



Statement of Intent
2012/13–2014/15

Taranaki District Health Board

DHB Contact Details

Statement of Intent 2012/13-2014/15

Name of DHB: Taranaki District Health Board
Address: Private Bag 2016
NEW PLYMOUTH 4342
New Zealand

Telephone number: +64 6 753 6139

Website: www.tdhb.org.nz

Taranaki DHB Vision

Taranaki Together, a healthy community
Taranaki whanui He Rohe Oranga

In 10 years:

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

Taranaki DHB Values

We work together by:

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

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1.0 Introduction

1.1 Executive Summary

The Statement of Intent has been prepared by Taranaki District Health Board (DHB) to outline for Parliament and the general public the performance that will be delivered during 2012/2013 by Taranaki DHB. The agreed performance measures are in the context of the Government's strategic and service priorities for the public health and disability sector.

The Taranaki District Health Board is ready to meet the significant challenges of 2012/13 onwards.

We remain focused upon improving performance, meeting national targets, living within our means now and ensuring the delivery of high quality services to the people of Taranaki.

Our plans and activities for 2012/13 concentrate on supporting service integration across all health care providers. At a national level this includes collective procurement with our DHBs in conjunction with Health Benefits Limited. At a regional level this includes developing and sustaining a workforce delivering robust clinical pathways for vulnerable services in the Midland Region; and cancer services in the Central Region. Locally we will continue service integration between the services delivered by the DHB and services delivered by our key primary care partners the Te Kawanui Māro Strategic Alliance, the Midland Health Network and the National Hauora Coalition.

A key focus at all levels will be the greater use of technology to help clinicians, patients and their carers to have the information they need when they most need it and to reduce duplication. This will be the aim of timely and potentially better care or treatment.

In the hospital services we will achieve our objectives through the ongoing hard work of our clinicians and support staff, and more broadly through collaboration with other providers and partners locally, including the community.

The Statement of Intent is supported by a Māori Health Plan, in line with Te Kawanui Māro (Taranaki Māori Health Strategy), developed together with the Māori Health Sector and Te Whare Punanga Kōrero, our Iwi relationship board. The Plan has been informed by the 2012 Whānau Ora Health Needs Assessment on Māori living in Taranaki. It sets challenging and practical steps to be taken in the years ahead to improve the health status of Taranaki Māori.

All of this work will be done sensitively, with the benefit of working together with others as we treat people with trust, respect and compassion – as we continue to strive for Taranaki Together, a Healthy Community – Taranaki Whanui He Rohe Oranga.



Mary K Bourke
Board Chair



Peter Catt
Deputy Chair



Tony Foulkes
Chief Executive

1.2 Context

1.2.2 Performance Story

The diagram presented on the following page provides a high level summary of our performance story. It shows the flows from input, to output, to impact, to outcome, as well as the links between the national, regional and local strategic intent.

There are five sub-stories which combine to form our overall performance story:

- i. National – reflects the direction that has been set by the Government at a national level.
- ii. Regional – reflects the direction set in Midland DHB Regional Services Plan (RSP).
- iii. Local – reflects what is important for the people and communities which make up Taranaki DHB.
- iv. Service performance – reflects the relationship between the outputs we produce and the impact we expect from them.
- v. Stewardship – reflects the resources such as people, performance, collaboration and information we use to produce our outputs.

While there is a single row in the service performance relating to outputs (output classes), this does not reflect the size or the significance of this part of our overall performance. This row is further expanded on in Section 5 in addition to our description of the output measures we intend to undertake and monitor.

Ministry of Health's Performance Story

Health & Disability System Outcomes	All New Zealanders lead longer, healthier and more independent lives		New Zealand’s economic growth is supported ¹	
Overarching Health Sector Goals	Better, Sooner, More Convenient Health Services for all New Zealanders			
Policy Drivers	Regional Collaboration		Integrated Care	Value for Money
Ministry of Health Intermediate Outcomes	Good health and independence are protected and promoted	A more unified and improved health and disability system	People receive better health and disability services	The health and disability system and services are trusted and can be used with confidence

Midland DHB's Performance Story

¹ As at 2009 health consumed 10.3% of New Zealand's GDP (gross domestic product). We are stewards of our share of that funding and must be accountable to the population we serve, as well as to the New Zealand taxpayer.

Midland Vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives				
Regional Strategic Outcomes	To improve the health of our population		To reduce or eliminate health inequalities		
Regional Outcome Indicators	To increase our average life expectancy	To reduce premature death rates		To improve our amenable mortality rate	
Regional Strategic Objectives	To build the workforce	Systems Integration across the continuum of care	To improve quality across agreed regional services	To improve clinical information systems	To improve Māori Health outcomes
By focusing on these objectives, we will be able to drive change that enables us to live within our means.					
RSP Focus Areas	Vulnerable Services	National Priority Services	Workforce	Information Systems	Key Enablers

Taranaki DHB's Performance Story

5-10 Year Outcomes	Vision : Taranaki Together, a Healthy Community - Taranaki Whanui He Rohe Oranga Mission: Improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki				
	People take greater responsibility for their health	People stay well in their homes and communities		People receive timely and appropriate care	
Focus Areas	Health Targets	Māori Health / Disparities	Health of Older People	Primary Health	Wellness / Chronic Conditions
3-5 Year Impacts	<ul style="list-style-type: none"> Fewer people smoke Reduction in vaccine preventable diseases People have healthier diets 		<ul style="list-style-type: none"> Children and adolescents have better oral health Early detection of treatable conditions People better at managing their long term conditions Fewer people are admitted to hospital for avoidable conditions People maintain functional independence 		<ul style="list-style-type: none"> People are seen promptly for acute care People have appropriate access to elective services Improved health status for people with a severe mental illness More people with end stage conditions are supported
Resources/ Inputs	People	Performance Management	Collaboration / Partnerships		Information
Output classes	Prevention Services	Early Detection and Management Services	Intensive Assessment and Treatment Services		Rehabilitation and Support Services

1.3 Background

Taranaki District Health Board (TDHB) was established on 1 January 2001 by the New Zealand Public Health and Disability Act 2000 (NZPHD Act) and is one of 20 DHBs in New Zealand. DHBs were established as vehicles for the public funding and provision of personal health services, public health services, and disability support services in respect of specified geographically defined populations. Each DHB is a Crown Entity, owned by the Crown for the purposes of section seven of the Crown Entities Act 2004 and is accountable to the Minister of Health who is the responsible Minister in terms of that Act.

1.4 National Operating Environment

This plan has been prepared within a wider strategic context for health set by the Government. The Government has a focus on Better Sooner More Convenient Services for all New Zealanders.

The Minister of Health (with Cabinet and the Government) develops policy for the Health and Disability Sector and provides leadership. The Minister is supported by the Ministry of Health and its business units, and advised by the Ministry, the National Health Board, Health Workforce New Zealand, the National Health Committee, and other Ministerial Advisory Committees. Accident services are funded by the Accident Compensation Corporation (ACC).

1.4.1 The Treaty of Waitangi

The Treaty of Waitangi (Te Tiriti o Waitangi) is widely acknowledged as the founding document of New Zealand and is often referred to in overarching strategies and plans throughout all sectors. Taranaki DHB is one of many organisations that value its importance in the context of the work we do. Central to the Treaty relationship and the acknowledgement of the Treaty principles, is a common understanding that Māori will have an important role in developing and implementing health strategies for Māori.

1.4.2 Structure of the Health Sector

Health and Disability Services in New Zealand are delivered by a complex network of organisations and people. Each has their role in working with others across the system to achieve better, sooner, more convenient services for all New Zealanders. The network of organisations is linked through a series of funding and accountability arrangements to ensure performance and service delivery across the health and disability system.

1.4.3 Ministry of Health and National Health Board (NHB)

The Ministry of Health² is the Government's primary agent in New Zealand's health and disability system, and has overall responsibility for the management and development of that system. The Ministry's job is to improve, promote and protect the health of New Zealanders. The Ministry acts as the Minister of Health's principal advisor on health policy and has a range of roles in the system. It funds a range of national services, including disability support and public health services, and has a number of regulatory functions.

² The Ministry's Statement of Intent outlines the strategic direction for the Ministry of Health.

The National Health Board (NHB) was established by the Government in November 2009, to address a number of issues³ and improve the quality, safety and sustainability of health care, for New Zealanders. The NHB is made up of a Ministerial appointed Board and a branded business unit within the Ministry of Health. This business unit was formed from a number of existing areas of the Ministry of Health, but with a fresh focus, approach and culture to create a more unified health and disability system.

1.4.4 Health Sector Challenges and Pressures

Major long-term systematic challenges and pressures are shaping the way health services will be delivered in the future. These not only impact New Zealand but the majority of health systems across the world. These challenges and pressures have implications across the national, regional and local levels, but to reduce duplication these items are only mentioned in this section.

Table: Summary of Health Sector Challenges and Pressures⁴

Challenge	Health Sector Pressures
Population is changing	<ul style="list-style-type: none"> ▪ Urban growth / rural decline ▪ Increasing ethnic diversity ▪ Evolving family structure ▪ Ageing population
Increasing burden of chronic conditions	<ul style="list-style-type: none"> ▪ Growth in the number of people living with chronic conditions ▪ Increased incidence of multiple complex symptoms and co-morbidities ▪ Greater chance of chronic conditions linked to lifestyle choices
Rate of funding growth is unsustainable	<ul style="list-style-type: none"> ▪ Clinicians and the public will expect access to new technologies and models of care (which will require new funding or robust prioritisation process (including disinvestment decisions) ▪ A decrease in the rate of funding growth (after a period of increases)
Substantial inequalities in health status persist	<ul style="list-style-type: none"> ▪ Inequalities in health status continue, with potential for disparities to worsen ▪ Long-term and intergenerational inequalities
Health system workforce shortages are worsening	<ul style="list-style-type: none"> ▪ International demand and an ageing workforce ▪ Decreased hours / availability as a result of: <ul style="list-style-type: none"> ○ regulated maximum working hours ○ changing lifestyle preferences ○ Super-specialisation of some medical professions ○ Rural workforce shortages
Multiple new technologies are being developed	<ul style="list-style-type: none"> ▪ Ongoing introduction of new diagnostic tools/tests and new therapeutics ▪ More accessible information for patients and clinicians ▪ Increased communication options and speed for patients and clinicians ▪ Continued growth in research and knowledge ▪ Increased understanding of need and service impacts
Public expectations are rising	<ul style="list-style-type: none"> ▪ Patients will be better informed ▪ Ongoing expectations of highly personalised services and extensive choices ▪ Increased diversity in service expectations as the population becomes more multicultural

³ Rapidly rising costs, increased demand for services, an ageing population and international shortages of skilled clinical specialists

⁴ Source: Trends in Service Design and New Models of Care: A Review (Ministry of Health NZ 2010)

1.5 Regional Operating Environment

New Zealand has been divided into a series of four DHB regions, being Northern, Midland, Central and South Island regions. We are considered part of the Midland DHB Region and are a key part of the health system for 851,768⁵ people. The five DHBs that make up the Midland DHB Region are identified in the following table.

Table: DHBs that form the Midland DHB Region

DHB Name	Website	Population
Bay of Plenty	www.bopdhb.govt.nz	214,780
Lakes	www.lakesdhb.govt.nz	103,220
Tairāwhiti	www.tdh.org.nz	46,620
Taranaki	www.tdhd.org.nz	110,100
Waikato	www.waikatodhb.govt.nz	370,110

Source: Population estimates Statistics NZ 2011 release

All five Midland DHBs have agreed to progress activities towards regional co-operation in a planned manner. This is in line with national expectations.

Our region has worked together to develop a Midland DHB Regional Services Plan (RSP). Our RSP describes a vision for the future of health services in the Midland Region and provides a framework for planning and acting collaboratively on a regional basis. The RSP outlines how our five DHBs intend to co-operate for regional service planning, funding and service provision in order to improve the quality of care as well as reduce service vulnerability and cost. Led by our clinical staff and partners from primary care, our RSP seeks to provide a focus on specific service priority areas and infrastructural enablers across the continuum of care⁶.

By actively participating in planning across the Midland DHB Region, we will reduce the duplication of effort and enable the five Midland DHBs to collectively develop more sustainable solutions. Regional planning identifies efficiencies, and a planned approach helps to ensure that specialist skills and input remain available at a local level. Collectively, working as a strong group of DHBs, we are in a better position to respond to the challenges facing our region's healthcare system.

Some distinguishing features of our region include:

- Highest proportion of Māori
- Low proportion of the population identifying as Asian or Pacific peoples
- Higher number of people living in rural areas
- Higher proportion of people living in lower deprivation quintiles
- Lower life expectancy than the New Zealand average
- Higher smoking rates than the New Zealand average

⁵ Based on population estimates Statistics NZ 2011 release

⁶ Further information on the Midland DHB RSP can be found in Section 2.3

1.6 Local Operating Environment

1.6.1 Geography

The Taranaki Region lies on the west coast of the North Island of New Zealand with a land area of 723,610 hectares (3% of New Zealand's area) and a population of 104,000 people (2006 Census).

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

1.6.2 Demography

a) Population Numbers

At the 2006 Census, 104,274 people were resident in Taranaki. This represents around 2.6% of the population of New Zealand. Two thirds of the population are resident in the New Plymouth District area.

b) Population Projections

The population of the Taranaki DHB area is projected to increase by 2.3% by 2026. This represents a much lower decrease than the projection for New Zealand as a whole. The Māori population in Taranaki is growing much faster than the non-Māori population, which is projected to decline. By 2026 Māori are projected to make up 20.6% of the total Taranaki population. The Māori population in Taranaki is also growing faster than the Māori and non-Māori population nationally.

c) Ethnicity

Taranaki DHB serves 2.8% of the Māori population of New Zealand. Māori make up 15.2% of the total Taranaki DHB population which is slightly higher than the national proportion of 14%.

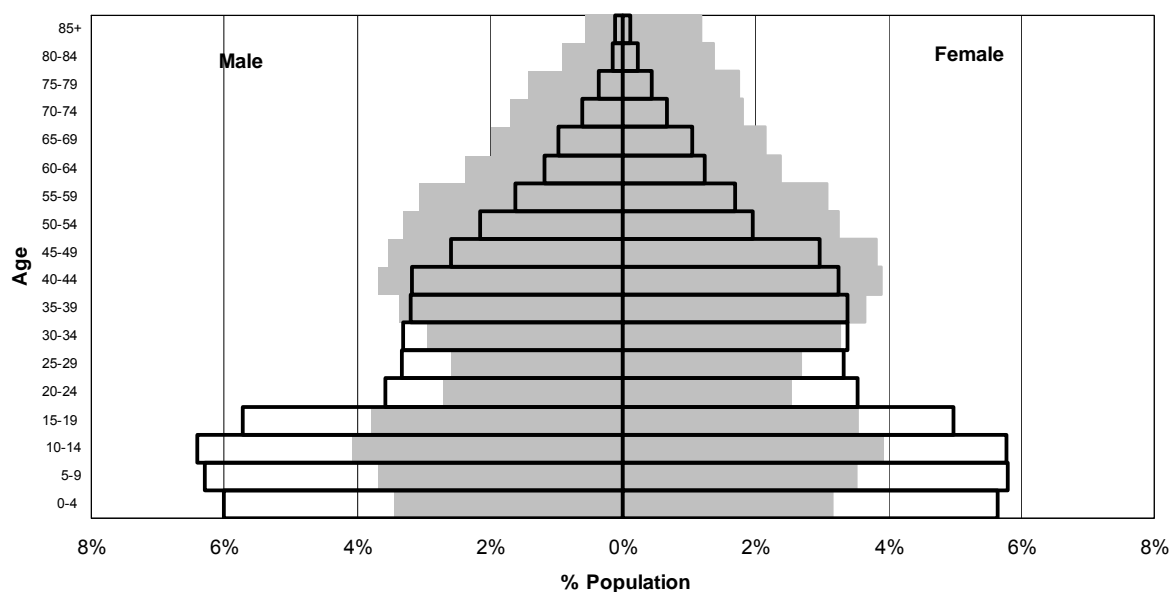
d) Population Age Structure

Based on 2012 population estimates, Taranaki DHB population has a similar proportion (20.7%) in the 0-14 years age group compared to the New Zealand population (20.3%) as a whole. Taranaki has a smaller proportion of 15-44 year age group (36.2%) compared to national picture (40.7%) and a higher proportion of those in each age group over 45 years. This indicates that the local population is older in structure than New Zealand as a whole.

The Māori population in Taranaki is young compared to the overall populations as shown in the population pyramid below. For Māori, 35.9% of the population resident in Taranaki is under 15 years of age compared to 21.8% for the total population. The difference is even more marked for older Māori, with 4.7% of the Māori population resident in Taranaki aged over 65 years compared to 14.8% for the total population.

Age Structure of Taranaki DHB, 2010

Māori Population (Black line) and Total Taranaki Population (Gray Shadow)



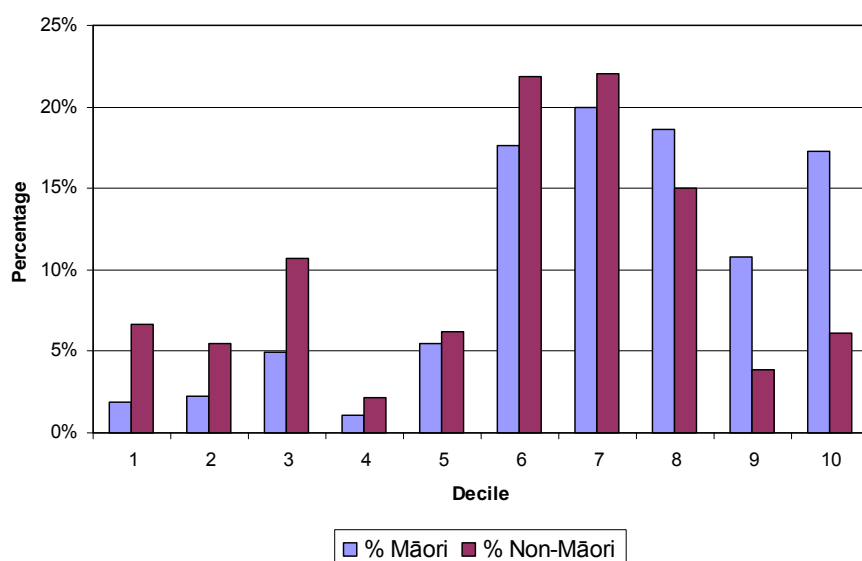
Source: Statistics NZ, Estimated Territorial Local Authority Population June 2010.

e) Index of Deprivation 2006 (NZDep2006)

NZDep2006 provides a numerical rating of socio-economic status of geographical areas using nine variables related to the conditions of daily life from the 2006 Census. NZDep2006 creates a score of one to ten. A score of one is allocated to the 10% of areas which are least deprived and ten is allocated to the 10% of areas which are most deprived.

Around 60% of Taranaki population is in Decile 6, 7, and 8 compared to 30% nationally. The Figure below shows the different pattern of deprivation for Māori and non-Māori in Taranaki. Non-Māori are over-represented in the wealthiest socio-economic deciles and Māori are over-represented in the lowest socio-economic deciles. Within Taranaki, 28% of Māori live in the most deprived 20% of areas compared to 10% of non-Māori. In contrast, 4.2 % of Māori live in 20% of the most affluent areas compared to 12.2% of non-Māori.

Proportion of Māori and Non-Māori in NZDep 2006 Deciles, Taranaki



DHB

Source: NZDep 2006.

1.6.3 Health Profile

a) Life Expectancy at Birth

Life expectancy provides a summary measure of the health of a population and comparisons of life expectancy between population groups provide an indication of the extent of health disparities. Māori in Taranaki experience a shorter life expectancy than non-Māori. Māori females have a life expectancy of 75.5 years compared to 82.5 years for non-Māori, a difference of 6.9 years. Māori males have a life expectancy of 72.4 years compared to 79.0 years for non-Māori, a difference of 6.6 years (refer below). This difference is less than that for the general New Zealand population at 7.7 years for females and 7.9 years for males.

b) Avoidable Mortality

Avoidable mortality refers to deaths occurring under the age of 75 years that could potentially have been avoided through population based interventions, or through preventative and curative interventions at an individual level. National and Taranaki rates of avoidable mortality are much higher among Māori than those in non-Māori. The leading causes of avoidable mortality in Taranaki DHB for non Māori are ischaemic heart disease, cerebro-vascular disease and chronic obstructive pulmonary disease (COPD) and lung cancer. For Māori in the Taranaki District, the leading causes of avoidable mortality are ischaemic heart disease, lung cancer, diabetes and chronic obstructive pulmonary disease (COPD).

c) Avoidable Hospitalisations 0-74 Years

Avoidable hospitalisations are hospitalisations of people aged less than 75 years that fall into the following groups:

- Preventative hospitalisation – hospitalisations resulting from diseases preventable through population-based health promotion strategies.
- Ambulatory sensitive hospitalisations – hospitalisations resulting from diseases sensitive to prophylactic or therapeutic interventions deliverable in a primary care setting.
- Injury preventable hospitalisations – hospitalisations avoidable through injury prevention.

The leading causes of avoidable hospitalisation in Taranaki are angina and chest pain, dental conditions, and respiratory infections.

d) Important Conditions and Risk and Protective Factors

Understanding the current health status of the population is an essential precursor to the identification of priority areas for health improvement. In 2011 Taranaki DHB completed a Whānau Ora Health Needs Assessment on the Māori Population in the Taranaki Areas. The following areas have been identified as priorities in terms of protective and risk factors and preventative care; smoking, alcohol and drug issues, breastfeeding, immunisation, breast screening and cervical screening. Priority health conditions identified were; diabetes, cardiovascular disease, lung cancer, breast cancer, respiratory disease (i.e. COPD and asthma), oral health, mental health and disability.

2.0 STRATEGIC DIRECTION

2.1 Our Strategic Direction

Our Vision:

Taranaki Together, A Healthy Community

Taranaki Whanui He Rohe Oranga

2.2 National Strategic Outcomes

The following diagram is part of our wider performance story⁷ and shows the national strategic direction. The outcomes identified here provide a broad framework for the wider health and disability system.

Diagram: National Portion of our Performance Story

Health & Disability System Outcomes	All New Zealanders lead longer, healthier and more independent lives		New Zealand’s economic growth is supported ⁸	
Overarching Health Sector Goals	Better, Sooner, More Convenient Health Services for all New Zealanders			
Policy Drivers	Regional Collaboration	Integrated Care		Value for Money
Ministry of Health Intermediate Outcomes	Good health and independence are protected and promoted	A more unified and improved health and disability system	People receive better health and disability services	The health and disability system and services are trusted and can be used with confidence

The system level outcomes include not only longer, healthier and more independent lives, but also support for sustainable economic growth. This latter outcome reflects the positive impact that better health will have on the ability of individuals to study, work and participate in their communities, as well as the direct contribution health sector organisations (like DHBs and PHOs) make to local economies.

The system level outcomes are long-term and are influenced by a number of factors and key stakeholders. The Ministry of Health has identified a set of intermediate outcomes that describe more specifically how they contribute to the system level outcomes.

We are one of twenty DHBs charged with giving affect to the overarching health sector goal of Better, Sooner, More Convenient Health Services for all New Zealanders. Three important policy drivers have been identified through which we, as part of the health sector, may best utilise resources to achieve Better, Sooner, More Convenient Health Services. These policy drivers (and definition) are:

⁷ See Section 1.2.2 for our full performance story

⁸ As at 2009 health consumed 10.3% of New Zealand's GDP (gross domestic product). We are stewards of our share of that funding and must be accountable to the population we serve, as well as to the New Zealand taxpayer.

- i. **Regional collaboration:** DHBs working together more effectively, whether regionally or sub-regionally.
- ii. **Integrated care:** includes both clinical and service integration to bring organisations and clinical professionals together, in order to improve outcomes for patients and service users through the delivery of integrated care. Integration is a key component of placing patients at the centre of the system, increasing the focus on prevention, avoidance of unplanned acute care and redesigning services closer to home.
- iii. **Value for money:** the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

2.2.1 Minister's Letter of Expectations

The Minister of Health has outlined his expectations for 2012/13 which enables us to plan and prioritise activity for the coming year. The Minister's expectations reinforce the Government's commitment to a public health system that delivers Better, Sooner, More Convenient care and lifting health outcomes for patients within constrained funding increases. All DHBs are expected to work co-operatively with the Ministry of Health on implementing the Governments' election commitments. For the 2012/13 year the Minister's expectations are:







- DHBs to lift productivity and keep to budget to contribute to an overall Government surplus in 2014/15.
- Focus more strongly on service integration, particularly with primary care, ensuring the scope of activity is broadened and *"the pace significantly stepped up"*.
- Shorter waiting times in *"a number of key areas including surgery, diagnostics and cancer care"*.
- National health targets including *"joint plans with primary care networks ... for at least the smoking, cardiovascular disease (CVD) and immunisation targets"*.
- An expectation that we will *"engage with primary/community care to develop integrated services for older people that support their continued safe, independent living at home, particularly after a hospital discharge"*.
- Greater *"integration between regional DHBs ... to make significant progress in implementing Regional Service Plans"*.
- Faster access to elective surgery — by delivering, on average, at least 4,000 extra operations each year; that no patient will wait longer than five months to receive a First Specialist Appointment or elective surgery by 1 July 2013 and a maximum of four months by 2014; and that we will reduce our waiting list over six months to zero.
- Improved access to diagnostic tests, by working with the Ministry of Health to establish maximum wait times for coronary, angiography, colonoscopy, MRI and CT scans.
- Shorter waits for cancer treatment (see *Health Targets*) and shorter waits for child and youth drug and alcohol treatment, with 80% of young people seen by an AOD health professional within three weeks, and urgent cases seen even faster.

2.2.2 National Health Targets

Improving performance across the sector is fundamental to the Government's goal of Better, Sooner, More Convenient health services to all New Zealanders. One of the mechanisms the Ministry of Health uses to monitor our performance⁹ is the national health targets. The following table outlines our target levels for each of the six national health targets. Each of these national health targets have been integrated into Section Four as appropriate.

