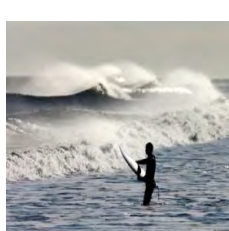




# Taranaki District Health Board

## Annual Plan 2015/16

Incorporating the Statement  
of Intent and Statement of  
Performance Expectations



This document presents our Annual Plan 2015/16 (referred to as the Plan). The Plan is broken into a number of modules that can be extracted for different purposes including presentation of our Statement of Intent 2015/18. Central to understanding this Plan, is our performance story which sets out our key outcomes (what we are trying to achieve), our impacts (our shorter term contribution to an outcome), our outputs (goods and services supplied), and our inputs (resources).

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

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## Module 1

# Introduction and Strategic Intentions



# MODULE 1: INTRODUCTION AND STRATEGIC INTENTIONS

## EXECUTIVE SUMMARY

The Taranaki District Health Board (TDHB) remains ready to meet the significant challenges the New Zealand public health system as a whole continues to face. We believe that with these challenges, come opportunities for service improvement and this plan details many service improvements and interventions which we believe will have positive impacts on the health status of our population.

Already we are seeing the impacts of an aging population – in 2011 there were four people in the workforce for every person 65 years and over – it is predicted that by 2031 there will be just half that number with two people in the workforce for every over-65 year old. Whilst increasing numbers of people are electing to work past the age of 65 there are also increasing numbers of people reaching the old/very old category of 85 plus – often with a high degree of frailty and high health need.

The fiscal environment remains constrained as health consumes an ever increasing portion of total government expenditure. Rapid advances in technology continue to fuel ‘tertiary creep’ and the public has high expectations of its health system. DHBs are continually looking for ways to increase allocative efficiency by investing in preventative care. Targeting of vulnerable populations is essential if we are to realise more equitable health outcomes.

Burden of disease is unevenly distributed throughout society; long term conditions and risk factors such as smoking, obesity and diabetes contribute to serious health disparity. The health of Maori remains an area in which we aim to improve with the detail found in *Te Matakite* –TDHB Maori Health Plan. The physical health of people with serious mental health issues is another area for concern, with a life expectancy in this group of 25 years less than for other New Zealanders.

There is a general acceptance that if we are to prepare well for a healthy health and disability sector, we must focus on the following four areas:

- 1. Better integration of services within health and across the social sector:**  
Strengthening integration within health and across government to support the most vulnerable, reduce inequities and address issues outside the health and disability system that impact on health.
- 2. Improving the way services are purchased and provided:**  
Ensuring funding models support change, building and supporting the key enablers and drivers of change: workforce, health information and capital.
- 3. Continuing to improve quality and performance:**  
Driving performance through measuring and rewarding the right things to improve quality.
- 4. Supporting leadership and capability for change:**  
Supporting strong governance, clinical and executive leadership and capability across the health sector.

To respond to these drivers there will be a need to develop and support new models of service delivery, including information systems, integration of care and workforce capacity. Underpinning change there must always be a commitment to provision of quality in health care delivery, and of course to sustainability.

A greater emphasis on care in the community will see more support for those with long term conditions, a greater emphasis on self-care, primary options to deliver short term acute care in the community, and better use of our valued health professionals who work within the community. To this end TDHB has been working with our Primary Care partners in a variety of forums including Alliance Leadership Teams.

This Annual Plan is supported by a Maori Health Plan, in line with Te Kawau Maro (Taranaki Maori Health Strategy), developed together with the Maori Health Sector and Te Whare Punanga Korero, our Iwi relationship board.

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



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

Jonathan Coleman  
Minister of Health



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

Pauline Lockett  
Chair



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

Sally Webb  
Deputy Chair



A blue ink signature of Tony Foulkes, written in a cursive style.

Tony Foulkes  
Chief Executive

# MINISTER'S LETTER OF APPROVAL

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## Office of Hon Dr Jonathan Coleman

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

Ms Pauline Lockett  
Chairperson  
Taranaki District Health Board  
Private Bag 2016  
New Plymouth 4342

Dear Ms Lockett

### **Taranaki District Health Board 2015/16 Annual Plan**

This letter is to advise you I have approved and signed Taranaki District Health Board's (DHB's) 2015/16 Annual Plan for one year.

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

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015, Vote Health received an additional \$1.7 billion in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, a refresh of the New Zealand Health Strategy is currently under way. The Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for the next three to five years for delivery of health services to New Zealanders. Thank you for your involvement to date and your continued input into the refresh.

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

The Government is determined to reach surplus in 2015/16. To assist with this, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2015/16 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2015/16.

### ***Health Shared Services Programme***

DHBs have committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to include cost and benefit impacts for the Finance Procurement and Supply Chain Initiative in Annual Plans where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

### ***National Health Targets***

Your Annual Plan provides a good range of actions that I am confident will support strong health target performance when implemented in 2015/16. However, your recent results show a need for improvement in the Increased Immunisation target. Please ensure all health target actions identified in your Annual Plan are fully implemented to help you to continue to deliver better outcomes for your population.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator became the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. I am concerned that the pace of progress needs to improve if the 85 percent target is to be achieved by July 2016. Please ensure delivery of this target remains a key priority for your teams.

### ***System Integration***

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Taranaki DHB intends to maintain primary care's current level of access to radiology and gastroscopy, and minor operations list. It is encouraging to see that you also intend to strengthen integration in 2015/16 by:

- developing locality population profiles by the end of quarter two and plans by the end of quarter four to better identify local need
- shifting B4 School Checks, NIR and outreach immunisation in quarters three and four
- expanding the uptake of Primary Options by the end of quarter two
- evaluating the acute demand programme in quarter one and agreeing an action plan by quarter three.

I look forward to being advised of your progress with this throughout the year. Where these services trigger the service change protocols you will need to follow the normal service change process.

### ***Better Public Services (BPS): Results for New Zealanders***

Of the ten whole-of-government key result areas, the health service is leading the following areas:

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

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whānau Ora, Children's Action Plan and Youth Mental Health.

### ***Tackling Obesity***

I am pleased to note that your Annual Plan includes a focus on obesity. I expect all DHBs to show leadership in this area by ensuring that they have healthy food policies and limits on sugar sweetened beverage sales in place within their DHBs. I have asked Ministry officials to look at what actions can be undertaken to help address childhood obesity, including, advice on a possible obesity target that will be meaningful and evidence based. I will be writing to all DHBs in coming months to outline proposed next steps.

***Annual Plan Approval***

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. I am aware you have a number of service reviews under way. I have asked the National Health Board to ensure regular updates are provided as these reviews progress. Please ensure that you advise the National Health Board as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'J. Coleman', with a long horizontal stroke extending to the right.

Hon Dr Jonathan Coleman  
**Minister of Health**

## 1.1 CONTEXT

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

This Plan sets out the activities we will undertake in terms of national, regional and local priorities. It describes to Parliament and to the New Zealand public what we intend to achieve in 2015/16, to improve the health of the Taranaki DHB population and to reduce or eliminate health inequalities.

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

We receive funding from Government to undertake our role. The amount of funding is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status characteristics. We are both a funder and provider of health services. In 2015/16 the Funder has a planned expenditure of \$323,151,336 in order to pay for services to improve the health of our community. This includes most personal health (services to improve the health of individuals), mental health and addictions, Maori health and health of older people services for the Taranaki DHB population.

The Hospital and Specialist Services, our Provider division (which includes Governance costs), will receive approximately \$166,246,549 (51.44%) of this funding with \$118,752,035 (36.75%) being utilised to fund services including those provided by non-government organisations (NGOs), primary care, pharmacy and laboratories. The remaining \$38,152,752 (11.81%) is allocated to fund services that are provided by other DHBs on behalf of Taranaki (inter-District Flows).

The Ministry of Health and National Health Board also have a role in the planning and funding of some services. Some services are funded and contracted nationally, for example public health services, breast and cervical screening as well as the provision of disability support services for people aged less than 65 years.

We are socially responsible and uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. We are responsible for monitoring and evaluating service delivery, including audits of the services we fund.

We are also increasingly working with other Government agencies such as the Ministry of Business Innovation and Enterprise (MBIE), Ministry of Social Development (MSD) and the Ministry of Education (MOE) to improve the services we provide in particular our most vulnerable populations.

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

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

## 1.2 PERFORMANCE STORY

The diagrams presented on the following pages provide a high level summary of our performance story (intervention logic). These diagrams demonstrate flow from resources through to, ultimately our desired outcomes, as well as the links between our national , regional and local strategies. The right hand column of the diagram indicates the relevant module of this Plan for further details.

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

### National Performance Story

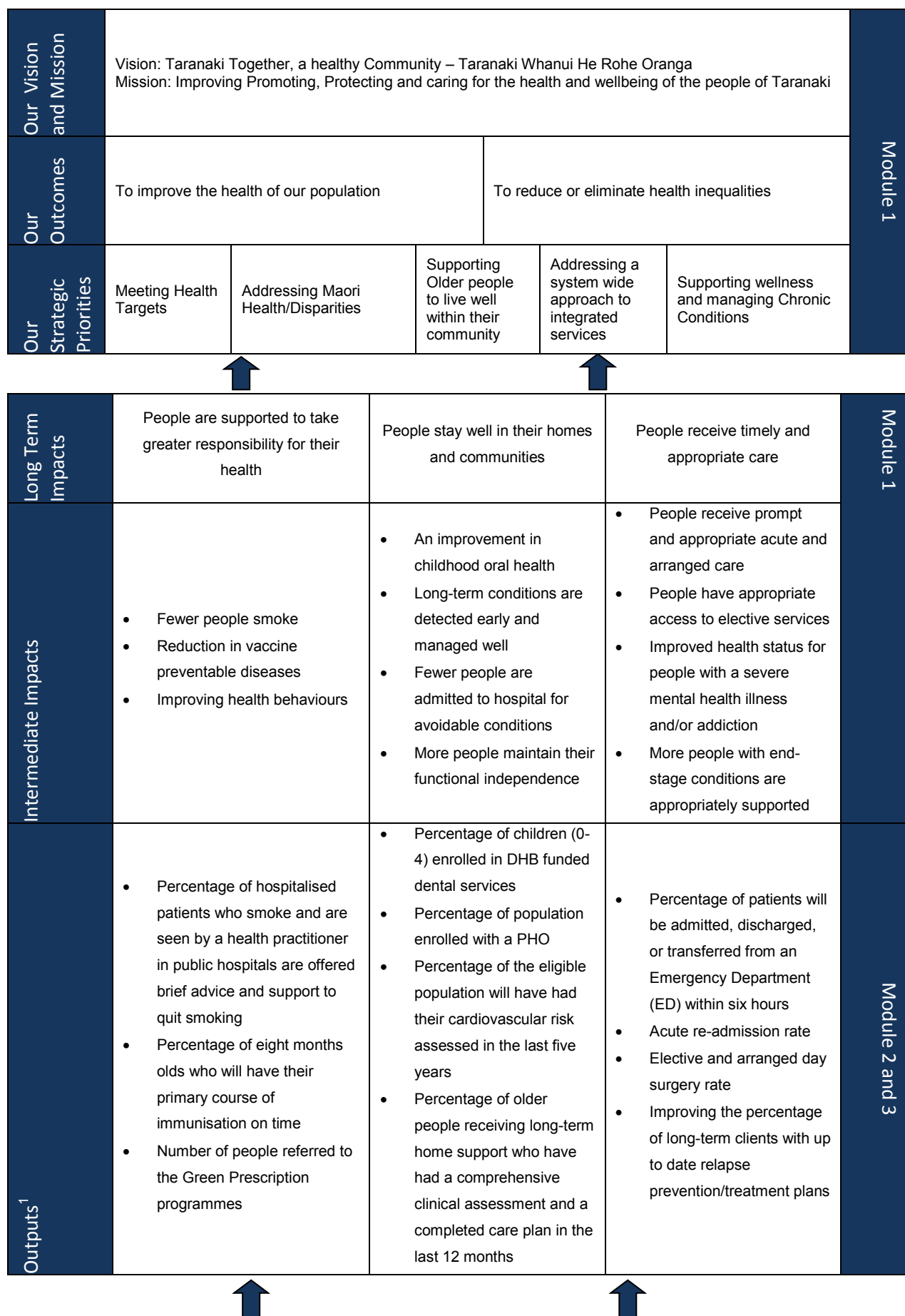
National Performance Story						Module 1
Health & disability system outcomes	All New Zealanders lead longer, healthier and more independent lives		The health system is cost effective and supports a productive economy			
Overarching health sector goals	Better, sooner, more convenient health services for all New Zealanders					
Ministry of health's high level outcomes	New Zealanders are healthier and more independent		High-quality health and disability services are delivered in a timely and accessible way		The future of the health and disability system is assured	
Policy Drivers	Regional Collaboration	Strong governance and clinical leadership		Integration between Primary and Secondary Care	Living within our means	



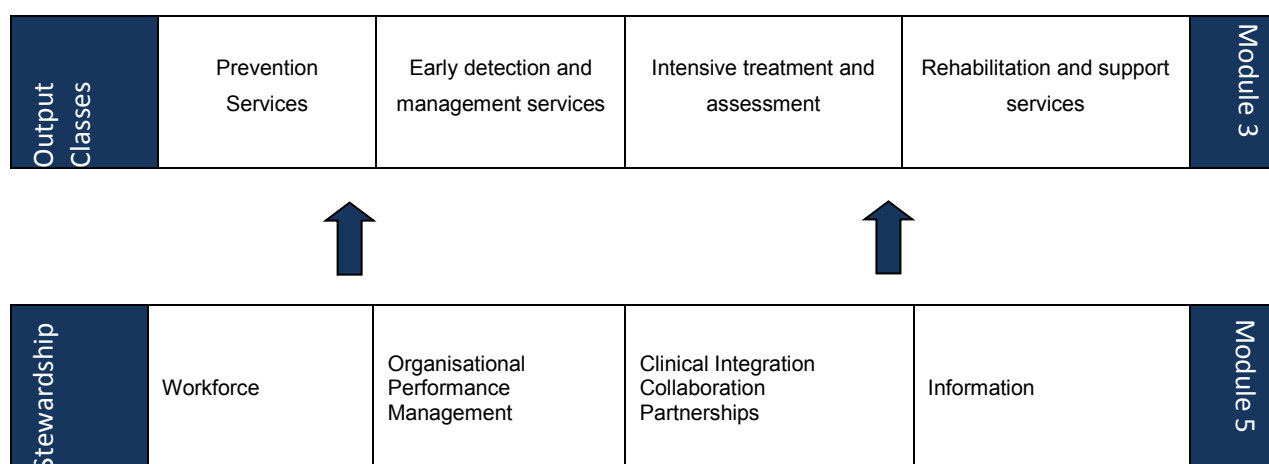
### Midland DHBs' Regional Performance Story

Midland Vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives "Healthy Communities – Integrated Healthcare"					Module 1
Midland Outcomes	To improve the health of our population			To reduce or eliminate health inequalities		
Regional Long Term Impacts	To increase our average life expectancy		To reduce premature death rates		To improve our amenable mortality rate	
Regional Strategic Objectives	To improve Maori health outcomes	Systems integration across the continuum of care	To improve quality access across agreed regional services	To improve clinical information systems	To build the workforce	Efficiently allocate public health system resources
By focusing on these objectives we will be able to drive change that enables us to live within our means						





<sup>1</sup> The outputs described are examples only. See module three for a comprehensive set of outputs.



## 1.3 NATIONAL OPERATING ENVIRONMENT

The Minister of Health with Cabinet and the Government develops policy for the health and disability sector. The Minister is supported by the Ministry of Health and its business units, 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). 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.

### 1.3.1 Treaty of Waitangi

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

### 1.3.2 Health Sector Challenges and Pressures

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

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

Challenge	Health Sector Pressures
Population is changing	<ul style="list-style-type: none"> <li>• Urban growth</li> <li>• Rural decline</li> <li>• Increasing ethnic diversity</li> <li>• Evolving family structure</li> <li>• Ageing population</li> </ul>
Increasing burden of chronic conditions	<ul style="list-style-type: none"> <li>• Growth in the number of people living with chronic conditions</li> <li>• Increased incidence of multiple, complex symptoms and co-morbidities</li> </ul>

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

Challenge	Health Sector Pressures
	<ul style="list-style-type: none"> <li>• Greater chance of chronic conditions linked to lifestyle choices</li> </ul>
Rate of funding growth is unsustainable	<ul style="list-style-type: none"> <li>• New technologies and models of care</li> <li>• A decrease in the rate of funding growth (after a recent period of increases)</li> </ul>
Substantial inequalities in health status persist	<ul style="list-style-type: none"> <li>• Inequalities in health status continue, with potential for disparities to worsen</li> <li>• Long term and inter-generational inequalities</li> </ul>
Health system workforce shortages are worsening	<ul style="list-style-type: none"> <li>• International demand and an ageing workforce</li> <li>• Decreased hours / availability as a result of: <ul style="list-style-type: none"> <li>– regulated maximum working hours</li> <li>– changing lifestyle preferences</li> <li>– super specialisation of some medical professions</li> <li>– rural workforce shortages</li> </ul> </li> </ul>
Multiple new technologies are being developed	<ul style="list-style-type: none"> <li>• Ongoing introduction of new diagnostic tools / tests and new therapeutics</li> <li>• More access to information for patients and clinicians</li> <li>• Increased communication options and speed for patients and clinicians</li> <li>• Continued growth in research and knowledge</li> <li>• Increased understanding of need and service impacts</li> </ul>
Public expectations are rising	<ul style="list-style-type: none"> <li>• Patients will be better informed</li> <li>• Ongoing expectations of highly personalised services and extensive choices</li> <li>• Increased diversity in service expectations as the population becomes more multi-cultural</li> </ul>

## 1.4 REGIONAL OPERATING ENVIRONMENT

Taranaki DHB is one of five DHBs that make up the Midland Region. In 2015/16 all five Midland DHBs will continue to progress activities towards regional cooperation in a planned manner. Collectively the Midland DHBs have developed and agreed a Midland DHB Regional Services Plan (RSP) which is available from: [www.healthshare.health.nz](http://www.healthshare.health.nz)

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

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

- Reduce duplication of effort
- Enable the Midland DHBs to collectively develop more sustainable solutions
- Identify efficiencies
- Ensure that specialist skills, services and input remain available at a local level

The health sector challenges and pressures (see table in section 1.3.2) all have implications at the regional level. Some distinguishing features of our region include:

- High proportion of population identifying as Māori;
- Low proportion of the population identifying as Asian or Pacific peoples;

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

- Higher number of people living in rural areas;
- Higher proportion of people living in areas identified as higher deprivation quintiles four and five;
- Lower life expectancy than the New Zealand average;
- Higher smoking rates than the New Zealand average.

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

## 1.5 LOCAL OPERATING ENVIRONMENT

### 1.5.1 Nature and Scope of Functions – Our Role and Purpose

As a DHB we:

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

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

- Relationship with one Primary Health Organisation
- 32 GP practices
- 21 dental practices
- 26 pharmacies.
- 19 community personal health providers
- Providers of community laboratory services and radiology services
- 7 community based mental health, and alcohol & addictions service
- 1 Māori mental health and alcohol & addictions service provider
- Support services for people with disability, including 28 residential facilities
- 16 providers of community health for older people services
- Hospital provider - facilities include Taranaki Base Hospital, Hawera Hospital and five community health centres in Waitara, Stratford, Opunake, Patea and Mokau.

### 1.5.1 Our Geography and Population

Our DHB serves a population of 118,560 (2015/16 Projection – Statistics NZ) and covers a geographic area of 723,610 hectares. It stretches from Mokau River in the north to Waitotara River in the south.

Our district takes in the major population centres of New Plymouth and Hawera. A detailed breakdown of our population is presented in the following table <sup>1</sup>.

**Ethnic group (grouped total responses) <sup>1</sup> Taranaki Region usually resident population count- 2013 Census**

European	89,802	86.2%
Māori	18,150	17.4%
Pacific Peoples	1,701	1.6%
Asian	3,594	3.5%
Middle Eastern/Latin American/African <sup>2</sup>	447	0.4%
Other Ethnicity <sup>3</sup>	2,112	2.0%

**Source:** Statistics New Zealand

1 Includes all people who stated each ethnic group, whether as their only ethnic group or as one of several. Where a person reported more than one ethnic group, they were counted in each applicable group.

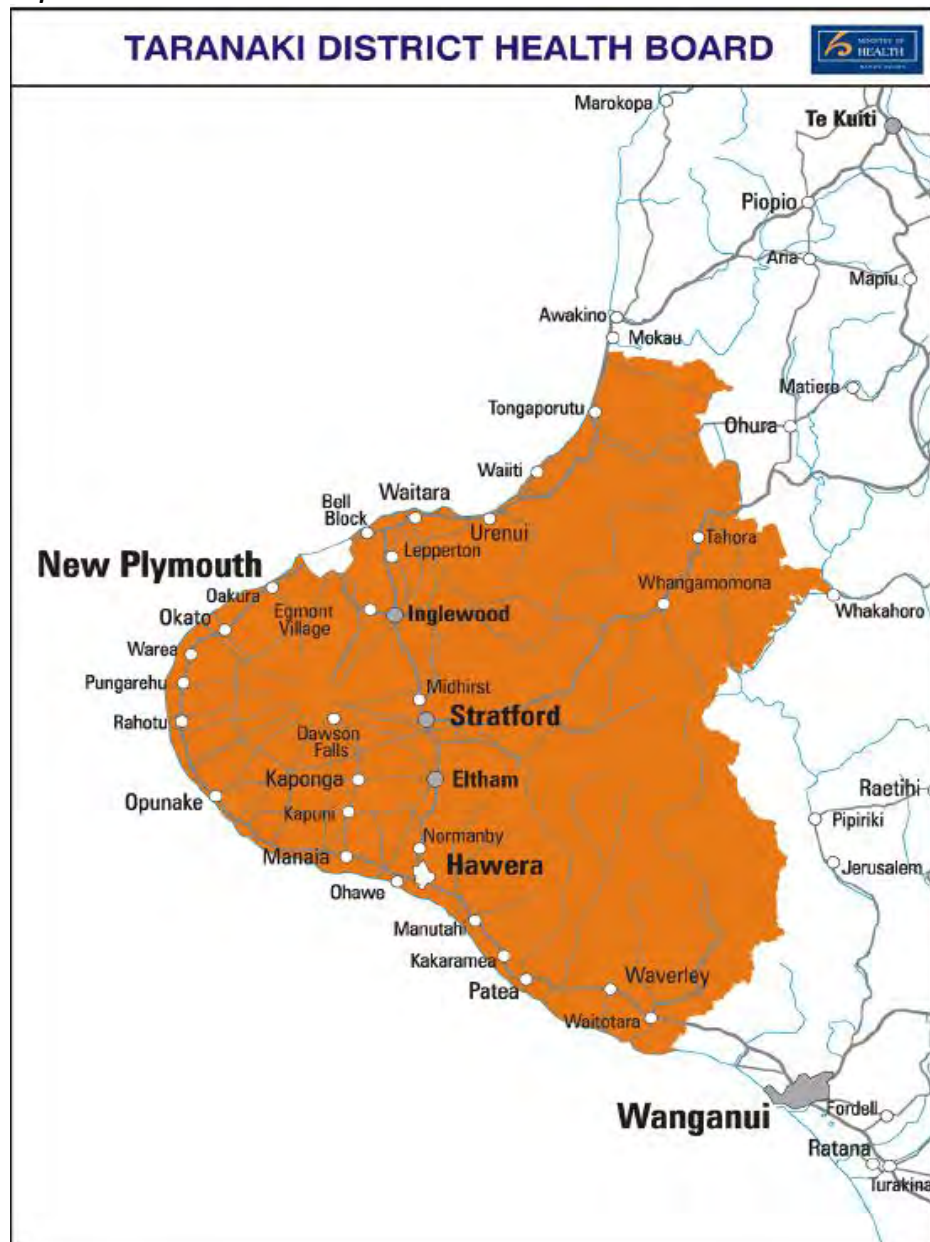
2 Middle Eastern, Latin American, and African was introduced as a new category for the 2006 Census.

3 Previously Middle Eastern, Latin American, and African responses were allocated to the 'other ethnicity' category.

Table: Taranaki DHB population by age and ethnicity – 2015/16 Projection Statistics NZ

Age Group	Ethnicity		
	Maori	Other	Total
00 – 24	11,060	27,485	38,545
25 – 44	5,110	23,905	29,015
45 – 64	3,930	27,175	31,104
65 – 74	860	10,213	11,073
75+	475	8,348	8,823
Total	21,435	97,126	118,560

#### Taranaki DHB Map



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

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

### 1.5.2 Health Profile

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

- Around 43% of Taranaki population live in NZDEP2013 Decile 6, 7 and 8 compared to 30% nationally. Non-Maori are over-represented in the wealthiest socio-economic deciles and Maori are over-represented in the lowest socio-economic deciles.
- Within Taranaki, 32% of Maori live in the most deprived 20% of areas compared to 14% of non-Maori. In contrast, 7% of Maori live in 20% of the most affluent areas compared to 16.3% of non-Maori.
- Maori in Taranaki experience a shorter life expectancy than non-Maori. Based on the 2011/12 HNA<sup>4</sup>, Maori females have a life expectancy of 75.5 years compared to 82.5 years for non-Maori, a difference of 6.9 years.
- Based on the 2011/12 HNA Maori males have a life expectancy of 72.4 years compared to 79.0 years for non-Maori, a difference of 6.6 years. This difference is less than that for the general New Zealand population at 7.7 years for females and 7.9 years for males.
- The leading causes of avoidable mortality in Taranaki DHB for non-Maori are ischaemic heart disease, cerebro-vascular disease and chronic obstructive pulmonary disease (COPD) and lung cancer. For Maori in the Taranaki District, the leading causes of avoidable mortality are ischaemic heart disease, lung cancer, diabetes and chronic obstructive pulmonary disease (COPD).

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

## 1.6 NATURE AND SCOPE OF FUNCTIONS

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

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<sup>4</sup> Taranaki DHB's Whānau Ora Health Needs Assessment† (Ratima and Jenkins, 2012)

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

## 1.7 STRATEGIC INTENTIONS

### 1.7.1 Our Vision

#### **Our Shared Vision - Te Matakite**

*Taranaki Together, A Healthy Community*

*Taranaki Whanui He Rohe Oranga*

#### **Our Mission – Te Kaupapa**

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

#### **Our Aims**

- To promote healthy lifestyles and self-responsibility
- To have the people and infrastructure to meet changing health needs
- To have people as healthy as they can be through promotion, prevention, early intervention and rehabilitation
- To have services that are people-centred and accessible where the health sector works as one
- To have a multi-agency approach to health
- To improve the health of Maori and groups with poor health status
- To lead and support the health and disability sector and provide stability throughout change
- To make the best use of the resources available

#### **Our Values**

How We Work Together With Others – Ngā Tikanga

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

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

### 1.7.2 National Context

There are two identified health system outcomes for New Zealand<sup>5</sup> as detailed in our performance story diagram. Further detail relating to these outcomes can be found in the Ministry of Health Statement of Intent.

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<sup>5</sup> Sourced from: Statement of Intent 2014 to 2017 – Ministry of Health

The outcomes are:

1. New Zealanders live longer, healthier, more independent lives
2. The health system is cost effective and supports a productive economy

The Ministry of Health and DHBs are charged with giving effect to the overarching goal for the health sector of Better, Sooner, More Convenient Health Services for all New Zealanders.

Positive health outcomes are a consequence of activities across the social sectors, not just the health sector. Initiatives such as Better Public Services and Social Sector Trials are examples of where the health sector and the social sectors are working together to deliver a collective impact.

#### ***1.7.2.1 Minister's Letter of Expectations***

The Minister of Health has outlined his expectations for the 2015/16 year, which enables us to plan and prioritise activity for the year. The Ministers expectations reinforce the Government's commitment to a public health system that delivers care closer to home and lifting health outcomes for patient within constrained funding increases. For the 2015/16 year the Minister's areas of priority focus are:

#### **Fiscal Discipline/Management of the Health Portfolio**

DHB's need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery.

#### **Leadership**

Strong clinical leadership and engagement should be embedded in DHBs and utilised in all aspect of DHBs core business. DHB governance, senior management and clinical leaders need to work together evidence to show appropriate clinical and executive leadership is in place to deliver on the Governments objectives.

#### **Integration between Primary and Secondary Care**

Integrating primary care with other parts of the health system is vital for better management of long-term conditions, mental health and addictions, an ageing population and patients in general. Pathways to achieve better coordinated health care and social services need to be developed and supported by clinical leaders in the community and hospital setting.

#### **National Health Targets**

DHBs must remain focused on achieving and improving performance against the health targets, particularly the primary care targets. DHBs will work directly with primary health organisations to drive performance against the relevant health targets.




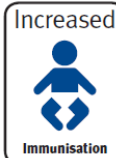
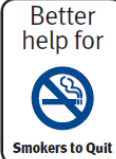

#### **Tackling Key Drivers of Morbidity**

Strengthen the link between physical activity and keeping New Zealanders healthy. All DHBs are expected to be considering what they can do to help reduce the incidence of obesity in New Zealand.

#### ***1.7.2.2 Nation-Wide Health Targets***

Improving performance across the sector is fundamental to the goal of Better, Sooner, More Convenient Health Services for all New Zealanders. One of the mechanisms used to monitor our performance is the nation-wide health targets. The following table outlines our target levels for each of the six health targets.

Table: Taranaki DHB Health Targets 2015/16

Health Target	Long Term Target	Taranaki DHB Target
 <p>Shorter stays in Emergency Departments</p>	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	Total 95 per cent
 <p>Improved access to Elective Surgery</p>	The volume of elective surgery will be increased nationally by at least 4,000 discharges per year.	5,424 total elective surgical discharges
 <p>Faster Cancer Treatment</p>	85 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.	85 per cent
 <p>Increased Immunisation</p>	95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	Total 95 per cent
 <p>Better help for Smokers to Quit</p>	<p>95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking</p> <p>90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.</p> <p>Progress towards 90 percent of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered brief advice and support to quit smoking.</p>	<p>Total 95 per cent</p> <p>Total 90 per cent</p>
 <p>More heart and diabetes checks</p>	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.	Total 90 per cent

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

New Zealand's State Sector, (which includes DHBs), faces increasing expectations for better public services in the context of prolonged financial constraints compounded by the global financial crisis. The key to doing more with less lies in productivity, innovation, and increased agility to provide services.

Agencies need to change, develop new business models, work more closely with others and harness new technologies in order to meet emerging challenges.

The area that health is taking a major role in is the results around supporting vulnerable children<sup>6</sup>, which are:

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

The Social Sector Trials (SSTs) involve Education, Health, Justice and Social Development, and the New Zealand Police working together to change the way that social services are delivered<sup>7</sup>. They test what happens when a local organisation or individual directs cross-agency resources, as well as local organisations and government agencies to deliver collaborative social services. There is one SST in our district in South Taranaki.

The Social Sector Trial in South Taranaki covers five distinct community areas, Hawera, Patea, Manaia, Eltham and Opunake all with quite different needs. Health, Justice, Ministry of Social Development, Education and Police are collectively working together in the region to:

- Reduce offending
- Reduce truancy
- Reduce young people's use of alcohol and other drugs
- Increase the number of young people in education, training and employment; and
- Support co-ordination and collaboration and community

Taranaki DHB will continue to offer workforce development and training opportunities to our agency partner's which provides consistency in tools being used in the community. Health is also working closely with the schools in South Taranaki and in 2015/16 in schools we will provide additional clinical psychology support and Alcohol and Drug group work and one on one intervention. Health will also be an active part of the truancy forums and actively working with the five communities and iwi be more responsive to specific needs of the distinct communities.

#### **1.7.2.4 Whānau Ora**

Whānau Ora is an approach that supports whānau to identify and achieve their own aspirations. It is a key cross-government work programme jointly implemented by a number of sectors, particularly health, education and social services.

#### **1.7.2.5 Non-financial Monitoring Framework**

Another mechanism used to monitor performance is the DHB non-financial monitoring framework. It is a key tool to provide assurance that DHBs deliver<sup>8</sup> in terms of the legislative requirements, and in terms of Government priorities. A summary of the monitoring framework, including our targets (where appropriate) has been included in Module 7.

#### **1.7.2.6 Policy Drivers**

Four important policy drivers have been identified through which the health sector may best utilise resources to achieve better sooner more convenient health care. They are:

1. Better Public Services (including Social Sector Trials): DHBs must work more effectively with other parts of the social sector. The Government's Better Public Services targets and the Social Sector Trials will help drive this integrated approach that puts the patient and user at the centre

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<sup>6</sup> For further information please see <http://www.ssc.govt.nz/bps-supporting-vulnerable-children>

<sup>7</sup> For further information please see <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/social-sector-trials/>

<sup>8</sup> "to the extent they are reasonably achievable within the funds provided" (NZPH&D Act 2000 S3(2))

of service delivery. DHBs are expected to work closely with other sectors such as education and housing specifically.

