division contracts services from a wide range of non-government organisation (NGO) providers, as well as other DHBs who often provide more specialist services.

Planning and Funding is responsible for oversight of the total funding package for our DHB and linking on this with the Ministry of Health. Planning and Funding role incorporates ensuring equitable acceptable and effective spending of health funds and ensuring that all services funded are delivered in line with expectations. It acts for the DHB in local and national technical and strategic forums working on the development of funding and pricing as well as service and purchasing frameworks.

In order to live within the available funding whilst maintaining sustainable services it is essential to ensure that services are funded at appropriate levels and that value from health expenditure is maximised in terms of both health gain and the DHBs priorities. Additional focus in these areas will be required given the fiscal constraints and the need for DHBs to make decisions based on information and analysis.

Planning is an integral part of purchasing and providing healthcare services. Planning is undertaken in partnership with key stakeholders, including:

- Ministry of Health
- National Health Board
- Midland DHBs
- Other DHBs
- Clinical leaders
- Primary Health Organisations
- Our primary care alliance partners
- Iwi/Māori
- Non-Government Organisations
- Clinical advisory groups
- Expert advisory groups
- Community health forums

## 5.5 Reporting and Consultation

### 5.5.1 Consultation with the Minister and the Ministry of Health

When making decisions, we follow an appropriate planning and consultation processes to avoid adverse financial, resource and clinical impacts on the affected population(s) and avoid unnecessary service instability. A well-managed process provides the confidence that:

- A robust process is followed
- There are sufficient controls in place to avoid unnecessary service instability
- The change is clinically appropriate and public confidence is managed

There are a range of matters that we must consult / notify the Minister of Health, the National Health Board and Ministry of Health. These matters are:

- Proposed service changes
- Acquisition of shares or other interests
- Entry into joint ventures and/or collaborative or cooperative agreements/arrangements
- Capital expenditure if required by policy and/or legislation
- Otherwise as required by legislation, regulation or contract

### 5.5.2 External Reporting

The Ministry of Health monitors our performance on behalf of the Minister. The mechanisms currently in place to achieve this are outlined in the following table.

*Table: External Reporting Framework*

Reporting	Frequency
Information requests	Ad hoc
Financial reporting	Monthly
National data collections	Monthly
Risk reporting	Quarterly
Health target reporting	Quarterly
Crown funding agreement non-financial reporting	Quarterly
DHB Non-financial monitoring framework	Quarterly
Annual Report and audited accounts	Annual



## Module 6: Service Configuration



## MODULE 6: SERVICE CONFIGURATION

### 6.1 Service Coverage

Taranaki DHB acknowledges that it has responsibility to fund other services outside the district, and will do so accordingly. The impact of this responsibility in the 2016/17 funding environment will largely be limited to:

- Determining alternative levels of services purchased from those indicated by Ministry of Health forecasts where there have been indications that volumes need to be increased or decreased in line with need and prioritisation
- Funding any additional acute inpatient activity to meet demand
- Purchasing services from outside the region (IDF outflows) where the DHB is unable to provide services locally
- Purchasing services previously provided within the district from outside the district should local provision be disrupted - to enable continuance of service coverage until longer term solutions are put in place.

Services not directly funded or provided by us include, but are not limited to:

- Well Child Services through Plunket, health camps etc
- National Contracts (Organ transplants and new services purchased nationally)
- Emergency Ambulance Services
- Strengthening Families
- Family Start
- Primary Response in Medical Emergencies (PRIME)

We have little influence in these areas in respect of service coverage. We will, however, seek to engage with the relevant providers as appropriate. There are also services such as Public Health and Disability support services for people under 65 years of age which are directly purchased by the Ministry of Health where the DHB along with other providers may deliver the services. In these areas the DHB will seek to engage and work collaboratively however decisions in relation to services purchased lie with the Ministry of Health.

#### 6.1.1 Service Issues

Taranaki DHB is developing a strategic case for change from a health system perspective and following table identifies emerging service issues other than what is already covered this plan or described within the context of the Midland Regional Service Plan. Taranaki DHB wishes to signal its intention to review and/or evaluate these in the coming year.

It has yet to be determined that there is a proven need for all changes to take place. Should the DHB consider in due course that a change is warranted, a formal service change process as outlined under the Operating Policy Framework (OPF) will be followed to ensure service coverage and the Minister's and the Ministry's requirements are met.

**Table: Service Issues 2016/17**

Type of Change	Description of Change	Benefits of Change	Link to Lower Funding Path	Change Due to Local, Regional, or National Reasons
Midland Regional Services Plan	As part of the Regional Services planning process action groups or networks have been established for identified areas.	<ul style="list-style-type: none"> <li>Reduce duplication of effort enabling DHBs to collectively develop sustainable solutions.</li> <li>Develop integrated approach to recruitment and retention within the global marketplace.</li> <li>Standardised planning, evaluation and procurement of new technology solutions within a clinical environment.</li> </ul>	Yes	This work is consistent with the national expectation of an increased focus on regional approaches, and with the strong focus on regionalisation agreed across the Midland DHBs.
Taranaki Integrated Health System	<p>Ongoing the redesign of non-acute services. This will involve many stakeholders working together to redesign the Taranaki Integrated Health System.</p> <p>A key to this will be the collective effort of local providers and communities, together with lessons from elsewhere</p>	<ul style="list-style-type: none"> <li>Developing new ways and potentially new locations for services to be delivered within the resources available</li> </ul>	Yes in longer term	Local and National
Managing Acute Demand	New options for acute demand and urgent primary care	<ul style="list-style-type: none"> <li>Support achievement of ED Health Target</li> <li>Increase options available in primary care after hours</li> <li>Increased enrolment of patients with PHOs</li> </ul>	Yes in longer term	Local