⁹ on behalf of the Minister

Table: Taranaki DHB Health Targets 2012/13

Health Target	Long Term Target	Taranaki DHB Target									
 <p>Shorter stays in Emergency Departments</p>	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	95%									
 <p>Improved access to Elective Surgery</p>	The volume of elective surgery will be increased by at least 4,000 discharges per year (compared with the recent average increase of 1,400 per year)	4,156 total elective surgical discharges									
 <p>Shorter waits for Cancer Treatment Radiotherapy</p>	Everyone needing radiation or chemotherapy treatment will have this within four weeks.	100%									
 <p>Increased Immunisation</p>	85% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90% by July 2014 and 95% by December 2014.	Māori 85% Total 85%									
 <p>Better help for Smokers to Quit</p>	<p>90% of patients who smoke and are seen by a health practitioner in primary care or 95% in public hospitals, are offered brief advice and support to quit smoking. Within the target a specialised identified group will include:</p> <p>Progress towards 90% 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.</p>	<table> <tr> <td></td><td>Primary Care</td><td>Hospitalised</td></tr> <tr> <td>Māori</td><td>90%</td><td>95%</td></tr> <tr> <td>Total</td><td>90%</td><td>95%</td></tr> </table> <p>90% of pregnant women who identify as smokers are offered advice and support to quit.</p>		Primary Care	Hospitalised	Māori	90%	95%	Total	90%	95%
	Primary Care	Hospitalised									
Māori	90%	95%									
Total	90%	95%									
 <p>More heart and diabetes checks</p>	90% of the eligible population will have had their cardiovascular risk assessed in the last five years. DHBs are required to achieve at least 75% by 1 July 2013, and DHBs exceeding 75% are expected to be actively moving toward the 90% goal.	Māori 75% Total 75%									

Having a specific focus on these targets will not only impact the chosen areas, but is expected to bring broader benefits such as relieving pressure and lifting performance across the sector. The national health targets are assessed annually to ensure they are relevant and align with the health priorities of the time.

2.2.3 Non-Financial Monitoring Framework

Another mechanism used by the Ministry of Health to monitor that we are improving performance is the DHB non-financial monitoring framework. It is a key tool to provide assurance that DHBs deliver in terms of the legislative requirements, and in terms of Government priorities, “to the extent they are reasonably achievable within the funds provided” - NZPH&D Act 2000 S3(2). The monitoring framework for 2012/13

enables the Ministry of Health can provide the Minister of Health, and other key stakeholders, to ‘see at a glance’ how well we are performing across the breadth of our activity, but with the balance of measures focused on government priorities.

2.3 Regional Strategic Outcomes

The Midland DHB Region has produced a Regional Service Plan (RSP), which has replaced the individual DHB District Strategic Plans. The strategic intent for the Midland DHB Region is described in our RSP and is presented the diagram below. Further information is available in the Midland DHB Region RSP¹⁰.

Diagram: Regional Portion of our Performance Story

Midland Vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives				
Regional Strategic Outcomes	To improve the health of our population		To reduce or eliminate health inequalities		
Regional Outcome Indicators	To increase our average life expectancy	To reduce premature death rates		To improve our amenable mortality rate	
Regional Strategic Objectives	To build the workforce	Systems Integration across the continuum of care	To improve quality across agreed regional services	To improve clinical information systems	To improve Māori Health outcomes
By focusing on these objectives, we will be able to drive change that enables us to live within our means.					
RSP Focus Areas	Vulnerable Services	National Priority Services	Workforce	Information Systems	Key Enablers

Our DHB is committed to being an active participant in the regional planning process. This is evidenced by both clinical and management representatives from our DHB being part of the various forums and networks that have been established to guide RSP implementation activities as well as directly funding regional work and positions through the entity known as HealthShare. This organisation (see *Section 3*) is tasked with coordinating the delivery of regional planning and implementation on behalf of the Midland DHB Region. The Midland DHBs have agreed two strategic outcomes:

Strategic Outcome 1: To improve the health of our population

Taking positive steps about how we live and what decisions we make right now is very important to our future health and wellbeing. Our services, programmes and initiatives will enable people to increase their skills and confidence to maintain good health or manage their health problems.

Strategic Outcome 2: To reduce or eliminate health inequalities

We are committed to moderating the effects of disparity through, firstly, *identifying* health disparities and, secondly, *funding and providing* programmes that target inequalities and improve access to services.

¹⁰RSP available on our website at <http://www.tdhd.org.nz>

For each of these Strategic Outcomes, the Midland DHBs have identified a core set of performance measures, which will demonstrate whether we are achieving our goals of making a positive difference in the health of our population and reducing health inequalities¹¹.

These link with the roles and functions DHBs are legislated to provide. These measures are:

- Life expectancy — Life expectancy is a calculation of life expectancy at birth based on the mortality rates of the population in each age in a given year.
- Premature Death — early death is the rate of deaths before the age of 75 years amenable mortality.
- Amenable mortality — are deaths that could in theory be averted by good health care.

These indicators will provide a high level a whole-of-system view of the health sector in the Midland Region. Monitoring those over time will give us a picture of the health of the Midland DHB Region with logic suggesting that the activities, actions and initiatives DHBs implement will impact on these indicators.

Looking at the life expectancy differences, early death rates, amenable mortality and infant mortality between populations and geographical areas as well as comparing our results to other regions and national averages will enable us to plan and target resources and activities where the most health gain can be made.

We have identified five regional strategic objectives our region will work towards. The objectives and a short description are outlined below.

2.3.1 Regional Objectives

To build the workforce

Workforce shortages are a key challenge to the health system's ability to provide a full range of accessible, high-quality health services. Simultaneously, economic pressures are posing new challenges around health spending and productivity. Improving the supply of the health workforce is only part of the answer. To find enduring solutions service providers will need to strengthen innovation, new ways of working and the development of sustainable workforces into the future. We will build the workforce by ensuring workforce development enables sustainable service delivery. The regional focus includes health workforces across the continuum of service delivery.

Systems integration across the continuum of care

We will work within a whole of system approach; ensuring regional services are integrated and delivered in a better, sooner, more convenient framework.

To improve quality across agreed regional services

We will work to improve the quality of the services we deliver as the Midland Region. Midland DHBs have adopted the Health Quality and Safety Commission's "Triple Aim" of:

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

To improve clinical information systems

¹¹ While we have developed a set of regionally consistent measures, there will be variation, allowing for local initiatives, responding to the needs of the population.

We are operating in a challenging environment. We need to make good decisions on health sector configurations and related models of care. Robust information is vital to enabling good decisions and providing a planned, structured approach to investment.

To improve Māori health outcomes

We will work with Iwi Māori to:

- Reduce health disparities by improving health outcomes for Māori and other population groups.
- Establish and maintain processes to enable Māori to participate in and contribute to strategies for Māori health improvement.
- Continue to foster the development of Māori capacity for participating in the Health and Disability Sector and for providing for the needs of Māori.
- Provide relevant information to Māori for the purposes above.

Focusing on our regional strategic objectives will allow us to achieve our aim of living within our means. If we live within our means we don't get distracted by short term cost reduction measures when we want to be improving health and reducing inequalities.

2.3.2 Regional Priorities

The following table summarises the service and infrastructure priorities in the Midland DHB RSP.

Diagram: Regional Service Plan Priorities

Service Priorities	Infrastructure Priorities
<u>Vulnerable Services</u> Maternity services Renal services Rural Health Health of Older People Radiology	Information systems Building the workforce Māori Health
<u>National Priority Services</u> Cardiac services Cancer control Elective services	<u>Key Enablers</u> Health Quality and Safety Commission National Health Committee Asset Planning
<u>Regional Activities</u> Mental Health and Addictions Smoke free Trauma Inter-hospital transfer	

2.4 Local Strategic Outcomes

To contribute achieving the outcomes at a national and regional level, we have identified our local strategic intent for 2012/13. Our strategic intent represents a continuation from previous years, as they are not short term issues easily resolved within a 12 month period. There is strong alignment between the strategic intent at the regional and local levels.

5-10 Year Outcomes	Vision: Taranaki together, a health community - Taranaki Whanui he Rohe Oranga Mission: Improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki		
	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate care

Diagram: Regional portion of our performance story

Focus Areas	Health Targets	Māori Health / Disparities	Health of Older People	Primary Health	Wellness / Chronic Conditions
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At a local level, we will be establishing a monitoring framework based on the Whānau Ora Health Needs Assessment to develop a monitoring framework for population health which enables the monitoring and reporting of a number of key outcome measures. Two high level indicators will be for life expectancy and avoidable mortality.

Life Expectancy

Māori in Taranaki experience a shorter life expectancy than non-Māori. Māori females have a life expectancy of 75.5 years compared to 82.5 years for non-Māori, a difference of 6.9 years. Māori males have a life expectancy of 72.4 years compared to 79.0 years for non-Māori, a difference of 6.6 years (Table 34). This difference is less than that for the general New Zealand population at 7.7 years for females and 7.9 years for males.

Life Expectancy at Birth (Years) in Taranaki and New Zealand by Gender, Māori and Non-Māori. Usually Resident, Prioritised, 2007-2010

	Taranaki		New Zealand	
Ethnicity	Female	Male	Female	Male
Māori	75.5	72.4	75.96	71.9
Non-Māori	82.5	79.0	83.62	79.8

Source: Mortality Data Set – Ministry of Health.

Avoidable Mortality

Avoidable mortality refers to deaths occurring under the age of 75 years that could potentially have been avoided through population based interventions, or through preventative and curative interventions at an individual level. National and Taranaki rates of avoidable mortality are much higher among Māori than those in non-Māori. The leading causes of avoidable mortality in Taranaki DHB for non Māori are ischaemic heart disease, cerebro-vascular disease and chronic obstructive pulmonary disease (COPD) and lung cancer. For Māori in the Taranaki District, the leading causes of avoidable mortality are ischaemic heart disease, lung cancer, diabetes and chronic obstructive pulmonary disease (COPD).

Age-standardised Avoidable Mortality per 100,000 Under 75 Years, Taranaki and New Zealand, 2006-2008

	Māori	Non Māori	Total
New Zealand			
Female	1538	512	2050
Male	2074	797	2871

Total	1793	651	2444
Taranaki			
Female	1494	563	2057
Male	2304	800	3104
Total	1892	678	2570

2.4.1 Local Strategic Priorities

The local priorities have been included in the framework to ensure items important to us that are not explicitly covered in the regional strategic intent are included within this Statement of Intent. An example of such an item is Redevelopment. Our priority areas and a short description are outlined in the following table.

Table: Our 2012/13 Priorities

Strategic Priority	Description
Financials	Ensuring delivery on agreed financial forecasts and the ability to live within our means
Regional collaboration	Improving clinical services quality and viability across the Midland Region and reducing duplication of effort and bureaucracy
Quality improvement	Constantly seeking opportunities to get better at how we function and improve effectiveness
Addressing chronic conditions	These conditions are the leading cause of ill health and premature death in New Zealand. They disproportionately affect low income earners, Māori and Pacific people.
Organisational and workforce development	Our workforce is our biggest asset.
Rural	A significant number of our people live in areas we consider as rural. We are planning for clinical sustainability in rural health services and exploring opportunities to get the workforce better joined up.
Redevelopment	Ensuring that the right things are being built as part of our building programmes. Buildings designed for the way in which services should be delivered in the future.
Reducing Health Inequalities	Prioritising actions to address unmet health and healthcare needs for Māori

2.4.2 Health Inequalities

Improving Māori health and contributing to Whānau Ora for Māori living in Taranaki are priorities for the Taranaki DHB. Understanding the Whānau Ora Health Needs Assessment of Māori living in Taranaki was considered necessary in order to determine priority areas for service planning for Māori that will lead to improved health outcomes and reduced inequalities in health.

A Whānau Ora Health Needs Assessment (HNA) provides a systematic method to assess the health needs of Māori living in Taranaki and was undertaken in 2011. This assessment identified that ongoing prioritisation of Māori health by TDHB is justified due to extensive unmet health and healthcare needs for Māori and wide and enduring ethnic inequalities in terms of health and access to health services relative to need.

The following were identified priorities:

- Improving Māori access to health care, particularly at the primary care level.
- Whānau Ora oriented service provision.
- Māori provider and Māori health workforce capacity and capability building.

- Strengthening the role of TDHB in intersectoral collaboration that contributes to Whānau Ora.
- Addressing specific protective and risk factors, preventative care needs, and health conditions.

As a DHB, reducing health inequalities sits across the spectrum of the activities we undertake. This manifests itself in a number of ways, examples include:

- 2012/13 Māori Health Plan¹²
- Te Kawau Mārō, Taranaki Māori Health Strategy.
- The setting of targets by ethnicity or by high needs.
- Supporting change in the contracting environment through local Māori Health Providers.
- Planning to increase the capacity of the Māori workforce across our district.
- Engaging with Te Whare Punanga Korero (TWPK) to provide advice and inform decision making e.g. Board appointments, drafting the Annual Plan and other documents of substance.
- Protecting existing Māori Health funding stream and applying any increase in funding to areas of highest health need.

2.5 Key Impacts

The diagram below sets out the Midland DHB regional approach to the impacts we expect to occur in response to the outputs delivered.

Diagram: Service Performance Portion of our Performance Story

5-10 Year Outcomes	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate care
3-5 Year Impacts	<ul style="list-style-type: none"> ▪ Fewer people smoke ▪ Reduction in vaccine preventable diseases ▪ People have healthier diets 	<ul style="list-style-type: none"> ▪ Children and adolescents have better oral health ▪ Early detection of treatable conditions ▪ People are better at managing their long term conditions ▪ Fewer people are admitted to hospital for avoidable conditions ▪ People maintain functional independence 	<ul style="list-style-type: none"> ▪ People are seen promptly for acute care ▪ People have appropriate access to elective services ▪ Improved health status for people with a severe mental illness ▪ More people with end stage conditions are supported

2.6 Key Measures of Performance

The following information presents how we intend to measure our intermediate impacts. Monitoring the impact measures will provide us with medium-term results to inform decision-making or highlight areas for further exploration.

2.6.1 People Take Greater Responsibility for Their Health

¹² See Maori Health Plan on TDHB website: <http://www.tdhub.org.nz>

Fewer people smoke

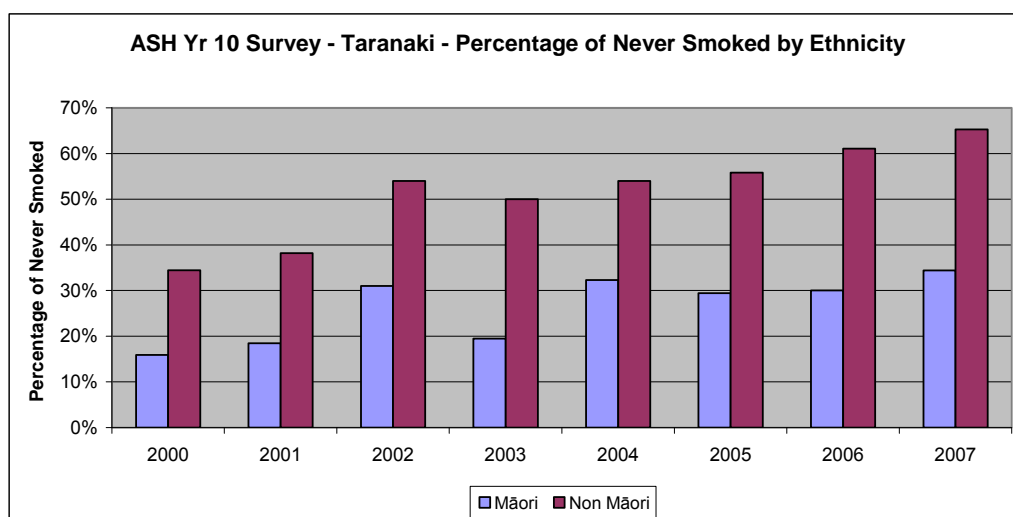
Why is this important?

Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is a major contributor to preventable illness and long term conditions, such as cancer, respiratory disease, heart disease and strokes. Reducing the prevalence of smoking is one of the greatest ways to influence 'better health' in the population both in the short, medium and long term.

How will we know we are succeeding?

An Increase proportion of Young People who are 'Never' smokers

The Action on Smoking and Health (ASH) Survey of year 10 students is a regular survey which is used throughout New Zealand as an indicator of smoking behaviour of young people. In 2008 the average age that 15–19 year-olds had their first cigarette was 13 years.¹³ This finding suggests young people are starting smoking before they reach high school age. Māori in Taranaki have a youthful population structure compared to non-Māori, and therefore make up a relatively high proportion of the local population of children and young people. Māori children and young people experience greater exposure to risk factors and poorer health outcomes than non-Māori children and young people.



Measure	Baseline 2007	Target 12/13	Target 13/14	Target 14/15
An increase in the percentage of Non Māori Year 10 students who have never smoked ¹⁴ (Qty)	65.27%	Increase	Increase	
An increase in the percentage of Māori Year 10 students who have never smoked ¹⁵ (Qty)	34.39%	Increase	Increase	

Source: Action on Smoking in Health Annual Survey 2007

A reduction in the prevalence of smoking in Taranaki

¹³ Ministry of Health. (2009). Tobacco Trends 2008: A brief update of tobacco use in New Zealand. Wellington: Ministry of Health.

¹⁴ Data Source: Paynter J. 2010. National Year 10 ASH snapshot survey, 1999-2009: trends in tobacco use by students aged 14-15 years. Report for Ministry of Health, Health Sponsorship Council and Action on Smoking and Health: Auckland, New Zealand. Note the survey is based on sample of students which is not representative of all areas in DHB area

¹⁵ Data Source: Paynter J. 2010. National Year 10 ASH snapshot survey, 1999-2009: trends in tobacco use by students aged 14-15 years. Report for Ministry of Health, Health Sponsorship Council and Action on Smoking and Health: Auckland, New Zealand. Note the survey is based on sample of students which is not representative of all areas in DHB area

The New Zealand Census prevalence data has been selected as the source for the indicator because it is the only regular full population survey that records smoking status. It is recognised as a data source at both national and international comparison. Māori have higher rates of smoking than other New Zealanders. 47% of Taranaki Māori females and 38% of Taranaki Māori males are regular smokers compared with around 21% of New Zealand Europeans. Rates of regular smoking in Taranaki Māori females are also higher than the national average. Explicitly locating Māori as a priority group recognises that in Taranaki there are wide ethnic inequalities in health status between Māori and non-Māori. It also reinforces the He Korowai Oranga objective that specific Māori health priorities should be identified and addressed. The Census is data the source for this measure and so availability of monitoring information will be dependant on Census data availability.

Measure	Baseline 2006	Next Census
A reduction in the census recorded regular smoking status in Māori Females	47%	Reduction
A reduction in the census recorded regular smoking status in Māori Males	38%	Reduction
A reduction in the census recorded regular smoking status in NZ European Taranaki population	21%	Reduction

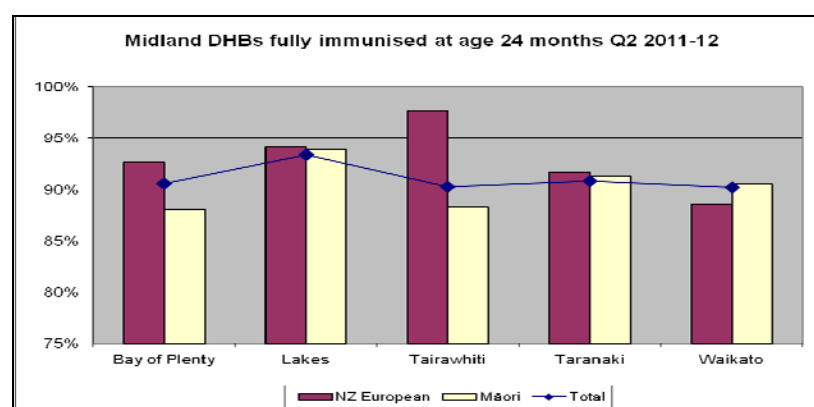
Reduction in vaccine preventable diseases

Why is this important?

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

How will we know we are succeeding?

Fully immunised at age two years means that, by the age of two a child has had three doses of diphtheria, tetanus and acellular pertussis vaccine, four doses of polio vaccine, three doses of Haemophilus influenza type B vaccine, three doses of hepatitis B vaccine (or four doses including a neonatal dose if required), four doses of pneumococcal conjugate vaccine and one dose of measles, mumps and rubella vaccine.



Measure	Baseline	Target 12/13	Target 13/14	Target 14/15
Immunisation Coverage in Taranaki Māori Children Aged 24 Months	91%	95%	Increasing	
Immunisation Coverage in Taranaki NZ European Children Aged 24 Months	92%	95%	Increasing	

Source: National Immunisation Register Baseline at Sept – Nov 2011

People have healthier diets

Why is this important?

Good nutrition is fundamental to health and to the prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in New Zealand each year¹⁶.

How will we know we are succeeding?

Information about obesity and overweight, fruit and vegetable consumption and physical activity can be from the New Zealand Health Survey 2006/07 and other sources. This data is not reliable at a local level due to small numbers in the survey samples and should be used cautiously for monitoring purposes. The ability to monitor effectively on this data is therefore dependant on the availability of data annually or at a largest enough sample size to be meaningful.

Measure	Baseline 2006/07	Target 12/13	Target 13/14	Target 14/15
Prevalence of at least 30 minutes of moderate physical activity on at least five days of the week in Māori Adults 15+ Māori	64%	Increasing		
Prevalence of at least 30 minutes of moderate physical activity on at least five days of the week in non - Māori Adults 15+ Māori	59%	Increasing		
Prevalence of Vegetable Consumption in Māori Adults 15+	57%	Increasing		
Prevalence of Vegetable Consumption in Non Māori Adults 15+	61%	Increasing		
Prevalence of Fruit Consumption in Māori Adults 15+	54%	Increasing		
Prevalence of Fruit Consumption in Non Māori Adults 15+	58%	Increasing		
Prevalence of Overweight and Obesity in Taranaki in Māori Adults 15+	42%	Decreasing		
Prevalence of Overweight and Obesity in Taranaki in Non Māori Adults 15+	25%	Decreasing		

2.6.2 People Stay Well in their Homes and Communities

An improvement in childhood oral health

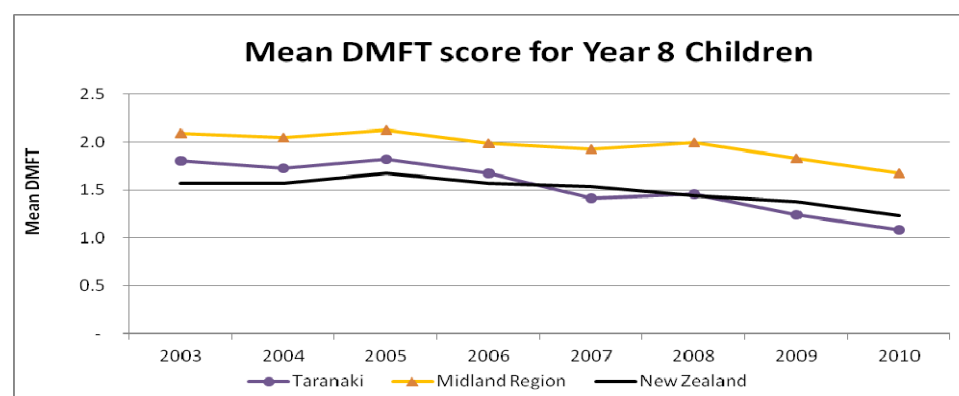
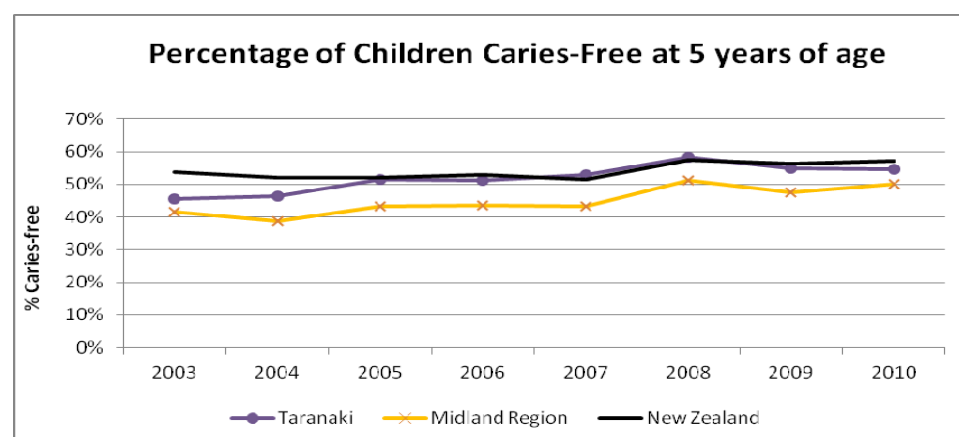
Why is this important?

¹⁶ Niki Stefanogiannis: Nutrition and the burden of disease in New Zealand; 1997-2011, Public Health Intelligence, Ministry of Health, Wellington

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

How will we know we are succeeding?

Māori have higher average counts of decayed, missing and filled deciduous (dmft) and permanent (DMFT) teeth than non-Māori. Māori have higher average counts of decayed, missing and filled deciduous (dmft) and permanent (DMFT) teeth than non-Māori.



Measure	Baseline 2010	Target 2012	Target 2013	Target 14/15
An increase in the percentage of children who are caries free at age five ¹⁷ - Māori	33%	60%	68%	Increasing
An increase in the percentage of children who are caries free at age five - Total	55%	60%	68%	Increasing
A reduction in the Mean decayed missing or filled teeth at year 8 - Māori	1.39	1.01	0.91	Reducing
A reduction in the Mean decayed missing or filled teeth at year 8 – Total	1.08	1.01	0.91	Reducing

¹⁷ Oral health indicators are for the calendar year

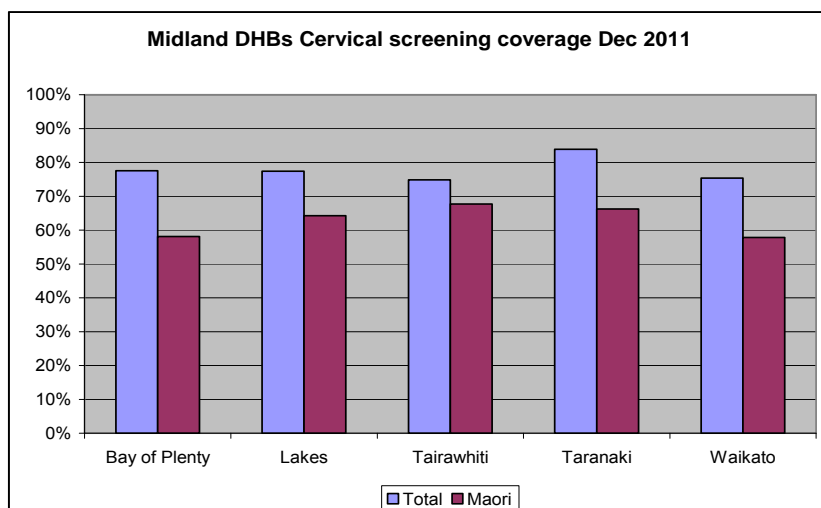
Early detection of treatable conditions

Why is this important?