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

### 1.7.3 Regional Context

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

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

Strategic Outcome 1: Improve the health of the Midland populations

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

Strategic Outcome 2: Eliminate health inequalities

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

The region has agreed six regional objectives, which are:

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

### 1.7.4 Local Context

To contribute to achieving the outcomes at a national and regional level, we have identified our local strategic intent for 2015/16. Our strategic intent represents a continuation from previous years, as the challenges we face are not short term issues easily resolved within a 12 month period. Our local strategic outcomes listed below align directly to the regional strategic outcomes outlined in the Regional services Plan (RSP).

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

Strategic Priority	Description
Maori Health/Disparities	<p>Improving Maori health and enabling a Whānau Ora approach to the health and wellbeing of Maori living in Taranaki, are priorities for the Taranaki DHB.</p> <p>The findings and implications identified in the Whānau Ora Health Needs Assessment and also those identified as national priorities have been expressed in TDHBs Māori Health Plan (MHP) and are a focus for our activities in 2015/16.</p>
Meeting and maintaining Health Targets	Taranaki DHB is committed to meeting the Health Targets. Improving our performance requires a 'whole of system' approach with a combination of focused attention, clinical leadership and system integration.
Financial Performance	Ensuring delivery on agreed financial forecasts and the ability to live within our means, while delivering national, regional and local initiatives.
Mama Pepi Tamariki	This is a focus on all children having the best start in life. Delivering on the Children's Action Plan, Health Beginnings and the Well Child Tamariki Ora Quality Improvement Framework are a priority for Taranaki DHB. The approach involves working closely with our agency partners, recognising the important contribution and accountability all agencies have in improving outcomes for all Taranaki children.
Youth	We will continue to implement the Taranaki Taiohi Health Strategy, Prime Ministers Youth Mental Health Project objectives and use the Social Sector Trial site as the platform to do things differently for Taranaki Taiohi.
Health of Older Persons	<p>We will continue working with primary and community care to deliver integrated services for older people to support their continued safe, independent living at home. Particularly important are avoiding hospital admission and care after a hospital discharge.</p> <p>We are also working with the Ministry to implement our commitment to improving home care, stroke services and dementia care pathways.</p>
Mental Health	We will continue with the redesign of the Mental Health and Addictions Services with an emphasis on achieving and aligning to align to the objectives of the Service Development Plan, <i>Rising to the Challenge</i> . The sector recognises the importance of robust early intervention strategies to maintain wellness for those experiencing Mental Health and Addictions issues. Service development takes into consideration a whole of life and whole of system approach. We also see our Primary Care partners as important for service integration. Work in this area will focus on Perinatal, Infant and children.
Service Integration and redesign of non-acute services	<p>This will involve many stakeholders working together to redesign the Taranaki Integrated Health System.</p> <p>A key to this will be the collective effort of local providers and communities, together with lessons from elsewhere developing new ways and potentially new locations for services to be delivered within the resources available.</p>

The local priorities have been included in our overall performance story to ensure items important to us that are not explicitly covered in the regional strategic intent are included within this Annual Plan.

## **1.8 KEY RISKS AND OPPORTUNITIES**

By its nature, the health sector is complex and challenging. We have identified the following risks and opportunities as being particularly relevant for 2015/16.

### **1.8.1 Achieving Health Equity**

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

The approach we intend to take includes:

- Implementing Te Matakite 2015/16 (our Māori Health Plan)
- Promoting screening services too hard to reach groups to increase early detection of disease
- Implementing services that target communities with identified health inequalities
- Setting targets by ethnicity or by high needs
- Supporting kaupapa Māori services where appropriate
- Increasing the capability of the Māori and Pacific workforce across our district
- Using an equity lens as part of decision-making processes
- Engaging with our joint Community and Public Health Disability Support Advisory Committee to provide advice and inform decision making
- Engaging with Iwi Governance bodies to provide advice and inform decision making
- Engaging with community health forums and expert advisory groups to provide and receive advice – this will include alliance mechanisms and Service Level Alliance Teams (ALTs) representing community/primary/DHB perspectives.
- Work with our Māori Health alliance partners towards improved outcomes for Māori

### **1.8.2 Living Within Our Means**

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

### **1.8.3 Health System Workforce Shortages**

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

Between 2001 and 2021 there is a projected to be a 47 percent increase in demand for registered health professionals in New Zealand; over the same period it is anticipated that there will be a 12 percent projected increase in supply<sup>9</sup>.

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

- Health Workforce New Zealand

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<sup>9</sup> Source: Trends in Service Design and New Models of Care: A Review, Ministry of Health 2010

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

#### 1.8.4 System Integration

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

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

Alliance Leadership Teams and Service Level Alliance Teams have a key role to play in the development of the 2015/16 DHB Annual Plan for Primary Care (including Rural Health) and Youth Health.

#### 1.8.5 Regional Integration

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

### 1.9 KEY MEASURES OF PERFORMANCE

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

#### 1.9.1 Outcome 1 – People are Supported to Take Greater Responsibility for their Health

##### Expectation

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

##### Why is this outcome a priority?

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

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

### 1.9.1.1 Fewer People Smoke

#### Why is this important?

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

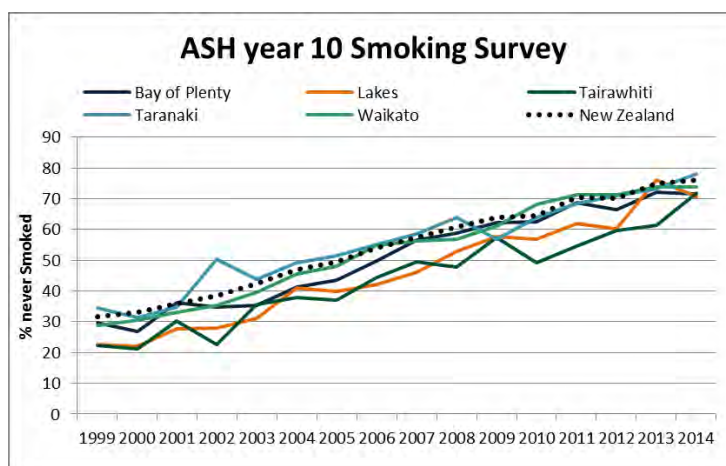


Figure 1 - Percentage of Year 10 high school students who have indicated they have never smoked, not even a puff in the annual ASH survey. ASH New Zealand 2014. Report for the Ministry of Health, Health Sponsorship Council and Action on Smoking and Health: Auckland, New Zealand.

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

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

Fewer People Smoke	Actual	Target	Target	Target
	2014	2015	2016	2017
Percentage of Year 10 Students who have never smoked	78.0%	>78.0%	Improve	

### 1.9.1.2 Reduction in Vaccine Preventable Diseases

#### Why is this important?

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

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

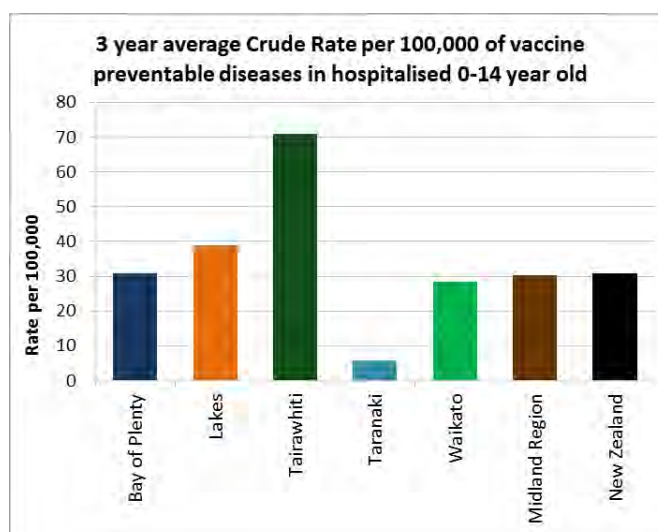


Figure 2 - 3 Year average Crude Rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year old

### How will we know we are succeeding?

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

Reduction in vaccine preventable diseases	Actual	Target	Target	Target
	11/12 to 13/14	13/14 to 15/16	14/15 to 16/17	15/16 to 17/18
3 Year average Crude Rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year old	5.87	<5.87	Decrease	

### 1.9.1.3 Improving Health Behaviours

#### 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 year.

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

By seeing a reduction in obesity, this is a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence people to make healthier choices. This outcome measure can be influenced by the number of referrals to the Green Prescription programme, the number of Active Families/Whānau Pakari participants discharged as Independently Active (by ethnicity), and demonstrable increases to breastfeeding rates.

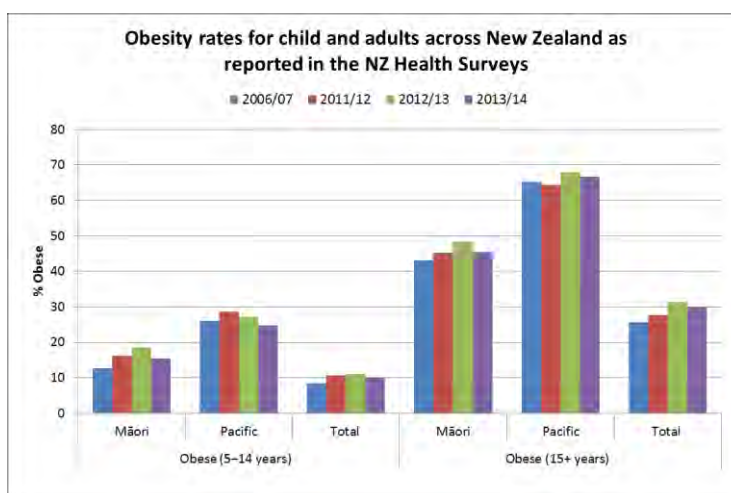


Figure 3 - 2013/14 New Zealand Health Survey.

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

Improving health behaviours	Actual	Target
	13/14	2015/16
% Obese of New Zealand 5 -14 years population	10.1	reduce rate of obesity
% Obese of New Zealand 15+ years population	29.9	reduce rate of obesity

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

#### Expectation

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

### Why is this outcome a priority?

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

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

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

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

#### 1.9.2.1 Children and Adolescents Have Better Oral Health

### Why is this important?

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

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

### How will we know we are succeeding?

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

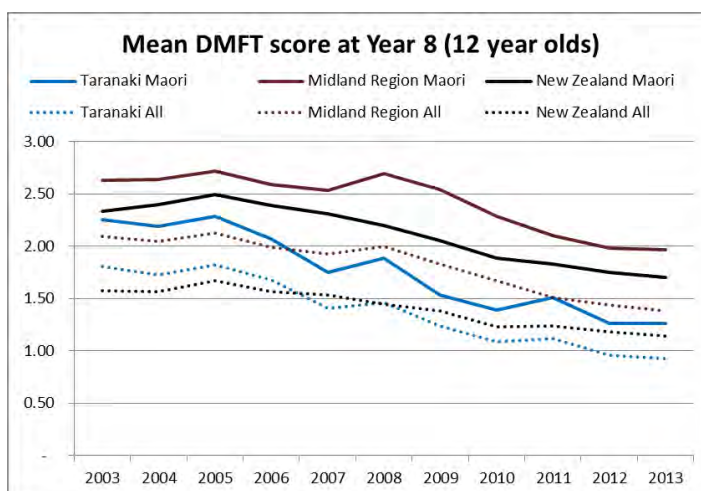


Figure 4 – Diseased, Missing and Filled Teeth (DMFT) for year 8 students in Taranaki DHB, Midland Region and New Zealand. Ministry of Health 2013

Children and adolescents have better oral health	Actual	Target	Target	Target
	2013	2015	2016	2017
Mean DFMT Year 8	0.93	<0.90	reduce	

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

#### Why is this important?

If we are to empower people to take greater responsibility for their health, to improve the health of our population and if we are to “contain costs” we have a significant opportunity by detecting conditions early. Early detection will lead to either successful treatment, or delaying or reducing the need for secondary and specialist care, enabling more people to stay well in their homes and communities for longer. Our greatest opportunity to do this is to manage

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

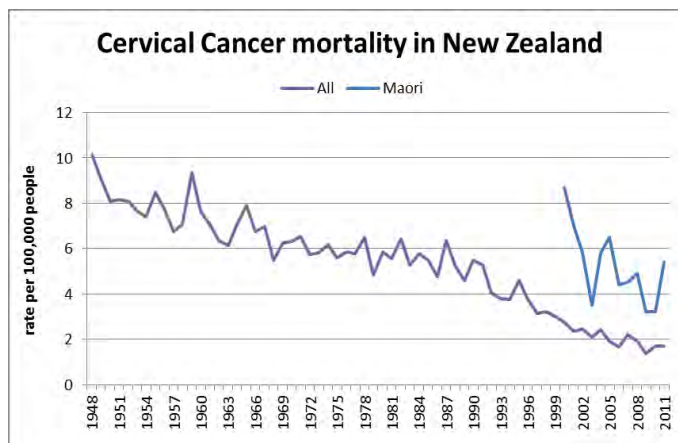


Figure 5 - Female Cervical Cancer mortality in New Zealand 1948 to 2010. Ministry of Health. 2013.

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

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

Cervical Cancer mortality in New Zealand	Actual	Target	Target	Target
	2011	2015	2016	2017
Aged Standardised rate for NZ	1.7	Decrease		

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

#### Why is this important?

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

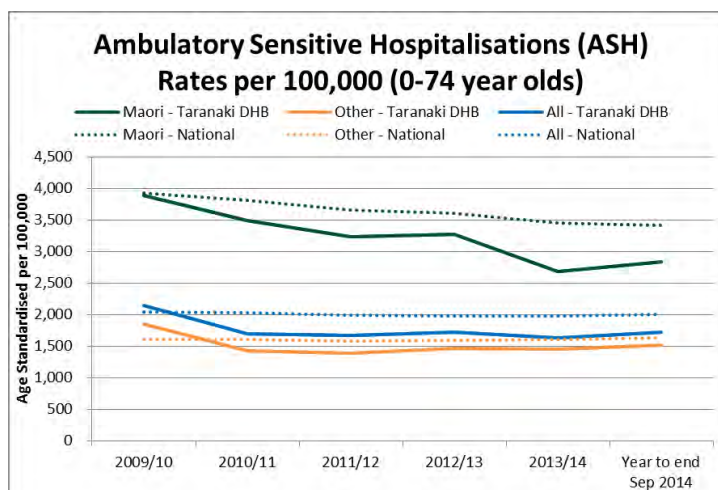


Figure 6 – Rate of Ambulatory Sensitive Hospitalisations, Ministry of Health, ASH summary by DHB, Q1 2014

A reduction in these admissions will reflect

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

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

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

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

Fewer people are admitted to hospital for avoidable conditions	Actual	Target	Target	Target
	2014	2015	2016	2017
Taranaki DHB 0-74 year olds	1,717	<1,688	decrease	

#### 1.9.2.4 People Maintain Functional Independence

##### Why is this important?

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

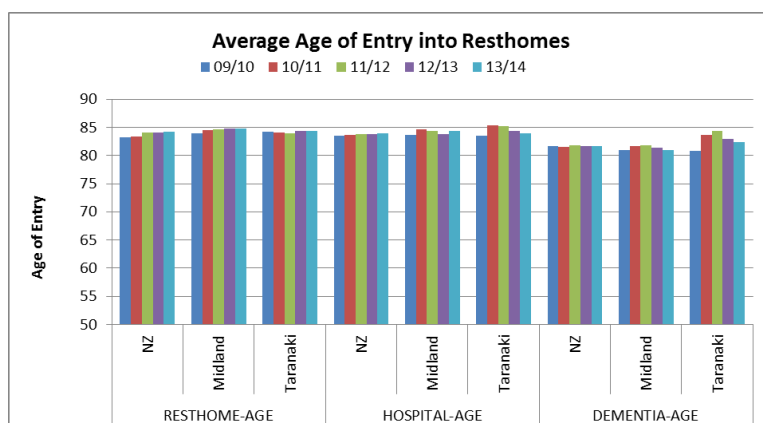


Figure 7 – Average age at entry to residential care facilities in each of the last 4 years for people under the Health of Older People funding stream. Data sourced from Client Claims Processing System (CCPS).

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

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

Average Age of Entry to Aged Related Residential Care	Actual	Target	Target	Target
	13/14	15/16	16/17	17/18
Rest Home	84.31	Increase		
Dementia	82.31	Increase		
Hospital	83.90	Increase		

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

#### Expectation

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

#### Why is this outcome a priority?

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

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

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

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

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

#### Why is this important?

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

The duration of stay in ED is influenced by services provided in the community to reduce inappropriate ED presentations, the effectiveness of services provided in ED and the hospital and community services provided following exit from ED. Reduced waiting time in ED is indicative of a coordinated 'whole of system' response to the urgent needs of the population.

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

When we see an increase in the percentage of people who visit our ED are admitted, discharged or transferred within six hours.

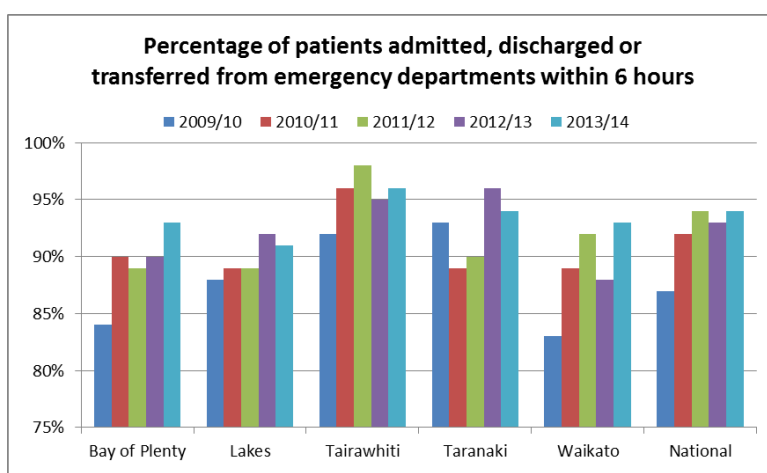


Figure 8 – Emergency Department Waiting times

Improved performance against this measure will not only improve outcomes for our population, but will improve the public's confidence in being able to access services when they need to.

Percentage of patients admitted, discharged or transferred from emergency departments within 6 hours	Actual	Target	Target	Target
	13/14	15/16	16/17	17/18
	94%	>95%	>95%	>95%

### 1.9.3.2 People Have Appropriate Access to Elective Services

#### Why is this important?

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

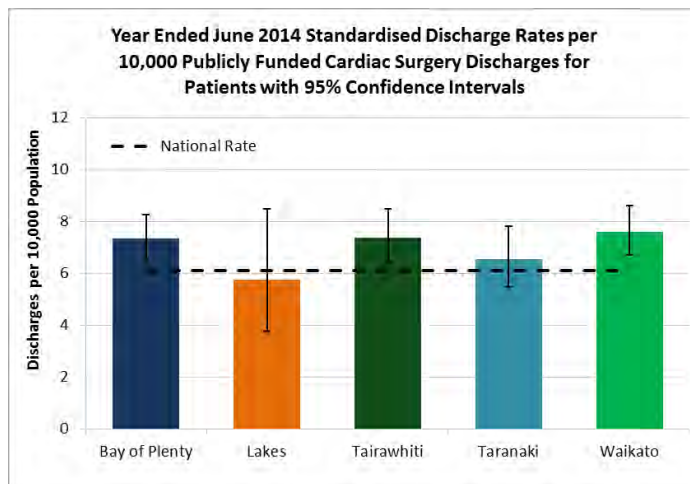
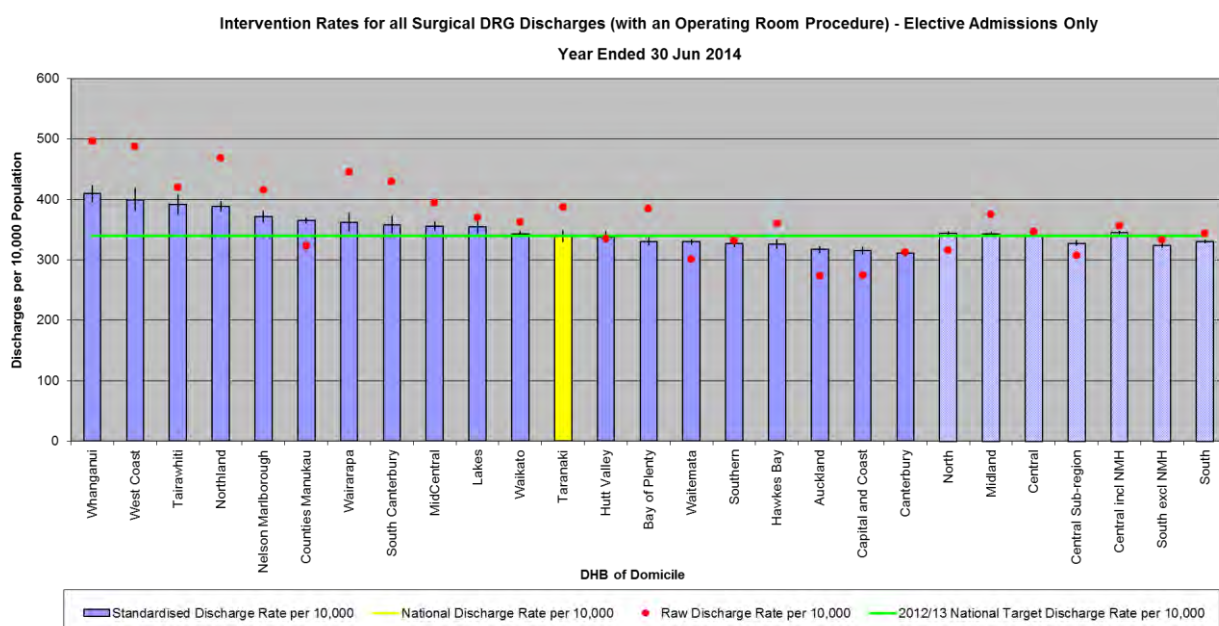


Figure 9 – Ministry of Health Year Ended June 2014 Standardised Discharge Rates per 10,000 for Publicly Funded Cardiac Surgery Discharges for patients with 95% Confidence Intervals

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

To meet the appropriate level of access, we want to ensure that our Standard Intervention Rates (SIRs) meet national expectations for elective procedures. The measure in Figure 9 is an example of comparative intervention rates only. It is only one of 43 SIR measures that are currently being monitored on a regular basis. Other examples of monitoring are as follows;

Elective service standardised intervention rates (per 10,000)	Actual DHB performance (13/14)		Target 15/16	Target 16/17	Target 17/18
	Major joint replacement	20.61	≥21	Maintain	Maintain
	Cataract procedures	31.09	≥27	Maintain	Maintain
	Cardiac surgery	6.56	≥6.5	Maintain	Maintain



### 1.9.3.3 Improved Access to Mental Health Services

#### Why is this important?

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

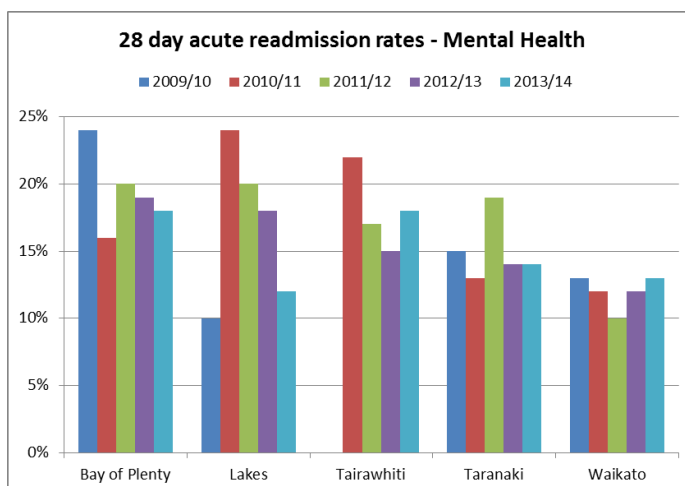


Figure 10 – Data from PRIMHD showing the percentage of mental health patient admissions who are readmitted to hospital within 28 days of a previous discharge

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

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

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

28 day acute re-admission rates	Actual	Target	Target	Target
	13/14	15/16	16/17	17/18
	14%	≤15 %	Decrease	

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

#### Why is this important?

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

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

Palliative care is being accessed. We want to facilitate early identification of palliative care need in primary care, within aged care facilities and also within our acute hospitals in collaboration with the specialist palliative care service. On-going education for these health professionals will be an essential

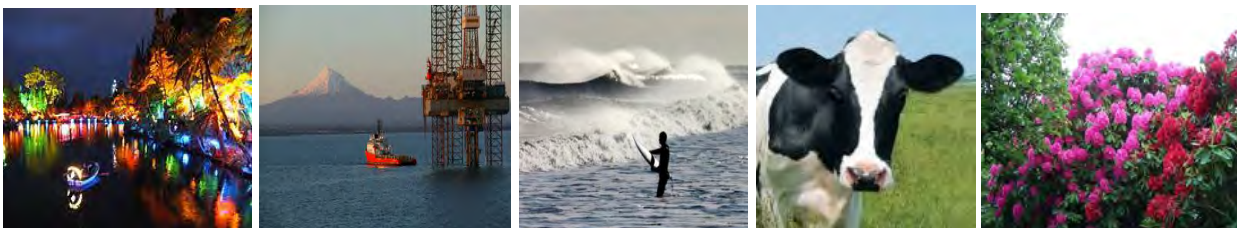
building block in ensuring all Taranaki people facing end-stage conditions have access to quality end of life care wherever they are located.

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



## Module 2

# Delivering on Priorities and Targets



## MODULE 2: DELIVERING ON PRIORITIES AND TARGETS

This module outlines the actions that are planned to be delivered to improve the performance of the health system in 2015/16 as well as how we will be measuring success. The actions in this module highlight what the health system will be doing to give effect to the overarching goal of Better Sooner More Convenient Health Services for all New Zealanders. Sections of this module have been developed in collaboration with our primary care partners.

The actions and measures presented in this module show:

- How we are implementing Government priorities
- How we are contributing to the activities in the Midland Region Service Plan, our Public Health Service Annual Plan and the Māori Health plan
- How we plan to improve performance in terms of our local priorities

Sections of this module have been developed in collaboration with key stakeholders both internal to the health sector and external. This helps us to ensure service planning is not done in silos. The methods we utilise include:

- An alliancing approach to service planning with our primary care partners
- Active engagement of clinical leaders / champions
- Working with other DHBs from the Midland region
- A collaborative cross-sector approach to working with vulnerable children and their families where information, services, resources are coordinated and shared to improve outcomes
- Working with NGOs with a view to including them in alliance arrangements in the future
- Utilising the expertise of community clinicians working across the service continuum with an educative and capacity building focus
- Expanding implementation of clinical pathways via Map of Medicine across the region to promote regional clinical collaboration and consistency
- Participating in the social sector trials work streams with cross agency partners

The narrative and tables in this module are clustered into the following topics:

- **Health Targets**
  - Shorter Stays in Emergency Departments
  - Improved Access to Elective Surgery
  - Faster Cancer Treatment
  - Increased Immunisation
  - Better Help for Smokers to Quit
  - More Heart and Diabetes Checks
- **Better Public Health Services**
  - Reducing Rheumatic Fever
  - Children's Action Plan
  - Whanau Ora
  - Prime Minister's Youth Mental Health Project
  - Social Sector Trials
- **System Integration**
  - Diabetes care improvement Packages
  - Long Term Conditions
  - Stroke
  - Cardiac Services
  - Improved Access to Diagnostics
  - System Integration
  - Primary Care
  - Health of Older People

- Rising to the challenge (mental health service development)
- Maternal and Child Health
- Cancer Services
- Spinal Cord Impairment Action Plan
- **Other**
  - National Entity Priority Initiatives
  - Improving Quality
  - Actions to Support Regional Delivery of Regional Priorities
  - Living Within Our Means

For further performance measures on the Governments priorities and the Health targets refer to Module 3 (Statement of Performance Expectations) and Module 7 (Performance Measures).

## 2.1 HEALTH TARGETS

### 2.1.1 Shorter Stays in Emergency Departments

#### 2.1.1.1 Our Approach

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

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

In a constrained system with limited capacity, our approach to managing patient flow becomes even more important. If we are to continue to deliver care, we will need to ensure that our capacity is matched to demand and the right care is delivered rapidly and responsively to reduce the risk of Emergency Department attendance and avoidable hospital admission. Increasing Emergency Department presentations and unplanned (acute) admissions to our hospitals consume resources and place pressure on clinical care, diminishing the effectiveness of hospital activity.

Activities that will contribute to achieving our target include:

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

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

#### 2.1.1.2 Linkages

- Minister's Letter of Expectations
- Health Target – Shorter stays in Emergency Departments
- Midland DHBs Regional Services Plan 2015/16
- Our Performance Story Impact: People receive timely and appropriate specialist care

### 2.1.1.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Shorter Stays in Emergency Departments:</b>  <b>Support the education campaign with Midlands Regional Health Network Charitable Trust (MHN) to ensure only those who need E.D. care present there, and that General Practices and others offer care as appropriate that enables patients to avoid the need to attend ED.</b>	<ul style="list-style-type: none"> <li>Diagnostic/analysis work to identify the main factors impacting on ED length of stay</li> <li>TDHB ED will align its quality activities to the ED Quality Framework implementing the mandatory measures in Q1</li> <li>three non-mandatory measures will be identified in Q1, quarter three learn from findings and commence the identification of future non-mandatory measures to monitor.</li> </ul>	<ul style="list-style-type: none"> <li>95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.</li> <li>All mandatory measures will be audited and reported as per guidelines in Quarter 1</li> <li>Non-mandatory measures will be included as identified and implemented</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Senior clinicians and managers continue working in partnership to enhance pathways through the ED. Representation across all clinical specialties and ED</li> </ul>	<ul style="list-style-type: none"> <li>95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.</li> </ul>	Quarterly Performance against the health target
	<ul style="list-style-type: none"> <li>Whole of organisation focus, with demonstrable support from senior managers and clinicians. ED Quality framework is utilised to monitor and support ED activity</li> </ul>	<ul style="list-style-type: none"> <li>Continue to report against the ED Quality Framework</li> </ul>	Quarterly Performance against the health target
	<p>Key activities include:</p> <ul style="list-style-type: none"> <li>Ongoing diagnostic/analysis of patients with extended length of stay to ensure service development continues.</li> <li>Work collaboratively with MHN to develop across sector processes to manage growth in the ED</li> <li>Focus on non-urgent ED presentations including analysis of why patients are attending the ED for non-emergency reasons</li> <li>Emergency Department medical and nursing resource aligns with the presentation patterns</li> <li>Appropriate resources placed on the most significant bottlenecks and constraints identified in the diagnostic analysis work</li> <li>Actions spanning the whole system – pre ED, within the ED, and post-ED</li> <li>Whole of organisation focus, with demonstrable support from senior managers and clinicians</li> </ul>	<ul style="list-style-type: none"> <li>Shorter stays health target: 95% of patients are admitted, transferred or discharged within 6 hours</li> <li>0% growth rate for ED presentations across all triage codes</li> </ul>	Quarterly reporting re progress on specific actions

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

### 2.1.2 Improved Access to Elective Services

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

#### 2.1.2.1 Our Approach

Managing patient length of stay is important to sustaining our elective service in terms of capacity. Reducing length of stay is critical to providing an efficient optimal use of our health budget. We will continue to focus on enhanced recovery models which are having a positive effect on our length of stay.