Type of Change	Description of Change	Benefits of Change	Link to Lower Funding Path	Change Due to Local, Regional, or National Reasons
Child and Youth	Service Level Alliance Team established in 2015/16 outcomes and recommendations to be considered in 2016/17	<ul style="list-style-type: none"> <li>• Co-ordinated Services across whole systems</li> <li>• Care Closer to Home</li> <li>• Improved Performance</li> </ul>	Yes in longer term	Local
Mental Health	Service Level Alliance Team established in 2015/16 outcomes and recommendations to be considered in 2016/17	<ul style="list-style-type: none"> <li>• Co-ordinated Services across whole systems</li> <li>• Care Closer to Home</li> <li>• Improved Performance</li> </ul>	Within Ring-fence principles	Local
Community Pharmacy	Development of Pharmacy Service in the Community	<ul style="list-style-type: none"> <li>• Co-ordinated Services across whole systems</li> <li>• Care Closer to Home</li> <li>• Improved Performance</li> </ul>	Yes	Local as part of a National Process
Pathology and Laboratory Services	Exploring options for the future direction of Laboratory and Pathology Services	<ul style="list-style-type: none"> <li>• Co-ordinated Services across whole systems</li> <li>• Improved Performance</li> </ul>	Yes	Local

## 6.2 Service Change

Service coverage exceptions and service changes must be formally approved before they are included in Annual Plans. The DHB had not signaled any significant proposed service changes for the 2016/17 year prior to the deadline established by the Ministry of Health of February 2016.

## Module 7: Performance Measures



## MODULE 7: PERFORMANCE MEASURES

### 7.1 Monitoring Framework Performance Measures

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- Achieving Government's priority goals/objectives and targets or 'Policy priorities'
- Meeting service coverage requirements and Supporting sector inter-connectedness or 'System Integration'
- Providing quality services efficiently or 'Ownership'
- Purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

Each performance measure has a nomenclature to assist with classification as follows:

**Code          Dimension**

PP Policy Priorities

SI System Integration

OP Outputs

OS Ownership

DV Developmental – establishment of baseline (no target/performance expectation is set)

Performance Measure	2016/17 Performance Expectation/Target		
PP6: Improving the Health Status of People With Severe Mental Illness Through Improved Access	Age 0-19	3.78%	
	Age 20-64	5.32% Māori 4.02% Total	
	Age 65+	3.50%	
PP7: Improving Mental Health Services Using Transition (discharge) Planning	Long Term Clients	Provide a report as specified	
	Child and Youth with a Transition (discharge) Plan.	At least 95% of clients discharged will have a transition (discharge) plan.	
PP8: Shorter Waits for Non-Urgent Mental Health and Addiction Services for 0-19 Year Olds	Mental Health Provider Arm		
	Age	<= 3 weeks	<=8 weeks
	0-19	80%	95%
	Addictions (Provider Arm and NGO)		

Performance Measure	2016/17 Performance Expectation/Target		
	Age	<= 3 weeks	<=8 weeks
	0-19	80%	95%
PP10: Oral Health- Mean DMFT Score at Year 8	Ratio year 1		0.85
	Ratio year 2		0.83
PP11: Children Caries-Free at Five Years of Age	Ratio year 1		64%
	Ratio year 2		64%
PP12: Utilisation of DHB-funded Dental Services by Adolescents (School Year 9 up to and including age 17 years)	% year 1		85%
	% year 2		85%
PP13: Improving the Number of Children Enrolled in DHB Funded Dental Services	0-4 years - % year 1		95%
	0-4 years - % year 2		95%
	Children not examined 0-12 years % year 1		6%
	Children not examined 0-12 years % year 2		5%
PP20: Improved Management for Long Term Conditions (CVD, Acute Heart Health, Diabetes and Stroke)	Report on delivery of the actions and milestones identified in the Annual Plan.		
Focus Area 1: Long Term Conditions			
Focus Area 2: Diabetes Services	Reporting on implementation of actions in the Diabetes Plan "Living Well with Diabetes." Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator).	Improve or maintain	
Focus Area 3: Cardiovascular Health (CVD)	Indicator 1: 90% of the eligible population will have had their cardiovascular risk assessed in the last five years.	90%	

Performance Measure	2016/17 Performance Expectation/Target	
	Indicator 2: 90% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years.	90%
	Report on delivery of the actions and milestones identified in the Annual Plan.	
Focus Area 4: Acute Heart Service	70% of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') by ethnicity.	70%
	Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	>95%
	Over 95% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge.	>95%
	Report on deliverables for acute heart services identified in annual plan and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI.	
Focus Area 5: Stroke Services	6% of potentially eligible stroke patients thrombolysed.	6%
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	80%
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	80%
	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP21: Immunisation Coverage	Percentage of two year olds fully immunised.	95%
	Percentage of five year olds fully immunised.	95% by end 2016/17
	Percentage of eligible girls fully immunised - HPV vaccine.	70%
PP22: Improving System Integration and SLMs	Report on delivery of the actions and milestones identified in the Annual Plan.  In relation to SLMs measures – a jointly agreed (by district alliances) system level measure improvement plan, including improvement milestones, will be provided at the end of Quarter 1 2016/17.	
PP23: Improving Wrap	The percentage of older people receiving long-term	95%