Early detection can delay or reduce the need for secondary and specialist care, enabling more people to stay well in their homes and communities for longer.

How will we know we are succeeding?

Although cervical screening coverage for both Māori and non-Māori in the Taranaki Region is higher than the national figures, the cervical screening coverage for Māori women in Taranaki (66.3%) is far lower than for non-Māori (86.7%).

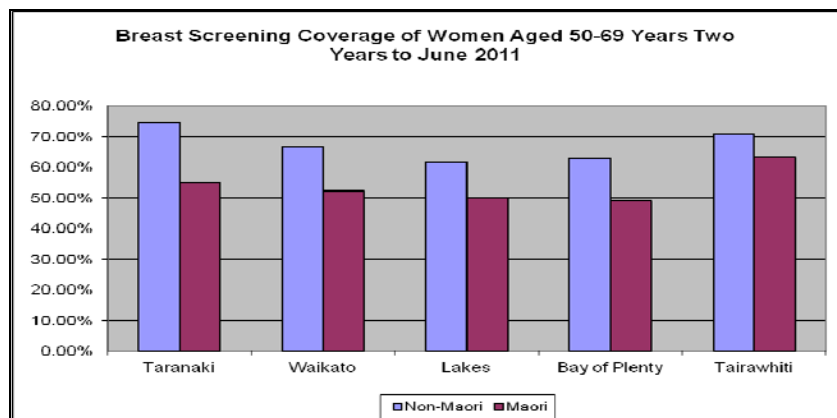


Measure Three Year Screening Coverage	Baseline 2008/2009	Target 12/13	Target 13/14	Target 14/15
Taranaki DHB Māori	66.3%	Increasing		
Taranaki DHB Total	83.9%	Increasing		

Source: National Cervical Screening Programme, December 2011.

Note Coverage is estimated using Statistics New Zealand projections for 2011 and adjusted for hysterectomy

The purpose of Breast Screening is to detect breast cancer at an early stage, in order to reduce breast cancer morbidity and mortality. In Taranaki, the screening coverage rate among Māori women is lower than for other ethnicities.



Measure Three Year Screening Coverage	Baseline Jun 2011	Target 12/13	Target 13/14	Target 14/15
Breast Screening Coverage, Proportion (%) of Women Aged 50-69 years Screened for the past 24 Months – Māori	55%	Increasing		
Breast Screening Coverage, Proportion (%) of Women Aged 50-69 years Screened for the past 24 Months - Non Māori	75%	Increasing		

Why is this important?

Long term conditions comprise the major health burden for New Zealand now and into the foreseeable future. By increasing the proportion of people with well managed conditions, we will reduce avoidable complications that require hospital-level intervention, such as amputation, kidney failure and blindness, and will improve people's quality of life, allowing more people to stay well in their homes and communities for longer.

How will we know we are succeeding?

Measure	Baseline	Target 12/13	Target 13/14	Target 14/15
Increased percent (and number) of people with diabetes will have satisfactory or better diabetes management (PP20)	Māori 68% Total 80%	Māori 83% Total 83%	Increased percent (and number)	
Age-standardised Diabetes Hospitalisation Rate Per 100,000 in Adults 15 Years and Over, Taranaki – Māori	1,894 ¹⁸	Reducing		
Age-standardised Diabetes Hospitalisation Rate Per 100,000 in Adults 15 Years and Over, Taranaki– Non Māori	766	Reducing		

A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable

Why is this important?

Reducing the number of avoidable hospital admissions ensures that patients who need services that can be provided in community settings receive them there rather than at hospitals. This will free up hospital staff and resources for more acute and urgent cases while also ensuring the services being funded in the community, including primary care, are being used optimally.

How will we know we are succeeding?

Measure		Baseline ¹⁹	Target 12/13	Target 13/14	Target 14/15
A reduction in the proportion of the population admitted to hospital with conditions considered preventable or avoidable	0 - 4 years				
	Māori	70	Remain below 95% of national rate	Remain below 95	
	Total	75	Remain below 95% of national rate		

¹⁸ The baseline for the age-standardised hospitalisation rate is 2009-11 data from the MoH National Minimum Dataset.

¹⁹ Maori Baseline determined by using Sept 2011 data released by MoH. Total Baseline information using Dec 2011 data released by MoH.

	45-64 years			
	Māori	115	95% of national rate	Remain below 95
	Total	82	Remain below 95% of national rate	
	0 – 74 years			
	Māori	85	Remain below 95% of national rate	Remain below 95
	Total	82	Remain below 95 % of national rate	

More people maintain their functional independence

Why is this important?

Loss of mobility, strength and balance is a recognised risk for older people, resulting in many older people being unable to remain at home in their own environment and needing to transfer into long term residential care. Once an older person enters Aged Related Residential Care (ARRC), their morbidity and mortality rates increase. Our aim is to focus home and community support services into identifying when an older person is at risk and provide access to community rehabilitation, restorative home based support services and meaningful activities. This will ensure that older people are made aware of the needs to remain active, to make use of aids and equipment around the home and to encourage social participation.²⁰

How will we know we are succeeding?

If older people can remain in their homes longer, the need for rest home level residential care will be constrained and should remain fairly static through to 2014 when the older population increase will be more evident. However, when people enter residential care, it tends to be at a higher level of care and for a shorter time. We expect to see an increase in demand for hospital and dementia levels of care. Annual occupancy surveys of residential care providers will identify the number of people in residential care at each level. The overall impact will be to increase and stabilise the average age of entry into rest home level of care.

Measure	Baseline 10/11	Target 12/13	Target 13/14	Target 14/15
Increase the average age of entry to a DHB subsidised rest home	82 years	Increasing		

2.6.3 People Receive Timely and Appropriate Specialist Care

People are seen promptly for acute care

Why is this important?

Long stays in emergency departments are linked to overcrowding, negative clinical outcomes and compromised standards of privacy and dignity for patients. The duration of stay in ED is influenced by services provided in the community to reduce inappropriate ED presentations, the effectiveness of services provided in ED and the hospital and community services provided following exit from ED. Reduced waiting times in ED is indicative of a co-ordinated 'whole of system' response to the urgent needs of the population.

How will we know we are succeeding?

²⁰ Note: Ministry of Health are responsible for funding disability support services for people under the age of 65 years.

Measure	Baseline Dec 2011	Target 12/13	Target 13/14	Target 14/15
Percentage of patients will be admitted, discharged, or transferred from an emergency department within six hours	91%	95%	95%	95%

People have appropriate access to ambulatory, elective and arranged services

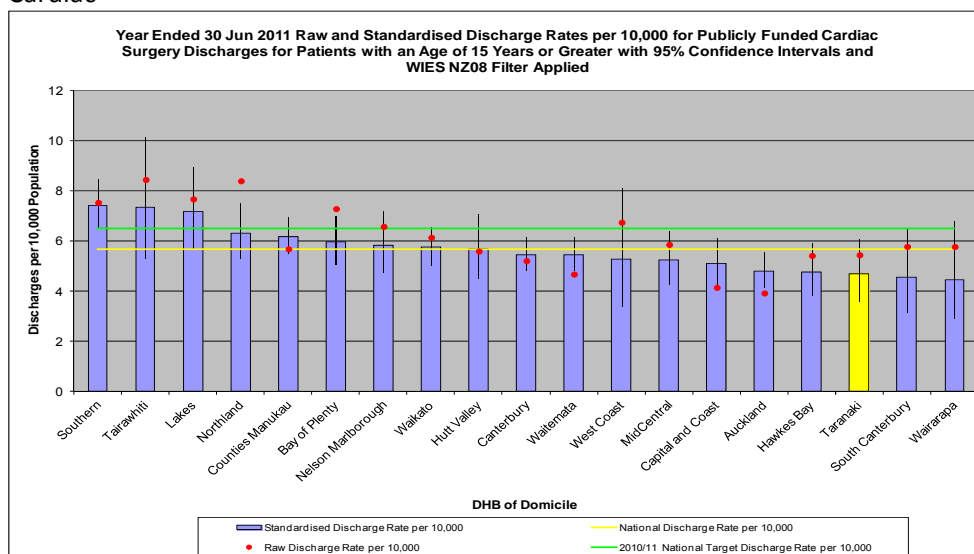
Why is this important?

Elective surgery reduces pain or discomfort, and improves independence and wellbeing. Increasing delivery will improve access and reduce waiting times. Improved performance against this measure is also indicative of improved hospital productivity to ensure the most effective use of resources so that wait times can be minimised and year-on-year growth is achieved.

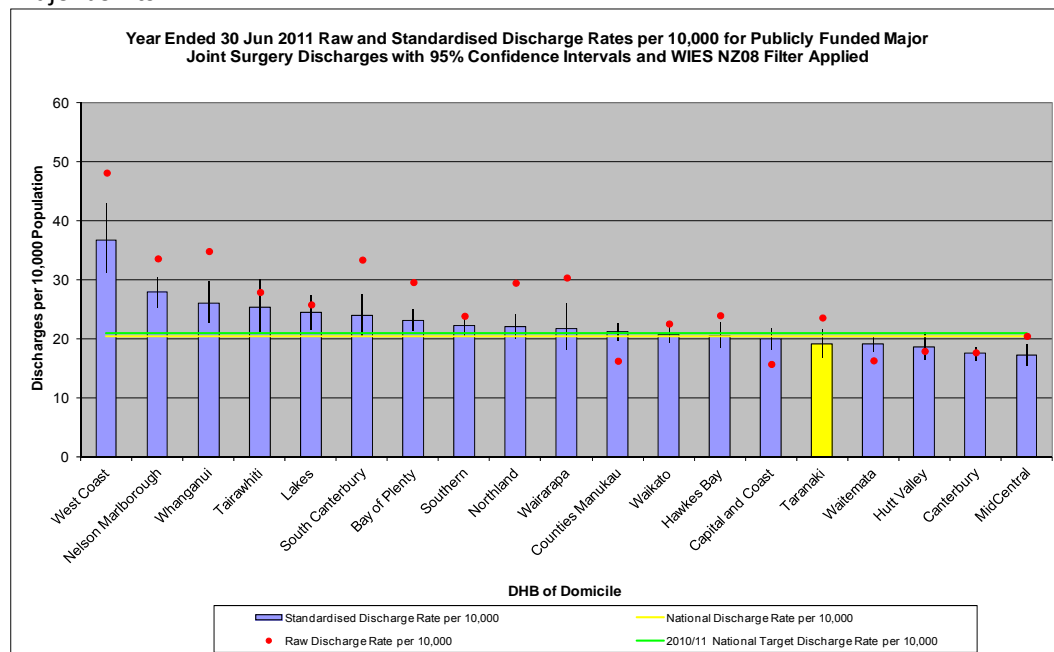
How will we know we are succeeding?

To meet the appropriate level of access, we want to ensure that our standard intervention rates (SIRs) for cardiac, major joint and cataract surgery meet national expectations.

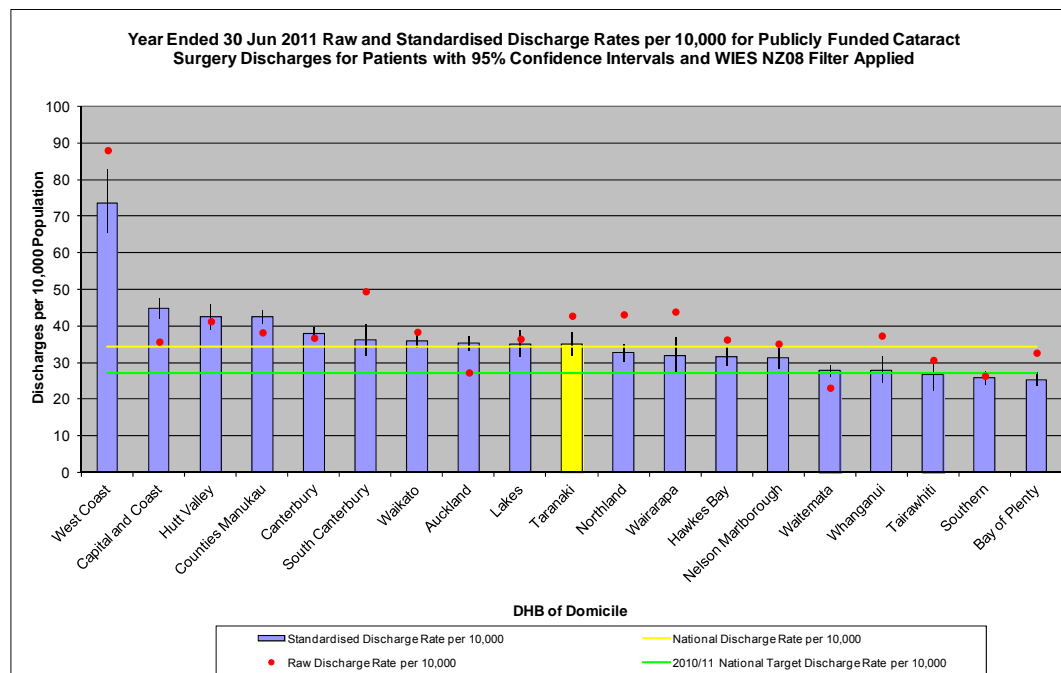
Cardiac



Major Joints



Cataracts



Measure	Baseline 10/11	Target 12/13	Target 13/14	Target 14/15
Our SIRs meet national expectations (per 10,000) for:				
Cardiac procedures	4.69	6.2	Meet National SIRs	
Major joint replacement procedures	19.08	21		
Cataract procedures	35.02	27		

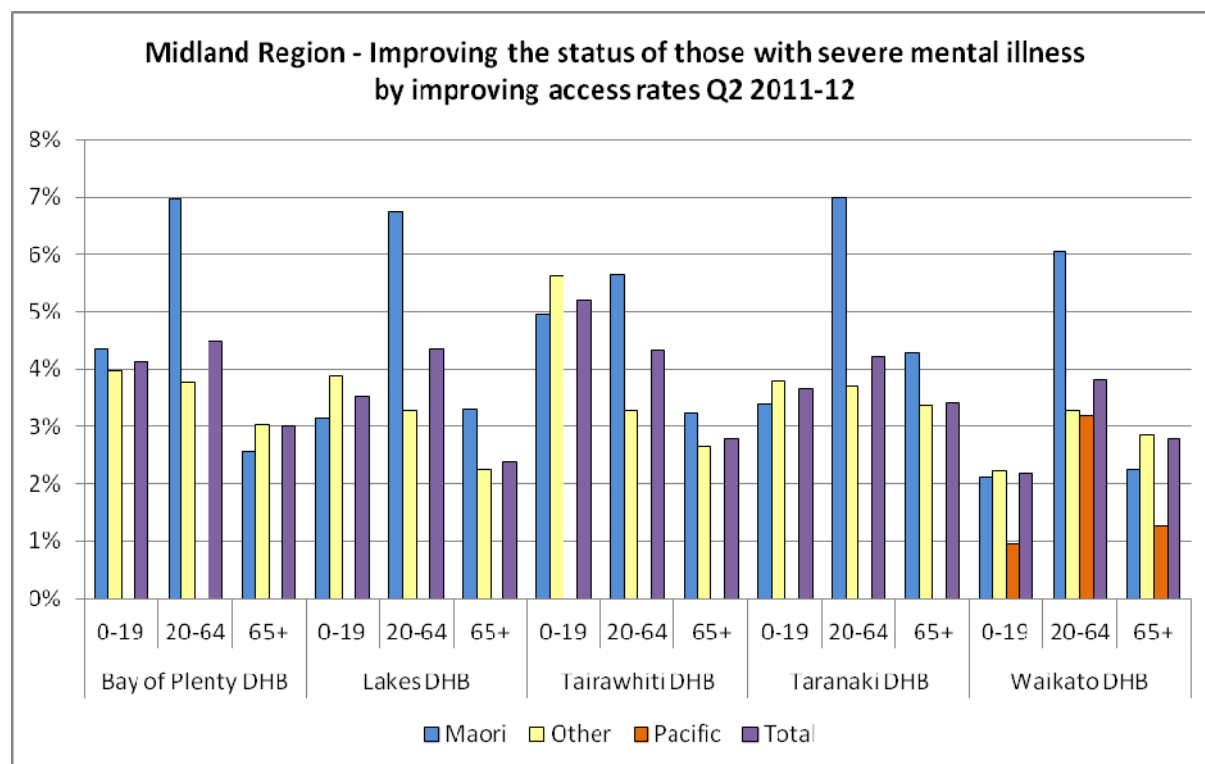
Reduction in unplanned readmission rate to mental health and addiction services

Why is this important?

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

How will we know we are succeeding?

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



Measure	Baseline 10/11	Target 12/13	Target 13/14	Target 14/15
Increased percentage of people domiciled in our DHB Region who access mental health services – PP6				
0-19 Māori	2.89%	3.70%	Maintain Targets	2012/13
0-19 Total	3.37%	3.70%		
20-64 Māori	6.79%	5.34%		
20-64 Total	4.08%	4.02%		
65+ Total	3.37%	3.46%		

More people with end stage conditions are supported

Why is this important?

For people in our population who have end stage conditions, it is important that they, their family and whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition of end-of-life choices heavily influence the quality of life an individual experiences during the dying process.

How will we know we are succeeding?

Historically, the majority of specialist palliative care has been provided for people with cancer and end stage renal failure, but often not for people with other end stage conditions like COPD, heart failure and dementia. Increasing access to people with a broader range of end stage conditions requires a change to the model of care that is a more flexible and dynamic model, where specialist and generalist palliative care may be required at different stages of a patients journey. This is compounded by an ageing population and an increasing need for palliative care generally. A number of projects are being led nationally, such as the development of the Specialist Palliative Care Service Specifications and the Resource and Capability Framework that will assist with clarifying the models of care, definitions of service and how this will impact on funding and purchasing models.

We will know we are succeeding by increasing the percentage of people that have end stage conditions other than cancer or renal failure, that access specialist palliative care. We will develop a system for capturing and measuring this information and Service Specifications for Specialist Palliative Care.

2.7 Key Risks and Opportunities

Factor	Description	Our Response
Operating in a tighter financial framework	<p>Significant and increasing pressure on costs for all providers with very limited /no scope for new strategic investment.</p> <p>The potential for extra costs (both capital and operational) arising from the building programme to result in budget deficits at a time of limited increases in funding.</p>	We will implement a range of practical options, including the continuing implementation of the workforce management programme and the reconfiguration of services, with the primary aim of reducing the overall cost of service delivery whilst maintaining access of core services.
Managing in a changeable environment	<p>Reduced ability of the executive and staff to properly manage day to day activity while dealing with:</p> <ul style="list-style-type: none"> The building programme and its associated operational change Thinking about and responding to regional and national requests for 	<p>We will ensure conscious management and prioritisation of work so that critical outputs are maintained and work loads balanced to minimise stress and work pressures on staff.</p> <p>We will ensure regular effective communication to and engage staff in change processes, ensuring that the Employee</p>

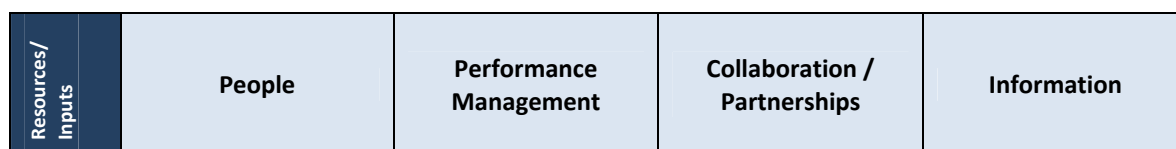
Factor	Description	Our Response
	<p>information/action as part of these two programmes of integration</p> <ul style="list-style-type: none"> Positioning the organisation for both of the above through interim staffing and other arrangements 	<p>Assistance Programme is available.</p> <p>We will ensure that contingency plans are developed for key roles and action any retention programme initiatives on a case by case basis.</p>
Regional integration	Integration between regional DHBs is important for both financial and clinical reasons.	We will work with the other Midland DHBs and be an active participant in the RSP development and implementation process.
Integrated care	Evidence shows that integrating primary care with other parts of the health system is vital for better management of long term conditions as well as responding to the pressure of an ageing population.	We will work with Midland Health Network, the National Hauora Coalition and our other primary care partners.

3.0 STEWARDSHIP

In delivering on our functions as a DHB and participating in the health sector, we have a broad set of responsibilities and interact with a diverse range of individuals and groups. To be as effective as possible, we must have capable leadership, an engaged workforce, a healthy organisational culture, sound relationships, robust and rigorous systems and the right infrastructure and assets.

This section is about inputs and describes how we intend to perform our functions and conduct our operations to achieve the outputs and impacts we seek to deliver²¹. It provides further detail on the stewardship portion of our performance story²².

Diagram: Stewardship portion of our performance story



3.1 Managing Our Business

As detailed in Sections 1 and 2, the environment we operate in is changing and there are a number of pressures and challenges DHBs face. The level of our success over the next few years will depend on our ability to adapt to the changing environment as we continue to improve the health of the Taranaki DHB population and reduce or eliminate health inequalities.

For the 2012/13 year we are nationally required to produce a workforce strategy which is summarised in Section 3.3.

3.1.1 Our People

The central part of our capability is our people. Providing health and disability services now and into the future depends on having a workforce that is well matched to the health needs of the community and appropriately skilled and located. We will look to create an environment to unleash innovation by staff empowerment.

Regional

The tables and graphs contained in this section have been developed with data sourced from DHB Shared Services. The first two tables provide an overall picture in terms of:

- Number of people employed²³ by a DHB in the Midland DHB Region
- Number of people employed²⁴ by a DHB in the Midland DHB Region who have identified as being Māori

²¹ See Section 2 (impacts) and Section 4 (outputs).