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

#### 2.1.2.2 Linkages

- Minister's Letter of Expectation
- Health Target – Improved Access to Elective Services
- Midland DHBs Regional Services Plan 2015/16
- Our Performance Story Impact: People receive timely and appropriate specialist care

#### 2.1.2.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Improved Access to Elective Surgery</b>	<ul style="list-style-type: none"> <li>Delivery against TDHB agreed volume schedule, including elective surgical discharges, to deliver the Electives Health Target</li> </ul>	<ul style="list-style-type: none"> <li>Delivery against agreed volume schedule, including a minimum of <b>5,424</b> elective surgical discharges in 2015/16 towards the Electives Health Target (will be provided in electives funding advice)</li> </ul>	Quarterly reporting
	<ul style="list-style-type: none"> <li>Standardised intervention rates and/or other mechanisms (such as demand analysis) will be used to assess areas of need for improved equity of access</li> </ul>	<ul style="list-style-type: none"> <li>Reported against non-financial reporting to MoH (Please see SI4): Elective services standardised intervention rates</li> </ul>	Quarterly reporting
	<ul style="list-style-type: none"> <li>Patient flow management will be improved to achieve further reductions in waiting times for</li> </ul>	<ul style="list-style-type: none"> <li>Elective Services Patient Flow Indicators expectations are met, and all patients wait four months</li> </ul>	Quarterly reporting

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	electives. No patient will wait longer than four months for First Specialist Assessment and/or treatment.	or less for first specialist assessment and treatment	
	<ul style="list-style-type: none"> <li>Implementation of the National Patient Flow Project</li> </ul>	<ul style="list-style-type: none"> <li>Compliance awarded for Phase Two</li> </ul>	Quarterly reporting
	<ul style="list-style-type: none"> <li>Initiatives to support improvements in electives access, quality of care, patient flow management, or that maximise available capacity and resources to include:               <ul style="list-style-type: none"> <li>Improving Day Cases for General Surgery Project</li> <li>Redesign of the internal referral process for elective services</li> <li>Production plans in place for all surgical specialties</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Achieved status in non-financial reporting framework - Ownership Dimension performance measures for Inpatient Length of Stay (OS3)</li> <li>Increasing the day case rate for selected general surgery procedures to 75% by December 2015</li> <li>Internal referral redesign complete by August 2015</li> <li>Production Plans In place for planning by July 2015</li> </ul>	Monthly reporting
	<ul style="list-style-type: none"> <li>Participate in regional planning with regard to Elective Surgery delivery ensuring equity of access across the region</li> </ul>	<ul style="list-style-type: none"> <li>Increased uptake of latest national CPAC tools to improve consistency in prioritisation decisions</li> <li>Participation and collaboration in regional activities</li> </ul>	Quarterly reporting
	<ul style="list-style-type: none"> <li>Patients will be prioritised for treatment using national, or nationally recognised, tools, and treatment will be in accordance with assigned priority and waiting time</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of all new scoring tools as they are introduced</li> </ul>	Quarterly reporting

### 2.1.3 Cancer Services/Faster Cancer Treatment

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

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

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

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

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

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

#### **2.1.3.1 Our Approach**

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

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

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

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

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

The DHB will apply the Equity of Healthcare for Maori: framework resource to improve the timeliness and quality of patient pathways across the cancer pathways

#### **2.1.3.2 Linkages**

- Minister's Letter of Expectations
- Health Target – Faster Cancer Treatment
- National Cancer Programme Work Programme
- Midland DHBs Regional Services Plan 2015/16
- Central Cancer Network Strategic Plan
- Taranaki Palliative Care Plan 2013-16
- Hei Pā Harakeke Action Plan
- Our Performance Story Impact: People receive timely and appropriate specialist care

### 2.1.3.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Shorter Waits for Cancer Treatment	<ul style="list-style-type: none"> <li>Maintain performance against the radiotherapy and chemotherapy wait time targets by investing in workforce and capacity as required</li> </ul>	<ul style="list-style-type: none"> <li>100% of patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy</li> </ul>	
	<ul style="list-style-type: none"> <li>Work with CCN to implement priority areas for the year identified in the regional radiation oncology capital and service plans</li> </ul>	<ul style="list-style-type: none"> <li>Implementation priorities identified by July 2015. Priorities completed by June 2016</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Work with CCN to continue implementation of the priority areas for each year identified in the National Medical Oncology Models of Care Implementation Plan 2012/13, including:               <ul style="list-style-type: none"> <li>Support the implementation of e-prescribing into both cancer centres ensuring process appropriate for TDHB site</li> <li>Implement SMO workforce priorities as identified by the national plan</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Implementation of agreed priorities identified by July 2015. Priorities completed by June 2016</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>To work with CCN to submit a joint proposal for service improvement initiatives (round 2) along the patient cancer pathway that supports the achievement of the 62 day indicator and/or implementation of the tumour standards recommendations completed in 2014/15.</li> <li>The new Health target to be achieved by July 2016 is 85 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.</li> </ul>	<ul style="list-style-type: none"> <li>Joint proposal developed and submitted</li> <li>85% of patients referred with a high suspicion of cancer and a need to be seen within two weeks receive their first treatment within 62 days</li> </ul>	Quarterly
Objective	Actions to Deliver Improved Performance	Measure	Reporting
Faster Cancer Treatment	<p><b>FCT Indicators</b></p> <p>Work with CCN to ensure a coordinated approach to identifying and implementing actions to improve faster cancer treatment data-collection systems, including:</p> <ul style="list-style-type: none"> <li>FCT trackers identify and implement processes to make FCT data collection systems/processes part of Business as Usual</li> </ul>	<ul style="list-style-type: none"> <li>% of patients (by DHB and ethnicity) referred urgently with a high suspicion of cancer and a need to be seen within two weeks who receive their first cancer treatments (or other management) within 62 days Target – 85%</li> <li>% of patients referred urgently with a high suspicion of cancer and need to be seen within two weeks who have their first specialist</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
		assessment within that timeframe <ul style="list-style-type: none"> <li>% of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days</li> </ul>	
	<b>MDM Development</b> Complete phased implementation of the regional Multidisciplinary Meeting (MDM) Implementation Plan within allocated funds. Priority activities: <ul style="list-style-type: none"> <li>Deliver MDMs against the National MDM Standards</li> <li>Review MDM access criteria against nationally developed criteria and adjust as required</li> </ul>	<ul style="list-style-type: none"> <li>100% of patients diagnosed with lung cancer access MDMs within 1 month of diagnosis</li> </ul>	Quarterly
	<b>Tumour Standards</b> Work with CCN to undertake the following actions to support use of the tumour standards: <ul style="list-style-type: none"> <li>Analyse the DHBs review of three tumour standards (different tumour types to the review undertaken in 2013-14 and 2014/15) to inform regional service improvement initiatives</li> <li>Implement the regional service improvement initiatives that were identified by the review of the tumour standards in 2013-14 and 2014/15</li> <li>Work with CCN to develop a coordinated approach to cancer pathway development via Map of Medicine / Health Pathways projects</li> <li>Active surveillance for prostate cancer will be undertaken in accordance with guidelines once developed.</li> </ul>	<ul style="list-style-type: none"> <li>Identification of the three prioritised tumour standards for review by Aug 2015</li> <li>Reviews completed by June 2016</li> </ul>	Quarterly
	<b>Care Coordination</b> <ul style="list-style-type: none"> <li>Support cancer nurse coordinators' professional development plan, including attendance at national and regional training and mentoring forums</li> <li>Support implementation of Budget 2014 initiatives; supportive care services for cancer patients are enhanced including employment of social work</li> </ul>	<ul style="list-style-type: none"> <li>Cancer Nurse Coordinator to attend National Forum by June 2016</li> <li>Number of patients referred to Cancer Nurse Coordinator per quarter</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>and psychologists within the cancer treatment team</p> <ul style="list-style-type: none"> <li>Continue to work with CCN to support active patient tracking aligned to CRISP and national patient flow</li> </ul>		
	<p><b>Health information Strategy</b></p> <p>A review against the cancer health Information strategy will be completed once finalised with implementation of strategies where appropriate</p>	<ul style="list-style-type: none"> <li>Review undertaken Quarter 2</li> </ul>	Quarterly
	<p><b>Primary Care</b></p> <p>Work with CCN to coordinate a focus on the front end of the process in primary care identification of high suspicion of cancer (HSC), including:</p> <ul style="list-style-type: none"> <li>Implementing nationally developed e-referral criteria for referral of patients with HSC from primary care</li> </ul>	<ul style="list-style-type: none"> <li>E-referral criteria developed in place by June 2016</li> </ul>	Quarterly
<b>Improved Waiting Times for Diagnostic Services (Colonoscopy)</b>	<p>TDHB will take a coordinated approach to identifying actions to improve waiting times and quality of endoscopy / colonoscopy services, including:</p> <ul style="list-style-type: none"> <li>Implementing the Endoscopy Quality Improvement (EQI) programme</li> <li>identifying and implementing improvements to colonoscopy services</li> <li>Monitoring waiting times for diagnostic and surveillance/follow up colonoscopy</li> </ul>	<p>Diagnostic colonoscopy:</p> <ul style="list-style-type: none"> <li>a. 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) 100% within 30 days (PP29)</li> <li>b. 65% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 120 days (PP29)</li> </ul>	<p>Quarterly</p> <p>Quarterly</p>
<b>Improving Palliative Care</b>	<p>Implementation of the Taranaki Palliative Care Plan (2013-2016); activities include:</p> <ul style="list-style-type: none"> <li>Palliative care training programme implemented</li> </ul>	<ul style="list-style-type: none"> <li>By June 2016 – 3 GP sessions, 5 Hospital based sessions and 50 Aged Care sessions.</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Undertake a review of Palliative Care Nursing Services</li> </ul>	<ul style="list-style-type: none"> <li>Review completed by December 2015</li> <li>Agreed recommendations following review would be commenced by 30 June 2016</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Implementation of End of Life Care pathway for the dying in aged residential care facilities</li> </ul>	<ul style="list-style-type: none"> <li>9 aged residential care facilities using End of Life Care pathway by Dec 2015 and</li> <li>30 facilities by 30 June 2016</li> </ul>	Quarterly

## 2.1.4 Increased Immunisation

### 2.1.4.1 Our Approach

During 2015/16 we will increase our focus on increasing immunisation in our district. There are many stakeholders from across the sector whose individual work forms part of the 'greater whole' in terms of the approach to supporting children in this district. The results against the target and initiatives planned for our district will reflect the combined effort of all these stakeholders.

We will work together through the DHB facilitated Taranaki Immunisation Steering Group, Operational Taskforce Group and peer networking through MOH facilitated national and regional teleconference. We will work closely with our primary care partners and continually seek to identify new ideas to re-energise areas of activity to maximise and sustain performance.

### 2.1.4.2 Linkages

- Our Performance Story Impact: People take greater responsibility for their health
- Better Public Services: Supporting vulnerable children

### 2.1.4.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Increased Immunisation</b>	<p>95 percent of eight months olds will have their primary course of immunisation (at six weeks, three months and five months immunisation events) on time.</p> <ol style="list-style-type: none"><li>1. Maintaining the Taranaki Immunisation Steering Group (TISG) that includes all the relevant stakeholders for the DHB's immunisation services including the Public Health Unit</li><li>2. Maintaining the Operational Taskforce Group to deliver on the priority areas of the Taranaki Immunisation Action Plan.</li><li>3. The TISG will meet quarterly to review, monitor and implement actions as identified through the Taranaki Immunisation Action Plan</li><li>4. Through the Taranaki Immunisation Action Plan identify key opportunities for linking with and supporting other agencies with identified activities on immunisation uptake.</li><li>5. Increase activity around opportunistic immunisations in Paediatrics Outpatients, Paediatric Ward, Emergency Departments and Accident and Medica Centres.</li><li>6. Identify immunisation status of children presenting at hospital (inpatients and outpatients),</li></ol>	<ul style="list-style-type: none"><li>• 95% of eight-month olds are fully immunised.</li><li>• Evidence of Immunisation Week activities through Narrative report on DHB and interagency activities to promote immunisation week (February 2016)</li></ul> <p>By December 2015 85% of 4 year olds are immunised by age 5</p> <p>By June 2106 95% of 4 year olds are immunised by age 5</p>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>after hours ED and primary health care through NIR look up for all presentations. Implement system for immunising opportunistically those children unimmunised or late.</p> <p>7. Work with the local MSD providers to ensure immunisation and engagement in primary care and WCTO are part of MSD contacts with families</p> <p>8. Identify other agency champions to provide key messages in Immunisation Week and at other times throughout the year.</p> <p>9. Shift the activities focused on the 8 month target to a focus on achieving the, six week, three and five month and four year targets immunisation.</p> <p>10. Actively monitor the change in focus through the TSIG and Operational Taskforce Group</p>		
	<p>Increasing children's immunisation rates for two years and five years to 95% by 2017.</p> <p>1. Include activities focused on achieving 5 year immunisation rates.</p> <p>2. Updating the DHB dashboard to include the additional immunisation stage milestones.</p> <p>3. Ensuring effective Outreach Immunisation Services that focus on different immunisation milestones.</p> <p>4. Finalise monitoring pathways with Primary Care on early identification of children due or overdue for immunisation.</p>	<ul style="list-style-type: none"> <li>85% of four year olds are fully immunised by age 5 December 2015</li> <li>90% of four year olds are fully immunised by age 5 by June 2016.</li> </ul>	Quarterly
<b>HPV Immunisation</b>	<ul style="list-style-type: none"> <li>TDHB will continue a school based HPV programme starting February 2014 via the Public Health Nurses including education, sessions for parents and children.</li> <li>Actively promote use of an online learning tool.</li> </ul>	<ul style="list-style-type: none"> <li>At least 65% of eligible girls have received dose three of the HPV vaccine.</li> </ul>	Monthly & Quarterly

### 2.1.5 Better Help for Smokers to Quit

Better Sooner More Convenient Health Services for New Zealanders in relation to tobacco means more smokers make more quit attempts, leading to more successful quit attempts and a reduction in smoking prevalence.

#### 2.1.5.1 Our Approach

Our children and tamariki need to grow up free of the risk of becoming addicted to tobacco and the effects of second-hand smoke. We recognise that actions we take at a regional and local level will link with the actions driven at a national level to contribute to the achievement of the goal of a Smokefree New Zealand by 2025.

A renewed impetus is required in order to achieve the Government's aspirational goal of a Smokefree New Zealand by 2025. Increased integration into all other aspects of health is critical to achieving Smokefree Aotearoa 2025. Supporting smokers to quit needs to be integrated into all primary, secondary and maternity health services and DHBs have a leading role.

We will be implementing the actions from our current Tobacco Control Plan. This plan has a focus on achieving the national health targets. We will continue to engage regularly with our primary care partners and share information about the health target as well as monitoring actual performance against planned performance.

Our focus on smoking during pregnancy is part of our Maternity Quality and Safety (MQSP) programme. We will be working with our primary care partners to make progress against the primary care portion of this priority.

#### 2.1.5.2 Linkages

- Minister's Letter of Expectations
- Health Target – Better Help for Smokers to Quit
- Parts of this section have been developed and agreed with our primary care partners
- Our Performance Story Impact: People stay well in their homes and communities
- Our Performance Story Impact: People receive timely and appropriate specialist care

#### 2.1.5.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Better Support for Smokers to Quit in Secondary Care</b>	<ul style="list-style-type: none"><li>• TDHB is committed to sustain performance against the secondary Care target<ul style="list-style-type: none"><li>○ Current unit procedures support ongoing process to ensure all patients who smoke are asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support for hospital based services</li></ul></li></ul>	<ul style="list-style-type: none"><li>• Maintain 95% of hospitalised patients who smoke and are seen by a health practitioner are offered brief advice and support to quit smoking</li><li>• Maintain 95% of hospitalised Maori patients who smoke are seen by a health practitioner are offered brief advice and support to quit smoking</li></ul>	Quarterly
	<ul style="list-style-type: none"><li>• To promote and monitor the use and access of Nicotine Replacement Therapy and Smoking Cessation medicines</li></ul>	<ul style="list-style-type: none"><li>• Increase percentage of hospitalised smokers receiving pharmacotherapy medicine by June 2016 from baseline determined by September 2015</li></ul>	Quarterly



Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Leadership Coordination and Collaboration</b>	<ul style="list-style-type: none"> <li>To Implement the Taranaki Tobacco Action Plan 2015-16</li> </ul>	<ul style="list-style-type: none"> <li>Taranaki Tobacco Action Plan 2015-16 milestones completed by June 2016</li> </ul>	Six Monthly
<b>Auahi Kore/Tupeka Kore Communities</b>	<ul style="list-style-type: none"> <li>To implement the South Taranaki Social Sector Trial project (SWEET) for agencies to support rangatahi and their whanau quit smoking               <ul style="list-style-type: none"> <li>To develop and implement the ABC approach and referral pathway</li> <li>To deliver stop smoking training and awareness activities to key SWEET agencies staff</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A Systematic ABC pathway established in SWEET agencies by June 2016</li> <li>Stop Smoking Training with SWEET agency professionals delivered by December 2015</li> </ul>	Six Monthly
	<ul style="list-style-type: none"> <li>To implement the Tupeka Kore Kohanga Reo initiative creating supportive and enabling environments that encourages and support Whanau to stop smoking               <ul style="list-style-type: none"> <li>To deliver stop smoking training for Kohanga Reo and Te Kopae</li> <li>To develop an Induction/Quit smoking pack for whanau</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Stop Smoking Training with Kohanga Reo and Te Kopae delivered by December 2015</li> <li>The induction/Quit smoking pack completed and implemented by March 2016</li> </ul>	Six Monthly

## 2.1.6 More Heart and Diabetes Checks

### 2.1.6.1 Our Approach

We will continue to work with our primary care partners to reduce the impact of long term conditions like cardiovascular disease. We provide funding to our primary care partners to enable implementation of their respective long term conditions programmes (which include a focus on the More Heart and Diabetes Checks Health Target). Our primary care partners use the allocated funding to support and incentivise performance of their practices. This approach is intended to contribute to the achievement of our outcomes of improving the health status of our population and reducing or eliminating health inequalities.

We are part of a sub-regional<sup>10</sup> approach (overseen by an Alliance Leadership Team) to the funding allocation of our primary care partners, the Midlands Health Network. This approach focuses on enabling implementation of their Long Term Conditions programme using funding from an agreed flexible funding pool to support and incentivise practices. This funding is allocated to practices through a funding allocation model which covers inputs, outputs and outcomes:

- Capacity funding - calculated in year one based on high needs; year 2 based on numbers in stratified risk categories with different categories buying different levels of intervention

<sup>10</sup> Sub-region in this case refers to the geographic areas covered by Lakes DHB, Tairāwhiti District Health, Taranaki DHB and Waikato DHB

- Coverage funding - as practices achieve agreed coverage targets in three bands in year one and then active care plans for year two; then the funding is adjusted to reflect that the harder to reach are being actively managed.
- Quality funding - year one coverage targets and some outcome; year two moving to less coverage and greater outcome

### 2.1.6.2 Linkages

- Minister's Letter of Expectation
- Health Target – More Heart and Diabetes Checks
- Section developed and agreed with our primary care partners
- Our Performance Story Impact: People stay well in their homes and communities

### 2.1.6.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>More Heart and Diabetes Checks</b>	<p>The extension of the Midlands Health Network Long Term Condition Program including the stratification and management of people at risk of and living with Diabetes.</p> <p>Enhanced ability and services through the strengthening and further shifting of hospital community based multi-disciplinary teams to be co-ordinated by and support the Health Care Homes in managing long term conditions. Further development of a range of electronic tools to support patients in self-management and providers in care support.</p> <ul style="list-style-type: none"> <li>• Implement cardiovascular disease management training for general practice.</li> <li>• Multidisciplinary team for cardiovascular disease</li> <li>• Virtual cardiovascular disease risk assessment project to support general practice activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing cardiovascular disease refresher for Network available</li> <li>• General practice has access to agreed multidisciplinary team for cardiovascular disease</li> <li>• Virtual cardiovascular disease risk assessment part of business as usual</li> </ul>	Quarterly

## 2.2 BETTER PUBLIC HEALTH SERVICES

### 2.2.1 Reducing Rheumatic Fever

Rheumatic Fever left untreated can damage the heart leading to life-long heart problems. Working to reduce and eliminate rheumatic fever can reduce the incidence of heart disease and/or related complications.

#### 2.2.1.1 Our Approach

During 2013/14 we developed our Rheumatic Fever Prevention Plan. While the incidence of Rheumatic Fever is low in Taranaki (less than 1 per 100,000 population) we expect to reduce both the incidence and impact of Rheumatic Fever across our district.

Our plan includes sections on:

- Overarching actions to reduce the incidence of Rheumatic Fever
- Investment in reducing Rheumatic Fever
- Actions preventing the transmission of Group A Streptococcal throat infections
- Actions to treat Group A Streptococcal throat infections quickly and effectively
- Actions facilitating the effective follow-up of identified Rheumatic Fever cases

#### 2.2.1.2 Linkages

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

#### 2.2.1.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Reduce the Incidence of Rheumatic Fever	<ul style="list-style-type: none"> <li>Implement the Rheumatic Fever Prevention Plan appropriate to the level of intervention required</li> </ul>	<ul style="list-style-type: none"> <li>The 2015/16 National target for Rheumatic Fever Hospitalisation rates is expected to be 55% lower than the average over the last 3 years</li> <li>For Taranaki this means a Target of 0.4 per 100,000. This is obviously less than a real person and so TDHB will continue to aim for a rate of Nil</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Ensuring that primary care providers and other health professionals likely to see high risk children follow the National Heart Foundation Sore Throat Management Guidelines</li> </ul>	<ul style="list-style-type: none"> <li>The Taranaki DHB Rheumatic Fever Prevention Plan has been operational since the start of October 2013</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Ensuring people with Group A streptococcal infections are treated appropriately within 7 days of developing symptoms</li> </ul>		
	<ul style="list-style-type: none"> <li>Ensuring that all cases of acute rheumatic fever are notified to the Medical Officer of Health within 7 days of hospital admission</li> </ul>	<ul style="list-style-type: none"> <li>There was only one case notified in 2013 – a 10 year old Maori child in June. This gives a notification rate of 0.9 per 100,000</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Reviewing all cases of Rheumatic Fever to identify any identifiable risk factors and system failure points</li> </ul>	<ul style="list-style-type: none"> <li>The activities in “What we are planning to do to achieve it” are reviewed annually</li> <li>An intersectoral project team then reviews the annual report and epidemiology of Rheumatic Fever in Taranaki over the previous year and decides on actions which are consistent with the level of need</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Ensuring patients with a past history of Rheumatic Fever</li> </ul>		

Objective	Actions to Deliver Improved Performance	Measure	Reporting																																																						
	receive monthly antibiotics not more than 5 days after due date																																																								
	<ul style="list-style-type: none"><li>Undertake a root cause analysis of every Rheumatic Fever case and identify systems failures</li></ul>	<ul style="list-style-type: none"><li>Provide a report on the lessons learned and actions taken following the root cause analysis to the Ministry each quarter</li></ul>																																																							
	<div><h3>Rheumatic Fever Notification Rates</h3><table><thead><tr><th>Year</th><th>NZ Rate</th><th>Taranaki Rate</th></tr></thead><tbody><tr><td>1997</td><td>2.8</td><td>1.0</td></tr><tr><td>1998</td><td>2.0</td><td>1.0</td></tr><tr><td>1999</td><td>2.8</td><td>1.0</td></tr><tr><td>2000</td><td>3.0</td><td>0.0</td></tr><tr><td>2001</td><td>3.0</td><td>0.0</td></tr><tr><td>2002</td><td>2.5</td><td>1.0</td></tr><tr><td>2003</td><td>3.8</td><td>0.0</td></tr><tr><td>2004</td><td>2.0</td><td>0.0</td></tr><tr><td>2005</td><td>2.0</td><td>0.0</td></tr><tr><td>2006</td><td>3.0</td><td>1.0</td></tr><tr><td>2007</td><td>3.5</td><td>0.0</td></tr><tr><td>2008</td><td>3.8</td><td>1.0</td></tr><tr><td>2009</td><td>3.2</td><td>1.0</td></tr><tr><td>2010</td><td>3.8</td><td>1.8</td></tr><tr><td>2011</td><td>3.8</td><td>0.0</td></tr><tr><td>2012</td><td>4.0</td><td>1.8</td></tr><tr><td>2013</td><td>4.0</td><td>1.0</td></tr></tbody></table></div>			Year	NZ Rate	Taranaki Rate	1997	2.8	1.0	1998	2.0	1.0	1999	2.8	1.0	2000	3.0	0.0	2001	3.0	0.0	2002	2.5	1.0	2003	3.8	0.0	2004	2.0	0.0	2005	2.0	0.0	2006	3.0	1.0	2007	3.5	0.0	2008	3.8	1.0	2009	3.2	1.0	2010	3.8	1.8	2011	3.8	0.0	2012	4.0	1.8	2013	4.0	1.0
Year	NZ Rate	Taranaki Rate																																																							
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### 2.2.2 Children's Action Plan

Supporting vulnerable children contributes to the Government's overall priorities by improving services and reducing avoidable expenditure in the justice, health and welfare systems – helping to deliver better public services within financial constraints and helping to build more competitive and productive economy.

#### 2.2.2.1 Our Approach

National Child Health Information Programme (NCHIP).

Ministry of Health and the National IT Board joined the team as the owner of the national programme, (renamed NCHIP) the goal of which was to develop as proof of concept, a child and youth health platform and co-ordination service.

The programme will create greater visibility of child health information and improve collaboration and standardisation in the delivery of health services of child health providers. It will also assist in the achievement of DHB health targets for immunisation, B4 Schools and obesity reduction. Registrations of Interest were sought from appropriate IT vendors via a closed tender process. Following the selection of a preferred vendor, pricing discussions and modelling of national roll out costs have occurred. Taranaki is will be rolling out the system in 2016.

#### 2.2.2.2 Linkages

- Minister's Letter of Expectation
- Health Target – Increased Immunisation
- Better Public Services: Result 2: Increase participation in quality early childhood education
- Better Public Services: Results 3: Increase infant immunisation rates and reduce the incidence of Rheumatic Fever
- Better Public Services: Result 4: Reduce the number of assaults on children
- Our Performance Story Impact: People take greater responsibility for their health

### 2.2.2.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Meeting the requirements of the Vulnerable Children's Act</b>	1. See actions as outlined in the Workforce section 5.3.4 including: <ul style="list-style-type: none"> <li>○ Vetting and screening all staff</li> <li>○ Training staff</li> <li>○ Audit and evaluation of screening</li> </ul>	<ul style="list-style-type: none"> <li>• 100% staff trained through the FVIP</li> <li>• 100% of women screened have results electronically recorded</li> </ul>	Quarterly
<b>Implementation of regional Children's Teams</b>	2. Continued participation in regional Children's Team governance and leadership involvement by DHB and non-DHB employed health professionals through review of all Paediatric meetings related to vulnerable children  3. Continued collaboration with other agencies to plan, test and monitor assessment processes to support early response systems, assessment processes and delivery of coordinated services for vulnerable children through improved information sharing systems and communication between agencies  4. Continued work to develop effective referral pathways to/from Children's Teams and primary and secondary health services  5. Continue to enable health professionals to attend necessary training to support Children's Teams	<ul style="list-style-type: none"> <li>• Establishment of multi-disciplinary Children's Teams</li> </ul>	
<b>Reducing the Number of Assaults on Children</b>	6. TDHB will continue to maintain and evaluate the FVIP and take remedial action if national audit scores of less than 80/100 occur	<ul style="list-style-type: none"> <li>• 100% of women over 16 screened</li> <li>• 100% of positive screenings are referred to appropriate services</li> <li>• Score of at least 80/100 for each of the child and partner abuse components of the family violence programme</li> </ul>	Quarterly
	7. TDHB will continue to input into the National Child Protection Alerts System including quarterly reviews	<ul style="list-style-type: none"> <li>• Quarterly reviews through 15/16</li> </ul>	Quarterly
	8. Where able and appropriate,		

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	TDHB will align with other child protection information systems		
	<b>Actions to reduce deaths from assault</b>  9. Training all staff to have knowledge, competence and skills to identify partner abuse and child abuse and neglect (CAN)  10. Training all staff to have confidence to support victims of PA and CAN, assess risks, document and refer to appropriate FV Specialist community services.  11. Training staff of the requirements of the Vulnerable Children's Act (VCA) so that they understand their duty of care to all vulnerable children, even if their index client/health consumer/patient is an adult. This is a huge change for services such as adult mental health, addiction services, midwifery, ED, etc.  12. Focus on training on the co-occurrence of partner abuse and child abuse. Not seen separate in VCA.  13. DVIP (MOU) Meeting in Taranaki. TDHB to meet fortnightly with reps from Police, MH, Woman's Refuge and CYF to discuss + manage high risk FV cases.  14. Paediatric Liaison meeting to discuss high risk FV children and other Care and Protection concerns. Safety care plans/child protection alerts to follow.  15. Maternity care, Wellbeing and Child Protection MDT starting March 2015 to identify and manage risks to the unborn baby and newborn.  16. When FV risks to a vulnerable child is high all the siblings will be included in the Report of	<ul style="list-style-type: none"> <li>• 65% of women over 16 screened</li> <li>• 65% of positive screenings are referred to appropriate services</li> <li>• Number of staff completing Monthly VIP 8 hour core training.</li> <li>• Number of staff completing FVIP training</li> <li>• Number of staff completing training on VCA.</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	Concern to CYF		
	<b>Actions to reduce hospitalisation</b>  17. Future Taranaki Children's Team (Child Action Plan) will reduce risks and vulnerability of children  18. Currently the TDHB VIP training advocates for admitting the vulnerable child in hospital at all times when high risk/ safety concerns exist rather than not admitting the child while investigations are completed in partnership with CYF & Police.  19. All above work to prevent assault on children and need for hospitalisation after assault happened.	<ul style="list-style-type: none"> <li>65% of women over 16 screened</li> <li>65% of positive screenings are referred to appropriate services</li> <li>Number of VIP training on CAN</li> </ul>	Quarterly
<b>Provide an effective continuum of services across primary and referred services</b>	<b>Services for Pregnant women with complex needs:</b> 20. Implement the National Toolkit  21. Actions as outlined around early engagement with an LMC under Child and Maternal Health Action Plan  22. Actions as outlined as part of FVIP initiatives  23. Continue to support the work all existing providers and governance groups  24. Increase the access to peri-natal mental health services through employment of a Peri-natal mental health Nurse and audit of the referral pathway	<ul style="list-style-type: none"> <li>National Toolkit implemented by December 2015</li> <li>Reduction in presentations of unbooked pregnant women</li> <li>Reduction in presentation of women who are not enrolled with the GP</li> </ul>	
	<b>Services for vulnerable children and their families:</b>  25. Alignment of policies for protecting vulnerable children across primary and secondary services  26. Review the lactation consultant service to ensure best support for vulnerable families  27. Continue to hold MDTs across services for vulnerable families	<ul style="list-style-type: none"> <li>Increase breast feeding rates</li> <li>Reduced readmissions due to feeding problems to attachment problems</li> </ul>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>identifying families that may need increased levels of support</p> <p>28. Review the Paediatric Liaison Meeting to align with the Childrens Team philosophy and to include support and Services for Vulnerable Pregnant Women, Infants and Families Toolkit</p> <p>29. Review current peri-natal mental health pathway to ensure appropriate referral and timely access – more direct access</p>	<ul style="list-style-type: none"> <li>Reduced transfers from post-natal to neonatal for reasons such as withdrawal from substance abuse</li> <li>TDHB mental health services attending Domestic Violence Intervention Programme fortnightly meetings</li> <li>Reduced wait time for peri-natal mental health services</li> </ul>	
	<p><b>Services for children in state care:</b></p> <p>30. Continue to support the Gateway Programme for children in care</p> <p>31. Ensure timely assessment by Paediatrician</p>	<ul style="list-style-type: none"> <li>National review of Gateway Programme</li> <li>Decreased time from referral to review by Paediatrician</li> </ul>	
	<p><b>Services for children with mental health and behavioural problems:</b></p> <p>32. Stocktake and review of services needed across primary and secondary services and align with service provision</p> <p>33. Explore tools other DHBs are using to support children with mental health and behavioural problems and their parents</p> <p>34. Audit referral pathways to understand where referral pathways are unclear</p>	<ul style="list-style-type: none"> <li>Improved capacity of services</li> <li>Improved access to services – reduced wait times for CAMHS</li> </ul>	
	<p><b>Services for mental health and addiction service users in their role as parents:</b></p> <p>35. Increased staff knowledge, identification, referral and management of child abuse and neglect</p> <p>36. Explore options around the provision of paediatric community support services</p>	<ul style="list-style-type: none"> <li>Increased referrals to specialist support for vulnerable children</li> <li>Reduce referrals of children with behavioural problems to CAMHS from Paediatricians</li> </ul>	

### 2.2.3 Whānau Ora

#### 2.2.3.1 Our Approach

The vision for Taranaki Maori is “Whānau Ora – whānau supported to achieve their maximum health and wellbeing”.

The Whānau Ora philosophy articulated by the Whānau Ora Taskforce, as it relates to health, provides the philosophical base for the TDHBs approach to Whānau Ora. The characteristics of the philosophy that give Whānau Ora definition and distinctiveness are as follows:

- Recognises a collective entity (whānau)
- Endorses a group capacity for self-management and self-determination
- Has an intergenerational dynamic. That is, Whānau Ora is about ongoing intergenerational transfers towards the goal of increasing sustainability of improved health outcomes
- Is built on a Māori cultural foundation
- Asserts a positive role for whānau within society
- Can be applied across a wide range of social and economic sectors

The implication for Taranaki DHB is that every service offered or funded, must contribute to the generation of self-management knowledge and skills that are owned by whānau.

With the changes that have evolved over the past two years, the impacts for the Taranaki DHB and its approach to Whānau Ora have been significant. The DHB's investment in Whānau Ora collectives is limited and indirect, through the contribution of Tui Ora Ltd. Tui Ora is a significant Maori health provider that delivers health services throughout Taranaki and is aligned and contractually bound to an alternative Maori provider collective which is not a recognised Whānau Ora collective. This arrangement, Te Kawau Maro Alliance, pre-dates the Whānau Ora collective initiatives, and is the primary Taranaki DHB vehicle for implementing the outcomes for Whānau described in the Whānau Ora Taskforce report that provides Taranaki DHB's philosophical base for Whānau Ora.

The Taranaki DHB is nevertheless committed to taking a whānau-centred approach by aligning activities to the whānau context described above, with the stakeholders that have a contribution to achieving those outcomes. The Taranaki Ora Whānau Ora collective is an important stakeholder in this undertaking.

