



TARANAKI DISTRICT HEALTH BOARD

TARANAKI DISTRICT HEALTH BOARD

ANNUAL PLAN

2017/18

Incorporating the 2017/18 Statement of Performance Expectations



Taranaki Together, a Healthy Community
Taranaki Whanui He Rohe Oranga

Mihi

*E anga ake ana te titiro ki te tihi o Taranaki.
Koia hoki he tongi e tataki mai i te tangata i tua o kō atu.
Koia tēnei he reo maioha noa e tataki mai i a koutou ki tata o kō mai.
Nau mai e rarau ki tēnei kainga, ki tēnei rouna mahara ki te hunga ora,
e noho nei hei marae whakatakoto kōrero mā tātou.
Tēnā whakatau mai ki Taranaki nei, ki tēnei ahu hauora.
Taranaki whanui, he rohe oranga.*

*Turning your gaze upon the peak of Taranaki.
Standing prominent a reference point for people travelling from beyond our region.
This acknowledgement also stands prominent as a reference point for you all who have come close.
Come forth and be settled within this environment, within this merging of ideas regarding life,
functioning as open ground upon which statements may be made and heard.
Give consideration to this welcome of Taranaki, this pursuit of health.
Taranaki together, a healthy community.*

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Mihi authored by Dr Ruakere Hond, Te Ati Awa, Ngati Ruanui

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Ministers 2017/18 Letter of Approval to Taranaki DHB

Office of Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance



Ms Pauline Lockett
Chair
Taranaki District Health Board
Private Bag 2016
New Plymouth 4323

21 DEC 2017

Dear Ms Lockett

Taranaki District Health Board 2017/18 Annual Plan

To formalise ongoing accountability and to provide surety, I have approved and signed your DHB's 2017/18 Annual Plan.

I would like to thank you, your board, and the DHB's staff for their efforts in developing your Annual Plan for 2017/18. I also appreciate your DHB's significant efforts to provide valuable health services to the public in a challenging environment, and I am confident that we can work together to improve outcomes for the population.

I understand your DHB has planned a deficit for 2017/18 and a track to breakeven in the out years. I trust that you have contingencies in place to ensure you achieve this planned result for 2017/18.

As you deliver services for your population, keep in mind that I will shortly be providing a Letter of Expectations to DHBs for the 2018/19 financial year that will provide further clarity on my priorities for DHB planning, such as public provision of health services, improving access to primary care, reducing inequalities and improving mental health services.

Please note that 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.

Please ensure that a copy of this letter is attached to any copies of your signed Annual Plan that are made available to the public. Thank you again for your leadership and efforts to deliver high quality and equitable health outcomes for your population.

I look forward to working with you in the future.

Yours sincerely

Hon Dr David Clark
Minister of Health

*Dear Pauline
Merry Christmas
and best wishes.
I look forward to
visiting Taranaki in
the New Year
David*

cc Ms Rosemary Clements, Chief Executive, Taranaki District Health Board

SECTION 1: Overview of Strategic Priorities

Strategic Intentions/Priorities

This Annual Plan articulates Taranaki DHB's commitment to meeting the Ministerial expectations, and our continued commitment to our Board's vision of Taranaki Together, a Healthy Community: Taranaki Whanui He Rohe Oranga.

New Zealand Health Strategy

First and foremost is the updated New Zealand Health Strategy, which outlines the high level direction of the New Zealand Health system over the next 10 years along with a Roadmap of Actions. The Strategy outlines five strategic themes to ensure all New Zealanders live well, stay well and get well (People-powered; Closer to home; Value and high performance; One team and Smart system) and 27 areas for action between 2016 to 2026.



More Effective Social Services

Also of major significance is the New Zealand Productivity Commission's report, More Effective Social Services. In June 2014, the Productivity Commission was asked to look at ways to improve how government agencies commission and purchase social services. The final report was released in mid-September 2015. It makes several recommendations about how to make social services more responsive, client-focused, accountable and innovative. There is a strong drive for DHBs to work together with other public, private and non-profit entities to achieve improved outcomes. The focus must be on health, not hospitals.

Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities is the first United Nations human rights treaty of the 21st century. The Convention makes it explicit that member countries must ensure the full realisation of all human rights and fundamental freedoms for all disabled people, on an equal basis with others, and without discrimination of any kind on the basis of disability. It will also help to ensure that mainstream services are inclusive of disabled people and delivered in non-discriminatory ways.

Healthy Ageing Strategy

This Strategy is designed to ensure our health system provides the care, support and treatment that older New Zealanders need and that level of care is sustainable. It has a strong focus on prevention, wellness and support for independence, recognising the importance of whanau and community in older people's lives.

Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018

To facilitate the delivery of high-quality health services that meet the needs of Pacific peoples, 'Ala Mo'ui has been developed nationally. This builds on the successes of the former plan, 'Ala Mo'ui 2010–2014. It sets out the strategic direction to address health needs of Pacific peoples and stipulates new actions, which will be delivered from 2014 to 2018.

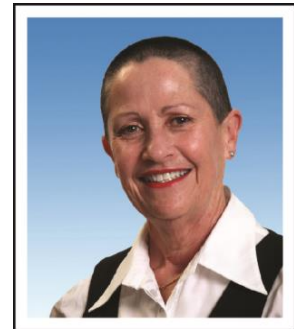
Treaty of Waitangi

The Treaty of Waitangi (Te Tiriti o Waitangi) is New Zealand's founding constitutional document and is often referred to in overarching strategies and plans throughout all sectors. Taranaki DHB values the importance of the Treaty. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure).

Message from the Chair

As we approach the 2017/18 year, we do so under the direction of a refreshed New Zealand Health Strategy. This Strategy sets the framework for the health system to address the pressures and significant service demands which in turn significantly challenge health budgets.

The Health Strategy pursues equitable outcomes for all New Zealanders, and accordingly there is a focus on achieving equitable health outcomes throughout this plan. We have worked closely with our Iwi governance group both directly and via the Māori health team to ensure integration of the themes of Pae Ora and Whanau Ora. Similarly, we recognise that equitable health outcomes are only possible where Councils and the wider community also share a role in achieving health and to this end the Board has adopted a Health in All Policies approach as we progress forward.



The role of Taranaki DHB governance is to provide strategic oversight of the management of our DHB to ensure we deliver on our fundamental objective – i.e. of working within allocated resources to improve, promote and protect the health of the Taranaki population, and to promote the independence of people who experience a disability. In doing this we will continue to strive to achieve health equity and achieve our vision.

Message from the Chief Executive

The Taranaki health system is no different to the New Zealand health system as a whole, in that it is facing intensifying supply and demand pressures that are impacting on clinical and financial sustainability. In response to these sustainability challenges, local health systems are redesigning their models of care and service configurations. The strategic direction of the New Zealand Health Strategy (NZHS) provides the system-level framework for redesign of models of care. The NZHS recognises that fundamental changes are needed, which place power in the hands of patients, enable care to be delivered close to home, integrate care across settings, and effectively deploy new technologies to improve access to high-quality care.



Taranaki District Health Board (DHB) has worked with a number of stakeholders to develop a Taranaki Health Action Plan (HAP). The HAP has a medium to long-term view for transforming the Taranaki health system. As part of implementation planning, existing operational and financial planning will be aligned to reflect the actions from the roadmap as the first year of implementation.

The HAP describes the transformational journey the Taranaki health system will take to redesign how care is delivered in the province to ensure the sustainable achievement of improving health outcomes.

Six focus areas will deliver on Taranaki's vision for the future, "Taranaki Together, A Healthy Community/Taranaki Whanui He Rohe Oranga."

1. Helping our people to live well, stay well and get well through health literacy and 'health in all policies' approaches
2. Integrating our care models through a one team, one system approach, starting with adults with physical health needs and health of older people, and then extending to mental health and addiction services
3. Using our community resources to support hospital capacity to enable a sustainable hospital infrastructure matched to population needs and models of care
4. Using analytics to drive improvement in value through improved performance, efficiency and quality of care
5. Developing a capable, sustainable workforce matched with health need and models of care
6. Improving access, efficiency and quality of care through managed uptake of new technologies – supporting changes in models of care

The Plan outlines an ambitious programme of work, but one that is essential for ensuring sustainability of the Taranaki health system, and the contribution it makes to community wellbeing. A plan is only of real value if its actions are delivered successfully, and on time. Reflecting this, the actions under each focus area have been phased to match the scale and pace of implementation with the system's capability to deliver. A project plan is currently under development to deliver on the HAP objectives for 2017/18.

Signatories:

Agreement for the Taranaki DHB 2017/18 Annual Plan

between



A stylized signature in blue ink, consisting of a large loop and a horizontal line.

Hon Dr David Clark
Minister of Health

Dated: 12 February 2018



A signature in black ink that reads "P Lockett" in a cursive style.

Pauline Lockett
Chair
Taranaki DHB
Dated: 17 July 2017



A signature in black ink that reads "R Clements" in a cursive style.


Rosemary Clements
Chief Executive
Taranaki DHB
Dated: 17 July 2017


SECTION 2: Delivering on Priorities and Targets



Government Planning Priorities


Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Prime Ministers Youth Mental Health Project	Value and High Performance	To progress DHB-led initiatives from the Prime Ministers Youth Mental Health project (Youth Mental Health Project Initiatives) in 2017/18	Deliverables against the initiative	PP25: Prime Ministers Youth Mental Health Project The percentage of discharge/transition plans to GPs will be maintained at 95% or more by June 2018. 85% of 0-19 year olds are seen within 3 weeks of referral 97% of 0-19 year olds are seen within 8 weeks of referral
		To partner with schools and the community to ensure that all year 9 students in decile 1-3 schools and any other high risk students receive a HEEADSSS Assessment (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Depression, Safety)	End of Q1 analysis of the cohort of students eligible for HEEADSSS assessment and establish a short list of high risk students completed	
		To implement a child and youth wellness model of care – expanding model of care to include mild to moderate by our Māori health provider (Te Kāwau Maro Alliance)	Q1 - outcome measures included in the Phase 1 (pilot) Report Q3 - expansion from pilot phase to implementation to service delivery	
		To improve access to Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and other Drugs (AOD) services through wait time targets and integrated case management which will enable all CAMHS staff to share the responsibility/ownership for managing referrals triage, risk, assessments and follow-up to enable better responsiveness for wait times and integrated management	Q1 - operational changes to the Multi-Disciplinary Team (MDT) process	
Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target	People Powered	To ensure that all Public Health Nursing staff have attended the family planning training and are able to educate and provide contraceptive under standing orders to put in place	Q2 - PHN staff trained and standing orders in place	PP38: Delivery of response actions agreed in annual plan
		To establish service continuity for sexual health services during periods of annual leave	Service continuity arrangements confirmed by Feb 2018	
		To review options for sexual health service provision in South Taranaki with the aim of better supporting Māori teens from the South	Review completed by 30 June 2018	


Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Supporting Vulnerable Children Better Public Service Target	One Team	To train 100% of staff in ED, Child Health, Midwifery, Mental Health, Sexual Health and Addiction Services in Family Violence Intervention Programme (FVIP) training within 6 months of commencing employment		PP27: Supporting Vulnerable Children
		To facilitate safe sharing of information about vulnerable children between the ministry for vulnerable children (CYF), Police, education and health professionals	Information sharing in place by Dec 2017	
		To increase the number of women who access care at Taranaki DHB screened for family violence	40% screened across DHB by July 2017 and 55% by Feb 2018	
		To implement shared care planning to ensure all vulnerable children are captured in our system, discussed with community agencies and receive appropriate care. TDHB is committed to implementing the above and continuing to reduce assaults on children.	Q1 - Maternity Action Group (MAG) and Paediatric Liaison Meeting (PLM) combine care plans	
Healthy Mums and Babies Better Public Service Target	One Team	To link with the future promotion activity of the Super Mama programme, including launching externally to the wider community with media coverage.	Q2 – Launch is undertaken	PP38 -Percentage of pregnant woman that are registered with a Lead Maternity Register in first trimester
		To link with the pilot for the Hapu Wananga pregnancy education programme -increasing communication around registering with an LMC early	Q2 – Hapu Wananga pilot is implemented.	
		To work with LMC's and General Practice services on information supplied to pregnant women on importance of booking with an LMC within 12 weeks.	Q3 – Consistent information is agreed and provided across all services.	
		To align promotional messages with community events.	Q3 – Q4 – Messages on early enrolment with LMC are factored into community events.	
Keeping Kids Healthy Better Public Service Target	One Team	To complete a project scope to inform the feasibility of a 'Healthy Homes' proposal to retrofit cold damp homes for those whanau who have 0-4 year olds attending ED frequently for respiratory conditions.	Q2 – Project scope completed Q4 – Agree extent of implementation of Project for 2018/19	PP38 - Reduction in hospital admission rates for a selected group of avoidable conditions aged 0-12 years. Reduction by 4% for Maori and 2.5% for others. An increase in four
		To identify 'frequent flyers' to ED and match with PHO/General Practice data including analysis by ethnicity.	Q2 – Matching and analysis completed.	
		To identify what can be put in place at General Practice to support this high needs vulnerable group to stay well including:	Q4 – Processes developed and completed.	