²² See Section 1.2.2

²³ All employees with contracted hours greater than 0 hours

²⁴ All employees with contracted hours greater than 0 hours

Table: Midland DHB staff numbers by DHB

Year ending	Bay of Plenty	Lakes	Tairāwhiti	Taranaki	Waikato	Midland DHB Region
30/09/07	2,274	1,230	616	1,331	5,058	10,509
30/09/08	2,377	1,086	593	1,375	5,231	10,662
30/09/09	2,605	1,132	675	1,397	5,503	11,312
30/09/10	2,526	1,138	683	1,404	5,758	11,509
30/09/11	2,595	1,151	701	1,400	5,875	11,722

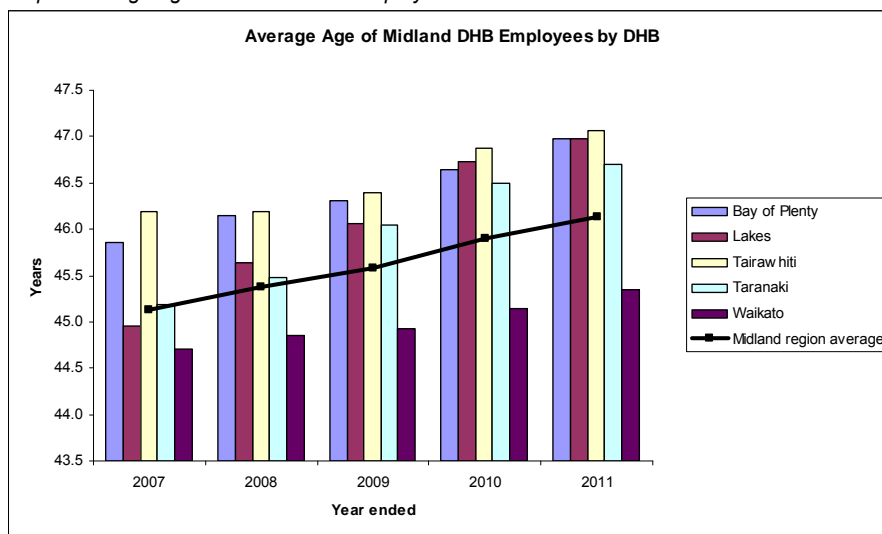
Table: Midland DHB staff identified as Māori numbers by DHB

Year ending	Bay of Plenty	Lakes	Tairāwhiti	Taranaki	Waikato	Midland DHB Region
30/09/07	228	158	138	76	524	1,124
30/09/08	262	172	131	81	527	1,173
30/09/09	288	174	168	86	553	1,269
30/09/10	257	185	165	87	573	1,267
30/09/11	261	185	182	91	574	1,293

The following two graphs present the:

- Average age of DHB employees²⁵ (by DHB) in the Midland DHB Region
- Average age of DHB employees²⁶ (by DHB) in the Midland DHB Region who have identified as being Māori

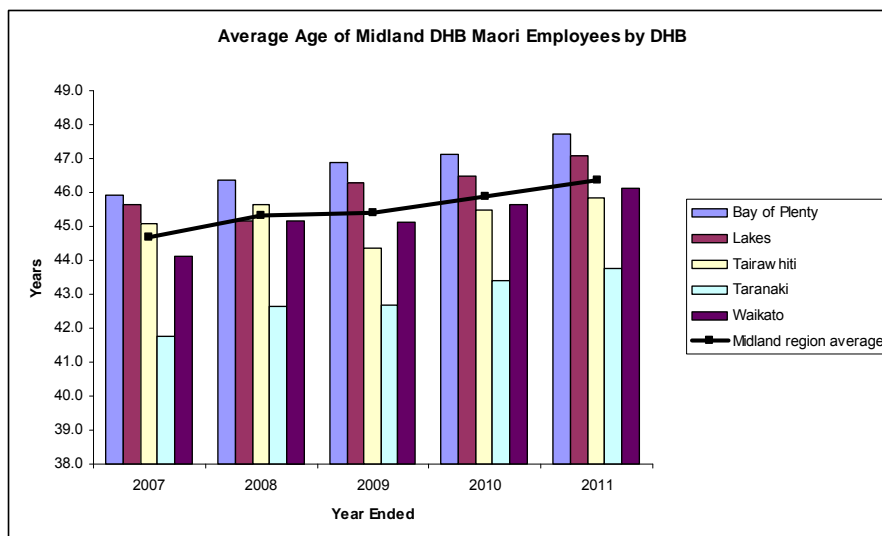
Graph: Average age of Midland DHB employees



²⁵ All employees with contracted hours greater than 0 hours

²⁶ All employees with contracted hours greater than 0 hours

Graph: Average age of Midland DHB Māori employees



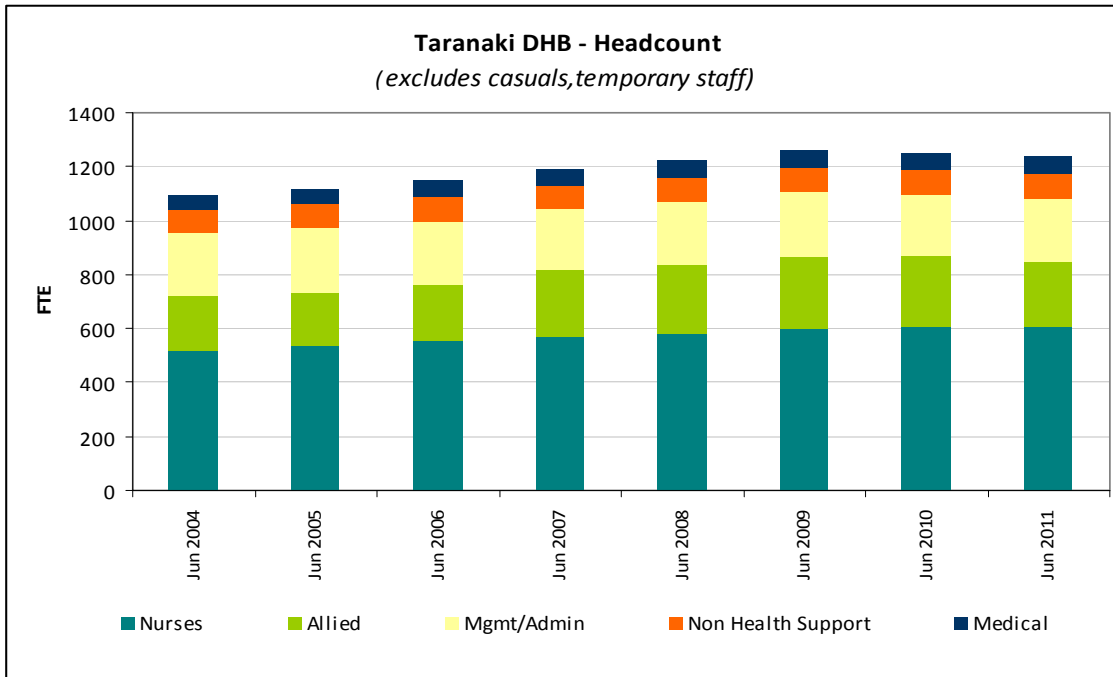
Local

Key points of note about our workforce (as at 1 July 2011) are:

- We employ 1431 staff in total.
- 81% of staff are female.
- The Māori workforce make up 6% of the overall staffing numbers.
- New Zealand non Māori make up the largest single ethnic group of employees (64%), with the next major ethnicities being European (15%) and Māori (6%).
- Our workforce is slightly older than the average for the New Zealand labour force.
- 42% of our workforce is over the age of 50 years.

The following graph represents the headcount of number of people employed within our organisation on 1 July each year (from 2004 to 2011) by occupational group. It shows a general increase in numbers since 2004 to 2009 with a levelling off of staffing numbers since then. Note that in July 2006, the Laboratory Service became part of the DHB, which was previously outsourced.

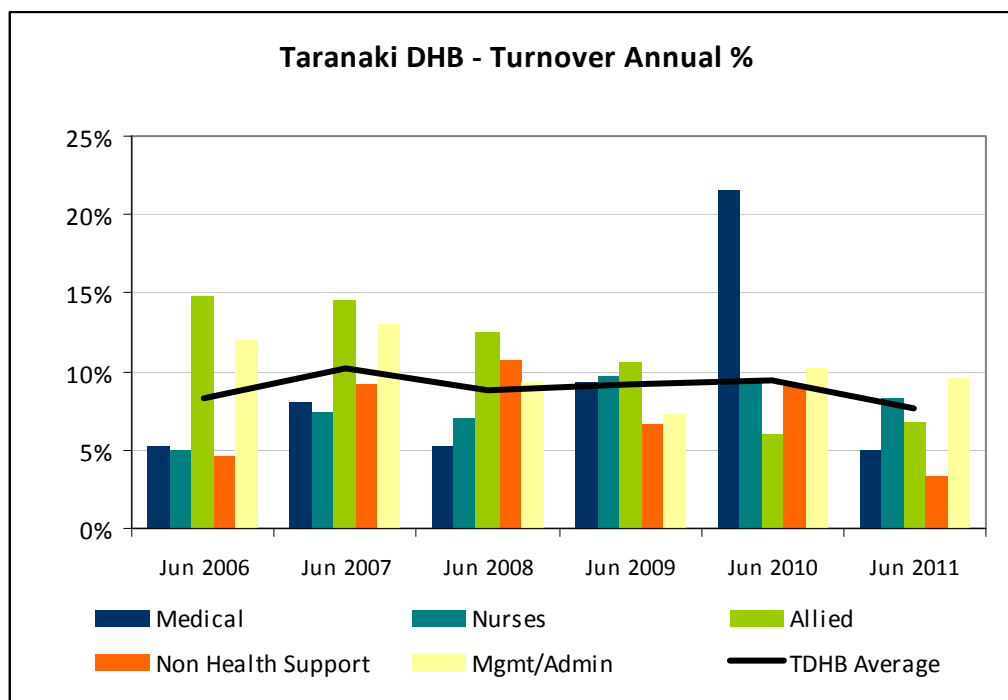
Graph: Headcount of staff employed at Taranaki DHB by occupational Group



Staff turnover represents the number of people leaving within a period, in this case over 12 months. It is presented as a percentage by dividing those leaving the organisation within the period from the number at the beginning of the period. Temporary and casual staff have been removed and the data does not include staff that transfer within the organisation.

The data, presented in the following graph, indicates a consistent average turnover of between 8% and 10%. The June 2010 statistic for medical staff is reflective of a number of short term locums leaving TDHB in this period as permanent appointments were made.

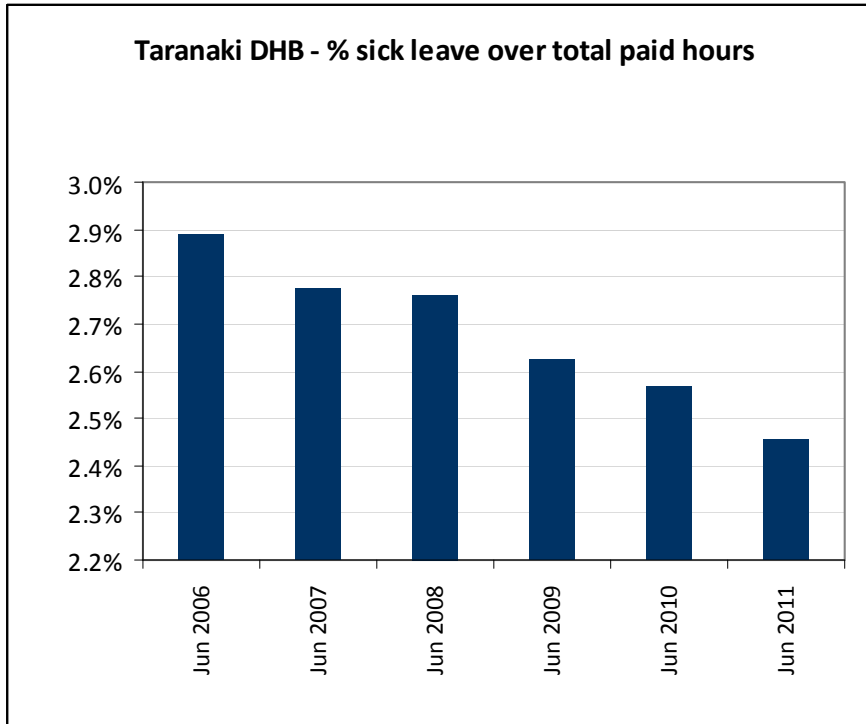
Graph: Percentage turnover by occupational group



Note: Registrar turnover will always be relatively high because of the nature of their employment.

The graph below indicates that the percentage of sick leave over total paid hours is reducing overall. A trend has been identified that more people are using annual leave once their sick leave is exhausted and this will not show up in the figures below. Further analysis is planned on this trend.

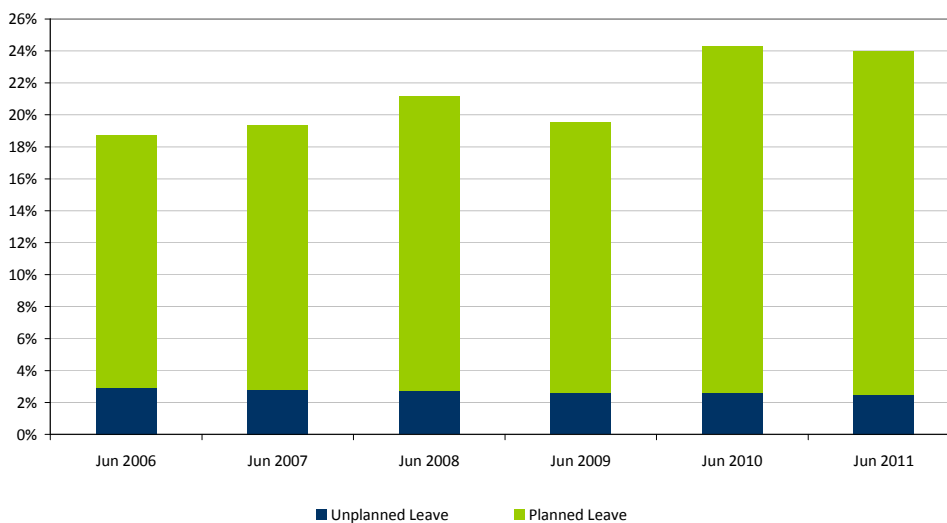
Graph: Percentage sick leave over total paid hours in financial years



Planned and unplanned leave can affect productivity and cost when replacement staff are required to maintain service delivery levels. Most employees receive five weeks leave per annum (five weeks leave equates to approximately 10% planned leave over paid hours).

The graph below provides annual information of the percentage of planned and unplanned leave over total paid hours. Leave is seasonal with most planned leave taken in the summer and most unplanned leave taken in the winter months.

Graph: Percentage planned and unplanned leave over paid hours



Accrued leave is another indicator of individuals' ability to take leave. The DHB accrues the value of the leave liability on the balance sheet. For the financial year ending 30 June 2011 TDHB's leave accrual was \$11.7 million.

3.1.2 Organisational Performance Management

Our performance is assessed on both non-financial and financial measures. The table in Section 3.7 provides an overview of the external reporting. Our overall planned performance as a funder and provider of health services for 2012/13 is outlined earlier in this plan and will be reported to our senior management, Board and the Ministry of Health on a regular basis.

a) Non-financial Performance Reporting

Non-financial performance, which relates to volume and performance expectations for health service provision (by Taranaki DHB Provider Arm, PHOs and the NGO's we fund) is monitored regularly.

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

We report quarterly to the Ministry of Health on the required measures in the DHB Non-Financial Monitoring Framework and regularly feed into benchmarking and quality programmes²⁷ to compare our performance with other providers. We report to our Board through the quarterly narrative reporting process on our performance against all the indicators in this Statement of Intent. These reports are provided and discussed in Board Meetings and the reports are available to the public as part of the relevant Board agenda available on our website. Taranaki DHB have implemented a series of workforce management tools and monthly performance reports regarding staffing that are reported to the Board and relevant Governance Committee, along with regular reports regarding compliance, quality, Māori Health, risk registers, and specific reports as requested from time to time.

We support the national expectation that the public should be informed about health system performance. The information on our non-financial performance is one of the tools used by the organisation to identify issues and inform decision-making to improve our performance.

b) Financial Performance Reporting

As part of our annual planning process we submit a set of financial templates to the Ministry of Health. The templates inform the tables and narrative presented in Section 5. We report monthly to the Ministry of Health against the financial templates.

We report on our financial performance monthly to our Board. This report includes commentary and financials as well as actions planned to improve financial performance.

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

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

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

²⁷ For example Health Roundtable, Hospital Quality and Productivity Project and the Australasian Rehabilitations Outcomes Centre (AROC)

3.1.3 Funding and Financial Management

We have an objective of strong financial performance and plan to maintain a close to breakeven or better than breakeven position and to minimise cyclical deficits. The following table sets out our key financial information.

	2010/11 \$M ACTUAL	2011/12 \$M FORECAST	2012/13 \$M PLANNED	2013/14 \$M PLANNED	2014/15 \$M PLANNED
Revenue (after adjustments)	312	318	324	334	342
Net Surplus/(Deficit)	1	0	0	(4)	(3)
Total Fixed Assets	102	130	170	166	158
Net Assets	74	73	72	68	64
Term Borrowings and Provisions	30	56	74	75	75

3.1.4 Health Benefits Limited

Health Benefits Limited (HBL) was established in July 2010 to reduce costs and deliver savings in administrative, support and procurement services for the health sector. HBL's role is to facilitate and lead initiatives that result in savings and efficiencies for District Health Boards (DHBs) on non-clinical initiatives.

The establishment of HBL is a critical development and its success fundamental to progress the wider work programme for transformational change in the health sector.

3.1.5 Risk Management

An electronic risk management process is in place, which facilitates escalation of risks from within the Funder Arm. A subcommittee of the Board - The Audit, Finance and Risk Committee review risks on a regular basis. Internal and external mechanisms are in place for evaluation of contracted providers; these are done on a planned and on an adhoc basis as required.

TDHB undertakes a range of routine and special audits with respect to primary care services and Fee for Service Agreements (including pharmacy, dental, home-based support services and Aged care).

All DHBs face pressure to meet additional expenditure which must be managed within allocated funding. There is pressure to devolve services to the primary area seen as a “lower cost platform” and to increase tertiary level interventions such as cardio-thoracic surgery and cardiology procedures. This creates increasing challenges for the viability of secondary services, particularly for provincial DHBs.

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

3.1.6 Performance and Management of Assets

We have developed a formal Asset Management Plan in accordance with Ministry of Health requirements. Our Asset Management Plan is informed by our long term financial model. Our long term financial model covers a 20 year period and provides a high level view on capital affordability of ‘big ticket items’.

For the items identified as 'non big ticket', there is a rolling three year process. As part of this process a comprehensive annual prioritisation exercise is undertaken, which includes a quarterly review to identify any potential need for re-prioritisation.

We have a well established building programme (Project Maunga) that will continue to roll-out during 2012/13.

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

3.1.7 Prioritisation

Prioritisation is the allocation or reallocation of funding, on the basis of evidence, to services which are more effective in improving the health of our population and reducing or eliminating health inequalities.

Since health resources are constrained, growth in expenditure in any service comes at the expense of another. If we do not intervene when unplanned changes are inconsistent with the strategic direction this leads to prioritisation through inertia. The risk is that major prioritisation decisions are made in this way rather than through a considered prioritisation process.

a) Regional Prioritisation

The Midland DHB Chief Executives have adopted a regional prioritisation framework. The framework provides a decision-making structured around regional investment.

b) Local Prioritisation

We have an established prioritisation process which involves key stakeholders who have both clinical, management and Māori health expertise and experience. We have developed a prioritisation template to ensure a focus on alignment with strategic direction and reducing or eliminating health inequalities.

3.1.8 Shared Decision-Making

a) Clinical Governance

A commitment to quality and patient safety places responsibility on the DHB to have effective mechanisms in place for planning, monitoring and managing the quality of clinical provided. Attempting to make the fundamental changes to the health system for the sector to "live within its means" will require strong clinical engagement and leadership. TDHB is driven by clinical engagement commitments through a range of initiatives.

Clinical input into decision making is facilitated by a model of shared management and clinician leadership at all levels within the DHB. Our Clinical Directors are formally part of the TDHB leadership team and fully involved in the financial and clinical management of their services. The TDHB Clinical Board is a multidisciplinary clinical forum, whose membership includes representatives from the primary, secondary and community sectors. Board members are represented on the Clinical Board and the Clinical Board is chaired by the Chief Medical Officer. The Clinical Board oversees the DHB's clinical activity, provides advice to the Chief Executive and Board on clinical issues and takes a proactive role in setting clinical policy and standards, encouraging best practice and innovation. Members support and influence the DHB's vision and values and play an important clinical leadership role, leading by example to raise the standard of patient care.

b) Māori Participation

We engage informally at many levels with Māori providers and the community. We observe the Treaty principles within the framework of the NZPHD Act (see *Section 1*). In our context they are:

Partnership – TDHB has in practice processes that enable Māori to engage and contribute to decisions at all levels of decision making, based on mutual understanding and co-operation.

Participation – TDHB is a joint partner in identifying priority areas for Māori health gain. Māori are involved in the overall strategic and operational planning processes.

Protection – TDHB is committed to a bi-cultural approach in its delivery of health and disability services which includes the utilisation of tikanga Māori. We are working with Māori to ensure the protection of Māori cultural concepts, values, practices and other taonga.

Tikanga a Iwi is adhered to with bi-culturalism actively promoted. The Board and staff are trained in bi-cultural approaches to health and disability service funding and provision of an in-house programme entitled He Retinga. This is supplemented for clinical staff by a programme of cultural competence. In the role of funder, TDHB is actively fostering Māori processes within all health and disability service providers and consistently applies the Health Equity Assessment tool (HEAT) to all its funding decisions. See also our Māori Health Plan (MHP) available on our TDHB website.

c) Community Input

We regularly engage with a number of advisory groups, working groups, consumer groups and community health forums. Their advice and input assists in the development of DHB strategies and plans.

Community Health Forums are made up of local people representing specific geographical regions. They support and advise us about local health issues, activities and priorities for their community. They are also mechanisms for ensuring communities are kept involved in and informed of DHB activities and issues.

d) Primary Health Alliance Leadership Teams

Alliance Leadership Teams (ALTs) have been established across the Midland Region with our primary care partners; the Midlands Health Network and the National Hauora Coalition. The ALT are populated by clinical leaders and managers from across primary and secondary care.

The purpose of the ALT is to lead and guide our Alliances as they improve health outcomes for our population. The aim of the ALT is to provide the direction to enable the provision of increasingly integrated and coordinated health services through clinically-led service development and its implementation within a “best for patient, best for system” framework.

3.2 Building Capability

The Health and Disability services sector has managed significant changes over the last two decades and the fast pace of change will increase in the future. For our DHB a significant change driver is the increased service demand arising from an ageing population that is facing an increasing burden of long-term diseases and multiple health issues. The focus will remain on improving the way patients are cared for; both in the hospitals and in the community to better manage acute demand and the burden of long-term (chronic) conditions. With the economic downturn and funding constraints for 2012/13 and beyond, it is clear that maintaining service coverage and investing in value areas will require greater efficiency, savings, and reprioritisation across the system.

Our well-established Service Planning Unit along with Project Maunga aims to improve patient outcomes and patient safety by freeing up staff time for patient care. Time will be freed up by eliminating waste and improving systems. The staff dealing with the daily realities of work in health care will be given tools and support so they can lead service improvements. Service improvements will be delivered within the organisations quality framework.

This section outlines the capabilities we will need in the next three to five years as well as touching on the approach in the short term to work towards developing these.

3.2.1 HealthShare Limited

HealthShare, established in 2001, is a regional Shared Services Agency jointly owned by Waikato, Bay of Plenty, Lakes, Taranaki and Tairāwhiti District Health Boards (shareholding DHBs). From August 2011 HealthShare has taken on an expanded role and now provides operational support to the Shareholding DHBs in a number of areas identified as benefiting from a regional solution.

HealthShare's Statement of Intent specifies the company's performance framework; the work to be undertaken in 2012/13 and the associated performance measures. HealthShare's Business Plan details, at a service level, the activities that have been purchased by the shareholding DHBs.

HealthShare will be in a state of evolution over the next few years. The services that HealthShare delivers to the region will continue to increase as national/regional back office solutions are developed by HBL and future regional cases for change are approved. The following regional services will be provided from HealthShare in 2012/13:

- Regional service planning and reporting facilitation
- Clinical Service Network facilitation including:
 - Clinical service network workstreams per the RSP
 - Maternity Quality and Safety regional programme, complementary to DHB programmes
- Workforce Development support, including the Midland Training Network [components of the function in transition in 2012/13]
- Regional clinical information systems development support [components of the function in transition in 2012/13]
- Shared services including:
 - Audit and Assurance service
 - Midland Smokefree programme

Taranaki DHB will spend \$478k purchasing the above services from HealthShare in 2012/13.

The following services have been approved to transition across to HealthShare in 2012/13 but are not included in current budget figures:

- Internal Audit regional coordination
- Recruitment and Selection regional service.

3.2.2 Information Communications Technology

Information Communications Technology (ICT) is a significant input/resource at both a regional and local level. Work in this area contributes directly to our regional strategic objective of improving clinical information systems.

Demand for projects and initiatives in this area of business have continued to increase. While we rely on ICT to complete our work we have a finite amount of resource available to undertake implementation activities. Therefore, this continued increase in demand means that the prioritisation of work is essential.

a) Regional

The development and implementation of the Midland Regional Information Services Plan (RISP) is a key enabler of the Midland RSP. The RISP is a component of the RSP through which the region document their IT capacity planning and action; bringing together the National Health IT Plan and regional priorities.

Activity in this area is being led by the Clinical Information Systems work stream. This work stream will implement the Midland RISP and advance National Health IT Board priorities, specifically the implementation of the National Health IT Plan priority areas. The activity includes:

- Implementing regional connectivity as a first phase of the Midland Connected Health programme, allowing health service providers to exchange information and data securely.
- Development of a Clinical Workstation Programme across the region will allow clinicians to have access to common tools.
- Medications Management Programme will include agreed region configuration /architecture for ePharmacy.
- Clinical Data Repository with secure access to core clinical information will also be developed.
- Implementation of a Regional talent management platform supporting regional recruitment.

b) Local

The strategic direction our DHB takes towards its ICT services reflects not only our vision of *'Taranaki Together, A Healthy Community'*, but also the implications and requirements of national and regional information strategies. Accordingly our approach to ICT services incorporates the requirements of the National Health Information Technology Plan (NHITP) an information framework and plan aimed at contributing to achievement of the Government's broad Health Strategies.

Our DHB also recognises that it must be a part of a regional response and as such aims to contribute to three regional information goals:

- Provide integrated/shared information to enhance health care planning and improve population health outcomes.
- Collaborate to reduce costs and enhance risk mitigation within information areas.
- Provide technical and information support for shared service initiatives in non-IT areas.

Delivering on these goals requires the transition from stand alone IT service provision to being part of a regional service delivery capability. The Midland DHBs have developed the Midland Region Information Services Plan (MRISP) which outlines a number of work streams aimed at advancing regional and national capability and ICT service consolidation. While challenged by the issue of affordability (given other demands on DHB resources), a number of prioritised regional initiatives have been identified for progression during 2012/13 including:

- Delivering the Midland One Health programme – implementing regional service delivery capacity.
- Implementing the ePharmacy solution as part of the medications Management Programme.
- Advancing the Clinical Workstation programme – implementing a regional Clinical data repository.
- Implementing the Acute Predict system to support regional cardiac /cardiology services.

3.2.3 Integrated Contracting

We are conscious of the whānau ora integrated agreement developments across the health and social services sectors. This process is being led by the Ministry of Social Development (MSD) who have

nominated the providers. This involves bringing together services across agencies (for example Ministry of Social Development, Ministry of Justice, and in the future – Taranaki DHB) to work with a defined population to ensure increased cohesion of service delivery.

We will look to take up integration opportunities as appropriate. When making decisions on integration, considerations we will take into account are:

- Consistent population coverage
- Position in the continuum of health services
- History of service / contract delivery
- Integrating agreements will not result in service gaps

3.2.4 Collaboration

We collaborate with other health and disability organisations, stakeholders and our community to decide what health and disability services are needed and how to best use the funding we receive from Government to improve, promote and protect the health and wellbeing of our population. We collaborate because working together with other groups on targeted areas often brings better outcomes than those groups working in isolation in the same area.

Through this collaboration, we ensure that services are well co-coordinated and cover the full continuum of care, with the patient at the centre. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the health system to achieve the best health outcomes for our community.

Working collaboratively with others, both across the sector and with other health and social service providers is integral to the success of our DHB in achieving our goals. We are committed to sharing resources with regional DHBs and providers as well as collaborating with the Ministry, The National Health Board, NGOs and other service providers in order to achieve specific outcomes. Our DHB is committed to working with other providers in order to influence the social determinants of health that are external to the health system to achieve the best health outcomes for the population.

National

At a national level the TDHB works with the health, education and justice sectors to improve outcomes for Taranaki population through health, nutrition, physical activity and mental health initiatives; crossing the sectors in an effort to meet shared goals. Similarly, we are committed to a number of national programmes, which will improve the health of the community, including B4 School Checks, Newborn Hearing Screening and the Human Papillomavirus Immunisation Programme. There are a number of other national programmes such as the National Value for Money Programme, National Procurement Programme and Workforce groups that our DHB is focused on to ensure our clinical and financial sustainability.

Regional

Extensive collaboration occurs at a regional and sub-regional level. We have committed significant time, resource and expertise into working with our primary care partners and participating in the RSP implementation processes.

