



TARANAKI DISTRICT HEALTH BOARD

TARANAKI DISTRICT HEALTH BOARD

ANNUAL PLAN

2018/19

Incorporating the 2018/19 Statement of Performance Expectations

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga



Mihi

Ko Puanga te hua o te tau hou.
Ka rewa i te atatū, ko te uranga o te rā.
Ka haehae i te pō, ka takina te pō ki tua.
E matarikoriko ana ki te pae o tō rangi.
E wherawhera ana ki ō pae ki mua.

Tēnei rā te puanga mai o te ora e rewa nei ki te tihi o Taranaki.
Te kōhae nei, te korakora nei ki te pae o te tau ki mua.
He ahunga rau, he hokinga mahara atu i te tau kua hipa
Te maunutanga mai o te tau pai, ko te tau kei runga.
Kia piri, kia tata mai ki te whare o Tāne whakapiripiri
Kia ihiihi, kia wanawana mai ki te kura o Tāne te wānanga
Kia tū, kia oho ki te paepae tapu o Tāne te waiora.
Taranaki e, kia horapa te pai, he tūāpapa ki te ora

*Puanga heralds the new year.
Rising at early dawn, the prelude of a new day.
Vanquishing the night, leaving darkness behind.
Gleaming on the cusp of the horizon.
Revealing what new horizons are possible.*

*This statement for wellbeing is like that star that rises above Taranaki.
Gleaming and radiating, signalling the threshold of the forthcoming year.
Reflecting back also to the achievements and events of the year past
The year is launched forward with aspirations of new productivity and growth
To draw people closer together in mind and spirit, the essence of our connection
To invigorate and excite with knowledge and insight, the essence of our intellect
To strengthen and awaken with values and practice, the essence of our wellbeing
Taranaki, may compassion be widespread, and the foundation of health*

Mihi authored by Ruakere Hono

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Ministers Letter of Approval to Taranaki DHB

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance



27 FEB 2019

Ms Pauline Lockett
Chair
Taranaki District Health Board
pauline.lockett23@gmail.com

Dear Pauline

Taranaki District Health Board 2018/19 Annual Plan

This letter is to advise you I have approved and signed Taranaki District Health Board's (DHB) 2018/19 Annual Plan for one year together with the Minister of Finance.

I have been clear that my expectation for the total DHB sector financial position was that it was an improvement on 2017/18. I am concerned that this expectation is unlikely to be met. I have previously emphasised to you that it is important DHBs are doing all they can individually and collectively – both regionally and nationally to live within the funding provided.

I understand your DHB has planned deficits for 2018/19 and the out years. I encourage your Board to consider appropriate activities to ensure that you reduce the projected deficits for 2018/19 and in the coming years. This will require a concerted effort and I trust that you will continue to work with the Ministry of Health to evaluate and improve your financial performance.

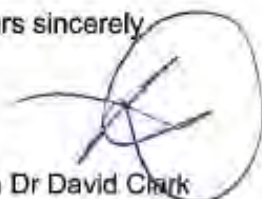
Your Production Plan is still to be confirmed, and you will work with the Ministry to resolve this.

I am aware you are planning a number of service reviews in the 2018/19 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. 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.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders. I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2018/19 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

A handwritten signature in blue ink, consisting of a large loop and several intersecting lines, positioned over the printed name of the Minister of Health.

Hon Dr David Clark
Minister of Health

cc: Ms Rosemary Clements, Chief Executive, Taranaki District Health Board,
rosemary.clements@tdhb.org.nz

SECTION 1: Overview of Strategic Priorities

1.1 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.

National

The 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).

The Taranaki DHB Annual Plan is underpinned by *Te Tiriti o Waitangi* principles of partnership, participation and protection. We acknowledge the special relationship between the Crown and *Tāngata Whenua* and will actively work with Māori to affirm *Te Tiriti o Waitangi* principles.

New Zealand Health Strategy

The New Zealand Health Strategy outlines the high level direction of the New Zealand health system over the next 10 years along with a Roadmap of Actions. The Strategy identifies five strategic themes for the changes that will take us toward this future:

- People-powered
- Closer to home
- Value and high performance
- One team
- Smart system

The strategy has a ten-year horizon, so impacts on not just immediate planning and service provision but enables and requires DHBs and the sector to have a clear roadmap for future



He Korowai Oranga

As New Zealand's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Pae Ora (Healthy Futures) is the Government's vision and aim for the refreshed strategy. It builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments). DHBs in particular should consider He Korowai Oranga in their planning, and in meeting their statutory objectives and functions for Māori health.

Healthy Ageing Strategy

The Healthy Ageing Strategy presents the strategic direction for change and a set of actions to improve the health of older people, into and throughout their later years. The Healthy Ageing Strategy vision is that "older people live well, age well, and have a respectful end of life in age-friendly communities". It takes a life-course approach that seeks to maximise health and wellbeing for all older people. 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.

The UN Convention on the Rights of Persons with Disabilities

The UN 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.

'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. 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, to be delivered from 2014 to 2018.

Regional

Midlands DHBs collaborate regionally to develop a Regional Services Plan (RSP). The RSP is a companion plan to DHB Annual Plans. HealthShare Ltd, the Midland DHBs' shared services agency, is tasked with developing the Midland RSP on their behalf. This work is done in consultation with the Midland DHBs Annual Plan Writers Group and DHB Executive Groups to ensure collaboration and 'line of sight' (alignment) between the region and DHB planning.

In this year's guidance, the Ministry has placed greater emphasis on the Regional Enablers, i.e. Equitable Access and Outcomes, Workforce, Technology and Digital Services, Quality, Clinical Leadership and Pathways. The implementation of an integrated Hepatitis C assessment and treatment service across community, primary and secondary care services has also been signalled as a regional priority.

Local

Taranaki Health Action Plan

The strategic direction for Taranaki DHB is outlined in the Taranaki Health Action Plan 2017-20. The Plan describes the transformational journey the Taranaki health system will take to redesign how care is delivered in the district to ensure the sustainable achievement of improving health outcomes.

The rationale for the Taranaki Health Action Plan is as follows:

- Improving patient access and population health outcomes, with a particular focus on improving equity for Māori
- Acknowledged clinical and financial sustainability issues
- Earlier strategic organisational review of Taranaki DHB identified opportunities to improve priority-setting and delivery

The Plan provides an overarching framework for the Taranaki health system, with a 10-year vision, underpinned by a targeted three-year programme of work that will position the system to achieve its long term vision.

Our six strategic focus areas are:

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

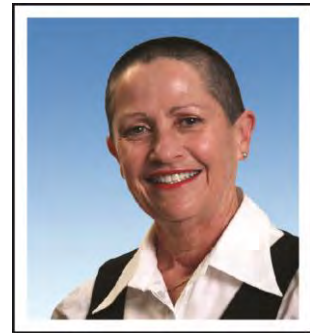
1.1.1 Population Performance

In line with the Ministry of Health's approach of exploring life course approaches as a way of understanding DHB population performance challenges, Taranaki DHB is committed to addressing local population challenges for the following life course groupings:

Life course group	One significant action that is to be delivered in 2018/19
Pregnancy	Implement the Hapu Wananga antenatal and parenting education programme aimed at supporting Māori mothers and whānau to achieve best outcomes for their babies using a kaupapa Māori approach
Early years and childhood	Implement zero fees access to General Practice for eligible children aged under 14 years
Adolescence and young adulthood	To implement and evaluate the Taiohi Wellness Service pilot project to taiohi aged 12-18 years within Taranaki Intermediate and High Schools to build confidence and resilience through the delivery of brief interventions
Adulthood	To implement three priority areas for action as identified in the 2018 Self Assessment against the Quality Standards for Diabetes Care
Older people	Delivery of key priority actions identified in the Taranaki Healthy Ageing Action Plan to support implementation of the National Healthy Ageing Strategy

1.2 Message from the Chair

The New Zealand health system continues to face a number of challenges, particularly in relation to achieving equity of access and outcomes for Māori. Health Equity has been identified as a priority for the Taranaki DHB - it is a key focus of the Taranaki Health Action Plan 2017-2020 and a consistent theme through this Annual Plan.



As well as addressing the disparities in health outcomes for disadvantaged populations, the DHB is tasked with managing the pressures and significant service demands which in turn significantly challenge health budgets. This requires DHBs to consider the impact of its funding decisions on achieving equitable outcomes. The inclusion of specific Equity Outcome Actions (EOA) in the 2018/19 Annual Plan aims to enable the achievement of health equity for all populations, including Māori.

While acknowledging the financial constraints we work within, in 2018/19 we will continue to deliver the strategic direction for Taranaki DHB that is outlined in the Taranaki Health Action Plan. The Plan describes the transformational journey the Taranaki health system will take to redesign how care is delivered in the district to ensure the sustainable achievement of improving health outcomes. As well as developing systems to ensure health information can be shared safely across a wider range of health professionals; we will also seek further opportunities to deliver services closer to home as part of a wider health system that works collaboratively with other Agencies to address the wider determinants of health.

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.

A handwritten signature in dark ink, appearing to read 'P. Lockett'.

PAULINE LOCKETT
Chair

1.3 Message from the Chief Executive

The strategic direction of the New Zealand Health Strategy (NZHS) and our Taranaki Health Action Plan 2017-2020 has provided a strong base from which we can create the enabling environment required for achieving transformational change within our health system. Empowering and partnering with patients; providing care closer to home; enabling integrated care across settings; and effectively utilising new technologies to improve access to high-quality care are critical success factors as we work towards this goal.



The strategic direction for Taranaki District Health Board (TDHB) is outlined in the Taranaki Health Action Plan. The Health Action Plan provides an overarching framework for the Taranaki health system, with a 10-year vision, underpinned by a targeted three-year programme of work that will position the system to achieve its long term vision. 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. Progress against the deliverables in this Plan is well underway and we are confident that we have the capability and capacity to deliver on our promises.

Improving patient access and population health outcomes continue to be a priority for our DHB. The Taranaki DHB acknowledges that Māori are the main population group that are affected by health inequity in Taranaki and we therefore have a particular focus on improving equity for Māori. In line with this, our DHB is committed to “Kia tū rangatira ai ngāi Māori ki te ara kākārīki” – a “journey to the greens” - which symbolises our commitment to transforming our dashboard of Māori health priority indicators from red to green. Working in partnership with Te Whare Punanga Korero and our local Māori Health providers towards eliminating health inequalities between Māori and non-Māori is a priority focus for our DHB, and the Equitable Outcome Actions (EOA) outlined in this Annual Plan are a sign of our commitment to achieving this.

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

A handwritten signature in black ink, appearing to read 'R. Clements'.

ROSEMARY CLEMENTS
Chief Executive

1.4 Message from the Chair - Te Whare Punanga Korero

*Whakarito i te ara whānui o Tū te ihiihi,
Tū te wehiwehi, Tū te nganahau.
Hautupua, hautawhito, houhou te Rongo e!
Rongo marae roa e tau,
Rongo tau tangata matua, e rarau!*

Kei ngā kawekawenga o rua tupua, kei ngā torotoronga o rua tawhito, tēnā koutou katoa. Tēnei hoki rā te au mihinga ki ngā māeroero o Taranaki hauhunga e hāpai nui ake i te mana o ngā uri, nō te pari marutuna o Parininihi, ki Taranaki tuawhenua, ki te awa ngūnguru o Waitōtara, tēnā koutou, tātou tahi.



Achieving equity in access and outcomes for Māori is a priority for the Taranaki DHB and a key focus of the Taranaki Health Action Plan. Te Whare Punanga Korero Trust is committed to supporting the DHB towards achieving this goal, lofty as it may seem in an environment in which ‘the reds’ dominate Māori health indicator dashboards, the demands of a growing youthful population at one end of the life course, and a growing elderly population at the other, place increasing pressures on the DHB to respond.

Te Whare Punanga Korero sees the challenges ahead as opportunities and is committed to continuing its role of monitoring progress against the activities outlined in this Plan, particularly those tagged as ‘Equity of Access for Māori’ actions. These are the activities that the Taranaki DHB and Te Whare Punanga Korero in partnership, have prioritised to accelerate towards eliminating health inequalities between Māori and non-Māori.

The DHB is committed to “Kia tū rangatira ai ngāi Māori ki te ara kākārīki”, journey to the greens, a metaphoric reference to transforming the dashboard of Māori health priority indicators from red to green. Te Whare Punanga korero will continue to be the iwi monitor and to work with the Taranaki DHB strategically on that journey.

The following whakawai given prominence by Te Whiti o Rongomai, aptly captures the perspective of the iwi:

He puāwai au nō runga i te tikanga
I am a descendant from righteous endeavour
He rau rengarenga nō roto i te Raukura
A healing herb from within the sacred emblem
Ko taku Raukura, he manawa nui ki te ao,
My sacred emblem is a symbol of my unwavering dedication,
He manawa nui ki te ao, he manawa nui ki te ao.
of prosperity, good health and well-being.
Na, Te Whiti O Rongomai

A handwritten signature in black ink, appearing to read 'Marty Davis'.

TE PAHUNGA (MARTY) DAVIS_
Chair - Te Whare Punanga Korero Trust

1.5 Signatories

Agreement for the Taranaki DHB 2018/19 Annual Plan

between



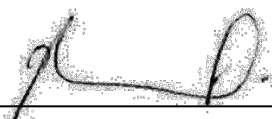
Hon Dr David Clark
Minister of Health
Dated: 13 February 2019



Hon Grant Robertson
Minister of Finance
Dated: 24 February 2019



Pauline Lockett
Chair
Taranaki DHB
Dated: 7 February 2019



Rosemary Clements
Chief Executive
Taranaki DHB
Dated: 7 February 2019



Te Pahunga (Marty) Davis
Chair
Te Whare Punanga Korero
Dated: 7 February 2019

SECTION 2: Delivering on Priorities and Targets

2.1 Health Equity in DHB Annual Plans

Health inequalities affect a range of population groups including Māori, Pacifica, low socio-economic quintile, rural, elderly, disabled, Lesbian Bisexual Gay Transgender (LGBT) communities, 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. Indeed a key focus of the Taranaki Health Action Plan 2017–2020 is to improve access and outcomes for Māori.

Taranaki DHB is required to consider and include Equity Outcome Actions (EOA) in the Annual Plan that will help it to achieve health equity for all its populations, including Māori. Activities in this Plan that demonstrate Taranaki DHB's commitment to reducing and eliminating inequities between Māori and non-Māori are highlighted in red in Section 2 of this Plan and are clearly identified with the acronym [EOA] immediately following the activity. A list of the Equity Outcome Actions is also listed separately in Appendix C of this plan.

Health Equity has also been identified as one of four strategic priorities for the Taranaki Public Health Unit (PHU). The PHU will demonstrate leadership by working in collaboration with other agencies on the social determinants of health as well as championing the provision of high quality health care that delivers equitable health outcomes for Māori. A key strategy for this work is supporting the application of the Ministry of Health's Health Equity Assessment Tool (HEAT) to PHU and DHB programmes, working with our Māori Health Team to support the DHB to integrate the use of HEAT into service planning, service improvement and evaluation.

2.1.1 Health Equity Tools

Taranaki DHB is committed to creating a fairer society where everyone has the opportunity for good health and where our health care system meets the needs and aspirations of Māori. Eliminating health outcome differences which are unnecessary and avoidable, but in addition are considered unfair and unjust, is a core theme of our work. We are committed to working in collaboration with other agencies through a Health in All Policies approach to address the social determinants of health as well championing the provision of high-quality health care that delivers equity of health outcomes for Māori.

A key strategy for this work will be through the use of health equity assessment tools in the planning, development and evaluation of local health services.

Taranaki DHB identifies the Ministry of Health's '*Health Equity Assessment Tool*' as its preferred methodology for undertaking Health equity assessment and guidance on its use is available from the DHB's Public Health Unit (PHU) and Māori Health Unit.

The Taranaki PHU Plan 2018/19 outlines a number of actions that demonstrate how the Health Equity Assessment Tool will be used to support service planning and decision making in the DHB in 2018/19. This includes the implementation of a framework to inform the use of the Ministry of Health's Health Equity Assessment Tool within the PHU and across the DHB; working with other health services to undertake two Health Equity Assessments; and completing a Health Equity review of the Taranaki DHB Pandemic Preparedness Plan.

Government Planning Priorities

The 2018/19 Planning Priorities are:

- Mental Health
- Primary Care Access
- Pharmacy Action Plan
- Child Health
- School-Based Health Services
- Public Delivery of Health Services
- Access to Elective Services
- Healthy Ageing
- Disability Support Services
- Improving Quality
- Climate Change
- Waste Disposal
- Fiscal Responsibility

Taranaki DHB has also identified specific actions being undertaken at a local level to deliver on the Regional Service Plan (RSP) priorities.

Local Planning Priorities

In response to discussions with the Ministry of Health about the strategic direction for 2018/19, it has been agreed that the following areas of work are key priority areas for the Taranaki DHB:

- Primary Care
- Mental Health
- Child Health
- Pathology & Laboratory Services

These priority areas will be supported by principles of equity, enhanced patient experience, value for money and strengthened resilience.

The specific actions that will be undertaken to deliver against the above priorities are outlined in the following table:

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Population Mental Health	One Team	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To implement 4 Quick Wins identified as part of the Taranaki DHB MH&A System Re-design Project</p> <ul style="list-style-type: none"> To explore the operational hours and work process for the MH&A Consult Liaison Nursing roles to ensure they are meeting Emergency Department and Service User needs. To review the Psychiatric Liaison role to General Practice to ensure it is meeting stakeholder requirements. To review Primary Mental Health Initiative (PMHI) voucher scheme with stakeholders to ensure it is meeting the needs of the consumers and service providers. To evaluate the Te Kawau Maro (TKM) Independent Living Pilot <p>To undertake a stocktake across MH&A Service providers on the activities undertaken to respond to the physical health needs of people who experience mental health and addiction and develop a sector wide training plan that supports the objectives of Te Pou o te Whakaaro Nui</p> <p>To facilitate cross sector input into the Mental Health Enquiry as required, and in line with MoH timeframes</p> <p>To implement the recommendations of the Vocational Employment Service Review, working in partnership with MSD, to ensure vocational services are evidence based and targeted to those in highest need [EOA]</p> <p>To implement the Supporting Families Healthy Children Self Assessment Tool and Guideline which has been developed in the Midland Region. Providers have a baseline from self-assessment and use this as a measure for continued improvements</p>	<p>Q2-Consult Liaison review completed</p> <p>Q1-Psychiatric Liaison role review completed</p> <p>Q2-PMHI review and completed</p> <p>Q3-Independent Living Pilot evaluation completed</p> <p>Q3-Stocktake completed and training plan developed</p> <p>As required</p> <p>Q2-New evidence-based service model developed</p> <p>Q4-Agreed process in place to commission new service</p> <p>Q3-Providers have undertaken the self-assessment tool and reported their findings to us</p>	<p>PP43: Population Mental Health</p> <p>PP8: Shorter Waits For Non-Urgent Mental Health and Addiction Services For 0-19 Year olds</p> <p>PP26: The Mental Health & Addiction Service Development Plan</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Mental Health and Addictions Improvement Activities	One Team	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To implement a project, informed by a comprehensive Health Equity Assessment, that aims to reduce the numbers of Māori on Community Treatment Orders, Section 29 to support HQSC focus on minimising restrictive care [EOA]</p> <p>As part of the National Quality Improvement Programme lead by the Health Quality Safety Commission (HQSC), which commenced in July 2017, service transitions were identified as one of the five main priorities. Taranaki DHB will focus on transitions from Child & Adolescent Mental Health Service (CAMHS) for the 2018/19 year with the aim to increase the completion rate of transition/ wellness recover documentation for all active (those that have had three or more face to face) and discharged clients</p> <p>Reviewing MHAS training programme to better equip staff with vital skills to safely & successfully avoid use of seclusion (additional and complementary to National SPEC training).</p> <p>Improved use and sharing of local and national seclusion data to assist in developing local momentum towards Zero Seclusion 2020 target.</p>	<p>Q4-Project implementation completed</p> <p>Q4-Quality improvement project completed</p> <p>Q3-Programme of learning identified</p> <p>Q4-Implementation and practice adaptation</p> <p>Ongoing Q3-report generating ethnicity based data</p>	<p>PP36: Reduce the rate of Māori under the Mental Health Act: Section 29 Community Treatment Orders</p> <p>PP7: Improving Mental Health Services Using Wellness and Transition (Discharge) Planning</p> <p>PP26: The Mental Health & Addiction Services Health & Addiction Service Development Plan</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Addictions	Value and High Performance	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>In order to meet the PP8 addiction related waiting times targets Taranaki DHB will undertake a project that strengthens CAMHS team integration into a multi agency approach to manage the high volume of referrals, ensuring that the referral is allocated to the most appropriate addiction service within DHB and NGOs</p> <p>To develop a process to ensure that referrals and wait times for non urgent CAMHS services are triaged according to needs to ensure the right service is in the right place at the right time and waiting times are reduced</p> <p>To integrate kaupapa Māori services into the pathway through a Service level Agreement between TDHB and Te Kawau Maro alliance [EOA]</p>	<p>Q2-Project implemented</p> <p>Q2-Appropriate resource is in place to reduce the waiting list</p> <p>Q3-Effective triage process developed and implemented</p> <p>Q4- Recruitment completed to support effective triage and reduction of wait lists</p> <p>Q2-Signed MoU in place</p>	PP8: Shorter Waits For Non-Urgent Mental Health and Addiction Services for 0-19 Year Olds

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Primary Health Care Access	Closer to Home	FOCUS AREA 3: Making best use of our primary and community resources to support hospital capacity	<p>To implement the Community Services Card (CSC) and Zero fees for children under 14 in General Practice in 100% of PHO practices across Taranaki to ensure access for at least 95% of the eligible population within 30 minutes travel time (including exemption from the standard \$5 charge on prescription medicine items)</p> <p>To implement CSC & Zero fees for under 14s for after hours care in ten PHO general practices to ensure access for at least 95% of the eligible population within 60 minutes travel time</p> <p>To implement the CSC initiative to improve access to primary care for those on low incomes (subject to MoH guidance)</p> <p>To ensure information in relation to practices/clinics providing in and after hours CSC & zero fees for under 14s is published on the Taranaki DHB website</p> <p>To work with the PHO to support implementation of the Health Care Home (HCH) model of care into General Practice</p> <p>To explore options for development of a long term sustainable integrated care model in South Taranaki</p>	<p>Q3-implementation of CSC & zero fees for under 14s (subject to MoH guidance)</p> <p>Q3-implementation of CSC & zero fees for under 14s (subject to MoH guidance)</p> <p>Q2-HCH model of care implemented in 6 General Practices covering 24% of the Taranaki population</p> <p>Q4-HCH model of care to cover 50% of the Taranaki population</p> <p>Q4-Future options identified</p>	<p>100% of PHO practices in the Taranaki DHB region offer CSC & zero fees for under 14s</p> <p>10 PHO practices in the Taranaki DHB region offer after hours CSC & zero fees for under 14s</p> <p>50% of the Taranaki population enrolled in a HCH</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
System Level Measures	Value and High Performance	FOCUS AREA 4: Using analytics to drive value	Refer to Appendix B – System Level Measures Plan 2018/19 as developed and agreed with all relevant stakeholders	As identified in the System Level Measures Plan 2018/19	PP22: Delivery of actions to improve system integration including SLMs