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		<ul style="list-style-type: none"> Enrolment at General Practice Smoking Cessation support to encourage smokefree homes and vehicles Active Care Plans; and MDT involvement where necessary 		year olds living in smokefree homes.
		<p>To undertake a Health Equity Assessment (HEAT) of Taranaki DHB funded oral health care services to identify barriers to enrolment and engagement for Maori in the Community Oral Health Service.</p> <p>To use the recommendations from the HEAT assessment to develop and implement a plan to eliminate current barriers for Maori to support ongoing engagement with the Community Oral Health Service for 0-4 year olds with an aim of improving oral health literacy for parents and care-givers.</p>	<p>Q3 – HEAT completed across the services.</p> <p>Q4 – Plan developed.</p>	
Increased Immunisation Health Target 	People Powered	To implement opportunistic and regular immunisation services being delivered after hours or on weekends where demand for outreach immunisation services is high	By Q2 implementation of after hours clinics	HT4: 95% of 8 months olds are fully immunised
		To implement a 'week day' review of inpatients and 'weekly' review of outpatients to identify unvaccinated children and, where clinically appropriate, provide immunisations by paediatric nurses; or refer the child to general practice or outreach	<p>By Q1 process for review embedded</p> <p>By Q2 process for track and tracing embedded</p>	
		To undertake an Health Equity Assessment (HEAT) of immunisation services and Implement recommendations including HPV	Complete HEAT by 31 December 2017	95% of 5 year olds are fully immunised
		To include immunisation status on all patient discharge summaries	By July 2017, agreed IT work plan	By December 2017 the gaps between Māori and Non-Māori immunisation uptake rates is reduced
		To improve Primary Health Care systems and enhance immunisation services by fully implementing electronic enrolment via NCHIP and further training to General Practice in conversations around those declining immunisation	<p>Q3 Electronic enrolment fully implemented</p> <p>Q2 Training sessions are undertaken by General Practices</p>	
		To promote access to influenza vaccinations for pregnant women and people >65 years of age through community pharmacy	75% of all people >65 years of age vaccinated for Influenza by Q4	PP21: Seasonal influenza coverage rates in >65's by Māori, Pacifica, other and total

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
Activity			Milestones	
<p>Shorter Stays in Emergency Departments Health Target</p> 	<p>Value and High Performance</p>	<p>To improve ED patient flow to ensure that 95% of patients are admitted, transferred or discharged within 6 hours</p> <ul style="list-style-type: none"> Complete roll out of Care Capacity Demand Management FTE analysis across the Hospital to ensure adequate resource available to predict ED demand and to improve patient flow (ICU, Paediatrics, Maternity, Mental Health) Roll out of Capacity at a Glance and Variance Response (VR) electronic whiteboards across the hospital to visually signal real time any resource issues that may pose a barrier to acute patient flow Ensure Variance Response Escalation plans are in place in each acute inpatient ward to address any barriers to patient flow Standard Operating Procedures (SOP) developed for senior ED nursing positions to clearly identify KPIs and their responsibilities related to maintaining effective patient flow and meeting the 6 hour target Daily breach evaluation to occur at Hospital wide Operational Meeting attended by all Nurse Managers and Duty Managers Variance Response Working Group to monitor and develop further strategies to manage hospital wide barriers to patient flow 	<p>Q2 –Maternity roll out</p> <p>Q3-Q4 – ICU, Paediatrics, Mental Health roll out</p> <p>Q2 – Complete roll out of VR whiteboards</p> <p>Plans in place by Q2</p> <p>SOP completed by Q1</p> <p>Ongoing monitoring of KPIs Q2-Q4 to identify areas requiring improvements</p> <p>Embedded by Q1</p> <p>Q1 Identify 2 specific targeted improvements</p>	<p>HT1: 95% of patients are admitted, transferred or discharged within 6 hours</p> <p>All measures monitored by ethnicity</p>
		<p>To develop an electronic ED dashboard to enable detailed monitoring and reporting of ED Quality Indicators (mandatory and non mandatory)</p>	<p>Q1 - Monitoring system rolled out and embedded</p> <p>Q2 Identify 3 specific measures to support targeted quality improvements</p>	<p>HT1: 95% of patients are admitted, transferred or discharged within 6 hours</p> <p>All measures monitored by ethnicity</p>
		<p>To progress regional cross sector initiatives to manage acute demand</p> <ul style="list-style-type: none"> Ongoing development of Map of Medicine (MOM) pathways Ongoing development of Primary Option Pathways as an effective alternative to ED presentation Increased numbers of Primary Health (PH) Redirections Community education initiatives and media publicity re appropriate use of ED 	<p>Q1-Q4</p> <p>0% growth or reduction in number of Triage 4 & 5 presentations to the ED</p> <p>Complete 2 MOM pathways</p> <p>Identify and develop 2 Primary Option pathways</p> <p>Increase of PH Redirections by 10%</p>	<p>The number of Triage 4 & 5 presentations to the ED by ethnicity</p>

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Improved Access to Elective Surgery Health Target 	Value and High Performance	To explore the level and type of services provided across the region (utilising the role delineation model) work collaboratively with the Midland Regional Elective team	Activities as identified in the Regional Services Plan are completed	HT2: Electives Health Target (5478 discharges)
		To meet patient flow indicators with all patients waiting 4 months or less for specialist assessment or treatment and to meet National Patient Flow requirements	Monthly Ministry of Health reports	SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives)
		To review elective services initiatives and ensure that prioritisation tools are being used in a manner that supports equitable, fair and appropriate access to care for all specialities across the whole Taranaki region	Review completed by Q4	Electives and Ambulatory Initiative Bariatric Initiative
		To prioritise patients for treatment using national, or nationally recognised tools and treatment in accordance with assigned priority and waiting time	Quarterly reporting on new tools	Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target 	One Team	To work with the Central Cancer Network (CCN): <ul style="list-style-type: none"> To implement the CCN Multi-Disciplinary Meeting (MDM) clinical resourcing project recommendations To participate regionally to identify improvements in Faster Cancer Treatment (FCT) Conduct regular audits of the FCT pathways, identifying quality improvement initiatives To implement quality initiatives following the head and neck tumour stream reviews 	Q1 recommendations to be endorsed regionally Q2-Q4 Implement recommendations Q1-Q4 – Plan and implement improvements Q1-Q4 - Audit and roll out of quality initiatives Q1 – Final recommendations complete Q2-Q4 – Implement recommendations	HT3: Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) HT3: Faster Cancer Treatment (62 day indicator) Improved FCT registration numbers to 75%
		To improve the identification of patients appropriate for FCT registration: <ul style="list-style-type: none"> Audit of missed patient registrations Development of an action plan to increase FCT registration numbers 	Q1 - Complete audit and plan in place Q2-Q4 Improvements in FCT registration numbers to 75%	PP29: Improving waiting times for diagnostic services - CT & MRI
		To develop ongoing strategies to improve cancer services including applying an equity lens: <ul style="list-style-type: none"> HEAT assessment completed for any new initiatives Adopt the Whanau Ora approach to planning service delivery 	Ongoing Q1-Q2 – Assessment of current services	All monitoring of targets by ethnicity

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		<ul style="list-style-type: none"> Action plan to be developed from completed audit of time frames for FCT patients from referral to seen by times Māori health team participation in FCT Governance Group to provide guidance on quality initiatives re health equity Māori Health Worker to join the Cancer Coordination Team to provide support to patients and provide guidance on service delivery Electronic dashboard solution for live tracking of the FCT patient journey to prevent breaches 	Q3 – Plan in Place Q4 Implement improvements Q1 – Action Plan Q2-Q4 – Implement Action Plan and ongoing Quarterly Audits Q1 – participation Q2-Q4 – Initiatives developed Q1-Q4 Q4 - Dashboard development	
		To strengthen engagement and participation from senior clinical staff <ul style="list-style-type: none"> Increased senior clinical staff participation in Governance Group Improve FCT information sharing via FCT monthly newsletter - to all Senior Clinicians 	Q1 Monthly	
Better Help for Smokers to Quit Health Target 	Smart System	To implement a range of actions in response to the Taranaki Strategic Tobacco Control Action Plan 2017-2025 with a focus on the implementation and supporting robust and quality pathways for referrals and feedback to smoking cessation services	Work with key stakeholders to develop Action Plan by end of Q2	Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals 95% of hospitalised smokers are given brief advice to quit 90% of PHO enrolled patients who smoke, have been offered help to quit smoking by a health care practitioner in the last 15 months Number of pregnant Māori women smokefree at 2 weeks postnatal PP34: Improving percentage of households smoke free at 6 weeks post
		To work with the Primary and Secondary Health Providers to increase referrals from Primary and Secondary Health Care into the Taranaki Stop Smoking Service with a focus on reducing inequity	Referral from Primary and Secondary increased to 90% by Q3	
		To ensure all providers who work with pregnant women attend workforce development on smokefree and implement active referral pathways	ABC training for maternity providers to be completed by Q2 Implement active referral pathways for pregnant smokers, with options for interventions including home visiting, incentive programmes and group programmes	

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		To monitor the health target rates and referral rates for Māori in primary and maternity services. Analyse the smoking cessation referral data to ensure referral rates for Māori reflect their current smoking rates across the TDHB population. Address the areas where referral rates are low through workforce development, awareness raising of services and marketing of Kaupapa Māori smoking cessation services	That a process is in place for analysing referral rates for Māori from primary and maternity services. Workforce development and engagement with referrers is implemented where referral rates for Māori are less than other ethnicities	natal 90% of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer (LMC) are offered advice to quit and/or support to quit smoking
Raising Healthy Kids Health Target 	Closer to home	To embed principles from the Healthy Conversations Training into B4SC practice for Public Health Nurses and Tamariki Ora providers	Healthy conversations training to be completed by Q1 and by Q4 Public Health Nurses report more confidence in discussing referrals	HT6: Healthy Kids Health Target. 95% of obese children identified in the B4 School check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions
		To undertake strengthening of the referral pathway of children identified BMI >98 th centile	Children identified as >98 th at B4Sc check referred to Whanau Pakari	
		To monitor and develop suitable responses to referral declines and case review of all cases not referred and not acknowledged and identify system failures in order to correct and provide feedback to providers	Referral rates for Māori will improve by 10% in Q2 and 20% in Q4 Declines followed up at 3 months	
		To identify areas where decline rates are higher for Māori and identify if there are any trends e.g. by provider, geographical area	Analysis undertaken by Q2 and plan to address gaps in service delivery developed	
Bowel Screening	Value and High Performance	To collaborate within the Midland region to ensure capacity to deliver the programme at a regional and local level	Taranaki DHB model for service delivery aligns with the Midland Regional model identified by Regional Co-ordinator by Q3	
		To develop capacity and capability within the endoscopy service to deliver both current diagnostic waiting time volumes and prepare for future bowel screening	Resources including capital, facilities and staff are sufficient to meet increased demand of the programme by Q4	PP29: Improving waiting times for diagnostic services – Colonoscopy

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		<p>To ensure IT functionality is available to deliver an effective service and reporting</p> <p>A commitment to utilising the National Bowel Screening Programme (NBSP) IT systems within local IT programmes to support the NBSP implementation</p>	Utilising the NBSP IT systems within local IT programmes by Q4	National Bowel Screening quality, equity and performance indicators
		To collaborate with a local Bowel Screening Initiative Group to plan the implementation of the Bowel Screening Programme within Taranaki DHB	Bowel Screening Group set up and planning by Q1	
		To engage with Māori Health Team and providers to minimise inequality in the service	The Māori Health Team are actively involved in the introduction of the programme	
Mental Health	People Powered	To implement a proactive approach to reducing the use of Section 29 (S29) if a person is admitted to the inpatient unit ensuring service users receive early engagement and intervention by their assigned key worker as indicated in management plans	<p>Following the completion of the S29 process service users will transfer to voluntary status. Process to be embedded as of Dec 2017</p> <p>Psycho education is embedded in practice for all patients that transfer to voluntary status by Dec 2017</p>	PP36: Reduce the rate of Māori on the Mental Health Act: Section 29 Community Treatment Orders relative to other ethnicities
		<p>To audit using a whanau ora approach the use of Section 29 by using the Consumer and Family Advisor to interview Whanau, the Tangata Whaiora and relevant keyworkers</p> <p>As a result of this work carried out in Q1&2 solutions are to be discussed at the MHAS clinical governance forum and then jointly agreed for implementation by April 2018</p>	<p>Audit Result for Q1&2 Collated and presented at February 2018 Clinical Governance forum</p> <p>Solutions identified in Governance Forum will be implemented by Q3</p>	
	Value and High Performance	<p>The life expectancy of people who experience mental health and/or addiction issues can be reduced by up to 25 years – the most common causes of premature death are cancer and cardiovascular disease. Many of these physical health problems are preventable, treatable and respond well to treatment if diagnosed early.</p> <p>Māori who experience mental health and/or addiction problems have a higher premature mortality rate than Māori in the general</p>	<p>Q1 Workshop completed and Action Plan signed off</p> <p>Q2 Commence implementation of the Action Plan</p> <p>Q2 Agreed recommendations from evaluation are implemented</p>	PP38: Delivery of response actions agreed in the Annual Plan

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		<p>population (one-third greater).</p> <p>In recognising this greater health need and the associated health inequity we can improve people's physical health outcomes early in the course of mental health.</p> <p>To develop a Taranaki Action Plan in conjunction with Te Pou to improve the physical health needs of those experiencing mental health and addictions issues.</p> <p>To implement recommendations from the evaluation of the Day Activity and Vocational Programmes</p>		
Healthy Ageing	Closer to Home	To implement the outcomes of the national IBT settlement agreement, equal pay negotiation and a review of home and community sector workforce service and funding models	Contracts in place	PP23: Improving Wrap Around Services – Health of Older People
		To ensure timely reassessment of older people in Aged Residential Care support Needs Assessment Service Coordination (NASC) led service improvement initiatives aimed at supporting older people to remain living independent for as long as possible. To undertake a HEAT assessment of any proposed changes to the NASC service to ensure equity issues are identified and addressed	Review of current NASC capacity by Q1 HEAT assessment completed by Q1 Recommendations from HEAT assessment implemented by Q3	
		To ensure specialist nursing support to Aged Residential Care to improve outcomes for older people with complex health needs following hospital discharge	Review of current Aged Residential Care CNS service by Q2	
		To work with ACC, HQSC and MoH to identify opportunities to further develop our falls and fracture prevention treatment services by integrating the TDHB Fracture Liaison Clinic with the Midland Health Network primary care based elderly falls assessment service	Review current service models and develop recommendations for service integration by Q2 Implementation of any recommendations by Q4	
		To implement the New Zealand Framework for Dementia Care and the Improving the Lives of People with Dementia documents to align with Midland regional planning commitments	Implementation of framework by Q4	
		To identify quality indicators and service development opportunities from the use of InterRAI assessment data work with Midlands DHBs	Quality indicators developed and utilised for service development initiatives by Q2	