### 2.2.3.2 Linkages

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

- New Zealanders living longer, healthier and more independent lives, and
  - The health system is cost effective and supports a productive economy
- supports the following sector outcomes:
- Improved health and equity for all populations
  - Best value for public health system resources
  - Improved quality, safety and experience of care
- and supports the following government priorities:
- Better Public Services
  - Health Targets
  - System Integration

### 2.2.3.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Whānau Ora	<ul style="list-style-type: none"> <li>• Strengthening the relationship that the DHB has with its local Whānau Ora Provider collectives including:</li> <li>• Continue to support the development of Tui Ora Ltd infrastructure through the Maori Provider Development Scheme and Te Kawau Maro Alliance</li> </ul>	<ul style="list-style-type: none"> <li>• The DHB will participate in quarterly ALT meetings and report on the participation and linkages with other community providers, including the Taranaki Ora Collective</li> <li>• Minutes reflect Te Kawau Maro Alliance (TKM), meeting quarterly to identify strategic</li> </ul>	Annually Q2

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>relationship, to enable Tui Ora to provide ongoing support to the Taranaki Ora Collective Information Systems implementation and management and other back-office support functions as required by the collective.</p> <ul style="list-style-type: none"> <li>• Create opportunity to involve Taranaki Ora Collective (Tui Ora Ltd and Tu Tama Wahine) in the development of Whanau Ora models of care by/with Te Kawai Maro Alliance (TKM) through the work of TKM's Service Level Alliance Teams (SLATS) to identify needs, analyse gaps and develop a Whanau Ora response to addressing needs in relation to: <ul style="list-style-type: none"> <li>○ All children have the best start in life</li> <li>○ All rangatahi realise their potential</li> <li>○ Living well with a long term condition</li> <li>○ All whanau have control of their quality of life</li> </ul> </li> <li>• Involve Whanau Ora providers and collective in strategic planning</li> </ul>	<p>issues related to delivery against the TKM Outcomes framework and jointly develop appropriate solutions.</p> <ul style="list-style-type: none"> <li>• The Alliance considers extending an invitation to Tu Tama Wahine (as a member of the Taranaki Ora collective) to contribute to the inter/multi-disciplinary development of Whanau Ora models of care by/with TKM through its Service Level Alliance Teams (SLATS). Tu Tama Wahine will be invited to participate in SLATs established during 2015/16. Monitor participation quarterly.</li> <li>• As a member of the TKM Alliance Leadership Team (ALT) the DHB will support the Taranaki Ora Collective (Tui Ora Ltd and Tu Tama Wahine), to deliver against the outcomes-based contract held with the TKM alliance.</li> <li>• Meeting initiated with Te Pou Matakana Commissioning Agency to identify opportunities to support Whanau Ora providers and the collective in Taranaki.</li> </ul>	
<b>Implementing Programmes of Action</b>	<ul style="list-style-type: none"> <li>• Participating in processes led by the MOH to obtain a broader health sector view on Whanau Ora implementation, including support to providers using the Whanau Ora Information System</li> <li>• Support the provider collectives in the planned activities for implementation in 2015/16; and substantive engagement with provider collectives</li> </ul>	<ul style="list-style-type: none"> <li>• Contribute to the development of the Whanau Ora Information System</li> <li>• Provide support to local Whanau Ora providers that implement the use of the Whanau Ora Information System (Mahere)</li> <li>• Establish processes to facilitate access by the Taranaki Ora collective, to the skills and services offered by the Taranaki DHB</li> </ul>	Six-monthly Q2 & Q4
<b>Supporting Strategic Change</b>	<ul style="list-style-type: none"> <li>• Strategic planning with the DHB includes participation of the Whānau Ora provider collectives; building and maintaining relationships with agencies implementing Whānau Ora; and support for Whānau Ora across all levels of the DHB, including at Board and Planning and Funding level</li> </ul>	<ul style="list-style-type: none"> <li>• Taranaki Ora collective participates in at least one TDHB strategic planning forum</li> <li>• TDHB participates / leads / facilitates at least one strategic funder forum involving local agencies involved in implementing Whānau Ora</li> </ul>	Annually Q2
<b>Changes to the Future Direction of Whānau Ora</b>	<ul style="list-style-type: none"> <li>• Identifying opportunities to collaborate with Whanau Ora Commissioning Agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Engage with Te Pou Matakana Commissioning Agency to identify opportunities to</li> </ul>	Annually Q4

Objective	Actions to Deliver Improved Performance	Measure	Reporting
		support Whanau Ora providers and collectives in Taranaki Implement agreed joint initiatives	

## 2.2.4 Prime Minister's Youth Mental Health Project

The Department of the Prime Minister and Cabinet developed a cross agency project looking at improving services for young people with, or at risk of, mild to moderate mental health disorders. The project is designed to build on existing successful interventions and to trial new initiatives for young people aged 12-19 years (inclusive) in settings in which young people live their lives: schools, the health system, their families and community, and online.

### 2.2.4.1 Our Approach

We will be working with our primary care partners to make progress against this priority. Our activities in this priority area are expected to mean young people will be able to access the services they require before their condition escalates to being a severe mental health disorder.

### 2.2.4.2 Linkages

- Minister's Letter of Expectation
- PP25 - Delivery of the Prime Minister's youth mental health initiative
- Our Performance Story Impact – People stay well in their homes and communities

### 2.2.4.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Prime Minister's Youth Mental Health Project</b>	<b>Initiative 1. School Based Health Services (SBHS)</b> <ol style="list-style-type: none"> <li>1. Maintain the SBHS in the Decile 1-3 schools, alternative education and teen parent units.</li> <li>2. Increase access to HEADSSS through the social sector trial secondary and intermediate schools by delivering screening and assessment to students who are logged on the schools risk register,</li> <li>3. Identify schools to implement the continuous quality framework and develop timeframe in 2015/16 for this to occur.</li> <li>4. Completion of 100% of year 9 student's psychosocial health assessment by end of November annually.</li> <li>5. By December 2015. We will review the clinic hours, service provision and nurse availability with an objective to ensuring the service is accessible for</li> </ol>	<ul style="list-style-type: none"> <li>• Quarterly reporting PP25</li> <li>• Number of students in Social Sector Trial site in non decile 1-3 schools who have had a HEADSSS assessment.</li> <li>• Number of schools implementing the quality improvement framework.</li> <li>• 100% of assessments completed by end of November</li> <li>• Review completed and clinic times adjusted as necessary</li> <li>• Reporting through Quarterly MOH indicators</li> </ul>	<p>Quarterly</p> <p>Quarterly</p>

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>young people.</p> <ul style="list-style-type: none"> <li>Survey of youth and of attendance rates.</li> <li>By February 2016 Implementation of changes where identified</li> </ul> <p>6. By December 2015 we will review our adherence to privacy and confidentiality policy with an objective of ensuring it is maintained at all times for our youth.</p>	<ul style="list-style-type: none"> <li>By January 2015 policy reviewed and updated where appropriate.</li> </ul>	
	<p><b>Initiative 3: Youth Primary Mental Health.</b></p> <p>1. Evaluation of Youth Group Therapy Programmes funded through the Primary Mental Health Initiative and delivered through the Social Sector Trial.</p>	<ul style="list-style-type: none"> <li>Quarterly reporting against the evaluation framework July and October 2015 and January 2016.</li> <li>Reporting against PP25 (links to PP26)</li> </ul>	Quarterly
	<p><b>Initiative 5: Improve the responsiveness of primary care to Youth.</b></p> <p>1. Work with Midlands Health Network on the development and implementation of technology platforms targeting:</p> <ul style="list-style-type: none"> <li>Youth Suicide</li> <li>Smoking</li> <li>Sexual Health</li> <li>Drug and Alcohol</li> </ul> <p>2. Continued development of the model of care for Rangatahi through the Te Kawanui Maro SLAT. Ensure representation of experience resources from the Social Sector Trial is included.</p> <p>3. Partner with young people as part of the development of the model of care and service recommendations align to the Taranaki Taiohi Health Strategy 2013-2016.</p> <p>4. Implementation of recommendations from SLAT that are agreed through the TKM Alliance Leadership Team.</p> <p>5. Implementation of RBA monitoring framework.</p>	<ul style="list-style-type: none"> <li>Reporting against PP25 (links to PP26).</li> </ul>	Quarterly
	<p><b>Initiative 6: Review and improve the follow-up care for those discharged from CAMHS and Youth AOD services:</b></p> <ul style="list-style-type: none"> <li>Consistently follow process of</li> </ul>	<ul style="list-style-type: none"> <li>The percentage of care plans will increase to 100% by June 2016</li> <li>PP8 Shorter waiting times for non-urgent MH&amp;A services for</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>completing care plans in letters to GP to be sent within 7 days of discharge</p> <ul style="list-style-type: none"> <li>Improve follow-up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction services by providing follow-up care plans to primary care providers. The follow-up care plans should be provided with the expectation that they are activated by the primary care provider within three weeks of discharge</li> </ul>	<p>0-19 year olds 3 weeks: 80% 8 weeks: 95%</p> <ul style="list-style-type: none"> <li>The percentage of care plans included in discharge summaries to GPs from CAMHS &amp; Youth AoD will increase to 100% by June 2016</li> <li>Implementation of audit findings <ul style="list-style-type: none"> <li>Referral processes</li> <li>Discharge planning and documentation</li> <li>Care planning</li> </ul> </li> </ul>	
	<p><b>Initiative 7. Improve access to CAMHS and Youth AOD services through wait times targets and integrated case management:</b></p> <ul style="list-style-type: none"> <li>Implement agreed action to meet the waiting time targets that by 2016 will enable: 80% of youth to access services within three weeks; 95% to access services within eight weeks</li> <li>TDHB will change the model of service through role redesign in order to complete initial assessments within three weeks of referrals</li> </ul>	<ul style="list-style-type: none"> <li>Delivery against target</li> <li>Measured through PP7 being the MOH Measurement of MH&amp;A waiting times. Targets being to achieve by June 2016</li> <li>80% of service users to be seen within three weeks of referral and 95% within eight weeks</li> </ul>	Quarterly

## 2.2.5 Social Sector Trials

### 2.2.5.1 Our Approach

The Social Sector Trials (SST) are focused on improving outcomes for young people, specifically by lowering youth crime, alcohol and drug consumption and truancy, and by increasing engagement with education and employment. Taranaki DHB's participation to the Social Sector Trial will continue through leadership groups and leadership forums. We will continue to assess service delivery models with the intention to provide greater integration and flexibility in how services can be responsive to the needs of youth in the Trial site.

#### 2.2.5.2 Linkages

- Minister's Letter of Expectations
- Prime Ministers Youth Mental Health Project
- Māori Health plan
- Section developed and agreed with our primary care partners

### 2.2.5.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Social Sector Trials</b>	<ol style="list-style-type: none"> <li>1. DHB will continue to participate SST Advisory and sub working groups to maximise input to decision making</li> <li>2. TKM Rangatahi will include representation from the Social Sector Trial.</li> <li>3. Recommendations for youth service models outside the Trial location will consider the gaps and strengths working across and with agencies.</li> <li>4. We will implement new actions developed in the SST 15/16 Action Plan.</li> <li>5. We will provide a therapeutic intervention for young people with mild to moderate mild to moderate mental health and addictions issues. <ul style="list-style-type: none"> <li>• By July 2015, implement this programme to all young people attending Alternative Education in South Taranaki</li> <li>• Between October 2015 and January 2016 a full evaluation of the programme will be completed by a research evaluator.</li> </ul> </li> <li>6. Increasing access to services for young people who have parents with mental illness and/or addiction issues. <ul style="list-style-type: none"> <li>• Network with existing MH&amp;A agencies and services, schools and youth services to receive referral for young people 12 years and up.</li> <li>• Provide COPMIA groups in Hawera and Opunake to support, inform and provide skills of resilience.</li> </ul> </li> <li>7. We will continue to support cross agency case coordination of at risk young people in the Trial.</li> <li>8. We will continue to seek opportunities for joint funding initiatives with other agency partners for service provision.</li> <li>9. We will work with schools to roll out HEADSSS across secondary and intermediate schools for young people on their risk</li> </ol>	<ul style="list-style-type: none"> <li>• Quarter Four confirmation and exception report against the actions.</li> <li>• By August 2015 an additional 24 young people identified for the programme</li> <li>• By March 2016 a final evaluation report will be available.</li> <li>• Quarterly updates through MOH and to Social Sector Trial.</li> </ul>	<b>Social Sector Trials</b> Quarterly reporting through the Trial to Ministers responsible for the trial.

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>registers.</p> <p>10. DHB will participate in the ongoing engagement/consultation processes with the communities as led by the SST and using information for continuous improvement and change management.</p> <p>11. Assess contracts where specialist youth MH&amp;A roles can flex to be responsive to the trials need for access to mild and moderate services.</p> <p>12. Regular meetings with SST trial leads to ensure independent advice sought</p>		

## 2.3 SYSTEM INTEGRATION

### 2.3.1 Diabetes Care (Including DICP)

#### 2.3.1.1 Our Approach

We will continue to work with our primary care partners to reduce the impact of long term conditions like cardiovascular disease. We provide funding to our primary care partners to enable implementation of their respective long term conditions programmes (which include a focus on the More Heart and Diabetes Checks Health Target). Our primary care partners use the allocated funding to support and incentivise performance of their practices. This approach is intended to contribute to the achievement of our outcomes of improving the health status of our population and reducing or eliminating health inequalities.

We are part of a sub-regional<sup>11</sup> approach (overseen by an Alliance Leadership Team) to the funding allocation of our primary care partners, the Midlands Health Network. This approach focuses on enabling implementation of their Long Term Conditions programme using funding from an agreed flexible funding pool to support and incentivise practices. This funding is allocated to practices through a funding allocation model which covers inputs, outputs and outcomes:

- Capacity funding - calculated in year one based on high needs; year 2 based on numbers in stratified risk categories with different categories buying different levels of intervention
- Coverage funding - as practices achieve agreed coverage targets in three bands in year one and then active care plans for year two; then the funding is adjusted to reflect that the harder to reach are being actively managed.
- Quality funding - year one coverage targets and some outcome; year two moving to less coverage and greater outcome

#### 2.3.1.2 Linkages

- Minister's Letter of Expectation
- Health Target – More Heart and Diabetes Checks
- Section developed and agreed with our primary care partners
- Our Performance Story Impact: People stay well in their homes and communities

<sup>11</sup> Sub-region in this case refers to the geographic areas covered by Lakes DHB, Tairāwhiti District Health, Taranaki DHB and Waikato DHB

### 2.3.1.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>More Heart and Diabetes Checks</b>	<ul style="list-style-type: none"> <li>Taranaki DHB continue to fund Midlands Health Network to deliver face to face contacts with a Social Worker or a Dietician and 420 face to face contacts with a Clinical Pharmacist as part of a MDT for people with LTC.</li> <li>Taranaki DHB continue to fund Midlands Health Network to deliver a DCIP in Taranaki</li> <li>Taranaki DHB continue to fund professional development for General Practice staff to ensure best outcomes for people living with Diabetes</li> <li>Taranaki DHB continue to fund Midlands Health Network to meet and maintain the More Heart and Diabetes target for all ethnicities</li> <li>Taranaki General Practices will have increased access to the extension of the Midlands Health Network Long Term Condition Program including the stratification and management of people at risk of and living with Diabetes.</li> <li>Further development of a range of electronic tools to support patients in self-management and providers in care support.</li> <li>Taranaki General Practices have access to cardiovascular disease management training for general practice.</li> <li>Taranaki General Practices have access to the Multidisciplinary team for patients with cardiovascular disease</li> <li>Continue with the virtual</li> </ul>	<ul style="list-style-type: none"> <li>MHN achieve agreed referral numbers to the MDT. This is reported quarterly through the Midland Health Network ALT.</li> <li>Increase in General Practice staff with Level 7 Diabetes training</li> <li>Increase in General Practice Insulin Initiation numbers</li> <li>90% of eligible people have had their CVD Risk assessment in the last five years across all ethnicities</li> <li>The risk stratification tool is used by General Practices to differentiate between those patients that are low, medium and high needs including ethnicity, to enable the most appropriate package of care. This is reported quarterly to the DHB through the Midland Health Network ALT.</li> <li>MHN will roll out the Health Care Home Model of care to Taranaki General Practices with quarterly reporting updates to the DHB through the MHN ALT.</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	cardiovascular disease risk assessment project to support Taranaki general practice activities.		
<b>Diabetes Care Improvement Packages</b>	<ul style="list-style-type: none"> <li>Midlands Health Network and Taranaki DHB are committed to implementing the 20 Quality Standards for Diabetes Care</li> <li>MHN will roll out the year of care planning as part of the implementation of the Health Care Home model of care implementation in Taranaki</li> <li>Taranaki General Practices will have increased access to the extension of the Midlands Health Network Long Term Condition Program including the stratification and management of people at risk of and living with Diabetes.</li> <li>The TDHB Diabetes Advisory Group will continue to include consumer representation and provide support and recommendations for the delivery of services to those people diagnosed with both Type 1 and Type 2 Diabetes.</li> </ul>	<ul style="list-style-type: none"> <li>Progress on the implementation of the 20 Quality Standards for Diabetes Care will be reported to the DHB through the MHN ALT Quarterly report</li> <li>Implementation progress of the HCH model of care implementation progress will be monitored through the MHN ALT quarterly reports to the DHB.</li> <li>An increase in the number of Diabetic patients referred to the MDT for Dietetics, Podiatry, Social Work and Clinical Pharmacist support reported through the MHN ALT to the DHB quarterly</li> <li>Continual service improvement for people with Type 1 and Type 2 Diabetes</li> </ul>	Quarterly

### 2.3.2 Long term Conditions

Long term conditions account for a significant number of potentially preventable presentations at emergency department and admissions to hospital. With an ageing population this burden will increase. Improving care for people with long term conditions can best be achieved through whole of the health system approach.

#### 2.3.2.1 Our Approach

We will continue to work with our primary care partners to reduce the impact of long term conditions. There will be a focus on ensuring the care of people with long term conditions takes place in the most appropriate setting (particularly community and primary settings), with primary care nurses and allied health professionals taking wider responsibility for helping people manage their ongoing health needs. Taranaki DHB, in collaboration with our primary care alliance partners, have identified actions to reduce the impact of long terms conditions that are driving demand upwards in our district

#### 2.3.2.2 Linkages

- Midland DHBs Regional Services Plan 2015/16
- Our Performance Story Impact: People stay well in their homes and communities
- Our Performance Story Impact: People receive timely and appropriate specialist care

### 2.3.2.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Long-term Conditions</b>	<ul style="list-style-type: none"> <li>Taranaki DHB continue to fund Midlands Health Network to deliver face to face contacts with a Social Worker or a Dietician Clinical Pharmacist as part of a MDT for people with LTC.</li> <li>Taranaki General Practices will have increased access to the extension of the Midlands Health Network Long Term Condition Program including the stratification and management of people at risk</li> <li>Further development of a range of electronic tools to support patients in self-management and providers in care support.</li> <li>Enhanced ability and services through the strengthening and further shifting of hospital community based multi-disciplinary teams to be co-ordinated by and support the Health Care Homes in managing long term conditions</li> <li>TDHB ensures complex LTC inpatients are managed by specialist interdisciplinary teams.</li> <li>Implementation of the enhanced pathway from inpatients to primary care is implemented to ensure support of complex patients back to primary care post discharge</li> </ul>	<ul style="list-style-type: none"> <li>MHN achieve agreed referral numbers to the MDT</li> <li>90% of eligible people have had their CVD Risk assessment in the last five years across all ethnicities</li> <li>Increased referrals from Taranaki General Practices to the multi-disciplinary teams</li> <li>Linkage with Ambulatory Sensitive Admissions to Hospital (ASH) rates</li> </ul>	Quarterly

## 2.3.3 Stroke Services

### 2.3.3.1 Our Approach

Stroke Services are identified as a priority area in our Regional Services Plan (RSP) (see Integration across continuums of care – 2015/16 RSP). HealthShare through the Midland Stroke Action Group are leading the development and implementation of regional actions.

### 2.3.3.2 Linkages

- Midland DHBs Regional Services Plan 2015/16
- Our Performance Story Impact: People stay well in their homes and communities
- Our Performance Story Impact: People receive timely and appropriate specialist care

### 2.3.3.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Stroke Services	<ul style="list-style-type: none"> <li>Stroke thrombolysis register maintained in line with national guidelines</li> <li>Continued participation in the Midlands Regional Stroke Network around thrombolysis audit</li> <li>Ongoing workforce training to support thrombolysis including development of a medical e-learning tool</li> <li>Continued provision of a credentialling Study Day for Nursing and Allied Health Staff</li> <li>Continued provision of the Stroke Self Learning Package for appropriate staff</li> <li>Quarterly in-service stroke education</li> <li>Continued use of the FIM Assessment tool for all stroke patients</li> <li>Review pathways for thrombolysis</li> </ul>	<ul style="list-style-type: none"> <li>6% of potentially eligible stroke patients thrombolysed</li> <li>80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway</li> <li>Availability of the medical e-learning tool by December 2015</li> <li>Three education sessions per year by the stroke CNS to include Stroke pathway, Stroke Care/ inclusive of thrombolysis management</li> <li>Quarterly Attendance at Midland Stroke Network meeting by lead stroke clinician and Stroke CNS</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Continue to provide a dedicated stroke team and area for management of people with stroke, thrombolysis, and transient ischaemic attack services supported by ongoing education and training for interdisciplinary teams</li> <li>Continue to provide an interdisciplinary team for early active rehabilitation</li> <li>Continue to provide an interdisciplinary team for community stroke rehabilitation regardless of age or where they live</li> </ul>	<ul style="list-style-type: none"> <li>100% of patients referred for rehabilitation receive rehabilitation within 10 days</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Maintenance of dedicated stroke beds for management of people with stroke, thrombolysis and TIA</li> <li>Continued provision of designated lead clinician for stroke</li> </ul>	<ul style="list-style-type: none"> <li>80 % of people admitted with stroke will be managed in the stroke unit.</li> <li>6% of eligible people admitted with stroke will be thrombolysed.</li> <li>Patients that are assessed at TIA are seen in the TIA clinic- following TDHBS TIA pathway</li> <li>Lead Clinician available Monday-Friday ( Geriatrician and CNS )</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Ensure consistent delivery of rehabilitation on a 7 day basis</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing discussion of 7 day per week allied health input in progress.</li> </ul>	
	<ul style="list-style-type: none"> <li>Participation in national and regional clinical stroke networks to support implementation and maintenance of stroke and thrombolysis services</li> </ul>		Quarterly
	<ul style="list-style-type: none"> <li>Support national and regional clinical stroke networks to implement actions to improve stroke services</li> </ul>		Quarterly
	<p>TDHB is a member of AROC (Australasian Rehabilitation Outcome Measure Centre)</p> <p>Each patient requiring stroke rehabilitation is measured on the following rehabilitation indicators at time of discharge</p> <ul style="list-style-type: none"> <li>Complications</li> <li>Discharge Destination</li> <li>Aspiration</li> <li>UTI</li> <li>Chest infection</li> </ul> <p>TDHB also measure via the FIM (Functional Independent Measure) what a person with a stroke/disability actually does. The tool assesses the need for assistance, and the type and amount of assistance required for a person with a disability to perform basic life activities effectively.</p> <p>Items that are directly measured are</p> <ul style="list-style-type: none"> <li>self-care transfers</li> <li>mobility</li> <li>Cognitive items ie communication, social interaction</li> <li>This is completed on admission, discharge and when required during their inpatient stay.</li> </ul>	<ul style="list-style-type: none"> <li>Data collected using these tools will support the treatment planning and rehabilitation for affected patients.</li> </ul>	Quarterly

### 2.3.4 Cardiac Services

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

### 2.3.4.1 Our Approach

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

In 2015/16 we will be continuing the work around the acute coronary syndrome (ACS) service delivery working with the regional group to deliver a timely service to our patients throughout the care pathway. We will continue to engage with our primary care partners in the planning and implementation activities that occur in this area.

### 2.3.4.2 Linkages

- Minister's Letter of Expectations
- Midland DHBs Regional Services Plan 2015/16
- Our Performance Story Impact: People receive timely and appropriate specialist care

### 2.3.4.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Cardiac Services	<ul style="list-style-type: none"> <li>Intervention rate for cardiac surgery is set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access</li> </ul>	<ul style="list-style-type: none"> <li>Agreement to and provision of a minimum of 88 total cardiac surgery discharges for local population in 2015/16</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Improve access to cardiac diagnostics to facilitate appropriate treatment referrals, including angiography, echocardiograms, exercise tolerance tests, etc</li> </ul>	<ul style="list-style-type: none"> <li>Refer PP29: Improved access to diagnostics. 95% of people will receive elective coronary angiograms within 90 days</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Enhanced patient referral pathways to support improved and timely access to all cardiac services</li> </ul>	<ul style="list-style-type: none"> <li>Improvement on current baselines</li> <li>ESPI compliance</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Manage waiting times for cardiac services, so that no patient waits longer than four months for first specialist assessment or treatment.</li> </ul>	<ul style="list-style-type: none"> <li>Elective Services Patient Flow Indicators: all patients wait four months or less for first specialist assessment and treatment</li> </ul>	Monthly
	<ul style="list-style-type: none"> <li>Undertake initiatives locally to ensure population access to cardiac services is not significantly below the agreed rates. This includes cardiac surgery, percutaneous revascularisation and coronary angiography</li> </ul>	<ul style="list-style-type: none"> <li>Refer SI4: Standardised Intervention Rates</li> <li>Cardiac surgery: 6.5 per 10,000 of population</li> <li>Percutaneous revascularisation: 12.5 per 10,000 of population</li> </ul>	
	<ul style="list-style-type: none"> <li>Participation in regional cardiology network activities</li> </ul>	Maintenance of regional collaboration and working groups	Quarterly
	<ul style="list-style-type: none"> <li>Embedding of ACCP pathway implemented in Taranaki in 2014/15</li> </ul>	Audit and Review of pathway to be completed Q2	Quarterly
	<ul style="list-style-type: none"> <li>Implement regionally agreed protocols and systems to optimise management of patients with heart failure</li> </ul>	<ul style="list-style-type: none"> <li>Reduced HF admissions, base line to be determined Q1</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Implementation of local cardiology recommendations</li> </ul>	<ul style="list-style-type: none"> <li>Coronary angiography: 34.7 per 10,000 of population</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Acute Coronary Syndrome</b>	<ul style="list-style-type: none"> <li>Taranaki DHB will Implement the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention</li> <li>TDHB and the midland region continue to enhance pathways for patients to ensure high risk ACS patients accepted for coronary angiography having it within 3 days of admission</li> <li>Increased local provision of angiography from Q3 for appropriate high risk ACS patients.</li> </ul>	<ul style="list-style-type: none"> <li>Indicator 1. &gt;70% of high risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission=Day 0)</li> </ul>	Performance reported against health target
	<ul style="list-style-type: none"> <li>Taranaki DHB will develop processes, protocols and systems to enable local risk stratification and transfer of appropriate high risk ACS patients</li> </ul>	<ul style="list-style-type: none"> <li>Indicator 2 &gt;95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS Q1 ACS and Cath/PCI registry data collection within 30 days</li> </ul>	Performance reported against health target
	<ul style="list-style-type: none"> <li>Taranaki DHB will work with the midland region, to improve outcomes for high risk ACS patients</li> </ul>		Performance reported against health target
	<ul style="list-style-type: none"> <li>Commission new angiography suite</li> <li>Embed processes to increase number of acute angiograms completed locally</li> </ul>	Sept 2015 new suite open	Performance reported against health target
	<ul style="list-style-type: none"> <li>TDHB cardiologists continue to meet with regional group to develop regional guidelines</li> </ul>		Performance reported against health target

## 2.3.5 Improved Access to Diagnostics

### 2.3.5.1 Our Approach

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

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

### 2.3.5.2 Linkages

- Our Performance Story Impact: People receive timely and appropriate care
- Improved Access to Elective Services

### 2.3.5.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Improved Access to Diagnostics</b>	<b>Radiology</b> In partnership with Fulford Radiology, Taranaki DHB will fully participate in the National Radiology Project. The Evolve Project Team will continue to work on improving access, reducing wait times, improving flow and increasing quality care with a focus on: <ul style="list-style-type: none"> <li>• Clear referral criteria and a streamlined triage process</li> <li>• Standardising radiology clinical pathways for best practice</li> <li>• Optimising patient flow through the radiology department to increase scanning time available</li> <li>• Better alignment of staffing rosters (including radiologists) to the incoming demand</li> <li>• Revising the scheduling and booking processes including a clear policy for DNA patients</li> <li>• Setting in place annual production planning processes</li> </ul>	<ul style="list-style-type: none"> <li>• 95% of accepted referrals for CT scans and 85% of accepted referrals for MRI scans will receive their scan within six weeks (42 days)</li> </ul>	Quarterly
	<b>Radiology</b> <ul style="list-style-type: none"> <li>• Work with the Midland Radiology Advisory Group to:               <ul style="list-style-type: none"> <li>○ Provide feedback and advice for the Map Of Medicine pathways and diagnostics for service delivery models</li> <li>○ Utilise regional benchmarking for performance improvement</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Representation, attendance and participation in national and regional clinical group activities</li> <li>• Agreed system changes are implemented</li> </ul>	Quarterly
	<b>Radiology and Colonoscopy/Endoscopy</b> <ul style="list-style-type: none"> <li>• Participate in activity relating to development and implementation of the National Patient Flow (NPF) system, including adapting data collection and submission to allow reporting to the NPF as required</li> </ul>	<ul style="list-style-type: none"> <li>• NPF compliance</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>• Continue to progress the implementation of the Global Rating Scale for Endoscopy with the support of the National Endoscopy team</li> </ul>	<ul style="list-style-type: none"> <li>• Self-assessments of GRS progress meet expected targets</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>• Multidisciplinary team to review and implement improvement initiatives around referral management, prioritisation process, single wait list, introduction of planning tool by</li> </ul>	<ul style="list-style-type: none"> <li>• 75% urgent symptomatic referrals seen within 14 days (100% within 30 days)</li> <li>• 65% non-urgent symptomatic referrals seen within 42 days (100% within 120 days)</li> </ul>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	July 2015 in order to meet expected waiting times	<ul style="list-style-type: none"> <li>65% surveillance referrals seen within 84 days of their due date (100% within 120 days)</li> </ul>	

## 2.3.6 Taranaki Integrated Health System

### 2.3.6.1 Our Approach

There is a growing commitment to the achievement of more effective system integration in partnership with primary care and other stakeholders. This is fundamental to strengthening our healthcare system and provides an opportunity for clinical leadership to drive improved system integration and Better Public Services

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

#### An Alliance Environment

In Taranaki we have a range of mechanisms to create an environment for integration that facilitate working together to develop and implement models of service delivery and new initiatives that provide improved health outcomes for the population of Taranaki. These include the Midland Alliance, Whakatuhonotanga Alliance and Taranaki Alliance Leadership Team. The aim of these mechanisms is to provide leadership and direction to enable the provision of increasingly integrated and co-ordinated health services, through clinically-led service development and its implementation within a “best for patient, best for system” (Whole of System) framework

#### Midland Health Network Alliance Work Plan

The TDHB work in collaboration with the Midlands Health Network as part of an Alliance framework. The Network plan (2014-17) describes how the DHB and the Midland Health Network founding partners work collectively as a Midland Alliance to improve the health of the population and achieve equity of outcome for everyone. This plan forms the basis of the Midland Alliance Workplan and is structured around three key layers that require development.

- Foundation level which is focussed on providing the best workforce for each Locality’s needs, improving systems, supporting high performance within practices and establishing tools for effective integration with the broader health and social care systems
- Practice Level working with practices to help them achieve their optimum performance and establishing enhanced general practice
- Service Redesign. Working to reengineer a range of existing services and creating new ones to maximise effectiveness in four key areas, Healthy Tamariki and Rangatahi, Supporting People with Mild Mental Health Conditions Living with a Long term condition and smoke free

#### Te Kawau Mārō

The District Health Board forms part of the Whakatuhonotanga Alliance for the Te Kawau Mārō Results Based Accountability Agreement to progress improved outcomes for Maori Health focus on improvements in four outcomes

- All Children have the best start in Life
- All rangitahi realise their potential
- All whanau live well with a long term condition
- All whanau have control over their quality of life

### **Taranaki Alliance Leadership Team**

The Taranaki Alliance Leadership Team provided governance and business ownership role for a number of Taranaki Specific initiatives and assist by driving progress toward the vision of Taranaki Together, A healthy Community.

### **Models of Service Delivery**

Those key models of service delivery include; Adult Physical Health Community Services, Management of Long Term Conditions (LTC) utilising the Multidisciplinary team (MDT), the management of Acute Demand including Primary Options in the community and Emergency Department redirection of low acuity patients safely back to Primary Care, implementation of clinical pathways 'Map of Medicine' and medication adherence support for those people living in the community with long term conditions. Shared information, data and processes will support integration initiatives such as clinical pathways and sharing of patient controlled health records between the Emergency Departments and General Practices. Direct referral for diagnostics and e-referral between providers, will continue to be progressed to achieve the health outcomes sought for 'co-ordinated care' for care sooner and closer to home

### **Primary Care Acute Demand Services**

The Taranaki Alliance Leadership Team has agreed to implement Primary Care Acute Demand Services in Taranaki. These services included components of Primary Options and Ed Redirection. These services have been initiated to move appropriate services out of secondary care into primary and represent a collaborative approach to Managing acute demand in Taranaki. The service was established in July 2014 and be evaluated in 2015-16 to inform future implementation approach.

### **Health Targets**

Achievement of the national Health Targets will be closely linked to these service delivery models and utilise systematic information processes for reporting and monitoring. Key targets for primary care focus are better help for smokers to quit; Increased immunisation; more heart and diabetes checks and reducing the current health disparities.