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Integration	Closer to Home	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To continue to work with the Taranaki Alliance Leadership to strengthen the alliance and to develop services based on robust analytics that reconfigure current services</p> <p>Embed the care models for adult physical health and health of older people through the establishment of the infrastructure and staffing for the Community Health Integration Centre (CHIC) to enable relevant referrals to be accepted by CHIC as a single point of access</p> <p>To utilise other workforces in primary health care settings by integrating the Taranaki DHB Fracture Liaison Service (FLS) into the PHO Falls Prevention Service while ensuring all patients with osteoporosis have access to comprehensive falls prevention assessment and intervention</p> <p>To develop a Communications Plan in partnership with the PHO to ensure communications about GP open/close books are proactively disseminated to Antenatal/Maternity care providers including LMCs, Hapu Wananga Facilitators, Maternity Ward Staff</p> <p>Increase newborn enrolment by:</p> <ul style="list-style-type: none"> Implementing strategies to increase enrolment in NCHIP (e.g. automatic enrolment, follow up unknown GP status) Identify challenges & opportunities to improve the journey of mother and baby through the health system through a patient journey mapping exercise 	<p>Q2-CHIC infrastructure in place</p> <p>Q3-Relevant referrals being accepted</p> <p>Q4-Evaluation of CHIC completed</p> <p>Q3-FLS service integrated into PHO Falls Prevention Service</p> <p>Q1-Communications Plan developed</p> <p>Q1-Completed follow up of "unknown" GP Status</p> <p>Q4 Development from B code to Automatic enrolment</p> <p>Q1-Recommendations endorsed</p> <p>Q4 Key recommendations implemented</p>	<p>PP22: Delivery of Actions To Improve System Integration Including SLMs</p> <p>PP32: Improving The Quality Of Ethnicity Data Collection In PHO And NHI Registers</p> <p>SI18: Improving Newborn Enrolment in General Practice</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance	Milestones	Measures
CVD and Diabetes Risk Assessment	One Team	FOCUS AREA 3: Making best use of our primary and community resources to support hospital capacity	<p>To develop an implementation plan that identifies three priority areas for action to improve quality of diabetes care from the 2018 Self Assessment against the Quality Standards for Diabetes Care</p> <p>To implement the top 2 priority areas from the 2018 Self Assessment against the Quality Standards for Diabetes Care (subject to endorsement of recommendations from TALT)</p> <p>To implement a service improvement initiative that aims to reduce Māori Did-Not-Attend (DNA) rates at Diabetes Clinics to a maximum of 9% [EOA]</p> <p>Taranaki DHB has consistently achieved the 90% CVD risk assessment target and will therefore shift our focus to Māori males aged 35-44 years old, as identified in our SLM Plan, by:</p> <ul style="list-style-type: none"> Supporting practices through their practice development plans to engage with Māori males Socialising uptake of the new CVD risk assessment in general practices 	<p>Q1-Implementation plan, including priority areas for action developed</p> <p>Q4-Top 2 priority actions implemented</p> <p>Q2-Service improvement initiative implemented</p> <p>Q4 – 90% of Māori males have received a CVD risk assessment</p>	<p>PP20: Improved Management for Long Term Conditions (CVD, Acute heart health, Diabetes, and Stroke)</p> <p>Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years</p> <p>Focus Area 2: Diabetes Services</p> <p>Focus Area 3: Cardiovascular Health</p> <p>SI9: SLM Amenable Mortality</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Pharmacy Action Plan	One Team	FOCUS AREA 3: Making best use of our primary and community resources to support hospital capacity	<p>To continue to support the vision of the Pharmacy Action Plan by working with Pharmacists, consumers and the wider health sector to develop integrated local services that make best use of the pharmacist workforce as opportunities arise</p> <p>To continue to engage with the agreed national process to develop and implement new contracting arrangements for the provision of integrated community pharmacist services in the community</p> <p>To undertake a Pharmacy Health Needs Assessment to identify local needs and service coverage issues to inform future commissioning of service provision</p> <p>To increase access to free Emergency Contraceptive Pill (ECP) by implementing and funding free pharmacy consultation for under 25's [EOA]</p>	<p>Q2-100% of Pharmacies on the new CPSA agreement</p> <p>Q1-Pharmacy Health Needs Assessment completed</p> <p>Q3-Community Pharmacy Services Development Plan completed</p> <p>Q2-Access to free ECP implemented through new CPSA agreement</p>	<p>PP20: Improved Management for Long Term Conditions</p> <p>Reduce the rate of teenage terminations of pregnancy per 10,000</p> <p>Reduce the teen birth rate per 10,000</p>
Support to Quit Smoking	One Team	FOCUS AREA 3: Making best use of our primary and community resources to support hospital capacity	<p>To provide clinical advice, support and education to GPs to increase prescribing rates for smoking cessation products and increase primary care referrals to Stop Smoking Support services with a focus on supporting general practices serving high needs populations [EOA]</p> <p>To extend the availability of brief advice and smoking cessation service referrals in community pharmacy settings through the delivery of a pilot programme that incentivises community pharmacies in priority communities to provide brief advice and referral [EOA]</p>	<p>Q1-Clinical Pharmacist appointed</p> <p>Q1 – Pilot project initiated with 2 community pharmacies in areas serving high needs population groups</p> <p>Q4-Evaluation of pilot project to inform decision regarding future service delivery</p>	<p>Percentage of Primary Health Organisations enrolled smokers offered advice to quit</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
School Based Health Services	Closer to Home	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To develop an Implementation Plan for the delivery of additional Home, Education, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality and Safety Assessment (HEEADSSS) targeted to Decile 4 Schools in Taranaki [EOA]</p> <p>To develop a high-level, equity focused implementation plan to identify the potential timeframes, enablers, constraints and funding required to support expansion of School Based Health Services (SBHS) to all public secondary schools in Taranaki (template to be provided by MoH in Q1)</p> <p>To undertake a stocktake of all DHB funded health services in public secondary schools within Taranaki (MoH to provide list of schools in Q1)</p>	<p>Q1-HEEADSSS Implementation Plan developed</p> <p>Q2 – Additional schools' assessments completed</p> <p>Q4-Implementation Plan for expansion of SBHS completed</p> <p>Q2-School Health Service Stocktake completed</p>	PP39 Supporting Health in Schools

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance	Milestones	Measures
Child Wellbeing	Value and High Performance	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To implement a service improvement project to improve access to the DHB's community dental services and reduce Do Not Attend (DNA) rates by Māori children aged 0 to 4 years [EOA]</p> <p>To implement the Hapū Wānanga antenatal education programme to address a range of determinants of health and wellbeing (e.g. nutrition, breast feeding, oral health, immunisations, safe sleeping and smoking) with a specific focus on Māori and high needs populations [EOA]</p> <p>To trial and evaluate the use of the Harti Hauora Assessment Tool alongside delivery of the Hapū Wānanga programme [EOA]</p> <p>To undertake a scope of Kaupapa Māori parenting programmes being delivered to either adapt a current model or develop/co-design a fit-for-purpose parenting programme that supports healthy child development in a life course approach, and applies the Hapū Wānanga model [EOA]</p> <p>To implement a referral pathway to the WISE Better Homes insulation programme from Hapū Wānanga and DHB clinical services working with whanau with children [EOA]</p>	<p>Q3-Service improvement implemented</p> <p>Q3-Evaluation report completed</p> <p>Q4-12 Hapu Wananga workshops delivered</p> <p>Q2-Harti Tool implemented</p> <p>Q4 – Evaluation completed</p> <p>Q2 – Project scope completed</p> <p>Q3 – Implementation Plan developed</p> <p>Q2-Referral pathway implemented</p>	<p>PP13: Improving the Number Of Children Enrolled In DHB Funded Dental Services</p> <p>PP11: Children Caries-Free At Five Years Of Age</p> <p>PP27: Supporting Child Well-Being</p> <p>PP37: Improving Breastfeeding Rates</p> <p>SI13: SLM Number Of Babies Who Live In A Smoke-Free Household At Six Weeks Post Natal</p> <p>PP21: Immunisation Coverage</p> <p>CFA Variation for Measurement of Performance Relating to Reducing Sudden Unexplained Death of an Infancy (SUDI) Infant Deaths</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Maternal Mental Health Services	Closer to Home	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To undertake a stocktake of community-based mental health services currently funded by the DHB, including antenatal, postpartum and funding provided to PHOs specifically to address primary mental health needs for pregnant women and men following the birth of their baby</p> <p>To undertake a funding review to identify and report on the number of women accessing primary maternal mental health services through PHO contracts and any other DHB funded primary mental health service</p> <p>To implement a Community Based Perinatal Maternal Mental Health Service within the Te Kawau Maro/Māori provider network aimed at supporting Māori mothers and moving the continuum of care to mild to moderate MH conditions [EOA]</p> <p>To implement the Hapu Wananga programme to improve maternal and child health (including maternal mental health) specifically aimed at Māori and high needs populations [EOA]</p>	<p>Q2-Stocktake completed</p> <p>Q4-Funding review completed</p> <p>Q1-Community Based Maternal Mental Health Service implemented</p> <p>Q4-Delivery of 12 Hapu Wananga workshops</p>	PP44: Maternal Mental Health
Supporting Health in Schools	Closer to Home	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To implement and evaluate the Taiohi Wellness Service pilot project to taiohi aged 12-18 years within Taranaki intermediate and high schools to build confidence and resilience through the delivery of brief interventions to taiohi [EOA]</p> <p>To develop a comprehensive pathway across agencies to improve cohesive supports to schools in the event of a suicide or attempted suicide</p> <p>To provide a comprehensive list of actions that aim to support health in schools within Taranaki</p>	<p>Q2-Pilot evaluation completed</p> <p>Q3-Taiohi service IT systems implemented</p> <p>Q2-Pathway implemented</p> <p>Q2-List of actions to be provided to MoH</p>	PP39 Supporting Health in Schools

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Immunisation	One Team	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To undergo a self-review process of the current Taranaki Immunisation Advisory Group to ensure equity-focussed member representation, review Terms Of Reference and assess strategic intent and access to ensure effectiveness and increase equity in relation to immunisation services as per 2018 Taranaki Public Health Unit HEAT recommendations [EOA]</p> <p>To assess current Taranaki outreach services against the recommendations from the 2016 MoH Outreach Immunisation Services Report to identify opportunities for future service improvement</p> <p>To review and assess immunisation declines, by ethnicity, within Taranaki to inform development of an action plan to reduce decline rates for high needs populations [EOA]</p> <p>To develop and implement a three year work plan based on the findings of the 17/18 Immunisation Health Equity Assessment (HEAT) Report to address identified primary health care access barriers [EOA]</p>	<p>Q2 - Review completed</p> <p>Q1 - Complete Outreach Service assessment</p> <p>Q3-Recommendations developed and approved</p> <p>Q2-Review completed</p> <p>Q4-Action plan developed</p> <p>Q2-Workplan developed</p> <p>Q4-Implementation of three priority actions from work plan completed</p>	PP21: Immunisation Coverage

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Responding to Childhood Obesity	One Team	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To continue to refer all children who are identified as obese at the Before School Check (B4SC) to the Whānau Pakari community-based, multidisciplinary intervention programme to provide weight management and lifestyle support to them and their whānau</p> <p>To undertake a health equity assessment of the Whānau Pakari obesity management programme with a focus on decline rates of Māori children to identify action that can be taken to increase equity of access and utilisation by Māori [EOA]</p>	<p>Ongoing</p> <p>Q3-Health equity assessment completed and recommendations developed</p>	<p>HT7: Percentage of obese children identified in the Before School Check (B4SC) Programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle intervention</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Access to Elective Services	Value and High Performance	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To review the level and type of services provided across the region, utilising the role lineation model, in collaboration with the Midland Regional Elective Team</p> <p>To review elective services initiatives and ensure that prioritisation tools are being used in a manner that supports equitable access to care for all specialities across the Taranaki region. The use of the impact on life questionnaire which is integral to the outcome of the prioritizing, is used by all specialities. The Māori Health Unit will continue to provide support in completing this questionnaire as well as supporting patients to attend appointments and to navigate the health system [EOA]</p> <p>To prioritise patients for treatment using national, or nationally recognised tools, and treat in accordance with assigned priority and waiting time. Taranaki DHB continues to work with the specialties that are not reaching national targets in terms of ESPI compliance.</p>	<p>Q4-Activities identified in the Regional Services Plan are completed</p> <p>Q4-Review completed and recommendations developed</p> <p>Q4 – Additional clinics and theatre lists will be implemented to achieve ESPI compliance</p>	<p>PP45 Number of Elective Surgery Discharges</p> <p>SI4: Standardised Intervention Rates</p> <p>OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Elective Services Patient Flow Indicators</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Shorter Stays in Emergency Department	Value and High Performance	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To continue to deliver the Emergency Department (ED) Re-direction initiative aimed at increasing numbers of redirections of triage 4 & 5 patients to primary healthcare</p> <p>To increase uptake of Primary Options as an effective alternative to ED through implementation of three additional primary option pathways</p> <p>To improve ED patient flow to ensure that 95% of patients are admitted, transferred or discharged within 6 hours by monitoring and developing further strategies to manage hospital wide barriers to patient flow in partnership with the Hospital Variance Reponse Working Group.</p> <p>To improve ED patient flow to ensure that 95% of patients are admitted, transferred or discharged within 6 hours by implementing Electronic Variance Response Escalation plans for each acute inpatient ward to address any barrier to flow</p> <p>Reports on ED waiting times to be produced by ethnicity to identify equity related access barriers to inform the development of actions to address identified issues [EOA]</p>	<p>Q4 – 10% increase of primary health re-directions</p> <p>Q4 – 3 additional primary options implemented</p> <p>Q2 – Identify 2 specific targeted improvements</p> <p>Q4 – Implement identified quality improvement</p> <p>Q2 – Complete roll out of electronic plans across hospital</p> <p>Q4 – Evaluation of effectiveness of plans</p> <p>Q3-Reporting process established</p> <p>Q4-Equity issues identified and at least one action identified</p>	Triage level 4 & 5s presenting to the ED as a percentage of the total population

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Strengthen Public Delivery of Health Services	Value and High Performance	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To strengthen public delivery of health services by progressing the following new service developments as part of Project Maunga:</p> <ul style="list-style-type: none"> - To undertake a rapid desk top appraisal of options that exists for the future maternity services to inform planning assumptions within the stage two Taranaki Base Hospital redevelopment on the Base Hospital campus - Explore the benefits of developing a Short Stay/Acute Assessment type unit to be co-located with a new Emergency Department for Project Maunga stage 2 facility planning - Explore Short Stay/Acute Assessment Unit models of care and clinical governance models to determine best fit for our vision of the future Taranaki health care environment 	<p>Q1-Appraisal completed</p> <p>Q2-Review completed</p> <p>Q4-Review completed</p>	SI16: Strengthening Public Delivery of Health Services

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance Activity	Milestones	Measures
Cancer Services	Value and High Performance	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To work with the Central Cancer Network (CCN) to:</p> <ul style="list-style-type: none"> - Participate in regional initiatives to identify and implement improvements to the Faster Cancer Treatment (FCT) programme - Implement quality initiatives in response to the Tumour Stream reviews <p>To improve the identification of patients appropriate for FCT registration by improving triaging of High Suspicion of Cancer (HSC) patients to increase number of 62 day registrations of up to 25%</p> <p>To ensure equity of access to timely diagnostics and treatment for all patient by:</p> <ul style="list-style-type: none"> - Reviewing all patients who breach timeframes, by ethnicity, to identify service improvement opportunities [EOA] - Māori health team participation in FCT Governance Group to provide guidance on health equity and quality [EOA] <p>To strengthen engagement and participation by senior clinical staff in the FCT Governance Group</p> <p>To provide support to people following their cancer treatment (survivorship) through referral to contracted cancer support services (eg. Tui Ora kaiawhina and Cancer Society)</p> <p>To implement the prostate cancer decision support tool to improve the referral pathway across primary and secondary services</p>	<p>Q4-Identified regional improvements implemented</p> <p>Q2-Develop a standardised local Head and Neck Tumour Pathway</p> <p>Q3-Trial and audit pathway</p> <p>Q4-Recommendations from Head & Neck Tumour Stream</p> <p>Q2-Audit flagging of HSC from Primary & Secondary Care completed</p> <p>Q4-Improvements resulting from audit implemented</p> <p>Q2-Audit monthly breaches</p> <p>Q3-Identify if breaches are linked with inequities</p> <p>Q4-Improvement resulting from identified breaches</p> <p>Q1-Māori Health representative identified for FCT governance group</p> <p>Q2-Participation of clinical staff in FCT governance group – increase by 50%</p> <p>Q1-Establish Quarterly meeting between DHB Cancer Coordination staff and Cancer Society</p> <p>Q2-Establish representation from TKM Cancer Support Nursing Service at FCT Governance group</p> <p>Q3-Embed the decision support tool into clinical practice</p>	<p>PP30: Faster Cancer Treatment</p> <p>PP29: Improving waiting times for diagnostic services</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Healthy Ageing	Closer to Home	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To implement the 2018/19 actions identified within the Taranaki Healthy Ageing Action Plan to support local implementation of the Healthy Ageing Strategy 2016</p> <p>To contribute to the DHB and Ministry led development of Future Models of Care for home and community support services</p> <p>To implement the findings of the 2018/19 Fracture Liaison Service (FLS) Review to promote and increase enrolment in primary care based integrated falls and fracture prevention services</p> <p>To develop and target interventions aimed at increasing uptake of influenza vaccinations for Māori over 65 years, by working with community pharmacies and Te Kawau Maro/Māori provider network to increase access to vaccinations in high needs localities [EOA]</p> <p>To identify drivers of acute demand for people 75+ years (or lower for disadvantaged populations) through activities identified within our SLM Plan for Acute Bed Days, including:</p> <ul style="list-style-type: none"> - Reviewing re-admission data to identify trends and indicators to inform future activities to reduce re-admission rates - Explore strategies to improve the quality of discharge planning and the role of allied health in preventing admissions, with a view to piloting a new model of care 	<p>Q4-100% of year 2 (2018/19) actions from the Taranaki Health Ageing Action Plan (2017-19) are implemented</p> <p>Q3-FLS Review recommendations fully implemented</p> <p>Q3-Project to increase access to influenza vaccinations implemented</p> <p>Q3-Data review completed and action plan developed</p> <p>Q4-Allied Health discharge planning project completed</p>	<p>PP23: Implementing the Healthy Ageing Strategy</p> <p>PP21: Immunisation Coverage (75% of 65+ Years Immunised – Flu Vaccine)</p> <p>SI7: SLM Total Acute Hospital Bed Days Per Capita</p> <p>Acute Re-Admission Rate 75+ Years</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Disability Support Services	One Team	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To undertake a stocktake and compile a list of resources that are available for people with disabilities when accessing Hospital and Specialist Services [EOA]</p> <p>To review Disability Responsive training (on-line module and TDIC Practical) and identify areas for improvement including staff engagement [EOA]</p> <p>To work in partnership with the disability community to promote the use of the Health Passport [EOA]</p> <p>To identify barriers to access for people with disabilities in relation to the booking of Hospital And Specialist Services appointments [EOA]</p>	<p>Q3-Stocktake completed Q4-Resources distributed</p> <p>Q2-Review and audit completed Q4-Areas for improvement and actions to improve staff engagement developed</p> <p>Q4-Audit of Health Passport (including baseline and post-implementation data) completed</p> <p>Q2-Patient access barrier survey completed Q4-Action plan developed</p>	<p>SI14: Disability Support Services</p> <p>% of staff that have completed on-line Disability Responsiveness Training by the end of Q4, 2018/19</p>

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Delivery of Regional Services Plan	One Team	FOCUS AREA 2: Integrating our care models through a one team, one system approach	<p>To implement a Taranaki Hepatitis C project to ensure Hepatitis C care is delivered in a consistent, patient centred way, in conjunction with the Midland region Hep C pathway, through the following actions:</p> <ul style="list-style-type: none"> - Confirm the clinical care pathway for Taranaki Hep C patients in line with the Midland Regional clinical pathway - Define model of service delivery based on clinical pathway, ensuring appropriate providers - Develop a Fibro scanning schedule for Taranaki utilising the Midland Mobile FibroScan service <p>To continue to participate in Regional Working Groups for vascular services and bowel screening services to support planning and implementation of service delivery that meets the needs of our population. This involves sharing of current pathway information, quality initiatives and workforce strategies.</p> <p>To continue to work in partnership with Waikato DHB to improve management of women requiring breast cancer care. This has involved joint surgery for women in Taranaki, local reconstruction when appropriate and local post operative care.</p>	<p>Q3-Pathway developed</p> <p>Q4-Service Model in place</p> <p>Q4-Fibro Scanning schedule in place</p> <p>Q2 – IDF Vascular Surgery to have stabilised and not increased in volume</p> <p>Q2 – to have completed two joint breast surgery cases</p>	SI2: Delivery of Regional Plans

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Improving Quality	Value and High Performance	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To improve equity in outcomes as measured by the Atlas of Healthcare Variation by implementing a service improvement initiative that aims to reduce Māori Did-Not-Attend (DNA) rates at Diabetes Clinics to a maximum of 9% [EOA]</p> <p>To monitor and initiate activity to improve responses to questions in the Patient Experience Survey which consistently receive the lowest scores. Priority will be given to areas where Māori are disproportionately represented. Inpatient patient experience survey information will be distributed quarterly as an infographic to Clinical Nurse Managers and relevant Operations Managers in order for analysis to occur at that level and for the establishment of improvement projects [EOA]</p> <p>To work towards becoming a Health Literate Organisation (HLO) through the following actions [EOA]:</p> <ul style="list-style-type: none"> - Socialising the concepts of health literacy and consulting and finalising the Health Literacy Framework - Agreeing priority projects and services planned or under way for Health Literacy Review - Implementing up to four Health Literacy reviews - Setting up a system to identify health literacy improvements made by the DHB and monitor progress towards becoming a HLO <p>To deliver best value for money by managing DHB finances in line with the Minister's expectation</p>	<p>Q2-Service improvement initiative implemented</p> <p>Q4-Project progress report completed</p> <p>Q2- Quarterly infographic and monitoring of related Improvement projects</p> <p>Q4-The success of related improvement projects will be evaluated utilising the Patient Inpatient Experience survey data.</p> <p>Q1 –Health Literacy Framework completed</p> <p>Q2-Priority projects agreed</p> <p>Q4-Health Literacy reviews completed</p> <p>Q4-Monitoring system developed</p>	SI17: Improving Quality