Another area of regional collaboration is in the area of public health. There are four public health units operating within the Midland DHB Region:

- Public Health Unit, Taranaki DHB
- Toi Te Ora – Public Health Service , Bay of Plenty and Lakes DHBs

- Population Health, Te Puna Waiora, Tairāwhiti DHB
- Population Health Service, Waikato DHB

In line with national direction, the Public Health Units in our region have established the Midland Regional Public Health Network. The Network will provide leadership for and strengthen the performance and sustainability of public health units. The Network will also develop and maintain relationships with the Midland Regional Services Planning Groups.

The goals of the Network are to:

- Enhance the consistency, co-ordination and quality of public health service delivery across the region.
- Plan together where there are benefits in doing so.

The Network's specific areas of focus for 2012/13 are outlined in the following table.

Table: Public Health Areas of Focus in the Midland DHB Region

Area of Focus	Specific Areas of Work
Workforce development and retention	Collaborative approach across the Midland region for general public health workforce professional development
Regional Public Health Clinical Network	Communication and actions as required to support national public health clinical network
Maintaining and developing regional linkages and contacts	Regular public health regional teleconferences and forums for staff groups
Communicable disease protocols	Develop regional protocols for an identified list of communicable diseases
Information sharing and knowledge management	Explore opportunities to collaborate in the areas of health intelligence and health needs analysis
Contingency planning	Collaborative approach to the development of service contingency plans for each unit linking to regional support as appropriate.

Local

We work with other agencies (for example Ministry of Education, Ministry of Justice, Ministry of Social Development, Police, Tertiary Education Commission, Housing NZ as well as other central government agencies and local government) to improve the determinants of health.

Whakatipuranga Rima Rau Trust (WRR) is an inter-agency trust established by Taranaki District Health Board, Ministry of Social Development, Te Puni Kokiri and Te Whare Punanga Korero. WRR was created to build an integrated approach focusing on the common objective of upskilling and developing the Māori Health and Disability workforce in Taranaki. This is an innovative multi agency and multi funder model which introduces a range of initiatives to address Māori workforce development through collaboration. In 2013/14 we will explore stronger collaboration between the DHB Public Health Unit and Māori Health Promotion Providers.

Transport: We will continue to collaborate with Taranaki Regional Council and others on the development of an integrated transport network for our province.

3.2.5 Long Term Demand Forecasting

We are experiencing an increasing mismatch of health service demand, supply and affordability. The health sector cannot continue to operate in the same way as it has been if we expect to be clinically and financially sustainable into the future. Forecasting long term demand is about planning for the future. The simplest forecasts occur in stable environments with plenty of good data and depend on the future resembling the past (the closer the resemblance the more accurate the forecast). However, the current environment is changing, the data available is limited and the future is not expected to closely resemble the past. Forecasting in these conditions is a complicated exercise requiring interpretation of data in the context of the wider health system, economic and social environment.

We will continue to participate in demand forecasting work as well as exploring the use of modelling and simulation techniques to assist in shaping services. These techniques can improve both efficiency and quality of services through a range of applications including:

- Waiting time reduction
- Scheduling
- Bed capacity management
- Workforce planning
- Commissioning

Long term demand forecasting is one of the tools we must use to inform decisions around reforming health sector configurations and related models of care if we are to move forward with a sustainable, affordable and fit for purpose health sector. These reforms have already begun in the shape of:

- Programmes developed to achieve the better, sooner, more convenient health care initiatives.
- Expectations for closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals.
- Regional service planning.
- The Productive Hospital (NHS Productive Programmes) – continuing successful implementation of the NHS productive programmes: productive ward, productive community, and the productive operating theatre across Taranaki, other NHS projects will be considered for implementation as appropriate.
- Facility Change Management – supporting staff in lean process redesign and change management for the completion of Project Maunga (New Plymouth Base Hospital campus redevelopment).

3.3 Strengthening Our Workforce

The State Services Commission requires all DHBs to produce a Workforce Strategy that shows alignment between business priorities, projected results and a planned approach to managing the people aspects of their business in the medium-long term. HWNZ has developed an overarching national strategy and guidelines specific to the health sector to support DHBs to meet this requirement within their planning process. Further detail on our workforce strategy is in Section 3.3.3.

3.3.1 Health Workforce New Zealand

Health Workforce New Zealand (HWNZ) was set up in 2009 to provide national leadership on the development of the country's health and disability workforce. HWNZ is a business unit of the National Health Board. Its work is overseen by an independent board with board members from business and across the health sector.

HWNZ has overall responsibility for planning and development of the health workforce. It aims to ensure that New Zealand has a fit-for-purpose, high quality and motivated health workforce, keeping pace with clinical innovations and the growing needs and expectations of service users and the public.

The traditional response to workforce planning will not meet New Zealand's future health and disability workforce demands. Therefore, HWNZ are leading changes that will move away from thinking only of increasing workforce numbers and towards investing in innovation and new roles, as well as continued development of the workforce.

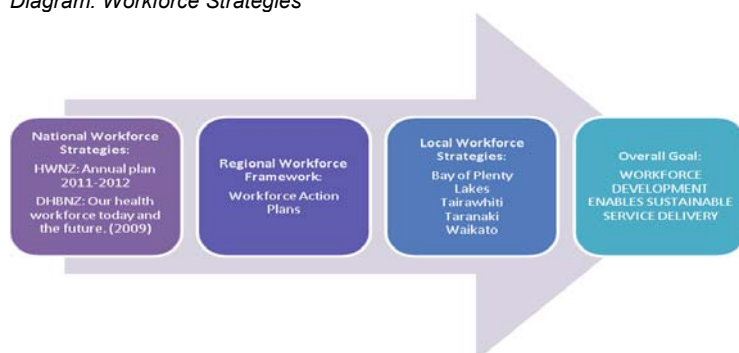
HWNZ have identified and set key enablers and priorities to support regional workforce activity for implementation in Regional Service Plans across the 2011/12 and 2012/13 planning cycles. Further details can be found in the Midland DHBs RSP 2012/13.

3.3.2 Regional

New Zealand faces a major challenge in acquiring a health workforce. Across the Midland DHB Region service providers are beginning to feel the effects of widely predicted workforce pressures and shortages²⁸.

A range of workforce strategies at local, regional and national levels is needed to respond to the challenges of sustainable service delivery. The following diagram highlights the interdependent nature of workforce strategies and the overarching goal of workforce development supporting sustainable service delivery.

Diagram: Workforce Strategies



The regional workforce work-stream will address the workforce change required to meet increasing demand for health services, and address the most commonly raised issues across the region relating to the future sustainability of the workforce. This includes the need to better anticipate future states and investigate regional collaborative activity that supports this approach. Workforce development activity underpins the collective response required to ensure access to quality, sustainable services across the whole region. Midland DHBs share responsibility for planning and undertaking forward-looking action on workforce development that minimises duplication. This includes regional collaboration to investigate the impact of reducing the rate of growth in health spending on workforce planning and development in general.

By working together as a region we will strengthen our health workforce in relation to culture, capability, capacity and change leadership. The four domains will be further developed and implemented through the strategic directions of regional workforce framework.

²⁸ The New Zealand Institute of Economic Research has estimated that by 2021 the health sector will need another 23,000 health professionals, a 35 percent increase

Regional Workforce Framework

The regional workforce framework is a key enabler of the Midland DHB RSP. It provides our region with an overarching workforce development pathway. The pathway aligns with national direction and will assist Midland DHBs to continue to work together to strengthen innovation, new ways of working and the development of sustainable workforces into the future. The goal, outcomes, principles and strategic directions that will support the development of the health workforce in Midland DHB Region are outlined in the following diagram.

Diagram: Midland DHB Region Regional Workforce Framework



The priority workforce initiatives for 2012/13 include²⁹:

- National and regional enablers including the Midland Training Network and hub activities
- Deliverables to progress sustainable service delivery through the work programmes of the Clinical Networks and Action Groups including development of a suite of tools to progress opportunities for innovation (integrated service and workforce planning; new ways of working initiatives and evidence based workforce design)
- A range of activities supporting the development of sustainable workforces across the regional forums including: increased workforce collaboration and cooperation; credentialing processes for clinical workforce groups; common recruitment approaches, reducing spend on locums; and opportunities to better use the current workforce
- Regional initiatives to build regional workforce capacity, capabilities and focus. This includes a single regional solution for e-learning and regional leadership development programs. In addition, a regional recruitment service with a common talent platform will be established to support the regional clinical services plan, while improving processes and efficiency across the region.

3.3.3 Local

Change continues to be driven by workforce shortages and an ageing workforce and ensuring that the DHB has an engaged and committed workforce. As agent for the Crown, the Minister has highlighted the expectation for DHBs to have in place the appropriate clinical and executive leadership to deliver the Government's objectives. This requires an improved retention of permanent clinical staff, a reduction of vacancy rates and strengthening clinical leadership and networks.

²⁹ Further details can be found in the Midland DHB RSP 2012/13

To this end, Taranaki DHB has developed a revised Human Resources Strategy along with Talent Management and Learning and Development frameworks. This will ensure continuity of services along with the development of clinical and leadership skills to ensure that appropriate, high quality patient care and services are delivered to best meet the needs of the people of Taranaki.

Recruitment

Recruitment is clearly an important focus in terms of ease of access to information for applicants and cost to DHBs.

The national job portal www.kiwihealth.careers.com has been implemented to create a “one stop shop” for those looking for a health job (be they overseas or domestic job seekers). Initially, all DHB and NZBS health job vacancies are being made available online. There are links available from the national job board to the local website. The intent of the national job portal is to facilitate easy access for applicants, reduce recruitment advertising costs as well as minimize any use of costly 3rd party agencies. TDHB will continue to contribute to the development of kiwihealthjobs.com and its associated work streams, strong standardised regional practice will further compliment local efforts, particularly as standard platforms and regional recruitment services are implemented during the year.

Workforce needs and gaps

Taranaki DHB has the following recruitment priorities for 2012/2013:

- **Maternity**
Midwifery remains a workforce that is difficult to recruit to and the average age of this workforce is close to 50 years of age. There is a focus on supporting the undergraduates midwifery programme and formalising a new graduate programme that will enable us to recruit and retain this talent pool. This is supported by the Taranaki DHB Health Scholarship programme which is anticipated to deliver graduates in the short to medium term.
- **Psychiatrists**
This workforce has had high turnover in recent years and we see our incumbent medical workforce as a target group to ‘grow our own’. We will continue to improve the vocational training programme that we are accredited to deliver to new trainees that will promote Taranaki as a training location of choice.
- **Rural Medicine**
Taranaki DHB has invested in obtaining College accreditation for the Hawera Hospital to be recognised as a training site for the rural hospital medicine scope of practice. This is a key element to attract, developing and retain a key workforce to deliver services in rural areas. To support this development nursing has proposed a number of projects which are currently under active consideration that target nurse-led clinics. We will continue discussions with the College in respect to the implementation of a rural medicine immersion programme to target trainee General Practitioners while at medical school.
- **Emergency medicine**
This speciality is recognised as having high staff turnover due to the appointment of short term appointees on contract up to 2 years. We are seeking to obtain accreditation by the College as a teaching hospital will that will enable us to implement a component of the vocational training programme and attract skilled people back to Taranaki.
- **Health of the Older people**
We will continue to have a role available to work within the Aged Care sector that will support with PDRP resources, education opportunities and advice.

- **General Practice**
Taranaki will work with local GPs to coordinate GPEP 1 placements who have commenced the vocational training programme and are employed by the DHB. We will make available GP House Officer placements subject to number and suitability of applicants, and availability of GP supervisors.
- **Career Plans for trainees**
The organisation will work with all trainees to develop career plans. We anticipate 100% compliance.
- **Medical Training placements**
Taranaki continues to offer as many medical training placements as possible however due to the size and nature of the work performed at Taranaki this is restricted to the areas of:
 - General medicine
 - General surgery
 - Orthopaedics
 - Paediatrics
 - Anaesthesia
 - Obstetrics and Gynaecology
 - Post Graduate Years 1 and 2
 - NETP, nurse graduates
 - Return to Nursing
 - Competency Assessment Programme, overseas trained nurses

Workforce Development: Developing Local Talent

Local Workforce development focuses on key issues and workforces. The development of an updated workforce plan to support service change or transition are underway or being developed and include priorities such as Hawera Hospital, the General Practice sector and retention/development of the medical workforce:

- **Hawera Hospital Workforce Development:** support the South Taranaki Projects – Alive with opportunities for better health care, to have a skilled workforce. This will include working alongside the community health providers on developing collaborative ways of working.
- **General Practice:** commitment to support the General Practice Education Programme (GPEP) to increase the number of fully qualified General Practitioners in the future.
- **Scholarship Programme:** initiative to provide workplace experience and mentoring, and financial support that will encourage young Taranaki people to health as a career. This will attract them back to Taranaki as a fully qualified health professional.
- **Centralised Professional Development:** implementation of a centralised system with a standard application and approval process in place to ensure consistency, fairness for the employee and value for money for the organisation.

Nurturing a connection between the secondary students of Taranaki and careers in the health sector is a key strategy the DHB employs to secure a sustainable workforce. TDHB plans to promote health as a career using the national website “Health Careers” at Career Expos, schools visits and Career Advisor familiarisation workshops. This will be supported by making available work experience placements.

The Incubator Programme continues to be delivered in Taranaki, the focus being for Māori secondary students that takes students through a structured and active learning process to generate career awareness and ambitions.

Māori Workforce Development

One of the challenges for Taranaki is to create a health workforce that is better representative of the population we serve. Currently, our Māori population is 16%, while the DHB employs only 7% Māori staff - these are often in the non-clinical areas. The TDHB aims to increase the Maori workforce to 8% by 30 June 2012 and to 9% by 30 June 2013. Initiatives to support proactive engagement of Maori by recruiting managers are being developed to support this undertaking.

Initiatives like Kia Ora Hauora and Whakapiki Ake are focused on encouraging Māori secondary school students to take science subjects and continue with tertiary education in health-related subjects.

Whakatipuranga Rima Rau is an inter-agency trust established by Taranaki District Health Board, Ministry of Social Development and Te Whare Punanga Korero created to build an integrated approach focusing on the common objective of upskilling and increasing the Māori Health and Disability workforce in Taranaki. This is an innovative multi agency and multi funder model which introduces a range of initiatives to address Māori workforce development through collaboration. We are pleased with recent indicators showing a 10% increase in Māori workforce participation.

Program highlights include:

- over 100 students and 6 schools participating in Incubator
- 2 Cadetships which are paid on job training positions to increase the Māori workforce
- 6 Internships to provide exposure to employees and to provide workplace experience for students who are currently studying in a health related tertiary degree programme
- 6 attended the Whakapiki Ake that is a University of Auckland Māori Health recruitment programme that actively engages with rangatahi Māori enrolled in secondary schools to promote health as a career

During 2012 the priorities for the Trustees are:

- Participation of at least 160 students and all 12 Taranaki secondary schools, in Incubator
- 4 new Cadetships and 6 Internships
- Streaming participants of Māori workforce activity through to the Scholarship programme
- Increase collaboration with and placement of students in TDHB services Māori health providers in the community

Project Maunga: New Models of Care and Workforce Modelling

Taranaki DHB has placed a strong emphasis on new models of care and the development of both secondary and primary led services. Examples include Project Maunga, Stroke Pathway, and Project Splice. Project Splice was established to improve integration, reduce duplication and reduce the risk of disconnect between multiple services that may be involved in providing care for older people and those with chronic health conditions.

Workforce Management

We are committed to ensuring the culture of accountability and responsiveness and in 2010 introduced Project Whakapai to have planned staffing in place and improve the management of staff costs. This ensures that we have both planned and optimal staffing in while ensuring accountability for results, budgets, staff and services rested with the appropriate leaders and managers. The results of this approach indicate that TDHB has been able to successfully arrest FTE growth while controlling staff costs.

Consequently, TDHB will continue to focus on workforce management during 2012 with an emphasis on how supplementary staffing is utilised for the Nursing, Allied Health and Administration workforces.

Clinical Leadership

TDHB is committed to clinical leadership and the development of strong, high performing clinical/management partnerships. This will drive both success and change as the DHB progresses with the redevelopment of New Plymouth Base Hospital, transformational service change at Hawera Hospital and the redevelopment of services and models of care as we strive to live within our means.

Clinical partnerships are reflected through the DHB's structures and most importantly on key leadership teams dealing with strategic and transformation project across funder and provider. This drives engagement and accountability at all levels. The Director of Nursing and Midwifery and the Chief Medical Advisor report to the Chief Executive, participate on the Clinical Board and have developed sound and successful relationships across the DHB and sector.

During 2011 clinical staff attended the Leadership in Practice Programme. TDHB will continue to support this programme in 2012 and sponsor senior clinical leaders to attend the Advance Leadership Programme.

Branding, Engagement and Retention

Taranaki DHB has continued to develop its employment brand and promotes the opportunities and benefits of relocating to and staying in the District. This is important given Taranaki's perceived geographical and travel challenges. Focus on the benefits of internal training opportunities and the building of relationships between mentor and mentee ensure that Taranaki is seen as a destination of choice. We are proud of the numbers of junior and senior doctors who return to the Taranaki health sector as their careers progress.

Employment Brand

The strong employer brand that TDHB has with medical students means we consistently attract a high number who select TDHB as their number one choice as the place to commence their career. The consequent retention rate for PGY1 Resident Medical Officers is 90% which is well above industry average. We will continue on focussing on the career development opportunities available and providing appropriate levels of support and mentoring.

Staff Engagement

Organisational health are central to Taranaki DHB to ensure the provision of high quality and effective services that meet the health needs of our community. Through leading staff engagement, flexible work practices, clinical leadership and development, the Taranaki DHB continues to attract top talent and also focuses on employee retention. Our staff turnover has been declining over the last number of years from more than 15% to 8% for the financial year 2010/2011.

We will continue to link with staff through various mechanisms and engagement forums with the development of strong union partnerships including LREG, JAC and JCC. Through BAG (Bi-partite Action Group) TDHB engages regarding change management and policy development particularly during times of organisational change and transformation.

At the same time, TDHB will continue to engage staff through a series of additional mechanism including communication forum, development of employee value proposition and social media recruitment.

We have appointed a Project Manager for Safe Staffing Healthy Workplaces DHB Care Capacity Demand Management Implementation Programme (CCDM). These projects will provide further opportunity for staff engagement, building commitment to new ways of working and improving care.

TDHB will conduct the clinical engagement survey as developed by the Otago University. This survey will cover 1049 staff currently engaged by the DHB. It is anticipated that the report from this survey will inform future engagement activity and actions, that will be managed by the DHB.

Retention and Change Management

The focus for 2012 remains on working with our clinical staff while supporting the organisation and staff through change including service transformation, HBL initiatives, HealthShare in terms of regional clinical services and support services such as recruitment, workforce and learning.

In addition, TDHB is reviewing its approach for recognising long service and developing retention initiatives for key occupational groups and talented staff.

Policies and Initiatives

TDHB has a number of policies and initiatives that promote equity, fairness and a safe and healthy work environment: For example:

- Learning and development framework that will foster continuous learning, extend our capabilities, establish a culture where learning is actively supported and removes barriers to learning in our environment.
- Talent management framework that focuses on *Talent Identification* – sourcing, recruitment and performance management, *Talent Planning* – workforce and succession planning and *Talent Development and Retention* – learning and development and retention strategies.
- Fair and transparent recruitment processes and automated candidate management systems to ensure Taranaki DHB meets current and future workforce needs and retains staff.
- Zero-tolerance of harassment and bullying with policy and bipartite forum action focused on achieving this outcome.
- Recognition within the workforce of the aspirations and needs of Māori, other ethnic or minority groups, women and people with disabilities.
- Equitable training and development opportunities for all employees.
- Compliance training.
- Clinical and non clinical leadership development programmes and equitable access to professional development for clinical staff.
- The management and disclosure of adverse events to ensure a safe quality working environment.
- Constructive engagement approaches to encourage retention.
- Commitment to DHB values and treating our people with respect and dignity.

Organisational Learning and Development

TDHB participates as a member of the Midland Regional Training Network in the design and implementation of:

- The Regional Training Hub
- E-Learning programmes
- The Midland Leadership Programme

The Midland DHBs, via the shared service organisation Health Share Limited, has appointed a Regional Development Manager to lead and facilitate regional workforce planning and development, including activities around the training hub. The General Managers Human Resources for the Midland DHBs meet on a monthly basis with Midlands Workforce Development as a standing agenda item.

The network will initially focus on the career opportunities and development of the medical workforce of PGY2 in the 2012/13 year. The network has also identified GP training, multi-disciplinary training and the development of rural hospital lists as important work areas for the network in the out years.

Locally we will deliver fit for purpose workshops that will enhance the skills and knowledge of managers using “toolkits” as the primary source of information.’

3.4 Quality and Safety

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

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

Our strategic quality and risk plan facilitates the progressive achievement of the DHB’s vision by assisting us to meet the challenge of continuously improving service provision and quality of care by ensuring patient safety and robust systems and processes.

Key projects include:

- Medication error reduction utilising e-pharmacy.
- Patient fall reduction.
- Patient pressure injury reduction.
- Reportable event process enhancement.
- The progressive roll out of ‘Productive’ series to inpatient wards and The Productive Operating Theatre.
- Improving hand hygiene practices.
- Increasing consumer participation.
- Implement National Maternity Quality and Safety Programme.

3.5 Organisational Health

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

3.5.1 Governance

The governance structure for DHBs is set out in the New Zealand Public Health and Disability Act. The Board consists of up to 11 members and they have overall responsibility for the operation of Taranaki DHB. Seven of the members are elected as part of the three yearly local body election process (last held in October 2010) and up to four members are appointed by the Minister of Health.

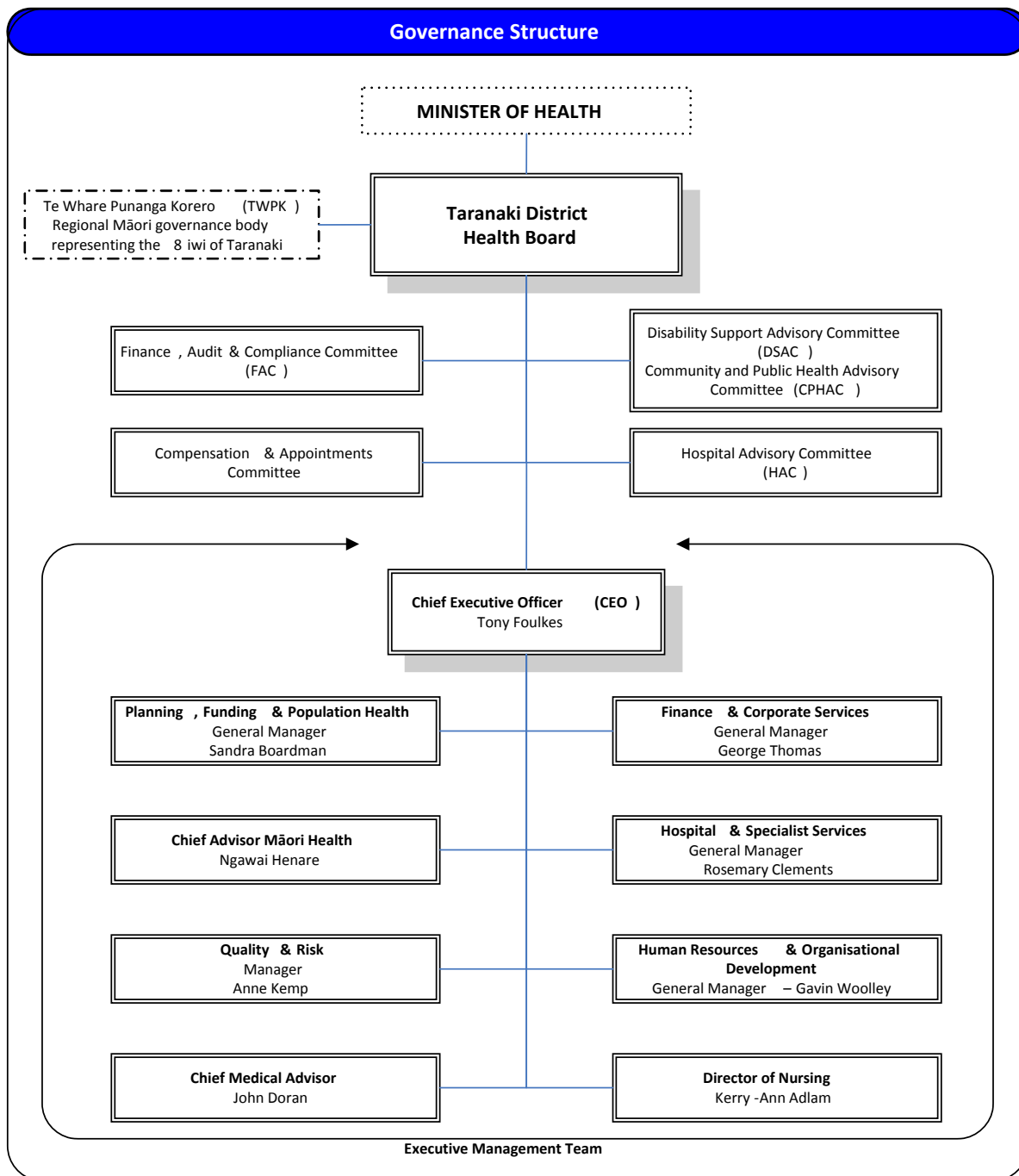
The Board is responsible for the overall governance of the Taranaki District Health Board. Within this role the functions carried out directly by the Board include:

- Approving major strategic and policy documents, including the Annual Plan, Statement of Intent and Budget.
- Monitoring the implementation of the Annual Plan, Statement of Intent and Budget.
- Monitoring the operating performance of the organisation.
- Considering recommendations on key issues.
- Maintaining and developing an effective working relationship with its Iwi partner Te Whare Punanga Korero.
- Ensuring that the DHB acts legally and responsibly.
- Appointing, evaluating and supporting the performance of the Chief Executive.

The governance of a District Health Board is a diverse and complex undertaking and the Board has established a number of committees so that it can carry out its responsibilities effectively.