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Living Well with Diabetes	Closer to Home	<p>To provide ready access (via e-referral) to an experienced Multi-Disciplinary Team (MDT) in the community for advice and follow up support.</p> <p>(This will enable improved access to care for Māori and other high needs patients across the region by removing the need to travel to secondary care)</p>	<p>Increase the numbers of referrals to the MDT by 10%</p> <p>The proportion of e-Referrals to MDT for patients who are Māori, Pacific or high risk is representative of the population mix</p>	<p>Number of referrals to MDT reported Quarterly</p> <p>Referrals to the MDT by ethnicity/quintile in Q2 and Q4</p>
		<p>To increase the number of diabetic patients who have an annual review with their General Practice team by using a proactive recall system to maintain contact with patients</p>	<p>Increase number of diabetic patients assessed by their GP practice by 10%</p>	<p>The number of Diabetic Annual Reviews completed by GP's in Q2 and Q4</p> <p>PP20: Report on proportion of patients with diabetes with an HbA1c above 64, 80 and 100 mmol/mol by total, high risk and Māori</p>
		<p>To make available Insulin Initiation in primary care within a structured programme. This will enable improved access to care for Māori and other high needs patients across the region, removing the need for referral to secondary care for insulin initiation</p>	<p>10% increase in the number of insulin initiations undertaken in General Practice</p> <p>By Q2 agree the Primary Option pathway to enable insulin initiation</p>	<p>Number of insulin initiations undertaken reported 6 monthly</p> <p>Primary Option pathway updated Q2</p>
Childhood Obesity Plan	Closer to Home	<p>To progress DHB-led initiatives from the Childhood Obesity Plan in 2017/18 including:</p> <p>A) Included in the Mama Pepe Hauora programme, TDHB will be increasing access to breastfeeding services to Māori, high needs and rural/remote women</p> <p>B) To enrol further Kohanga Reo into oranga mokopuna programme to enhance nutrition and physical activity programme for early childhood education settings</p>	<p>Q1: Establish implementation action plans for the 2017-18 year on the obesity plan</p> <p>A) Number of community Lactation consultants in South Taranaki are increased by Q2</p> <p>B) 6 Kohanga Reo will be recruited/enrolled by Q3</p>	<p>PP38: Delivery of response actions agreed in Annual Plan</p> <p>PP37: Child Health Breastfeeding</p>
		<p>To achieve the Raising Healthy Kids Target the Raising Healthy Kids Working Group will monitor and strengthen referral pathways into the Whanau Pakari Programme with a focus on reducing inequality</p>	<p>Q2: Raising Healthy Kids Target Achieved</p>	

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		Using a HEAT Tool, undertake a Health Equity Assessment of Whanau Pakari initiatives currently underway in the Childhood Obesity Plan	Q1: Initiatives that will be assessed will be identified Q2-4: Complete HEAT assessment and plan appropriate response	
Child Health	Value and High Performance	To enrol all babies born at Taranaki Base Hospital into the Community Oral Health Service unless the parents choose to opt off	Regular reporting will reflect increased enrolment	PP13: Oral Health 95% of Taranaki Preschool children enrolled in the COHS reported by Māori, Pacifica, Other and Total
		To ensure LMC's provide safe sleep information to patients post natally and before they are discharged from LMC care e.g. 49 days. Care Plans are available on the postnatal ward We will work with WCTO and Plunket on information related to safe sleep to ensure there is consistency in the training applied	100% of caregivers of Māori infants are provided with SUDI information at Well Child Tamariki Ora Core Contact 1	CFA Variation for measurement of performance relating to Reducing SUDI infant deaths
		To maintain the Taranaki Child Health Service Leadership Alliance Team to oversee work programme for Child Health Services Partner with other agencies to undertake a stocktake of child health services (from antenatal through to rangatahi) to identify the service gaps, access issues and duplications	By September 2017 define work programme for 2017/18	
Disability Support Services	One Team	To undertake a stocktake of available resources that would support people with a disability when they interact with hospital based services (e.g. hearing supports, sign language, interpreters etc)	Stocktake undertaken annually	PP38: Delivery of response actions agreed in Annual Plan
		To audit current training practice to identify areas for improvement, such as consumer engagement/involvement	Audit undertaken annually	
		To assess the 2017 roll out of visitor and nominated support person policy and to gauge public awareness of the policy and the leaflet	Review undertaken by Q2	
		To implement care plans that identify disabilities to accompany the individual through their journey in and out of hospital	Annual review of implementation	

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Primary Care Integration	Closer to Home	To complete preparation work for Single Point of Access (SPOA) to include a second HEAT assessment before implementation	Q1 Implementation milestones agreed Q4 HEAT completed	PP22: Delivery of actions to improve system integration including SLMs Equity of access for Māori peoples to the services delivered through the SPOA
		To initiate the SPOA for adult and older peoples services	SPOA established Dec 2017	
		To establish alliance governance framework for SPOA for integration and wider work plan	Alliance arrangement in place by 30 Sept 2017	
	Value and High Performance	Māori representation will be included in the Integration Alliance Governance framework to ensure the HEAT assessment recommendation of Māori being involved in the development of the model of care and implementation of the SPOA is actioned and includes the three principles of the Treaty of Waitangi: 1. Partnership 2. Participation 3. Protection	Māori representatives appointed to the Alliance Governance group by 30 Sept 2017	
		To undertake Local Community Team demand and service analysis to inform future model of care	Analysis completed by 30 June 2018	
Pharmacy Action Plan	One Team	To implement activities as outlined in pharmacy contracting arrangements	By Q1	Taranaki pharmacy agreements signed
		To complete a Health Needs Assessment (HNA) to inform the development of a Taranaki Community Pharmacy Strategy 2017-2025	Strategy completed and agreed by Q3	
		To identify potential local services to be purchased using the Taranaki Pharmacy Strategy	Plan developed and agreed for following year by Q3	
		To implement publicly funded influenza vaccinations into those Community Pharmacies with accredited vaccinators and cold chain approval	By Q1	The number of eligible people reported by ethnicity accessing influenza vaccinations from approved Pharmacies
Improving Quality	Value and High Performance	To increase the response rate of the National Patient Experience Survey from 21% to 30% (note 21% is the average response rate for Q3 2014 to Q4 2016). Data to include break down by ethnicity as possible	31 December 2017	SLM3: 30% response rate achieved by 31 December 2018
		To establish Quality Improvement Plans, utilising PDSA methodology, for the Communication and Partnership domains	30 September 2017	Plans established and endorsed

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		To implement the Communication and Partnership Quality Improvement plans and evaluate success via the Patient Experience Survey against set targets	From 1 December 2017	Plans implemented Monitoring via the Patient Experience Survey demonstrate improvement
		To establish a Taranaki DHB Consumer Council	30 June 2018	Consumer Council in place
Living within our Means	Value and High Performance	Taranaki DHB commits to managing our finances prudently, and in line with Ministerial expectations, and will ensure all planned financials align with previously agreed results with continued focus on internal cost controls and efficiency initiatives	Development of a Savings Plan Continuation of the structural changes initiated and currently in the pipeline	Agreed financial templates
Delivery of Regional Service Plan		CARDIAC To participate regionally in Heart Failure service redesign improvement project To establish and embed ethnicity data reporting and health equity assessment to inform future services To complete an atrial fibrillation stocktake to inform service design regionally	Stocktake Q2 Q1-Q4 Stocktake Q3	PP29: Improved access to diagnostics. Elective Services Patient Flow Indicators (ESPI): all patients wait four months or less for First Specialist Assessments (FSA) S14: Standardised Intervention Rates
		HEPATITIS C To implement , support and utilise new regional Hepatitis C services	By Q4	
		STROKE To support and facilitate the implementation of a pathway of care for accessing thrombectomy services through Auckland DHB by setting up a working party to develop an implementation model in 2017/2018 To support and facilitate the development of a pathway of care for accessing thrombectomy services through Waikato DHB (five-year timeframe by ensuring regional and national clinical stroke network meetings are attended by the Lead Stroke Clinician and Stroke CNS	National Clot Retrieval strategy is adopted at a national level by July 2017 Taranaki DHB Thrombectomy Working Party in place by October 2017	Clot Retrieval pathway in place at Taranaki DHB by July 2018

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		MAJOR TRAUMA To support and develop action plans to meet the recommendations of the regional Business Case for Major Trauma services	Submission of data to the NZ Major Trauma Registry no more than 30 days after patient discharge Attainment of the service specifications agreed to in the MTS regional Business Case 2017-2022 Achieve consistent trauma data entry Address the recommendations from the RACS Trauma Verification 2017 Support professional development of Trauma Service staff	

Financial Performance Summary

(refer to Appendix One for further detail)

Prospective Statement of Financial Performance (Comprehensive Income) for the four years ended 30 June 2018, 2019, 2020 and 2021

Statement of Comprehensive Income	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	Audited Actual	Forecast	Plan	Plan	Plan	Plan
	\$000	\$000	\$000	\$000	\$000	\$000
Revenue						
Ministry of Health Revenue	340,315	347,352	361,954	370,096	378,238	386,380
Other Government Revenue	6,075	7,190	7,572	7,725	7,881	8,039
Other Revenue	9,059	9,503	10,008	10,253	10,506	10,766
Total Revenue	355,449	364,045	379,534	388,074	396,625	405,185
Expenditure						
Personnel	123,086	130,874	136,728	139,462	142,250	145,093
Outsourced	18,207	16,163	14,870	15,168	15,471	15,780
Clinical Supplies	26,489	28,056	26,524	27,054	27,595	28,146
Infrastructure and Non Clinical	14,809	13,685	12,795	13,340	13,806	13,562
Payments to Non-DHB Providers	152,540	154,811	165,657	169,650	173,648	177,652
Interest	2,644	1,457	0	0	0	0
Depreciation and Amortisation	15,521	16,462	16,657	16,657	16,657	16,657
Capital Charge	5,822	4,347	8,303	8,243	8,198	8,195
Total Expenditure	359,118	365,855	381,534	389,574	397,625	405,085
Other Comprehensive Income						
Revaluation of Land and Building	0	0	0	0	0	
Total Comprehensive Income/(Deficit)	(3,669)	(1,810)	(2,000)	(1,500)	(1,000)	100

Prospective Financial Performance by Output Class for the three years ended 30 June 2018, 2019 and 2020

Prospective Summary of Revenues and Expenses by Output Class	2017-18 Plan	2018-19 Plan	2019-20 Plan
	\$000	\$000	\$000
Early Detection			
Total Revenue	88,922	90,923	92,926
Total Expenditure	89,391	91,274	93,161
Net Surplus / (Deficit)	(469)	(351)	(235)
Rehabilitation and Support			
Total Revenue	57,726	59,025	60,326
Total Expenditure	58,030	59,253	60,477
Net Surplus / (Deficit)	(304)	(228)	(151)
Prevention			
Total Revenue	7,970	8,149	8,329
Total Expenditure	8,012	8,181	8,350
Net Surplus / (Deficit)	(42)	(32)	(21)
Intensive Assessment and Treatment			
Total Revenue	224,916	229,977	235,044
Total Expenditure	226,101	230,866	235,637
Net Surplus / (Deficit)	(1,185)	(889)	(593)
Consolidated Surplus / (Deficit)	(2,000)	(1,500)	(1,000)

Local and Regional Enablers

Government Planning Priority	Link To NZ Health Strategy	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Information Technology	Smart System	<p>To progress eSPACE programme and projects to support DHB led models</p> <ul style="list-style-type: none"> • Electronic Transfer of Care • Forms and Pathways Mental Health • Diagnostic Results • Medicines Management 	eSPACE Programme is a 4 year Roadmap which is yet to have definitive milestones established and is dependent on processes to evaluate and set the priorities and affordability aspects. The Roadmap has been committed to by the 5 DHBs (at Board & CE level) and is as defined within the Business Case submitted to the Ministry. Progression of the programme, inclusive of establishment of definitive milestones, is dependent on Ministry and Cabinet approval of the Business Case.	Quarterly reports from regional leads.
		<p>To progress IT support of national initiatives such as</p> <ul style="list-style-type: none"> • National Bowel Screening Programme • National Maternity Programme 	<p>The Midland region and each of the 5 DHBs are working towards the establishment of the bowel screening service in accordance with the evolving programme and plans being developed by the Ministry. Accordingly the Midland regional Business Case for the establishment of the Regional Centres (BSRC) has been submitted and reviewed by the Ministry. The Ministry have indicated that Waikato DHB is within tranche 2 (2018). We have provided a high-level indicative estimate of the likely budgetary costs for integration with the national solution. We await further information from the Ministry to commence planning and scoping to enable the development of the Waikato DHB Business Case</p> <p>National Maternity programme – TDHB is awaiting confirmation from MOH as to the direction this program is heading before we can commit to milestones</p>	

		To progress IT components of the Integration Project with Primary Care	Sign off of Business Case (Q1) Project based according to plan (Q2 – Q4)	
		To replace Picture Archiving Communication System and Radiology Information System	Sign off of Business Case (Q1) Project based according to plan (Q1 – Q4)	
		To progress Medication Management by: <ul style="list-style-type: none"> • Finalisation of Universal List of Medicines • Rollout of MedChart to all clinical areas in Taranaki DHB • Medications reconciliation 	Determine regional approach (Q1) Sign off on Business Case/s (Q2) Projects according to plan (Q2 – Q4)	
Workforce	One Team	To enhance capacity and build the analyst network to share knowledge and skills to increase utilisation and access to workforce information. To identify opportunities to increase the rural medical workforce using established education and training programmes. Establish first community based attachment in the primary sector Introduction of 5th year medical students into the rural immersion programme	By Q2 By Q1 By Q3	Percentage of Māori employed in the Taranaki DHB workforce commence HR workforce data Attachment established Students enrolled
		Enhance diversity To identify opportunities to enhance numbers of Māori in the health workforce via policy, systems and processes; and identify opportunities to support Kia Ora Hauora/ WhyOra graduates to transition to work	By Q3	Number of Māori students graduating from tertiary study placed into employment
		Enhance succession planning Support the implementation of the State Services Commission leadership and talent management framework, aligned to Taranaki DHB initiatives	By Q2	Establishment of a national shared approach based on implementation of the SSC framework

		Build workforce culture Embed the organisational mapping and alignment framework to support sustainable change towards an effective way to work as one team	By Q1	Commence realignment of management structure
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SECTION 3: Service Configuration

Service Coverage

All DHBs are required to deliver a minimum of services, as defined in The Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under Section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually.