Government Planning Priority	Link to NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Climate Change	Value and High Performance	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To undertake a stocktake to identify activity/actions being delivered, including procurement, that are expected to positively mitigate or adapt to the effects of climate change</p> <p>To develop a Taranaki DHB Sustainability Policy to establish guiding principles including maximising efficiency and minimising harm and document the DHB's commitment to sustainable procurement, energy and carbon management, sustainable waste management, water management and designing the built environment</p>	<p>Q2-Stocktake completed</p> <p>Q4-Sustainability Policy established</p>	PP40 Responding to Climate Change
Waste Disposal	Value and High Performance	FOCUS AREA 1: Helping our people to live well, stay well and get well	<p>To undertake a stocktake to identify activity/actions to support the environmental disposal of hospital and community waste products (including cytotoxic waste)</p> <p>To establish a waste management review to develop more sustainable waste management processes at all its campuses to identify streams and implement waste reduction actions</p>	<p>Q2-Stocktake completed</p> <p>Q4-Waste management review completed</p>	PP41 Waste Disposal
Fiscal Responsibilities	Value and High Performance	FOCUS AREA 4: Using analytics to drive value	Taranaki DHB commits to delivering best value for money by managing their finances in line with the Minister's expectations.		Agreed financial templates

Financial Performance Summary

(For further detail refer to Appendix A 2018-22 Financial Performance Plan - Page 53)

Prospective Statement of Financial Performance (Comprehensive Income) for the four years ended 30 June 2019, 2020, 2021 and 2022

(\$'000)	Audited	Audited		Planned			
	2016/17	2017/18		2018/19	2019/20	2020/21	2021/22
Revenue							
Devolved Funding	341,200	356,708		369,229	379,648	390,073	400,500
Non-Devolved Contracts	6,549	6,549		6,521	6,586	6,651	6,717
Inter-DHB & Interprovider Revenue	4,885	5,056		4,992	5,206	5,427	5,657
Other Revenue	11,975	13,117		12,787	13,024	13,266	13,514
Total Revenue	364,609	381,430		393,529	404,464	415,417	426,388
DHB Provided Expenditure							
Personnel	131,136	142,651		148,186	151,148	154,171	157,252
Outsourced Personnel & Support	2,230	2,777		2,845	2,901	2,959	3,018
Outsourced Clinical Services	14,279	13,032		13,217	13,481	13,751	14,026
Clinical Supplies	27,974	30,924		31,963	32,602	33,253	33,919
Infrastructure & Non-Clinical Supplies	38,049	38,194		43,174	44,986	44,593	44,428
Total DHB Provided Expenditure	213,668	227,578		239,385	245,118	248,727	252,643
Other Providers							
Personal Health	64,147	64,882		67,959	69,614	70,492	71,278
Mental Health	11,030	10,590		11,196	11,520	11,844	12,284
Public Health	676	693		991	1,010	1,031	1,052
DSS	37,478	44,205		45,882	46,799	47,734	48,686
Maori Health	2,879	2,887		2,965	3,025	3,086	3,148
IDFs	36,401	38,884		38,884	40,082	41,314	42,584
Total Other Providers	152,611	162,141		167,877	172,050	175,501	179,032
Total Expenditure	366,279	389,719		407,262	417,168	424,228	431,675
Total Consolidated Result	(1,670)	(8,289)		(13,733)	(12,704)	(8,811)	(5,287)
By Arm							
Provider	(18,072)	(25,879)		(26,533)	(26,157)	(23,645)	(22,509)
Governance	35	5		0	0	0	0
Funder	16,367	17,585		12,800	13,453	14,834	17,222
Public Health	(1,670)	(8,289)		(13,733)	(12,704)	(8,811)	(5,287)

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

	2018-19	2019-20	2020-21
Prospective Summary of Revenues and Expenses by Output Class	Plan	Plan	Plan
	\$000	\$000	\$000
Early Detection			
Total Revenue	90,444	92,957	95,475
Total Expenditure	93,600	95,877	97,500
Net Surplus / (Deficit)	(3,156)	(2,920)	(2,025)
Rehabilitation and Support			
Total Revenue	52,937	54,408	55,882
Total Expenditure	54,785	56,117	57,067
Net Surplus / (Deficit)	(1,847)	(1,709)	(1,185)
Prevention			
Total Revenue	8,318	8,549	8,781
Total Expenditure	8,608	8,818	8,967
Net Surplus / (Deficit)	(290)	(269)	(186)
Intensive Assessment and Treatment			
Total Revenue	241,829	248,549	255,280
Total Expenditure	250,268	256,356	260,694
Net Surplus / (Deficit)	(8,439)	(7,807)	(5,414)
Consolidated Surplus / (Deficit)	(13,733)	(12,704)	(8,811)

SECTION 3: Service Configuration

3.1 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 2018/19.

3.2 Service Change

Taranaki DHB has developed a Health Action Plan which will lead change from a health system perspective. 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 services in the coming year.

Service coverage exceptions and service changes must be formally approved before they are included in Annual Plans. 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 1: Service Issues 2018/19

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 are in place for a number of 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 continuing 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 the Taranaki Health Action Plan and Project Connect	<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 and more targeted changes associated with defined services	<ul style="list-style-type: none"> • Whole system services redesign • Review of existing services and models of care • 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
Child Health	Implementation of responsive and appropriate models of care for Antenatal Education and other child health determinants	<ul style="list-style-type: none"> • Increase access to services • Great emphasis on equity of access and appropriate service provision 	Local
Fracture Liaison Service	Implementation of options from the Fracture Liaison Service review completed in May 2017	<ul style="list-style-type: none"> • Increase access to services • Alignment with other Primary Care based Falls Prevention Services 	Local
Māori Health Services	Review of current Alliance arrangements for Te Kawau Maro Alliance	<ul style="list-style-type: none"> • Ensure focus on improving equity of health outcomes 	Local
Non Secure Psycho-geriatric Service Pilot	Continuation of a one year pilot residential care service for older people with mental health conditions requiring specialised care in a non secure service	<ul style="list-style-type: none"> • Responding to an identified service gap • Improved support for older people with complex needs 	Local
Community Mental Residential Service Pilot	Evaluation of the Te Kawau Maro Independent Living Pilot	<ul style="list-style-type: none"> • Supporting independent living options as an alternative to residential based care 	Local

Mental Health Vocational/ Employment Support Services	To implement the findings of the service review, including implementing an evidence based model of service delivery which strengthens working relationships with MSD to support good employment outcomes for people with mental health conditions	<ul style="list-style-type: none"> • Reduce duplication between current DHB funded vocational services and MDS employment support services • Delivery of evidence-based services that focus on achieving equity-based outcomes 	Local
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SECTION 4: Stewardship

As part of their stewardship role DHBs have statutory responsibilities to improve, promote and protect the health of people and communities. Taranaki DHB is committed to working in partnership with the Public Health Unit in their work on health promotion; delivering services that enhance the effectiveness of prevention activities in other parts of the health system; working within a Health in All Policies framework; and undertaking regulatory functions.

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.tdhub.org.nz/misc/planning_documents.shtml

4.1 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:

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	\$M	\$M	\$M	\$M	\$M	\$M
	ACTUAL	AUDITED	PLANNED	PLANNED	PLANNED	PLANNED
Revenue	364.61	381.43	393.53	404.46	415.42	426.39
Net Surplus/(Deficit)	(1.67)	(8.29)	(13.73)	(12.70)	(8.81)	(5.29)
Total Fixed Assets	176.95	221.23	216.43	211.13	206.83	202.53
Crown Equity	147.62	187.47	172.78	159.12	149.35	143.10
Term Borrowings and Provisions	50.61	58.77	62.49	70.52	75.66	77.88

Taranaki DHB's key financial indicators are a consolidated operating deficit of \$13.73M for 2018/19 which comprises a deficit of \$26.53M in the hospital provider, a financial breakeven for the DHB Governance & Funding Administration and a surplus of \$12.80M 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 2018/19 and out years is contained in Appendix A (Financial Performance Plan).

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:

- Contracted/Accrued FTE
- FTE categories ie. Medical, Nursing, Allied Health, Support and Management & Administration FTEs.
- 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, implemented in 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.

4.2 Building Capability

Capital and Infrastructure Development

Base line capital expenditure during 2018/19 is forecast at \$14.10M. This includes \$7.0M investment in Information and Communication Technology (ICT) besides \$3.0 M in clinical and theatre. Outlay for minor site redevelopment expenditure is \$3.0M.

Scoping and planning for Stage 2 of Project Maunga has commenced with preliminary works in progress. Early documentation (Risk assessment, Point of Entry) has been submitted to Treasury, and discussions are in progress with the Capital Investment Committee (CIC) on next steps to progress the business case, preferably under an accelerated business approval and delivery programme. The estimated capital cost based on the preliminary scope (subject to approval) is \$270M. The planning and resources required to progress the business case through the different stages leading to approval are being established.

The business case for Project Maunga 2 is subject to prioritisation by the Capital Investment Committee, and approval by joint Ministers, the Minister of Health and Minister of Finance.

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 details about Taranaki DHB's current IT initiatives are contained in the Midland Region Information Services Plan 2017–2021 which aligns with the 2018/19 Midlands Regional Service Plan, and in Section 4.4 (IT) below.

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 2018/19 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, including supporting national DHB initiatives in leadership and talent management.
- Implementation of the HR Strategic Plan (3 year focus)
- Launch and implementation of new Taranaki DHB Values
- Implementation of the Taranaki DHB Recognition framework
- Implementation of the 'My Feedback' performance appraisal and individual development framework
- Team development, collaboration and business partnering professional development programme
- Employee wellbeing initiatives, including supporting national DHB programmes
- Taranaki DHB 2018 Staff Survey results benchmarked against Midland DHB results

Care Capacity Demand Management

Taranaki DHB is committed to implementing Care Capacity Demand Management (CCDM) by June 2021 through a phased delivery approach to accommodate appropriate recruitment and establishment processes.

For the 2018-19 year, the following actions are planned:

Q2 - Develop a plan for roll out of CCDM across all clinical areas

Q3 - Recruit to safe staffing programme roles

Q4 – Design and implement a reporting structure for monitoring progress of the CCDM/Safe Staffing programme

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 independent charitable trust established by Taranaki District Health Board, Ministry of Social Development and Te Whare Punanga Korero Trust. WRR was created to build an integrated approach focusing on increasing the Māori health and disability workforce to equal the proportion of Māori in the Taranaki population. Its role is to fill the Māori workforce development pipeline with Māori pursuing health workforce careers. This is an innovative multi-agency and multi funder model which introduces a range of initiatives to address Māori workforce development through collaboration.

4.3 Workforce

4.3.1 Healthy Ageing Workforce

Links to Taranaki Health Action Plan Focus Area 5: Developing a capable, sustainable workforce matched with health need and models of care

Regional

The 2018-19 Annual Plan builds on foundations set out in the 2017-18 Midland Regional Services Plan (RSP). The primary piece of work in the 2017-18 Midland RSP related to identifying workforces working with older people and their whānau, and developing a sustainable mechanism for collecting a minimum workforce data set outside of the DHBs provider functions.

Following discussion with the Ministry of Health in August 2017 it was agreed that Central Region Technical Advisory Services (CTAS) would take the national lead for this work. CTAS is the national DHB workforce data repository as well as providing analytics and reporting from that data set. Since 2017, a national project group has been formed led by CTAS which includes a major sector service provider. The group is identifying the data set, reporting timeframes, collection process, data repository, and analytics and reporting. A business case is being drafted to request additional resourcing to progress this work.

Midlands DHBs will utilise the outcome from the national work to develop any sector wide workforce plans for the older persons' workforce.

Local

Taranaki DHB have a number of actions in place to support the Healthy Ageing Workforce to ensure that older people have the training and support they require to deliver high-quality, person centred care.

Key areas of work led by the DHB include:

1. Planning and providing high quality training and professional development for the medical workforce at all levels of practice – Chief Medical Advisor to support Training & Education Committee to provide governance to medical training in TDHB
2. Taranaki Aged Care Leadership Forum – a quarterly education programme aimed at aged care facility manager and clinical managers to support them to meet professional development training requirements outlined in the Age Related Residential Care contract
3. Aged Care Study Days – regular study days aimed at Registered Nurses (RNs) working in aged residential care and home and community sector support service agencies focusing on specialist areas of geriatric care (e.g. wound care, continence)

4. Aged Care Gerontology Clinical Nurse Specialist (CNS) – a full time specialist nursing role providing training and specialist clinical support to RNs in aged residential care to support the care of older residents with complex health needs
5. Wound Care CNS – a full time specialist wound care nursing support role that delivers training, advice and clinical care as required in aged residential care
6. Palliative Care CNS – 1.4FTE palliative care specialist nursing role, delivered through Hospice Taranaki, providing support to aged care RNs and caregivers working with older people with generalist and specialist palliative care needs in aged residential care
7. Specialist Service Support – telephone based advice and support from specialist staff working in Taranaki DHB Health of Older People services to aged residential care as required
8. Taranaki DHB in-house and outreach training – training provided by DHB specialist staff for both RNs and caregivers on specific care topics as required
9. Regional Dementia Behavioural Specialist Nurse – a regional specialist training role, aimed at dementia and psychogeriatric residential care facilities across the region
10. Hauora Workforce training programme – administering the Hauora Workforce funding to support the unregulated Māori aged care workforce to access health care training

4.4 Health Literacy

Health literacy contributes to health equity and has the potential for an improved consumer experience, a reduction in health-related costs, and empowerment of individuals/whanau to make appropriate choices for their health and wellbeing. An essential part of health literacy is a focus on how health systems, health care providers and practitioners can support consumers to access and understand health services.

Taranaki DHB is committed to building an understanding of health literacy amongst those leading, working in and supporting the health sector in Taranaki, with the aim and intent of creating and supporting a health system and providing services that are easy for people to understand and access. In addition there is the need to build the health literacy skills and knowledge of communities that enable them to define, understand and manage their health in ways that are meaningful to them and which empower whanau to confidently self-manage their own health conditions.

The DHB is on a pathway to becoming a Health Literate Organisation, as outlined in our Health Action Plan 2017-2020, and Section 2 of this Annual Plan outlines specific actions to progress towards this aim. The Taranaki Public Health Unit (PHU) Plan 2018/19 has also outlined specific actions supporting the implementation of the Taranaki DHB Health Literacy Plan with a particular focus on advocacy around health equity/literacy acute demand management (including helping our population live well with long term conditions).

4.5 Information Technology (IT)

Government Planning Priority	Link To NZ Health Strategy	Link to TDHB Health Action Plan	Taranaki DHB Key Actions to Deliver Improved Performance		Measures
			Milestones	Activity	
Information Technology	Smart System	FOCUS AREA 6: Improving access, efficiency and quality of care through the managed uptake of new technologies	To progress IT support of national initiatives such as <ul style="list-style-type: none"> National Maternity Programme 	Q2-Business case for implementation of the National Maternity Programme at Taranaki DHB is developed	Quarterly reports from project leads
			To progress IT components of the Integration Project with Primary Care subject to identifying business requirements and development of business case	Q2-Sign off of Business Case Q3-Project implemented in line with plan	
			To replace Picture Archiving Communication System and Radiology Information System	Q1-Sign off of Business Case Q1-Implementation planning study completed Q4-Project implemented according to plan	
			To progress MedChart application to support safe and effective Medication Management within Taranaki DHB by: <ul style="list-style-type: none"> Convert MedChart from MIMS to NZULM (Universal List of Medicines) Develop a priority list of Medication Management projects that could include MedChart Upgrade and rollout of MedChart 	Q1-Conversion to NZULM completed Q2-Priority list of projects identified. Initiative user requests created, prioritised, approved by EMT and added to the Portfolio.	
			To conclude Patient Administration System Upgrade (WebPAS Upgrade from version 10.07 to latest version)	Q1-WebPAS upgrade completed	
			To replace Clinical and Corporate Messaging	Q2-Taranaki DHB RFP process completed Q3-Sign off of Business Case Q4-Commencement of project according to plan	

			To progress Clinical & Business Intelligence CBI Scenario Implementation to refine and consolidate the process for business intelligence requests and providing a stable operational platform	Q1-Scenario implementation Q2-Stable operational platform	
			To develop 5 year rolling Portfolio view for software, hardware and Network infrastructure and process to maintain currency.	Q1-Complete ICT Service Level Agreement (SLA) Q2-Draft view Q3-Complete process to maintain currency Q3-Sign off of Portfolio view	
			To complete rollout of technology to enable virtual health as driven by clinical business needs.	Q4-Completion of Telemedicine technology rollout according to EMT priorities	
			Continue progress towards compliance with HISF and NZISM and creating a cybersecurity aware and conscious organisation	Q1-Current security project completion Q2-HISF/NZISM Internal Audit Q3-Commence new project with recommendations from internal audit	

SECTION 5: Performance Measures

5.1 2018/19 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 2018/19.

Performance measure	Performance expectation	
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes.	
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	3.78%
	Age 20-64	4.02%
	Age 65+	3.5%
PP7: Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.	
	95% of audited files meet accepted good practice.	
	Report on activities in the Annual Plan.	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	80% of people seen within 3 weeks.	
	95% of people seen within 8 weeks.	
	Report on activities in the Annual Plan.	
PP10: Oral Health- Mean DMFT score at Year 8	Year 1	0.61
	Year 2	0.61
PP11: Children caries-free at five years of age	Year 1	61%
	Year 2	61%

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	Year 1	95% of children enrolled
		≤10% children aged 0-12 years not examined
	Year 2	95% of children enrolled
		≤10% children aged 0-12 years not examined
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)		
Focus Area 1: Long term conditions	Report on activities in the Annual Plan.	
Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.	
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).	
Focus Area 3: Cardiovascular health	90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.	
	Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years.	90%
Focus Area 4: Acute heart service	>70% of high-risk patients receive an angiogram within 3 days of admission.	
	>95% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days and ≥99% within 3 months.	
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF	
Focus Area 4: Acute heart service (continued from previous page)	Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5-classes).	
Focus Area 5: Stroke services	10% or more of potentially eligible stroke patients thrombolysed 24/7.	
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	
	60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team ie RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.	
PP21: Immunisation coverage	95% of two year olds fully immunised	
	95% of five year olds fully immunised	
	75% of girls fully immunised – HPV vaccine	
	75% of 65+ year olds immunised – flu vaccine	
	Report on activities in the Annual Plan	
PP22: Delivery of actions to improve system integration including SLMs		Report on activities in the Annual Plan.
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan.	
	Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4 – 6 for assessment urgency	Baseline to be established
PP25: Youth mental health initiatives	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.	
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).	
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	

PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.	
PP27: Supporting child well-being	Report on activities in the Annual Plan.	
PP28: Reducing Rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever	≤ 0.3 per 100,000
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	
	95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	
	90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.	
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.	
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.	
PP30: Faster cancer treatment		85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
		Report on activities in the Annual Plan.
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	
PP32: Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).	
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.	
PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	
PP37: Improving breastfeeding rates	70% of infants are exclusively or fully breastfed at three months.	
PP39 Supporting Health in Schools	Report on activities in the Annual Plan.	
PP40 Responding to climate change	Report on activities in the Annual Plan	
PP41 Waste disposal	Report on activities in the Annual Plan	
PP43 Population mental health	Report on activities in the Annual Plan	
PP44 Maternal mental health	Report on activities in the Annual Plan	
PP45 Elective Surgical Discharges	>5511	
SI1: Ambulatory sensitive hospitalisations	0-4	See System Level Measure Improvement Plan
	45-64	<5166
SI2: Delivery of Regional Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population.	
	Cataract procedures - a target intervention rate of 27 per 10,000 of population.	
	Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population.	
	Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population.	
	Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.	
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.	
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	

SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI10: Improving cervical screening coverage	80% coverage for all ethnic groups and overall.	
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall.	
SI12: SLM youth access to and utilisation of youth appropriate health services	See System Level Measure Improvement Plan	
SI13: SLM number of babies who live in a smoke-free household at six weeks post natal	See System Level Measure Improvement Plan	
SI14: Disability support services	Report on activities in the Annual Plan	
SI15: Addressing local population challenges by life course	Report on activities in the Annual Plan	
SI16: Strengthening Public Delivery of Health Services	Report on activities in the Annual Plan	
SI17: Improving quality	Report on activities in the Annual Plan	
SI18: Improving newborn enrolment in General Practice	55% of newborns enrolled in General Practice by 6 weeks of age 85% of newborns enrolled in General Practice by 3 months of age Report on activities in the Annual Plan	
OS3: Inpatient length of stay	Elective LOS	1.45 days
	Acute LOS	2.3 days
OS8: Reducing Acute Readmissions to Hospital	≤6.9%	
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 >1% and ≤3%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% and ≤ 2%
	Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and ≤ 2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and ≤ 85%
	Invalid NHI data updates	TBC
Focus Area 2: Improving the quality of data submitted to National Collections	NBRIS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	≥ 97% and <99.5%
	National Collections File load Success	≥ 98% and <99.5%
	Assessment of data reported to NMDS	≥ 75%
	Timeliness of NNPAC data	≥ 95% and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified about data quality audits.
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	

APPENDIX A: 2018/19 Statement of Performance Expectations

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

E92



TARANAKI DISTRICT HEALTH BOARD

STATEMENT OF PERFORMANCE EXPECTATIONS 2018/19

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga



The 2018/19 Annual Plan has yet to be agreed by the Minister of Health and the Taranaki District Health Board. The 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. The SPE may be subject to further change as a result of the process of finalising the DHB Annual Plan for 2018/19 with the Ministry of Health.

While our 2018/19 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 2018/19. 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.



Signed:

pp 

Rosemary Clements
Chief Executive
Taranaki DHB
Dated:



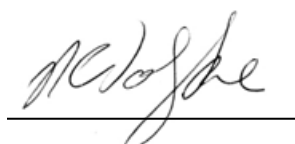
Signed:



Pauline Lockett
Chair
Taranaki DHB
Dated:



Signed:



Neil Volzke
Deputy Chair
Taranaki DHB
Dated:

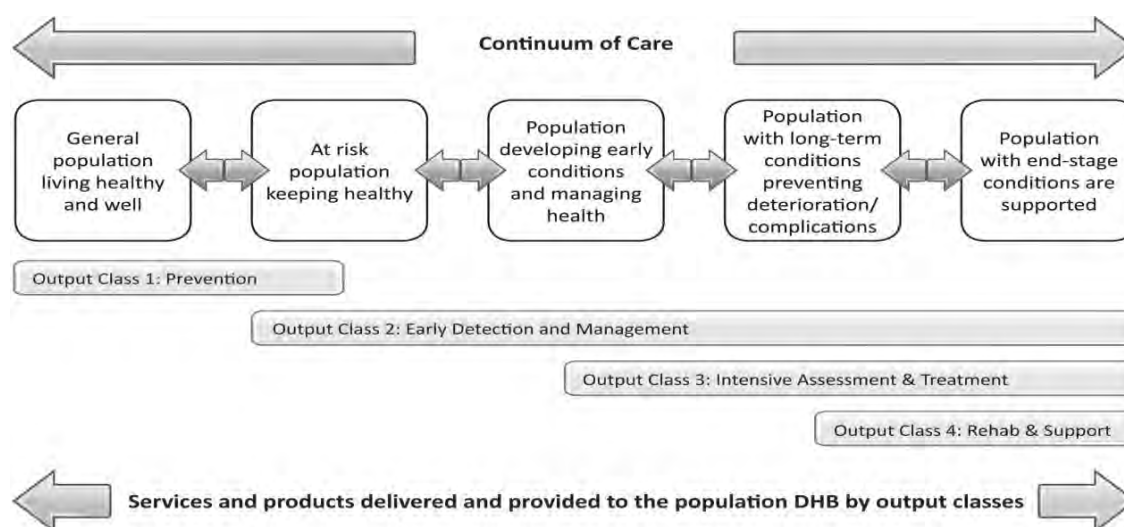
2018/19 Statement of Performance Expectations

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop this Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2018/19. 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.