Performance Measure	2016/17 Performance Expectation/Target	
Around Services – Health of Older People	home support who have a comprehensive clinical assessment and an individual care plan.	
	<p>Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI Long Term Care Facility (LTCF) assessment completed within 230 days of the previous assessment.</p> <p>The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first Long Term Care Facility (LTCF) assessment.</p>	<p>95%</p> <p>95%</p>
PP25: Prime Minister's Youth Mental Health Project	<p><i>Initiative 1: School Based Health Services (SBHS) in Decile One to Three Secondary Schools, Teen Parent Units and Alternative Education Facilities:</i></p> <ol style="list-style-type: none"> <li>1. Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided.</li> <li>2. Provide quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.</li> </ol> <p><i>Initiative 3: Youth Primary Mental Health</i></p> <ol style="list-style-type: none"> <li>1. Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: <ul style="list-style-type: none"> <li>• Early identification of mental health and/or addiction issues.</li> <li>• Better access to timely and appropriate treatment and follow up.</li> <li>• Equitable access for Māori, Pacific and low decile youth populations.</li> </ul> </li> <li>2. Provide quantitative reports using the template provided under PP26.</li> </ol> <p><i>Initiative 5: Improve the Responsiveness of Primary Care to Youth.</i></p> <ol style="list-style-type: none"> <li>1. Provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements.</li> <li>2. Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.</li> </ol>	

Performance Measure	2016/17 Performance Expectation/Target	
PP26: The Mental Health and Addiction Service Development Plan	Provide reports as specified for each focus area: <ul style="list-style-type: none"> <li>• Primary Mental Health</li> <li>• District Suicide Prevention and Postvention</li> <li>• Improving Crisis Response Services</li> <li>• Improve Outcomes for Children</li> <li>• Improving Employment and Physical Health Needs of People with Low Prevalence Conditions</li> </ul>	
PP27: Supporting Vulnerable Children	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing Rheumatic Fever	Report on progress in following up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever.	
	Hospitalisation rate (per 100,000 DHB total population) for Acute Rheumatic Fever.	0.3 per 100,000
	Reports on progress in following up known risk factors and system failure points in cases of recurrent Rheumatic Fever.	
PP29: Improving Waiting Times for Diagnostic Services	1. Coronary Angiography – 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	95%
	2. CT and MRI – 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days).	CT: 95% MRI: 85%
	3. Diagnostic Colonoscopy <ul style="list-style-type: none"> <li>a. 85% of people accepted for an urgent Diagnostic Colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.</li> <li>b. 70% of people accepted for a non urgent Diagnostic Colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.</li> </ul>	85% within 14 days 70% within 42 days
	Surveillance Colonoscopy <ul style="list-style-type: none"> <li>c. 70% of people waiting for a Surveillance Colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.</li> </ul>	70% within 84 days
PP30: Faster Cancer Treatment	Part A: Faster Cancer Treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management)

Performance Measure	2016/17 Performance Expectation/Target	
		within 31 days from date of decision-to-treat.
	Part B: Shorter Waits for Cancer Treatment - Radiotherapy and Chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat.
PP31: Better Help for Smokers to Quit in Public Hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	95%
SI1: Ambulatory Sensitive (avoidable) Hospital Admissions	Age group 0 – 4 years	A jointly agreed (by district alliances) system level measure improvement plan, including improvement milestone, will be provided at the end of Quarter 1 2016/17 via measure PP22.
	Age group 45-64 years	<4,201 (Total)
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring Delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	
SI4: Standardised Intervention Rates (SIRs)	Major Joint Replacement	An intervention rate of 21.0 per 10,000 of population
	Cataract Procedures	An intervention rate of 27.0 per 10,000

Performance Measure	2016/17 Performance Expectation/Target	
	Cardiac Surgery	A target intervention rate of 6.5 per 10,000 of population  DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate.
	Percutaneous Revascularization	A target rate of at least 12.5 per 10,000 of population
	Coronary Angiography Services	A target rate of at least 34.7 per 10,000 of population
SI5: Delivery of Whānau Ora	Performance expectations are met across all the measures associated with the five priority areas: <ul style="list-style-type: none"> <li>• Mental Health</li> <li>• Asthma</li> <li>• Oral health</li> <li>• Obesity</li> <li>• Tobacco</li> </ul> and narrative reports cover all areas indicated.	
SI7: SLM total acute hospital bed days per capita	A jointly agreed (by district alliances) system level measure improvement plan, including improvement milestone, will be provided at the end of Quarter 1 2016/17 via measure PP22.	
SI8: SLM patient experience of care	Hospital	Provide a report each quarter as specified in the measure definition.  A jointly agreed (by district alliances) system level measure improvement plan, including improvement milestone, will be provided at the end of Quarter 1 2016/17 via measure PP22.
	Primary Care	A jointly agreed (by district alliances) system level measure improvement plan, including improvement