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. Taranaki DHB may, pursuant to Section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

Taranaki DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2017/18.

Service Change

Taranaki DHB is developing a Health Action Plan to implement change from a health system perspective and the following table identifies emerging service issues other than what is already covered in 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.

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 2017/18 year prior to the deadline established by the Ministry of Health of February 2018.

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 2017/18

Change	Description of Change	Benefits of Change	Change for 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"> • Reduce duplication of effort enabling DHBs to collectively develop sustainable solutions • Develop integrated approach to recruitment and retention within the global marketplace • Standardised planning, evaluation and procurement of new technology solutions within a clinical environment 	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	Implementation of Community Services Integration Project	<ul style="list-style-type: none"> • Implementing new service models for adult physical health and health of older people • Developing locality based services to be delivered within the resources available 	Local and National

Managing Acute Demand	New options for acute demand and urgent primary care	<ul style="list-style-type: none"> • Support achievement of ED Health Target • Increase options available in primary care after hours • Increased enrolment of patients with PHOs 	Local
Mental Health	Initiation of Whole system services redesign	<ul style="list-style-type: none"> • Whole system services redesign • Care Closer to Home • Improved performance 	Local
Community Pharmacy	Implement the national pharmacy contracting arrangements and develop local services once agreed.	<ul style="list-style-type: none"> • More Integration across the primary care team. • Improved access to pharmacist services by consumers • Consumer empowerment • Safe supply of medicines to the customer • Improved support for vulnerable populations • More use of pharmacists as a first point of contact within primary care. 	National and local process
Pathology and Laboratory Services	Implementing options for the future direction of Laboratory and Pathology Services	<ul style="list-style-type: none"> • Co-ordinated services across whole systems • Improved performance 	Local
Eating Disorders	<p>Historically there had been increased funding allocated to the Midland region however a significant portion of this funding was directed towards a supra-regional service in Auckland</p> <p>There has been agreement to exit components of the Auckland supra-regional service and a project is underway to develop an enhanced Midland approach to service delivery</p> <p>This is expected to see access for residential services continue to be delivered outside the region but all other services delivered locally with regional support</p>	This change is expected to provide an increase in local access and reduce fragmentation between specialist eating disorder services and other mental health services involved with eating disorder clients	Regional

SECTION 4: Stewardship

(Refer to Taranaki DHB's 2016/17 Statement of Intent for more information)

This section provides an outline of the arrangements and systems that Taranaki DHB has in place to manage our core functions and to deliver planned services. Greater detail is included in Taranaki DHB's three-yearly Statement of Intent, which was last produced for the 2016/17 year and is available on our website at http://www.tdhb.org.nz/misc/planning_documents.shtml

Managing our Business

Organisational Performance Management

Taranaki DHB's performance is assessed on both financial and non-financial measures, which are measured and reported at various level(s) of the organisation. These may be reported daily, weekly, fortnightly or monthly as appropriate.

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

Funding and Financial Management

Taranaki DHB's key financial indicators are outlined in the table below:

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	\$M	\$M	\$M	\$M	\$M	\$M
	ACTUAL	FORECAST	PLANNED	PLANNED	PLANNED	PLANNED
Revenue	355.449	364.045	379.534	388.074	396.625	405.185
Net Surplus/(Deficit)	(3.669)	(1.810)	(2.000)	(1.500)	(1.000)	0.100
Total Fixed Assets	180.258	175.371	173.914	171.457	169.000	164.043
Crown Equity	76.252	147.484	144.525	142.066	140.107	139.248
Term Borrowings and Provisions	74.661	0.661	0.686	0.701	0.716	0.731

Taranaki DHB's key financial indicators are a consolidated operating deficit of \$2.00M for 2017/18 which comprises a deficit of \$19.00M in the hospital provider, a financial breakeven for the DHB Governance & Funding Administration and a surplus of \$17.00M in the DHB Funder operations. These are assessed against and reported through Taranaki DHB's performance management process to the Board and Finance, Audit and Compliance Committee on a monthly basis.

Further information about Taranaki DHB's planned financial position for 2017/18 and out years is contained in Appendix A (Financial Performance Plan) commencing on page 52.

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 such as:

- 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.

These are assessed against and reported through Taranaki DHB's performance management process to our senior management, Board and Ministry of Health on a regular basis.

Investment and Asset Management

All DHBs are required to complete a stand-alone Long Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across Government, the Investment Management and Asset Management Performance (IMAP) system.

Shared Service Arrangements and Ownership Interests

HealthShare Limited (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 DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk Management

Taranaki DHB has a formal risk management and reporting system, which utilises an electronic integrated quality and risk system called Datix. This was implemented across the DHB from April 2017. Reporting to the Taranaki DHB Board, Executive Management Team and other key committees occurs on a regular basis. The Taranaki DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality Assurance and Improvement

Taranaki DHB's approach to quality assurance and improvement is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

Health Equity

Health inequalities affect a range of population groups including Māori, Pacifica, low socio-economic quintile, low income workers who have difficulty accessing health services during working hours, rural, elderly, disabled, migrants, refugees, those with poor English language skills, and those living in specified localities.

The Taranaki DHB acknowledges that Māori are the main population group that are affected by health inequity in Taranaki and that the DHB has obligations under the Treaty of Waitangi to ensure Māori achieve the same health status as non-Māori.

The Taranaki DHB approach to health equity in 2017/18 therefore focuses on improving outcomes and achieving equity for Māori. To achieve this there is a commitment to:

- Health equity assessment using the Health Equity Assessment Tool (HEAT) being scheduled and/or carried out to assess the effectiveness of existing services or new service models, programmes, policies and projects, as each case requires
- Applying whānau-centred health information management that supports whānau to better self-manage their own health and wellbeing
- Setting, monitoring and reporting 'no differential' targets for Māori and non-Māori for all monitored activity

Building Capability

Capital and Infrastructure Development

Base line capital expenditure during 2017/18 is forecast at \$15.20M. This includes investment of \$6.0M (TDHB share) in a new integrated pathology laboratory consequent to the successful procurement of pathology services for the region (RFP process currently underway). Based on current time lines, the investment is expected to span two planning periods (2017/18 and 2018/19).

Scoping and planning for Stages 2 and 3 of Project Maunga has commenced with preliminary works in progress. The planning and resources required to progress the Business Case through the different stages leading to approval are being established. With the efflux of time and inflation, indications are that the capital outlay required for Stages 2 and 3 will sharply increase to \$70M and \$40M (from the 2007 estimates of \$37M and \$28M) respectively. The capital budget for these two stages will be established when the scoping and preliminary design are completed.

Details are contained in the Financial Performance Summary section of this document.

Information Technology and Communications Systems

Taranaki DHB's information technology and communication systems goals align with the national and regional strategic direction for IT. Further detail about Taranaki DHB's current IT initiatives are contained in the 2017/18 Midlands Regional Service Plan, and in the section on local and regional enablers within this document in Section 2.

Workforce

Below is a short summary of Taranaki DHB's organisational culture, leadership and workforce development initiatives. Further detail about the Midland regional approach to workforce is contained in the 2017/18 Midland Regional Service Plan.

Key focus areas for Taranaki DHB will be:

- Enhancing capacity through increasing the use and span of workforce data to inform workforce planning and modelling and committing to implementing the pre-vocational medical training programme.
- Enhancing diversity through identifying ways to increase representation of Māori in the health workforce.
- Enhancing succession planning through supporting DHBs to implement the State Service Commission leadership and talent management initiatives.
- Building workforce culture by focusing on valuing high performance and engagement.

Co-operative Developments

Taranaki DHB collaborates with a number of external organisations and entities 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 Kāwau 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.

SECTION 5: Performance Measures

2017/18 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

HS Health Strategy

PP Policy Priorities

SI System Integration

OP Outputs

OS Ownership

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

Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.

Performance Measure		2017/18 Performance Expectation/Target
HS: Supporting delivery of the New Zealand Health Strategy		Quarterly highlight report against the Strategy themes.
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	Targets will be set through Q2 reporting
	Age 20-64	Targets will be set through Q2 reporting
	Age 65+	Targets will be set through Q2 reporting
PP7: Improving mental health services using wellness and transition (discharge) planning	Discharged clients with a quality transition or wellness plan	95%
	Audited files meet accepted good practice	95%
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health (Provider Arm)	80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.
	Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.

PP10: Oral Health-Mean DMFT score at Year 8	Year 1 %		0.7
	Year 2 %		0.7
PP11: Children caries-free at five years of age	Year 1 %		64%
	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 %		≤10%
	Children not examined 0-12 years – Year 2 %		≤10%
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions		Report on delivery of the actions and milestones identified in the Annual Plan
	Focus Area 2: Diabetes services	Reporting on implementation of actions in the Diabetes Plan “Living Well with Diabetes.”	Improve or maintain
		Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).	
	Focus Area 3: Cardiovascular health	Indicator 1: Eligible population will have had their cardiovascular risk assessed in the last 5 years.	90%
		Indicator 2: Percentage of ‘eligible Māori men in the PHO aged 35-44 years’ who have had their cardiovascular risk assessed in the past 5 years.	90%
	Focus Area 4: Acute heart service	High-risk patients receive an angiogram within 3 days of admission.	70% Māori 70% Non Māori
		Patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	95%
		Patients undergoing cardiac surgery at the regional cardiac centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge.	95%
	Focus Area 5: Stroke services	Percentage of potentially eligible stroke patient’s thrombolysed 24/7.	8%
		Stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	80%
		Patients admitted with acute stroke who are transferred to inpatient rehabilitation	80%

		services are transferred within 7 days of acute admission.	
PP21: Immunisation coverage	Focus Area 1	% of two year olds fully immunised	95%
		% of five year olds fully immunised	95%
	Focus Area 2	% of girls fully immunised – HPV vaccine	75%
	Focus Area 3	% of 65+ year olds immunised – flu vaccine	75%
PP22: Delivery of actions to improve system integration including SLMs			Report on activities in the Annual Plan
PP23: Implementing the Healthy Ageing Strategy	Deliverable Part 1: Actions and milestones to deliver on the commitment in the DHB’s 2017/18 Annual Plan to implement the Healthy Ageing Strategy (including workforce regularisation).		Provision of complete reports
	Deliverable Part 2: Percentage of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.		95%
PP25: Prime Minister’s Youth Mental Health Project	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement <i>Youth Health Care in Secondary Schools: A framework for continuous quality improvement</i> in each school (or group of schools) with SBHS.		Provision of complete report
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).		Provision of complete report
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB’s youth population.		Provision of complete report
PP26: The Mental Health and Addiction Service Development Plan	Provide reports as specified for each focus area: <ul style="list-style-type: none">FA1 - Primary Mental HealthFA2 - District Suicide Prevention and PostventionFA3 - Improving Crisis Response servicesFA4 - Improving outcomes for childrenFA5 - Improving employment and physical health needs of people with low prevalence conditions.		Provision of complete reports
PP27: Supporting Vulnerable Children			Report on delivery of the actions and milestones identified in the Annual Plan
PP28: Reducing Rheumatic Fever	Focus Area 1: Reducing the Incidence of First Episode Rheumatic Fever, Part 1.	Report progress against BPS target.	Provision of complete report
		Provide progress report against Rheumatic Fever Prevention Plan.	Provision of complete report
		Provide report on lessons learned and actions taken following reviews.	Provision of complete report
	Focus Area 1: Reducing the Incidence of First Episode Rheumatic Fever, Part 2.	Acute Rheumatic Fever hospitalisation rate if above the agreed target and outside a 95% confidence interval of agreed target.	Provision of exception report (if applicable)
	Focus Area 2: Facilitating the effective follow-up of identified Rheumatic Fever cases.		Provision of complete report

PP29: Improving Waiting Times for Diagnostic Services	Coronary Angiography - 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	95%
	CT and MRI - 95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	CT: 95% MRI: 90%
	Diagnostic Colonoscopy - 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.	90% in 14 days 100% in 30 days
	Diagnostic Colonoscopy - 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.	70% in 42 days 100% in 90 days
	Diagnostic Colonoscopy - 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.	70% in 84 days 100% in 120 days
PP30: Faster Cancer Treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	85%
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%
PP32: Improving the Quality of Ethnicity Data Collection in PHO and NHI Registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).	Provision of complete report
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.	90%
PP36: Reduce the rate of Māori under the Mental Health Act: Section 29 Community Treatment Orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	10% reduction by end of 2017/18 reporting year
PP37: Improving Breastfeeding Rates	Infants are exclusively or fully breastfed at three months.	60%
PP38: Delivery of response actions agreed in annual plan		Report on activities in the Annual Plan
SI1: Ambulatory Sensitive Hospitalisations	Age Group 0 – 4 Years	As per SLM Improvement Plan reported through PP22
	Age Group 45-64 Years	<4,160 (Total)
SI2: Delivery of Regional Plans	Provision of a progress report on behalf of the region agreed by all DHBs within the region.	Provision of complete report
SI3: Ensuring Delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	Provision of complete report
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures	An intervention rate of 21 per 10,000 of population.
	Cataract procedures	An intervention rate of 27 per 10,000 of population.
	Cardiac surgery	An intervention rate of 6.5 per 10,000 of population.
	Percutaneous revascularization	An intervention rate of 12.5 per 10,000 of population.
	Coronary angiography services	An intervention rate of 34.7 per 10,000 of population.

SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas: <ul style="list-style-type: none">Mental HealthAsthmaOral healthObesityTobacco		Provision of complete reports
SI7: SLM Total Acute Hospital Bed Days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.		As per SLM Improvement Plan reported through PP22
SI8: SLM patient experience of care	Focus area 1: National inpatient survey		Provide patient experience data and establish baselines for future target
	Focus area 2: Primary care survey	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	As per SLM Improvement Plan reported through PP22
SI9: SLM Amenable Mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.		As per SLM Improvement Plan reported through PP22
SI10: Improving Cervical Screening Coverage	80% coverage for all ethnic groups (Māori, Pacific, Asian, and European/Other) and Overall		80%
SI11: Improving Breast Screening Rates	70% coverage for all ethnic groups (Māori, Pacific and European/Other) and Overall		70%
OS3: Inpatient Average Length of Stay (LOS)	Elective LOS		1.47 days
	Acute LOS		2.3 days
OS8: Reducing Acute Readmissions to Hospital			TBC
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the Quality of Data within The NHI	New NHI registration in error (causing duplication), Group B	≤3%
		Recording of non-specific ethnicity in new NHI registrations	≤2%
		Update of specific ethnicity value in existing NHI record with non-specific value	≤2%
		Validated addresses excluding overseas, unknown and dot (.) in line 1	>76%
		Invalid NHI data updates (no confirmed Target)	TBC
	Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	≥97%
		National Collections File load Success	≥98%
		Assessment of data reported to NMDS	≥75%
		Timeliness of NNPAC data	≥95%

	Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Routine audits with appropriate corrective actions where required	Provide reports as specified about data quality audits.
OP1: Mental Health Output Delivery Against Plan	<p>Volume delivery for specialist Mental Health and Addiction services is within:</p> <ol style="list-style-type: none"> 1. 5% variance (+/-) of planned volumes for services measured by FTE; 2. 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; and 3. actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan. 		Targets met
DV4: Improving Patient Experience			No performance expectation
DV6: SLM Youth Access to and Utilisation of Youth Appropriate Health Services			No performance expectation
DV7: SLM Number of Babies who live in a Smoke-Free Household At Six Weeks Post Natal			No performance expectation

APPENDIX A: 2017/18 Statement of Performance Expectations

Presented to the House of Representatives pursuant to sections 149(L) of the Crown Entities Act 2004

E92



TARANAKI DISTRICT HEALTH BOARD

STATEMENT OF PERFORMANCE EXPECTATIONS 2017/18



Taranaki Together, a Healthy Community
Taranaki Whanui He Rohe Oranga

This Statement of Performance Expectations (SPE) is an integral part of the Annual Plan. However, in order to meet the requirements of Section 149(L) of the Crown Entities Act 2004, we are pleased to present the following information which forms the Statement of Performance Expectations.

While our 2017/18 Annual Plan articulates the strategic direction and activities our DHB intends to take over the next few years. The information contained in this Plan supports the assessment of the activities outlined.

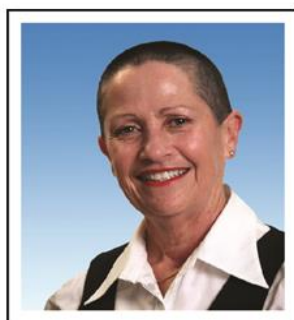
We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop this Statement of Performance Expectations in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2017/18. 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. 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.



A handwritten signature in black ink, appearing to be 'R. Clements', written over a horizontal line.

Rosemary Clements
Chief Executive
Taranaki DHB
Dated: 23 November 2017



A handwritten signature in black ink, appearing to be 'P. Lockett', written over a horizontal line.

Pauline Lockett
Chair
Taranaki DHB
Dated: 23 November 2017

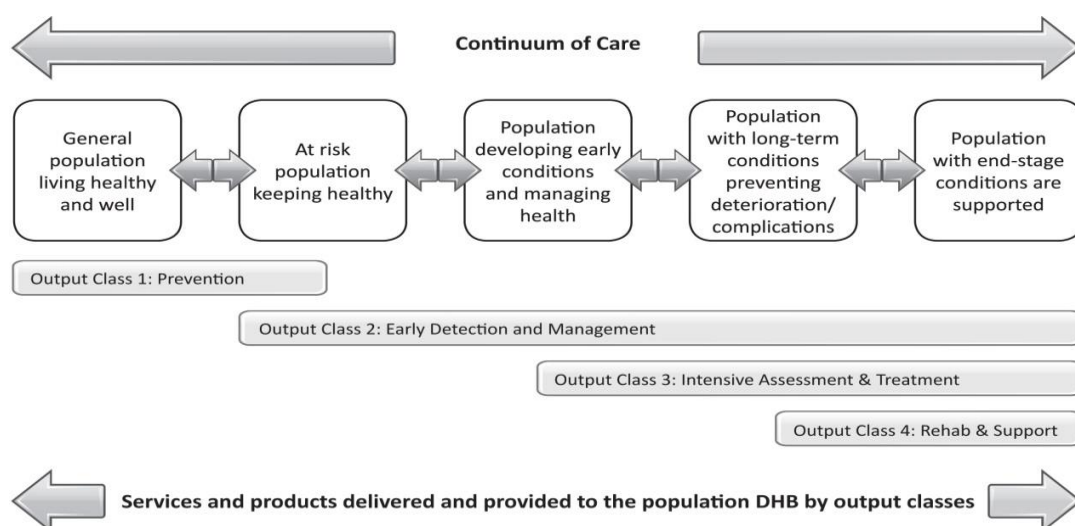


A handwritten signature in black ink, appearing to be 'N. Volzke', written over a horizontal line.

Neil Volzke
Deputy Chair
Taranaki DHB
Dated: 23 November 2017

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. There are four output classes that have been agreed nationally. They represent a continuum of care, as follows:



Output Class	Definition
Prevention	Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.
Early Detection and Management	Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.
Intensive Assessment and Treatment Services	Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together. They include: Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services, Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services, Emergency Department

	services including triage, diagnostic, therapeutic and disposition services. On a continuum of care these services are at the complex end of treatment services and focussed on individuals.
Rehabilitation and Support	Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum on care these services provide support for individuals.

Prospective Financial Performance by Output Class for the three years ended 30 June 2018, 2019 and 2020

Prospective Summary of Revenues and Expenses by Output Class	2017-18 Plan \$000	2018-19 Plan \$000	2019-20 Plan \$000
Early Detection			
Total Revenue	88,922	90,923	92,926
Total Expenditure	89,391	91,274	93,161
Net Surplus / (Deficit)	(469)	(351)	(235)
Rehabilitation and Support			
Total Revenue	57,726	59,025	60,326
Total Expenditure	58,030	59,253	60,477
Net Surplus / (Deficit)	(304)	(228)	(151)
Prevention			
Total Revenue	7,970	8,149	8,329
Total Expenditure	8,012	8,181	8,350
Net Surplus / (Deficit)	(42)	(32)	(21)
Intensive Assessment and Treatment			
Total Revenue	224,916	229,977	235,044
Total Expenditure	226,101	230,866	235,637
Net Surplus / (Deficit)	(1,185)	(889)	(593)
Consolidated Surplus / (Deficit)	(2,000)	(1,500)	(1,000)

Guide to Reading the Statement of Performance Expectations

The following points provided should be kept in mind when reading the Statement of Performance Expectations:

- Baseline 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
- National/Regional Result figures show the 2015/16 national or regional average for the output performance measure (where available)
- 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

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"> Fewer people smoke 	<ul style="list-style-type: none"> Reduction in vaccine preventable diseases 	<ul style="list-style-type: none"> Improving health behaviours

Fewer People Smoke

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Percentage of hospitalised smokers offered advice to quit	Māori	1	qn/t	99%		97%	95%	n/a	n/a
	Non-Māori	1	qn/t	99%		97%	95%	n/a	n/a
	Total	1	qn/t	98%		97%	95%	94%	n/a
Percentage of Primary Health Organisations enrolled smokers offered advice to quit	Māori	1	qn/t	93%	2014/15	86%	90%	n/a	n/a
	Non-Māori	1	qn/t	86%	2014/15	86%	90%	n/a	n/a
	Total	1	qn/t	88%	2014/15	86%	90%	88%	88%
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	96%	90%	n/a	n/a
	Non-Māori	1	qn/t	79%	2013/14	96%	90%	n/a	n/a
	Total	1	qn/t	83%	2013/14	96%	90%	n/a	n/a

Reduction in Vaccine Preventable Diseases

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Percentage of eight month olds fully immunised	Māori	1	qn/t	81%		92%	95%	90%	87%
	Non-Māori	1	qn/t	92%		93%	95%	94%	91%
	Total	1	qn/t	89%		94%	95%	93%	90%

Improving Health Behaviours

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Percentage of infants who are fully, exclusively or partially breastfed at 6 months	Māori	1	qn/t	50%		49%	65%	n/a	n/a
	Non-Māori	1	qn/t	64%		68%	65%	n/a	n/a
	Total	1	qn/t	61%		62%	65%	n/a	n/a
Percentage of pregnant woman that are registered with an Lead Maternity Carer in the first trimester	Māori	1	qn/t	62%	2015	New measure	80%	n/a	n/a
	Non-Māori	1	qn/t	85%	2015	New measure	80%	n/a	n/a
	Total	1	qn/t	79%	2015	New measure	80%	n/a	n/a
Reduce the rate of teenage terminations of pregnancy per 10,000	Māori	1	qn/t	163		132	<132	n/a	n/a
	Non-Māori	1	qn/t	120		60	<160	n/a	n/a
	Total	1	qn/t	131		82	<82	n/a	n/a
Reduce the teen birth rate per 10,000	Māori	1	qn/t	350		217	<217	n/a	n/a
	Non-Māori	1	qn/t	144		97	<97	n/a	n/a
	Total	1	qn/t	195		134	<134	n/a	n/a
The number of referrals to the GRx (Green Prescription) programmes	Adult	1	qn/t	1132		1351	1714	n/a	n/a
	Children	1	qn/t	96		87	35	n/a	n/a
Percentage of obese children identified in the Before School Check (B4SC) Programme offered a referral to a health professional for clinical assessment and intervention	Māori	1	qn/t	n/a		New Measure	95%	n/a	n/a
	Non-Māori	1	qn/t	n/a		New Measure	95%	n/a	n/a
	Total	1	qn/t	n/a		New Measure	95%	n/a	n/a

People Stay Well in their Homes and Communities

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

An Improvement in Childhood Oral Health

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Percentage of adolescent utilisation of DHB funded dental services	Total	2	qn	77%		74%	85%	72%	70%
Percentage of children (0-4) enrolled in DHB funded dental services	Māori	2	qn	59%		79%	95%	n/a	n/a
	Non-Māori	2	qn	82%		102%	95%	n/a	n/a
	Total	2	qn	75%		94%	95%	n/a	n/a
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Total	2	qn/t	9%		3%	10%	n/a	n/a
Access by tamariki and rangatahi to oral health services: Proportion of tamariki and rangatahi that have annual oral healthcare plans in place	0-4 yrs	2	qn/t	n/a		New measure	95%	n/a	n/a
	12-18 yrs	2	qn/t	n/a		New measure	85%	n/a	n/a

Long Term Conditions are Detected Early and Managed Well

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Percentage of eligible women (25-69) have a cervical cancer screen every 3 years	Māori	1	qn/t	73%		68%	80%	66%	69%
	Non-Māori	1	qn/t	88%		81%	80%	78%	80%
	Total	1	qn/t	86%		79%	80%	77%	77%
Percentage of eligible women (50-69) have a breast screen in the last 2 years	Māori	1	qn/t	63%		62%	70%	65%	61%
	Non-Māori	1	qn/t	77%		75%	70%	72%	71%
	Total	1	qn/t	76%		73%	70%	71%	69%
Percentage of population enrolled with a PHO	Māori	2	qn	85%		83%	90%	89%	93%
	Non-Māori	2	qn	97%		96%	97%	95%	97%
	Total	2	qn	95%		93%	97%	94%	96%

Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Māori	2	qn	63%		89%	90%	87%	88%
	Non-Māori	2	qn	75%		92%	90%	91%	92%
	Total	2	qn	73%		92%	90%	91%	91%

Fewer People are admitted to Hospital for Avoidable Conditions

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Percentage of eligible population who have had their B4 school checks completed	High Needs	1	qn/t	86%		90%	90%	93%	n/a
	Total	1	qn/t	88%		94%	90%	92%	n/a
Triage level 4 & 5s presenting to the Emergency Department as a percentage of the total population	Māori	2&3	qn	25%		22%	<23%	n/a	n/a
Reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0-12 years old	Māori	1	qn	48.3	2015/16	New measure	<48.3	52.6	n/a
	Non-Māori	1	qn	30.4	2015/16	New measure	<30.4	28.3	n/a
	Total	1	qn	36.4	2015/16	New measure	<36.4	39.8	n/a

More People Maintain Their Functional Independence

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
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%		96%	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	91%		83%	100%	n/a	n/a

People Receive Timely and Appropriate Care

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

People Receive Prompt and Appropriate Acute and Arranged Care

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Acute inpatient average length of stay	Total	3	ql/t	2.61 days	2014/15	2.61 days	2.3 days	2.55 days	2.58 days
Acute Re-admission rate	Total	3	ql/t	5.22%		7.30%	≤6.9%	7.90%	7.80%
Acute Re-admission rate 75+ years	Total	3	ql/t	8.66%		10.10%	≤10.9%	10.60%	10.60%
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total primary and secondary deliveries	Total	3	ql	20%		17%	<18%	n/a	n/a
Faster cancer treatment (62 day indicator)	Total	3	ql/t	77%	2014/15	76%	90%	74%	71%
Percentage of patients who require chemotherapy are treated with 4 weeks	Total	3	qn/t	100%	2015/16	100%	100%	n/a	n/a
Percentage of patients who require radiation are treated with 4 weeks	Total	3	qn/t	100%	2015/16	100%	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		87%	85%	86%	88%