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.

Output Class	Definition
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

	2018-19	2019-20	2020-21
Prospective Summary of Revenues and Expenses by Output Class	Plan	Plan	Plan
	\$000	\$000	\$000
Early Detection			
Total Revenue	90,444	92,957	95,475
Total Expenditure	93,600	95,877	97,500
Net Surplus / (Deficit)	(3,156)	(2,920)	(2,025)
Rehabilitation and Support			
Total Revenue	52,937	54,408	55,882
Total Expenditure	54,785	56,117	57,067
Net Surplus / (Deficit)	(1,847)	(1,709)	(1,185)
Prevention			
Total Revenue	8,318	8,549	8,781
Total Expenditure	8,608	8,818	8,967
Net Surplus / (Deficit)	(290)	(269)	(186)
Intensive Assessment and Treatment			
Total Revenue	241,829	248,549	255,280
Total Expenditure	250,268	256,356	260,694
Net Surplus / (Deficit)	(8,439)	(7,807)	(5,414)
Consolidated Surplus / (Deficit)	(13,733)	(12,704)	(8,811)

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 2014/15 financial year unless otherwise stated
- National/Regional Result figures show the 2016/17 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 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Percentage of Primary Health Organisations enrolled smokers offered advice to quit	Māori	1	qn/t	93%		87%	90%	n/a	n/a
	Non-Māori	1	qn/t	86%		86%	90%	n/a	n/a
	Total	1	qn/t	88%		86%	90%	89%	n/a
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	89%		100%	90%	93%	94%
	Non-Māori	1	qn/t	91%		94%	90%	n/a	n/a
	Total	1	qn/t	90%		96%	90%	92%	93%

Reduction in Vaccine Preventable Diseases

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Percentage of eight month olds fully immunised	Māori	1	qn/t	89%		90%	95%	88%	84%
	Non-Māori	1	qn/t	93%		93%	95%	94%	90%
	Total	1	qn/t	91%		92%	95%	92%	88%

Improving Health Behaviours

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Percentage of infants who are fully, exclusively or partially breastfed at 3 months	Māori	1	qn/t	47%		New Measure	70%	46%	46%
	Non-Māori	1	qn/t	58%		New Measure	70%	60%	n/a
	Total	1	qn/t	55%		New Measure	70%	58%	57%
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	179		71	<71	n/a	n/a
	Non-Māori	1	qn/t	106		70	<70	n/a	n/a
	Total	1	qn/t	125		70	<70	n/a	n/a
Reduce the teen birth rate per 10,000	Māori	1	qn/t	276		142	<142	n/a	n/a
	Non-Māori	1	qn/t	117		58	<58	n/a	n/a
	Total	1	qn/t	159		84	<84	n/a	n/a
The number of referrals to the GRx (Green Prescription) programmes – Adult	Māori	1	qn/t	361	2016/17	New Measure	343	n/a	n/a
	Non-Māori	1	qn/t	1047	2016/17	New Measure	1371	n/a	n/a
	Total	1	qn/t	1281		1408	1714	n/a	n/a
The number of referrals to the GRx (Green Prescription) programmes – Children	Māori	1	qn/t	60	2016/17	New Measure	12	n/a	n/a
	Non-Māori	1	qn/t	74	2016/17	New Measure	48	n/a	n/a
	Total	1	qn/t	80		134	60	n/a	n/a

People Stay Well in their Home and Communities

Long Term Impact	People Stay Well in Their Homes and Communities			
Intermediate Impacts	<ul style="list-style-type: none"> 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 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Percentage of adolescent utilisation of DHB funded dental services	Total	2	qn	54%		72%	85%	n/a	n/a
Percentage of children (0-4) enrolled in DHB funded dental services	Māori	2	qn	59%		81%	95%	n/a	n/a
	Non-Māori	2	qn	81%		101%	95%	n/a	n/a
	Total	2	qn	74%		95	95%	n/a	n/a
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination	Māori	2	qn	3.8		New Measure	10%	n/a	n/a
	Non-Māori	2	qn	1.1		New Measure	10%	n/a	n/a
	Total	2	qn	2%		6%	10%	n/a	n/a

Long Term Conditions are Detected Early and Managed Well

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Percentage of eligible women (25-69) have a cervical cancer screen every 3 years	Māori	1	qn/t	64%		73%	80%	65%	69%
	Non-Māori	1	qn/t	81%		82%	80%	77%	80%
	Total	1	qn/t	79%		81%	80%	75%	78%
Percentage of eligible women (50-69) have a breast screen in the last 2 years	Māori	1	qn/t	61%		62%	70%	65%	60%
	Non-Māori	1	qn/t	75%		76%	70%	73%	72%
	Total	1	qn/t	74%		75%	70%	72%	70%
Percentage of population enrolled with a PHO	Māori	2	qn	84%		84%	90%	90%	94%
	Non-Māori	2	qn	95%		96%	90%	94%	96%
	Total	2	qn	95%		94%	90%	94%	96%
Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years	Māori	2	qn	88%		88%	90%	87%	89%
	Non-Māori	2	qn	92%		91%	90%	90%	92%
	Total	2	qn	91%		90%	90%	90%	92%

Fewer People are admitted to Hospital for Avoidable Conditions

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Percentage of eligible population who have had their B4 school checks completed	High Needs	1	qn/t	87%		96%	90%	92%	n/a
	Total	1	qn/t	91%		104%	90%	94%	n/a
Triage level 4 & 5s presenting to the Emergency Department as a percentage of the total population	Māori	2&3	qn	30%	2016/17	New Measure	<23%	n/a	n/a
	Non-Māori	2&3	qn	19%	2016/17	New Measure	<23%	n/a	n/a
	Total	2&3	qn	23%		21%	<23%	n/a	n/a
100% of PHO practices in the Taranaki DHB region offer zero fees access to under 13/14 year olds	Total	2	qn	100%	2017/18	New Measure	100%	n/a	n/a
10 PHO practices in the Taranaki DHB region offer zero fees after hours care to under 13/14 year olds	Total	2	qn	10	2017/18	New Measure	10	n/a	n/a

More People Maintain their Functional Independence

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Percentage of inpatients who complete the National Inpatient Patient Experience Survey.	Total	4	ql	19%		New Measure	30%	24%	n/a
% of staff that have completed on-line Disability Responsiveness Training by the end of Q4, 2018/19	Total	2	qn	2.2%	2017/18	New Measure	7.6%	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 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Acute inpatient average length of stay	Total	3	ql/t	3.93 days		2.71 days	2.3 days	2.53 days	n/a
Acute Re-admission rate	Total	3	ql/t	7.2%		7.8%	≤6.9%	7.90%	n/a
Acute Re-admission rate 75+ years	Total	3	ql/t	10.5%		10.9%	≤10.9%	10.7%	n/a
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total primary and secondary deliveries	Māori	3	ql	14%	2015/16	New Measure	<18%	n/a	n/a
	Non-Māori	3	ql	18%	2015/16	New Measure	<18%	n/a	n/a
	Total	3	ql	20%		19%	<18%	n/a	n/a
Faster cancer treatment (62 day indicator)	Māori	3	ql/t	100%		New Measure	90%	n/a	n/a
	Non-Māori	3	ql/t	70%		New Measure	90%	n/a	n/a
	Total	3	ql/t	77%		80%	90%	81%	81%
Percentage of patients with a confirmed diagnosis of cancer who receive their first cancer treatment with 31 days of diagnosis	Total	3	ql/t	82%		90%	85%	89%	89%

People Have Appropriate Access to Elective Services

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Did-not-attend percentage for outpatient services	Māori	3	qn/t	19%		18%	5%	13%	13%
	Non-Māori	3	qn/t	6%		6%	5%	5%	5%
	Total	3	qn/t	9%		8%	5%	6%	7%
Number of surgical discharges under the elective initiative	Total	3	qn	5293		6,236	5511	204,035	n/a
Percentage of patients waiting longer than four months for their first specialist assessment	Total	3	qn/t	0%		0.3%	0.0%	0.6%	n/a
Elective inpatient length of stay	Total	3	ql/t	2.96 days		1.49 days	1.45 days	1.56 days	n/a

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

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Percentage of Child and Youth clients discharged with a transition (discharge) plan.	Total	3	qn/t/ql	12%		95%	95%	n/a	n/a
Percentage of people referred for non-urgent addiction services are seen within 3 weeks	0-19 yrs	3	qn/t	71%		98%	80%	85%	88%
	20-64 yrs	3	qn/t	77%		77%	80%	81%	78%
	65+ yrs	3	qn/t	100%		82%	80%	81%	89%
Percentage of people referred for non-urgent mental health are seen within 3 weeks	0-19 yrs	3	qn/t	71%		62%	80%	69%	69%
	20-64 yrs	3	qn/t	69%		78%	80%	83%	80%
	65+ yrs	3	qn/t	91%		95%	80%	86%	89%

More People with End Stage Conditions are Supported Appropriately

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
A reduction in the percentage of palliative care clients who have had an Emergency Department presentation	Māori	3	qn/t	New Measure		New Measure	≤11.0%	n/a	n/a
	Non-Māori	3	qn/t	New Measure		New Measure	≤11.0%	n/a	n/a
	Total	3	qn/t	9.3%		9.8%	≤11.0%	n/a	n/a

Support Services

Outputs	Group	Output Class	Measure Type	Baseline 14/15	Alternative Baseline date	Audited Result 2016/17	Target 2018/19	National Result 2016/17	Midland Result 2016/17
Improved wait times for diagnostic services - accepted referrals receive their CT scan within 42 days	CT	2	qn/t	86%	2014/15	78%	95%	88%	91%
Improved wait times for diagnostic services - accepted referrals receive their MRI scan within 42 days	MRI	2	qn/t	45%	2014/15	58%	90%	61%	81%
Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes	Cat 1 within 24 hours	2	qn/t	100%		100%	90%	n/a	n/a
	Cat 2 within 96 hours	2	qn/t	100%		100%	90%	n/a	n/a
	Cat 3 within 72 hours	2	qn/t	90%		90%	90%	n/a	n/a
Percentage of Māori employed in the Health and disability workforce at the Taranaki DHB	Māori	4	qn	8.42%		8.89%	18%	n/a	n/a

Appendix A 2018-22 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)	2016/17 audited	Year 0 2017/18 audited	Year 1 2018/19 forecast	Year 2 2019/20 forecast	Year 3 2020/21 forecast	Year 4 2021/22 forecast
Hospital Provider + Governance Funding (incl other income)	195,409	201,704	212,852	218,961	225,082	230,134
Non Hospital Provider Funding (NGO)	169,200	179,726	180,677	185,503	190,335	196,254
TOTAL FUNDING	364,609	381,430	393,529	404,464	415,417	426,388
Hospital Provider + Governance expenditure	213,668	227,578	239,385	245,118	248,727	252,643
Payments to Non Hospital Providers (NGO)	152,611	162,141	167,877	172,050	175,501	179,032
TOTAL OPERATING EXPENSES & PAYMENTS	366,279	389,719	407,262	417,168	424,228	431,675
Hospital Provider + Governance Operating Deficit	-18,259	-25,874	-26,533	-26,157	-23,645	-22,509
TDHB Funder surplus	16,589	17,585	12,800	13,453	14,834	17,222
CONSOLIDATED FINANCIAL RESULT	-1,670	-8,289	-13,733	-12,704	-8,811	-5,287

The net consolidated financial projections for the planning period 2018-22 are:

- a) 2018/19: Deficit \$13.73M
- b) 2019/20: Deficit \$12.70M
- c) 2020/21: Deficit \$8.81M
- d) 2021/22: Deficit \$5.29M

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

1. Key points from the Budgeted Financials: 2018-22

Taranaki DHB's PBFF share has reduced from 2.66% (2016/17) to 2.64% in 2017/18 and reduced further to 2.63% in 2018/19. Population estimates indicate that Taranaki DHB's population in 2018/19 will show an increase of 0.91% or an increase of 1,085 from the 2017/18 population projection. With such a low population growth rate, Taranaki DHB will continue to be in transitional funding for 2018/19 and has received only minimum growth on funding allocation. The longer term forecast is that the DHB's PBFF share will continue to reduce (please refer to Section 2.1 for details).

The increase in core funding for 2018/19 over 2017/18 is 3.08% or \$10.60M. Taranaki DHB has the third lowest level of increase amongst the DHBs in New Zealand.

The quantum of funding for 2018/19 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 four fiscal planning periods.
- These financial projections reflect a common trend across the entire planning period 2018-22; 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 (2018/19) 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 \$6.60M).
- 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 2018/19 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 2018/19 for Taranaki DHB to support national and regional agencies (NZHPL, Health Share, other National Agencies) is circa \$2.55M – 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 (to the extent practical and permissible) and re-align service configurations in its hospital service operations to reduce the current deficit.
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 quantum of annual funding increases received by TDHB is grossly inadequate to support its current services and infrastructure. Operating deficits are inevitable – and will increase year on year at forecast funding levels. Operating cash flow will be impacted.
- b) That the DHB is faced with increasing demand for health services against a backdrop of nominal annual funding increases, therefore targeted changes within its operating framework (including the non-hospital sector) are necessary.
- c) The operating cost to funding gap in the Hospital Provider operations cannot be bridged by changes along the margins and short term measures, and
- d) 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
- e) that these changes will take time, will need to transcend political sensitivities and communal expectations in a collaborative (and time challenged) manner, and
- f) 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
- g) 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) – the core facts

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

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 population in 18/19 will be 120,050 people. This is an increase of 1,085 (or 0.91%) from the 2017/18 population projection (See Table 1) – one of the lowest of the DHBs and indicates that the Taranaki population is growing much slower than the country as a whole.*

Table 1: DHB Population Projection Variance

Year	2016/17	2017/18	Change
2016 Population Series	118,965	120,230	1,265
2017 Population Series	118,880	120,050	1,170
Change	-85	-180	1,085

Taranaki DHBs population growth rate is ranked 16th out of all DHBs. 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 2018/19 and has received only minimum growth allocation.

The Taranaki DHB PBFF share in 2018/19 is calculated @ 2.63%. The increase in core funding for 2018/19 over 2017/18 is 3.08% or \$10.60M. Taranaki DHB has the third lowest level of increase amongst the DHBs 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 2018/19. 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	2021-22
Actual	2.71%	2.68%	2.66%	2.64%	2.63%			
Forecast						2.61%	2.59%	2.57%

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 2018/19 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 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 2018/19 the planned Funder surplus is \$12.80M. 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 \$26.53M 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.
 - b) Outsourced clinical staff – primarily psychiatrists.
 - c) Diagnostics.
 - d) Acute services including 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 2018/19 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 (in particular the NOS programme) 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 94% 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 10% in ACC revenues is planned for 2018/19, whilst miscellaneous income assumes \$1.0M to be raised through community donations.
8. During the plan period 2018-22, baseline capital expenditure will be contained within depreciation provisions, so that additional equity injection or borrowing is not required despite continuing operating deficits. The cash flow is deteriorating, and this situation is not sustainable in the short to medium term.
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 2018/22 and out years.

3. Key Financial Assumptions

The following key assumptions have been employed in the preparation of the financial statements for the four year planning period 2018-22.

3.1 Application of Public Benefit Entity Accounting Standards

The DAP financial template for the plan period 2018-22 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 District Annual Plan 2018-22 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 2018/19 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: an increase of 2% has been assumed in 2018/19 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 primarily in ICT costs, this cost centre has seen annual increases above the average and will continue to put pressure on costs and cashflow as more ICT projects come on stream. 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, OAG contracts and regional arrangements have been recognised. Gains from local initiatives and projects have been built into the relevant expense budgets.
- e) Other expenditure reductions: the 2018/19 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. Based on expenditure to date and forecasts, no surplus is likely to remain on 30 June 2018. No surpluses from Mental Health services are envisaged during the 2018-22 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 2018/19 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 2018/19 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. Taranaki DHB is required to undertake a full asset revaluation once every 5 years.

Taranaki DHB conducted a full asset revaluation as at 30 June 2018 in accordance with the stipulated cycle. The summary impacts of the revaluation in the books and costs of the DHB are as under:

- Increase in value of Land & Buildings: \$49.09M
- Increase in Reserves: \$49.09M
- Increase in Depreciation due to revaluation impact: \$0.78M
- Increase in Capital charge due to revaluation impact: \$2.55M.

Provision has been made as appropriate in the 2018/19 financials and future periods for the impacts of asset revaluation noted above.

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.

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 2018-22.

Financial ratios	TDHB 2017-18	Year1 2018-19	Year2 2019-20	Year3 2020-21	Year4 2021-22
	unaudited	plan	plan	plan	plan
1 Revenue to net funds employed	2.58	2.73	2.86	2.98	3.10
2 Operating margin to revenue	2%	1%	2%	2%	3%
3 Operating return on net funds employed	6%	2%	4%	7%	10%

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 (2018-19)	Year 2 (2019-20)	Year 3 (2020-21)	Year 4 (2021-22)	Total (2018-22)
<u>Operating</u>					
Clinical Equipment	3,000	3,000	3,000	3,000	12,000
Other Equipment	500	500	500	500	2,000
Motor Vehicles	600	100	100	100	900
Minor Site Redevelopment (including prior year WIP)	3,000	3,000	3,000	3,000	12,000
Information Technology	7,000	7,000	8,000	8,000	30,000
TOTAL	14,100	13,600	14,600	14,600	56,900
<u>Strategic</u>					
Base Hospital redevelopment. Project Maunga – Stage 2	Scoping & development of BC	Development of BC	Approval of BC	Procurement to start construction.	
TOTAL	-	-	-	-	-
GRAND TOTAL	14,100	13,600	14,600	14,600	56,900
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	14,100	13,600	14,600	14,600	56,900

Note: The strategic capital expenditure is in reference to the development of the business case for Stage 2 of Project Maunga. All preliminary work to inform the business case has been completed, and at the time of writing this draft Plan the DHB was preparing to submit the Strategic Assessment to the National Capital Investment Committee at its meeting scheduled for mid September 2018. The capital investment for Stage 2 is estimated at \$270M – subject to approval of the scope and design. Funding to support the build is expected to be largely from Crown equity, with an amount of \$25M being targeted from community support and local corporates.

4.10 Capital Divestment

The disposal of surplus assets proposed during the period 2018-22 is as follows:

Asset	Book value (\$)	Realisable Value (\$)	Gain/(loss) On sale (\$)	Timing
* Miscellaneous equipment (discarded/obsolete)	0	Not Material	0	2018-22
* Surplus land	0	0	0	n/a
* Vehicles	0	Not Material	0	2018-22
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

1. Paid/Contracted/Core FTEs

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

	Average 2017/18		Yr 1 - 2018/19		Yr 2 - 2019/20		Yr 3 - 2020/21		Yr 4 - 2021/22	
	Contract	Accrued	Contract	Accrued	Contract	Accrued	Contract	Accrued	Contract	Accrued
* Medical	184	188	187	191	188	192	188	192	190	194
* Nursing	620	647	626	653	634	662	636	664	638	666
* Allied Health	274	274	276	276	276	276	277	277	277	277
* Support	98	100	99	101	99	101	99	101	100	102
* Mgt & Admin	284	289	286	291	286	291	286	291	288	293
* Gov & Funding Admin	19	19	20	20	20	20	20	20	21	21
TOTAL	1479	1517	1494	1533	1503	1542	1506	1545	1514	1553

- Medical FTE count has seen a quantum increase during 2017/18 to meet MECA conditions, primarily in relation to rosters, in addition to filling vacancies. Any increase planned for 2018/19 is 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 marginal increases YOY in response to activity, 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. Of particular note is the potential impact of the MECA settlement on staffing levels and CCDM commitments, which has the likelihood to see increases in core numbers and costs. Movements in Allied Health and support staff are likely to be contained and are constantly

reviewed for efficiencies and optimum service delivery - any increase being restricted to meeting 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.

- 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 as was witnessed during 2017/18. 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

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.

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. Cost: \$80M.

The other 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, Pathology, ICU, Renal and Radiotherapy (TBC).	\$270M (estimate)	Tentative: 2021-2022	Preliminary works commenced. Business case under development.
STAGE 3	Ambulatory, OPD Administration.	\$80M (estimate)	Tentative : 2025-2026	Supplementary business case to be progressed.
TOTAL		\$430M (estimate) <i>See notes</i>	2011 – 2026	

Notes:

1. Scoping and planning for Stage 2 of Project Maunga has commenced with preliminary works in progress. Early documentation (Risk assessment, Point of Entry) has been submitted to Treasury, and discussions are in progress with the Capital Investment Committee (CIC) on next steps to progress the business case, preferably under an accelerated business approval and delivery programme. The estimated capital cost based on the preliminary scope (subject to approval) is \$270M. The planning and resources required to progress the business case through the different stages leading to approval are being established.
2. Each of the stages can be visualised as standalone projects, yet forming part of one coherent facilities redevelopment programme for the Base Hospital in New Plymouth, thus enabling affordability to both Taranaki DHB and the National Health capital budget.

An updated Schedule of Capital Intentions has been submitted.

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 2018/19 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.	\$0.40M	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.	\$0.30M	Reduce diagnostic costs.
Demand Management: e-referrals, i-procurement and review of internal systems	Reviews of service delivery against targets and contracts.	\$0.50M	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.	\$0.60M	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.	\$0.80M	Reduce operating deficit
TOTAL		\$3.00M	

The Annual Plan has identified a cost to funding gap of circa \$3.00M to arrive at its planned financial result for 2018/19, 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 2018/19 are:

- Overdraft facilities (as per OPF guidelines) are assumed to be available under the DHB collective treasury and banking arrangement (currently with BNZ). Taranaki DHB has been in overdraft during certain periods of the 2018 primarily on the back of a sharp increase in its consolidated financial deficit from \$ 1.67M (2016/17) to \$ 8.29M for the year 2017/18 just ended. The deficit planned for 2018/19 is \$ 13.73M.
- No additional equity or deficit support is envisaged at this stage. It is expected that base line capital expenditure will be contained within the level of depreciation for 2018/19 and out years. Cash flow will be managed by capital prioritisation and working capital management, the intention is to limit any overdraft.
- The continuing deficit and low levels of funding increases, year on year, is proving to be corrosive. Liquidity is becoming more acute, with the monthly cashflow remaining in OD on a regular basis at month end. Eventually it will result in the DHB seeking equity support – despite acute management of working capital and cost control measures in place. It is only a matter of time.