Shared information, data and processes will support integration initiatives such as clinical pathways and sharing of patient controlled health records between the Emergency Departments and General Practices. Direct referral for diagnostics and e-referral between providers, will continue to be progressed to achieve the health outcomes sought for 'co-ordinated care' for care sooner and closer to home.

### **Intersectional Dimensions**

These strategies will also benefit and support cross sectorial linkage to other social sector organisations and initiatives such as 'Whanau Ora', Children's Action Plan, the Social Sector Trial and youth mental health initiatives. Taranaki DHB values the work of NGO providers and will continue to seek to engage them in key strategic ventures that reduce inequality and improve health outcomes.

#### **2.3.6.2 Linkages**

- Midland DHBs Regional Services Plan 2015/16
- Our Performance Story Impact: People stay well in their homes and communities
- Our Performance Story Impact: People receive timely and appropriate specialist care

#### **2.3.6.3 Action Plan**

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Progress Development of Taranaki Alliance Leadership Team Work plan	<ul style="list-style-type: none"><li>• Achievement of milestones outlined in work programme Taranaki Alliance Leadership Team by 30 July 2015</li></ul>	<ul style="list-style-type: none"><li>• Provide Quarterly updates on progress against new milestones agreed at Taranaki Alliance Leadership Team</li><li>• Quarter Reports demonstrated</li></ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
		Service development projects are developed with the context of the Taranaki Alliance Leadership (TALT) Evidence of MHN and TKM engagement in Annual Plan	
Progress the Taranaki Integrated Health Care Project	<ul style="list-style-type: none"> <li>Implement an agreed Integrated Model of Care for the Taranaki region which includes the Health Care Homes</li> </ul>	<ul style="list-style-type: none"> <li>Confirm the project plan</li> <li>Identify any services to be shifted</li> <li>Confirm the implementation plan, including budget and outcomes</li> <li>Begin implementation of services that are approved by the board</li> </ul>	Q1 Q2  Q3  Q4
Primary Care Acute Demand Services	<ul style="list-style-type: none"> <li>Continued Implementation of Primary Care Acute Demand</li> <li>Evaluate Primary Care Acute Demand</li> <li>Agree future approach to ED redirection/ Primary Options</li> </ul>	<ul style="list-style-type: none"> <li>Number of primary Options and Emergency Department Redirections episodes in period 01 July – 30 September and 01 October – 31 December</li> <li>Complete Evaluation by September 2015</li> <li>Action Plan agreed by TALT</li> </ul>	Quarterly   Q1  Q2

### 2.3.7 Primary Care

#### 2.3.7.1 Our Approach

We will work with our primary care partner specifically the TDHB work in collaboration with the Midlands Health Network as part of an Alliance framework. The Network plan (2014-17) describes how the DHB and the Midland Health Network founding partners work collectively as a Midland Alliance to improve the health of the population and achieve equity of outcome for everyone.

Midland Health Network models of care currently being implemented including;

- Long Term Condition Management Programme
- Multidisciplinary Teams
- Primary Options for clinical co-ordination of people requiring an integrated service between primary and secondary acute presentations. These programmes ensure people can access services closer to home and in a primary care setting and assist reduction of unnecessary presentations to ED

#### 2.3.7.2 Linkages

- Performance Story Impact: People stay well in their homes and communities
- Prime Minister's Youth Mental Health Project – Youth Services
- Strong linkages exist to other primary care focused services such as:
  - Shorter Stays in ED
  - Increased Immunisations
  - Better Help for smokers to quit
  - More Heart and Diabetes checks
  - Long Term conditions
  - Improved Access to Diagnostics
  - Maternal and Child Health
  - Green Prescription

### 2.3.7.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Multidisciplinary Teams for Long Term Conditions	<ul style="list-style-type: none"> <li>Continue development and access to co-ordinated series of packages of care through a primary care long term conditions Allied Health Multidisciplinary Team</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly reporting to the DHB from the MHN ALT showing the continued growth in the referrals from General Practice</li> </ul>	Quarterly
Primary Care Acute Demand Services	<ul style="list-style-type: none"> <li>Continued Implementation of Primary Care Acute Demand</li> <li>Evaluate Primary Care Acute Demand</li> <li>Agree future approach to ED redirection/ Primary Options</li> </ul>	<ul style="list-style-type: none"> <li>Number of primary options and Emergency Department Redirections episodes in period 01 July – 30 September and 01 October – 31 December</li> <li>Completion of Interim Evaluation report by 31 August 2015</li> <li>Completion of Evaluation report by 30 January 2016</li> <li>Action Plan agreed by TALT</li> </ul>	Quarterly Q1 and Q2  Q1  Q3   Q3
Enhanced Primary Care	<ul style="list-style-type: none"> <li>Further development and roll out of the Health Care Home model of care to ensure a fit for purpose sustainable primary care environment - create capacity for patient-specific appointments</li> </ul>	<ul style="list-style-type: none"> <li>Increase Taranaki population will be covered by Health Care Home by 2017</li> <li>Greater standardisation and increased capacity within primary care</li> <li>Roll out to create capacity for patient-specific appointments – 30 percent of practices</li> </ul>	Quarterly ALT Report
	<ul style="list-style-type: none"> <li>Scope the potential for the development of Expert Patient Groups for those with common needs to facilitate self-management of long term conditions.</li> </ul>	<ul style="list-style-type: none"> <li>Scope Completed</li> <li>Quarterly reporting to the DHB from the MHN ALT on the progress toward Self-management groups establishment</li> </ul>	Quarterly ALT Report
	<ul style="list-style-type: none"> <li>Working with general practice to introduce an improved primary care overflow and out of hours service</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly reporting to the DHB from the MHN ALT on progress toward greater standardisation and increased capacity within primary care</li> </ul>	Quarterly ALT Report
	<ul style="list-style-type: none"> <li>Rural Service Level Alliance Team plan for distribution of the Rural Primary Care funding implemented</li> </ul>	<ul style="list-style-type: none"> <li>Rural Service Level Alliance submitted to MHN ALT by December 2015</li> </ul>	Quarterly ALT Report
Map of Medicine	<ul style="list-style-type: none"> <li>Continuation of the localisation of the Map of Medicine programme</li> <li>Implement the MoM Strategy paper recommendations</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly reporting to the DHB from the MHN ALT on the utilisation by Taranaki practitioners of the clinical pathways</li> <li>Clinical Utilisation has increasing trend</li> <li>E referral link to specific MOM</li> </ul>	Quarterly ALT Report

Objective	Actions to Deliver Improved Performance	Measure	Reporting
		pathways <ul style="list-style-type: none"> <li>• Prioritise the high demand, high need clinical pathways ensuring they include the pathway from primary to secondary on to tertiary if required and them back to the health Care Home in Primary Care.</li> </ul>	Quarterly ALT Report
Direct Access	<ul style="list-style-type: none"> <li>• Maintenance of direct GP access to:               <ol style="list-style-type: none"> <li>1. gastroscopy</li> <li>2. minor operations list</li> </ol> </li> <li>• TDHB will maintain and support specialist advice services for GPs in their management of patients in the primary care environment.</li> <li>• The Annual Plan process is jointly agreed by TDHB and MHN</li> </ul>	<ul style="list-style-type: none"> <li>• These services are Mental Health and Paediatrics Specialist services pathways implemented by Quarter 2, 2014.</li> <li>• Both TDHB and MHN sign off of Annual Plan prior to submission to the MoH.</li> </ul>	
Implementation of Free Under 13 Years	<ul style="list-style-type: none"> <li>• Taranaki DHB will contract with MHN to provide free first level medical care for under 13's year olds both in hours and out of hours.</li> <li>• Taranaki DHB will contract with Community Pharmacies co-located with the two accident and Medical Clinics to provide dispensing services 7 days a week free of charge to all under 13 year olds</li> </ul>	<ul style="list-style-type: none"> <li>• From 1 July 2015 95% of under 13 year olds will have access to free first level medical care in Taranaki within one hours travelling time.</li> <li>• From 1 July 2015 95% of under 13 year olds will have access to free dispensing of medications in Taranaki within one hours travelling time</li> </ul>	

## 2.3.8 Health of Older People

### 2.3.8.1 Our Approach

During 2015/16 we will continue to work with our primary care partners and regional DHBs to develop and refine integrated services that will address the needs of older people - from those with basic needs to those whose needs have a greater complexity, working towards a restorative outcome wherever possible.

During 2015/16 we will continue our focus on establishing a regional approach to the delivery of Home and Community Support Services. The Midland DHB region will participate in the development of the national Health of Older People Steering Group's national framework and on the cost implications of quality care. Where applicable we will use the framework to inform decision-making about the implementation of a Midland DHB regional approach.

### 2.3.8.2 Linkages

- Our Performance Story Impact: People receive timely and appropriate specialist care
- Midland District Health Boards Regional Services Plan 2015/16
- Midlands Health of Older People Clinical Action Network Action Plan

### 2.3.8.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Health of Older People	<b>Rapid response and discharge management services (wrap around services) (PP23)</b> <ul style="list-style-type: none"> <li>TDHB will progress the implementation of an ED Rapid Response Service aimed at identifying elderly with complex comorbidities and optimising their management to maintain functional independence and reduce avoidable readmission to ED and hospital</li> </ul>	<ul style="list-style-type: none"> <li>Appointment of an ED CNS by 16 July 2016 following development of a Rapid Response Model</li> <li>Number of over 65's who undergo initial assessment by a rapid response service in ED (establish baseline in 2015/16-through use of existing patient management system MOMENTUM- ED Screener.</li> <li>Reduction in over 75s ASH rates</li> <li>Reduced ED re-presentation for over 75s (Progress establishment of baseline in 2015/16)</li> </ul>	Quarterly
	<b>Home and Community Support Services for Older People (PP23)</b> <p>Use of interRAI measures to progress and compare performance with other DHBs.</p> <ul style="list-style-type: none"> <li>TDHB will use interRAI measures to compare performance with other DHBs across the Midlands Region (e.g. comparisons of service utilisation across different age groups)</li> <li>TDHB continues to participate in the HOP Midlands Regional Action Group around development of consistent quality interRAI measures</li> </ul> <p>Implementation of the In Between Travel agreement</p> <ul style="list-style-type: none"> <li>TDHB will transfer funding resulting from the national In Between Funding travel settlement from TDHB to HCSS providers as per national guidance</li> </ul> <p>Regional HCSS initiative</p> <ul style="list-style-type: none"> <li>TDHB will continue to participate in the Midlands Region HCSS Redesign Project</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of using interRAI measures to progress and compare performance with other DHBs in the Midlands Region (narrative report)</li> <li>Evidence of funding transfer to HCSS providers</li> <li>Narrative report on progress</li> </ul>	Quarterly
	<b>Dementia Care Pathways (PP23)</b> <p>Proactive and coordinated development of dementia care pathways will continue, building on previous work to develop further components of the dementia</p>		Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>pathway.</p> <p>Actions to support early diagnosis include:</p> <ul style="list-style-type: none"> <li>• Provision of support and education for staff regarding dementia care</li> <li>• Survey of staff trained pre and post training</li> </ul> <p>Actions to support patients and their families on diagnosis include:</p> <ul style="list-style-type: none"> <li>• Continue to deliver Living Well Groups aimed at people recently diagnosed with dementia and their carers</li> </ul> <p>Local Dementia Pathway initiatives:</p> <ul style="list-style-type: none"> <li>• Continue to meet locally to maintain the Taranaki Map of Medicine Pathway dementia pathway</li> </ul> <p>Regional Dementia Pathway initiatives</p> <ul style="list-style-type: none"> <li>• Work with Midland DHBs to implement region-wide Dementia Education Programme for Primary Care through development of education resources and use of Educators delivering workshops to Primary Care clinicians</li> <li>• Continued regional implementation of the Regional Dementia Pathway</li> </ul>	<ul style="list-style-type: none"> <li>• 50% of all GP Practices have training provided</li> <li>• Awareness of dementia care in the community increased</li> <li>• Delivery of two Living Well Groups by June 2016</li> <li>• Dementia care pathway localisation meetings every six months</li> <li>• Dementia Education resources developed by December 2015</li> <li>• Number of education workshops delivered to Primary Care (baseline to be established in 2015/16)</li> <li>• Narrative report on progress of regional Dementia Pathway implementation</li> </ul>	
	<p><b>Fracture Liaison Service (PP23)</b></p> <ul style="list-style-type: none"> <li>• TDHB will continue to deliver the Fracture Liaison Service (which was established 1 July 2014)</li> <li>• TDHB will continue to monitor and measure the number of people who are seen by the Fracture Liaison Service and the treatment that they receive</li> <li>• Outcome measures such as referral to other services (e.g. Green Prescription at Sport Taranaki, Community Support Service, InterRAI Assessment) will be entered into the data base and</li> </ul>	<ul style="list-style-type: none"> <li>• Number of over 50s assessed by the Fracture Liaison Service (all referrals will be entered into the FLS Database)</li> <li>• Number of over 50s assessed by Fracture Liaison Service who are referred for DEXA scans</li> <li>• Number of over 50s assessed by FLS that have received appropriate treatment (i.e. osteoporosis treatment) and/or referral on to appropriate service (e.g. fall prevention programmes, referral for</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>reported quarterly</p> <ul style="list-style-type: none"> <li>The FLS programme will be audited to assess compliance</li> </ul>	<p>interRAI assessment, Green Prescription, etc) - as recorded on the FLS Database</p> <ul style="list-style-type: none"> <li>While the patient is still active within the service the patient's clinical file will be updated and progress documented. Once episode of care is complete this is linked to the patients IBA record.</li> <li>Audit completed and report produced by July 2015</li> </ul>	
	<p><b>Comprehensive Clinical Assessment in Residential Care and In Home Settings (PP23) (PP18)</b></p> <ul style="list-style-type: none"> <li>Older people referred for an interRAI assessment to access publicly funded care services will undergo the assessment and have a service allocated/declined in a timely manner</li> </ul>	<ul style="list-style-type: none"> <li>The number and percentage of older people who have received long term home and community support services in the last 3 months who have had an interRAI Homecare or Contact assessment and completed care plan (including evidence of the total number of older people who have received long terms home and community support services)</li> <li>The percentage of older people in aged residential care by facility who have a second InterRAI LTCF assessment completed 230 days after admission.</li> <li>Taranaki DHB Community Support Service have initiated a priority allocation system which will be recorded in the urgency box on the Service Coordination Information Data Base (SCID) Needs Assessment screen. The number and percentage of clients referred from any source to complete an interRAI assessment (Contact or Home Care) will be in line with national timeframes for crisis, high, medium and low risk clients as follows:</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
		<ul style="list-style-type: none"> <li>- Crisis – within 24-48 hours</li> <li>- High risk – 1-5 days for assessment and maximum 5 days to service co-ordination</li> <li>- Medium risk – 1-10 days for assessment and maximum 10 days to service co-ordination</li> <li>- Low risk – 1-15 days for assessment and maximum 15 days to service co-ordination</li> </ul> <p>These assessment and coordination time frames will be auditable from the Service Coordination Information Data Base (SCID).</p>	
	<b>HOP Specialists (PP23)</b> <ul style="list-style-type: none"> <li>• TDHB will continue the use of DHB specialist HOP services (Geriatricians, Gerontology Nurse Specialist) to advise and train health professionals in primary care and aged residential care to ensure quality outcomes for older people.</li> <li>• TDHB will provide ongoing multidisciplinary specialist support for the TDHB Enhanced Intermediate Care Service. The service is designed to facilitate the transition from hospital to home by maximising a person's functional ability and independence. A multi-disciplinary team of health care professionals, including occupational therapists, physiotherapists, doctors, nurses and rest home staff all work together to provide a restorative programme of rehabilitation for up to six weeks.</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain the number of hours/ consultations that specialist HOP services provide advice and/or training to health professionals in primary care and aged residential care at a minimum of 250 hours/ consultations per quarter</li> <li>• Effectiveness of the MDT specialist input to the Enhanced Intermediate Care Service will be based on the percentage of clients that return to their own homes in the community (independent living) following discharge from the intermediate care service. The target for TDHB is that 75 % of people will be discharged to their own homes.</li> </ul>	Quarterly
	<b>Regional Alignment:</b> <ul style="list-style-type: none"> <li>• Continue to engage with Midland DHBs in development of the new service model and funding model for restorative home support</li> </ul>	<ul style="list-style-type: none"> <li>• New service and funding model for Midlands Region agreed upon by 30 June 2015</li> </ul>	Quarterly

## 2.3.9 Rising to the Challenge 2012-2017

### 2.3.9.1 Our Approach

We will continue to work collaboratively with other Government Agencies, our Non-Government Organisations (NGO), Primary Care partners and regional colleagues to assist in the delivering of the outcomes in the Mental Health and Addiction Service Development Plan.

### 2.3.9.2 Linkages

- Our Performance Story Impact: People receive timely and appropriate specialist care
- Midland District Health Boards Regional Services Plan 2015/16
- Mental Health and Addiction Service Development Plan

### 2.3.9.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Mental Health Service Development Plan</b>	<b>1. Make better use of resources/value for money</b>  1.1 Progress the integration of Adult and Child and Youth Key Performance Indicators into a revised clinical governance framework  1.2 Develop strategies around assertive engagement with newly referred people  1.3 Use data collected around inpatient discharge delays to initiate discussion with key partners around removing barriers to discharge  1.4 Redesigned process - begin discharge planning process on day one of admission. People to have a goal discharge date.  1.5 In 2015/16 will continue to work with the sector to review the current service models with an aim to improve the effectiveness of service provision. Focus on early intervention and prevention.	<ul style="list-style-type: none"> <li>• PP26 Reporting quarterly against Rising to the Challenge</li> <li>• Improving the health status of people with severe mental illness PP6</li> <li>• PP8 Waiting time for adult outpatient services meets milestone of 80% being seen &lt;= 3 weeks and 95% being seen &lt;= 8 weeks to be achieved by end December 2015</li> <li>• Type and number of discharges recorded - reduced total number of delayed discharge days</li> <li>• 50% of people have goal discharge date by December 2015 with 75% by June 2016</li> <li>• PP26 Reporting quarterly through Rising to the Challenge</li> </ul>	Quarterly
	<b>2. Improve integration between primary and specialist services</b>  2.1 Localised development and production of mental health and addictions Map Of Medicine pathways 2.2 Provide education and training for GPs:	<ul style="list-style-type: none"> <li>• PP26 Reporting quarterly against Rising to the Challenge</li> <li>• Prioritised pathways will be published by December 2015</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Management of patients using Map of Medicine Pathways</li> <li>Dementia pathways</li> <li>Children Of Parents with Mental Illness and/or Addictions (COPMIA)</li> <li>Addiction</li> <li>Relapse prevention plans</li> </ul> <p>2.3 Implementation of a project for management of non-complex Clozapine in primary care</p> <p>2.4 Work with Midlands Health Network to establish review of current service</p> <p>2.4.1 Review includes: reviewing access, clinical entry and referral criteria. Determining the providers required and the referral process to these providers e.g.</p> <ul style="list-style-type: none"> <li>NGO providers</li> <li>PMH Coordinators</li> <li>Counsellors</li> <li>Psychologists</li> <li>Secondary Care</li> </ul> <p>2.4.2 Determining the types of interventions required such as:</p> <ul style="list-style-type: none"> <li>Electronic health tools</li> <li>Phone contacts</li> <li>Face to face (1:1)</li> <li>Face to face (group)</li> </ul> <p>2.4.3 And provider capability covering:</p> <ul style="list-style-type: none"> <li>Youth appropriate</li> <li>Culturally appropriate</li> <li>Alcohol and Drug</li> <li>Addictions</li> </ul> <p>2.4.4. Complete a service manual available for centralised triage service.</p> <p>2.5 Work with Midlands Health Network and wider sector to establish a SLAT to review the impact of implementing the stepped-care and shared-care model.</p> <p>2.6 Quarterly management meetings are in place to discuss MH&amp;A strategy and operational matters.</p>	<ul style="list-style-type: none"> <li>Training content decided by September 2015 and training programme in place end June 2016</li> <li>80% of non-complex Clozapine clients transitioned to primary care management December 2015</li> <li>By November 2015 establish terms of reference for the review.</li> <li>By March 2016, review completed and recommendations available</li> <li>By June 2016 manual completed.</li> <li>By March 2016 implementation of SLAT recommendations</li> </ul>	
	<b>3. Cementing and building on gains in resilience and recovery with for people with low-prevalence</b>	<ul style="list-style-type: none"> <li>PP26 Reporting quarterly against Rising to the Challenge</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p><b>conditions and/or high needs</b></p> <p>3.1 Audit of available data on number of people who were asked and then indicate they have parenting responsibilities</p> <p>3.2 Increasing number of people with relapse plans in place through review of current plan format, staff training twice yearly, raised service user awareness through plan development at 3-monthly review meetings, and development of community booklet</p> <p>3.3 To support employment specialists in the Mental health and Addictions Services by:</p> <p>3.3.1 NGO employment specialists will attend monthly MDT for A&amp;D service.</p> <p>3.3.2 Adult MH services employment specialists will be available on site weekly.</p>	<ul style="list-style-type: none"> <li>Minimum of 10% of notes audited within current caseload once per year</li> <li>Relapse prevention plan format includes provision for the care of children during acute episodes</li> <li>80% of patients have relapse plans by June 2016. Milestone of 75% at end December 2015</li> <li>PP26 Reporting quarterly against Rising to the Challenge</li> </ul>	
	<p><b>4. Deliver increased access for all age groups</b></p> <p>4.1 To reduce DNA rates through range of activities including exploring options around GP and family engagement, surveying patients to ask them why they do not attend and looking at DNA rates across teams</p> <p>4.2 Review service entry and exit criteria for community service users against current client base – review service users with sub-clinical HONOS scores for potential discharge from service</p> <p>4.3 Utilise HONOS sub-clinical data routinely to assist MDTs in decision making regarding entry and exit</p> <p>4.4 Support the implementation of COPMIA services in 15/16 and will work with the MOH to implement the national guidelines</p>	<ul style="list-style-type: none"> <li>PP26 Reporting quarterly against Rising to the Challenge</li> <li>Current DNA rate 13%. Aim to reduce to 12% by December 2015 and less than 10% by June 2016</li> <li>Current sub-clinical HONOSCa = 9%. Current sub-clinical HONOS = 8.5%</li> <li>25% reduction in number of sub-clinical HONOS scores on caseload</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Implementation of the New Zealand Suicide Prevention Strategy 2006-2016 and the New Zealand Suicide Prevention Action Plan 2013-2016.	<p><b>5. Implementation of the Taranaki Suicide Prevention and Postvention Plan 2015-2017</b></p> <p>5.1 By June 2015, Taranaki in conjunction with the wider community, agencies and key stakeholders will have completed a Taranaki Suicide Prevention and Postvention Plan 2015-2017.</p> <p>5.2 We will implement the activity described in the Plan across 2015 – 2017 years.</p> <p>5.3 We will have a directory of whole of sector services available for suicide postvention and prevention.</p> <p>5.4 The implementation Plan will include workforce development and training needs, activity to integrate cross agency response to suicide postvention.</p>	<ul style="list-style-type: none"> <li>By July 2015, MOH will have signed of the Plan.</li> <li>June 2016 report against the activity achieved for the implementation of the Plan.</li> <li>Quarterly reporting as per any MOH requirements for 15/16</li> </ul>	Quarterly

### 2.3.10 Maternal and Child Health

#### 2.3.10.1 Our Approach

We intend to undertake actions to improve the access that pregnant women, babies, children and families have to services that maintain good health and independence through:

- Supporting them to enrol with a GP and Well Child Tamariki Ora (WCTO) provider as early as possible
- Alerting health providers when a child or young person is due for a health milestone
- Better informing all providers about the progress of a child or young person
- Investing in services to increase breastfeeding rates

#### 2.3.10.2 Linkages

- Our Performance Story Impact: People stay well in their homes and communities
- Our Performance Story Impact: People take greater responsibility for their health
- Midland District Health Boards Regional Services Plan 2015/16

#### 2.3.10.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Timely Registration with an LMC and increased number of	<b>1 TDHB will increase the number of women who register with an LMC by week 12 of their pregnancy by</b>	<ul style="list-style-type: none"> <li>At least 80% of women register with an LMC by week 12 of their pregnancy</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
women who receive continuity of primary maternity care during their pregnancy	<p>1.1 Maintenance of TDHB Internet site around accessing an LMC</p> <p>1.2 Increase the number of women who receive continuity of primary maternity care during their pregnancy access through a community LMC</p> <p>1.3 Increase the number of women who register with an LMC in their first trimester with a focus on Māori women living in areas of high deprivation</p> <p>1.4 Work with LMC's and the Te Kawau Maro Mama, Matua, Pepi, Tamariki services to increase uptake to pregnancy and parenting education.</p> <p>1.5 Support the implementation of the Hapu Wananga Curriculum once completed.</p> <p>1.6 Continue to provide GP/Practice Nurse education to have patients contact the Maternity Unit if they are unable to find a Midwife</p> <p>1.7 Continue to provide flyers relating to the top 5 things to do in early pregnancy</p> <p>1.8 Working with the Health Promotion Unit, Secondary Schools and alternate education sites to provide information to young women on early pregnancy screening and engagement with an LMC</p>	<ul style="list-style-type: none"> <li>95% of pregnant women receiving continuity of primary maternity care through a community LMC.</li> <li>30% of Māori, Pacific and teen pregnant women complete DHB funded pregnancy and parenting education.</li> </ul>	
Newborn Enrolment	<p>1. <b>All newborn babies are enrolled with a PHO and registered with a GP, Well Child Tamariki Ora (WCTO) provider and Community Oral Health Services by:</b></p> <p>2.1 Continuing to provide a system to support all babies to be enrolled as soon as possible following birth</p> <p>2.2 Education of parents and written information given on discharge to encourage enrolment</p> <p>2.3 Develop a system for babies born outside of DHB facilities</p>	<ul style="list-style-type: none"> <li>98% of newborns are enrolled with a PHO, GP, WCTO provider and COHS by three months</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	that ensures enrolment  2.4 Annually monitor and audit 10% of the discharge checklist to ensure all relevant services are discussed with the parents leading to enrolment		
<b>B4 School Checks</b>	2. <b>Maintain B4 School Check coverage to 90% of the eligible population</b>  3.1 Providing additional B4 School Check Clinics to support increased coverage  3.2 Routinely recalling all those who DNA	<ul style="list-style-type: none"> <li>90% of children receive a B4 school check including at least 90% of children living in high deprivation areas</li> </ul>	Quarterly
<b>Oral Health – await MOH measures</b>	3. Auditing of IT database Titanium to match with DHB Patient Management System to identify and contact those currently not enrolled	Monitoring achievement against targets as listed below	
	4. Mobile dental units being utilised more efficiently during school holiday time	PP10 Oral Health DMFT Score at Year 8 is 0.9	Quarterly
	5. Family based checks continue	PP11 – 64% of five year olds caries free	
	6. Text to remind changing to a local 0800 number to ensure more texts are sent back	PP12 - 85% adolescent utilisation	Quarterly
	7. Implementation of the actions from the Menemene Mai Oral Health Project – aiming to improve the oral health among Maori children thus reducing the disparity in oral health outcomes between Maori and Non-Maori	PP13 - 90% of preschool enrolled and 8% of children overdue for their scheduled examination	Quarterly
	8. Delivery against the Taranaki WCTO QIF Indicator 16 – Children are caries free at five years of age	Increasing the numbers of Maori children who are caries free at five years of age from 35% currently to 40% by December 2015	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Services for Pregnant Women, Babies, Children and Families – await MOH measures	<p>9. Services for pregnant women, babies, children and families deliver best possible outcomes and support equity of outcomes:</p> <p>10.1 TDHB will provide services for pregnant women, babies, children and families that are of high quality and are nationally consistent by:</p> <ul style="list-style-type: none"> <li>○ Maternity Quality and Safety programme (MQSP) meeting regarding TDHB's care and clinical outcomes with actions relating to these occurring</li> <li>○ Mental health pathway for pregnant women – implementation to be continued</li> <li>○ Continuing to work closely with Maori health to capture vulnerable women and families to ensure earlier access to appropriate services</li> <li>○ Rollout of second phase of the Midland Regional Perinatal and Infant Mental Health project. Working across agencies</li> <li>○ Implement the Mama Pepe Hauora service</li> </ul>	<p>Improved performance against WCTO Quality Indicators measuring access as agreed with MoH</p> <p>Quarterly Regional and local Reporting against project milestones.</p> <p>Reporting against the MQSP milestones</p>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>(also Links to Section 2.1.5.3 )</p> <p>10.2 Ensure all patients who smoke are asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support for hospital based maternity services</p> <ul style="list-style-type: none"> <li>To communicate Taranaki DHB quarterly results from Ministry of Health to local Midwives and LMCs</li> </ul> <p>10.3 To monitor the use and access of Nicotine Replacement Therapy and Smoking Cessation medicines within hospital based maternity services</p> <ul style="list-style-type: none"> <li>Determine a baseline by 30 April 2015</li> </ul> <p>10.4 To monitor the number of pregnant smokers to specialist stop smoking services</p> <ul style="list-style-type: none"> <li>Determine a baseline by 30 April 2015</li> </ul> <p>10.5 TDHB Hospital Service to work with specialist stop smoking services and PHOs to inform ways in which Hospital Services can improve its stop smoking advice and referral service for pregnant women</p> <ul style="list-style-type: none"> <li>To develop and establish a referral process and pathway for hospitalised pregnant smokers to specialist stop smoking cessations services by December 2015</li> <li>By August 2015 development of the training plan for Hospital Midwives and LMC's furthering education and resources for stop smoking support</li> <li>Reporting against WCTO QIF Plan Outcome: Indicator 19 – Mothers are smokefree at two weeks postnatal</li> </ul>	<p>Maintain 95% of hospitalised pregnant patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking</p> <p>Maintain 95% of hospitalised pregnant Maori patients who smoke are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking</p> <p>Increase percentage of hospitalised Pregnant smokers receiving pharmacotherapy medicine by June 2016</p> <p>Increase of direct referral numbers to specialist stop smoking services by June 2016</p>	Quarterly
<b>Maternity Quality &amp; Safety</b>	10. Ensure the Maternity Quality and Safety Programme is maintained and integrated into DHB wide quality programme	NZ Maternity Clinical Indicators	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>and initiatives</p> <p>11. Continue to participate in the Midland Maternity Action Group to provide regional benchmarking and sharing of quality initiatives</p> <p>12. Development of local targets to ensure improvement of maternal and infant health outcomes</p> <p>13. Completion of an Annual Report on Maternity Services</p>	<p>Regional maternity indicators comparisons</p> <p>Local targets developed by December 2015</p> <p>Submission of Annual Report on Maternity Services</p>	
<b>Gestational Diabetes</b>	14. Implement the national guidelines for the screening, diagnosis and management of gestational diabetes	<p>Establish baseline data for:</p> <ul style="list-style-type: none"> <li>Number of woman who have had an HbA1c &lt;20 weeks</li> <li>Number of woman who have had oral glucose tolerance test or oral glucose challenge test at 24-28 weeks</li> <li>Number of green prescriptions issued to woman with diabetes in Pregnancy</li> </ul>	Quarterly
<b>Improving Breastfeeding Rates</b>	15. Maintain the Baby Friendly Community Initiative (BFCl) via the MPH service	By June 2015 all three organisations achieve annual BFCl education status	6 Monthly
	16. Expand Breastfeeding Welcome Here (BFWH) framework via the MPH Service	<p>By July 2015 a contract will be in place to ensure delivery of services. This will include reporting the number of:</p> <ul style="list-style-type: none"> <li>Early Childhood settings that will be BFWH accredited in priority communities</li> <li>New Peer Support Referrals received</li> <li>Community lactation consultations provided</li> </ul> <p>Breastfeeding rates recorded as a subset of WCTO rates</p>	6 Monthly
	17. Continue to deliver the Peer Support Counselling Service via the MPH service		
	18. Continue to deliver the Community Lactation Service as an extension of Peer Support via the MPH service		
	19. Reporting against WCTO QIF Plan Outcome: Indicator 13 – Infants are exclusively or fully breastfed at three months of age	<ul style="list-style-type: none"> <li>By December 2015 delivery against identified actions in the WCTO QIF Plan</li> <li>Improve quality and consistency of data recording and reporting with MPH service</li> </ul>	6 Monthly
<b>Mama Pepe Hauora Programme on Improving Maternal and Infant</b>	20. To improve women's health during pregnancy and the post-natal period through promotion of healthy eating, breastfeeding and physical activity :	<ul style="list-style-type: none"> <li>By June 2016 provide six monthly support and updates to the agreed number of settings that previously received the MPH Toolkit</li> <li>By June 2016 deliver Toolkit</li> </ul>	6 Monthly
	21.1 Supporting five priority		6 Monthly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Nutrition, Physical Activity and Breastfeeding</b>	communities to develop, implement, and evaluate at least one new maternal and child physical activity and nutrition initiative in each community	<p>including promotion of key breastfeeding, nutrition and physical activity messages for mothers and infants to Early Childhood Education settings in priority communities</p> <ul style="list-style-type: none"> <li>• Implement the Healthy Heart Award, Active Movement professional development, MPH policy template, BFWH accreditation and equipment toolbox with Early Childhood Education settings in priority communities</li> <li>• Review and provide additional support to five new initiatives previously implemented</li> </ul>	
	21. Promote healthy feeding of babies including encouraging and supporting breastfeeding	<ul style="list-style-type: none"> <li>• By June 2016 the number of Peer Support referrals are received which meet agreed contractual volumes</li> <li>• By June 2016 the number of new Community Lactation patients seen will meet agreed contractual volumes</li> </ul>	6 Monthly
	22. Maintaining accreditation and expanding the content of the Baby Friendly Community Initiative (BFCI) with the existing three providers to include maternal and child physical activity and nutrition	<ul style="list-style-type: none"> <li>• Each organisation will undertake annual education (including physical activity and nutrition) to maintain BFCI standards to achieve reaccrreditation</li> </ul>	6 Monthly
	23. Leadership on HEPA and Whangai U collaborative groups for physical activity, nutrition, and breastfeeding	<ul style="list-style-type: none"> <li>• Quarterly meetings of each group</li> </ul>	6 Monthly
<b>Implementation of UNHSEIP Regime changes</b>	<p>24. Implement the new national aABR protocol.</p> <p>25. Transition to new equipment.</p> <p>26. Implement NHIMS (New-born Hearing Screening Information Management System) by June 2015</p>	<ul style="list-style-type: none"> <li>• By October 2015 all newborn hearing screenings will follow the new protocol.</li> <li>• By June 2016 all newborn hearing screenings will be carried out using the new standard Beraphone equipment</li> <li>• By June 2016 the UNHSEIP (Universal Newborn Hearing Screening and Early Intervention Programme) will adopt the NHIMS.</li> </ul>	Quarterly

### 2.3.11 Shorter Waits for Cancer Treatment/Faster Cancer Treatment

Due to the similarity/overlap in service delivery and monitoring we have combined this section with that described in section 2.1.3 (See Health Targets – Cancer Services).