The balance of skills and experience of the Board is kept under regular review. Additional knowledge and expertise has been recruited to assist where needed with the work of the advisory committees. The Board publishes when and where its advisory committees meet and members of the public are welcome to observe most of the meetings, other than items of a confidential or commercial nature.

The following Chart outlines the Taranaki DHB Governance Structure:



Te Whare Punanga Korero:

The members of this Trust represent the eight Iwi of Taranaki. A Memorandum of Understanding between Taranaki DHB and Te Whare Punanga Korero enables Māori to contribute to decision-making and participate in the delivery of health and disability services with a view to improving health outcomes for Māori. Te Whare Punanga Korero interacts with the DHB and the wider sector through various Taranaki DHB, NGO and Iwi Māori forums to advance its purposes. Some of these interactions include:

- Regular meetings with the Taranaki DHB Board Chair and other members, as well as DHB officials to discuss, monitor and develop responses to Māori health needs.
- Participation in Taranaki DHB's strategic planning and governance training agendas.
- Participation in a range of project based steering group activities where projects impact significantly on Māori.

- Participation in Māori health collective strategic planning for Māori health gain.

An important role of Te Whare Punanga Korero is to work with Taranaki DHB in achieving the objectives of the Māori Health Plan and the Māori Health objectives of the Annual Plan and Statement of Intent.

Details of the meetings are publicly available on our website: <http://www.tdhub.org.nz>

3.5.2 Providing Health and Disability Services

As well as being responsible for planning and funding the health and disability services that will be delivered in the Taranaki region, we also provide a significant share of those services as the ‘owner’ of hospital and specialist services. These services are provided through our Provider Arm Division from two key facilities being New Plymouth and Hawera Hospitals, supported by various clinics and facilities across the province.

Hospital services comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with ‘facilities’ classified as hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together.

They include:

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

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

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

There are a total of 237 beds at New Plymouth Base Hospital, including the Special Care Baby Unit, Maternity and Mental Health. Of these, approximately 153 in-patient beds are available for medical and surgical patients (including critical care and coronary care) and 10 for day stays (surgical/medical), with a further 22 for children and older people. 27 beds are designated for mental health patients. There are 26 beds available for maternity, including 8 for the special care baby unit.

Taranaki DHB is currently undergoing facility redevelopment (Project Maunga) to better enable the DHB to provide health services to match population demand and expectations.

The primary focus of this project is to generate efficiencies and improvements to prevalent models of care through consolidation of hospital services and systems into a more compact footprint, which will lend more flexibility and efficiency to operations both in the immediate and long term. In doing so, it will also provide a more user friendly hospital and wellness environment to patients, staff and public.

Taranaki DHB will ensure that both Hospitals provide the amount of elective operations, procedures and assessments agreed to with the Ministry of Health. We will review the key operations we perform to ensure we are delivering the right level of service for the people in our region. We will demonstrate innovative strategies, or alternative delivery options aimed at increasing elective capacity, including initiatives across the primary/secondary interface.

3.5.3 Planning and Funding Health and Disability Services

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

- Assessing our population's current and future health needs.
- Determining the best mix and range of services to be purchased.
- Building partnerships with service providers, Government agencies and other DHBs.
- Engaging with our stakeholders and community through participatory consultation.
- Leading the development of new service plans and strategies in health priority areas.
- Prioritising and implementing national health and disability policies and strategies in relation to local need.
- Undertaking and managing contractual agreements with service providers.
- Monitoring, auditing and evaluating service delivery.

While the Planning and Funding Division contracts services from our own Provider Arm, they also contract services from a wide range of Non-Government Organisations (NGO), as well as other DHBs who often provide more specialist services.

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

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

3.5.4 Ownership of Crown Assets

Taranaki DHB is a Crown Entity with ownership of:

- Taranaki Base Hospital delivering a full range of secondary services. These are New Zealand Role Delineation Model Level 4 for Emergency Medicine, General Medicine, Maternity and Neonates, Paediatrics, Health of Older Persons and Specialist Rehabilitation; and Level 3 for Oncology and Haematology, and Surgical Services.

- Hawera Hospital delivering New Zealand Role Delineation Model Level 2 services in Emergency Medicine, Medicine, Surgery, Maternity and Older Adult Services; and Level 1 Paediatrics.
- Mental Health and Addiction Services with acute inpatient facilities and community facilities in New Plymouth.
- Public Health Unit providing a range of Health Promotion, Health Protection and Medical Officer of Health services in New Plymouth.
- HIQ – a wholly-owned subsidiary delivering operational and strategic information systems support to the DHB.
- Allied Laundry Services Ltd – ownership shared with Hawke’s Bay, MidCentral, and Whanganui DHBs for the provision of laundry and linen services.
- Fulford Radiology Services Ltd – joint ownership with Taranaki Radiologists Ltd, providing a comprehensive range of imaging services to the district.
- HealthShare – ownership shared with Bay of Plenty, Lakes, Tairāwhiti, and Waikato DHBs for the provision of routine and issues-based quality audit of service providers.
- Health Centres at Patea, Mokau, Opunake, Stratford and Waitara, delivering community and outpatient services.

3.6 Reporting and Consultation

3.6.1 Consultation with the Minister and the Ministry of Health

Implementing health policy is complex and challenging, with a multitude of difficult decisions to be made. There is considerable public pressure to expand public spending on new medical technologies and greater levels of care and interventions.

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

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

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

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

3.6.2 External Reporting

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

Table: External Reporting Framework

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

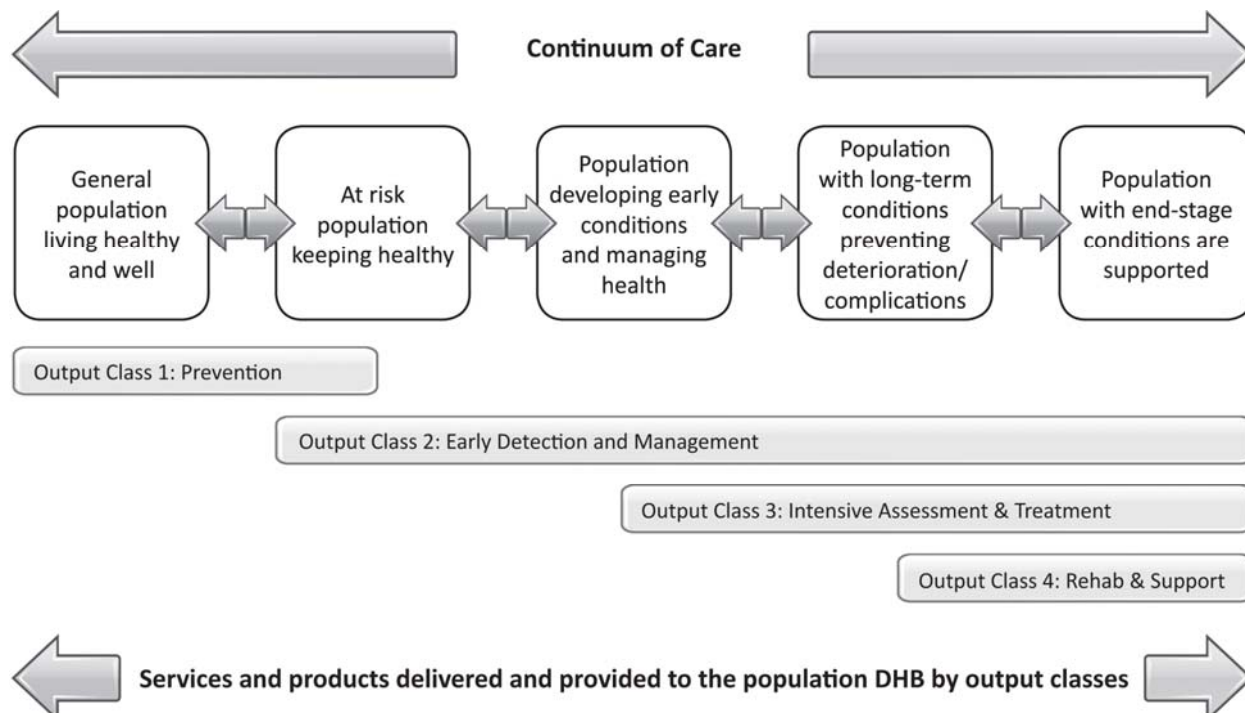
4.0 STATEMENT OF FORECAST SERVICE PERFORMANCE

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Forecast Service Performance 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 2012/13. 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 section 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.

4.1 Output Classes

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



4.1.1 Output Class Definitions

Each output class is comprised of several categories defining more specifically the services which the output class relates to. The table below provides a brief description of each output class and category.

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

		5	Well Child Services <i>These services are aimed at our most vulnerable group – our children. Services and programmes targeted towards our children today will significantly impact upon our adult population of tomorrow. Success is measured by (a) a comprehensive range of services, including immunisation, assessment of children before they start school and (b) services provided to a broad range of children, including a focus on Māori and those children of high deprivation, to reduce health disparities.</i>
2	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, including general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule), child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.	6	Primary Healthcare and GP Services <i>These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at delivering Better, Sooner and More Convenient services and improving, maintaining or restoring our population's health. Success is measured by high levels of enrolment with our PHOs (Primary Health Organisations) as it indicates engagement, accessibility and responsiveness of primary healthcare services.</i>
		7	Oral Health Services <i>These services are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. While high levels of enrolment, timely access and treatment are important, ultimately success is measured by results – children who are caries-free, and reducing the number of decayed, missing or filled teeth.</i>
		8	Primary Community Care Programmes <i>These services are offered in local community settings by teams of healthcare professionals (other than general practitioners (GPs), registered nurses, nurse practitioners) aimed at delivering Better, Sooner and More Convenient services and improving, maintaining or restoring our population's health. Success is measured by rates of participation.</i>
		9	Pharmacy Services <i>These services include the provision and dispensing of medicines and are demand-driven, i.e. by patients and prescribers (nurse specialists, GPs and specialists). As long term conditions become more prevalent, we are likely to see an increased dispensing of</i>

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

<p>nursing and day services across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services</p> <ul style="list-style-type: none"> ▪ Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services ▪ Emergency Department services including triage, diagnostic, therapeutic and disposition services <p>On a continuum of care these services are at the complex end of treatment services and focused on individuals, rather than groups.</p>		<p>Success is measured by (a) timely services; (b) services that are provided in an effective and efficient way and (c) that we make the best use of our resources.³⁰</p>
	14	<p>Acute (Emergency Department/Inpatient/Outpatient) Services</p> <p><i>These are services that have an abrupt onset, are often short in duration and rapidly progressive, for which the need for care is urgent. They may lead to a hospital admission. Hospital-based services include Emergency Departments (ED), short-stay acute assessments and intensive care services. Success is measured by (a) timeliness (waiting times), (b) productivity (length of stay), (c) outcome measures such as readmission rates, to indicate quality of service provision, and (d) managing demand by either maintaining or reducing the number of ED presentations, which is indicative of a strong primary/secondary integration.</i></p>
	15	<p>Maternity Services</p> <p><i>These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in the home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include specialist obstetric, lactation, anaesthetic, paediatric and radiology services. Success is measured by (a) ensuring that our proportion of caesarian deliveries³¹ is consistent with the national average; and (b) that we maintain our post natal length of stay (days).</i></p>
	16	<p>Assessment Treatment and Rehabilitation</p> <p><i>These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to GPs, home and community care providers, aged residential care (ARC) facilities and voluntary groups. Success is measured by an increase in the rate of people discharged home with support, rather than to ARC or hospital environments (where appropriate).</i></p>

³⁰ While the OAG has indicated a preference for patient satisfaction survey results to be included as a qualitative measure, the Midland DHBs have elected not to include them because there are some questions regarding the reliability and validity of data, and the requirement to implement them nationally has been discontinued. See the NZ Medical Journal, 7 August 2009, Vol 122 No 1300.

³¹ While some caesarians are necessary on either an arranged or acute basis, overall we want to see as many babies delivered with no surgical intervention as possible, particularly as surgery introduces an element of risk to either the mother or her baby.

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

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

4.1.2 Output Class Funding Allocation

The following table outlines the funding and expenditure associated with the allocation of the output classes described above.

Output Class	Planned Revenue (\$000s)	Planned Expenditure (\$000s)
Prevention	9,336	9,257
Early Detection and Management	79,279	78,614
Intensive Assessment and Treatment Services	185,369	183,813
Rehabilitation and Support	49,821	49,403
TOTAL	323,805	321,087

4.2 Impacts

Over the next three years, we will fund and provide outputs (goods and services) which will make a positive impact on the health and wellbeing of our population. We have presented the output performance measures and targets in this section by long term impacts and intermediate impacts.

5-10 Year Outcomes	People take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate care
3-5 Year Impacts	<ul style="list-style-type: none"> Fewer people smoke Reduction in vaccine preventable diseases People have healthier diets 	<ul style="list-style-type: none"> Children and adolescents have better oral health Early detection of treatable conditions People are better at managing their long term conditions Fewer people are admitted to hospital for avoidable conditions People maintain functional independence 	<ul style="list-style-type: none"> People are seen promptly for acute care People have appropriate access to elective services Improved health status for people with a severe mental illness More people with end stage conditions are supported

For more details on each impact, please refer to Section 2.

4.3 Guide to Understanding Statement of Forecast Service Performance:

The following definitions are included to aid understanding of the rest of this section.

Quantity – measures that are purely quantitative in nature help establish baselines and provide useful comparisons.

Timeliness – we have included measures that demonstrate delivering services in a more timely way, consistent with the Better, Sooner, More Convenient philosophy, and recognising that providing

health services sooner (e.g. “*within 28 days*”) or regularly (e.g. “*every three years*”), is more likely to eliminate or reduce either the onset or impact of conditions. Another dimension to timeliness is represented by our desire to improve health outcomes at certain life stages, for example “*at age two*” or “*12-18*”.

Quality – where possible, we have included measures that are qualitative in nature. For example, increasing the percentage of the population who receive a particular service, targeting a service towards a particular population group (e.g. by age, ethnicity or deprivation) to reduce health disparities, or focusing on outcomes-based measures, rather than outputs.

Baseline – *this* represents the latest available data for comparison. Unless stated otherwise, the baseline will be 2010/11 data.

Target 2012/13 – this represents our goal for 2012/13. Where we are able to identify ethnicity or high needs the targets have been set to reflect the need to reduce inequalities.

Average – We have included the current regional or national average where available.

Please note that:

- There are measures which can contribute to one or more impacts for example Average Inpatient Length of Stay has been included in the ‘People are seen promptly for acute care’ but will also relate to ‘People have appropriate access to elective services’.
- Wherever possible, we have listed outputs based on the Māori and Total population to focus greater attention on reducing health inequalities for Māori.³²
- Some measures have been adopted regionally.

³² TDHB is not a DHB identified by the Ministry as having a statistically significant Pacific Island population. Based on the 2011 November population projection update for the 2011/12 financial year, DHBs where the Pacific proportion of their total population is greater than 5% are Auckland (11%), Counties (22%), Waitemata (7%), Capital Coast (7%) and Hutt (8%). No other DHB has a proportion greater than 3%.

4.4 Outcome: People to take greater responsibility for their health

Impact: Fewer people smoke:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Providing Smokers with Smoking Cessation advice and support – see also Sections 2 and 3 (<i>Health Targets</i>)	1							
Hospitalised smokers		1	✓			83%	95%	88%
<ul style="list-style-type: none"> Total Population Māori 		1	✓			84%	95%	88%
Primary care ³³	1	1, 2	✓			30%	90%	N/A
<ul style="list-style-type: none"> Total Population High needs 						28%	90%	
An increase in the number of health professionals trained in Smoking Cessation support;	1	1	✓					
<ul style="list-style-type: none"> Secondary Primary 						30	>30	N/A
						42	>42	
Number of tobacco controlled purchase operations (CPOs) ³⁴	1	2	✓			2	2	N/A
No. of referrals our DHB has made to Quitline	1	1	✓			265	>265	N/A

³³ As at Quarter 1, 2011/12.

³⁴ Controlled Purchase Operations are undertaken by Health Protection team in the Public Health units. Underage ‘mystery’ customers attempt to purchase tobacco products from a number of retailers during each operation.

Impact: Reduction in vaccine preventable diseases:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Children are fully immunised at eight months – see <i>Health Targets</i> ³⁵ and <i>Section 3</i> <ul style="list-style-type: none"> Total Population Māori 	1	4, 5	√	√		New Measure	85% 85%	NA
Number of people who decline child immunisations at eight months	1	1, 4, 5	√		√	New Measure	≤5%	NA
Percentage of the population (>65 years) who receive the seasonal influenza immunisation ³⁶ <ul style="list-style-type: none"> Total Population Māori 	1	4	√			68.4% 60.15%	70% 70%	65.5%
Percentage of eligible young women (year 8) who have received dose 3 of the HPV vaccination in the academic year <ul style="list-style-type: none"> Total Population Māori 	1	4	√	√		47% 54%	60% 60%	44% 52%

³⁵ Based on the Quarter 1 2011/12 results – see Section 3.

³⁶ Baseline data is from December 2011 PHO Performance Programme results. The volume target is significant, as we are seeing an increase in the percentage of our population aged 65+. See also the Māori Health Plan (MHP) on TDHB website.

Impact: People have healthier diets:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Number of schools engaged in the Health Promoting Schools programme;	1	1	√			17	17	N/A
Percentage of schools in the district who participate in the Health Promoting Schools programme	1	1	√			25%	25%	N/A
Percentage of decile 1 and 2 schools participating in the Health Promoting Schools programme	1	1	√			91%	91%	N/A
Increasing the number of infants who are exclusively breastfed (SI7) at : <i>6 weeks</i> <ul style="list-style-type: none"> • Māori • Total Population <i>3 months</i> <ul style="list-style-type: none"> • Māori • Total Population <i>6 months</i> <ul style="list-style-type: none"> • Māori • Total Population 	1	1, 5	√	√		60% 70%	74% 74%	N/A
Our hospital facilities maintain their Baby Friendly Hospital Initiative accreditation ³⁷	1	1,5			√	Accredited	Remain Accredited	N/A

³⁷ The Baby Friendly Hospital Initiative is a global campaign of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The goal is to increase breastfeeding initiation and duration rates by protecting, promoting and supporting breastfeeding.

4.5 Outcome: People stay well in their homes and communities

Impact: Children and Adolescents have better oral health:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline (2010)	Target 2012/13	Average (2010)
Percentage of Children (0-4) enrolled in DHB funded dental service (PP13)	3	7	√			75%	82% - 2012 85% - 2013	58%
A reduction in the inequalities gap between the percentage of Māori and other ethnicity 0-4 year olds enrolled with DHB funded dental service	3	7	√	√		30%	<30%	35%
Percentage of enrolled pre-school and primary school children overdue for their scheduled dental examination (PP13)	3	7		√	√	3%	3% - 2012 3% - 2013	12%
Percentage of adolescent utilisation of DHB funded dental services (PP12)	3	7	√			71%	85% - 2012 85% - 2012	68%

Impact: Treatable conditions are detected early and people are better at managing their long term-conditions:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Percentage of population enrolled with a PHO ³⁸ <ul style="list-style-type: none"> Total Population Māori 	2	6	√			96% 84%	96% 96%	96% 86%
Percentage of eligible population who have their CVD check completed within the last 5 years (HT) <ul style="list-style-type: none"> Total Māori 	2	6	√	√		70% 57%	75% 75%	39% 42%
Percentage of diabetic reviews completed against the population expected to have been diagnosed with diabetes (PP20) <ul style="list-style-type: none"> Total High Needs 	2	6	√			90% 92%	95% 95%	68% 77%
Number of eligible women (25-69) have a cervical cancer screen every three years ³⁹ <ul style="list-style-type: none"> Total Population Māori 	1	1, 3	√			22,649 2,530	22,900 2,670	N/A N/A
Number of eligible women (50-69) have a breast screen examination every two years <ul style="list-style-type: none"> Total Population Māori 	1	1, 3	√			9,486 660	9,506 708	N/A N/A

³⁸ Access to primary care has been shown to have positive benefits in maintaining good health, including early detection and managing long term conditions. It also reduces the economic cost of ill health and is key in reducing disparities in health.

³⁹ The programme continues to be for 20-69 years olds but the MOH reporting will change reporting to 25-69 years olds. Baseline data from Dec 2011

Impact: Fewer people are admitted to hospital for avoidable conditions:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Percentage of eligible population have their Before School Checks completed ⁴⁰ <ul style="list-style-type: none"> Total Population High Needs 	1	3	√			87% 83%	80% 80%	72% 75%
Percentage of children engaged in the Well Child/Tamariki Ora Programme ⁴¹	1	2	√			New Measure	80%	N/A
Percentage of Rest Home residents receiving vitamin D supplement from their GP ⁴²	2	1	√			50%	75%	60%
Percentage of all Emergency Department presentation who are triaged at level 4 or 5 ⁴³	3	14	√	√		57%	55%	N/A

⁴⁰ Before School checks is a nationwide programme offering a free health and development check for four year olds. It aims to identify and address any health, behavioural, social or developmental concerns which could affect a child's ability to get the most benefit from school. Health checks include vision hearing and oral.

⁴¹ The Well Child programme is a free service which runs from six weeks after birth to entry into school. It establishes strong foundations for a child's on-going health and development. MoH has established a data collection process in 2011-12.

⁴² Vitamin D strengthens bones and reduces the negative impact of falls. While we would prefer to include data for the at risk population (ie over 75 years) we can only access data for rest home residents.

⁴³ The Emergency Department services in New Zealand utilises a scale of 1-5 triages, with 1 being the most urgent. Triage 4 and 5 may be more appropriately seen in the primary sector.

Impact: People maintain functional independence

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
For those with aged related and chronic health conditions we aim to reduce the rate of residential care to home based support funding	4	20,21	√			1 : 2.29	1:2.28	N/A
Increase in the number of clients utilising Residential Respite Bed Days	4	23	√			11	22	N/A
Percentage of older people receiving long term home support who have had comprehensive clinical assessment and a completed care plan in the last twelve months. (PP18)	4	17,21	√	√		New Measure	95%	N/A
Increased number of in-home respite for clients with dementia	4	23	√			New Measure	12	N/A
Number of people accessing intermediate care beds <Local TDHB>	4,19	16,19	√			New Measure	32	N/A
Percentage of people accessing Primary Mental Health Initiative <ul style="list-style-type: none"> Adults Youth 	2	11	√			80% 20%	<80% >20%	N/A
Percentage of people who access Primary Mental Health Initiative who are Māori <ul style="list-style-type: none"> Adults Youth 	2	11	√			15% 50%	>15% >50%	N/A

4.6 Outcome: People Receive Timely and Appropriate Specialist Care

Impact: People are seen promptly for acute care:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Number of acute inpatient presentations	3	14	√			13,247	13,247	N/A
Percentage of Emergency Department presentations that are admitted	3	14	√	√		27%	25%	N/A
Acute admission rate (OS8)	3	14	√		√	11.5	10.1	10.1
The rate of Hospital Acquired Bloodstream Infections	3	13,14,15,16			√	0.32	0.30	N/A
Inpatient average length of stay reduced – bed days(OS3)	3	13,14	√	√		4.01	4.01	4.02
Radiation Oncology and Chemotherapy wait times are within 4 weeks of being ready for treatment. (HT)	3	13		√		100% (6 Weeks)	100% (4 weeks)	

Impact: People have appropriate access to elective services:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Number of first specialist assessments (Elective report)	3	13	✓			11,295	10,548	N/A
Number of elective discharges (Electives report) ⁴⁴ <ul style="list-style-type: none"> Total Cardiology Cardiothoracic Orthopedics Ophthalmology 	3	13	✓			5,185 ⁴⁵ 439 36 555 667	4,892 323 50 569 630	N/A
ESPIs (Elective Services Performance Indicators) <ul style="list-style-type: none"> ESPI 1 – timely processing of referrals ESPI 2 - % of patients waiting 5 months for their FSA ESPI 3 – patients waiting without a commitment to treatment ESPI6 - patients in active review who have not received assessment within 6 months 	3	13	✓	✓		97% 3.1% (6 months) 0% 4.5%	100% 0% (5 months) <5% <15%	N/A
Elective and arranged Day of Surgery rate is achieved (OS7)	3	13	✓			83%	95%	81%
Elective and arranged Day Surgery rate is achieved (OS6)	3	13	✓			54.2%	59.6%	56.5%
Theatre Utilisation percentage is maintained at agreed optimum level (OS5)	3	13	✓			77%	85%	N/A

⁴⁴ This represents the total electives initiative which includes surgical discharges and medical discharges (Cardiology and Inpatient Dental services)

⁴⁵ These baseline volumes represent over-delivery against last year's targets. This addressed a back-log of patients required to achieve the Minister's expectation that no-one should wait greater than six months by 30 June 2012.

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Did-not Attend rate for outpatient services <ul style="list-style-type: none"> Total Population Māori 	3	13	√			11% 22%	<11% <11%	N/A
Total number of funded maternity deliveries in the DHB region <ul style="list-style-type: none"> Secondary Primary Total 	2,3	6,15	√			1,284 185 1,469	1,284 185 1,469	N/A
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total births	3	15	√	√		21%	<21%	N/A

Impact: Improved health status for people with severe mental illness and addictions:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
People referred for non-urgent mental health services are seen within eight weeks – Provider Arm(PP8)	3	12		√		New Measure	80%	N/A
People referred for non-urgent addiction services are seen within eight weeks – Provider Arm and NGO (PP8)	3	12		√		New Measure	78%	N/A
A referral of a young person (0-19) is seen by alcohol or other drug health professional within 3 weeks – Provider Arm and NGO (PP8)	3	12		√		New Measure	55%	N/A
Improving the percentage of long-term adult clients (20 year old +) with up to date relapse prevention/treatment plans (PP7) <ul style="list-style-type: none"> Māori Non-Māori 	3	12	√			94% 98%	95% 95%	N/A

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Improving the percentage of long-term child clients with up to date relapse prevention/treatment plans (PP7) <ul style="list-style-type: none"> Total Māori 	3	12	√			100% 100%	95% 95%	N/A
Acute inpatient (HoNOS) ⁴⁶ effect size – Significant improvement (KPI1)	3	12			√	47%	>47%	N/A
Average length of acute inpatient stays (KPI8)	3	12	√	√		15 days	14-21 days	N/A
Pates of post discharge community care (KPI18)	2,3	11,12	√	√		67%	80%	N/A
Percentage of Mental health and addiction funding allocated to Primary versus Secondary providers <Local TDHB>	2,3	11,12	√			30.9%	31.3%	N/A

Impact: People with end stage conditions are supported:

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Number of specialist palliative clients supported by our DHB Hospice	4	18	√			456	456	NA
The percentage of non-cancer versus cancer specialist palliative clients supported by our DHB	4	18	√			68% Cancer 32% non-cancer	68% Cancer 32% non-cancer	NA

⁴⁶ HoNOS: Health of the Nation Outcome Scale: Measures behaviour, impairment, symptoms and social functioning with the Mental Health Services. 'Significant improvement' is the count of compliant referral closures that have had a reduction in HoNOS score from admission to discharge of six points or more.