8. Sensitivity Analysis: Budgetary Risks carried in Annual Plan 2018/19

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 2018/19

Unbudgeted financial risk	Est. risk (\$M)	75% risk (\$M)	50% risk (\$M)	25% risk (\$M)	Probability factor (% risk)
Wage budget (MECA conditions)	0.60	0.45	0.30	0.15	75%
Timing of gains from savings plan	1.60	1.20	0.80	0.40	75%
Clinical supplies	1.00	0.75	0.50	0.25	75%
General overheads	0.40	0.30	0.20	0.10	25%
Likely impact on 2018/19 planned financial result	\$3.60M	\$2.70M	\$1.80M	\$0.90M	\$2.50M

The overall risk is expected to be **\$3.60M** for 2018/19, 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 2018/19

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	75%
IDF Above Plan	1.00	0.75	0.50	0.25	50%
Pharmaceuticals	0.40	0.30	0.20	0.10	25%
Health of Older People	1.00	0.75	0.50	0.25	50%
Pathology and Laboratory Service Development and Change	1.00	0.75	0.50	0.25	75%
Potential impact on 2017/18 planned financial result	6.40M	4.80M	3.20M	1.60M	4.10M

The overall exposure is estimated at around **\$6.40M** for 2018/19, while the probability factor is estimated to be around 65% leaving a residual risk equating to about **\$4.10M**.

These risks are expected to be managed through contract monitoring.

9. Statement of Comprehensive Income

	Audited	Audited		Planned			
	2016/17	2017/18		2018/19	2019/20	2020/21	2021/22
Revenue							
Devolved Funding	341,200	356,708		369,229	379,648	390,073	400,500
Non-Devolved Contracts	6,549	6,549		6,521	6,586	6,651	6,717
Inter-DHB & Interprovider Revenue	4,885	5,056		4,992	5,206	5,427	5,657
Other Revenue	11,975	13,117		12,787	13,024	13,266	13,514
Total Revenue	364,609	381,430		393,529	404,464	415,417	426,388
DHB Provided Expenditure							
Personnel	131,136	142,651		148,186	151,148	154,171	157,252
Outsourced Personnel & Support	2,230	2,777		2,845	2,901	2,959	3,018
Outsourced Clinical Services	14,279	13,032		13,217	13,481	13,751	14,026
Clinical Supplies	27,974	30,924		31,963	32,602	33,253	33,919
Infrastructure & Non-Clinical Supplies	38,049	38,194		43,174	44,986	44,593	44,428
Total DHB Provided Expenditure	213,668	227,578		239,385	245,118	248,727	252,643
Other Providers							
Personal Health	64,147	64,882		67,959	69,614	70,492	71,278
Mental Health	11,030	10,590		11,196	11,520	11,844	12,284
Public Health	676	693		991	1,010	1,031	1,052
DSS	37,478	44,205		45,882	46,799	47,734	48,686
Maori Health	2,879	2,887		2,965	3,025	3,086	3,148
IDFs	36,401	38,884		38,884	40,082	41,314	42,584
Total Other Providers	152,611	162,141		167,877	172,050	175,501	179,032
Total Expenditure	366,279	389,719		407,262	417,168	424,228	431,675
Total Consolidated Result	(1,670)	(8,289)		(13,733)	(12,704)	(8,811)	(5,287)
By Arm							
Provider	(18,072)	(25,879)		(26,533)	(26,157)	(23,645)	(22,509)
Governance	35	5		0	0	0	0
Funder	16,367	17,585		12,800	13,453	14,834	17,222
Public Health	(1,670)	(8,289)		(13,733)	(12,704)	(8,811)	(5,287)

10. Consolidated Statement of Financial Position

(\$'000)									
		2016/17	2017/18		2018/19	2019/20	2020/21	2021/22	
		audited	forecast		plan	plan	plan	plan	
CURRENT ASSETS									
* Bank Account		282	317		405	493	581	669	
* ST investments		2890	2890		0	0	0	0	
* Prepayments		2704	2809		2909	3009	3109	3209	
* Debtors (net of provision)		10903	14186		11163	10712	10261	10360	
* Inventory		3103	3332		2927	2876	2825	2839	
		19882	23534		17404	17090	16776	17077	
CURRENT LIABILITIES									
* Bank Account		3349	4578		7674	14242	17087	18901	
* Creditors & other payables		20303	22386		21647	21398	21984	22042	
* Term Loans (current portion)		0	0		0	0	0	0	
* Provisions		26953	31805		33170	34880	36585	36940	
		50605	58769		62491	70520	75656	77883	
WORKING CAPITAL		-30723	-35235		-45087	-53430	-58880	-60806	
NON CURRENT ASSETS									
* Net Fixed Assets		176946	221230		216431	211132	206833	202534	
* Investments		1451	1595		1595	1595	1595	1595	
* Trust funds		844	779		779	779	779	779	
		179241	223604		218805	213506	209207	204908	
NET FUNDS EMPLOYED		148518	188369		173718	160076	150327	144102	
NON CURRENT LIABILITIES									
* Provisions - non current		894	901		941	961	981	1001	
* Term Loans		0	0		0	0	0	0	
		894	901		941	961	981	1001	
CROWN EQUITY									
* Crown Equity		95248	94290		93332	92374	91416	90458	
* Reserves		68293	117319		117319	117319	117319	117319	
* Retained earnings		-15917	-24141		-37874	-50578	-59389	-64676	
		147624	187468		172777	159115	149346	143101	
NET FUNDS EMPLOYED		148518	188369		173718	160076	150327	144102	

11. Consolidated Statement of Cashflow

(\$'000)											
			2016/17 audited	2017/18 forecast		2018/19 plan	2019/20 plan	2020/21 plan		2021/22 plan	
OPERATING ACTIVITIES											
* MOH funding			350042	358726		378817	386684	397174		407117	
* Other revenue			16431	17644		17397	17843	18306		18784	
total receipts			366473	376370		396214	404527	415480		425901	
* Payment of salaries & operating exp.			196057	203032		216465	224712	227816		233350	
* Payment to providers & DHB's			153099	161653		170977	172125	175251		179107	
total payments			349156	364685		387442	396837	403067		412457	
NET CASHFLOW FROM OPERATIONS			17317	11685		8772	7690	12413		13444	
INVESTING ACTIVITIES											
* Interest & Dividends Received			359	401		388	388	388		388	
* Sale of fixed assets etc			144	121		0	0	0		0	
* (Increase) / decrease in investments			0	-45		2890	0	0		0	
* Capital expenditure			-11745	-12398		-14100	-13600	-14600		-14600	
NET CASHFLOW FROM INVESTING			-11242	-11921		-10822	-13212	-14212		-14212	
FINANCING ACTIVITIES											
* Equity injections / repayments			-958	-958		-958	-958	-958		-958	
* Borrowings			0	0		0	0	0		0	
* Payment of debts			0	0		0	0	0		0	
NET CASHFLOW FROM FINANCING			-958	-958		-958	-958	-958		-958	
Total cash in			365515	375412		395256	403569	414522		424943	
Total cashout			-360398	-376606		-398264	-410049	-417279		-426669	
NET CASHFLOW			5117	-1194		-3008	-6480	-2757		-1726	
Add: Cash (opening)			-8184	-3067		-4261	-7269	-13749		-16506	
CASH (CLOSING)			-3067	-4261		-7269	-13749	-16506		-18232	

12. Consolidated Statement of Movement in Equity

(\$'000)									
					2017/18 forecast	2018/19 plan	2019/20 plan	2020/21 plan	2021/22 plan
EQUITY AT THE BEGINNING OF PERIOD					147624	187468	172777	159115	149346
* Net results for the period					-8289	-13733	-12704	-8811	-5287
* Revaluation of Fixed assets					49091	0	0	0	0
* Equity Injections / (repayments)					-958	-958	-958	-958	-958
* Other					0	0	0	0	0
EQUITY AT THE END OF THE PERIOD					187468	172777	159115	149346	143101

APPENDIX B: List of Equitable Outcomes Actions

This is a list of all the Equity Outcome Actions contained throughout Section 2 of this Plan. These actions are specific to improving the indicators in the TDHB's 'Kia tū rangatira ai ngāi Māori ki te ara kākārīki'.

Māori Health Priorities focus are identified in this list as 'Kia tū rangatira ai ngāi Māori ki te ara kākārīki'.

GOVERNMENT PLANNING PRIORITY	ACTIVITY/ EQUITABLE OUTCOMES ACTIONS
Population Mental Health	<p>To evaluate the Taiohi Wellness Service delivered by Te Kawau Māro to ensure that high needs taiohi Māori have timely access to primary mental health and Alcohol and other drug services.</p> <p>To implement the recommendations of the Vocational Employment Service Review, working in partnership with MSD, to ensure vocational services are evidence based and targeted to those in highest need.</p>
Mental Health and Addictions Improvement Activities	To implement a project, informed by a comprehensive Health Equity Assessment, that aims to reduce the numbers of Māori on Community Treatment Orders, Section 29 to support HQSC focus on minimising restrictive care. <i>'Kia tū rangatira ai ngāi Māori ki te ara kākārīki'</i>
Addictions	To integrate kaupapa Māori services into the pathway through a Service level Agreement between TDHB and Te Kawau Maro alliance.
CVD and Diabetes Risk Assessment	To implement a service improvement initiative that aims to reduce Māori Did-Not-Attend (DNA) rates at Diabetes Clinics to a maximum of 9%. <i>'Kia tū rangatira ai ngāi Māori ki te ara kākārīki'</i>
Pharmacy Action Plan	To increase access to free Emergency Contraceptive Pill (ECP) by implementing and funding free pharmacy consultation for under 25's.
Support To Quit Smoking	<p>To provide clinical advice, support and education to GPs to increase prescribing rates for smoking cessation products and increase primary care referrals to Stop Smoking Support services with a focus on supporting general practices serving high needs populations. <i>'Kia tū rangatira ai ngāi Māori ki te ara kākārīki'</i></p> <p>To extend the availability of brief advice and smoking cessation referrals in community pharmacy settings through the delivery of a pilot programme that incentivises community pharmacies in priority communities to provide brief advice and referral. <i>'Kia tū rangatira ai ngāi Māori ki te ara kākārīki'</i></p>
Child Wellbeing	<p>To implement a service improvement project to improve access to the DHB's community dental services and reduce Do Not Attend (DNA) rates by Māori children aged 0 to 4 years. <i>'Kia tū rangatira ai ngāi Māori ki te ara kākārīki'</i></p> <p>To implement the Hapu Wananga antenatal education programme to address a range of determinants of health and wellbeing (e.g. nutrition, breast feeding, oral health, immunisations, safe sleeping and smoking) with a specific focus on Māori and high needs populations. <i>'Kia tū rangatira ai ngāi Māori ki te ara kākārīki'</i></p>

GOVERNMENT PLANNING PRIORITY	ACTIVITY/ EQUITABLE OUTCOMES ACTIONS
	<p>To trial and evaluate the use of the Harti Hauora Assessment Tool alongside delivery of the Hapu Wananga programme. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i></p> <p>To undertake a scope of Kaupapa Māori parenting programmes being delivered to either adapt a current model or develop/co-design a fit-for-purpose parenting programme that supports healthy child development in a life course approach, and applies the Hapū Wānanga model. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i></p> <p>To implement a referral pathway to the WISE Better Homes insulation programme from Hapu Wananga and DHB clinical services working with whanau with children. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i></p>
Maternal Mental Health Services	<p>To implement a Community Based Perinatal Maternal Mental Health Service within Te Kawau Maro/Māori provider network aimed at supporting Māori mothers and moving the continuum of care to mild to moderate MH conditions.</p> <p>To implement the Hapu Wananga programme to improve maternal and child health (including maternal mental health) specifically aimed at Māori and high needs populations.</p>
Supporting Health in Schools	<p>To implement and evaluate the Taiohi Wellness Service pilot project to taiohi aged 12-18 years within Taranaki intermediate and high schools to build confidence and resilience through the delivery of brief interventions to taiohi.</p>
School Based Health Services	<p>To develop an Implementation Plan for the delivery of additional HEADSSS assessments targeted to Decile 4 Schools in Taranaki.</p>
Immunisation	<p>To undergo a self-review process of the current Taranaki Immunisation Steering Group to ensure equity-focussed member representation, review terms of reference and assess strategic intent and access to ensure effectiveness and increase equity in relation to immunisation services as per 2018 Taranaki Public Health Unit HEAT recommendations. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i></p> <p>To review and assess immunisation declines, by ethnicity, within Taranaki to inform development of an action plan to reduce decline rates for high needs populations. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i></p> <p>To develop and implement a three year work plan based on the findings of the 17/18 Immunisation Health Equity Assessment (HEAT) Report to address identified primary health care access barriers. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i></p>
Responding to Childhood Obesity	<p>To undertake a health equity assessment of the Whānau Pakari obesity management programme with a focus on decline rates of Māori children to identify action that can be taken to increase equity of access and utilisation by Māori.</p>

GOVERNMENT PLANNING PRIORITY	ACTIVITY/ EQUITABLE OUTCOMES ACTIONS
Access to Elective Services	To review elective services initiatives and ensure that prioritisation tools are being used in a manner that supports equitable access to care for all specialities across the Taranaki region The use of the impact on life questionnaire which is integral to the outcome of the prioritizing, is used by all specialities. The Māori Health Unit will continue to provide support in completing this questionnaire as well as supporting patients to attend appointments and to navigate the health system.
Cancer Services	To ensure equity of access to timely diagnostics and treatment for all patient by: <ul style="list-style-type: none"> • Reviewing all patients who breach timeframes, by ethnicity, to identify service improvement opportunities • Māori health team participation in FCT Governance Group to provide guidance on health equity and quality
Healthy Ageing	To develop and target interventions aimed at increasing uptake of influenza vaccinations for Māori over 65 years, by working with community pharmacies and Te Kawau Maro/Māori provider network to increase access to vaccinations in high needs localities. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i>
Disability Support Services	To undertake a stocktake and compile a list of resources that are available for people with disabilities when accessing Hospital and Specialist Services. To review Disability Responsive training (on-line module and TDIC Practical) and identify areas for improvement including staff engagement. To work in partnership with the Disability community to promote the use of the Health Passport. To identify barriers to access for people with disabilities in relation to the booking of hospital and specialist services appointments.
Improving Quality	To improve equity in outcomes as measured by the Atlas of Healthcare Variation by implementing a service improvement initiative that aims to reduce Māori Did-Not-Attend (DNA) rates at Diabetes Clinics to a maximum of 9%. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i> To monitor and initiate activity to improve responses to questions in the Patient Experience Survey which consistently receive the lowest scores. Priority will be given to areas where Māori are disproportionately represented. Inpatient patient experience survey information will be distributed quarterly as an infographic to Clinical Nurse Managers and relevant Operations Managers in order for analysis to occur at that level and for the establishment of improvement projects. <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i> - To work towards becoming a Health Literate Organisation (HLO) through the following actions: <ul style="list-style-type: none"> • Socialising the concepts of health literacy and consulting and finalising the Health Literacy Framework • Agreeing priority projects and services planned or under way for Health Literacy Review • Implementing up to four Health Literacy reviews • Setting up a system to identify health literacy improvements made by the DHB and monitor progress towards becoming a HLO

SYSTEM LEVEL MEASURES	MĀORI HEALTH PRIORITIES WITH EQUITABLE OUTCOMES ACTIONS ATTACHED <i>(refer to System Level Measures Plan for detail)</i>
ASH: 0-4 year old children <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i>	<ul style="list-style-type: none"> • ASH 0 – 4 year old children • DNA rates children 0 – 4 • Immunisation at 8 months • PHO enrolment children 0 – 4 • Pre-school dental enrolments
Acute Hospital Bed Days per Capita	<ul style="list-style-type: none"> • Ambulatory Sensitive Hospitalisation 45 – 64 years • Influenza immunisation age 65+ <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i>
Patient Experience of Care	<ul style="list-style-type: none"> • Adult inpatient • Primary care
Amenable Mortality	<ul style="list-style-type: none"> • Breast screening women 25 – 69 <i>‘Kia tū rangatira ai ngāi Māori ki te ara kākārīki’</i> • Diabetes management • CVD risk assessment • Suicide prevention • PHO enrolment of Māori men • Building resilience in school age children
Youth System Level Measure	<ul style="list-style-type: none"> • Youth self harm
Proportion of babies who live in a smoke-free household at six weeks	<ul style="list-style-type: none"> • Hapu wahine who are smoke-free at two weeks postnatal <i>‘Haerenga ki nga Kakariki’</i> • Hapu Wananga as a vehicle to link hapu wahine with the services they need

APPENDIX C: System Level Measures Improvement Plan 2018/19



TARANAKI

System Level Measures Improvement Plan 2018/19



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Introduction and Background

System Level Measures (SLMs) are high level aspirational goals for the health system that align with the five strategic themes in the New Zealand Health Strategy and other national strategic priorities, such as Health Targets. They are focussed on improving health outcomes for vulnerable populations including children and youth. System Level Measures have evolved from the primary care focused Integrated Performance Incentive Framework (IPIF), which aimed to shift health performance measurement away from outputs to outcomes.

District Health Boards (DHBs), Primary Health Organisations (PHOs) and District Alliances are expected to drive the development and implementation of a System Level Measures. In order to achieve this, Taranaki DHB and Pinnacle Midlands Health Network have developed this System Level Measures Improvement Plan, which includes a range of meaningful contributory measures, which in turn are underpinned by local clinically led quality improvement initiatives. Planning for and reporting of System Level Measures therefore requires DHB's, PHOs and Alliances to work with providers across the spectrum of care to determine how they will improve the well-being of their local population.

System Level Measures have nationally consistent definitions and performance that must be reported to the Ministry of Health. Contributory measures have nationally consistent definitions and data sets, but are selected locally and do not need to be reported to the Ministry of Health. District Alliances may agree to use a local indicator based on local data. This is considered a local continuous quality improvement activity and will not be used for benchmarking performance.

This System Level Measures Improvement Plan for 2018/19 therefore sets out agreed milestones for each of the following SLMs:

- Ambulatory sensitive hospitalisations per 100,000 for 0-4 years olds – “Keeping Children Out of Hospital”
- Acute hospital bed day utilisation per capita – “Using Health Resources Effectively”
- Patient Experience of Care – “Person Centred Care”
- Amenable Mortality – “Prevention and Early Detection”
- Youth Measure – “Youth are Healthy, Safe and Supported”
- Proportion of babies who live in a smoke-free household at six weeks post-natal – “A Healthy Start”

The Taranaki Region has determined all Contributory Measures, end of year milestones, and Activities through the establishment of a working group for each System Level Measure. Working groups are made up of a Champion, Manager, and key stakeholders who are demonstrated clinical, operational or strategic leaders in the respective areas of their System Level Measure. A number of our Champions are also members of the Taranaki Alliance Leadership Team and/or their respective organisation's Executive Leadership Teams, encouraging strong strategic links across Taranaki organisations. Champions and Managers report progress back to the Taranaki Alliance Leadership Team.

In selecting Contributory Measures and end of year milestones, working groups have looked to ensure that each measure is Meaningful (aligns to the SLM and is contextual to local need), Measurable (data is available and of sufficient quality) and Representative (representative of the range of local needs).

In selecting key Activities, groups have looked to ensure that activities are appropriately reflected in DHB Directorate and PHO Service Plans.

System Level Measures – Overview

Ambulatory Sensitive Hospitalisations	Acute Hospital Bed Days per Capita	Patient Experience of Care	Amenable Mortality	Youth System Level Measure	Proportion of babies who live in a smoke-free household at six weeks
Children Fully Immunised By Two Years	Respiratory Acute Hospital Bed Days	Hospitalised patients completing an adult in-patient survey	HbA1c Test Results	Mental Health and Well Being	Pregnant women registered with a Lead Maternity Carer within first trimester of pregnancy
Reduce “Frequent Flyers” ASH cohort	Cellulitis Acute Hospital Bed Days	Patients registered to use general practice portals	Melanoma Cancer Mortality Rate		Pregnant women who identify as smokers at registration
Hospital admissions for children aged five years with dental caries as primary diagnosis	Acute readmissions to hospital	GP Practices using the primary care patient experience survey	PHO enrolled people within the eligible population who have had a CVD risk recorded within the last five years		Infants who are exclusively or fully breastfed at three months
Respiratory ASH presentations	Inpatient Average Length Of Stay (ALOS) for acute admissions	Patient Experience of Care Survey Results	Suicide Rate		
			Breast Cancer Screening Coverage (50-69)		

Ambulatory Sensitive Hospitalisations (ASH): 0-4 year old children – “Keeping children out of hospital”

Where are we now?

Ambulatory Sensitive Hospitalisations Summary

Ambulatory sensitive hospitalisation (ASH) rates for 0-4 year olds in Taranaki DHB have been gradually increasing over the last five years, with the Māori rate consistently above the Total rate. The Other ethnicity group is now above the National total. Taranaki DHB has the 8th highest ASH rates for total population and 6th highest ASH rates for Māori in New Zealand.

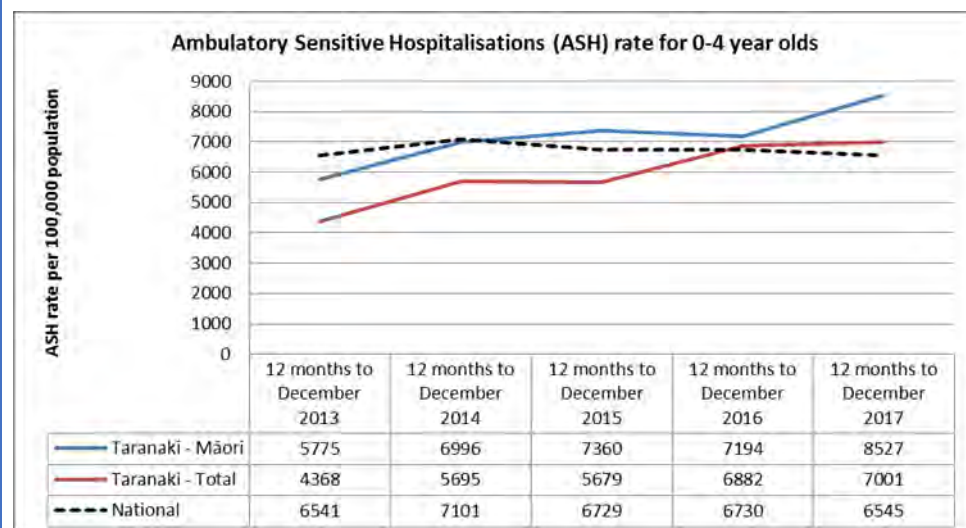
The most prevalent clinical conditions that contribute to Taranaki DHB’s ASH rate include respiratory conditions (infections and asthma), gastroenteritis and dental conditions. Only three of Taranaki DHB’s top ten ASH presentations are below the national average. These are upper and ENT respiratory infections, lower respiratory infections and cellulitis.