Performance Measure	2016/17 Performance Expectation/Target	
		milestone, will be provided at the end of Quarter 1 2016/17 via measure PP22.
SI9: SLM amenable mortality	A jointly agreed (by district alliances) system level measure improvement plan, including improvement milestone, will be provided at the end of Quarter 1 2016/17 via measure PP22.	
OS3: Inpatient Length of Stay	Elective LOS	1.52 days
	Acute LOS	2.35 days
OS8: Reducing Acute Readmissions to Hospital	tba - indicator definition under review	
OS10: Improving the Quality of Identity Data Within the National Health Index (NHI) and Data Submitted to National Collections  Focus Area 1: Improving the Quality of Identity Data	New NHI registration in error	≤3%
	A. Greater than 2% and less than or equal to 4%	
	B. Greater than 1% and less than or equal to 3%	
	C. Greater than 1.5% and less than or equal to 6%	
	Recording of non-specific ethnicity.	≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value.	≤2%
Focus Area 2: Improving the Quality of Data Submitted to National Collections	Validated addresses unknown.	>76%
	Invalid NHI data updates. (no confirmed target)	tbc
	NBRS links to NN PAC and NMDS	≥97%
	National collections file load success	≥98%
OP1: Mental Health Output Delivery Against Plan	Assessment of data reported NMDS	≥75%
	NN PAC timeliness	≥95%
OP1: Mental Health Output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction Services is within: a) 5% variance (+/-) of planned volumes for services measured by FTE, b) 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	
Developmental measure DV6: SLM youth access to and utilisation of youth appropriate health services.	No performance target/expectation set	

Performance Measure	2016/17 Performance Expectation/Target
Developmental measure DV7: SLM number of babies who live in a smoke free house hold at 6 weeks post natal.	No performance target/expectation set

## Module 8: **Appendices**



## MODULE 8: APPENDICES

### 8.1 Glossary Of Terms

TERM	MEANING
<b>Activity</b>	What an agency does to convert inputs to Outputs.
<b>Capability</b>	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.
<b>Cost Containment</b>	Reducing costs or cost growth in general, whether through improved efficiency, or other means such as contract negotiation/consolidation, changes to budget management, changes in structure etc.
<b>Crown Agent</b>	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)
<b>Crown Entity</b>	A generic term for a diverse range of entities within one of the five 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 arm's length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
<b>Crown Entity Subsidiary</b>	A crown company is a company that is incorporated under the <u>Companies Act 1993</u> that are controlled by Crown entities and that are: (a) a subsidiary of another Crown entity under <u>sections 5 to 8</u> of the Companies Act 1993; or (b) a multi-parent subsidiary of 2 or more Crown entities <u>New CE Act 2013 s7 1(c)</u> .
<b>Efficiency</b>	Reducing the cost of inputs relative to the value of outputs.
<b>Effectiveness</b>	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.
<b>Impact</b>	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).
<b>Impact Measures</b>	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.
<b>Input</b>	The resources such as labour, materials, money, people, information technology used by departments to produce outputs, that will achieve the Government's stated outcomes.
<b>Intervention</b>	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
<b>Intervention Logic Model</b>	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: <a href="http://www.ssc.govt.nz">www.ssc.govt.nz</a> ).
<b>Intermediate Outcome</b>	See Outcomes.
<b>Living Within Means</b>	Providing the expected level of outputs within a break even budget or NHB agreed deficit step toward break even by a specific time.
<b>Management Systems</b>	Are the supporting systems and policies used by the DHB in conducting its business.
<b>Measure</b>	A measure identifies the focus for measurement: it specifies what is to be measured.
<b>Multi-Parent Subsidiary</b>	A company (incorporated under the Act) is a multi-parent if, under <u>sections 5 to 8</u> of the <u>Companies Act 1993</u> , — <ul style="list-style-type: none"> <li>• (a) the company is not a subsidiary of any one Crown entity; but</li> <li>(b) if 2 or more Crown entities were treated as 1 entity (a <b>combined entity</b>), with their rights, entitlements, and interests in relation to the company taken together, the company would be a subsidiary of the combined entity (<u>New CE Act s7(1 – 2)</u>).</li> </ul>
<b>Objectives</b>	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 Governance...etc are ‘internal to the organisation and enable the achievement of ‘outputs’.
<b>Outcome</b>	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).
<b>Output Agreement</b>	Output agreement/output plan - See Purchase Agreement An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs. Responsible Minister may set standards, terms, and conditions in respect of certain classes of outputs.
<b>Output Classes</b>	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).
<b>Outputs</b>	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).

<b>Ownership</b>	<p>The Crown's core interests as 'owner' can be thought of as:</p> <p>Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown;</p> <p>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;</p> <p>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.</p>
<b>Performance Measures</b>	<p>Selected measures must align with the DHBs Regional Service Plan and Annual Plan. 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 (2014/15) and show intended results for the three subsequent financial years.</p>
<b>Priorities</b>	<p>Statements of medium term policy priorities.</p>
<b>Productivity</b>	<p>Increasing outputs relative to inputs (i.e.: either more outputs produced with the same inputs, or the same output produced using fewer inputs).</p>
<b>Purchase Agreement</b>	<p>A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs.</p>
<b>Regional Collaboration</b>	<p>Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist:</p> <p>Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB</p> <p>Midland: Bay of Plenty DHB, Lakes DHB, Tairāwhiti DHB, Taranaki DHB and Waikato DHB</p> <p>Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB</p> <p>Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB</p> <p>Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network contains eight DHBs, Taranaki DHB and Tairāwhiti DHB in addition to the Central Region DHBs.</p>
<b>Results</b>	<p>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.</p>
<b>Standards of Service Measures</b>	<p>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.</p>
<b>Statement of Performance Expectations (SPE)</b>	<p>Government departments and Crown entities are required to include audited statements of objectives and statements of performance expectations with their financial statements. These statements report whether the organisation has met its service objectives for the year.</p>