4.7 Support Services

We also fund and deliver services which contribute towards a range of the impacts above

Outputs	Output Class	Output Class Category	Quantity	Timeliness	Quality	Baseline	Target 2012/13	Average
Total number of pharmaceutical items dispensed in the community	2	9	√			1,875,407	1,875,407	N/A
Total number of community referred radiology RVUs	2	10	√			40,762	40,762	N/A
Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes; Category 1 within 24 hours ⁴⁷ Category 2 within 96 hours Category 3 within 72 hours	2	10	√				⁴⁸	N/A
						95%	90%	
						95%	90%	
						90%	90%	

⁴⁷ Category 1: Automated tests (90% non-urgent tests completed and communicated to practitioners within 24 hours)

Tests CBC, Creatinine, Electrolytes, LFT, Lipids, INR, TSH, Glucose, CRP, Ferritin, B12/Folate, PSA, Iron Studies, U. Microalbumin

Category 2: Microbiology tests (90% non-urgent tests completed and communicated to practitioners within 96 hours)

Tests Urinalysis, Swabs, Faeces, Sputum

Category 3: Histology tests (90% non-urgent tests completed and communicated to practitioners within 72 hours)

Tests: Biopsies

⁴⁸ 90% is the contractual performance expectation for our community laboratory provider. They have surpassed the contractual performance in the baseline period Jan – Dec 2011

5.0 CONSOLIDATED FINANCIAL SUMMARY: 2012-15

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)	2010/11 audited	Year 0 2011/12 Forecast	Year 1 2012/13 plan	Year 2 2013/14 plan	Year 3 2014/15 plan
Hospital Provider + Governance Funding (including other income)	168,465	170,466	172,807	176,923	181,445
Non Hospital Provider Funding (NGO)	143,279	147,927	150,998	155,272	159,549
TOTAL FUNDING	311,744	318,393	323,805	332,195	340,994
Hospital Provider + Governance Operating Expenses	175,716	178,366	179,089	186,823	188,445
Payments to Non Hospital Providers (NGO)	134,529	139,927	141,998	147,772	153,049
TOTAL OPERATING EXPENSES & PAYMENTS	310,245	318,293	321,087	334,595	341,494
Hospital Provider + Governance Operating Deficit	-7,251	-7,900	-6,282	-9,900	-7,000
TDHB Funder surplus	8,750	8,000	9,000	7,500	6,500
CONSOLIDATED FINANCIAL RESULT	1,499	100	2,718	-2,400	-500

The net consolidated financial projection for the planning period 2012-15 is:

- 2012-13: Surplus \$ 2.72M
- 2013-14: Deficit \$ 2.40M
- 2014-15: Deficit \$ 0.50M

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

5.1 Key Points from the Budgeted Financials 2012-15

- The Board has planned for a consolidated financial surplus in Year 1 followed by reducing financial deficits in Year 2 & 3.
- These financial projections reflect a common trend across the entire planning period 2012-15, clearly indicating that cost growth in the hospital provider operations is significantly in excess of funding received, leaving residual operating deficits. The relatively better consolidated financial result is solely on account of the surpluses generated in the Funder operations during each of the fiscal periods under consideration.

- Stage 1 of the hospital redevelopment programme (Project Maunga) has commenced in August 2013 and is scheduled for completion in December 2013, with the Acute Services Block housing theatres and patient wards planned for occupation in July 2013.
- Year 2 & 3 (and future periods) will carry additional costs incidental to the hospital redevelopment. These additional costs per annum are interest on new loans (\$ 1.80M), additional depreciation charges (\$ 2.50M) and loss of interest income on deposits (\$ 1.20M) . Total new costs: \$ 5.50M.
- The hospital provider budget for Year 1 (2012-13) assumes \$ 2.00M in savings to be generated from cost reduction and efficiency initiatives. These savings are primarily in workforce management (Project Whakapai) (\$ 0.50M), service reconfigurations (\$ 1.00M) and gains from ongoing projects (\$ 0.50M). The 2 years following also assume \$ 2.00 per annum savings. (Please refer to the “Cost & efficiency initiatives” section for details).
- Likewise, the DHB Funder operations is planning to reprioritise funding and drive initiatives to enable the DHB Funder operations to manage its costs down and deliver the operating surplus planned for 2012/13 and years following.
- It is not practical to estimate with confidence the likely costs and benefits to this DHB from Health Benefit Limited (HBL) driven business cases as these are in its review stages, and require validation and additional information. No savings have been assumed from HBL initiatives and projects. Indicative business cases developed by HBL show net costs likely to be incurred by DHBs in the initial years of implementation (Year 1 & 2) , with benefits to arise only in later years (Year 3 onwards). Due to the likelihood of these costs undergoing changes and lack of clarity between capital and operating expenditure it has been assumed that any costs arising during the plan period will have to be met from other areas. Savings through reduced pricing from collective procurement projects have been factored into clinical supply and consumable costs over the plan period.
- Likewise, additional costs are likely to arise from implementation of plans for regionalisation of services and back office functions, including Information Services. It is expected that there will be new costs and investment required in the short term to generate benefits over the longer term. It is assumed that these costs will be captured as and when incurred and managed within a contingency amount set aside in the plan (\$ 0.20M). The operating budget is severely constrained to absorb more costs – either from HBL or regional initiatives.
- The Hospital Provider Arm is facing a significant budgetary cost to funding gap resulting in operating deficits in each year covered by this plan. This financial gap could increase to \$8.28M in 2012/13 if other identified risks and associated costs (estimated at \$2.00M) were to materialise fully. With the residual risk estimated at \$1.30M, the resultant financial gap could be in the region of \$7.58M. Likewise, the DHB Funder is also faced with an overall exposure in its operations estimated at around \$5.40M for 2012/13, with a probability factor leaving a residual risk equating to about \$3.20M. This is in addition to the financial risks carried by the Hospital Services operations. (Please refer the “Sensitivity Analysis” section for details).
- The Board recognises that the operating cost to funding gap in the Hospital Provider operations will need to be addressed through options that could result in significant changes to models of care, service configurations and re-alignment of services within funding available. It acknowledges these changes are essential if the Hospital Services arm is to remain financially viable when faced with increased costs on several fronts.
- In context of increasing cost structures and continuing operating deficits, it is to be noted that Taranaki DHB has embarked on a staged redevelopment of the Base Hospital inpatient facilities. There are several compelling reasons to undertake the redevelopment, but none more compelling than the fact that the current hospital layout and structures are not conducive for delivery of complex clinical pathways and modern models of care. Consolidation of specialist services and improved models of care and pathways will result in more efficient use of clinical resources and thereby reduction in core operating costs. The redevelopment will pave the way for a recovery plan for Hospital Services to align itself more efficiently – both clinically and financially. The impact will be evident post redevelopment of the Base Hospital facilities, and will partially negate the costs associated with the hospital redevelopment.

In the final analysis, the Board is faced with:

1. A continuing deficit in the Hospital Provider operations in each of the plan years.
2. Additional financial exposure in its expense budgets which could materialise in part or full.
3. The need to make radical changes and re-align service configurations in its hospital service operations to reduce the current deficit.
4. The financial recovery for its Hospital Provider operations being largely dependent on cost reductions incidental to services rationalisation and work force management for the current plan period, and efficiencies arising from the redevelopment of the hospital facilities in the years following.
5. Its Funder operations having to significantly reduce investment in additional services during the period the hospital operation is going through this transition.

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

5.2 Key Financial Risks

5.2.1 Taranaki DHB's Funder Operations

1. The 2012/13 Funding Envelope indicates an increase of \$8.51 million over the 2011/12 Funding Package start point. The increase includes \$4.3 million demographics and \$4.2 million as a contribution to cost pressures. Whilst this increase is welcome, it is not as great as the general funding and expenditure pressures being experienced by the DHB.
2. The Government has made no decision on funding for 2013/14 and 2014/15. Taranaki DHB has therefore prepared the Statement of Intent on the assumption that funding increases for cost growth in out years will be of the same nominal value as 2012/13.
3. Taranaki DHB's share of population based funding for 2012/13 remains virtually unchanged at 2.74% with a forecast reduction to 2.73% in 2012/13, reflecting the slower population growth of Taranaki in comparison to other parts of the country.
4. The Funding Envelope advice indicates that there may be some further additional funding made available to DHBs from non-devolved funding held by the Ministry of Health for 2012/13. Further advice on devolution of funding is awaited. However, it is assumed that any funding would already be committed to contracts currently held by the Ministry and which would be transferred to DHBs.
5. General hospital and specialist services delivered by the DHB's own Provider Arm are purchased through the Internal Services Level Agreement between the Funder and Provider Arms. The Provider Arm is being paid in a composite of National IDF prices and local prices acknowledging affordability and capacity issues. Mental health services delivered by the DHB Provider Arm are funded by a local price mechanism. Significant reconfiguration of the DHB hospital and specialist services is planned over the next three years to bring the cost of service delivery closer to the funding available.
6. In order to maintain a consolidated breakeven position the Funder is required to achieve significant surpluses over the next three years to offset planned deficits in the Provider Arm whilst it is undergoing service reconfiguration to a lower cost base. In 2012/13 the planned Funder surplus is \$9.00 million, reducing to \$7.50 million in 2013/14 and \$6.50 million in 2014/15 (after strategic expenditure). Delivery of these surpluses will present a significant challenge for the Funder.

7. The absence of a risk reserve will severely limit the Funder's ability to fund transition costs of new models of care and respond to unexpected demands in year.
8. In order to deliver a net \$9.00 million surplus the Funder plans to deliver further service configuration. These changes are transformational in nature and it is believed will deliver better services for less cost.
9. In addition the implementation of InterRAI and consequent standardised assessment for rest home entry is also expected to deliver a reduction in the number of people entering rest homes and a reduction in expenditure growth in this area.

5.2.2 Taranaki DHB's Hospital Provider Operations

1. The funding for cost growth in 2012/13 is 1.49%. However, the real cost growth in hospital provider services is well in excess of this adjustor. The year on year cost movements across several expenditure lines are on an average between 3% and 5%. This gap between funding and real cost growth has resulted in a budgetary deficit of \$6.28M after considering all current efficiencies and cost savings. This growth is particularly evident in the following:
 - a. Wages
 - b. Clinical staff – primarily nursing
 - c. Outsourced clinical staff – primarily locum doctors and psychiatrists
 - d. Diagnostics – primarily radiology
 - e. Blood costs, pharmaceuticals, air ambulance retrieval costs
 - f. Acute services such as renal, intensive care, mental health inpatient services, emergency services
 - g. Increasing cost impacts of statutory compliances, financial standards, quality and accreditation deficits and adherence to a number of legislative requirements
 - h. General overhead costs – primarily utilities, travel, transport, legal, professional services, communication costs etc.
 - i. Information and communication technology (ICT) capital investment and operating costs.
 - j. Start-up costs and investment in several national and regional initiatives and business cases.

Overall, the Hospital Provider's financial plan for the three year period is highly geared and has no flexibility to accommodate unplanned cost movements. Its operating budget carries financial risks and it is highly dependent on the realisation of targeted savings within planned timelines to meet its 2012/13 and out year financial targets.

The overall impact is a financial exposure close to \$2.00M, with a probability factor leaving \$1.30M as a real and potential risk. (Please refer 'Sensitivity Analysis' section). This is besides the \$ 2.00M savings to be realised from targeted initiatives.

2. In applying the budgetary assumptions we have recognised ongoing quality improvements and those compliance costs of which TDHB has been aware. The financial budget is vulnerable to small movements in costs over stated assumptions or increased costs resulting from unforeseen clinical safety and legislative compliance expectations.
3. The Hospital Services Provider is fully dependent on sustainable revenue streams. With over 90% of its revenue derived from health funding (via DHB Funder and the Ministry of Health), the Hospital Provider has few alternate income streams for significant revenue growth opportunities. In the 2012/13 budget there has been a reduction in ACC revenues (\$ 0.94M) in view of changes in ACC referrals and contracts. Consequently, contributions from ACC work have reduced with corresponding impact on the financial result.

4. In view of the increasing cost pressures, the financial budget for the Provider Arm continues to hinge on a number of efficiency initiatives, which are expected to generate approximately \$2.00M of reduced operating costs during 2012/13. (Please refer to the “Cost & Efficiency initiatives” section for details).

In summary, the gap between funding and the realistic cost model for services has resulted in a very sensitive financial budget for the planning period 2012/13 and out years. In financial terms the budgetary gap in the draft hospital provider budget presented for the period 2012/13 is around \$2.00M. The hospital provider will have to bridge this budgetary gap in an urgent and time sensitive manner through a range of initiatives, rationalisation of services, workforce management, regional co-operations and realisation of gains from ongoing projects. These measures will have to be undertaken in order to exit costs and reduce the deficit in a planned manner to realistic funding levels. From an operational perspective, realisation of the cost reductions contemplated in the hospital services operations could extend beyond a 12 month financial planning framework.

5.3 Key Financial Strategies

- a) The Hospital Provider Arm is faced with an operating deficit of \$6.28M in its 2012/13 plan, which is comparatively lower than the forecast deficit of 7.90M for 2011/12. The Hospital Provider has identified a number of key areas to meet this planned financial result, these being:
 - A targeted reduction of \$4.00M in operating costs (with \$1.00M to be achieved in 2012/13) through service reconfigurations and changed models of care. These strategic changes will span more than a single financial period to be fully implemented, but are the only realistic options to achieve financial sustainability in the hospital services operations. (Focus: service reviews, changes to models of care, community referred diagnostics, relocation of outpatient and procedure services).
 - Workforce management and resource allocation with the aid of software programmes is expected to realise a further \$ 0.50M in cost reductions in 2012/13 (Focus: Project Whakapai).
 - Integration of Health Centre services/facilities with primary care and other providers. (Focus: Health Centres)
 - Selective capital investment in Information Technology aimed at improving work flows and processes, and releasing FTEs. (Focus: Payroll rostering in conjunction with Project Whakapai)
 - Development of regional networks to support effective local service delivery of vulnerable services. (Focus: Midland Clinical Services Plan, regional services collaboration)
 - Effective and robust clinical pathways for after hours care. (Focus: Base Hospital and Hawera Hospital)
 - Focus on chronic disease management, health of older people strategies. (DHB Funder Strategic Plan)
 - Service reviews. (Focus: Allied Health Services, Mental Health services, Renal, Cardiology)
 - Staffing reviews aimed at improving productivity and reduction in core FTEs. (Focus: FTE and vacancy management across all DHB operations in conjunction with Project Whakapai)
 - Implementing processes and procurement initiatives developed by HBL and National collective programmes.

Overall the approach will be to implement a range of practical options including a strategic review of the range of services provided (including relationship with other services), with the primary aim of reducing the overall cost of service delivery whilst maintaining access of core services to the people of Taranaki.

- b) These options will be progressed in conjunction with the redevelopment of the inpatient facilities at the Base Hospital. The facility redevelopment is expected to deliver greater workflow efficiencies and an overall reduction in costs in several areas of its operations. Underpinning this redevelopment is the need to configure the facilities to meet the services profile for the future, increased elective volumes and achieve maximum efficiency and effectiveness of service delivery.
- c) Considering the trends in demand for health services, it is obvious that longer term sustainability, both clinical and financial, will continue to be the key focus for Taranaki DHB and in particular its hospital operations. To achieve this balance, Taranaki DHB has embarked on the development of strategies and processes that involve:
 - Identifying and evaluating service options to match costs with funding
 - Alignment towards a more sustainable clinical services model in line with funding
 - Internal cost controls and closer monitoring of operating budgets
 - Achievement of systems and process improvements, initiatives and efficiency gains
 - Technology driven solutions
 - Sustained focus on longer term strategic plans, whilst continuing to proactively address immediate and medium term risks and issues
- d) Investment and cash outlay for committed strategic initiatives such as Workforce Development, Māori Health Gains and Hospital Provider services projects will continue to be funded below the line using prior period retained surpluses.
- e) Primary sector cost pressures will be mitigated through management of demand driven services, contract delivery and integration of Services with providers, while the secondary service aligns itself.
- f) During the plan period 2012-15, baseline capital expenditure is expected to be contained within annual depreciation provisions, so that additional equity injection or borrowing is not required. The only exception will be funding to support the stages of the hospital redevelopment programme in line with funding approvals.

5.4 Key Financial Assumptions

The following key assumptions have been employed in the preparation of the financial statements for the three-year planning period 2012/15.

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

The financial template for the plan period 2012-15 and comparative years has been prepared in accordance with NZIFRS.

5.4.2 Equity and Borrowing

- a) The Statement of Intent 2012-15 has not assumed any additional Crown equity.
- b) Term borrowing from the Crown Health Financing Agency (CHFA) to fund the first stage of the capital redevelopment programme proposed for the inpatient facilities at the Base Hospital has been included in the Annual Plan 2012-13. Approval for Stage 1 (estimated cost: \$80M) of the redevelopment was received in July 2008, which includes a CHFA funded borrowing of \$45M. The construction has commenced and is scheduled for completion by December 2013, with the inpatient block comprising theatres and wards becoming operational in July 2013.

- c) With the exception of the capital outlay envisaged on inpatient facilities redevelopment as noted above, base line capital expenditure outlay is expected to be contained within the level of depreciation for 2012/13 and the two years following.
- d) Taranaki DHB was moved from “standard monitoring” to “performance watch” status on the performance monitoring scale in July 2010. It was advised that monthly funding will continue to be received in advance, no change to this methodology has been assumed.

5.4.3 Operating Expenditure

- a) Wage costs: in principle, wage budgets for employee groups covered by national MECA settlements are essentially in accordance with the agreement(s) and in line with collective assumptions agreed nationally.
- b) Clinical supplies: average around 0.5% for 2012/13 + estimated on activity levels + reduced for local efficiencies and procurement gains.
- c) General operating expenditure: average 0.5% for 2012/13 + confirmed outflows + reduced for local efficiencies and procurement gains.
- d) Value for Money (VFM) impacts: cost reductions and gains likely to ensue from the collective procurement contracts undertaken by HBL/ National VFM programmes have been recognised in the financial templates. No cost savings have been assumed from the shared services initiatives currently being progressed by HBL (FMSC, FMSS, HRIS etc) since indicative business cases point to upfront capital investment and costs being required in order to gain cost benefits further down the line. Equally, costs related to implementation have not been considered since details are not available. In the absence of definitive timelines and due to budgetary constraints these will have to be managed within existing budgets as and when they occur. Gains from local initiatives and projects have been built into the relevant expense budgets.
- e) Other expenditure reductions: the 2012/13 expense budget assumes efficiencies and cost reductions arising from the following:
 - f) Services rationalisation: \$ 1.00 M (across the 2 hospitals + health centres).
 - g) Project Whakapai (FTE and workflow management) : \$ 0.50 M (implementation of pending recommendations)
 - h) Gains and efficiencies from ongoing projects : \$ 0.50M (theatre, wards, InterRAI rollout, Project Splice)
 - i) The sum total of \$ 2.00M is being identified separately as a credit in the financial template and statements to enable independent tracking and reporting against these initiatives.

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

5.5.1 Mental Health Services

In keeping with the guidelines on treatment of “Mental Health Ring fence surplus” the amount of any under-expenditure carried forward from previous accounting periods has been reported as a surplus in Taranaki DHB’s Statement of Financial Performance in the year the surplus is generated. The ring fenced surpluses as at the beginning of FY 2010/11 have been fully applied to Mental Health Services either in the Hospital Provider or community during 2011/12. Based on expenditure to date and forecasts, there is no surplus likely to remain on 30 June 2012. No surpluses from Mental Health services are envisaged during the 2012-15 plan period and, if any surpluses do eventuate, these will be ring fenced and expended in the year(s) following.

5.5.2 Mental Health Services and Strategic Initiatives Expenditure

Expenditure on strategic projects and initiatives (viz. Workforce Development, Māori Health Gains) is being funded from prior period retained surpluses and is in line with the strategic direction set by Taranaki DHB.

5.5.3 Interest Rates

Interest rates have been assumed along current monetary indicators and commitments and averaged as appropriate over the mix of funding streams and options as follows. Interest on CHFA loans are as per the loan drawdown schedule.

	Overdraft	CHFA Loans (existing)	CHFA Loans (new)	Deposits	Equity
Year 1 (2012/13)	8.00%	6.44%	4.00%	4.00%	8.00%
Year 2 (2013/14)	9.00%	6.44%	4.15%	5.00%	8.00%
Year 3 (2014/15)	10.00%	6.44%	4.15%	6.00%	8.00%

Notes:

1. CHFA total approved facility is \$74M, with \$56.80M expected to be utilised by 30 June 2012, and \$ 74.00M fully drawn down by 30 June 2013 when the acute services block of the hospital redevelopment is completed and becomes operational. This is inclusive of the \$43M new term debt from CHFA approved for Stage 1 of the Base Hospital redevelopment project.
2. TDHB has transactional banking arrangements with ASB bank. Approved overdraft facilities are available on standby basis (uncommitted) with ASB. No financial covenants have been stipulated by ASB for transactional banking and standby overdraft arrangements. The shift to the DHB collective banking & transactional arrangement is expected to be undertaken during the first half of 2013 closer to the completion of the hospital redevelopment project.
3. TDHB currently has short term deposits with Kiwi Bank and ASB Bank, which forms part of the capital funding set aside for the hospital redevelopment project currently in progress.

5.5.4 Asset Revaluation and its Impact

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

No provision has been made in the 2012/13 financials arising from any impacts of asset revaluation on 30 June 2012. It is assumed that there will be no material movements requiring an adjustment to the current asset base. Conversely, should there be a material movement, it is assumed that any related capital charge increase will be funded/base line adjusted in accordance with current Treasury guidelines. The impact of the new hospital redevelopment on current building values has been factored in the recent revaluations (as @ 30 June 2011) and treated appropriately.

5.5.5 Depreciation

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

5.5.6 Capital Charge

Capital charges have been calculated in line with existing methodology, adjusted for monthly movements in operating results and closing balance of shareholders funds. A schedule has been agreed with the Ministry of Health for payment of outstanding capital charge arising from the revaluation of assets. Payments against this schedule have commenced in July 2011.

5.5.7 Leasing

The Annual Plan and Statement of Intent 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.

5.5.8 Financial Covenants and Ratios

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

The following are some key financial ratios as derived from the consolidated financial statements for the period 2012-15.

Financial ratios	TDHB 2011/12	TDHB 2012/13	TDHB 2013/14	TDHB 2014/15
	forecast	plan	plan	plan
1 Revenue to net funds employed	2.39	2.13	2.24	2.32
2 Operating margin to revenue	4%	5%	5%	5%
3 Operating return on net funds employed	9%	11%	11%	11%
4 Interest cover ratio	5.96	9.21	4.41	4.56
5 Debt to debt equity ratio	43%	49%	50%	51%

5.5.9 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 NZIFRS in the financial statements. All policies have been applied on a basis consistent with the previous period.

5.5.10 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 (2012/13)	Year 2 (2013/14)	Year 3 (2014/15)	Total (2012/2015)
Operating				
Clinical Equipment	2,000	2,000	2,000	6,000
Other Equipment	450	450	450	1,350
Motor Vehicles	50	50	50	150
Minor Site Redevelopment (excluding prior year WIP)	500	500	500	1,500
SUB - TOTAL	3,000	3,000	5,000	11,000
Information Technology (100% subsidiary - HIQ Ltd)	4,000	4,000	4,000	12,000
TOTAL	7,000	7,000	7,000	21,000
Strategic				
Community Oral Health Project	-	-	-	-
Base Hospital redevelopment project	45,000	3,000	-	48,000
TOTAL	45,000	3,000	-	48,000
GRAND TOTAL	52,000	10,000	7,000	69,000
Sources of Funding				
Crown Equity	0	0	0	0
Bank Borrowing	0	0	0	0
CHFA Term Loans	17,200	2,000	0	19,200
Internal Cash Accruals	34,800	8,000	7,000	49,800

Note: Capital outlay on Information and Communication Technology (ICT) is in relation to capital investment in HIQ Ltd, which is a 100% subsidiary of TDHB.

5.5.11 Capital Divestment

The disposal of surplus assets proposed during the period 2012-15 is as follows:

Asset	Book value (\$)	Realisable Value (\$)	Gain/(loss) On sale (\$)	Timing
* Miscellaneous equipment (discarded/obsolete)				
* Surplus land	0	Not material	0	2012/15
* Vehicles	0	0	0	n/a
	0	Not Material	0	2012/15
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.