Measure description:

Non-Standardised Rate per 100,000 as per non-financial quarterly measure – System Integration 1

Baseline Data

Five year trend to December 2017



Key Contributing Clinical Conditions

Top 10 ASH conditions for 12 months to December 2017	ASH rate per 100,000			
	Māori	Other	Total	National
Upper and ENT respiratory infections	1,822	1,421	1,549	1,577
Asthma	1,744	1,293	1,437	1,192
Gastroenteritis/dehydration	1,085	1,293	1,227	1,067
Dental conditions	1,434	710	942	890
Pneumonia	1,124	455	669	580
Lower respiratory infections	426	383	397	404
Cellulitis	349	200	248	472
Constipation	78	255	198	139
Dermatitis and eczema	349	128	198	139
GORD	39	91	74	63

Where do we want to be?

Long term goal: To reduce and maintain the 0-4 years ASH rate for both Māori and non-Māori to fewer than 5,200 people per 100,000 population by 30 June 2023

Target for 2018/19: <8,500 per 100,000 for Māori

Rationale: Aiming for a 5% annual reduction, with a view to achieving a 25% reduction

How will we get there? (Contributory Measures)

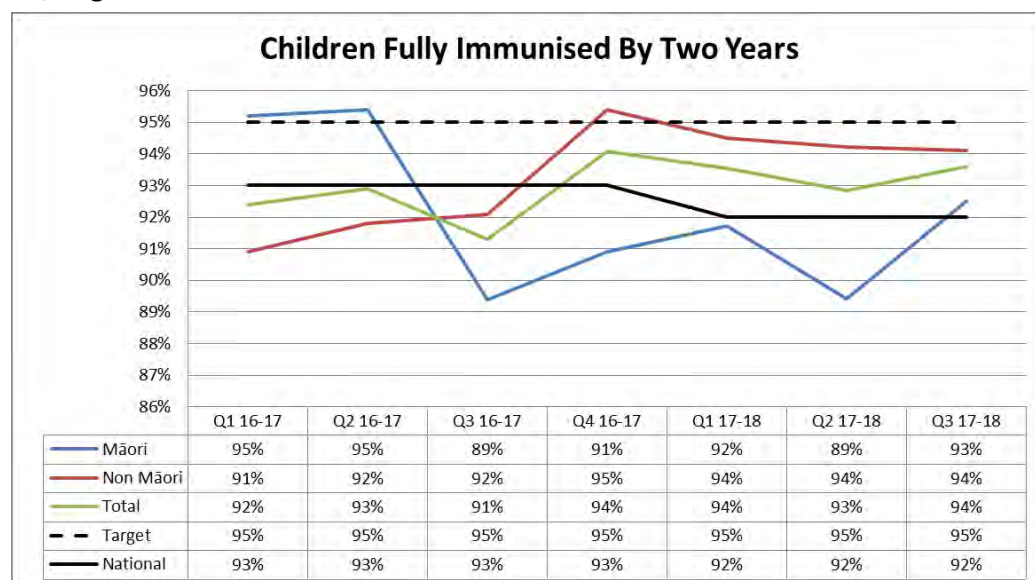
2.1.1 Children Fully Immunised By Two Years

Measure description: PHO-enrolled children who are enrolled on the NIR in the CI Programme and have completed the last dose of their age-appropriate vaccinations (as per the National Immunisation Schedule) on the day that they turn two

Baseline Data:

Activities that will enable us to achieve the goal

18/19 goal: 95% for Māori and non-Māori children



- Identify activities to increase immunisation rates via a process mapping exercise for mother and child journey (**PHO/Public Health**)
- Implement recommendations from the 2017 immunisation HEAT assessment (**Public Health**)
- Undertake an assessment of 2016 MoH Outreach Immunisation Services recommendations within Taranaki (**P&F**)
- Develop a three year work plan with activities to reduce access barriers for Māori (**Public Health**)
- Explore option of undertaking immunisations as part of WCTO checks (**TKM**)

2.1.2 Reduce “Frequent Flyers” ASH cohort

Measure description: Unique ASH 0-4 patients who present to hospital services 3 or more times in a year

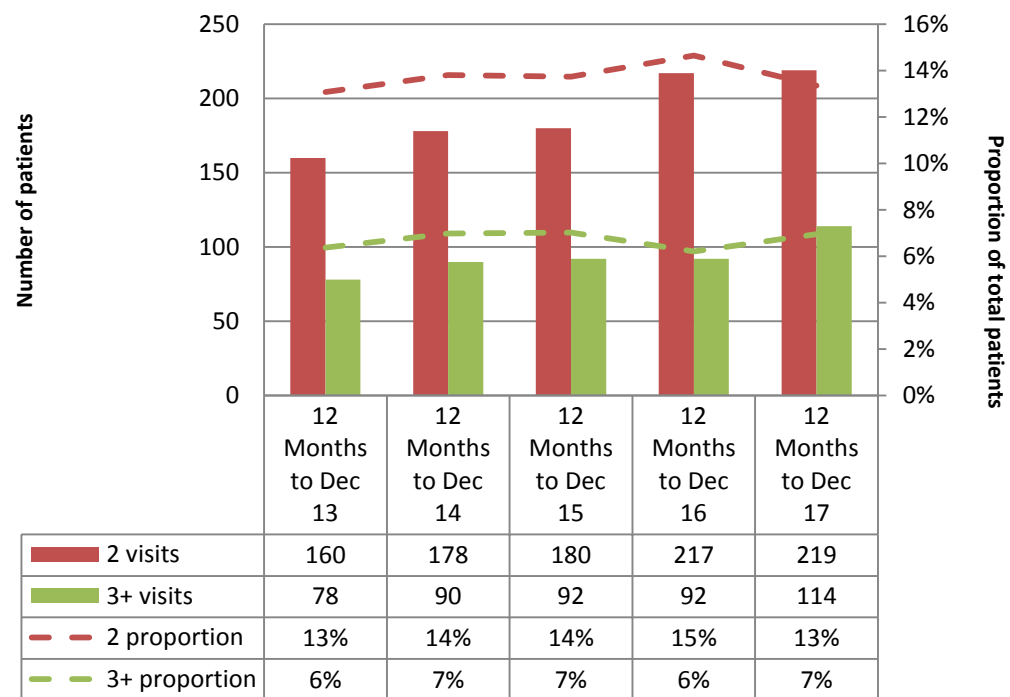
Baseline Data

Activities that will enable us to achieve the goal

18/19 goal: 3+ presentations < 90 per annum and 6% of all presentations

- Share details of ASH “frequent flyers” with practices to enable them to develop local actions to reduce this measure **(PHO)**
- Paediatric department to on-forward Māori ASH DNAs to the Māori Health team to identify actions that will improve attendance and reduce ASH rates **(Māori Health & Paeds Dept)**

Number of individual patients (0-4 years old) with more than one Hospital admission in a 12 month period



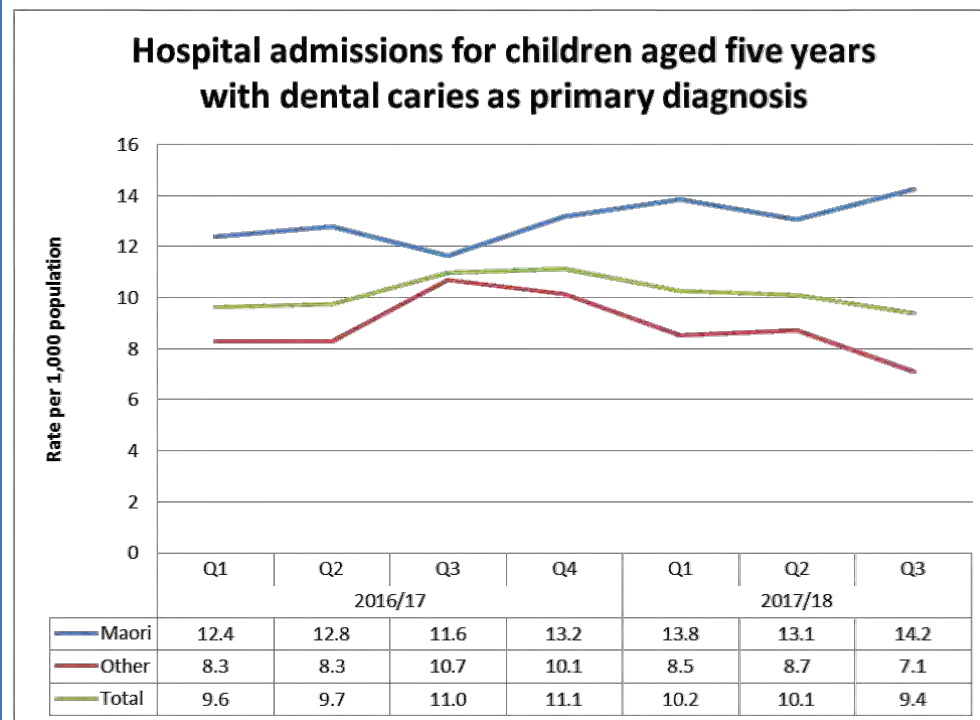
2.1.3 Hospital admissions for children aged five years with dental caries as primary diagnosis

Measure description: The total number of children under five years of age who are enrolled with the DHB at the beginning of the qualifying year who were admitted to hospital under a primary diagnosis of dental caries (ICD 10 Code K02).

Baseline Data

Activities that will enable us to achieve the goal

18/19 goal: ≤10 per 1,000 for Māori and non-Māori



- Implement a service improvement initiative aimed at reducing the DNA rate of 0-4yrs oral health services based on the findings of the 2018 HEAT assessment (**Māori Health**)
- Develop a local oral health outcomes framework (utilising existing national indicators where available), and use this as a foundation for a whole of sector oral health workshop to map current patient flows and identify areas for improvement (**P&F**)

2.1.4 Respiratory ASH Presentations

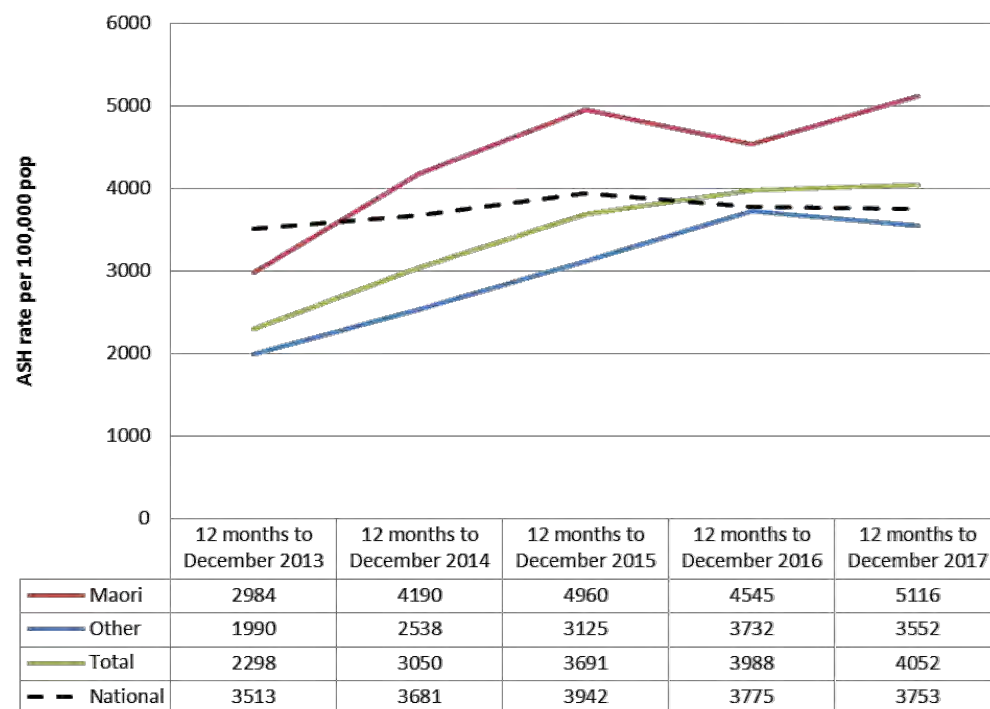
Measure description: The total number of respiratory ASH presentations for children age 0-4 (Asthma, Lower respiratory infections, Pneumonia, Upper and ENT respiratory infections)

Baseline Data

Activities that will enable us to achieve the goal

18/19 goal: ≤4000 for Māori and non-Māori

Respiratory ASH rate per 100,000 pop (0-4)



- Implement a referral pathway to home insulation programs for at risk whānau **(P&F)**
- Expansion of current respiratory primary options to help reduce acute hospitalisations for this respiratory cohort **(PHO)**
- Implement 'Lungs for Life' – flagging high risk children presenting to the Paeds service to ensure they are referred on to appropriate support services e.g. respiratory surveillance, GP, care plans **(DHB - Paeds Dept)**
- Develop an environmental profile in the patient assessment to increase onward referral to appropriate services **(DHB - Paeds Dept)**
- Undertake a mapping exercise of current respiratory related resources, with a view to developing a more closely aligned and focussed respiratory service that supports children to stay out of hospital **(P&F)**

Acute Hospital Bed Days per Capita – “Using Health Resources Effectively”

Where are we now?

Acute Hospital Bed Days per Capita Summary

Taranaki DHB's acute hospital bed days rate for total population has remained steady since 2015. Our Māori population generally has a higher bed day rate. Acute hospital bed days rates are highly correlated with age, with the exception of 0-4 year olds, and Taranaki DHB generally conforms to this trend, with the exception of fewer acute hospital bed days in the 70+ year old groups than the national average. The most prevalent clinical conditions that contribute to Taranaki DHB's Acute Hospital Bed Days per Capita rate are respiratory Infections/Inflammations, Stroke and Other Cerebrovascular Disorders, Heart Failure and Shock and Chronic Obstructive Airways Disease.

Measure description

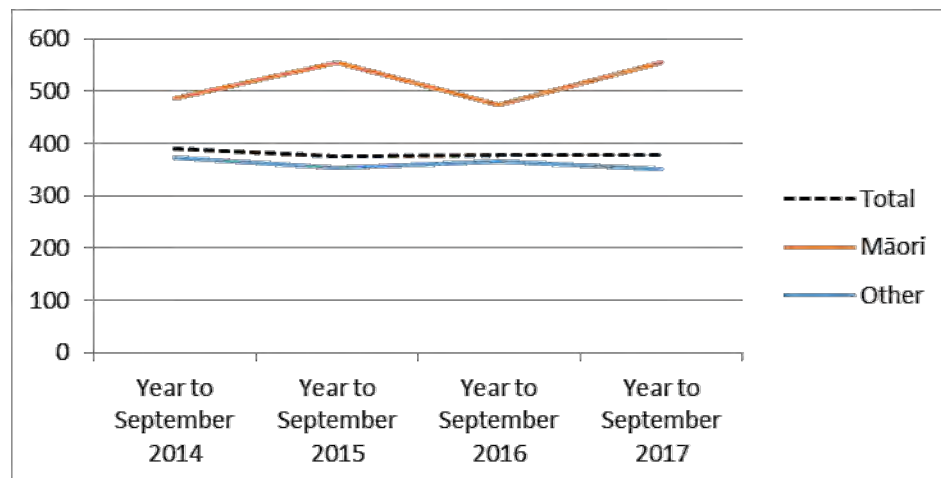
The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand (NZ) resident population. The acute bed days per capita rates are presented using the number of bed days for acute hospital stays per 1000 population domiciled within a District Health Board (DHB) with age standardisation.

The measure is calculated quarterly with a rolling 12-month data period. Acute hospital bed days are calculated by adding up the length of stays in days for patients presented to a NZ hospital acutely that are publicly funded.

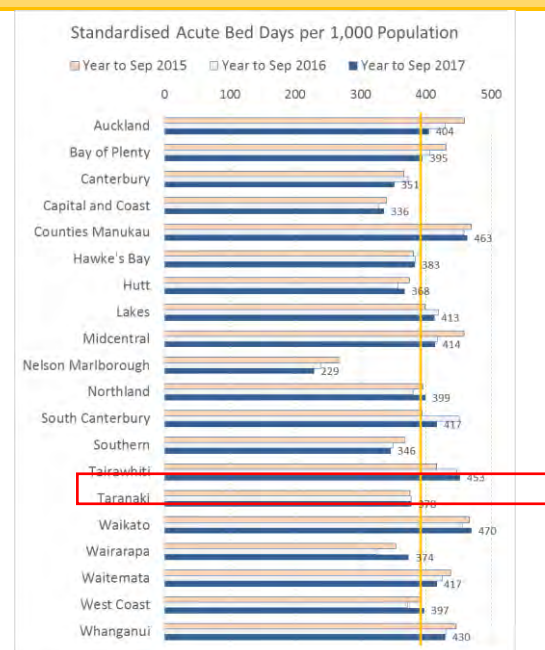
A stay is counted if the first event in that stay is classified as an acute inpatient event.

The acute bed days per capita measure can be age standardised at domicile DHB level.

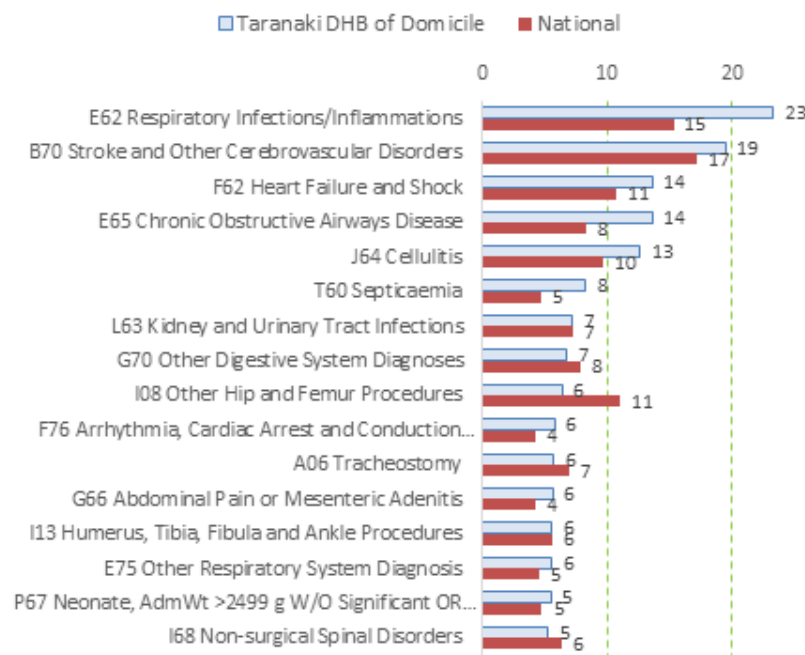
Baseline Data – 4 year trend to September 2017



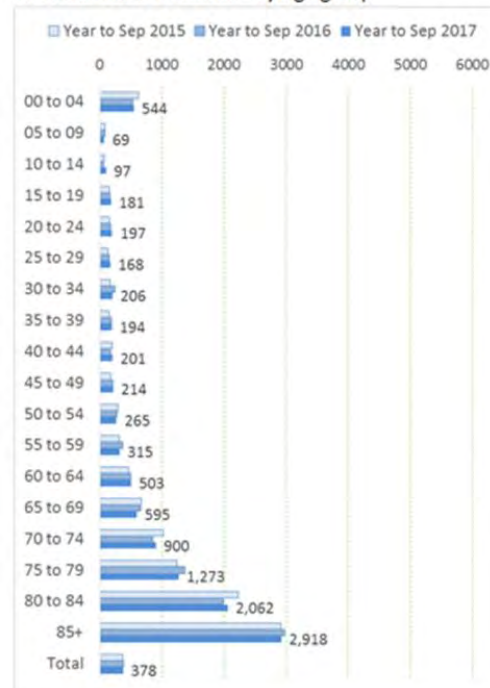
Acute Bed Days per 1,000 Population					
Year to September 2012	Year to September 2013	Year to September 2014	Year to September 2015	Year to September 2016	Year to September 2017
N/A	N/A	391	375	377	378



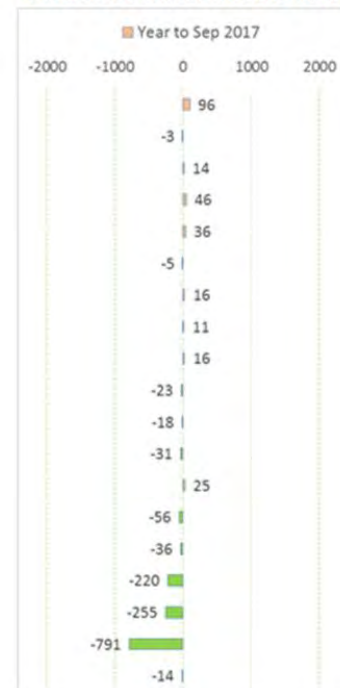
Key contributing clinical conditions



Taranaki DHB of Domicile - by Age group



Difference between DHB and NZ rates



Where do we want to be?

Long term goal:	Reduce and maintain Acute Hospital Bed Days per Capita rate to fewer than 350 days per 1,000 population by 30 June 2023, with equity of outcome for Māori.
Target for 2018/19:	Less than 500 Acute Hospital Bed Days per Capita for Māori
Rationale:	The Taranaki Health Action Plan forecasts 33 extra beds will be utilised by 2026 given no changes in current utilisation rates. Changes to our models of care are anticipated to hold the current number of beds, instead investing the money in improved care in the outpatient, community and primary settings. This, alongside Taranaki DHB's plans to reduce average LOS should approximate to 350 days long term goal.