<b>Statement of Service Performance (SSP)</b>	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.
<b>Strategy</b>	See Ownership.
<b>Sub Regional Collaboration</b>	Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalised with an agreement e.g. Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (central Alliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.
<b>Targets</b>	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.
<b>Values</b>	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.
<b>Value for Money</b>	The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

## 8.2 Output Class Definitions

Output Class		Category of Output Class	
1	<p><b>Prevention</b></p> <p>Preventative services are publicly funded services that protect and promote health the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. Preventative services address individual behaviours by targeting population-wide physical and social environments to influence health and wellbeing.</p> <p>Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. High need and at risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services represent our best opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.</p>	1	<p><b>Health Promotion and Education</b></p> <p><i>These services inform people about risks, encourage them to self-manage, become healthier and, as a result, live longer. Success is measured by a continuum from awareness and engagement, reinforcing the message by specific programmes and support, through to seeing behaviours changing for the better.</i></p>
		2	<p><b>Statutory Regulation</b></p> <p><i>These services sustainably manage environments to support people and communities to make healthier choices and maintain health and safety. They include: compliance monitoring with liquor licensing and smoke free environment legislation, assurance of safe drinking water, proper management of hazardous substances and effective quarantine and bio-security procedures. Success is measured by compliance with legislation.</i></p>
		3	<p><b>Population Based Screening</b></p> <p><i>These services are mostly funded and provided through the National Screening Unit and help to identify either (a) people at risk of illness; or (b) conditions at an earlier stage. They include breast and cervical cancer screening and antenatal HIV screening. Success is measured by high coverage rates.</i></p>
		4	<p><b>Immunisation</b></p> <p><i>These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the rate of immunisations across all age groups, both routinely and in response to specific risk. Success is measured by a high coverage rate.</i></p>
		5	<p><b>Well Child Services</b></p> <p><i>These services are aimed at our most vulnerable group – our children. Services and programmes targeted towards our children today will significantly impact upon our adult population of tomorrow. Success is measured by (a) a comprehensive range of services, including immunisation, assessment of children before they start school and (b) services provided to a broad range of children, including a focus on Māori and those children of high deprivation, to reduce health disparities.</i></p>

Output Class		Category of Output Class	
2	<b>Early Detection and Management</b> Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings, including general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule), child and adolescent oral health and dental services.  These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.	6	<b>Primary Healthcare and GP Services</b> <i>These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at delivering Better, Sooner and More Convenient services and improving, maintaining or restoring our population's health. Success is measured by high levels of enrolment with our PHOs (Primary Health Organisations) as it indicates engagement, accessibility and responsiveness of primary healthcare services.</i>
		7	<b>Oral Health Services</b> <i>These services are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. While high levels of enrolment, timely access and treatment are important, ultimately success is measured by results – children who are caries-free, and reducing the number of decayed, missing or filled teeth.</i>
		8	<b>Primary Community Care Programmes</b> <i>These services are offered in local community settings by teams of healthcare professionals (other than general practitioners (GPs), registered nurses, nurse practitioners) aimed at delivering Better, Sooner and More Convenient services and improving, maintaining or restoring our population's health. Success is measured by rates of participation.</i>
		9	<b>Pharmacy Services</b> <i>These services include the provision and dispensing of medicines and are demand-driven, i.e. by patients and prescribers (nurse specialists, GPs and specialists). As long term conditions become more prevalent, we are likely to see an increased dispensing of medicines. Success is measured by (a) medication management for people on multiple medications to reduce potential negative interactive effects and (b) maintaining or reduction the level of prescribed medicines.</i>

Output Class		Category of Output Class	
		<b>10</b>	<b>Community Referred Testing and Diagnosis</b> <i>These are services to which a health professional may refer a patient to help diagnose a health condition, or as part of treatment. They are provided by health personnel such as laboratory technicians, medical radiation technologists and nurses. Success is measured by timely access to diagnostics to improve clinical referral processes and decision-making.</i>
		<b>11</b>	<b>Mental Health Services</b> <i>These services are provided to people who are affected by mental illness or addictions. They include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed. Success is measured by timely access to services, particularly for our children and youth, so that we can eliminate, or reduce the severity of, mental health conditions and addictions.</i>
<b>3</b>	<b>Intensive Assessment and Treatment</b> Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex, more costly and provided by health care professionals that work closely together.  They include: <ul style="list-style-type: none"> <li>▪ Ambulatory services (including</li> </ul>	<b>12</b>	<b>Specialist Mental Health Services</b> <i>These services are provided to people who are most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed. Success is measured by (a) timely access to services, particularly for our children and youth, so that we can eliminate, or reduce the severity of, mental health conditions and addictions; and (b) a reduction in relapses.</i>
		<b>13</b>	<b>Elective (inpatient/outpatient) Services</b> <i>These are assessment and treatment services that are provided to people who do not need immediate hospital treatment and who require booked or arranged services. This includes elective surgery, but also non surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or pre-admission assessments). Success is measured by (a) timely services; (b) services that are provided in an effective and efficient way and (c) that we make the best use of our resources.<sup>1</sup></i>