### 2.3.12 Spinal Cord Impairment Action Plan

#### 2.3.12.1 Our Approach

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

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

#### 2.3.12.2 Linkages

- Midland District Health Boards Regional Services Plan 2015/16
- Our Performance Story Impact: People receive timely and appropriate specialist care

#### 2.3.12.3 Action Plan

Objective	Actions to deliver improved performance	Measured by	Reporting requirements
<b>Spinal Cord Impairment Action Plan</b>	<ul style="list-style-type: none"><li>• We will ensure information and actions outlined in the plan are disseminated to clinicians via its clinical governance mechanism and will ensure pathways that explicitly outline process and align with the action plan are developed.</li><li>• TDHB intends to engage with ambulance and other providers to implement the SCI pre-hospital destination and referral pathway. There are appropriate pathways in place for all other trauma patients.</li></ul>	<ul style="list-style-type: none"><li>• A confirmation and exception report in the second quarter of 2015/16 on progress made against actions in the Spinal Cord Impairment Action Plan in 2014/15 and to date in 2015/16.</li><li>• A confirmation and exception report in the fourth quarter of 2015/16 on actions identified in the DHB's 2015/16 Annual Plan.</li></ul>	Six monthly

## 2.4 OTHER

### 2.4.1 National Entity Initiatives

#### 2.4.1.1 Our Approach

We are expected to align our planning with the planning intentions key national agencies. Each of these national agencies has initiatives for the 2015/16 year, which could impact on our DHB. The following table outlines the initiatives each agency has identified as a priority and the DHB has signalled its level of commitment in the last column.

#### 2.4.1.2 Linkages

- Midland District Health Boards Regional Services Plan 2015/16
- Module 4 – Financial Performance
- 

#### 2.4.1.3 Action Plan

Entity	Initiative	Description	Summary of benefits	DHB Commitment
Health Shared Services	Finance, Procurement & Supply Chain	HBL and DHBs are working together to implement a national Finance, Procurement and Supply Chain programme to combine their purchasing power - through standardising the ways goods and services are ordered, delivered, stored and paid.	Replanning. Revised numbers to be advised at the conclusion of this process.	The DHB will commit resources to the implementation of the FPSC initiative, and fully factor in expected budget benefit impacts.

	Food	HSS and DHBs are currently assessing options as part of completing the detailed business case for reducing the costs of Food services. It is a priority to improve the overall quality of hospital food service to ensure good nutrition for all patients.	Financial modelling in the Detailed Business Cases currently with DHBs for approval indicates that over the proposed 15 year contract term total sector benefits will be between \$155m - \$190m on a NPV basis. Individual DHB budgetary benefits will be advised when the Detailed Business Cases are approved, in line with existing agreements with DHB CFOs.	
	Linen & Laundry	HSS and DHBs are currently assessing options as part of completing the detailed business case for reducing the costs of Linen & Laundry services, while improving service delivery quality.	Financial modelling in the Detailed Business Cases currently with DHBs for approval indicates that over the proposed 10 year contract term total sector benefits will be between \$65m - \$85m on a NPV basis. Individual DHB budgetary benefits will be advised when the Detailed Business Cases are approved, in line with existing agreements with DHB CFOs.	
	National Infrastructure Platform	The vision is for a national infrastructure platform with agreed standards and policies and a single governing organisation, delivered out of significantly fewer than the 40-50 current physical data centres. It will also align the health sector's infrastructure services with the Government's overall Information Communications Technology goal of harnessing technology to deliver better, trusted public services.	Financial modelling in the Detailed Business Cases currently with DHBs for approval indicates that over a 10 year timeframe total sector benefits will be \$169m on a NPV basis. Individual DHB budgetary benefits will be advised when the Detailed Business Cases are approved, in line with existing agreements with DHB CFOs.	



		parents of infants, school aged children, teens and adults. The information provided helps parents make informed health choices for their babies and children, and alerts and prompts New Zealanders to get themselves or their families vaccinated at the appropriate times.		
	Alcohol Pregnancy and Alcohol Screening and Brief Intervention	The Alcohol and Pregnancy work programme is to contribute towards a reduction in harms related to prenatal alcohol exposure by: 1.reducing the number of women consuming alcohol while they are pregnant 2.increasing public awareness of the risk associated with alcohol consumption during pregnancy 3. supporting health professionals (particularly primary care providers) to respond in a routine, effective and consistent way to women who are drinking while pregnant or planning to become pregnant.	Aligns with government and non-government initiatives and calls for action in this area, including: (1) Government's response to the Health Select Committee's inquiry into improving child health outcomes, (2) expectation from industry that the Government will undertake other activities to promote alcohol and pregnancy messages, to support their voluntary pregnancy warning labelling efforts, (3) Ministry of Health's work to develop a FASD action plan. Harmful alcohol use was estimated to cost New Zealand \$4.9 billion in 2005/06 (Berl 2009). However, previous estimates have ranged from \$735 million to \$16.1 billion (Law Commission, 2009, p168)	The DHB will support work undertaken by the HPA to reduce alcohol consumption during pregnancy, including, for example, encouraging primary and secondary care health professionals to engage with and support alcohol and pregnancy initiatives and working with HPA to identify and support innovative local practice that supports women to reduce alcohol consumption during pregnancy.
		HPA also has a programme of work to support Alcohol Screening and Brief Intervention in primary settings. This aligns with DHB work in this area.	This aligns to Government health priorities, health outcome impacts, and health system enablers. There is also evidence that if delivered across the population, SBI can reduce alcohol-harm in the community.	The DHB will support work undertaken by the HPA re alcohol screening and brief intervention

HQSC	Surgical site infection programme (SSIP) - National Infection Surveillance Data Warehouse	DHB support for ongoing hosting costs of the national surveillance data warehouse from July 2015 (\$0.24m p.a.).	Goal - Removal / reduction in preventable patient harm resulting from surgical site infections throughout the New Zealand health and disability sector. An ability to deliver a consistent approach to the monitoring of SSIs. An ability to provide accurate outcome measures for SSI. Measurement of reduction in SSI rates. Financial benefits will vary by DHB. The additional cost of treating patients with an SSI has been conservatively estimated at \$21,000 per SSI	The DHB will commit to meeting infection control expectations in accordance with Operational Policy Framework - Section 9.8.
	Surgical site infection programme (SSIP) - DHB Infections Management systems (ICNet NG system)	DHB adoption of Infections Prevention and Control Systems investment and implementation including local integrations. Both Hospital and Community with National hosting. Costs are dependent on DHBs' decision to take up the system. Overall sector costs estimated at \$1.5m capital and \$2.5m ongoing operating.	National and local surgical site infection surveillance system to generate verifiable information that drives practice change and improvement	The DHB will continue development of infection management systems at our local DHB level.
	National inpatient patient experience survey and reporting system - Patient experience indicators	National in-patient survey to be used by all DHBs quarterly that can be incorporated in existing local patient experience surveys that provides a nationally consistent model of patient experience indicators	Patient experience indicators help measure and report how consumers and patients actually experience the health system. eg. what happened to them and how did it make them feel? By capturing this consistently and coherently across New Zealand's health system, this information can be used to make substantial improvements to both the experience and the actual quality of care received. Efficiencies are achieved with one nationally consistent system and contract, compared to individual, and/or non compatible systems.	The DHB commits to surveying patient experience of the care they received using the national core survey, at least quarterly.
	Capability and Leadership	Programmes to support improvement science and increased clinical leadership.	Building sector capability and clinical leadership and a culture of quality and safety improvement. Uptake of increased sector leadership, good practice and transfer of improvements skills and expertise. Financial benefits will vary by DHB. Outcome measures still under development	The DHB will meet expectations in accordance with Operational Policy Framework Section 9.3 & 9.4.6.

	Primary Care - patient experience survey and reporting system	Similar proposal to the national in-patient experience survey to be used by PHOs	Help measure and report how consumers and patients actually experience the health system from a primary care perspective.	The DHB will support this work through linkages to the IPIF programme
Health Workforce NZ	Increasing the number of sonographers	The sonographer workforce needs to grow by 300 full time equivalent (FTE) employees over the period to 2023, more than double the current FTE numbers, to enable more timely delivery of healthcare services, and meet the faster cancer health target, increased demand from demographic change and growth of sonography as a diagnostic tool. In 2013, HWNZ funded 33.2 FTEs and in 2014, 46.2 FTEs.	Increasing the sonographer workforce will enable more timely delivery of healthcare services, meet faster cancer health targets and meet increased demand for sonography as a diagnostic tool. HWNZ is contributing \$27,000 per trainee per annum to employers for their trainees over the 3 year training programme	The DHB supports the regional approach being undertaken to address key workforce requirements with respect to the sonography workforce
	Expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses	A Government policy 2014 health workforce commitment is to expand the role and number of nurse practitioners, clinical nurse specialists and palliative care nurses.	Nurse practitioners can, amongst other services, assess, diagnose and prescribe medicines for specific groups. Clinical nurse specialists cover a wide range of specialties including diabetes, cardiology, respite care, wound care, care of the elderly, mental health and addiction. Expansion of the nurse practitioner and clinical nurse specialist role, especially the palliative care nurse role will enable medical staff to undertake more complex procedures and improve service delivery HWNZ is already funding the training component of these roles	The DHB supports the regional approach to reviewing the roles of nurse practitioners, clinical nurse specialists and palliative care nurses
	Create new nurse specialist palliative care educator and support roles	A Government policy 2014 health workforce commitment is to create 60 nurse specialist palliative care educator and support roles at hospices.	Palliative care nurse specialist will provide training, mentoring and hands on support for staff across aged residential care, GP practices and home-based support services. The investment will be consistent with HWNZ's current investment in postgraduate nurse training. Government policy commitment September 2014: \$7m to create 60 nurse specialist palliative care educators and support roles at hospices	To be confirmed

	Expanding the role of specialist nurses to perform colonoscopies	A Government policy 2014 health workforce commitment is to expand the role of nurses and train specialist nurses to perform colonoscopies. The Ministry of Health is developing and implementing an advanced nursing role in endoscopy for senior nurses with relevant post-graduate education and experience.	Nurse endoscopists will be able to identify whether a person has bowel cancer and can find and remove pre-cancerous growths. Nurse endoscopists will make a direct contribution and an indirect contribution to service delivery, including enabling release of medical staff to undertake more complex procedures. Development of the nurse endoscopist role is critical to the delivery of bowel screening in New Zealand. Government policy commitment September 2014: \$8m over 4 years to increase the number of colonoscopies performed	To be confirmed
	Increasing the number of medical physicists	There is a low retention rate of graduates from the Medical Physics programme and a low number of postgraduate positions available to graduates, despite reported staff shortages. The number of medical physicists needs to grow to enable more timely delivery of health care services and meet the faster cancer health target.	Radiation therapy is reliant on an adequate supply of medical physicists to plan and implement patient treatment programmes. Increasing the number of medical physicists will allow succession planning of a small workforce, vital to DHB workforce and service planning. HWNZ is already funding the training of medical physicists.	The DHB supports the regional/national approach to addressing key workforce requirements with regard to the medical physicist workforce.
	Increasing the number of medical community based training places and providing access to primary care/community settings for prevocational trainees	As part of the revised New Zealand Curriculum Framework for Prevocational Medical Training, the Medical Council will require PGY1 and PGY2 interns to undertake one clinical attachment in a community-based setting by the end of 2020. HWNZ is working with the Medical Council, the Royal New Zealand College of General Practitioners and district health boards to ensure employment and funding arrangements support these requirements.	More medical trainees are exposed to quality community-based training experiences, and will have increased experience of integrated care and choose to vocationally train in general practice. An increase in the number and availability of prevocational clinical attachments across DHB will support RMO career progression. HWNZ is reviewing funding arrangements to support community-based placements.	The DHB supports the regional approach to providing access to community-based placements.

National Health Information Technology Board	eMedicines Reconciliation (eMR) with eDischarge Summary	Implementation of electronic reconciliation of medicines on admission and discharge from hospital.	Without medicines reconciliation, studies have shown that there is up to a 50% error rate in the patient's drug chart. eMR reduces this rate to below 10%. eMR enhances both patient safety, the quality of clinical decision-making and the efficiency of managing the patient's drug chart.	N/A to TDHB as already implemented eMR.
	Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR)	Implementation of a regional Clinical Workstation (Orion, Concerto) and Clinical data repository (mixed products). The CWS is a web based system, accessed via a single sign-on that connects multiple clinical applications and data sources to provide clinicians with secure access to patient data. A CDR is a database of patient identifiable clinical information such as medications, laboratory results, radiology reports, care plans, patient letters and discharge summaries.	Clinical Workstation and Clinical Data Repository allow a patient centric view of clinical information from a hospital (or community) setting. It is the basis for a regional electronic health record and is the essential platform enabling support of other high value functionality like eMR, electronic orders, results sign-off. It will also support a person's on-line access to their own health record	TDHB commits to implementing the regional Clinical Workstation (CWS) (Orion, Concerto) and Clinical Data Repository (CDR), noting that we already use the Orion Concerto and Sysmex Éclair products locally.
	Replacement of Legacy Patient Administration Systems	The 8 DHBs with legacy PAS need to progress implementation of a supported system that is aligned with the regional plan. The PAS supports and manages the administrative details of a patients encounter with a hospital or DHB service. It supports the management of the hospital resources used to provide patient care such as clinical staff, rooms, beds and equipment.	Hospital based patient administration systems are a fundamental enabler to support other high value functionality, like Clinical Workstation and National Patient Flow. 8 DHB's need to replace their obsolete systems	The DHB is aligned with the regional Patient Administration System (PAS)

	National Patient Flow MoH contribution to National Patient Flow	National Patient Flow will create a new national collection that provides a view of wait times, health events and outcomes in a patients journey through secondary and tertiary care.	National Patient Flow aligns with the vision of better integrating care so that patients can receive the appropriate services, in the right setting and in a timely way to improve overall health outcomes. Patients, referrers and providers need to better understand demand for services and waiting times.	The DHB commits to collecting Phase 2 information from July 2015 and to collecting Phase 3 information from July 2016.
	Patient and Provider Portals (formerly self care portals)	<p>Portals are an on-line IT tool that will enable individuals to have access to their own health information. It will also allow hospital based services, in particular, ED, to have access to a summary view of primary care information. In later phases, it will enable patients to communicate with their primary health practitioners and add information to their health record.</p> <p>Each of the General Practice Patient Management System (PMS) vendors are developing portals, and Orion Health is developing a portal in conjunction with Canterbury DHB eSCRv project.</p>	<p>This is an essential delivery to achieve the IT Board's vision of "a core set of personal health information available to [patients] and their treatment providers regardless of setting". Portals will enable people to take more control of their own care. They will change the way care is delivered and save time for patients and practices.</p> <p>Recent surveys indicate that 15 to 20% of patients are interested in enrolling for portal access.</p>	The DHB will continue to work with our PHO to enable individuals to have access to their own health information and allow hospital based services, in particular, ED, to have access to a summary view of primary care information.
National Health Committee	Pull model prioritisation (proactive work programme)	<p>Prioritise future work programmes by undertaking review of two or three major programme budget spends (Tier 1 comparative analysis). Business Plan intentions to compare musculo-skeletal and eye, and endocrinology and neoplasm. A second tier of work will analyse specific disease states for suitability to undertake Health Technology Assessments and to lead the sector to develop improved models of care.</p> <p>Stakeholder engagement throughout process including with National</p>	<p>Clinical outcomes are improved and the cost curve for health is bent by using a programme budget to identify large and fast growing health sector spends where there are models of care which deliver outcomes which can be improved and there is a reliance on technologies for which the evidence is untested.</p> <p>Notional budget will be identified through cost avoidance, efficiency and quality improvements and re-prioritisation.</p>	<p>The DHB will work collaboratively with the NHC to solve sector issues by:</p> <ul style="list-style-type: none"> <li>- engaging with and providing advice on prioritisation and assessments including through the National Prioritisation Reference Group</li> <li>- referring technologies that are driving fast-growing expenditure to the NHC for prioritisation and assessment where appropriate</li> <li>- introducing consistently or not introducing emerging technologies based on the NHC recommendations</li> </ul>

		Prioritisation Working Group to be established in early 2015.		<p>- holding technologies, which may be useful, but for which there is insufficient evidence, or which the NHC is assessing for further diffusing or out of business as usual</p> <p>- providing clinical and business expertise and research time to design and run field evaluations where possible.</p>
	Push model prioritisation (reactive work programme)	Call for sector to refer significant technology issues to the NHC for assessment. Process undertaken with assistance from the National Prioritisation Working Group.	Clinical outcomes are improved and the cost curve for health is bent by identifying new and significantly expanding technology cost drivers for the sector which are not captured by the NHC through the proactive referral process. Notional budget will be identified through cost avoidance, efficiency and quality improvements and re-prioritisation.	
	Innovation fund evidence generation activity	Trial promising technologies outside business as usual while evidence is gathered for final recommendations.	Hold technologies, which may be useful, but for which there is insufficient evidence, out of business as usual while the evidence is gathered in a standardised manner to support improved clinical outcomes in a fiscally sustainable manner. Notional budget will be identified through cost avoidance, efficiency and quality improvements and re-prioritisation.	
Pharmac	Hospital Medical Devices - Pharmac Procurement Activity	National contracting is the first stage towards full management of hospital medical devices. This activity is building PHARMAC's capability.	<p>Helps achieve national consistency in medical devices, improve transparency of decision-making and improve the cost-effectiveness of public spending to generate savings for re-investment into health, i.e. Reflects Cabinet requirement (August 2012) for PHARMAC to assume this role.</p> <p>A minimum level of savings is achieved from nationally negotiated contracts based on the current mix of product use (current contracts have achieved more than \$2 million minimum savings per annum). The level of savings achieved could significantly increase if DHBs shift to the national contracts and increase the amount of these products in their overall product mix.</p>	The DHB will continue to support PHARMAC's national contracting activity for hospital medical devices. This includes committing to implement new national medical device contracts, when appropriate and assisting with product evaluations where possible.

		Reflects transition from national contracting towards steady state - which includes assessment of new devices, health technology assessment, active category management, category reviews and tendering.	PHARMAC expect to shift towards product standardisation in at least one category it is already working in during 2015. This will lead to increased national consistency in product use . Product standardisation will lead to additional commercial gains beyond those achieved with national contracting.	The DHB will support effective implementation of any product standardisation undertaken by PHARMAC during 2015/16
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The following table describes the planned funding allocated to the National Entities initiatives for the 2015/16 year:

2015/16	Inclusions in 2015/16 DHB Annual Plan 2015/16 Year One **				
Plan Year One	Capital	Operating Costs		Operating	Net
	Costs	One-Off	Ongoing	Benefits	Operating
	\$'000's	\$'000's	\$'000's	\$'000's	\$'000's
<b>HBL</b>					
Information Services - Procurement					0
Human Resources					0
Procurement					0
Banking and Insurance					0
healthAlliance					0
DHB Initiatives / All of Government					0
<b>NH IT Board</b>					
Microsoft G2012					0
eMedicines Reconciliation (eMR) with eDischarge Summary			(20)		(20)
Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR)					0
Replacement of Legacy Patient Administration Systems					0
National Patient Flow		(139)			(139)
MoH contribution to National Patient Flow		(139)			(139)
Provider & Patient Portal	(100)				0
<b>HQSC</b>					
Surgical site infection programme (SSIP) - National Infection Surveillance			(7)		(7)
SSIP DHB Infections Management systems (ICNet NG system)	(55)		(73)		(73)
Patient experience indicators			(1)		(1)
<b>Total Impact for Taranaki DHB</b>	<b>2015 / 16</b>	<b>(155)</b>	<b>(278)</b>	<b>(101)</b>	<b>0</b>
					<b>(379)</b>

## 2.4.2 Improving Quality

Quality and patient safety are a top priority with many initiatives successfully in place and others underway. But there is always more to do. Staff want to make a difference for our patients and their ongoing actions are critical to patient safety.

### 2.4.2.1 Our Approach

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

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

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

- Quality and risk framework
- Strategic objectives
- Dimensions of quality and our associated goals
- Quality and risk committee structure
- Staff responsibilities
- Links into the Health Quality and Safety Commission's areas of focus identified in their Statement of Intent

We are committed to implementing the initiatives specified by the Health Quality and Safety Commission including the National Patient Safety 'Open for Better Care' Campaign focuses that commenced in May 2013.

The key work areas are:

- Continuing to keep our patients safe by participating in the national patient safety campaign:
  - reducing falls resulting in harm led by the Falls Prevention Steering Group
  - reducing surgical site infection led by the Infection Control Committee
  - reducing peri-operative harm (including safety in theatres and Venous Thromboembolism prevention) via the Productive Operating Theatre programme and the Venous Thromboembolism working party
  - reducing medication errors led by the Safe Medication and Pharmacology and Therapeutics Committees
- Improving our hand hygiene compliance
- Reducing the number of patients who develop a pressure injury whilst in hospital
- Minimising seclusion practice in mental health
- Improving our customer care and responsiveness to patient/client needs
  - Increase patient/client/family/whanau participation
  - Continue to comply with the national inpatient experience survey
  - Comply with the Health Quality and Safety Commission's guidance in relation to the annual Quality Accounts document.
  - Review and enhance if appropriate our local mortality and morbidity review process and support national efforts in this area.
  - Contribute to the Midland regional implementation of the 'Open for better care' national patient safety campaign.
  - Implement a Midland DHB integrated electronic quality and risk management system.
  - Review and update the Taranaki DHB's Strategic Quality & Risk Plan for the 2015-18 period.

These areas were chosen because of the common themes identified from our monitoring processes including but not limited to audit, serious events and patient/client complaints received.

#### 2.4.2.2 Linkages

- Taranaki DHB Strategic Quality & Risk Plan 2012-2015
- Quality & Safety Markers
- Serious and Sentinel Event processes including reporting, review, corrective action implementation and evaluation
- Patient/Client satisfaction
- Taranaki DHB Patient and Family/Whanau Centred Care Framework
- Taranaki DHB Quality Annual Report

#### 2.4.2.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
Improving Quality	HQSC priorities for 2015/16 are subject to confirmation following the conclusion of the Health Sector Forum led prioritisation process		
	Identify actions to support projects that make a difference to improving the quality of care, reducing patient harm (Quality & Safety Markers) and contribute to the national patient	<ul style="list-style-type: none"> <li>• 90% of older patients are given a falls risk assessment.</li> <li>• 98% of older patient assessed as at risk of falling receive an</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>safety campaign 'Open for better care'.</p> <ul style="list-style-type: none"> <li>Falls Risk Assessment. Continue with: <ul style="list-style-type: none"> <li>Raising staff awareness</li> <li>Real time auditing and feedback</li> <li>Improving our post falls review process</li> <li>Analysing contributing factors (patients not seeking assistance, patient safety and privacy)</li> <li>The feasibility of a Taranaki Integrated Falls Prevention Service in conjunction with ACC is investigated and implemented if considered feasible.</li> </ul> </li> <li>Hand Hygiene. Continue with: <ul style="list-style-type: none"> <li>Staff education particularly targeting Health Care Assistants via compulsory refresher training and targeted in-service sessions to occupational groups</li> <li>Regular organisation wide good hand hygiene awareness activities</li> <li>Continue our auditing activities expanding focus areas and moments audited as auditing resource is realised</li> <li>Continue to monitor results and take action via the PDSA cycle to enable improvement</li> </ul> </li> <li>Surgical Safety Checklist <ul style="list-style-type: none"> <li>Explore options, consult, agree and implement actions that enable the checklist to be utilised as a teamwork and communication tool that supports briefing and debriefing for each theatre list.</li> <li>Monitor results and take action via PDSA cycle to enable improvement</li> </ul> </li> <li>Work with the Commission to implement new perioperative harm (Quality &amp; Safety Markers(s) during 2015/16 in readiness for public reporting in 2016/17.</li> <li>Prophylactic Cephazolin <math>\geq 2g</math> is given to patients having hip and knee replacements. <ul style="list-style-type: none"> <li>Continue with our auditing and feedback to staff</li> </ul> </li> </ul>	<p>individualised care plan addressing these risks.</p> <ul style="list-style-type: none"> <li>80% compliance with good hand hygiene practice</li> <li>Agreed action plan is implemented.</li> <li>Monitoring of teamwork and communication effectiveness occurs and meets/exceeds targets agreed.</li> <li>Briefing and debriefing occurs for each theatre list.</li> <li>100% of hip and knee replacement patients receive Cephazolin <math>\geq 2g</math> as surgical prophylaxis</li> <li>100% of hip and knee replacement patients receive prophylactic Cephazolin 0-60 minutes before incision.</li> </ul>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>programme.</p> <ul style="list-style-type: none"> <li>Prophylactic Cephazolin is given 0-60 minutes before incision. <ul style="list-style-type: none"> <li>Continue with our auditing and feedback to staff programme</li> <li>Monitor results and take action via the PDSA cycle to enable improvement.</li> </ul> </li> <li>Skin Preparation. Continue with: <ul style="list-style-type: none"> <li>The use of appropriate skin preparation.</li> <li>Clipping and not shaving</li> <li>Our auditing and feedback to staff programme</li> <li>Monitor results and take action via the PDSA cycle to enable improvement.</li> </ul> </li> <li>Medication Safety. Continue with: <ul style="list-style-type: none"> <li>Our auditing, monitoring and reporting activities, including use of the Medication Trigger Tool and participating in the Commission's medication safety focus on the national patient safety campaign</li> <li>The implementation of our e-pharmacy programme locally and regionally.</li> <li>Roll out of e-prescribing to other inpatient areas</li> <li>Roll out of eMedicines Reconciliation programme, including at admission, transfer and discharge</li> <li>Monitor results and take action via the PDSA cycle to enable improvement</li> <li>Roll out to e-prescribing in the inpatient areas.</li> <li>Expansion and auditing of our eMedicines Reconciliation programme.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>100% of hip and knee replacement patients have appropriate skin preparation</li> <li>Meeting/exceeding the targets as outlined in our medication safety project documents.</li> <li>E-prescribing is rolled out to other clinical areas</li> <li>Meeting/exceeding the targets as outlined in our eMedicine Reconciliation project documents.</li> </ul>	
	<ul style="list-style-type: none"> <li>Ongoing identification and implementation of actions to support the reduction of patient pressure injury development while in hospital</li> </ul>	<ul style="list-style-type: none"> <li>Decreased incidence of inpatient pressure injury development as identified through reporting and monitoring processes</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Ongoing Identification and implementation of actions to support the minimisation of seclusion practice in mental health</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring of seclusion practice within mental health shows a decrease over time</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Ongoing Identification and implementation of actions to support an improved experience through increased patient, client,</li> </ul>	<ul style="list-style-type: none"> <li>Patient and Family/Whānau Centred Care Framework implemented</li> <li>Increased patient/client</li> </ul>	Quarterly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<p>family, whanau involvement in decision making (at all levels).</p> <ul style="list-style-type: none"> <li>Continue to comply with the national inpatient experience survey include exploring strategies to increase the rate of electronic responses including but not limited to: <ul style="list-style-type: none"> <li>Continuing to raise awareness with our administrative staff re the importance of capturing/ checking email addresses as part of the 'clerking' process for each patient</li> <li>Explore a proactive media release supported by an in-hospital promotion</li> </ul> </li> </ul>	<p>satisfaction levels over the 2015-16 year as identified from survey.</p> <ul style="list-style-type: none"> <li>Increased patient/client participation across the DHB defined through defined evaluation processes associated with the Patient and Family/Whānau Centred Care Framework</li> <li>Collection and therefore use of email addresses for the Patient Experience Survey increases each quarter.</li> </ul>	<p>Quarterly</p> <p>Six monthly</p> <p>Quarterly</p>
	<ul style="list-style-type: none"> <li>Identify actions to support continued implementation of an improved, representative and value-added Quality Accounts document. These actions include but are not limited to: <ul style="list-style-type: none"> <li>Utilisation of meaningful and relevant measures for example Quality and Safety Marker and Patient Experience results.</li> <li>Ensuring a whole-of-system focus that enables and demonstrates continuous quality and safety improvement.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>The 2015-16 Quality Accounts document builds on the 2014-15 document to better reflect the evaluation of the DHB's DAP measures, Quality &amp; Risk Strategic Plan dimensions of Quality and better reflect the whole of the DHB rather than a Hospital and Specialist Services focus.</li> <li>As well, we will be able to demonstrate patient/family/whanau/community input into the Accounts document.</li> </ul>	December 2015
	<ul style="list-style-type: none"> <li>Implementation of a Midland DHB integrated electronic quality and risk management system</li> </ul>	<ul style="list-style-type: none"> <li>Successful implementation of an integrated system that results in improved effectiveness, efficiency and ultimately patient safety</li> </ul>	February 2016
	<ul style="list-style-type: none"> <li>Monitor, review and enhance our local mortality and morbidity review processes and consider advice from national mortality review committees and implement as appropriate.</li> <li>Continue to support and contribute where possible to the national processes in regard to mortality and morbidity including supporting the Commission's review processes associated with operative procedures, once established.</li> <li>Continue with annual formal reporting by Specialties to the Clinical Board that includes mortality and morbidity.</li> <li>Continue with the annual formal reporting to the Clinical Board by the Mortality and Morbidity Review Committee.</li> </ul>	<ul style="list-style-type: none"> <li>Local mortality and morbidity processes and national advice reviewed and activities to improve identified and actioned.</li> <li>Perioperative Mortality Review Committee processes are supported by the DHB.</li> <li>Clinical Board receives reviews and comments on annual reports from Specialities and the Mortality and Morbidity Review Committee.</li> </ul>	Six monthly

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	<ul style="list-style-type: none"> <li>Explore, agree, document and implement with the other Midland DHBs a regional approach to the 'Open for better care' national patient safety campaign.</li> </ul>	<ul style="list-style-type: none"> <li>A regional structure with actions is in place, implemented and monitored for effectiveness</li> </ul>	Six monthly
	<ul style="list-style-type: none"> <li>The Taranaki DHB's Quality &amp; Risk Strategic Plan is reviewed, updated, approved and implemented for the 2015-18 period.</li> </ul>	<ul style="list-style-type: none"> <li>The Taranaki DHB Quality &amp; Risk Strategic Plan 2015-18 is in place.</li> </ul>	October 2015

### 2.4.3 Living Within Our Means

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

#### 2.4.3.1 Our Approach

Taranaki DHB recognises it faces significant challenges in delivering services within available resources. We have outlined in Module 4 our financial forecast to 2018/19. In order to achieve those targets this Annual Plan contains cost containment strategies that align with our targets of a \$737K surplus in 2015/16, and maintenance breakeven/surplus in 2016/17 and beyond.

Our DHB has well developed budgetary control systems to manage operating and capital expenditure. The major financial risks faced by the DHB are those relating to cost increases in our provider arm. We provide regular financial information to our Board and the MoH/NHB.

We will be focusing on the following initiatives to enable us to live within our means:

- Work to support and advance their initiatives to achieving savings and efficiencies for non-clinical initiatives)
- Productive Wards, Communities and Radiology Programmes (engages front line staff in improving quality and productivity through redesign and streamlining the working environment and daily processes)

These initiatives will all have a role to play in ensuring we operate in a financially responsible manner (which means ensuring delivery on agreed financial forecasts within available funding). This is important for the health of the organisation generally and to meet the significant demands that arise from our building programme.