People Have Appropriate Access to Elective Services

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Did-not-attend percentage for outpatient services	Māori	3	qn/t	19%		17%	5%	13%	13%
	Non-Māori	3	qn/t	7%		6%	5%	5%	5%
	Total	3	qn/t	9%		8%	5%	6%	7%
Number of surgical discharges under the elective initiative	Total	3	qn	113%		6,180	5,478	200,323	n/a
Percentage of patients waiting longer than four months for their first specialist assessment	Total	3	qn/t	0.11%		0.57%	0.00%	0.67%	n/a
Elective inpatient length of stay	Total	3	ql/t	1.52 days	2014/15	1.55 days	1.47 days	1.61 days	1.6 days

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 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Percentage of Child and Youth clients discharged with a transition (discharge) plan.	Total	3	qn/t/q	12%	2014/15	80%	95%	n/a	n/a
Percentage of people referred for addiction services are seen within 3 weeks	0-19 yrs	3	qn/t	62%		84%	80%	87%	91%
	20-64 yrs	3	qn/t	65%		83%	80%	82%	91%
	65+ yrs	3	qn/t	57%		63%	80%	86%	89%
Percentage of people referred for non-urgent mental health are seen within 3 weeks	0-19 yrs	3	qn/t	56%		80%	80%	70%	70%
	20-64 yrs	3	qn/t	84%		90%	80%	84%	87%
	65+ yrs	3	qn/t	89%		90%	80%	81%	83%
The percentage of discharge transition plans sent to GPs within 7 days will be maintained at 95%	0-19 Years	3	qn/t	n/a		New Measure	95%	n/a	n/a

More People with End Stage Conditions are Supported Appropriately

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
A reduction in the percentage of palliative care clients who have had an Emergency Department presentation	Total	3	qn/t	11%		10.0%	≤11.0%	n/a	n/a

Support Services

Outputs	Group	Output Class	Measure Type	Baseline 12/13	Alternative Baseline date	Audited Result 2015/16	Target 2017/18	National Result 2015/16	Midland Result 2015/16
Improved wait times for diagnostic services - accepted referrals receive their CT scan within 42 days	CT	2	qn/t	63%	2014/15	82%	95%	87%	89%
Improved wait times for diagnostic services - accepted referrals receive their MRI scan within 42 days	MRI	2	qn/t	57%	2014/15	94%	90%	70%	80%
Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Cat 1 within 24 hours	2	qn/t	95%		100%	90%	n/a	n/a
	Cat 2 within 96 hours	2	qn/t	95%		100%	90%	n/a	n/a
	Cat 3 within 72 hours	2	qn/t	90%		86%	90%	n/a	n/a
Percentage of Māori employed in the Health and disability workforce at the Taranaki DHB	Māori	4	qn	8.55%	2015/16	8.55%	18%	n/a	n/a

2017-21 Financial Performance Plan

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)	2015/16 audited	Year 0 2016/17 unaudited	Year 1 2017/18 forecast	Year 2 2018/19 forecast	Year 3 2019/20 forecast	Year 4 2020/21 forecast
Hospital Provider + Governance Funding (incl other income)	191,877	193,064	196,877	201,424	205,977	210,533
Non Hospital Provider Funding (NGO)	163,572	170,981	182,657	186,650	190,648	194,652
TOTAL FUNDING	355,449	364,045	379,534	388,074	396,625	405,185
Hospital Provider + Governance expenditure	206,578	211,044	215,877	219,924	223,977	227,433
Payments to Non Hospital Providers (NGO)	152,540	154,811	165,657	169,650	173,648	177,652
TOTAL OPERATING EXPENSES & PAYMENTS	359,118	365,855	381,534	389,574	397,625	405,085
Hospital Provider + Governance Operating Deficit	-14,701	-17,980	-19,000	-18,500	-18,000	-16,900
TDHB Funder surplus	11,032	16,170	17,000	17,000	17,000	17,000
CONSOLIDATED FINANCIAL RESULT	-3,669	-1,810	-2,000	-1,500	-1,000	100

The net consolidated financial projections for the planning period 2017-21 are:

- 2017/18: Deficit \$2.00M
- 2018/19: Deficit \$1.50M
- 2019/20: Deficit \$1.00M
- 2020/21: Surplus \$0.10M

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

1. Key Points from the Budgeted Financials: 2017-21

Taranaki DHB's PBFF share had reduced from 2.79% (2015/16) to 2.67% in 2016/17 and reduced further to 2.65% in 2017/18. Population estimates indicate that Taranaki DHB's population in 2017/18 will show an increase of 0.72% or an increase of 855 from the 2016/17 population projection (please refer Section 2.1 for details). With such a low population growth rate, Taranaki DHB will continue to be in transitional funding for 2017/18 and has received only minimum growth on 2016/17 allocation. The longer term forecast is that the DHB's PBFF share will continue to reduce.

The Taranaki DHB PBFF share in 2017/18 is calculated @ 2.65%. The increase in core funding for 2017/18 over 2016/17 is 2.50% or \$8.14M. Taranaki DHB has the lowest level of increase of any DHB in New Zealand.

The quantum of funding for 2017/18 will require the Board to actively work to restrain costs growth and also requires potential service changes. Equally, the ability to retain funds for investment in services and improvements is severely impacted.

- Against this backdrop, the Board has planned for a consolidated financial deficit, albeit reducing, for each of the initial 3 (three) fiscal periods, with a financial breakeven forecast for Year 4 (2020-21).
- These financial projections reflect a common trend across the entire planning period 2017-21; 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 and clinical supplies (Please refer Sec: 8 - Sensitivity Analysis for details). In addition, there is a cost to funding gap of \$3.00M which is required to be bridged through savings and initiatives. (Please refer to the Section 6: Cost & Efficiency Initiatives section for details).
- The Hospital Provider (and consolidated) financial result in Year 1 (2017/18) and out years continues to be materially influenced by the flow on 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 2017/18 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: 8 - Sensitivity Analysis for details).
- Collectively, the total cost budgeted in 2017/18 for Taranaki DHB to support national and regional agencies (NZHPL, Health Share, other National Agencies) is circa \$1.80M – and increasing year on year. The operating budget is very limited in its ability 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 its 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 structural changes and re-align service configurations in its hospital service operations to reduce the current deficit. Change is inevitable.*
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 reduce investment in community services during the period the hospital operation is going through this transition.*

The Board notes:

- a) That the DHB 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 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 and initiatives - a timeframe spanning 1 to 5 years (as a minimum) is required to bring about meaningful change, and in summary
- f) The financial risk assessment of the current Annual Plan is rated “medium to high” risk under the assumptions and risks stated.

2. Key Risks

2.1 Taranaki DHB’s Funder Operations

Population Based Funding Share (PBFF)

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

Whilst other factors impact on the PBFF share weighting (e.g. age structure and ethnicity), deprivation of the total population number is the most significant factor. Population estimates indicate that Taranaki DHB’s (TDHB) population in 17/18 will be 118,965 people. This is an increase of 855 (or 0.72%) from the 2016/17 population projection (See Table 1)

Table 1: DHB Population Projection Variance

Year	2016/17	2017/18	Change
2015 Population Series	118,110	119,180	1,070
2016 Population Series	117,585	118,965	1,380
Change	-525	-215	855

Taranaki DHBs population growth rate is ranked 18th out of all DHBs (only Wairarapa and West Coast DHBs have lower population growth rates) with such a low population growth rate, Taranaki DHB is unlikely to meet the minimum growth rate set by the Ministry without transitional support. Taranaki DHB will continue to be in transitional funding for 2017/18 and has received only minimum growth on 2016/17 allocation.

The Taranaki DHB PBFF share in 2017/18 is calculated @ 2.65%. The increase in core funding for 2017/18 over 2016/17 is 2.50% or \$8.14M. Taranaki DHB has the lowest level of increase of any DHB in New Zealand.

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 2017/18. Small changes to PBFF percentages result in significant change to funding allocations. The longer term forecast is that the DHB’s PBFF share will continue to reduce.

Table 2 – Taranaki District Health Board PBFF Share

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

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 2017/18 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. Importantly, the ability to carry funds for investment in services and improvements is severely impacted.

The range of pressures that the Taranaki Health System is experiencing is interdependent as noted below:

- ✓ Cost Pressures in Hospital and Specialist Services
- ✓ Cost Pressures in NGO Sector
- ✓ Strategic Investment to progress the Health Action Plan

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 previous 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 surpluses. For 2017/18 the planned Funder surplus is \$17M. This presents a significant challenge for the Funder.

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 \$19.00M 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) Wages – including MECA settlement impacts over plan assumptions.
 - b) Outsourced clinical staff – primarily locum doctors and psychiatrists.
 - c) Diagnostics.
 - d) Acute services such as cardiology, mental health inpatient services and emergency department.
 - 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) Increasing cost contributions to national and regional agencies, 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 2017/18 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) driven 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 approved Midland regional projects and contribution to HealthShare (the regional shared services entity) has been provided. Investment in the Midland e-Space programme will be prioritised along with other national and local IT projects.
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. 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. An increase of 5% in ACC revenues is planned for 2017/18, whilst miscellaneous income assumes \$1.0M to be raised through community donations.
8. During the plan period 2017-21, 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.
9. 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 2017/18 and out years. From a realistic point for realisation of gains from initiatives, a rolling 1 to 5 year planning horizon is assumed.

3. Key Financial Assumptions

The following key assumptions have been employed in the preparation of the financial statements for the four year planning period 2017-21.

3.1 Application of Public Benefit Entity Accounting Standards

The Annual Plan financial template for the plan period 2017-21 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).

3.2 Equity and Borrowing

- a) The Annual Plan 2017-21 has not assumed any additional Crown equity.
- b) The conversion of term debt (\$74M) to Crown equity was completed on 15 February 2017.
- c) Base line capital expenditure is expected to be contained within the level of depreciation for 2017/18 and the three years following.
- d) Taranaki DHB is currently on “performance watch - remedial” status on the performance monitoring scale.

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 2017/18 based on estimated activity levels, reduced for local efficiencies and procurement gains. There is a potential risk in this line.
- c) General operating expenditure: increase noted in ICT costs, the decrease in finance costs offset with increase in capital charge incidental to debt conversion to equity in February 2017. Local efficiencies and cost controls have been built in 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 programmes have been recognised. Gains from local initiatives and projects have been built into the relevant expense budgets.
- e) Other expenditure reductions: the 2017/18 expense budget assumes efficiencies and cost reductions arising from the following:
 - Prioritised service levels
 - Length of stay and patient throughput
 - FTE management
 - Contract tracking + renegotiation + monitoring
 - Demand and capacity management

4. Budgetary Outlay and Assumptions

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 Financial Year 2017/18 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 2017. No surpluses from Mental Health services are envisaged during the 2017-21 plan period and, if any surpluses do eventuate, these will be ring fenced and expended in the year(s) following.

4.2 Interest Income and Payment

Interest on term loans (\$74M) carried in previous periods is NIL in 2017/18 and out years on account of conversion of all term loans to equity in February 2017. Interest on overdraft (usually at month end) is netted off against interest income on overnight deposits under the sweep arrangement of the collective banking and treasury programme, resulting in net interest income for 2017/18 and out years.

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 2017/18 financials arising from any impacts of asset revaluation as on 30 June 2017. A detailed revaluation exercise was completed on 30 June 2013, and updated upon completion of the new build (Project Maunga) in June 2015. An assessment completed @ 30 June 2017 indicated that there has been no material movement (<10%) and consequently no adjustment is required to the current asset base.

4.4 Depreciation

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

4.5 Capital Charge

Capital charge has been calculated in line with existing methodology, adjusted for donations and closing balance of shareholders funds. The increase in equity (\$74M) incidental to the debt equity swap has a consequential increase in capital charge. The difference in cost has been recognised as an increase in revenue to be received via a Top Slice arrangement – with no impact to the bottom line for 2017/18 and out years.

4.6 Leasing

The 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.

4.7 Financial Ratios

The following are some Key Financial Ratios as derived from the consolidated financial statements for the period 2017-21.

Financial Ratios	TDHB 2016-17	Year 1 2017-18	Year 2 2018-19	Year 3 2019-20	Year 4 2020-21
	unaudited	plan	plan	plan	plan
1. Revenue to net funds employed	2.46	2.61	2.72	2.82	2.89
2. Operating margin to revenue	4%	4%	4%	5%	4%
3. Operating return on net funds employed	11%	10%	11%	11%	12%
4. Interest cover ratio	11.06	-	-	-	-
5. Debt to debt equity ratio	-	-	-	-	-

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).

4.9 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 (2017-18)	Year 2 (2018-19)	Year 3 (2019-20)	Year 4 (2020-21)	Total (2017-21)
Operating					
Clinical Equipment	3,000	3,000	3,000	3,000	12,000
Other Equipment	500	500	500	500	2,000
Motor Vehicles	700	700	700	200	2,300
Minor Site Redevelopment (including prior year WIP)	5,000	4,000	4,000	2,000	15,000
Information Technology	6,000	6,000	6,000	6,000	24,000
TOTAL	15,200	14,200	14,200	11,700	55,300
Strategic					
Base Hospital redevelopment. Project Maunga – Stage 2	Scoping & development of BC	Development of BC	Development of BC & submission	Approval	
TOTAL	-	-	-	-	-
GRAND TOTAL	15,200	14,200	14,200	11,700	55,300
Sources of Funding					
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	15,200	14,200	14,200	11,700	55,300

4.10 Capital Divestment

The disposal of surplus assets proposed during the period 2017-21 is as follows:

Asset	Book value (\$)	Realisable Value (\$)	Gain/(loss) On sale (\$)	Timing
* Miscellaneous equipment (discarded/obsolete)	0	Not material	0	2017-21
* Surplus land	0	0	0	n/a
* Vehicles	0	Not Material	0	2017-21
Total	0	0	0	

Taranaki DHB will ensure that disposal of any land transferred to, or vested in it pursuant to the Health Sector (Transfers) Act 1993 will be subject to approval by the Minister of Health. Taranaki DHB will work closely with the Office of Treaty Settlements to ensure the relevant protection mechanisms that address the Crown's obligations under the Treaty of Waitangi and any processes relating to the Crown's good governance obligations to Māori sites of significance are addressed.