<sup>1</sup> While the OAG has indicated a preference for patient satisfaction survey results to be included as a qualitative measure, the Midland DHBs have elected not to include them because there are some questions regarding the reliability

Output Class	Category of Output Class
<ul style="list-style-type: none"> <li>outpatient, district nursing and day services across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services</li> <li>Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services</li> <li>Emergency Department services including triage, diagnostic, therapeutic and disposition services</li> </ul> <p>On a continuum of care these services are at the complex end of treatment services and focused on individuals, rather than groups.</p>	<p><b>14 Acute (Emergency Department/Inpatient/Outpatient) Services</b></p> <p><i>These are services that have an abrupt onset, are often short in duration and rapidly progressive, for which the need for care is urgent. They may lead to a hospital admission. Hospital-based services include Emergency Departments (ED), short-stay acute assessments and intensive care services. Success is measured by (a) timeliness (waiting times), (b) productivity (length of stay), (c) outcome measures such as readmission rates, to indicate quality of service provision, and (d) managing demand by either maintaining or reducing the number of ED presentations, which is indicative of a strong primary/secondary integration.</i></p>
	<p><b>15 Maternity Services</b></p> <p><i>These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in the home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include specialist obstetric, lactation, anaesthetic, paediatric and radiology services. Success is measured by (a) ensuring that our proportion of caesarian deliveries<sup>1</sup> is consistent with the national average; and (b) that we maintain our post natal length of stay (days).</i></p>
	<p><b>16 Assessment Treatment and Rehabilitation</b></p> <p><i>These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to GPs, home and community care providers, aged residential care (ARC) facilities and voluntary groups. Success is measured by an increase in the rate of people discharged home with support, rather than to ARC or hospital environments (where appropriate).</i></p>

<sup>1</sup> While some caesarians are necessary on either an arranged or acute basis, overall we want to see as many babies delivered with no surgical intervention as possible, particularly as surgery introduces an element of risk to either the mother or her baby.

Output Class		Category of Output Class	
<b>4</b>	<b>Rehabilitation and Support</b>  Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services including palliative care services, home-based support services and residential care services.  On a continuum of care these services provide support for individuals following a health-related event.	<b>17</b>	<b>Needs Assessment and Service Coordination</b>  <i>These are services that determine a person's eligibility and need for publicly-funded support services and then assist the person to determine the best mix of support services, based on their strengths, resources and goals. The support is delivered by an integrated team in the person's own home or community. Success is measured by (a) increasing the number of assessments completed using a clinically accepted assessment tool, (b) providing timely assessments and (c) increasing the number of assessments provided to those who are most likely to require an assessment (i.e. people 65+ and people who have entered ARC).</i>
		<b>18</b>	<b>Palliative Care Services</b>  <i>These are services that improve the quality of life of patients and their families facing the problems associated with life-threatening or long term conditions, through the relief of suffering by early intervention, assessment, treatment of pain and other supports. Success is measured by providing timely and appropriate palliative care that is patient-driven, and avoids unnecessary and/or painful treatment which does not positively impact on either the patient's quality or length of life.</i>
		<b>19</b>	<b>Rehabilitation Services</b>  <i>These are services that restore or maximise people's health or functional ability, following a health-related event. They include mental health community support, physical or occupational therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral of the right people to the right service.</i>
		<b>20</b>	<b>Aged Related Residential Care (ARC) Services</b>  <i>These services are provided to meet the needs of a person who has been assessed as requiring long term residential care in a hospital or rest home indefinitely. Success is measured, particularly with our ageing population and a decrease in the number of subsidised bed days, by (a) more people being successfully supported to continue living in their own homes, (b) balancing our level of home-based support (see below) and (c) the quality of ARC.</i>

Output Class		Category of Output Class	
		<b>21</b>	<b>Home Based Support Services</b> <i>These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. Success is measured by (a) an increase in the number of people being supported as indicative of an increased capacity in the system (b) a decreased or delayed entry into ARC or hospital services.</i>
		<b>22</b>	<b>Life Long Disability</b> <i>These are services designed to support people who have a lifelong disability to continue living in their own homes and to retain as much independence as possible. Success is measured by an increase in the number of people being supported as indicative of an increased capacity in the system.</i>
		<b>23</b>	<b>Respite Care and Day Care Services</b> <i>These services provide people who suffer from dementia or a long term condition with a break, so that a crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term in nature. They may also include support and respite for families, caregivers and others affected. Success is measured by an increase in the level of services provided over time, so that more people are supported and able to remain in their own homes.</i>

### 8.3 Output Class Revenue and Expenditure

The following table outlines the funding and expenditure associated with the allocation of the output classes described above (utilising the Funder's planned NGO expenditure and the Provider Arm's planned production):

**Table: Output Class Revenue and Expenditure**

Output Class	Planned Revenue (\$000s)*	Planned Expenditure (\$000s)*
Prevention	7,715	7,757
Early Detection and Management	87,629	88,109
Intensive Assessment and Treatment Services	217,039	218,228
Rehabilitation and Support	52,651	52,940
<b>TOTAL</b>	<b>365,034</b>	<b>367,034</b>