How will we get there? (Contributory Measures)

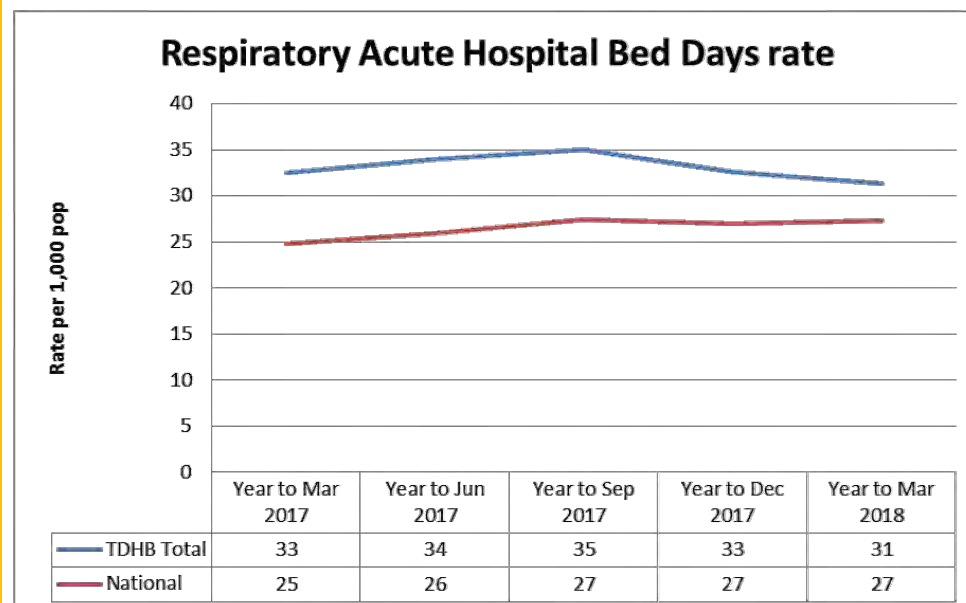
2.2.1 Respiratory Acute Hospital Bed Days

Measure description: The rate of acute hospital bed days related to respiratory conditions (DRGs E62, E75, E41 & E69)

Baseline Data

Activities that will enable us to achieve the goal

18/19 goal: ≤30 per 1,000



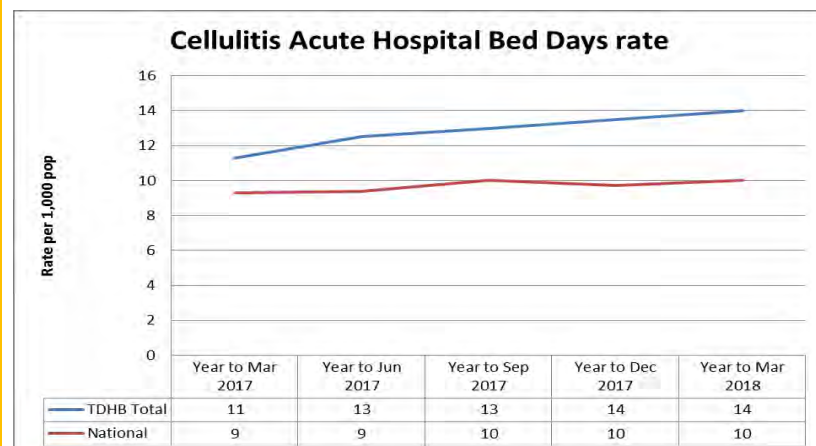
- Expansion of current respiratory primary options in primary care to help reduce respiratory related acute hospitalisations (**PHO**)
- Undertake a mapping and reconciliation exercise of current respiratory services against best practice national and international standards, with a group of clinical experts, to develop a more closely aligned and focussed respiratory service that keep patients out of hospital (**P&F/DHB - Allied Health**)

2.2.2 Cellulitis Acute Hospital Bed Days

Measure description: The rate of acute hospital bed days related to cellulitis (DRG J64)

Baseline Data

18/19 goal: ≤11 per 1,000



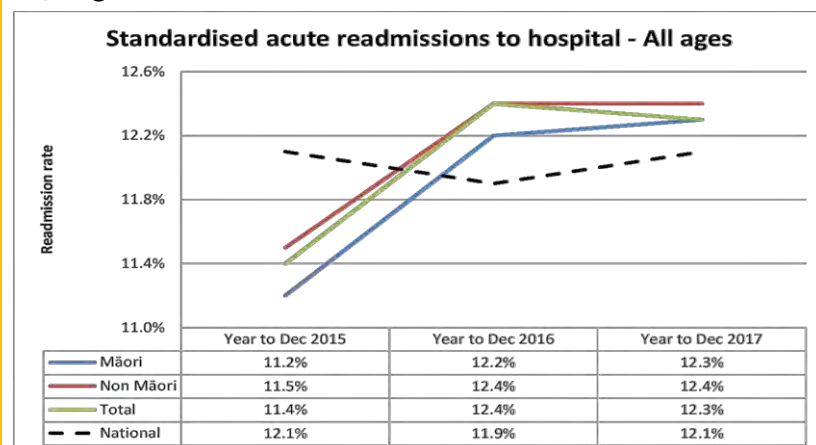
- Drill down into cellulitis data to look for indicators on ways to better manage this cohort (e.g. locality, frequent flyers, general practice, ARC) **(P&F)**
- Promote the cellulitis primary options and ED redirection pathways in general practices to increase uptake **(PHO)**

2.2.3 Acute readmissions to hospital

Measure description: Total number of acute readmission events per DHB of domicile per year

Baseline Data

18/19 goal: ≤12% for Māori and non-Māori



Activities that will enable us to achieve the goal

- Review of re-admission data to look at trends and indicators on where to focus efforts to reduce re-admission rates **(P&F)**
- Explore strategies to improve the quality of discharge planning and the role of allied health in preventing admissions, with a view to piloting a new model of care **(DHB – Allied Health)**
- Implementation of a SPOA for refers to ensure complex clients receive coordinated and timely care **(DHB)**
- Roll out Health Care Homes to more Taranaki practices to increase capacity in primary care and enable more proactive activity **(PHO)**
- Integrate the fracture liaison service with the PHO falls prevention service to ensure all patients with osteoporosis access a comprehensive service and reduce the likelihood of further injury **(P&F)**

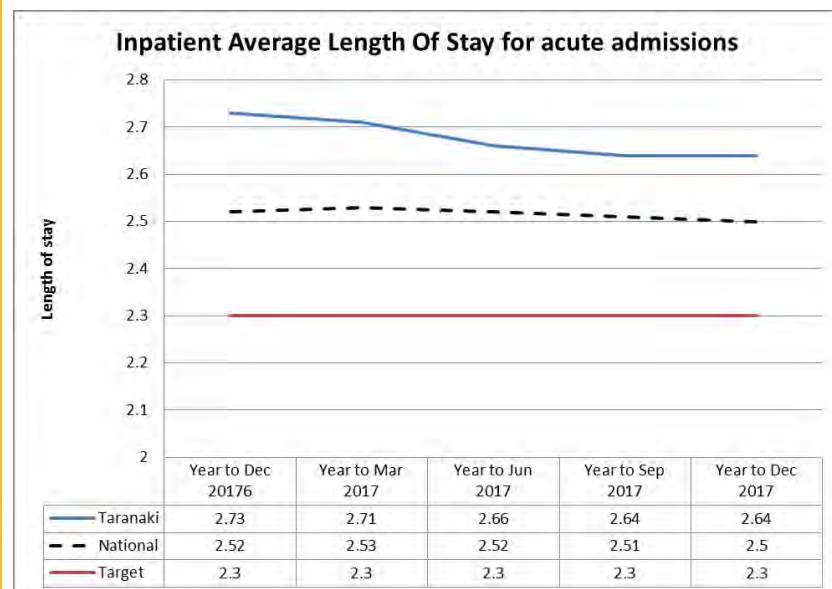
2.2.4 Inpatient Average Length Of Stay (ALOS) for acute admissions

Measure description: Average length stay for patients in the eligible population who are acutely admitted to hospital

Baseline Data

Activities that will enable us to achieve the goal

18/19 goal: ≤2.6 days



- Drill down into outliers (<24 hours or Long LoS) **(P&F)**
- Identify models for improving the quality and timeliness of discharge planning, based on the NHS SAFER concept, with a view to piloting a new model of care **(DHB – Allied Health)**
- Roll out the ARC Nurse Practitioner training programme to provide specialist clinical support to ARC facilities managing older people with complex needs to support earlier discharge from hospital to ARC and reduce readmission rates from ARC **(DHB)**
- Explore strategies to improve the quality of discharge planning and the role of all health professionals in preventing admissions, with a view to piloting a new model of care **(DHB – Allied Health)**

Patient Experience of Care – “Person Centred Care”

Where are we now?

Patient Experience of Care

The results of the adult inpatient and primary patient experience surveys are typically in line with or above the New Zealand average.

The primary care patient experience survey has been taken up by 28 of the 29 (97%) General Practices in Taranaki DHB as part of practice accreditation activity.

Measure description

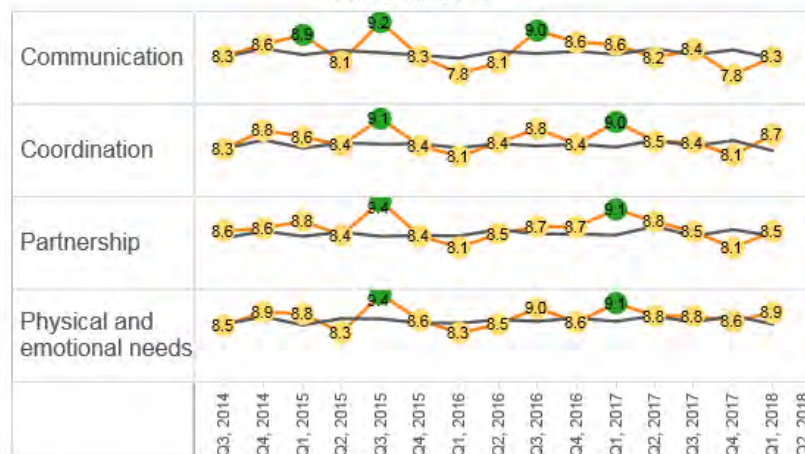
As per HQSC – patient experience reporting

Baseline Data

Activities that will enable us to achieve the goal

Taranaki DHB

Score out of 10

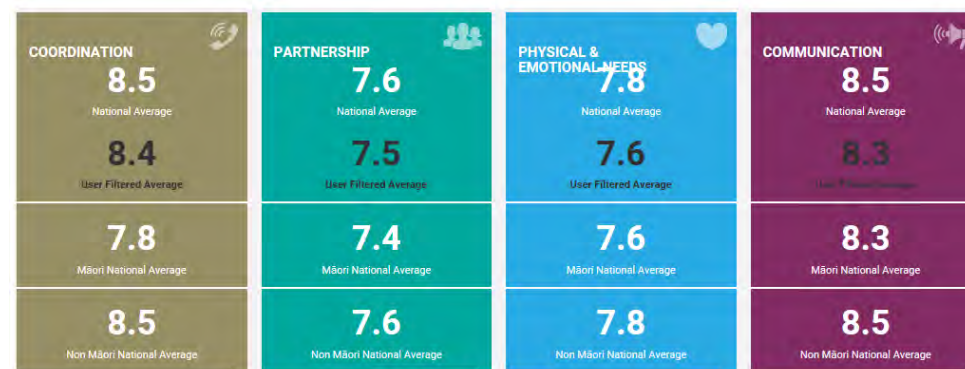


District health board (DHB)

■ New Zealand

■ Taranaki DHB

Primary Care Patient Experience Survey



Where do we want to be?

Long term goal: Consistently scoring at least 9/10 for each domain in the adult inpatient and primary experience survey by 30 June 2023

Target for 2018/19: Consistently at or above the national average across all domains

Rationale: Whilst generally equal to or better than the national average, the low sample size for the adult inpatient PES means there is significant variation across each of the domains. We anticipate that larger sampling will dampen this variation and give us more confidence that the impact of quality improvement initiatives will be reflected in the survey scores. We have not built sufficient history of data for the primary PES to establish the stability of this measure, but aim to have a sample size of ≈30 per practice.

How will we get there? (Contributory Measures)

2.3.1 Patient Experience of Care Survey Results

Measure description: Sum of weighted scores out of ten for each of the four domains for both the hospital and primary survey

Activities that will enable us to achieve the goal

18/19 goal:

Primary PES: Improve the result for the lowest scoring question

Adult Inpatient PES: Consistently at or above the national average across all domains

Adult Inpatient PES:

- Review results each quarter, and develop and share successes and challenges within the DHB (**DHB – Q&R**)
- Review lowest scoring question and develop actions (**DHB – Q&R**)
- Break down survey results by Māori/non-Māori and develop appropriate quality improvement initiatives (**Māori Health**)

Primary PES

- Benchmark results against other Midland DHBs to identify local challenges and develop local quality improvement initiatives (**PHO**)
- Feedback primary PES results to practices (**PHO**)
- Improve the lowest scoring question (coordination - was there a time when test results or information was not available) through increased adoption of patient portals and ergo access to laboratory results (**PHO**)

General

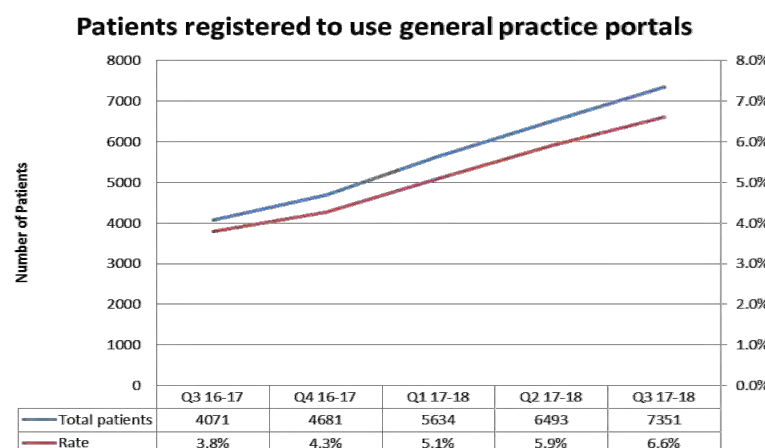
- Look to include a patient/consumer into the membership of this SLM group (**DHB – Q&R & Māori Health**)

2.3.2 Patients registered to use general practice portals

Measure description: Number of patients that have an active username and login to use general practice portals

Baseline Data

18/19 goal: 20%



Activities that will enable us to achieve the goal

- Roll out My Indici platform (**PHO**)
- Improve communication directly with patients about adopting portals by (**PHO**):
 - Advertising portals in answer phone messages
 - Encouraging patients to use portals for lab results
- Promote adoption of patient portal on DHB Facebook page (**DHB – Q&R**)

2.3.3 Number of patients completing the adult in-patient and primary patient experience surveys

Measure description: Number of hospitalised patients aged 15 years and over that provided feedback via the adult in-patient survey & number of patients completing the primary patient experience survey

Baseline Data

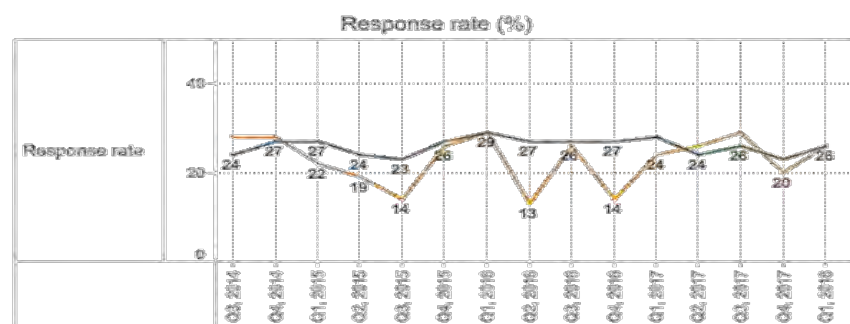
18/19 goal:

Primary PES: ~30 surveys per practice (noting we do not expect to be able to do this for solo practices)

Adult Inpatient PES: ≥30% response rate

We plan on setting a goal for a minimum number of survey returns in the future. However, given this will take some time, we have focussed on a response rate for 18/19.

Taranaki DHB



District health board (DHB)
 New Zealand
 Taranaki DHB

Activities that will enable us to achieve the goal

Adult Inpatient PES

- Determine a statistically appropriate sample size and ensure it is representative (**Public Health & Māori Health**)
- Pilot collection of patient email addresses (**DHB – Q&R**)
- Trial using a paper survey for one quarter to see if this improves return rates (**DHB – Q&R**)

Primary PES

- Feedback primary PES results to practices each quarter via face to face meetings, information in newsletters, targeted conversations with practices with high opt offs and/or low survey numbers (**PHO**)

Amenable Mortality – “Prevention and Early Detection”

Where are we now?

Amenable Mortality Summary

Total amenable mortality rates have generally been declining in Taranaki, sitting just above the national rate

Disparities between Māori and non- Māori amendable mortality rates persist, with Māori rates 150% higher than non- Māori in 2015.

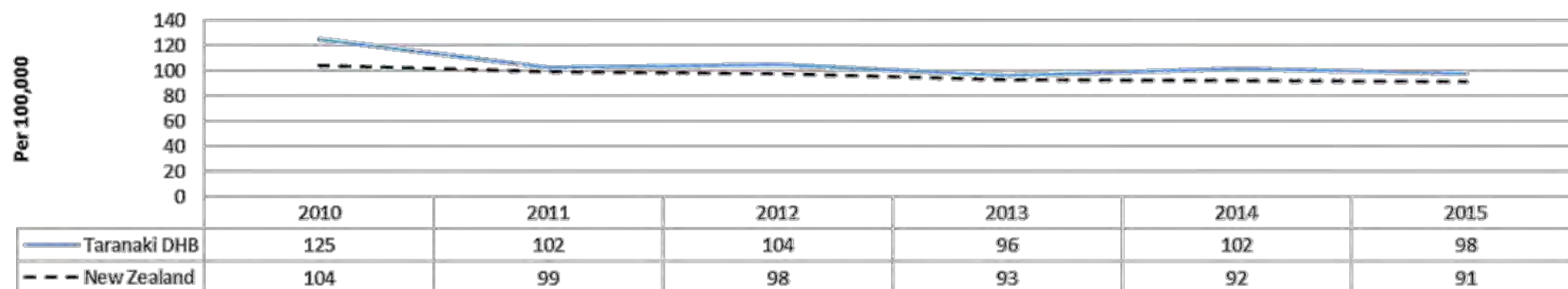
Coronary disease is the single largest cause of amenable mortality, followed by COPD, cerebrovascular disease, diabetes and melanoma of the skin.

Measure description

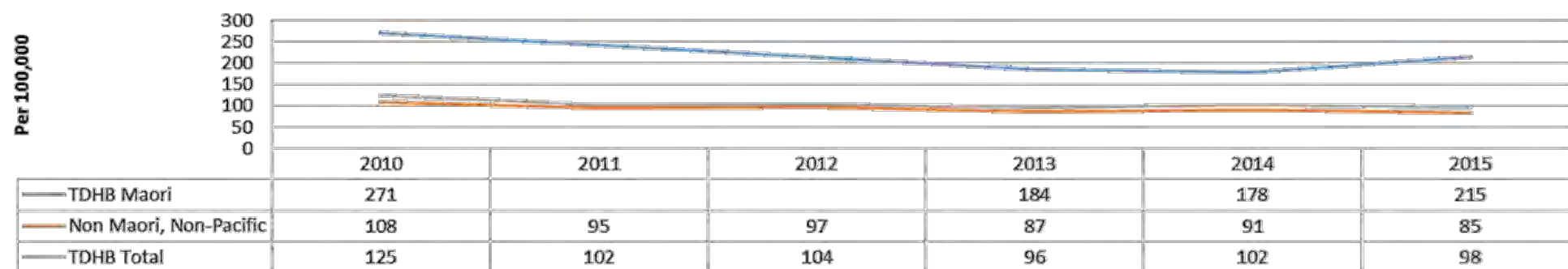
Age standardised rate per 100,000, calculated by MOH using estimated resident population as at June 2015.

Baseline Data – 6 year trend to 2015

Amenable Mortality rate



Amenable Mortality rate

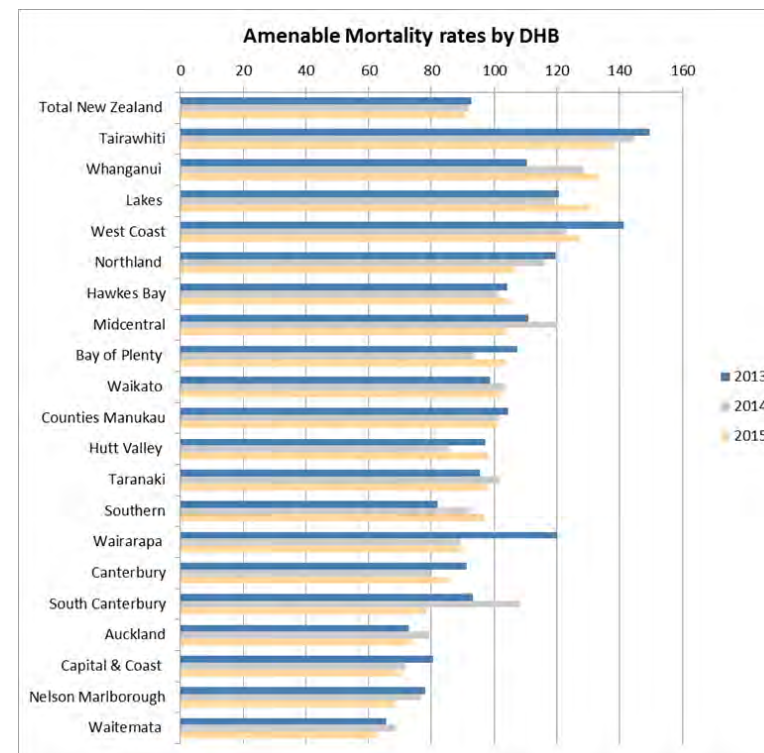


Taranaki DHB - Amenable mortality deaths, 0-74 year olds, 2015 ONLY

Coronary disease	35
COPD	18
Cerebrovascular diseases	16
Diabetes	13
Melanoma of skin	11
Female breast cancer	11
Prostate cancer	10
Suicide	8
Land transport accidents excluding trains	7
Stomach cancer	7

Taranaki DHB - Amenable mortality deaths, 0-74 year olds, 2010 - 2015

Coronary disease	266
COPD	90
Suicide	82
Cerebrovascular diseases	80
Diabetes	66
Female breast cancer	59
Land transport accidents excluding trains	59
Melanoma of skin	40
Rectal cancer	36
Prostate cancer	33



Where do we want to be?

Long term goal: Reduce amenable mortality rates for Māori and Non-Māori to a rate of 95 per 100,000 or below

Target for 2018/19: Reduce amenable mortality rates for Māori to 192 and non-Māori to 99 per 100,000 or below

Rationale: Saving Lives Amenable Mortality in New Zealand, 1996-2006, states that "...a one-third reduction from the current level of amenable mortality represents a feasible target." Taranaki's long term goal balances this aspiration with the need to close the equity gap for Māori.