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.

	Forecast 2016/17		Yr 1 - 2017/18		Yr 2 - 2018/19		Yr 3 - 2019/20		Yr 4 - 2020/21	
	Contract	Accrued	Contract	Accrued	Contract	Accrued	Contract	Accrued	Contract	Accrued
* Medical	164	167	174	177	174	177	175	179	176	180
* Nursing	619	652	604	630	610	637	615	642	618	645
* Allied Health	267	282	272	294	272	294	270	292	270	292
* Support	96	99	96	98	96	98	96	98	96	98
* Mgt & Admin	271	278	277	282	277	282	277	282	277	282
* Gov & Funding Admin	16	18	18	18	18	18	18	18	18	18
TOTAL	1433	1496	1441	1500	1447	1506	1451	1510	1455	1515

- 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 will show only marginal increases year on year, and 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, any increase being recruitment to existing vacant positions. Management and Administration staffs 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 has been 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 (introduced in 2009), having contained demand through internal reviews and restructures. 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 contain FTE growth, however it is acknowledged that there will be demand for clinical resources due to increase in activity levels – primarily acute demand. 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.

5. Capital Expenditure: Strategic

5.1 Base Hospital Inpatient Facilities Development Programme

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

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	Timeline	Status
STAGE 1	Theatres, Ambulatory, Inpatient wards	\$80M	Start: Aug 2011 Finish: June 2014	Completed.
STAGE 2	Maternity, Neonatal, ED, Radiology, ICU	\$37M (2007 estimate)	Tentative: 2021-2022	Preliminary works commenced. Business Case to be developed.
STAGE 3	OPD, Administration, Renal	\$28M (2007 estimate)	Tentative : 2025-2026	Supplementary Business Case to be progressed.
TOTAL		\$145M (2007 estimate) <i>See notes</i>	2011 – 2026	

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. Scoping and planning for Stage 2 of Project Maunga has commenced with preliminary works in progress. The planning and resources required to progress the Business Case through the different stages leading to approval are being established. The capital budget for Stage 2 and 3 are currently based on cost estimates drawn in 2007 at the time of Stage 1 finalization. With the efflux of time and inflation, indications are that the capital outlay required for Stages 2 and 3 will increase to \$70M and \$40M (from the 2007 estimates of \$37M and \$28M) respectively. The capital budget for these two stages will be established when the scoping and preliminary design are completed.
3. Each of the stages can be visualised as stand alone projects, yet forming part of one coherent facilities redevelopment programme for the Base Hospital in New Plymouth, thus enabling affordability to both Taranaki DHB and the National Health capital budget.

An updated Schedule of Capital Intentions has been submitted.

6. Cost and Efficiency Initiatives

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope. There is a growing financial gap. 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.

The following key initiatives are being considered within the Hospital Provider operations to generate efficiency gains, and bridge its cost to funding gap if it has to meet its plan target for 2017/18 and contain its growing operating deficit.

Initiatives	Proposal	Potential Est. (\$)	Impact
Internal cost controls: Campus wide cost management strategies to reduce discretionary costs	Target specific areas of cost for efficiency gains including review of service delivery and demand.	\$0.50M	Reduce operating costs
Diagnostic Initiatives: Review of referral processes and patterns in diagnostic services – radiology and pathology	Review and re-structure of diagnostic service frameworks and processes.	\$0.80M	Reduce diagnostic costs.
Demand Management: e-referrals, i-procurement and review of internal systems	Reviews of service delivery against targets and contracts.	\$0.40M	Reduce service costs
Project Cost management: Review and re-negotiation of service contracts against delivery and measurable outcomes	Ongoing review of contracts in the DHB Funder and Hospital services.	\$0.50M	Reduce operating costs
Staff strategies: FTE vacancy management + other staffing initiatives	Range of FTE management initiatives across the organisation.	\$0.40M	Reduce operating costs
Additional savings initiatives:	Additional savings initiatives to be identified and evaluated.	\$0.40M	Reduce operating deficit
TOTAL		\$3.00M	

The Annual Plan 2017/18 has identified a cost to funding gap of circa \$3.00M, 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 progressively generate cost savings and have been recognised in current and out years.

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

The financial management 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 is part of a broader primary secondary integration initiative currently under consideration.

7. Banking and Cash Flow

The primary assumptions carried in the Financial Plan 2017/18 are:

- Overdraft facilities (as per OPF guidelines) are assumed to be available under the DHB collective treasury and banking arrangement (currently with Westpac - changing to BNZ).
- 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 2017/18 and out years.
- The shift of capital financing from Crown debt to Crown equity has been completed. 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 2017/18 has been effected as it is assumed there will be no impact to the bottom line for 2017/18 and out years.

8. Sensitivity Analysis: Budgetary Risks Carried in Annual Plan 2017/18

The Annual Plan carries some key financial risks – *besides the \$3.00M cost to funding gap (see Sec: 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 2017/18

Unbudgeted financial risk	Est. risk (\$M)	75% risk (\$M)	50% risk (\$M)	25% risk (\$M)	Probability factor (% risk)
Wage budget (incl RMO wage bill)	1.00	0.75	0.50	0.25	75%
Timing of gains from savings plan	1.40	1.05	0.70	0.35	75%
Clinical supplies	0.80	0.60	0.40	0.20	75%
General overheads	0.40	0.30	0.20	0.10	25%
Likely impact on 2017/18 planned financial result	\$3.60M	\$2.70M	\$1.80M	\$0.90M	\$2.50M

The overall risk is expected to be **\$3.60M** for 2017/18, while the probability factor is estimated to be around **70%** leaving a residual risk equating to about **\$2.50M**. The risk is expected to be managed through a mix of:

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

DHB Funder Operations – Key Risks in 2017/18

Unbudgeted financial risk	Est. risk (\$'M)	75% risk (\$'M)	50% risk (\$'M)	25% risk (\$'M)	Probability factor (% risk)
Hospital provider deficit increase	3.00	2.25	1.50	0.75	50%
IDF Above Plan	1.00	0.75	0.50	0.25	50%
Pharmaceuticals	0.50	0.375	0.25	0.125	25%
Health of Older People	1.00	0.75	0.50	0.25	50%
Pathology services transition	1.00	0.75	0.50	0.25	50%
Potential impact on 2017/18 planned financial result	6.50M	4.875M	3.25M	1.625M	3.125M

The overall exposure is estimated at around **\$6.50M** for 2017/18, while the probability factor is estimated to be around **50%** leaving a residual risk equating to about **\$3.12M**.

These risks are expected to be managed through contract monitoring.

9. Statement of Comprehensive Income

(\$'000)	Audited	Forecast		Planned			
	2015/16	2016/17		2017/18	2018/19	2019/20	2020/21
Revenue							
Devolved Funding	333,768	340,828		355,433	363,510	371,587	379,663
Non-Devolved Contracts	6,547	6,524		6,521	6,586	6,651	6,717
Inter-DHB & Interprovider Revenue	4,147	4,885		4,954	5,127	5,306	5,491
Other Revenue	10,987	11,808		12,626	12,851	13,081	13,314
Total Revenue	355,449	364,045		379,534	388,074	396,625	405,185
DHB Provided Expenditure							
Personnel	123,086	130,874		136,728	139,462	142,250	145,093
Outsourced Personnel & Support	1,390	2,223		1,694	1,728	1,762	1,797
Outsourced Clinical Services	16,817	13,940		13,176	13,440	13,709	13,983
Clinical Supplies	26,489	28,056		26,524	27,054	27,595	28,146
Infrastructure & Non-Clinical Supplies	38,796	35,951		37,755	38,240	38,661	38,414
Total DHB Provided Expenditure	206,578	211,044		215,877	219,924	223,977	227,433
Other Providers							
Personal Health	61,483	66,347		66,829	68,600	70,335	72,027
Mental Health	10,974	11,030		11,168	11,442	11,714	11,986
Public Health	888	676		751	766	781	797
DSS	37,595	37,478		44,683	45,576	46,486	47,416
Maori Health	2,863	2,879		2,879	2,936	2,994	3,054
IDFs	38,737	36,401		39,347	40,330	41,338	42,372
Total Other Providers	152,540	154,811		165,657	169,650	173,648	177,652
Total Expenditure	359,118	365,855		381,534	389,574	397,625	405,085
Total Consolidated Result	(3,669)	(1,810)		(2,000)	(1,500)	(1,000)	100
Represented By:							
Provider	(18,890)	(18,078)		(19,000)	(18,500)	(18,000)	(16,900)
Governance	59	98		0	0	0	0
Funder	15,162	16,170		17,000	17,000	17,000	17,000
	(3,669)	(1,810)		(2,000)	(1,500)	(1,000)	100

10. Consolidated Statement of Financial Position

(\$'000)									
			2015/16 audited	2016/17 unaudited		2017/18 plan	2018/19 plan	2019/20 plan	2020/21 plan
CURRENT ASSETS									
* Bank Account			488	270		270	270	270	2619
* ST investments			2890	2890		2890	2890	2890	2890
* Prepayments			1417	2705		1625	1640	1655	1670
* Debtors (net of provision)			11897	8708		8798	8828	8858	8888
* Inventory			2798	2818		2833	2837	2841	2845
			19490	17391		16416	16465	16514	18912
CURRENT LIABILITIES									
* Bank Account			8672	3349		3521	3069	2060	0
* Creditors & other payables			18685	18872		18757	19055	19410	19565
* Term Loans (current portion)			0	0		0	0	0	0
* Provisions			25204	26080		26525	26715	26905	27095
			52561	48301		48803	48839	48375	46660
WORKING CAPITAL			-33071	-30910		-32387	-32374	-31861	-27748
NON CURRENT ASSETS									
* Net Fixed Assets			180258	175371		173914	171457	169000	164043
* Investments			2911	2869		2869	2869	2869	2869
* Trust funds			815	815		815	815	815	815
			183984	179055		177598	175141	172684	167727
NET FUNDS EMPLOYED			150913	148145		145211	142767	140823	139979
NON CURRENT LIABILITIES									
* Provisions - non current			661	661		686	701	716	731
* Term Loans			74000	0		0	0	0	0
			74661	661		686	701	716	731
CROWN EQUITY									
* Crown Equity			22206	95248		94289	93330	92371	91412
* Reserves			68264	68264		68264	68264	68264	68264
* Retained earnings			-14218	-16028		-18028	-19528	-20528	-20428
			76252	147484		144525	142066	140107	139248
NET FUNDS EMPLOYED			150913	148145		145211	142767	140823	139979
Debt: Debt equity ratio			49%	0%		0%	0%	0%	0%

11. Consolidated Statement of Cashflow

(\$'000)									
	2015/16 audited	2016/17 unaudited	2017/18 plan	2018/19 plan	2019/20 plan	2020/21 plan			
OPERATING ACTIVITIES									
* MOH funding	341559	351840	360823	370096	378213	386355			
* Other revenue	14773	16265	17125	17552	17986	18404			
total receipts	356332	368105	377948	387648	396199	404759			
* Payment of salaries & operating exp.	190060	194307	197605	203031	207084	210540			
* Payment to providers & DHB's	152718	156710	164757	169407	173348	177552			
total payments	342778	351017	362362	372438	380432	388092			
NET CASHFLOW FROM OPERATIONS	13554	17088	15586	15210	15767	16667			
INVESTING ACTIVITIES									
* Interest & Dividends Received	345	436	401	401	401	401			
* Sale of fixed assets etc	85	84	0	0	0	0			
* (Increase) / decrease in investments	359	0	0	0	0	0			
* Capital expenditure	-13304	-11545	-15200	-14200	-14200	-11700			
NET CASHFLOW FROM INVESTING	-12515	-11025	-14799	-13799	-13799	-11299			
FINANCING ACTIVITIES									
* Equity injections / repayments	-958	73042	-959	-959	-959	-959			
* Borrowings	0	0	0	0	0	0			
* Payment of debts	0	-74000	0	0	0	0			
NET CASHFLOW FROM FINANCING	-958	-958	-959	-959	-959	-959			
Total cash in	355374	367147	376989	386689	395240	403800			
Total cashout	-355293	-362042	-377161	-386237	-394231	-399391			
NET CASHFLOW	81	5105	-172	452	1009	4409			
Add: Cash (opening)	-8265	-8184	-3079	-3251	-2799	-1790			
CASH (CLOSING)	-8184	-3079	-3251	-2799	-1790	2619			

12. Consolidated Statement of Movement in Equity

					2016/17 forecast	2017/18 plan	2018/19 plan	2019/20 plan	2020/21 plan
EQUITY AT THE BEGINNING OF PERIOD					76252	147484	144525	142066	140107
* Net results for the period					-1810	-2000	-1500	-1000	100
* Revaluation of Fixed assets					0	0	0	0	0
* Equity Injections / (repayments)					73042	-959	-959	-959	-959
* Other					0	0	0	0	0
EQUITY AT THE END OF THE PERIOD					147484	144525	142066	140107	139248



2017-2018

System Level Measures
Improvement Plan
Taranaki District Health Board
and
Midlands Regional Health Network

Prologue

Meetings held between Taranaki DHB and our Primary Care partner Pinnacle Midlands Health Network, in March and May 2017 agreed that the approach towards System Level Measures planning to date has had insufficient timeframes to develop a robust system wide improvement plan for service provision designed specifically to improve patient outcomes.