## 8.4 Output Measure Rationale

Measure	Rationale	Output Class/Category	Dimension of Performance
Percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt	Prevention Services/Health Promotion and Education	Quantity
Percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking	Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt	Prevention Services/Health Promotion and Education	Quantity
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit	Pregnancy is a period during which women are motivated to quit smoking, and evidence-based tobacco cessation programmes can significantly increase the likelihood of this. Reducing smoking in pregnancy would be well supported by New Zealanders, is easy to understand and leads to significant positive outcomes across the whole of life span	Prevention Services/Health Promotion and Education	Quantity
Percentage of eight month olds fully immunised	Immunisation can protect against harmful infections, which can cause serious complications, including death. It is one of the most effective, and cost-effective medical interventions to prevent disease	Prevention Services/ Immunisation	Quantity
Percentage of population over 65 years who are immunised against influenza		Prevention Services/ Immunisation/Well Child	Quantity/ Timeliness
		Prevention Services/ Immunisation/Well Child	Quantity/ Timeliness
Percentage of infants fully and exclusively breastfeed at six months	Breastfeeding is the unequalled way of providing ideal food for the healthy growth and development of infants and toddlers. This measure supports the sector to get ahead of the chronic disease burden. (Includes partial breastfeeding at six months.)	Prevention Services / Health Promotion and Education	Quantity/ Timeliness
The number of referrals to the GRx (Green Prescription) programmes	A Green Prescription (GRx) is a health professional’s written advice to a patient to be physically active, as part of the patient’s health management. Research published in the New Zealand Medical Journal indicates that a Green Prescription is an inexpensive way of increasing activity.	Prevention Services / Health Promotion and Education	Quantity
Reduce the teen birth rate	Having babies at a very young age can increase maternal risk factors such as high blood pressure and preeclampsia. There is also the increased likelihood of those without parental/guardian support receiving less pre-natal support.	Prevention Services/Health Promotion and Education	Quantity
Reduce the rate of teenage terminations of pregnancy	Teenage pregnancy is associated with difficulties in psychological, sexual and overall health. We also want to measure both teen pregnancy and termination rates to ensure that one does not increase while the other decreases.	Prevention Services/Health Promotion and Education	Quantity
Percentage of children under five years of age (i.e. aged 0 – 4 years of age inclusive) who	Research shows that improving oral health in childhood and adolescence has benefits over a lifetime.	Early Detection and Management Services/Oral Health	Quantity

Measure	Rationale	Output Class/Category	Dimension of Performance
are enrolled with DHB-funded oral health services			
Percentage of pre-school and primary school children (0 – 12 years) who are overdue for their planned recall period			Quantity
Percentage of adolescents accessing DHB funded oral health services			Quantity
Percentage of population enrolled with a primary health organisation	Access to primary care has been shown to have positive benefits in maintaining good health. It can reduce the economic cost of ill health by intervening early.	Early Detection and Management Services/ Primary Healthcare	Quantity
Percentage of people who are enrolled with a primary health organisation and have had their cardiovascular risk assessed in the last five years	By increasing the percentage of people being checked for long-term conditions ensures these are identified early and managed appropriately, and aid in the promotion and protection of good health and independence.	Early Detection and Management Services/ Primary Healthcare	Quantity
Maintain or improve appropriate management of microalbuminuria or overt nephropathy in patients with diabetes			
Percentage of eligible women (20-69) have a cervical cancer screen every 3 years	Cervical cancer is one of the most preventable of all cancers. Having regular cervical smears can reduce a woman's risk of developing cervical cancer by 90%.	Prevention Services/ Population Based Screening	Quantity
Percentage of eligible women (50-69) have a breast screen in the last 3 years	Breast screening is a proven way for finding breast cancers early to reduce the risk of dying of breast cancer	Prevention Services/ Population Based Screening	Quantity
Increase the number of packages of care available to youth under the Primary Mental Health Initiative	Primary mental health initiative is funded to increase the availability of services in Primary Health Organisations for patients with mild to moderate mental health issues. In line with our Taiohi Health Strategy and the Prime Minister's Youth Mental Health project we are expecting the actions in our Annual Plan will result in an increase in youth accessing these services.	Early Detection and Management Services/ Primary Mental Health and Addictions	Quantity
Percentage of Rest Home residents receiving vitamin D supplement from their GP	Vitamin D supplementation has been demonstrated to improve mineral bone density and reduce falls.	Prevention Services/Health Promotion and Education	Quantity
Percentage of all Emergency Department presentations who are triaged at levels 4&5	Emergency department services utilise a scale of one to five triage, with one being the most urgent. Triage category four and five may more appropriately be seen in primary care.	Intensive Assessment and Treatment Services/Acute Services	Quantity
Percentage of eligible children have their B4 School Checks completed	A nationwide programme offering a health and development check for four year olds	Prevention Services/ Well Child	Quantity
Hospitalisation rates per 100,000 for acute Rheumatic Fever	Rheumatic Fever arises as a result of a throat infection with Group A Streptococcal bacteria. It predominantly affects children between 5 and 14 years of age. In New Zealand, evidence points to poorer housing conditions (especially	Prevention Services/ Well Child	Quantity