5.5.12 Personnel

a) Paid / Contracted / Core FTEs:

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

CONTRACTED

	Actual 2010-11	Forecast 2011-12	Yr 1 2012-13	Yr 2 2013-14	Yr 3 2014-15
PROVIDER					
Medical Personnel	120	132	143	145	145
Nursing Personnel	552	558	539	545	540
Allied Health Personnel	209	220	222	226	226
Support Personnel	87	89	81	83	83
Management & Administration	226	224	236	236	231
	1,194	1,223	1,221	1,235	1,225
GOVERNANCE	15	17	15	15	15
SUBSIDIARY (HIQ Ltd)	38	40	40	40	42
TOTAL	1,247	1,280	1,276	1,290	1,282

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

- An initiative/project has been underway utilising proprietary workforce allocation and real-time monitoring software to actively manage supplementary staff costs arising from use of casuals, backfills, overtime and locums across the whole of the organisation – code named *Project Whakapai*. The manner in which the workforce is profiled and rostered will initially reflect in increase of core FTE's, but with an overall reduction in the wage bill (\$) – primarily because of reduction in use of casuals, overtime, backfills, leave rosters and other marginal costs that tend to drive wages disproportionate to staff numbers deployed. This is an interactive workforce management tool and has inbuilt levels of authority and decision matrixes with a centralised allocations unit. Project Whakapai went live in October 2010 and is expected to promote a significant change in the traditional methods of workforce allocation and management with resultant slowing down of the annual wage bill and optimised allocation of available workforce.
- Medical FTE count will increase on the assumption that vacancies are likely to be filled over the coming period in lieu of locum cover (with corresponding drop in locum costs). Nursing staff are expected to stabilise over the 3 year plan period due to more efficient management of staffing (Project Whakapai) and reductions likely from services reconfigurations. Movements in Allied Health and support staff are likely to remain steady, whilst Management and Administration staff are also expected to be remain at current levels , with possible reduction in back office and administration staff arising from efficiency reviews and reduction in staff managed through attrition. Reduction of FTEs is a primary goal to reduce operating costs and the deficit, and the service reconfiguration

changes proposed for 2012/13 and the two years following are expected to contain growth in FTEs besides bringing FTE reductions across nursing and related areas arising from closer internal monitoring of FTE movements and deferment of vacancies.

- Taranaki DHB is currently tracking below the Ministerial cap set for Management and Administration staff having made significant reductions over the recent period through internal reviews and restructures, and is expected to remain below the cap over the plan period.
- HIQ Ltd (a fully owned subsidiary of Taranaki DHB) staffing is likely to marginally increase over the plan period, mainly due to national and shared service projects undertaken by HIQ Ltd (for which separate project specific revenue is being received). Likewise, the likely FTE's related to the Community Oral Health Project are likely to follow the growth as noted in line with the rollout of the project across the community.
- In principle, the personnel budget has not planned for FTE increases – rather a phased reduction in FTEs to manage the overall wage bill carried by the DHB. Though there will be movements due to workforce profiling, vacancies, increases in clinical activity and service specifications, reductions planned in other staff lines should result in net decrease in the core FTE base. There will also be likely reductions from changes to services and models of care that are planned for 2012/13 and out years. The overall strategy is to cap and reduce core FTEs; however it is acknowledged that there is likely to be demand for clinical resources due to an expected increase in normal activity levels – both acute and elective. Additionally, as the current year statistics indicate, there has been an increase in specialising patients (one-on-one care) in ICU and Mental Health inpatient admissions. With introduction of management tools such as Project Whakapai, TDHB will continue to aggressively pursue measures and initiatives to increase productivity of existing staff and reduce the demand for locums and casual staff within the hospital and specialist services.

b) Accrued FTEs:

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

ACCRUED

	Actual 2010-11	Forecast 2011-12	Yr 1 2012-13	Yr 2 2013-14	Yr 3 2014-15
PROVIDER					
Medical Personnel	135	146	161	162	162
Nursing Personnel	563	569	550	556	550
Allied Health Personnel	215	226	230	233	233
Support Personnel	90	92	84	87	87
Management & Administration	253	232	245	245	245
	1,238	1,265	1,270	1,283	1,277
GOVERNANCE	16	18	16	16	16
SUBSIDIARY (HIQ Ltd)	40	42	42	42	44
TOTAL	1,294	1,325	1,328	1,341	1,337

5.6 Capital Expenditure 2012/13 (Strategic)

5.6.1 Community Oral Health Project

The capital expenditure related to the rollout of the Community Oral Health Project is being separately funded by the MoH in line with an approved business case. The total capital outlay is \$3.04M to be invested in fixed and mobile dental facilities, and related clinical equipment. Construction of fixed facilities has been completed. Of the total, \$2.85M have been spent by 30 June 2011, and the balance (\$ 0.19M) will be expended by 30 June 2012.

5.6.2 Base Hospital Inpatient Facilities Development Programme (Project Maunga)

The business case for the redevelopment of the Base Hospital inpatient facilities was approved in July 2008. Construction has commenced in August 2011. The Acute Services Block comprising theatres and inpatient wards is expected to be ready for occupation by July 2013, and the project fully completed by December 2013.

The primary focus of this project is to generate efficiencies and improvements to prevalent models of care through consolidation of hospital services and systems into a more compact footprint, which will lend more flexibility and efficiency to operations both in the immediate and long term. In doing so, it will also provide a more user friendly hospital and wellness environment to patients, staff and public.

5.6.3 Proposed Base Hospital Redevelopment Programme and Financial Outlay

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

Stages	Comprising	Estimated Cost	Construction Timeline	Status
1 STAGE 1	Theatres, Ambulatory, Inpatient wards	\$80M	Start: Aug 2011 Finish: Dec 2013	In progress.
2 STAGE 2	Maternity, Neonatal, ED	\$37M	Tentative: July 2017	Supplementary business case to be progressed.
3 STAGE 3	OPD, Laboratory, CSD, Administration	\$28M	Tentative : July 2020	Supplementary business case to be progressed.
TOTAL		\$145M	Aug 2011 – June 2021	

Notes:

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

5.6.4 Financing Plan for Stage 1 (Project Maunga): Commenced Aug 2011 – End Dec 2013

The plan for financing Stage 1 is as follows:

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

1. TDHB has, over recent years, built up cash reserves from its annual operating surpluses. These cash reserves, together with base line depreciation reserves, have enabled it to be an equal partner in this development. The internal investment of \$35M (44% of project capital cost) is a combination of current cash reserves and future free cash flows plus donations from local community trusts and organisations. TDHB is committed and confident of generating the necessary investment by the time the project reaches the active phase. Additionally, TDHB will rationalise its annual base line capital expenditure over the immediate following financial periods with the aim of generating as much cash flow as possible to support the project.
2. TDHB will borrow \$45M in the form of debt financing from CHFA. A loan schedule has been agreed, with the funds to be drawn down in tranches by June 2013.
3. Contingency cash lines are on standby in the form of working capital facilities (uncommitted) with ASB Bank. Whilst it is acknowledged that this line of credit is not permitted for capital purposes, it nonetheless provides backup liquidity should it be required.

Key dates and timelines

Construction has commenced in August 2011. The Acute Services Block housing theatres and wards will be ready for occupation in July 2013. The project will be fully completed by December 2013.

Schedule of capital Intentions

An updated Schedule of Capital Intentions has been submitted.

5.7 Cost and Efficiency Initiatives

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope. In addition, it has to balance its long-term strategies with short-term objectives while continuing to provide a clinically safe and quality service. The DHB will also be faced with managing the redevelopment of its Base Hospital facilities scheduled to be completed by December 2013. Under this capped environment, with increasing operating costs and demand for services, the Hospital Provider Arm will need to achieve sustainability – both clinical and financial. Taranaki DHB recognises the need for continuous service improvements and efficiency gains while it attempts to re-position itself continually to meet the challenge.

The strategy is to continuously progress short term initiatives and service reviews to provide immediate gains, while progressing a series of more strategic changes in conjunction with regional services planning to

achieve longer term sustainability. The latter is needed to rationalise the growth in demand for services and operating costs, besides the need to arrest and reduce the financial deficit.

The following key initiatives are planned during 2012/13 within the Hospital Provider operations to generate efficiency gains and reduce operating costs:

Initiative	Proposal	Potential (\$)	Impact
Services reconfiguration and rationalisation (Cardiology Services, Mental Health, Renal)	Review models of care and services profile.	\$1.0M	Reduce service cost
FTE management + workforce allocation	Project Whakapai – Phase III – Implementation of pending recommendations and continuing improvement	\$0.50M	Contain cost growth + FTE reduction
Realise gains and efficiencies from ongoing projects	Theatre productivity, Inter-Rai, Project Splice , more effective Wards, TPOT, Health Round Table.	\$0.50M	Contain cost growth
TOTAL		\$2.00M	

Faced with a cost to funding gap in its operating budget, the Hospital Provider Arm will continue to explore all practical options with the aim of reducing its overall cost of services delivery, whilst improving productivity and efficiency of operations. This financial recovery plan is an ongoing process, will involve partnering with primary sector providers and is expected to span more than one fiscal year in view of their strategic components and broader implications.

The Statement of Intent has identified the above major initiatives and highlighted the same as cost reduction measures in its financial budget. In the absence of specific information at this stage in the planning process, the amount of \$ 2.00M is identified separately as a credit arising to overall cost structures rather than being built into the operating budgets and expense lines. The gains from these initiatives are also expected to flow into future periods and have been recognised in the out years.

Gains from local initiatives and projects have been built into the relevant expense budgets.

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

5.8 Debt and Equity

The current debt profile of Taranaki DHB is loans totalling \$29M with the Crown Health Financing Agency (CHFA), drawn down against an approved loan limit of \$31M. The primary assumptions carried in the financial plan 2012/13 are:

- a) No overdraft borrowing for working capital requirements is envisaged (though a backup facility with ASB is available if required – financial covenants will be stipulated only upon commitment and utilisation of this facility), on the assumption that TDHB will continue to receive it's funding in advance.
- b) We have not budgeted for any additional equity in 2012/13. It is expected that base line capital expenditure will be contained within the level of depreciation for 2012/13. Additional borrowing of \$ 45M to partially finance the first stage of the Base Hospital redevelopment is being drawn down over the 2011-13 plan periods in tranches as agreed with CHFA.
- c) No additional equity or deficit support is envisaged.

5.9 Sensitivity Analysis: Plan 2012/13

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

DHB Hospital Provider Operations

Unbudgeted financial risk	Est. risk (\$M)	75% risk (\$M)	50% risk (\$M)	25% risk (\$M)	Probability factor (% risk)
FTE + wage budget	0.50	0.38	0.25	0.13	75%
Outsourced locum costs	0.50	0.38	0.25	0.13	75%
Diagnostic costs	0.20	0.15	0.10	0.05	75%
Clinical supplies	0.30	0.22	0.15	0.08	50%
General overheads	0.50	0.38	0.25	0.13	50%
Likely impact on 2012/13 planned financial result	\$2.00M	\$1.50M	\$1.00M	\$0.50M	\$1.30M

The analysis estimates an overall exposure of circa **\$2.00M** for 2012/13, which could arise from a combination of cost drivers as identified above. The overall probability factor is estimated to be around 65% leaving a residual risk equating to about **\$1.30M**. 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
- Achievement of internal efficiency projects and service reviews

DHB Funder Operations

Unbudgeted financial risk	Estimated risk (\$'M)	75% risk (\$'M)	50% risk (\$'M)	25% risk (\$'M)	Probability factor (% risk)
Tertiary IDF	1.00	0.75	0.50	0.25	25%
IDF Inflows/ Outflows	1.50	1.125	0.75	0.375	75%
Pharmacy	1.00	0.75	0.50	0.25	50%
Provider Arm expenditure	1.50	1.13	0.75	0.38	75%
Income in Advance	0.405	0.30	0.20	0.10	50%
Likely impact on 2012/13 planned financial result	5.40M	4.05M	2.70M	1.35M	3.20M

The overall exposure is estimated at around **\$5.40M** for 2012/13, while the probability factor is estimated to be around 60% leaving a residual risk equating to about **\$3.20M**.

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

5.10 Statement of Comprehensive Income

TARANAKI DISTRICT HEALTH BOARD									
STATEMENT OF COMPREHENSIVE INCOME									
DISTRICT ANNUAL PLAN : 2011/14									
Year -1		FORECAST			Year 0		(\$'000)		
Consolidated		Hosp+Gov Funder Consolidated			Consolidated		Provider Governan:		
Audited 2010/11		Forecast Forecast Forecast			Plan Plan Plan		2012/13 2012/13 2012/13		
2011/12 2011/12 2011/12		2012/13 2012/13 2012/13			2012/13 2012/13 2012/13		2012/13 2012/13 2012/13		
REVENUE									
* MOH funding	152403	154599		154599	158694	0	158694		158694
	138143		142965	142965				146675	146675
* Funding & Governance	2370	2411		2411	0	2597	2597		2597
* ACC Revenue	6592	4477		4477	4084	0	4084		4084
* CTA revenue	2100	1864		1864	2166	0	2166		2166
* Other revenue	10136	7115	4962	12077	5266	0	5266	4323	9589
TOTAL REVENUE	311744	170466	147927	318393	170210	2597	172807	150998	323805
EXPENDITURE									
Personnel costs									
- medical	25080	26851		26851	27273	0	27273		27273
- nursing	39639	41248		41248	40826	0	40826		40826
- allied health	15277	14051		14051	14449	0	14449		14449
- support	3846	3778		3778	3636	0	3636		3636
- mgt & admin	17952	18415		18415	19100	1303	20403		20403
total	101794	104343	0	104343	105284	1303	106587	0	106587
Outsourced services									
- clinical services	20542	19036		19036	17956	0	17956		17956
- other outsourced	3715	2498		2498	1595	200	1795		1795
total	24257	21534	0	21534	19551	200	19751	0	19751
Clinical supplies									
- treatment disposables	8288	8900		8900	8859	0	8859		8859
- diagnostic supplies	1218	1161		1161	1395	0	1395		1395
- instruments & equip	972	1070		1070	1123	0	1123		1123
- patient appliances	1059	1051		1051	1086	0	1086		1086
- implants & prostheses	2405	2212		2212	2010	0	2010		2010
- pharmaceuticals	3937	4302		4302	3980	0	3980		3980
- other clinical & client costs	2748	3438		3438	3570	0	3570		3570
total	20627	22134	0	22134	22023	0	22023	0	22023

TARANAKI DISTRICT HEALTH BOARD										
STATEMENT OF COMPREHENSIVE INCOME										
DISTRICT ANNUAL PLAN : 2011/14										
									(\$'000)	
		Year -1	FORECAST		Year 0					Year 1
		Consolidated	Hosp+Gov	Funder	Consolidated	Provider	Governan:	Hosp+Gov	Funder	Consolidated
		Audited	Forecast	Forecast	Forecast	Plan	Plan	Plan	Plan	Plan
		2010/11	2011/12	2011/12	2011/12	2012/13	2012/13	2012/13	2012/13	2012/13
Infrastructure & other op.costs										
- hotel services & laundry	3211	3201	3201	3201	3274	1	3275			3275
- facilities	3154	3221	3221	3221	3344	0	3344			3344
- transport	1051	952	952	952	853	46	899			899
- IT systems & telecom	3916	1662	1662	1662	1682	0	1682			1682
- professional fees	1422	1592	1592	1592	1952	134	2086			2086
- other op.expenses	-897	1525	1525	1525	762	429	1191			1191
- democracy	369	265	265	265	1	282	283			283
- depreciation	9187	10019	10019	10019	12068	0	12068			12068
- interest	2014	2039	2039	2039	1800	0	1800			1800
- cost & efficiency initiatives	0	0	0	0	-2000	0	-2000			-2000
- Payment to - NGO providers										
- personal health	61645		61611	61611				62111		62111
- mental health	8151		8496	8496				8569		8569
- disability support services	32709		34912	34912				37203		37203
- public health	284		185	185				876		876
- maori health	1463		2012	2012				1379		1379
- IDF's	29880		32411	32411				31316		31316
total	157559	24476	139627	164103	23736	892	24628	141454		166082
TOTAL OPERATING EXPENSES	304237	172487	139627	312114	170594	2395	172989	141454		314443
SURPLUS before capital charge	7507	-2021	8300	6279	-384	202	-182	9544		9362
- Capital charge	5748	5879		5879	6100	0	6100			6100
SURPLUS (before strategic exp)	1759	-7900	8300	400	-6484	202	-6282	9544		3262
STRATEGIC EXPENDITURE										
Mental health Ring-fenced surplus	0		0	0				0		0
Workforce Development	198		200	200				44		44
Maori Health Gains Project	199		100	100				500		500
Hospital Provider Strategic Projects	0		0	0				0		0
NET SURPLUS/(DEFICIT) (after strategic expenditure)	1362	-7900	8000	100	-6484	202	-6282	9000		2718
OTHER COMPREHENSIVE INCOME										
* Gain/(Loss) on asset revaluation	0	0		0	0					0
*Gain/(Loss) on sale of assets	34	0		0	0					0
*Share of surplus/(loss) from associates	103	0			0					0
Total Other Comprehensive Income	137	0	0	0	0	0	0	0		0
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	1499	-7900	8000	100	-6484	202	-6282	9000		2718
Interest Cover ratio	6.31			5.96						9.21
Revenue to Net Funds employed	3.00	1.28		2.39	1.12					2.13
Operating margin to Revenue ratio	4%	3%		4%	4%					5%
Op. return on Net Funds employed	12%	3%		9%	5%					11%

TARANAKI DISTRICT HEALTH BOARD												
STATEMENT OF COMPREHENSIVE INCOME												
DISTRICT ANNUAL PLAN : 2011/14												
						Year 2					Year 3	
			Provider	Goverman:	Funder	Consolidated		Provider	Goverman:	Funder	Consolidated	
			Plan	Plan	Plan	Plan		Plan	Plan	Plan	Plan	
			2013/14	2013/14	2013/14	2013/14		2014/15	2014/15	2014/15	2014/15	
Infrastructure & other op.costs												
- hotel services & laundry			3339	1		3340		3406	1		3407	
- facilities			3411			3411		3479			3479	
- transport			870	47		917		887	48		935	
- IT systems & telecom			1716			1716		1750			1750	
- professional fees			1991	137		2128		2031	140		2171	
- other op.expenses			918	438		1356		918	447		1365	
- democracy			1	288		289		1	288		289	
- depreciation			14536			14536		13161			13161	
- interest			3561			3561		3561			3561	
- cost & efficiency initiatives			-2000			-2000		-2000			-2000	
- Payment to - NGO providers												
- personal health					64858	64858				67237	67237	
- mental health					8803	8803				9036	9036	
- disability support services					38835	38835				40270	40270	
- public health					914	914				948	948	
- maori health					1461	1461				1533	1533	
- IDF's					32401	32401				33525	33525	
total			28343	911	147272	176526		27194	924	152549	180667	
TOTAL OPERATING EXPENSES			178138	2444	147272	327854		179985	2488	152549	335022	
SURPLUS before capital charge			-3885	226	8000	4341		-1283	255	7000	5972	
- Capital charge			6241			6241		5972			5972	
SURPLUS (before strategic exp)			-10126	226	8000	-1900		-7255	255	7000	0	
STRATEGIC EXPENDITURE												
Mental health Ring-fenced surplus					0	0				0	0	
Workforce Development					0	0				0	0	
Maori Health Gains Project					500	500				500	500	
Hospital Provider Strategic Projects					0	0				0	0	
NET SURPLUS/(DEFICIT) (after strategic expenditure)			-10126	226	7500	-2400		-7255	255	6500	-500	
OTHER COMPREHENSIVE INCOME												
* Gain/(Loss) on asset revaluation			0			0		0			0	
*Gain/(Loss) on sale of assets			0			0		0			0	
*Share of surplus/(loss) from associates			0			0		0			0	
Total Other Comprehensive Income			0	0	0	0		0	0	0	0	
TOTAL COMPREHENSIVE INCOME FOR THE YEAR			-10126	226	7500	-2400		-7255	255	6500	-500	
Interest Cover ratio						4.41					4.56	
Revenue to Net Funds employed			1.17			2.24		1.22			2.32	
Operating margin to Revenue ratio			5%			5%		5%			5%	
Op. return on Net Funds employed			5%			11%		6%			11%	

5.11 Consolidated Statement of Financial Position

TARANAKI DISTRICT HEALTH BOARD DISTRICT ANNUAL PLAN 2012/13 CONSOLIDATED STATEMENT OF FINANCIAL POSITION (\$'000)						
	2010/11 audited	2011/12 forecast		2012/13 plan	2013/14 plan	2014/15 plan
CURRENT ASSETS						
* Bank Account	3069	3004		1504	1354	1454
* Prepayments +ST investments	31320	32350		8400	5425	5450
* Debtors (net of provision)	8471	8445		9190	9415	9635
* Inventory	2628	2650		2695	2740	2785
	45488	46449		21789	18934	19324
CURRENT LIABILITIES						
* Creditors & other payables	26038	26280		21070	17040	12571
* Term Loans (current portion)	0	0		0	0	0
* Provisions	19195	19635		20710	21115	21720
	45233	45915		41780	38155	34291
WORKING CAPITAL	255	534		-19991	-19221	-14967
NON CURRENT ASSETS						
* Net Fixed Assets	101862	130725		170657	166121	159960
* Investments	984	984		984	984	984
* Trust funds	724	724		724	724	724
	103570	132433		172365	167829	161668
NET FUNDS EMPLOYED	103825	132967		152374	148608	146701
NON CURRENT LIABILITIES						
* Provisions - non current	809	825		825	850	875
* Retentions	0	457		905	473	0
* Term Loans	29000	56800		74000	74000	74000
	29809	58082		75730	75323	74875
CROWN EQUITY						
* Crown Equity	25115	25884		24925	23966	23007
* Reserves	52629	52629		52629	52629	52629
* Retained earnings	-3728	-3628		-910	-3310	-3810
	74016	74885		76644	73285	71826
NET FUNDS EMPLOYED	103825	132967		152374	148608	146701
Debt: Debt equity ratio	28%	43%		49%	50%	51%

5.12 Consolidated Statement of Cashflows

TARANAKI DISTRICT HEALTH BOARD DISTRICT ANNUAL PLAN 2011-15 CONSOLIDATED STATEMENT OF CASHFLOWS (\$'000)						
	2010/11 audited	2011/12 forecast		2012/13 plan	2013/14 plan	2014/15 plan
OPERATING ACTIVITIES						
* MOH funding	294350	301494		309387	318371	326890
* Other revenue	14431	14925		12713	12989	13274
total receipts	308781	316419		322100	331360	340164
* Payment of salaries & operating exp.	163343	169748		167320	171628	175024
* Payment to providers & DHB's	135875	137333		145481	152483	157641
total payments	299218	307081		312801	324111	332665
NET CASHFLOW FROM OPERATIONS	9563	9338		9299	7249	7499
INVESTING ACTIVITIES						
* Interest Received	2089	1921		960	560	560
* Sale of fixed assets etc	559	-11		0	0	0
* (Increase) / decrease in investments	-91	-1000		24000	3000	0
* Capital expenditure	-11905	-38882		-52000	-10000	-7000
NET CASHFLOW FROM INVESTING	-9348	-37972		-27040	-6440	-6440
FINANCING ACTIVITIES						
* Equity injections / repayments	555	769		-959	-959	-959
* Borrowings	0	27800		17200	0	0
* Payment of debts	-526	0		0	0	0
NET CASHFLOW FROM FINANCING	29	28569		16241	-959	-959
Total cash in	308810	344988		338341	330401	339205
Total cashout	-308566	-345053		-339841	-330551	-339105
NET CASHFLOW	244	-65		-1500	-150	100
Add: Cash (opening)	2825	3069		3004	1504	1354
CASH (CLOSING)	3069	3004		1504	1354	1454

5.13 Consolidated Statement of Movement in Equity

<u>TARANAKI DISTRICT HEALT BOARD</u>					
<u>DISTRICT ANNUAL PLAN 2011-15</u>					
CONSOLIDATED STATEMENT OF MOVEMENT IN EQUITY					
	2011/12 forecast		2012/13 plan	2013/14 plan	2014/15 plan
EQUITY AT THE BEGINNING OF PERIOD	74016		74885	76644	73285
* Net results for the period	100		2718	-2400	-500
* Revaluation of Fixed assets	0		0	0	0
* Equity Injections / (repayments)	769		-959	-959	-959
* Other	0		0	0	0
EQUITY AT THE END OF THE PERIOD	74885		76644	73285	71826

6.0 GLOSSARY OF TERMS

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

Model	<p>provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes</p> <p>(Refer State Services Commission ‘Performance Measurement – Advice and examples on how to develop effective frameworks: www.ssc.govt.nz)</p>
Intermediate Outcome	See Outcomes
Living within Means	Providing the expected level of outputs within a break even budget or NHB agreed deficit step toward break even by a specific time.
Management Systems	Are the supporting systems and policies used by the DHB in conducting its business.
Measure	A measure identifies the focus for measurement: it specifies what is to be measured
Objectives	Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve “outputs”. E.g., Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving Governance...etc are ‘internal to the organisation and enable the achievement of ‘outputs’.
Outcome	<p>Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. In common usage, however, the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome. (Refer http://www.ssc.govt.nz/glossary/)</p> <p>A state or condition of society, the economy or the environment and includes a change in that state or condition. (Public Finance Act 1989).</p>
Output Agreement	<p>Output agreement/output plan - See Purchase Agreement (refer to http://www.ssc.govt.nz/glossary/)</p> <p>An output agreement is to assist a Minister and a Crown entity (DHB) to clarify, align, and manage their respective expectations and responsibilities in relation to the funding and production of certain outputs, including the particular standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs (see s170 (2) CE Act 2004).</p>
Output Classes	<p>Are an aggregation of outputs. (Public Finance Act 1989)</p> <p>Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) CE Act 2004). Are groups of similar outputs (Public Finance Act 1989).</p>
Outputs	Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).

Ownership

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

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

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

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

Performance Measures

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

Priorities

Statements of medium term policy priorities.

Productivity

Increasing outputs relative to inputs (i.e.: either more outputs produced with the same inputs, or the same output produced using fewer inputs)

Purchase Agreement

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

Regional Collaboration

Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist.

- Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB
- Midland: Bay of Plenty DHB, Lakes DHB, Tairāwhiti DHB, Taranaki DHB and Waikato DHB
- Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB
- Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB

Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network contains eight DHBs, Taranaki DHB and Tairāwhiti DHB in addition to the Central Region DHBs.

Results	<p>Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once.</p> <p>(http://www.ssc.govt.nz/glossary/)</p>
Standards of Service Measures	<p>Measures of the quality of service to clients focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.</p>
Statement of Service Performance (SSP)	<p>Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. (http://www.ssc.govt.nz/glossary/)</p>
Strategy	<p>See Ownership</p> <p>(http://www.ssc.govt.nz/glossary/)</p>
Sub Regional Collaboration	<p>Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalised with an agreement e.g., Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (central Alliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.</p>
Targets	<p>Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.</p>
Values	<p>The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. (http://www.ssc.govt.nz/glossary/)</p>
Value for money	<p>The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.</p>