In light of this, the Taranaki Alliance Leadership Team (TALT) sees the 2017/18 year as an opportune time for a transitional approach towards system level planning guided by the System Level Measures baselines to target planning for services, integration and improved care pathways. Throughout the final quarter of the 2017/18 year we will work through the following stages with the appropriate teams (clinical and non-clinical):

- Undertake detailed analysis of the baseline data and “current situation”. We will do this locally and also compare regionally for any potential alignment and synergies.
- Define priority areas using the above analysis – again locally initially then with the consideration for any regionally consistent priority areas
- Give comprehensive consideration to true system level/integrated improvement in service models over an appropriate period of time 5 years
- Determine the improvement milestones and contributory measures that align with those action points in the above findings.

Signed 

David Oldershaw
Acting Chief Executive
Pinnacle Midland Health Network

Dated 2/8/17.

Signed 

Rosemary Clements
Chief Executive
Taranaki District Health Board

Dated 1/8/17

2016/17 Baseline						
	Year to September 2016	Year to September 2016		Years 2009 - 2013	2015/16	Jul 16 – Dec 16
Summary	0-4 ASH Rates per 100,000	Standardised Acute Bed Days per 1,000 population	Patient Experience of Care	Amenable Mortality	Youth Measure per 100,000	Smokefree Households @ 6 Weeks post natal
			Patient Experience Survey			
Māori	7248	477	-	221.8	554.6	-
Non-Māori	-	-	-	101.6	550.0	-
Other	6556	366	-	-	-	-
Pasifika	-	284	-	-	-	-
Total Baseline	6779	377	0%	112.0	-	98.4%
2017/18 Milestones						
Māori	6969	459	-	213.3	500	-
Non-Māori	-	-	-	99.1	500	-
Other	6396	357	-	-	-	-
Pasifika	-	273	-	-	-	-
Total	-	-	90%	-	-	99.4%
	2.5% improvement in Other & 4% improvement in Māori	2.5% improvement in Other & 4% improvement in Māori and Pasifika	An increase from 0% of General Practices offering the patient experience survey to 90%	2.5% improvement for Non-Māori & 4% improvement for Māori	Reduction in self harm hospitalisation rates for Māori and Non-Māori	1% improvement for all ethnicities

Ambulatory Sensitive Hospitalisations (ASH)

ASH Rates per 100,000 population for 0-4 year olds

All baseline data is at

The contributory measures chosen make up the current top six ASH conditions for Taranaki for 0-4 Year olds. Taranaki DHB and Pinnacle Midlands Health Network believe improving outcomes for pre-schoolers affected by these conditions will provide the best opportunity to reduce ASH Rates per 100,000 population for 0-4 year olds in Taranaki. Measuring the milestones by ethnicity is an acknowledgement of the need to reduce the current disparities between Māori and other ethnicities.

We will monitor against a target of achieving a reduction of 4% for Māori and 2.5% for 'other' non- Māori in order to reduce inequality during 2017-2018

Taranaki DHB			
Baseline		Baseline 16/17 (year to Sept 2016)	Milestones 17/18
	Māori	7248	6969
	Other	6556	6396
	Total	6779	-

ASH rates in 0-4 year olds		
Improvement milestone	Actions/Activities	Contributory measures
A reduction by 4% for Māori and 2.5% for 'other' across the DHB in order to reduce inequality was the agreed 2017/2018 milestone. Note the 'total' row has been removed as it is not possible to estimate this with any accuracy.	Complete a Project Scope to inform the feasibility of a "Healthy Homes" proposal to retrofit cold damp homes for those whanau who have 0-4 year olds attending ED frequently for respiratory conditions by end of Q2	A reduction in hospital admissions for children aged five years with a primary diagnosis of asthma
	Decided on extent of implementation of Project in 2018/19 by Q4 Identify 'frequent flyers' to ED and match with PHO/General Practice data including analysis by ethnicity by end of Q2 Identify what can be put in place at the General Practice to support this high needs vulnerable group to stay well including: <ul style="list-style-type: none"> Enrolment with a General Practice Smoking Cessation support to encourage smokefree homes and vehicles Active care plans MDT involvement where necessary by end of Q4 	A reduction in four year old children living in smokefree homes
	Undertake a Health Equity Assessment (HEAT) of Taranaki DHB funded Oral Health Care services to identify barriers to enrolment and engagement for Māori in the Community Oral Health Service by Q3 Using the recommendations from the HEAT assessment develop and implement a plan to eliminate current barriers for Māori to support ongoing engagement with the Community Oral Health service for 0- year olds with the aim of improving oral health literacy for parents and caregivers by Q4	Reduced hospital admissions for children aged five years with dental caries as primary diagnosis

Acute Bed Days

Number of bed days for acute hospital stays per 1000 population domiciled within Taranaki DHB per year (standardised)

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers. This includes access to diagnostics services.

The measure will be used to manage the demand for acute inpatient services on the health system. The intent of the measure is to reflect integration between community, primary, and secondary care and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care.

The measure aligns well with the New Zealand Health Strategy's five themes, in particular - value and high performance.

	Taranaki DHB		
		Baseline 16/17 (year to Sept 2016)	Milestones 17/18
Baseline *using census 2013 usual resident population	Māori	477	459
	Other	366	357
	Pasifika	284	273
	Total	377	-

Acute Hospital Bed Days		
Improvement milestone	Actions/Activities	Contributory measures
<i>A reduction of 2.5% for non-Māori and non-Pasifika/Other and 4% for Māori and Pasifika has been agreed as the 2017-2018 milestone. The 'total' row values have been ignored in the milestones column as it is difficult to calculate across varying rates of reduction.</i>	Promote increased utilisation of Primary Options at General Practices for DVT and Cellulitis to provide care closer to home by Q4	A reduction in hospitalisations due to cellulitis and DVT
	Ensure baseline data of numbers by ethnicity of people admitted to hospital for Cellulitis and DVT by the end of Q1 and for future Q	
	Increase the availability of influenza vaccines in Community Pharmacies for people >65 years and pregnant woman	Increased number of eligible people vaccinated against influenza
	Extend ACC fall's prevention programme in Taranaki from Q1	A reduction in the acute/arranged hospital admissions of PHO enrolled population aged 15 to 74 years
	Ensure Baseline data for acute bed days for people due to falls by the end of Q1	

Patient Experience of Care

90% of general practices uptake the primary care patient experience survey by 30 June 2018

- The percentage of GP practices using the primary care patient experience survey to inform quality improvement measured by the uptake of the primary care survey developed by the Health Quality & Safety Commission (HQSC)
- An increase in the percentage of General Practices offering patient e-portal
- An increase in the percentage of patients using the patients e-portal

The purpose of these measures is to ensure patients in New Zealand are receiving quality, effective and integrated health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. Having General Practices using the patient care survey is a first step to identifying the patient perception of the quality of their health care in the community.

How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Improved patient experience of care will reflect better integration of health care at the service level, better access to information and more timely access to care.

An increase in General Practices enrolling their patients in the e-portal will increase patient health literacy and promote the use of IT to better utilise GP appointments which will support a change in the model of care in General Practice to move toward a more sustainable service.

Taranaki DHB			
Baseline		Baseline 16/17	Milestones Q4 17/18
	Increase in General Practices uptake of Patient Experience Survey	0%	90%
Improvement milestone	Actions/Activities		Contributory measures
An increase from 0% of General Practices offering the patient experience survey to 90%	Support for General Practices to register with Cemplicity		The number of GP practices who offer the Patient Experience Survey to patients
	Support General Practices with training to enable uptake of the Patient Experience Survey		
	Actively encourage and support patients to complete the patient experience survey		The number of patients who complete the Patient Experience Survey after interacting with a General Practice
	Encourage General Practices to collect and update patient email addresses to enable higher completion rates of the patient experience survey		
	Actively encourage and support patients to enrol in the e-portal programme		The proportion of patients who are registered with the e-portal programme increases to 15%
Actively encourage and support general practices to enrol patients in the e-portal programme			

Amenable Mortality Rates

Untimely, Unnecessary deaths from causes amenable to health care (per 100,000)

About half the deaths under 75 years of age in New Zealand are classified as amenable according to the current code list. That is, they are ‘untimely, unnecessary’ deaths from causes amenable to health care.

We will monitor against a target of achieving 4% for Māori and 2.5% for non- Māori categories in order to reduce the gap between Māori and non-Māori. The ‘total’ row values have been removed as it is difficult to calculate with varying rates of reduction.

	Taranaki DHB		
		Baseline 16/17 (2009-2013)	Milestones 20/21
Baseline	Māori	221.8	213.3
	Non-Māori	101.6	99.1
	Total	112.0	-

Amenable Mortality (not financially incentivised)		
Improvement milestone	Actions/Activities	Contributory measures
<i>Reduction for the milestones is set at 4% for Māori and 2.5% for ‘other’, Pacific and non-Māori categories in order to reduce the gap between Māori and non-Māori. The ‘total’ row values have been ignored in the milestones column as it is difficult to calculate across varying rates of reduction.</i>	Implement a referral pathway for identified smokers to the specialist smoking cessation provider from Community Pharmacy	Increased percentage of registered smokers who have been referred to a smoking cessation service
	Implement a referral pathway for identified smokers to the specialist smoking cessation provider from General Practices	
	Ensure the prioritise smoking cessation support for Māori and pregnant woman within these pathways	
	Strengthen recall system for all people with a diagnosis of Diabetes within General Practice	Percentage of enrolled people in the PHO within the eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64mmol/mol or less ¹
	Strengthen a recall system for all people with a diagnosis of CVDRA within General Practice General Practice	Percentage of PHO enrolled people within the eligible population who have had a CVD risk recorded within the last five years and/or measure showing good management of CVD risk ²

¹ People living with diabetes are regarded as leading partners in their own care within systems that ensure they can manage their own condition effectively with appropriate support.

² Cardiovascular disease, including heart attacks and strokes, are substantially preventable with lifestyle advice and treatment for those at moderate or higher risk.

Youth are healthy, safe and supported

Developmental measure for 2017-2018

Young people (10-24 years of age) are valuable to our community with important contributions to make now and in the future. As agencies and providers of health care we're entrusted with supporting the wellbeing of our young people.

Domain: Mental Health and Wellbeing

National Indicator: Self harm hospitalisations and short stay ED presentations for under 24 year olds

Why it is a focus: As a result of a Mental Health and Addictions SLAT in 2016 a significant gap was acknowledged in the continuum of care for young people. The majority of current service provision is targeted towards the acute/specialist end of care and very little towards early intervention and prevention. The development of a Child and Youth Wellness Service will provide a gateway for young people and their family/whanau to access targeted interventions in a coordinated and managed way to prevent their problems from escalating.

During the development and pilot phase the service will work with identified General Practices, schools, CAMHS and other relevant stakeholders to support timely access for young people to evidenced based interventions.

Baseline data is calculated at the rate per 100,000 of the population

	Taranaki DHB		
Baseline		Baseline 15/16	Milestones 17/18
	Māori	554.6	500
	Non-Māori	550.0	500
Improvement milestone	Actions/Activities		Contributory measures
LOCAL 10% reduction from baseline 15/16 on the rates of admission for intentional self harm. For 15/16 Māori were disproportionately represented in the rates of admission which is not reflected in previous years stats.	Implement a Child and Youth Wellness Service (shifting the continuum of care from specialist mental health and addictions – to primary/community level mild to moderate system response). <ol style="list-style-type: none"> 1. Establish Team (4.0 FTE Youth Wellness Clinicians, 1.0 FTE CAMHS Clinician) 2. Programme development, Pathways to Access, Policies and procedures, toolkits /programmes. 3. Engage with stakeholders (Pilot / prototyping with schools, GPs) 4. Develop outcomes framework and reporting measures 5. Build an evaluation framework. 6. Build IT infrastructure – built into Whanau Tahī 		<ul style="list-style-type: none"> • Reduction in the % of referrals to CAMHS services (baseline to be calculated). • By 31 August 2017 all positions recruited to. • By 30 September 2017, Engagement process and programme development completed. • By 30 September 2017 reporting and outcome measurement developed. • By 30 September 2017 evaluation framework completed. • By 30 January 2018 Electronic Client Management system is developed.

Proportion of babies who live in a smoke-free household at six weeks post-natal

Developmental Measure 2017-2018

A reduction in the prevalence of smoking in women who are intending pregnancy or who are pregnant is a priority. Maternal smoking is associated with a range of poor neonatal and child health outcomes, as is exposure to second-hand cigarette smoke in the environment in which an infant lives. This measure will focus attention beyond just maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care.

Babies who live in a smokefree household at 6 weeks post natal. Base-line data by ethnicity will be collected for the 6 weeks post natal population during 2017/2018 as it is not available at present.

	Taranaki DHB		
Baseline		Baseline 16/17 (July 16 – December 16)	Milestones 17/18
	Māori	-	-
	Non-Māori	-	-
	Total	98.4%	99.4%

Improvement milestone	Actions/Activities	Contributory measures
1% improvement in the proportion of babies who live in a smoke-free household at six weeks post-natal (all ethnicities).	<ol style="list-style-type: none"> 1. Establish the Hapu Wananga, a kaupapa Māori antenatal and parenting education programme, with a focus on identifying and referring pregnant Māori women and their whanau who smoke into the Taranaki smoking cessation specialist services. 2. Work with LMC's, Community Pharmacy and GP services to establish referral pathways for pregnant Māori women who smoke into the Taranaki smoking cessation specialist service. 3. Work with WCTO providers to ensure that ethnicity is recorded for all contacts so baselines can be set for the 2018/19 System Level Measure by ethnicity. 	<ol style="list-style-type: none"> 1. Healthy mums and babies; by 2021, 90% of pregnant women are registered with a LMC in their first trimester, with an interim target of 80%, with equitable rates for all population groups. 2. Percentage of women identified as smokers at first registration with LMC 3. Percentage of Māori women identified as smokers during post-natal period (two weeks after birth)