Measure	Rationale	Output Class/Category	Dimension of Performance
	overcrowding) and general social deprivation as risk factors for Rheumatic Fever.		
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months	More consistent and comprehensive assessment of the older person which enables determination of service capacity and service planning information	Rehabilitation and Support Services/Needs Assessment and Service Coordination	Quantity
For those with aged related and chronic health conditions we aim to reduce the rate of rest home level of residential care to home based support and respite funding	By focusing the models of care in community services such as home based support and respite services to have a more restorative approach we expect that the proportion of funding required to allocate to rest home residential care to comparatively reduce.	Rehabilitation and Support Services / Age Related Residential Care Services	Quantity
Increased number of clients accessing respite services	In line with community services for older people having a more restorative approach and a focus on meeting the needs of informal carers we expect the number of clients accessing respite services will increase.	Rehabilitation and Support Services	Quantity
Percentage of patients aged 75 and over (Māori and Pacific Islanders 55 and over) that are given a falls risk assessment	Falls in the elderly contribute to a reduction in the quality of life including loss of independence, early entry into Rest Home residence and premature death. To ensure that the risk of inpatient falls in the elderly is minimised we aim to provide a risk assessment to all eligible patients.	Intensive treatment and assessment.	Quality
Acute re-admission rate	<p>Unplanned readmissions will usually present to emergency departments, and may result in admission to hospital for further treatment. This puts pressure on emergency departments and inpatient hospital capacity, efficiency and productivity.</p> <p>An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services.</p>	Intensive Assessment and Treatment Services/Acute Services	Quality
Average length of inpatient stay	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, we will positively impact hospital productivity through freeing up beds and other resources so it can provide more elective surgery, reduce waiting times in the emergency department or make savings. Supporting patients to return home sooner may, in part, be achieved by reducing the rate of patient complications and better use of the time clinical staff spend with patients. Patients will also be less at risk of contracting nosocomial infections.	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quality

Measure	Rationale	Output Class/Category	Dimension of Performance
Percentage of patients who require radiation or chemotherapy are treated with 4 weeks	Specialist cancer treatment and symptom control is essential in reducing the impact of cancer	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quantity
Percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016	Implementation of Faster cancer treatment supports the overarching goal of Better, Sooner, More Convenient Health Services for New Zealanders. The key strategic planning considerations of integration, regionalisation and value for money are all supported by implementation of these indicators.	Intensive Assessment and Treatment Services/Elective Services	Quantity
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total deliveries	The longer-term aim is to reduce the risks associated with an unnecessary Caesarean section, reduce the number of women at risk of a subsequent Caesarean section and reduce the number of women who experience difficulties with their second and subsequent births as a consequence of a primary Caesarean section.	Intensive Assessment and Treatment Services/Elective Services	Quantity
Percentage of operations where venous thromboembolism (blood clot) was considered as part of the surgical checklist	Venous thromboembolism can cause long term debilitating damage so the assessment and appropriate preventative actions to all surgical patients will increase not only the overall quality of life but also reduce the toll of long term ill health or even death.	Intensive Assessment and Treatment Services Acute/ Elective Services	Quality
Percentage of patients waiting longer than four months for their first specialist assessment	Patients have a much better chance of recovering and getting on with their lives where they are diagnosed and treated and returned home in a timely way.	Intensive Assessment and Treatment Services/Elective Services	Quantity/ Timeliness
Number of surgical discharges under the elective initiative	Elective surgery reduces pain or discomfort, and improves independence and wellbeing. Increasing delivery should will improve access and reduce waiting times.	Intensive Assessment and Treatment Services/Elective Services	Quantity
Percentage of people who did not attend (DNA) their scheduled appointment for an outpatient service	Reducing did not attends is a key objective in terms of removing waste in the system	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quantity
Percentage of people referred for non-urgent mental health services are seen within three weeks	Access and shorter waits are very important to patients. Earlier treatment in the progression of illness links to better outcomes as evidenced in international literature. Timeliness is also a key quality indicator in calls for improvement to the health care system.	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Timeliness/ Quality
Improving the percentage of long-term clients with up to date relapse prevention/treatment plans	When long term clients with serious mental illness have agreed relapse prevention plans that enable them to better co-produce their mental health and well-being outcomes	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Quantity
Average length of stay in an adult mental health and addiction inpatient unit	Mental health and addiction services seek to support service users in the least restrictive environment. Performance on this indicator provides some information about the extent to which this is being achieved.  Length of stay is the main driver of variation in inpatient episode cost and reflects differences	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Quantity

Measure	Rationale	Output Class/Category	Dimension of Performance
	<p>between mental health service organisations resources, service practices and service user case-mix.</p> <p>This indicator, alongside others promotes a more complete understanding off an organisation's overall model of service delivery.</p>		
Rates of post-discharge community care	A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. Service users leaving hospital after an admission with a formal discharge plan involving linkages with community services and supports are less likely to need early readmission. Research indicates that service users have increased vulnerability immediately following discharge, including higher risk for suicide.	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Quality
A reduction in the percentage of palliative care clients who have had an Emergency Department presentation	The Taranaki Palliative Care Strategy highlighted the need for an increase in the generalist workforce who are trained and supported by our Specialist Palliative Care Provider to provide quality palliative care underpinned by Advanced Care Planning. We expect that delivery of enhanced palliative care pathways, particularly in aged residential care, will lead to a reduction in the percentage of palliative care patients who present to our Emergency Departments.	Intensive Assessment and Treatment Services	
Improved wait times for diagnostic services – accepted referrals for CT and MRI receive their scan within 6 weeks (Developmental Measure 2)	Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management.	Intensive Assessment and Treatment Services/Elective Services	Quantity/ Timeliness
Non urgent community laboratory tests are completed and communicated to practitioners within the relevant category time-frames			
Number of community pharmacy prescriptions	The new Community Pharmacy contract will encourage greater efficiency and a more patient focused service. We expect volume of prescriptions to decrease overall	Early detection and management/Pharmacy Services	Quantity