#### 2.4.3.2 Linkages

- Stewardship Module
- Midland District Health Boards Regional Services Plan 2015/16

#### 2.4.3.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Living Within Our Means</b>	<ul style="list-style-type: none"> <li>Operate within agreed financial plans (and fund capital investment from internal sources)</li> </ul>	<ul style="list-style-type: none"> <li>System Integration 3: Ensuring delivery of Service Coverage</li> </ul>	Quarterly
	<ul style="list-style-type: none"> <li>Appropriate clinical and executive leadership</li> </ul>		
	<ul style="list-style-type: none"> <li>Review clinical pathways with the objectives of: reducing LOS,</li> </ul>	<ul style="list-style-type: none"> <li>Ownership OS3: Inpatient Length of Stay</li> </ul>	

Objective	Actions to Deliver Improved Performance	Measure	Reporting
	reducing readmission rates, increased theatre utilisation, increasing day case rates	<ul style="list-style-type: none"> <li>Ownership OS8: Reducing Acute Readmissions to Hospital</li> <li>Output 1: Output Delivery Against Plan</li> <li>Reduction in number of presentations to ED</li> <li>Day surgery rates to increase to 85% of appropriate cases</li> </ul>	
	<ul style="list-style-type: none"> <li>Continue collaboration with primary/community providers with a view to integrating appropriate services and reducing avoidable admissions</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in number of presentations to ED</li> </ul>	
	<ul style="list-style-type: none"> <li>IDF flow will be monitored with the aim of reducing outflow by bringing appropriately trained clinicians to TDHB to complete procedures within the hospital</li> </ul>	<ul style="list-style-type: none"> <li>IDF outflow rates to reduce</li> </ul>	
	<ul style="list-style-type: none"> <li>The Paediatric model of care will continue to be reviewed in order to ensure patients are treated appropriately across the primary-secondary care continuum</li> </ul>		
	<ul style="list-style-type: none"> <li>TDHB will continue to run initiatives such as Releasing Time To Care and a Theatre User Group to realise operational efficiencies in measures such as LOS, readmission rate, and theatre utilisation</li> </ul>		
	<ul style="list-style-type: none"> <li>TDHB will review the opportunity for further efficiencies from diagnostic services</li> </ul>		

## 2.4.4 Supporting Delivery of Regional Priorities

### 2.4.4.1 Our Approach

Within the Midland Regional Plan we aim to develop the principles of culture, capability, capacity and change leadership. We recognised that there are longstanding gaps and weaknesses in our knowledge around the current workforce, particularly relating to the capability and capacity.

In 2015/16 the overarching imperative for TDHB to meet our goals, are collaboration and connectedness locally, regionally and nationally.

Throughout this Annual Plan there are a number of activities identified that we have planned to undertake which support the delivery of the regional priorities identified in our shared regional service plan. This section includes only those areas not covered elsewhere such as regional trauma, health workforce and information technology

### 2.4.4.2 Linkages

- Module Five - Stewardship
- Midland District Health Boards Regional Services Plan 2015/16
- Midland Region Information Services Plan
- Midland Region Workforce Plan
- National Entity Initiatives

#### 2.4.4.3 Action Plan

Objective	Actions to Deliver Improved Performance	Measure	Reporting
<b>Actions to support delivery of trauma regional priority initiatives</b>	<ul style="list-style-type: none"> <li>Taranaki DHB will participate in the Regional Trauma Team multi-disciplinary teams and in the regional training network</li> <li>Supporting work towards Regional Trauma Centre Accreditation (level III)</li> <li>Monthly mortality and morbidity reviews of major trauma and fulfilling learning/action points</li> <li>Senior clinician involvement in trauma care quality improvement programme audit and training</li> </ul>	<ul style="list-style-type: none"> <li>Attendance at regional trauma meetings</li> <li>Monitoring key trauma performance indicators to track improvements made</li> </ul>	Quarterly
<b>Growing the Health Workforce through Strengthening Recruitment, Retention and Repatriation</b>	<ul style="list-style-type: none"> <li>Retention and recruitment strategies for rural and primary care workforces</li> </ul>	Establish 'warm welcome here' sites in each DHB in order to recruit, orient and socialise new health professionals to rural areas and to facilitate collegiality within the sector	Quarter 4
<b>Strengthening Health Workforce Intelligence</b>	<ul style="list-style-type: none"> <li>TDHB will support the provision of a demographic information and forecasting model for all workforces identified by the Clinical Networks and some base line intelligence to target vulnerable, hard to recruit, new &amp; emerging workforces</li> </ul>	<ul style="list-style-type: none"> <li>Participation and contribution to workforce planning to:               <ul style="list-style-type: none"> <li>Improve our understanding of current demographics</li> <li>Enable us to model workforces for future needs</li> </ul> </li> </ul>	Quarter 4
<b>Building and Expanding the Capability of the Health Workforce</b>	<ul style="list-style-type: none"> <li>Develop a Midland Region platform and suite of e-Learning programmes for the health workforce</li> </ul>	<ul style="list-style-type: none"> <li>Develop a business case that proposes the future model of the Managed Virtual Learning environment (MVLE)</li> </ul>	Quarter 1
<b>Delivery of Regional IT Priorities</b>	<ul style="list-style-type: none"> <li>Review the deployment of the Orion CWS application within the Midland region. This will require significant reprioritisation of current activities at both a local and regional level to enable this to be brought forward</li> <li>Further information is available in the Midland DHBs RSP for 2015/18</li> <li>TDHB will contribute to and actively participate in the regionally agreed objectives and initiatives</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly reporting against RSP activities</li> </ul>	Quarterly

## Module 3

# Statement of Performance Expectations



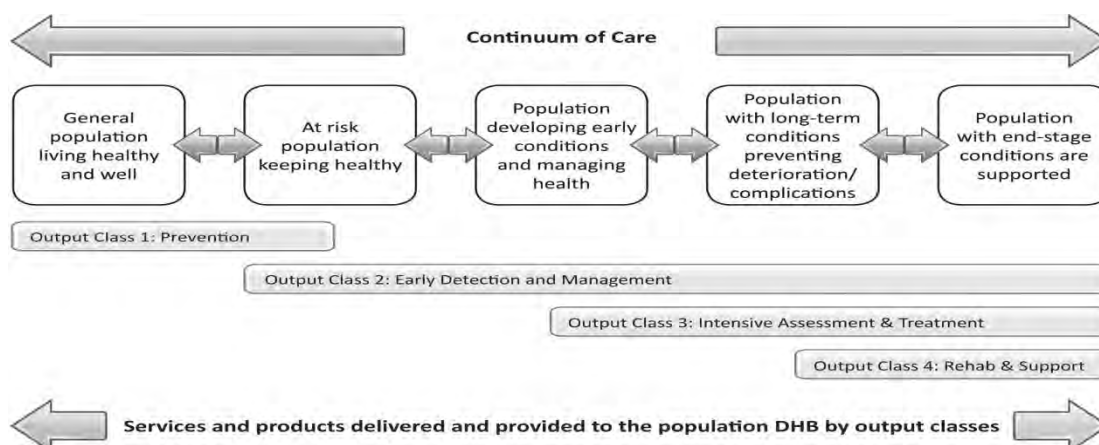
## MODULE 3: STATEMENT OF PERFORMANCE EXPECTATIONS

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop this Statement of Performance Expectations (SPE) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2015/16. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the full range of outputs that we fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes (see modules 1 and 2). Where possible, we have included with each measure past performance as baseline data.

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

### 3.1 OUTPUT CLASSES

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



### 3.2 GUIDE TO READING THE STATEMENT OF PERFORMANCE EXPECTATIONS

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

- Further detail of the performance story logic and rationale is contained in Module 1
- Baseline and National/Regional Result figures for the output performance measures are for the 2012/13 financial year unless otherwise stated
- In the performance measures table and where available the average column presents the national or regional average for the output performance measure
- Most measures have been adopted regionally
- Some measures fall across more than one impact. Where this is the case they have only been included once

- Measurement type key: qn = Quantity t = Timeliness ql = Quality
- There are some services we provide that support the rest of the health system so we have included these in a “Support Services” section of our performance story
- Detailed information about various programme definitions and rationale for each output measure is provided in Module 8.4
- National data collections will be occurring during 2015/16 through the Quality and Safety Commission’s National patient Safety Campaign. TDHBs Quality Programme Outcomes will be presented in our 2015/16 Quality Account Report

### 3.3 PEOPLE ARE SUPPORTED TO TAKE GREATER RESPONSIBILITY FOR THEIR HEALTH

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

#### 3.3.1 Fewer People Smoke

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of hospitalised smokers offered advice to quit (Health Target)	1	qn/t				National Regional	
Maori			95%	95%	95%	96%	96%
Non-Maori			96%	96%	95%	95%	96%
Total			95%	96%	95%	95%	96%
Percentage of Primary Health Organisations enrolled smokers offered advice to quit (Health Target)	1	qn/t				National	
Maori				88%*	90%	88%*	
Non-Maori					90%		
Total			71%	84%	90%	86%	
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit (Health Target)	1	qn/t					
Maori					Progress towards		
Non-Maori			New Measure	90%	90%	New Measure	
Total				79%	90%		
				83%	90%		

\*2013/14 and prior this was reported as High Needs rather than Maori

### 3.3.2 Reduction in Vaccine Preventable Diseases

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of eight month olds fully immunised (Health Target & MHP)	1	qn/t				National Regional	
Maori			89%	84%	95%	88%	85%
Non-Maori			89%	92%	95%	93%	90%
Total			89%	90%	95%	92%	88%
Percentage of the population >65 years who have received the seasonal influenza immunisation (PHO Performance Programme & Maori Health Plan)	1	qn/t				National	
Maori			69%*	67%*	75%	65%*	
Non-Maori					75%		
Total			70%	67%	75%	66%	

\*2013/14 and prior this was reported as High Needs rather than Maori

### 3.3.3 Improving Health Behaviours

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of infants who are fully, exclusively or partially breastfed at 6 months (Maori Health Plan)	1	qn/t				National	
Maori			50%^	50%^	65%	54%	
Non-Maori			64%^	64%^	65%	69%	
Total			61%^	61%^	65%	66%	
The number of referrals to the GRx (Green Prescription) programmes (Local Contract)	1	qn/t					
Adult			1132	1199	1646	Not Available	
Children			96*	106*	35		
Reduce the teen birth rate per 10,000	1	qn/t				National Regional	
Maori			350	285	<285	329	332
Non-Maori			144	123	<123	93	105
Total			195	164	<164	144	186
Reduce the rate of teenage terminations of pregnancy per 10,000	1	qn/t				National Regional	
Maori			163	146	<146	107	101
Non-Maori			120	142	<120	59	85
Total			131	143	<131	70	91

^ Baseline taken from 2013/14 as definition changed to include partially breastfed infants

\* GRx Active Families programme numbers boosted by Taranaki DHB's Whanau Pakari research.

### 3.4 PEOPLE STAY WELL IN THEIR HOMES AND COMMUNITIES

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

#### 3.4.1 An Improvement in Childhood Oral Health

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of children (0-4) enrolled in DHB funded dental services (Policy Priority 13 & Maori Health Plan)	2	qn				National	Regional
Maori			59%	59%	90%	59%	63%
Non-Maori			82%	80%	90%	77%	75%
Total			75%	73%	90%	73%	72%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (Policy Priority 13)	2	qn/t	9%	7%	8%	10%	11%
Percentage of adolescent utilisation of DHB funded dental services (Policy Priority 12)	2	qn	77%	79%	85%	70%	69%

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

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of population enrolled with a PHO (Maori Health Plan)	2	qn				National	Regional
Maori			85%	88%	98%	91%	96%
Non-Maori			97%	98%	98%	97%	98%
Total			95%	96%	98%	96%	98%
Percent of the eligible population will have had their cardiovascular risk assessed in the last five years (Health Target & Maori Health Plan)	2	qn				National	Regional
Maori			63%	79%	90%	81%	80%
Non-Maori			75%	89%	90%	86%	88%
Total			73%	88%	90%	85%	86%

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of eligible women (25-69) have a cervical cancer screen every 3 years (Maori Health Plan) Maori Non-Maori Total	1	qn/t	72% 87% 85%	73% 88% 86%	80% 80% 80%	National 63% 79% 77%	Regional 66% 83% 79%
Percentage of eligible women (50-69) have a breast screen in the last 2 years (Maori Health Plan) Maori Non-Maori Total	1	qn/t	63% 77% 76%	65% 78% 77%	70% 70% 70%	National 66% 73% 72%	Regional 61% 70% 68%
Increase the number of packages of care available to youth under the Primary Mental Health Initiative (Maori Health Plan) Maori Non-Maori Total	2	qn	New Measure	45 112 157	63 187 250	Not Available	

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

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of Rest Home residents receiving vitamin D supplement from their GP Total	4	qn	75%	73%	75%	Not Available	
Triage level 4 & 5s presenting to the Emergency Department as a percentage of the total population	2&3	qn	25%	23%	<23%	National 11%	Regional 16%
Percentage of eligible population who have had their B4 school checks completed High Needs Total	1	qn/t	86% 88%	106% 102%	90% 90%	National 90% 91%	Regional 91% 93%

### 3.4.4 More People Maintain their Functional Independence

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months (Policy Priority 23)	4	qn/t	41%	83%	95%	Not Available	

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result
For those with aged related and chronic health conditions we aim to reduce the rate of rest home level of residential care to home based support and respite funding	4	qn	ARRC:HBSS 2.34:1	2.41:1	2.40:1	Not Available
Increased number of clients accessing respite services	4	qn	156	238	>156	Not Available
Percentage of patients aged 75 and over (Maori and Pacific Islanders 55 and over) that are given a falls risk assessment	3	ql	91%	92%	100%	Not available

### 3.5 PEOPLE RECEIVE TIMELY AND APPROPRIATE CARE

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

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

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Acute Re-admission rate (Ownership Dimension 8)	3	ql/t	5.49%	7.1%	≤6.9%	National 7.77%	Regional 7.26%
Acute Re-admission rate 75+ years (Ownership Dimension 8)	3	ql/t	8.90%	10.5%	≤10.9%	National 10.69%	Regional 10.04%
Acute inpatient average length of stay (Ownership Dimension 3)	3	ql/t	4.07 days	4.04 days	4.07 days	National 3.93 days	
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July (Health Target also)	3	qn/t	Redefined	81% (Q2 14/15)	85%	National 67%	

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of patients with a confirmed diagnosis of cancer who receive their first cancer treatment with 31 days of diagnosis (Policy Priority 30)	3	qn/t	Redefined	74% (Q2 14/15)	80%	National 83%	
Percentage of patients who require radiation or chemotherapy are treated with 4 weeks (Policy Priority 30)	3	qn/t	Redefined	100% (Q2 14/15)	100%	National 100%	Regional 100%
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total primary and secondary deliveries	3	ql	20%	21%	<18%	National 18%	Regional 17%
Percentage of operations where venous thromboembolism (blood clot) was considered as part of the surgical checklist	3	ql	91%	100%	100%	Not available	

### 3.5.2 People Have Appropriate Access to Elective Services

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result	
Percentage of patients waiting longer than four months for their first specialist assessment (Elective Service Performance Indicator 2)	3	qn/t	0.11%	3.1%	0%	National 3.8%	Regional 3.8%
Number of surgical discharges under the elective initiative (Health Target)	3	qn	4,660	4,814*	5,424	N/A	
Elective inpatient length of stay (Ownership Dimension 3) # <i>This measure has been revised to now include day stay cases.</i>	3	ql/t	3.21 days	2.87 days#	1.53 days	National 3.23 days	
Did-not-attend percentage for outpatient services (Maori Health Plan)	3	qn/t				National	Regional
Maori			19%	21%	5%	12%	15%
Non-Maori			7%	7%	5%	5%	6%
Total			9%	10%	5%	6%	8%

\*The number of surgical discharges performed during 2013-14 was greater than Plan. We expect that during 2015-16 we will manage the volumes to meet the Plan live within our means.

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

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (Policy Priority 8)	3	qn/t				National Regional
Mental Health						
0-19 yr olds			61%	59%	80%	69% 71%
20-64 yr olds			80%	74%	80%	84% 78%
65+ yr olds			87%	86%	80%	84% 85%
Addictions						
0-19 yr olds			86%	77%	80%	80% 78%
20-64 yr olds			76%	81%	70%	79% 72%
65+ yr olds			83%	78%	70%	85% 77%
Percentage of Child and Youth clients discharged with a transition (discharge) plan. (Policy Priority 7)	3	qn/t/ql				
Total			97%	99%	95%	Not Available
Average length of acute inpatient stays (KPI 8)	3	qn/t/ql				National Average
Maori				18 days	14-21 days	17 days
Total			15 days	16 days	14-21 days	18 days
Rates of post-discharge community care (KPI 19)	3	qn/t/ql				National Average
Maori				35%	90-100%	60%
Total			53%	56%	90-100%	61%

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

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result
A reduction in the percentage of palliative care clients who have had an Emergency Department presentation	3	qn/t	11%	7%	≤11%	Not Available

### 3.6 SUPPORT SERVICES

Outputs	Output Class	Measure Type	Baseline 12/13	Audited Result 13/14	Target 2015/16	National/Regional Result
Improved wait times for diagnostic services - accepted referrals receive their scan within 42 days (PP29) Computed Tomography (CT) Magnetic Resonance Imaging (MRI)	2	qn/t	77% 44%	75% 56%	95% 85%	Not Available
Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes: Category 1: Within 24 hours Category 2: Within 96 hours Category 3: Within 72 hours	2	qn/t	95% 95% 90%	93% 95% 90%	90% 90% 90%	Not Available

## Module 4

# Financial Performance



## MODULE 4: FINANCIAL PERFORMANCE

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

(\$'000)	2013/14 audited	Year 0 2014/15 Forecast		Year 1 2015/16 plan	Year 2 2016/17 plan	Year3 2017/18 plan	Year4 2018/19 plan
Hospital Provider + Governance Funding (including other income)	180,579	179,975		184,709	188,918	193,635	198,351
Non Hospital Provider Funding (NGO)	153,819	159,740		169,930	178,380	186,829	195,282
<b>TOTAL FUNDING</b>	<b>334,398</b>	<b>339,715</b>		<b>354,639</b>	<b>367,298</b>	<b>380,464</b>	<b>393,633</b>
Hospital Provider + Governance Operating Expenses	189,792	190,910		196,772	200,067	203,920	208,355
Payments to Non Hospital Providers (NGO)	147,882	149,740		157,130	166,459	175,747	184,481
<b>TOTAL OPERATING EXPENSES &amp; PAYMENTS</b>	<b>337,674</b>	<b>340,650</b>		<b>353,902</b>	<b>366,526</b>	<b>379,667</b>	<b>392,836</b>
<b>Hospital Provider + Governance Operating Deficit</b>	<b>(13,126)</b>	<b>(10,935)</b>		<b>(12,063)</b>	<b>(11,149)</b>	<b>(10,285)</b>	<b>(10,004)</b>
<b>TDHB Funder surplus</b>	<b>9,850</b>	<b>10,000</b>		<b>12,800</b>	<b>11,921</b>	<b>11,082</b>	<b>10,801</b>
<b>CONSOLIDATED FINANCIAL RESULT</b>	<b>(3,276)</b>	<b>(935)</b>		<b>737</b>	<b>772</b>	<b>797</b>	<b>797</b>

The net consolidated financial projection for the planning period 2015-19 is:

- 2015-16: Surplus \$ 0.74M
- 2016-17: Surplus \$ 0.77M
- 2017-18: Surplus \$ 0.80M
- 2018-19: Surplus \$ 0.80M

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

## 4.1 KEY POINTS FROM THE BUDGETED FINANCIALS 2015-19

- The Board has planned for a consolidated financial surplus for each of the fiscal periods covered by the planning period 2015-19.
- These financial projections reflect a common trend across the entire planning period 2015-19, clearly indicating that cost growth in the hospital provider operations is significantly in excess of its funding, leaving incessant operating deficits. The relatively better consolidated financial result is solely on account of surpluses generated in the Funder operations during each of the fiscal periods under consideration, which is not sustainable, nor ideal for strategic health services planning for the local community.
- Stage 1 of the hospital redevelopment programme (Project Maunga) has been delivered to budget and time, bringing the \$ 80M project to conclusion.
- The hospital provider (and consolidated) financial result in Year 1 (2015-16) is materially influenced by the cost impacts of Project Maunga. Increased depreciation (\$ 3.10M), cost of borrowing (\$ 2.02M), loss of interest income on deposits (\$ 1.30M) has resulted in \$ 6.42M addition to operating expenditure in 2015-16 and future fiscal periods.
- The hospital provider budget for Year 1 is *after* targeted cost reductions and budget trimming of \$ 4.00M – primarily in management of diagnostics costs and activity levels. There is real exposure should these fail to eventuate or fall short. This is in addition to the savings plan already in place to realise savings for the current 2014-15 year. These savings are being sought from improved service level management, monitoring of contracted volumes, targeted cost reduction initiatives, reduced staffing costs and service reconfigurations amongst a range of other initiatives. (Please refer to the “Cost & efficiency initiatives” section for details).
- In addition to the targeted \$ 4.00M in cost reductions noted earlier to be delivered by the hospital provider in Year 1, there is an expenditure to revenue gap of \$ 1.56M in Year 1 that are yet to be identified against initiatives and savings – taking the total to circa \$ 5.56M as the budgetary gap to be bridged over a 12 month period.
- Likewise, the DHB Funder operations is planning to reprioritise funding and drive strategic initiatives to enable the DHB Funder operations to manage its costs down and deliver the operating surplus planned for 2015/16 and years following.
- It is difficult to estimate with certainty the likely costs and benefits to this DHB from Health Benefit Limited (HBL) driven business cases as these are in various stages of delivery. Outgoings in capital investment and contribution to HBL’s operating expenditure have been recognised based on information available.
- Indicative savings through reduced pricing from collective procurement projects, All of Government (AOG) initiatives and other collaborative efforts have been factored into clinical supply and consumable costs over the plan period. Likewise, operating expenditure outflow to support these national initiatives has been recognised.
- TDHB’s share in supporting the Midland regional projects and contribution to HealthShare (the regional shared services entity) has been recognised.
- Collectively, the total cost budgeted in 2015-16 for TDHB to support national and regional agencies (HBL, Health Share, other National Agencies) is circa \$ 1.75M – and is increasing year on year.
- The operating budget is severely limited to absorb these new (and increasing) costs arising on different fronts – noting that benefits, if any, are likely to accrue only in future periods.
- The Hospital Provider Arm is facing a significant cost to funding gap resulting in operating deficits in each year covered by this plan. This gap will increase if other identified risks and associated costs (estimated at \$3.60M) were to materialise fully. With the residual risk at \$2.53M, the resultant financial gap would be in the region of \$6.53M. Likewise, the DHB Funder is also faced with exposure estimated at around \$6.05M for 2015/16, with a residual risk equating to about \$3.72M. (Please refer the “Sensitivity Analysis” section for details). These risks are in addition to the expenditure to revenue gap of \$ 1.56M in the hospital provider in Year 1 that is yet to be identified against initiatives and savings.
- The Board recognises that the operating cost to funding gap in the Hospital Provider operations will need to be addressed through options that will result in significant changes to models of care, service

configurations and re-alignment of services within funding available. It acknowledges that structural changes will have to be pursued if the Hospital Services arm is to remain financially viable when faced with increased costs on several fronts, besides the cost impacts of Project Maunga.

- On the other hand, gains from Project Maunga will materialise in 2015-16 and future periods. 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 contribute towards a recovery plan for Hospital Services to align itself more efficiently – both clinical and financial. This is itself will not remove or reduce the deficit.
- Faced with increased demand for health services and nominal annual funding increases, targeted changes within its operating framework (and the non-hospital sector) are inevitable.

In the final analysis, the Board is faced with:

1. A continuing core deficit in the Hospital Provider operations in each of the plan years.
2. Additional financial exposure in its expense budgets which could materialise in part or full.
3. The need to make radical changes and re-align service configurations in its hospital service operations to reduce the current deficit.
4. The financial recovery for its Hospital Provider operations being largely dependent on cost reductions incidental to services rationalisation, capacity and work force management, 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, with reliance on timely outcomes from service changes and initiatives, Taranaki District Health Board's financial risk assessment of the current District Annual Plan is rated "medium to high" risk under the assumptions and risks as stated.

## 4.2 KEY RISKS

### 4.2.1 Taranaki DHB's Funder Operations

1. Taranaki DHB's increase in funding from the Funding Envelope for 2015/16 is \$12.9million.
2. Other adjustments have been made in-year 2014-15 e.g. capital charges. As a result the change in total funder revenue between 2014/15 start point and 2015-16 advice is an increase of \$16.2m
3. There has been a significant change in the Taranaki DHB's PBFF share in 2015/16. This is due to the rebasing of the population from Census. In 2015/16 Taranaki DHBs PBFF share increased to 2.79% from 2.72% in 2014/15.
4. Change in 2015/16 DHB growth was capped at minimum growth of 1.5% and maximum growth of 4.25% to smooth the impact of demographic change across DHBs. Taranaki DHB reached the maximum growth cap.
5. Taranaki DHBs PBFF share is forecast to decline in future years. As a consequence this level of growth cannot be relied upon for future year

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Rebased	2.79%	2.79%	2.79%	2.78%	2.76%	2.75%	2.74%	2.72%
Actual	2.73%	2.72%	2.79%					

Source: Funding Advice - Table 3 DHB Shared Including Rural, Overseas and Unmet Need % Dec 2014

6. The Government has made no decision on out-year funding. To ensure consistency across all DHBs, Taranaki DHB has prepared the Annual Plan using the planning assumption that funding increases in out-years will be of the same nominal value as stated in the planning guidance.

7. Whilst the level of funding for Taranaki DHB is equitable when compared to the proposed increases for other DHBs, the level of increase is considerably lower than the cost and service pressures faced by the DHB Funder and Provider Arm
8. The range of pressures that the Taranaki Health System is experiencing can be described into the five interdependent categories below
  - Cost Pressures in Hospital and Specialist Services
  - Cost Pressures in NGO Sector
  - Reserve Funds for Future Year to Support DHB Capital Investment in Medium Term or/and Provide an Organisational Operational Contingency
  - Strategic Investment to progress Integrated System Approach
  - Investment for Improved Outcomes in Specific Population Groups e.g. Child and Youth, Maori or Mental Health Service Clients
9. The allocation of resources is a pragmatic approach to investment given the information available at this time and reflects prioritisation in line with DHB funding responsibilities and the Minister's Letter of Expectation. The following principles have been used to guide the proposed allocation of funding in 2015/16 from a Funder perspective:
  - Meet planned organisational consolidated position (break-even).
  - Contribute to ability to effectively manage Provider and Funder cost pressures. DHBs are required to maintain core services for the local population and ensure continued elective growth consistent with the Government Policy and reduce deficits where they currently exist. DHBs are expected to meet the demographic needs of an ageing and growing population within the funding provided.
  - Ensure that improved outcomes in specific population groups e.g. Child and Youth, Maori or Mental Health Service Clients will be secured through any new investment.
  - Allocate strategic investment to progress integrated system approach.
  - Capital reserves and contingency only considered in the context of affordability.
10. General hospital and specialist services delivered by the DHB's own Provider Arm will be paid in a composite of National IDF prices and local prices acknowledging affordability and capacity issues. Mental health services delivered by the DHB's Provider Arm are funded by a local price mechanism.
11. In order to offset planned deficits in the Provider Arm, whilst service reconfiguration is undertaken to a lower cost base, the Funder is required to achieve significant surpluses. In 2015/16 the planned Funder surplus is \$12.8 million. This presents a significant challenge for the Funder.
12. A proportion of this surplus is identified as a strategic reserve for future years. The intent of this approach is to facilitate the focus on 'models of service', advanced relationship with PHO and other sector partners, allow 'transition funding', and facilitation of transfer of services to primary care. Any strategic investment in future years will be linked to the development of project and business case development to be undertaken in 2015/16.
13. This allocation reflects risk for the Funder in terms of management of cost and volumes, but provides some support for management of cost pressures whilst establishing a limited opportunity for strategic investment. The allocation is based on strategic considerations and a balanced approach to meet the expectation of single fiscal year.
14. The key risks associated with achievement of this surplus include
  - Achievement of planned deficits in the Provider Arm.
  - Growth in Inter District Flows.
  - Growth in Health of Older People.
  - Containment of growth in pharmaceuticals.

#### 4.2.2 Taranaki DHB's Hospital Provider Operations

1. The funding contribution for cost pressure in 2015/16 is 0.37%. 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 \$12.06M after considering all current efficiencies and cost savings, including ongoing costs totalling \$ 6.42M related to Project Maunga.

2. Cost pressures are particularly evident in the following areas:

- a. Clinical staff costs – primarily nursing.
- b. Outsourced clinical staff – primarily locum doctors and psychiatrists.
- c. Diagnostics – primarily radiology.
- d. Acute services such as cardiology, mental health inpatient services and emergency services.
- e. Increasing cost impacts of statutory compliances, quality and accreditation deficits and numerous legislative requirements.
- f. Information and communication technology (ICT) capital investment and increased operating costs for network infrastructure and software licences.
- g. Operating cost contributions, capital investment and participation in national and regional initiatives and business cases.

Overall, the Hospital Provider's financial plan for the planning period is highly geared and has no flexibility to accommodate unplanned cost movements. Its operating budget carries financial risks and it is highly dependent on the realisation of targeted savings within planned timelines to meet its 2015/16 and out year financial targets.

3. 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 clinical compliance expectations and legislative changes.
4. The Hospital Services Provider is dependent on sustainable revenue streams. With about 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 revenue growth. There is a marginal increase (2%) in ACC revenues planned for 2015/16 arising from increased theatre capacity post Project Maunga. Miscellaneous income also assumes \$ 2.00M to be raised through community donations.
  - In view of the increasing cost pressures, the financial budget for the Provider Arm continues to hinge on a number of efficiency initiatives and cost reductions, which have to generate \$4.00M of reduced operating costs during 2015/16. (Please refer to the "Cost & Efficiency initiatives" section for details). In addition there is expenditure to revenue gap of \$ 1.56M in Year 1 that is yet to be identified against initiatives and savings.
5. During the plan period 2015-19, baseline capital expenditure will be contained within depreciation provisions, so that additional equity injection or borrowing is not required despite operating deficits.

In the final analysis, the gap between funding and the realistic cost model for services plus the cost impact of Project Maunga has resulted in a very sensitive financial budget for the planning period 2015/16 and out years. *Due to funding constraints, the hospital provider can bridge this budgetary gap only through targeted structural reforms that can release material costs from existing services and arrangements.* In parallel, the ongoing initiatives comprising rationalisation of services, workforce management, regional co-operations and realisation of gains from ongoing projects must continue. Collectively, all 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 a realistic view point and timeframes, the quantum of cost savings required from the hospital services will likely span a 3 plus year planning horizon – if existing services and levels are to be maintained.

## 4.3 KEY FINANCIAL ASSUMPTIONS

The following key assumptions have been employed in the preparation of the financial statements for the four year planning period 2015-19.

### 4.3.1 Application of Public Benefit Entity Accounting Standards

The DAP financial template for the plan period 2015-19 and comparative years has been prepared in accordance with NZ GAAP. They comply with Public Benefit Entity Standards which include the Public Benefit Entity International Public Sector Accounting Standards (PBE IPSAS).

### 4.3.2 Equity and Borrowing

- a) The District Annual Plan 2015-19 has not assumed any additional Crown equity.
- b) The Base hospital redevelopment (Project Maunga) was completed in early 2015 and \$ 45M term loan incidental to the project is fully drawn and applied.
- c) Base line capital expenditure is expected to be contained within the level of depreciation for 2015/16 and the three years following.
- d) Taranaki DHB is currently under “performance watch - remedial” status on the performance monitoring scale.

### 4.3.3 Operating Expenditure assumptions:

- a) Wage costs: in principle, wage budgets for employee groups covered by national MECA settlements are essentially in accordance with current agreement(s) and in line with collective planning assumptions. MECA's which are yet to be settled (eg. NZNO) have a budgetary provision for wage increases - and presents a risk should final settlement exceed the provision.
- b) Clinical supplies: average increase of 3% for 2015/16 based on estimated activity levels, reduced for local efficiencies and procurement gains.
- c) General operating expenditure (excluding depreciation and interest): average increase of 2.5% for 2015/16, 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 DAP financials. Gains from local initiatives and projects have been built into the relevant expense budgets.
- e) Other expenditure reductions: the 2015/16 expense budget assumes efficiencies and cost reductions arising from the following:
  - Prioritised service levels
  - Length of stay and patient throughput
  - FTE management + reduced staffing costs
  - Contract tracking + monitoring.
  - Demand and capacity management

## 4.4 TDHB FUNDER – “RING FENCE PRINCIPLE” AND APPLICATION OF SURPLUS/DEFICITS

### 4.4.1 Mental Health Services

In keeping with the guidelines on treatment of “Mental Health Ring fence surplus” the amount of any under-expenditure carried forward from previous accounting periods has been reported as a surplus in Taranaki DHB's Statement of Financial Performance in the year the surplus is generated. The ring fenced surpluses as at the beginning of FY 2015/16 have been fully applied to Mental Health Services either in the Hospital Provider or community during the year. Based on expenditure to date and forecasts, no surplus is likely to remain on 30 June 2015. No surpluses from Mental Health services are envisaged during the 2015-

19 plan period and, if any surpluses do eventuate, these will be ring fenced and expended in the year(s) following.