How will we get there? (Contributory Measures)

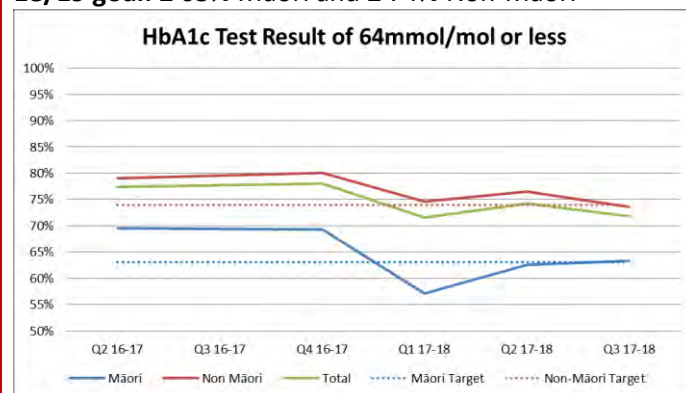
2.4.1 HbA1c Test Results

Measure description: Count of enrolled people in the PHO 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

Baseline Data

Activities that will enable us to achieve the goals

18/19 goal: $\geq 63\%$ Māori and $\geq 74\%$ Non-Māori



- Implement priority recommendations identified in the 2018 self-assessment against the National Standards for Diabetes **(P&F)**
- Examine NMDS data to assess patient numbers with repeated admissions to hospital with HbA1C $>64\%$, and develop recommendations to better manage this cohort **(P&F)**

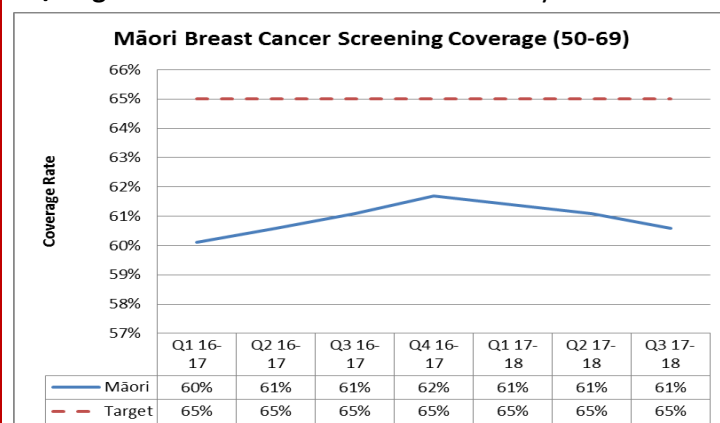
2.4.2 Breast Cancer Screening Coverage (50-69)

Measure description: The number of women enrolled with a PHO aged 50 to 69 years who received a mammogram from a Breast Screen Aotearoa provider in the past 2 years

Baseline Data

Activities that will enable us to achieve the goals

18/19 goal: 65% for Māori Wahine 50 to 69 years



- Review breast screening data to look for indicators on ways to better manage this cohort (e.g. age, soc/dep, frequency of screening) **(Breast Screening Service)**
- Develop a shared action plan for priority women in Taranaki, including potentially data sharing **(Breast Screening Service)**
- Delivery of breast screening health promotion activities within PHO & Māori Health providers **(TKM)**

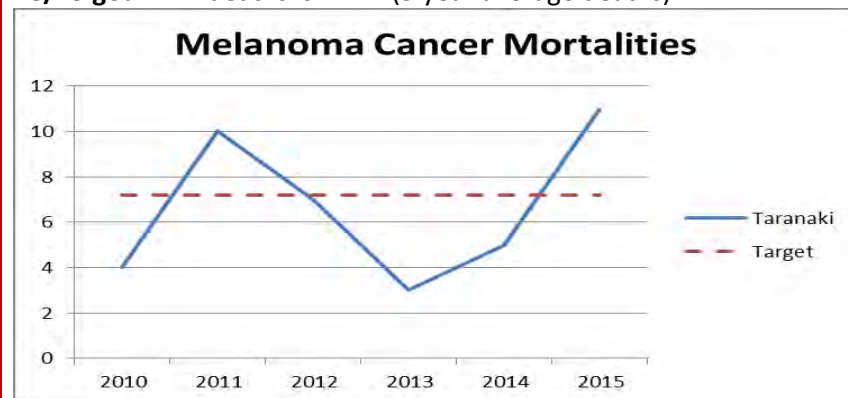
2.4.3 Melanoma Cancer Mortality Rate

Measure description: Rate of deaths related to melanoma within amenable mortality data

Baseline Data

Activities that will enable us to achieve the goals

18/19 goal: AM deaths is ≤ 7.2 (5 year average deaths)



- Review melanoma mortality data to look for indicators on ways to better manage this cohort (**DHB - Medical**)
- Undertake a stocktake of current screening and/or treatment providers, including intervention rates & wait times across Taranaki (Private & Public) (**DHB - Medical**)
- Qualitative investigation into Taranaki's melanoma rates and outcomes, engaging with local Taranaki and Central Region Cancer Treatment Centre (**Public Health**)

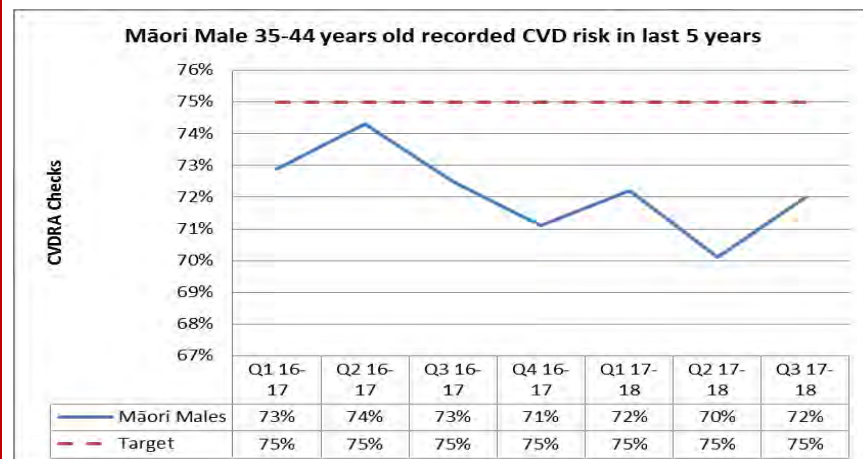
2.4.4 PHO enrolled people within the eligible population who have had a CVD risk recorded within the last five years

Measure description: Count of enrolled people in the PHO within the eligible population who have had a CVD risk recorded within the last five years

Baseline Data

Activities that will enable us to achieve the goals

18/19 goal: Māori Male 35-44 years old recorded CVD risk in 5 years $\geq 75\%$



Taranaki has consistently achieved the 90% CVD target. We have therefore shifted focus to Māori Male 35-44 years old

- Support practices through their practice development plans to engage with Māori Males (**PHO**)
- Socialise uptake of the new CVD risk assessment in General Practices (**PHO**)

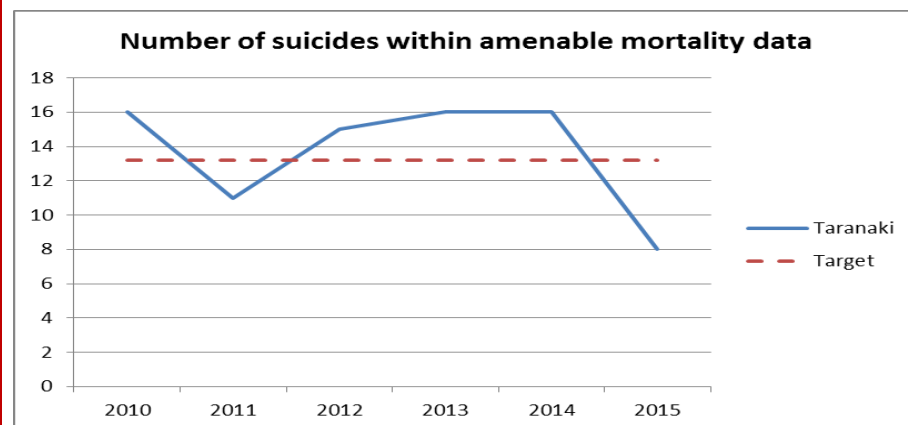
2.4.5 Suicide Rate

Measure description: Number of suicides within amenable mortality data

Baseline Data

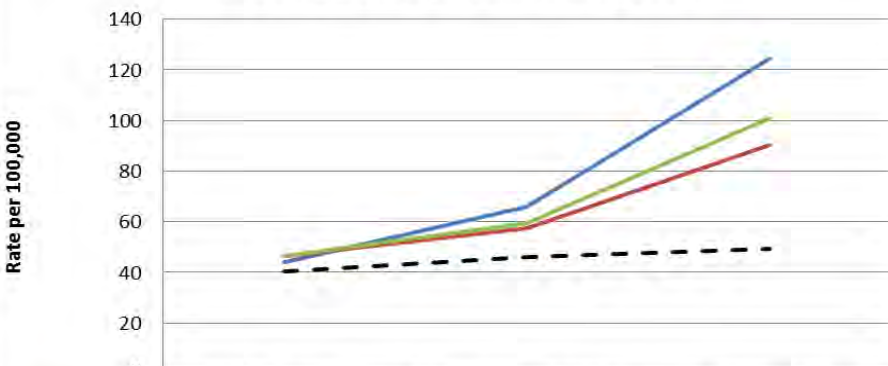
Activities that will enable us to achieve the goals

18/19 goal: Reduce the number of suicides ≤ 13.2 (5 year average deaths)



- Implementation of actions in the Taranaki Suicide Prevention and Postvention Action Plan 2018-2020 (**Suicide Advisory Group**)
e.g.
 - Identify the impact of alcohol on self-harm, suicidal behaviour and completed suicides to inform alcohol harm reduction initiatives (**Taranaki Alcohol Harm Reduction Group**)
 - Development of School Holiday Programmes focussing on resiliency and wellbeing (**Tui Ora**)

Youth System Level Measure – “Youth are healthy, safe and supported”

Where are we now?		Youth System Level Measure Summary																					
In 2017/18, Taranaki DHB selected the Domain “Mental Health and Well Being”.																							
Measure description																							
Reductions in total number of self harm hospitalisations and short stay ED presentations for 10 - 24 year olds, rate per 100,000																							
Numerator:	Number of youth (10 – 24) who are domiciled in the DHB district who were hospitalised or presented to ED with self harm injuries the last 12 months																						
Denominator:	Number of youth who are domiciled in the DHB district (10-24)																						
Source:	MoH provides quarterly																						
Where do we want to be?																							
Long term goal:	Below the national average with equity for Māori																						
Target for 2018/19:	A 25% reduction in self harm hospitalisations and short stay ED presentations for 10 - 24 year old Māori																						
Rationale:	Taranaki has the highest rate of youth self harm in New Zealand. Returning this measure to below the national average would be a significant achievement.																						
Baseline Data – 3 year trend to March 2018		Activities that will enable us to achieve the goals																					
<div><h3>Self Harm Hospitalisation rate</h3><table><thead><tr><th></th><th>Year to Mar 2016</th><th>Year to Mar 2017</th><th>Year to Mar 2018</th></tr></thead><tbody><tr><td>Maori</td><td>44</td><td>66</td><td>124</td></tr><tr><td>Other</td><td>47</td><td>57</td><td>90</td></tr><tr><td>Total</td><td>46</td><td>59</td><td>101</td></tr><tr><td>National</td><td>40</td><td>46</td><td>49</td></tr></tbody></table></div>			Year to Mar 2016	Year to Mar 2017	Year to Mar 2018	Maori	44	66	124	Other	47	57	90	Total	46	59	101	National	40	46	49	<ul style="list-style-type: none">• Drill down into youth self harm data to look for indicators on ways to better manage this cohort (e.g. locality, frequent flyers, general practice) (P&F)• Undertake of stocktake of services, to include:<ul style="list-style-type: none">- Mapping existing providers and what they offer (PHO/P&F)- A survey of ‘unmet need’ and wait lists (TKM)- Review what apps or technology could be used to help reduce youth self harm (Taranaki Alcohol Harm Reduction Group)• Establish the Taiohi Wellness Service Pilot, and undertake an evaluation:<ul style="list-style-type: none">- Placing Psychologists/Councillors in schools – pilot in 4 schools (TKM)- Roll out Health Promotion Service – 4 schools (TKM)	
	Year to Mar 2016	Year to Mar 2017	Year to Mar 2018																				
Maori	44	66	124																				
Other	47	57	90																				
Total	46	59	101																				
National	40	46	49																				

Proportion of babies who live in a smoke-free household at six weeks – “A healthy start”

Where are we now?

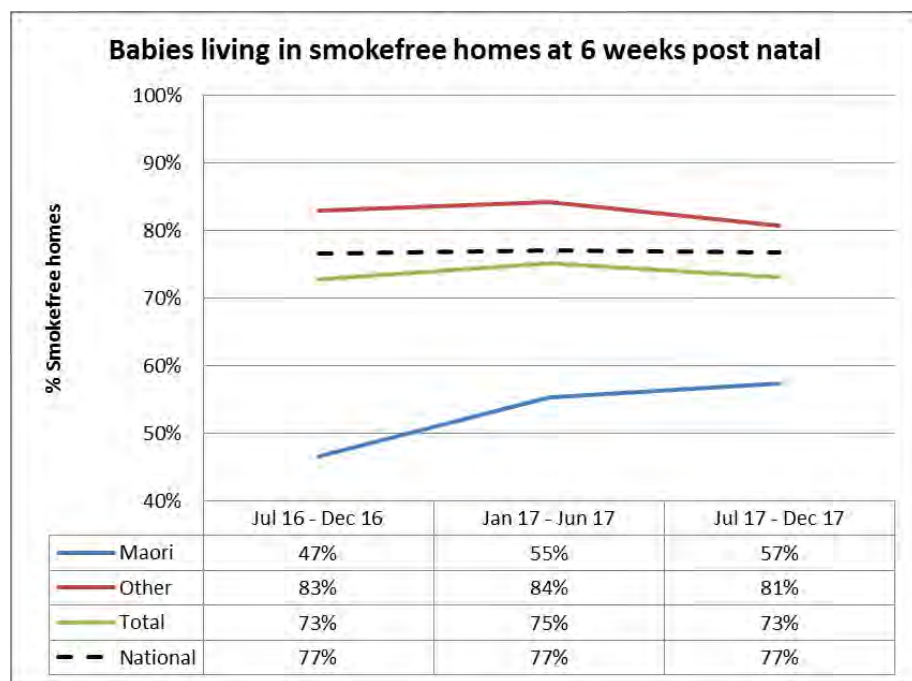
Proportion of babies who live in a smoke-free household at six weeks

This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care.

Measure description

Number of new babies with no recorded for household smoker at a WCTO Core Contact before 50 days of age, divided by Number of new babies with Yes or No recorded for household smoker at a WCTO Core Contact before 50 days of age (i.e. not null)

Baseline Data – three reporting periods going back to July 2016



Where do we want to be?

Long term goal: 95% of Māori and Non-Māori babies will live in smokefree homes

Target for 2018/19: Reduce inequity by increasing the number of Māori babies living in smokefree homes to 70% whilst maintaining current non-Māori rates

Rationale: Taranaki has a significant equity gap between Māori and non-Māori, and our focus will be to reduce and then eliminate this gap.

How will we get there? (Contributory Measures)

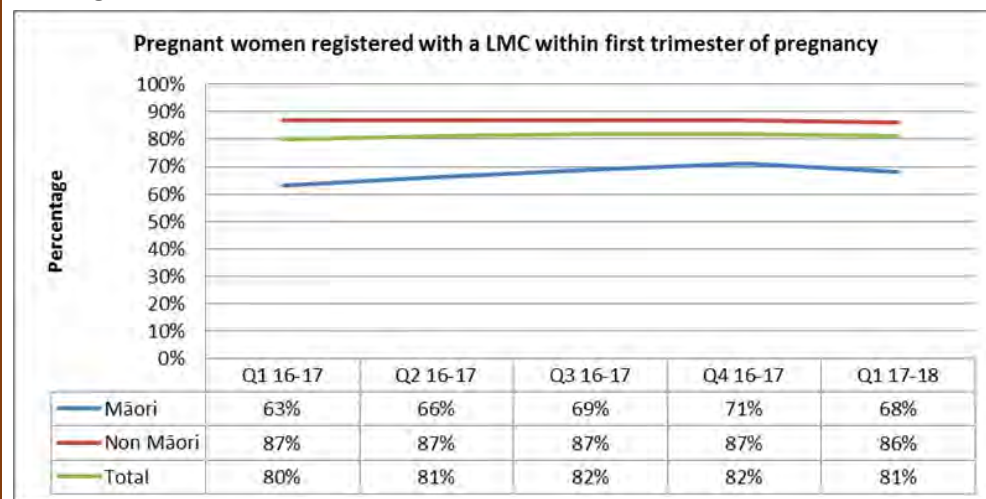
2.6.1 Pregnant women registered with a Lead Maternity Carer within first trimester of pregnancy

Measure description: Total number of women who register with an LMC in the first trimester of pregnancy

Baseline Data

Activities that will enable us to achieve the goals

18/19 goal: ≥85% for Māori & non-Māori



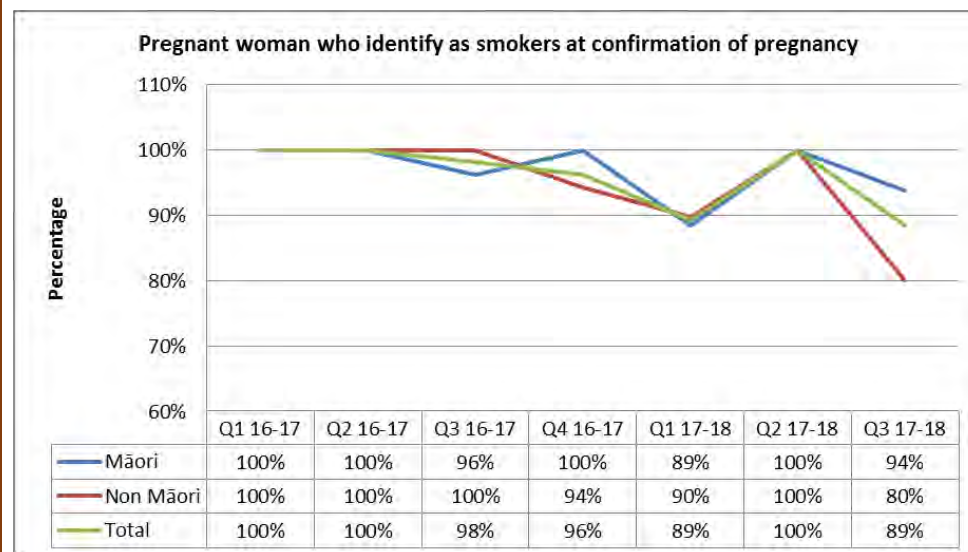
- Undertake a Health Equity Assessment (HEA) to understand why less Māori women are registering with an LMC in the first trimester of pregnancy compared to non Māori **(DHB - Māori Health)**
- Work with key stakeholders to implement recommendations from HEA **(DHB – Māori Health)**
- Implement Hapū Wānanga, a kaupapa Māori antenatal education programme that will identify the services Māori women and their whanau engaged in the programme need and will make appropriate linkages including referrals to LMCs if required, Māori provider networks, smoking cessation services, home insulation services and other providers of services for mama and pepi **(P&F/Māori Health)**

2.6.2 Pregnant woman who identify as smokers at confirmation of pregnancy

Measure description: Percentage or number of pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking

Baseline Data

18/19 goal: 100% of Māori hapū wāhine are offered brief advice and support to stop smoking, whilst maintaining current rate for non-Māori



Activities that will enable us to achieve the goals

- Develop a tobacco outcomes framework (**P&F**)
- Undertake a co-design process with hapū māmā, PHO, Te Kawau Maro alliance/Māori provider network and other key stakeholders to:
 - Understand the pathways and barriers for hapu wāhine accessing cessation services and design referral pathways and processes to overcome the barriers ready for pilot implementation in 2019/20 – Q4
 - Investigate successful incentives-based programmes for Māori women to quit smoking, develop and implement at least one such intervention as a trial in two locations (North and South Taranaki) by Q4 (**Tui Ora TSSS**)
- Establish a Smokefree Maternity Coordinator (**DHB - Maternity**)

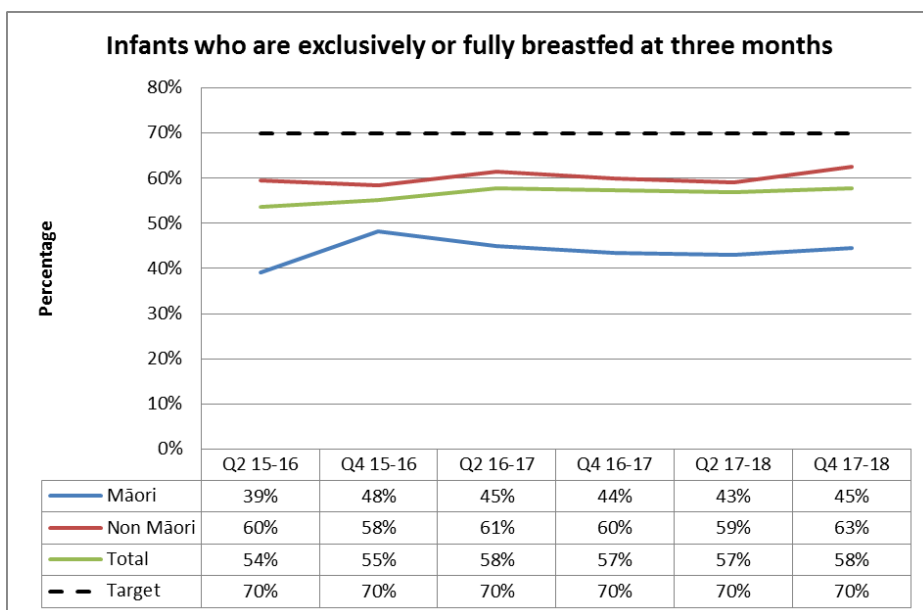
2.6.3 Infants who are exclusively or fully breastfed at three months

Measure description: Infants who receive a WCTO Core Contact between 10 weeks and 15 weeks 6 days of age with a recorded breastfeeding status of 'Exclusive' or 'Full'

Baseline Data

Activities that will enable us to achieve the goals

18/19 goal: Reduce the equity gap by 50%




- Explore reasons for drop off breastfeeding in rates at 3 months **(P&F)**
- Review the Tiaki Ūkaipō Breastfeeding Peer Support Programme **(Tui Ora)**
- Implement Hapu Wananga (see above), which includes automatic referral of Hapu Mama and Whānau to the Taranaki Stop Smoking Service **(P&F/Māori Health)**

Performance, Monitoring and Reporting

System Level Measure	Frequency	Governance Responsibility	SLM Champion	SLM Manager	SLM Working Group
Ambulatory Sensitive Hospitalisations, 0-4 year olds			"Keeping Children Out of Hospital"		
	Quarterly	Taranaki Alliance Leadership Team			
Acute Bed Days			"Using Health Resources Effectively"		
	Quarterly	Taranaki Alliance Leadership Team			
Patient Experience of Care			"Person Centred Care"		
	Quarterly	Taranaki Alliance Leadership Team			
Amenable Mortality			"Prevention and Early Detection"		
	Quarterly	Taranaki Alliance Leadership Team			
Youth System Level Measure			"Youth are Healthy, Safe and Supported"		
	Quarterly	Taranaki Alliance Leadership Team			
Proportion of babies who live in a smoke-free household at six weeks post-natal "A healthy start"					
	Quarterly	Taranaki Alliance Leadership Team			

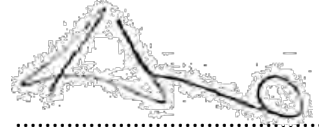
Signatories



Rosemary Clements
Chief Executive
Taranaki District Health Board



David Oldershaw
Chief Executive
Pinnacle Midlands Health Network



Hayden Wano
Chief Executive
Tui Ora Limited
(On behalf of Te Kawau Māro)