#### 4.4.2 Interest Rates

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

	Overdraft	DMO/MOH Loans (Average)	DMO/MOH Loans (new)	Deposits	Equity
Year 1 (2015/16)	4.75%	4.35%	-	4.25%	8.00%
Year 2 (2016/17)	4.80%	4.50%	-	4.30%	8.00%
Year 3 (2017/18)	5.25%	4.50%	-	4.75%	8.00%
Year 4 (2018/19)	6.00%	4.75%	-	5.50%	8.00%

#### Notes:

1. DMO/MOH total approved facility is \$74M, with the full limit having been drawn down with the completion of Project Maunga in early 2015.
2. TDHB is in the DHB collective banking & transactional arrangement with Westpac. Monthly closing cash balances are mostly positive, on odd occasions dipping into over draft for limited periods during certain month ends.

#### 4.4.3 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 2015/16 financials arising from any impacts of asset revaluation as on 30 June 2015. A detailed revaluation exercise was completed on 30 June 2013, and updated upon completion of the new build (Project Maunga). It is therefore assumed that there will be no material movements requiring an adjustment to the current asset base. The impact of the new hospital redevelopment on current building values has been factored in the recent revaluations and treated appropriately. Conversely, should there be a material movement, it is assumed that any related capital charge increase will be funded/base line adjusted in accordance with current Treasury guidelines.

#### 4.4.4 Depreciation

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

#### 4.4.5 Capital Charge

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

#### 4.4.6 Leasing

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

#### 4.4.7 Financial Covenants and Ratios

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

The following are some key financial ratios as derived from the consolidated financial statements for the period 2015-19.

Financial ratios	TDHB 2014/15	Year1 2015/16	Year2 2016/17	Year3 2017/18	Year4 2018/19
	forecast	plan	plan	plan	plan
1 Revenue to net funds employed	2.14	2.24	2.32	2.41	2.49
2 Operating margin to revenue	5%	6%	5%	5%	5%
3 Operating return on net funds employed	11%	12%	12%	12%	12%
4 Interest cover ratio	5.70	6.75	6.64	6.64	6.64
5 Debt to debt equity ratio	47%	47%	47%	47%	47%

#### 4.4.8 Changes in Accounting Policies

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

#### 4.4.9 Capital Investment

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

Capital Outlay (\$'000)	Year 1 (2015/16)	Year 2 (2016/17)	Year 3 (2017/18)	Year 4 (2018/19)	Total (2015-19)
<b><u>Operating</u></b>					
Clinical Equipment	3,000	3,000	3,000	3,000	12,000
Other Equipment	500	500	500	500	2,000
Motor Vehicles	350	700	1,000	200	2,250
Minor Site Redevelopment (excluding prior year WIP)	5,500	2,000	2,000	2,500	12,000
Information Technology	6,000	6,000	6,000	6,000	24,000
<b>TOTAL</b>	<b>15,350</b>	<b>12,200</b>	<b>12,500</b>	<b>12,200</b>	<b>52,250</b>
<b><u>Strategic</u></b>					
Base Hospital redevelopment project – Stage 2	-	-	-	-	-
<b>TOTAL</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>GRAND TOTAL</b>	<b>15,350</b>	<b>12,200</b>	<b>12,500</b>	<b>12,200</b>	<b>52,250</b>
<b><u>Sources of Funding</u></b>					
Crown Equity	0	0	0	0	0
Bank Borrowing	0	0	0	0	0
DMO/MOH Term Loans	0	0	0	0	0
Internal Cash Accruals	15,350	12,200	12,500	12,200	52,250

#### 4.4.10 Capital Divestment

A: The disposal of surplus assets proposed during the period 2015-19 is as follows:

Asset	Book value (\$)	Realisable Value (\$)	Gain/(loss) On sale (\$)	Timing
* Miscellaneous equipment (discarded/obsolete)	0	Not material	0	2015-19
* Surplus land	0	0	0	n/a
* Vehicles	0	Not Material	0	2015-19
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	

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

#### 4.4.11 Personnel

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

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

##### CONTRACTED

	Forecast 2014-15	Yr 1 2015-16	Yr 2 2016-17	Yr 3 2017-18	Yr 4 2018-19
<b>PROVIDER</b>					
Medical Personnel	149	154	155	155	157
Nursing Personnel	550	554	557	560	565
Allied Health Personnel	246	248	245	245	242
Support Personnel	78	78	78	78	80
Management & Administration	270	275	275	275	275
	<b>1,293</b>	<b>1,309</b>	<b>1,310</b>	<b>1,313</b>	<b>1319</b>
<b>GOVERNANCE</b>	17	17	17	17	17
<b>TOTAL</b>	<b>1,310</b>	<b>1,326</b>	<b>1,327</b>	<b>1,330</b>	<b>1336</b>

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

- Project Whakapai – the initiative/project has become entrenched into the hospital services operations utilising proprietary workforce allocation and real-time monitoring software to actively manage supplementary staff costs arising from use of casuals, backfills, overtime and locums continue to provide the framework for management and budgeting of FTEs. This interactive workforce management tool has inbuilt levels of authority and decision matrixes with a centralised allocations unit. Project Whakapai promotes 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 4 year plan period due to more efficient management of staffing (Project Whakapai) and efficiencies from services reconfigurations and changing models of care within the hospital and mental health services. Movements in Allied Health and support staff are

likely to remain steady, whilst Management and Administration staff are also expected to remain at current levels, with any increases relating to staffing new funded projects. Capping FTE growth with improved productivity and more efficient and smarter workflows is a key goal for Taranaki DHB to manage the cost growth and the deficit.

- Taranaki DHB is currently tracking within the Ministerial cap set for Management and Administration staff having made significant reductions over the recent period through internal reviews and restructures, and is expected to remain below the cap over the plan period.
- In principle, the personnel budget has not planned for core FTE increases – other than FTEs required to deliver new projects and nationally driven initiatives. Additionally, there will be impacts from changes to services and models of care incidental to the hospital redevelopment project. The overall strategy is to cap FTE growth, however it is acknowledged that there will be demand for clinical resources due to increase in activity levels – both acute and elective. Additionally, as recent trends indicate, there has been an increase in specialising patients (one-on-one care) in ICU and Mental Health inpatient admissions. With introduction of management tools, 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 four year plan period is as below:

#### ACCRUED

	Forecast 2014-15	Yr 1 2015-16	Yr 2 2016-17	Yr 3 2017-18	Yr 4 2018-19
<b>PROVIDER</b>					
Medical Personnel	150	160	162	162	166
Nursing Personnel	570	575	580	585	590
Allied Health Personnel	254	258	254	254	250
Support Personnel	80	82	82	82	84
Management & Administration	276	282	282	282	282
	<b>1,330</b>	<b>1,357</b>	<b>1,360</b>	<b>1,365</b>	<b>1372</b>
<b>GOVERNANCE</b>	19	19	19	19	19
<b>TOTAL</b>	<b>1,349</b>	<b>1,376</b>	<b>1,379</b>	<b>1,384</b>	<b>1391</b>

## 4.5 CAPITAL EXPENDITURE 2015/16 (STRATEGIC)

### 4.5.1 Base Hospital Inpatient Facilities Development Programme

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

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

The Base hospital Master Plan envisages a 3 Stage redevelopment of the Base Hospital core inpatient facilities and support systems, such that it is both financially and operationally feasible over a defined timeline. The components of the programme are as follows:

Stages	Comprising	Estimated Cost	Construction Timeline	Status
1 <b>STAGE 1</b>	Theatres, Ambulatory, Inpatient wards	\$80M	Start: Aug 2011 Finish: June 2014	Completed.
2 <b>STAGE 2</b>	Maternity, Neonatal, ED	\$37M	Tentative: 2020-2021	Supplementary business case to be progressed.
3 <b>STAGE 3</b>	OPD, Laboratory, Administration	\$28M	Tentative : 2024-2025	Supplementary business case to be progressed.
<b>TOTAL</b>		<b>\$145M</b>	<b>2011 – 2025</b>	

**Notes:**

1. Stages 2 and 3 are discrete components of the overall Master Plan for the redevelopment of inpatient facilities at the Base Hospital.
2. As Stage 1 is now complete, it is envisaged that supplementary business cases will be developed for each of the remaining stages and forwarded to National Capital Committee for approval and funding.
3. In short, each of the stages can be visualised as standalone projects, yet forming part of one coherent facilities redevelopment programme for the Base Hospital in New Plymouth, thus enabling affordability to both Taranaki DHB and the National Health capital budget.

An updated Schedule of Capital Intentions has been submitted.

## 4.6 COST AND EFFICIENCY INITIATIVES

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

The following key initiatives are being considered within the Hospital Provider operations to generate efficiency gains, and contain or reduce operating costs.

Initiatives	Proposal	Potential Est. (\$)	Impact
Campus wide cost management strategies including service efficiencies and prioritisation.	Target specific areas of cost for efficiency gains including review of service delivery and demand.	\$0.90M	Reduce operating costs
Targeted review of contracted diagnostic services costs – radiology and pathology.	Review and re-structure of diagnostic service frameworks and processes.	\$2.33M	Reduce diagnostic costs.
Service reconfiguration	Reviews of service delivery against targets and contracts.	\$1.27M	Reduce service costs
Other initiatives yet to be identified	Ongoing review of several cost lines and services to generate cost savings.	\$1.20M	Reduce operating costs
<b>TOTAL</b>		<b>\$5.70M</b>	

The DAP 2015/16 has identified a cost to funding gap of \$ 5.70M, which has to be bridged by a range of saving initiatives and cost reduction plans as outlined. The services initiatives commenced in prior years will also generate cost savings in future periods, and have been recognised in out years.

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

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

## 4.7 DEBT AND EQUITY

The debt profile of Taranaki DHB as at 01 July 2015 will be term loans of \$74M with the Debt Management Office (DMO)/MOH, fully drawn down against the approved loan limit of \$74M. The primary assumptions carried in the financial plan 2015/16 are:

- a) Overdraft facilities (as per OPF guidelines) are assumed to be available under the DHB collective banking arrangement with West Pac.
- b) No additional equity or deficit support is envisaged. It is expected that base line capital expenditure will be contained within the level of depreciation for 2015/16 and out years.

## 4.8 SENSITIVITY ANALYSIS: PLAN 2015/16

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

### DHB Hospital Provider Operations – key risks

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	0.12	75%
Timing of gains from initiatives	2.00	1.50	1.00	0.50	75%
Diagnostic costs	0.40	0.30	0.20	0.10	75%
Clinical supplies	0.30	0.22	0.15	0.08	50%
General overheads	0.40	0.30	0.20	0.10	50%
<b>Likely impact on 2015/16 planned financial result</b>	<b>\$3.60M</b>	<b>\$2.70M</b>	<b>\$1.80M</b>	<b>\$0.90M</b>	<b>\$2.53M</b>

The analysis estimates an overall exposure of circa **\$3.60M** for 2015/16, which could arise from a combination of cost drivers as identified above. The overall probability factor is estimated to be around 70% leaving a residual risk equating to about **\$2.53M**. The risk is expected to be managed through a mix of:

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

### DHB Funder Operations – Key Risks

Unbudgeted financial risk	Estimated risk (\$'M)	75% risk (\$'M)	50% risk (\$'M)	25% risk (\$'M)	Probability factor (% risk)
Pharmaceuticals	0.30	0.22	<b>0.15</b>	0.08	50%
IDF outflows	1.50	<b>1.13</b>	0.75	0.38	75%
CCP > 0.37% and < 1.00%	1.25	<b>0.94</b>	0.63	0.31	75%
Older People Services	3.00	2.25	<b>1.50</b>	0.75	50%
<b>Potential impact on 2015/16 planned financial result</b>	<b>6.05M</b>	<b>4.54M</b>	<b>3.03M</b>	<b>1.51M</b>	<b>3.72M</b>

The overall exposure is estimated at around **\$6.05M** for 2015/16, while the probability factor is estimated to be around 60% leaving a residual risk equating to about **\$3.72M**.

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

## 4.9 STATEMENT OF COMPREHENSIVE INCOME

TARANAKI DISTRICT HEALTH BOARD										
STATEMENT OF COMPREHENSIVE INCOME										
DISTRICT ANNUAL PLAN 2016-19										
	Year -1	FORECAST		Year 0	(\$'000)					
	Consolidated Audited 2013/14	Hosp+Gov Forecast 2014/15	Funder Forecast 2014/15	Consolidated Forecast 2014/15	Provider Plan 2015/16	Governan: Plan 2015/16	Hosp+Gov Plan 2015/16	Funder Plan 2015/16	Consolidated Plan 2015/16	Year 1
<b>REVENUE</b>										
* MOH funding	161957	164384		164384	168708	0	168708		168708	
	153819		155665	155665				165817	165817	
* Funding & Governance	2040	2466		2466	0	2576	2576		2576	
* ACC Revenue	4648	4962	83	5045	5055	0	5055	84	5139	
* CTA revenue	1898	2300		2300	2282	0	2282		2282	
* Other revenue	10036	5863	3992	9855	6088	0	6088	4029	10117	
<b>TOTAL REVENUE</b>	<b>334398</b>	<b>179975</b>	<b>159740</b>	<b>339715</b>	<b>182133</b>	<b>2576</b>	<b>184709</b>	<b>169930</b>	<b>354639</b>	
<b>EXPENDITURE</b>										
<b>Personnel costs</b>										
- medical	28865	29616		29616	30069	0	30069		30069	
- nursing	44163	43849		43849	46210	0	46210		46210	
- allied health	15737	16105		16105	16237	0	16237		16237	
- support	4320	4141		4141	4432	0	4432		4432	
- mgt & admin	18110	17280		17280	17416	1537	18953		18953	
<b>total</b>	<b>111195</b>	<b>110991</b>	<b>0</b>	<b>110991</b>	<b>114364</b>	<b>1537</b>	<b>115901</b>	<b>0</b>	<b>115901</b>	
<b>Outsourced services</b>										
- clinical services	17933	17210		17210	15963	0	15963		15963	
- other outsourced	2078	1797		1797	1900	0	1900		1900	
<b>total</b>	<b>20011</b>	<b>19007</b>	<b>0</b>	<b>19007</b>	<b>17863</b>	<b>0</b>	<b>17863</b>	<b>0</b>	<b>17863</b>	
<b>Clinical supplies</b>										
- treatment disposables	8698	8312		8312	8532	0	8532		8532	
- diagnostic supplies	1364	1353		1353	1369	0	1369		1369	
- instruments & equip	1133	1222		1222	1346	0	1346		1346	
- patient appliances	1153	1117		1117	1161	0	1161		1161	
- implants & prostheses	2514	2298		2298	2628	0	2628		2628	
- pharmaceuticals	4197	3947		3947	4292	0	4292		4292	
- other clinical & client costs	4073	3909		3909	4064	0	4064		4064	
<b>total</b>	<b>23132</b>	<b>22158</b>	<b>0</b>	<b>22158</b>	<b>23392</b>	<b>0</b>	<b>23392</b>	<b>0</b>	<b>23392</b>	
<b>Infrastructure &amp; other op.costs</b>										
- hotel services & laundry	3091	2975		2975	3176	1	3177		3177	
- facilities	4015	4112		4112	4155	0	4155		4155	
- transport	811	645		645	604	26	630		630	
- IT systems & telecom	4105	4336		4336	5179	0	5179		5179	
- professional fees	2500	2661		2661	2550	422	2972		2972	
- other op.expenses	233	-1570		-1570	-218	258	40		40	
- democracy	369	333		333	1	292	293		293	
- depreciation	12151	15792		15792	15770	0	15770		15770	
- interest	1486	3162		3162	2872	0	2872		2872	
- cost & efficiency initiatives	0	0		0	-1561	0	-1561		-1561	
- <b>Payment to - NGO providers</b>										
- personal health	62422		61347	61347				68674	68674	
- mental health	9776		10555	10555				10875	10875	
- disability support services	35789		36990	36990				38567	38567	
- public health	892		935	935				813	813	
- maori health	2890		2813	2813				2831	2831	
- IDF's	36113		37100	37100				38170	38170	
<b>total</b>	<b>176643</b>	<b>32446</b>	<b>149740</b>	<b>182186</b>	<b>32528</b>	<b>999</b>	<b>33527</b>	<b>159930</b>	<b>193457</b>	
<b>TOTAL OPERATING EXPENSES</b>	<b>330981</b>	<b>184602</b>	<b>149740</b>	<b>334342</b>	<b>188147</b>	<b>2536</b>	<b>190683</b>	<b>159930</b>	<b>350613</b>	
<b>SURPLUS before capital charge</b>	<b>3417</b>	<b>-4627</b>	<b>10000</b>	<b>5373</b>	<b>-6014</b>	<b>40</b>	<b>-5974</b>	<b>10000</b>	<b>4026</b>	
- Capital charge	6693	6308		6308	6089	0	6089		6089	
<b>SURPLUS (before strategic exp)</b>	<b>-3276</b>	<b>-10935</b>	<b>10000</b>	<b>-935</b>	<b>-12103</b>	<b>40</b>	<b>-12063</b>	<b>10000</b>	<b>-2063</b>	
<b>STRATEGIC EXPENDITURE</b>										
Funder transition Investment Fund	0		0	0				-2800	-2800	
<b>NET SURPLUS/(DEFICIT) after Strategic</b>	<b>-3276</b>	<b>-10935</b>	<b>10000</b>	<b>-935</b>	<b>-12103</b>	<b>40</b>	<b>-12063</b>	<b>12800</b>	<b>737</b>	
<b>OTHER COMPREHENSIVE INCOME</b>										
* Gain/(Loss) on asset revaluation	0	0		0	0				0	
*Gain/(Loss) on sale of assets	0	0		0	0				0	
*Share of surplus/(loss) from associates	0	0		0	0				0	
<b>Total Other Comprehensive Income</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>TOTAL COMPREHENSIVE INCOME FOR THE YEAR</b>	<b>-3276</b>	<b>-10935</b>	<b>10000</b>	<b>-935</b>	<b>-12103</b>	<b>40</b>	<b>-12063</b>	<b>12800</b>	<b>737</b>	
Interest Cover ratio	6.97			5.70					6.75	
Revenue to Net Funds employed	2.08	1.14		2.14	1.15				2.24	
Operating margin to Revenue ratio	3%	5%		5%	4%				6%	
Op. return on Net Funds employed	6%	5%		11%	4%				12%	

TARANAKI DISTRICT HEALTH BOARD															
STATEMENT OF COMPREHENSIVE INCOME															
DISTRICT ANNUAL PLAN 2016-19															
	Year 2					Year 3					Year 4				
	Provider	Governan:	Funder	Consolidated		Provider	Governan:	Funder	Consolidated		Provider	Governan:	Funder	Consolidated	
	Plan	Plan	Plan	Plan		Plan	Plan	Plan	Plan		Plan	Plan	Plan	Plan	
	2016/17	2016/17	2016/17	2016/17		2017/18	2017/18	2017/18	2017/18		2018/19	2018/19	2018/19	2018/19	
REVENUE															
* MOH funding	173203			173203		177702			177702		182199			182199	
			174169	174169				182518	182518				190869	190869	
* Funding & Governance		2685		2685			2794		2794			2903		2903	
* ACC Revenue	5106		85	5191		5157		86	5243		5209		87	5296	
* CTA revenue	2305			2305		2328			2328		2351			2351	
* Other revenue	5619		4126	9745		5654		4225	9879		5689		4326	10015	
TOTAL REVENUE	186233	2685	178380	367298		190841	2794	186829	380464		195448	2903	195282	393633	
EXPENDITURE															
Personnel costs															
- medical	30370			30370		30978			30978		31599			31599	
- nursing	46672			46672		47606			47606		48558			48558	
- allied health	16401			16401		16728			16728		17063			17063	
- support	4476			4476		4565			4565		4656			4656	
- mgt & admin	17589	1559		19148		17941	1581		19522		18300	1604		19904	
total	115508	1559	0	117067		117818	1581	0	119399		120176	1604	0	121780	
Outsourced services															
- clinical services	16123			16123		16526			16526		17022			17022	
- other outsourced	1919			1919		1967			1967		2025			2025	
total	18042	0	0	18042		18493	0	0	18493		19047	0	0	19047	
Clinical supplies															
- treatment disposables	8617			8617		8832			8832		9097			9097	
- diagnostic supplies	1383			1383		1418			1418		1461			1461	
- instruments & equip	1359			1359		1393			1393		1435			1435	
- patient appliances	1173			1173		1202			1202		1238			1238	
- implants & prostheses	2654			2654		2720			2720		2802			2802	
- pharmaceuticals	4335			4335		4443			4443		4576			4576	
- other clinical & client costs	4105			4105		4208			4208		4334			4334	
total	23626	0	0	23626		24216	0	0	24216		24943	0	0	24943	
Infrastructure & other op.costs															
- hotel services & laundry	3208	1		3209		3288	1		3289		3387	1		3388	
- facilities	4197			4197		4302			4302		4431			4431	
- transport	610	27		637		625	28		653		644	29		673	
- IT systems & telecom	5231			5231		5362			5362		5523			5523	
- professional fees	2576	430		3006		2640	439		3079		2719	448		3167	
- other op.expenses	-282	241		-41		-289	317		28		-100	398		298	
- democracy	1	298		299		1	304		305		1	310		311	
- depreciation	15770			15770		15770			15770		15770			15770	
- interest	2935			2935		2935			2935		2935			2935	
- cost & efficiency initiatives	0			0					0					0	
- Payment to - NGO providers															
- personal health			70140	70140			74335		74335			78152		78152	
- mental health			11572	11572			12278		12278			12983		12983	
- disability support services			41075	41075			43541		43541			45783		45783	
- public health			866	866			918		918			965		965	
- maori health			3016	3016			3197		3197			3361		3361	
- IDF's			39790	39790			41478		41478			43237		43237	
total	34246	997	166459	201702		34634	1089	175747	211470		35310	1186	184481	220977	
TOTAL OPERATING EXPENSES	191422	2556	166459	360437		195161	2670	175747	373578		199476	2790	184481	386747	
SURPLUS before capital charge	-5189	129	11921	6861		-4320	124	11082	6886		-4028	113	10801	6886	
- Capital charge	6089			6089		6089			6089		6089			6089	
SURPLUS (before strategic exp)	-11278	129	11921	772		-10409	124	11082	797		-10117	113	10801	797	
STRATEGIC EXPENDITURE															
Funder transition Investment Fund			0	0				0	0				0	0	
NET SURPLUS/(DEFICIT) after Strategic	-11278	129	11921	772		-10409	124	11082	797		-10117	113	10801	797	
OTHER COMPREHENSIVE INCOME															
* Gain/(Loss) on asset revaluation	0			0		0			0		0			0	
*Gain/(Loss) on sale of assets	0			0		0			0		0			0	
*Share of surplus/(loss) from associates	0			0		0			0		0			0	
Total Other Comprehensive Income	0	0	0	0		0	0	0	0		0	0	0	0	
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	-11278	129	11921	772		-10409	124	11082	797		-10117	113	10801	797	
Interest Cover ratio				6.64					6.64					6.64	
Revenue to Net Funds employed	1.18			2.32		1.21			2.41		1.24			2.49	
Operating margin to Revenue ratio	4%			5%		4%			5%		5%			5%	
Op. return on Net Funds employed	5%			12%		5%			12%		5%			12%	

## 4.10 CONSOLIDATED STATEMENT OF FINANCIAL POSITION

TARANAKI DISTRICT HEALTH BOARD								
DISTRICT ANNUAL PLAN 2016-19								
CONSOLIDATED STATEMENT OF FINANCIAL POSITION								
(\$'000)								
	2013/14 audited	2014/15 forecast		2015/16 plan	2016/17 plan	2017/18 plan	2018/19 plan	
<b>CURRENT ASSETS</b>								
* Bank Account	-1095	255		355	405	455	505	
* Prepayments +ST investments	3641	750		850	850	850	850	
* Debtors (net of provision)	9760	9820		10120	10370	10620	10870	
* Inventory	2604	2605		2700	2795	2890	2985	
	14910	13430		14025	14420	14815	15210	
<b>CURRENT LIABILITIES</b>								
* Creditors & other payables	25033	23845		23347	20189	17306	14123	
* Term Loans (current portion)	0	0		0	0	0	0	
* Provisions	23084	23115		23930	24060	24190	24320	
	48117	46960		47277	44249	41496	38443	
<b>WORKING CAPITAL</b>	-33207	-33530		-33252	-29829	-26681	-23233	
<b>NON CURRENT ASSETS</b>								
* Net Fixed Assets	189973	187843		187423	183853	180583	177013	
* Investments	2908	3476		3476	3476	3476	3476	
* Trust funds	758	758		758	758	758	758	
	193639	192077		191657	188087	184817	181247	
<b>NET FUNDS EMPLOYED</b>	<b>160432</b>	<b>158547</b>		<b>158405</b>	<b>158258</b>	<b>158136</b>	<b>158014</b>	
<b>NON CURRENT LIABILITIES</b>								
* Provisions - non current	936	945		1025	1065	1105	1145	
* Term Loans	74000	74000		74000	74000	74000	74000	
	74936	74945		75025	75065	75105	75145	
<b>CROWN EQUITY</b>								
* Crown Equity	24067	23108		22149	21190	20231	19272	
* Reserves	68207	68207		68207	68207	68207	68207	
* Retained earnings	-6778	-7713		-6976	-6204	-5407	-4610	
	85496	83602		83380	83193	83031	82869	
<b>NET FUNDS EMPLOYED</b>	<b>160432</b>	<b>158547</b>		<b>158405</b>	<b>158258</b>	<b>158136</b>	<b>158014</b>	
<b>Debt: Debt equity ratio</b>	46%	47%		47%	47%	47%	47%	

## 4.11 CONSOLIDATED STATEMENT OF CASHFLOWS

TARANAKI DISTRICT HEALTH BOARD DISTRICT ANNUAL PLAN 2016-19								
CONSOLIDATED STATEMENT OF CASHFLOWS								
(\$'000)								
	2013/14 audited	2014/15 forecast		2015/16 plan	2016/17 plan	2017/18 plan	2018/19 plan	
<b>OPERATING ACTIVITIES</b>								
* MOH funding	316567	324263		339082	35112	365092	378072	
* Other revenue	13978	14247		14672	331351	14537	14726	
<b>total receipts</b>	<b>330545</b>	<b>338510</b>		<b>353754</b>	<b>366463</b>	<b>379629</b>	<b>392798</b>	
* Payment of salaries & operating exp.	184757	174882		178974	185274	187949	192482	
* Payment to providers & DHB's	144031	150589		158956	168565	178756	187692	
<b>total payments</b>	<b>328788</b>	<b>325471</b>		<b>337930</b>	<b>353839</b>	<b>366705</b>	<b>380174</b>	
<b>NET CASHFLOW FROM OPERATIONS</b>	<b>1757</b>	<b>13039</b>		<b>15824</b>	<b>12624</b>	<b>12924</b>	<b>12624</b>	
<b>INVESTING ACTIVITIES</b>								
* Interest & Dividends Received	697	610		585	585	585	585	
* Sale of fixed assets etc	31	0		0	0	0	0	
* (Increase) / decrease in investments	7794	2322		0	0	0	0	
* Capital expenditure	-16187	-13662		-15350	-12200	-12500	-12200	
<b>NET CASHFLOW FROM INVESTING</b>	<b>-7665</b>	<b>-10730</b>		<b>-14765</b>	<b>-11615</b>	<b>-11915</b>	<b>-11615</b>	
<b>FINANCING ACTIVITIES</b>								
* Equity injections / repayments	-959	-959		-959	-959	-959	-959	
* Borrowings	2000	0		0	0	0	0	
* Payment of debts	-980	0		0	0	0	0	
<b>NET CASHFLOW FROM FINANCING</b>	<b>61</b>	<b>-959</b>		<b>-959</b>	<b>-959</b>	<b>-959</b>	<b>-959</b>	
Total cash in	330606	337551		352795	365504	378670	391839	
Total cashout	-336453	-336201		-352695	-365454	-378620	-391789	
<b>NET CASHFLOW</b>	<b>-5847</b>	<b>1350</b>		<b>100</b>	<b>50</b>	<b>50</b>	<b>50</b>	
Add: Cash (opening)	4752	-1095		255	355	405	455	
<b>CASH (CLOSING)</b>	<b>-1095</b>	<b>255</b>		<b>355</b>	<b>405</b>	<b>455</b>	<b>505</b>	

## 4.12 CONSOLIDATED STATEMENT OF MOVEMENT IN EQUITY

<b>TARANAKI DISTRICT HEALT BOARD</b>					
<b>DISTRICT ANNUAL PLAN 2016-19</b>					
<b>CONSOLIDATED STATEMENT OF MOVEMENT IN EQUITY</b>					
	2014/15 forecast	2015/16 plan	2016/17 plan	2017/18 plan	2018/19 plan
<b>EQUITY AT THE BEGINNING OF PERIOD</b>	<b>85496</b>	<b>83602</b>	<b>83380</b>	<b>83193</b>	<b>83031</b>
* Net results for the period	-935	737	772	797	797
* Revaluation of Fixed assets	0	0	0	0	0
* Equity Injections / (repayments)	-959	-959	-959	-959	-959
* Other	0	0	0	0	0
<b>EQUITY AT THE END OF THE PERIOD</b>	<b>83602</b>	<b>83380</b>	<b>83193</b>	<b>83031</b>	<b>82869</b>



## Module 5

## Stewardship



## MODULE 5: STEWARDSHIP

### 5.1 MANAGING OUR BUSINESS

Ability to adapt in a changing environment is critical if we are to provide effective, sustainable services.

This module describes Taranaki DHB's stewardship as owner, provider and funder of our assets, workforce, and infrastructure to build, adapt and maintain organisational capacity in order to perform the functions and conduct the operations that will deliver the outputs and impacts we seek. It provides further detail on the stewardship portion of our performance story.

#### 5.1.1 Our People

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

Key points of note about our workforce (as at 31 December 2014) are:

- We employed 1,244.29 FTE of staff
- 82% of staff were female
- We have a multi-cultural workforce with 39 different ethnicities working together to provide health services in many settings
- The Maori workforce made up around 8.47% of the overall staffing numbers with 33% in support roles (non-health support, administration, management) and 67% in clinical roles (medical, nursing, allied)
- New Zealand non-Maori make up the largest single ethnic group of employees (67%)
- 57% of our workforce is over the age of 45 years

As at 31 December 2014, Taranaki DHB's workforce was broken down as follows:

Workforce	Subgroup	FTE
Medical	SMO	78.93
	RMO	64.50
Nursing		516.70
Allied		243.71
Non Health Support		81.36
Management/ Administration		259.09
<b>Total</b>		<b>1,244.29</b>

#### 5.1.2 Organisational Performance Management

Our performance is assessed on both non-financial and financial measures. The table in Section 5.5.2 of this module provides an overview of the external reporting. Our overall planned performance as a funder and provider of health services for 2015/16 is outlined in this plan and will be reported to our senior management, Board and the Ministry of Health on a regular basis.

##### 5.1.2.1 Non-financial Performance Reporting

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

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

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

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

#### 5.1.2.2 Financial Performance Reporting

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

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

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

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

#### 5.1.3 Funding and Financial Management

The following table sets out our key financial indicators:

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	\$M	\$M	\$M	\$M	\$M	\$M
	ACTUAL	FORECAST	PLANNED	PLANNED	PLANNED	PLANNED
Revenue	334.398	339.715	354.639	367.298	380.464	393.663
Net Surplus/(Deficit)	(3.276)	(0.935)	0.737	0.772	0.797	0.797
Total Fixed Assets	189.973	187.843	187.423	183.853	180.583	177.013
Net Assets	85.496	83.602	83.380	83.193	83.031	82.869
Term Borrowings and Provisions	74.936	74.945	75.025	75.065	75.105	75.145

#### 5.1.4 National Health Sector Agencies

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

- National Health Information Technology Board
- Health Workforce New Zealand

- PHARMAC
- Health Quality and Safety Commission
- National Health Committee

See Module 2, section 2.4 for activities we will undertake to support the work of these National Agencies.

### 5.1.5 Risk Management

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

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

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

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

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

### 5.1.6 Performance and Management of Assets

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

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

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

### 5.1.7 Shared Decision-making

#### 5.1.7.1 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, 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.

#### **5.1.7.2 Māori Participation**

We have a governance relationship, through a memorandum of understanding, with local Iwi/Māori represented by Te Whare Punanga Korero (TWPK) Iwi relationship Board. TWPK has representatives from each of the eight Iwi within Taranaki.

The memorandum of understanding underpins a “good faith” relationship between the parties by recognising the legitimacy of the TWPK Board to represent the interests of Māori, as well as the legitimacy of the Board as the statutory body charged with the determination, prioritisation and funding of health and disability services.

We have a number of established mechanisms to enable Māori to participate in and contribute to strategies for Māori health gain. These include:

- TWPK (as above)
- Partnership and contract with preferred Maori Health Provider - Te Kawau Maro Alliance
- Maori Health Team relationships within the community and provider networks

#### **5.1.7.2 Primary Health Alliance Leadership Teams**

An Alliance Leadership Team (ALT) has been established across the Midland region with our primary care partners, the Midlands Health Network. The ALT is 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 co-ordinated health services through clinically-led service development and its implementation within a “best for patient, best for system” framework.

#### **5.1.7.3 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.

## **5.2 BUILDING CAPABILITY**

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.

### 5.2.1 HealthShare Limited

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

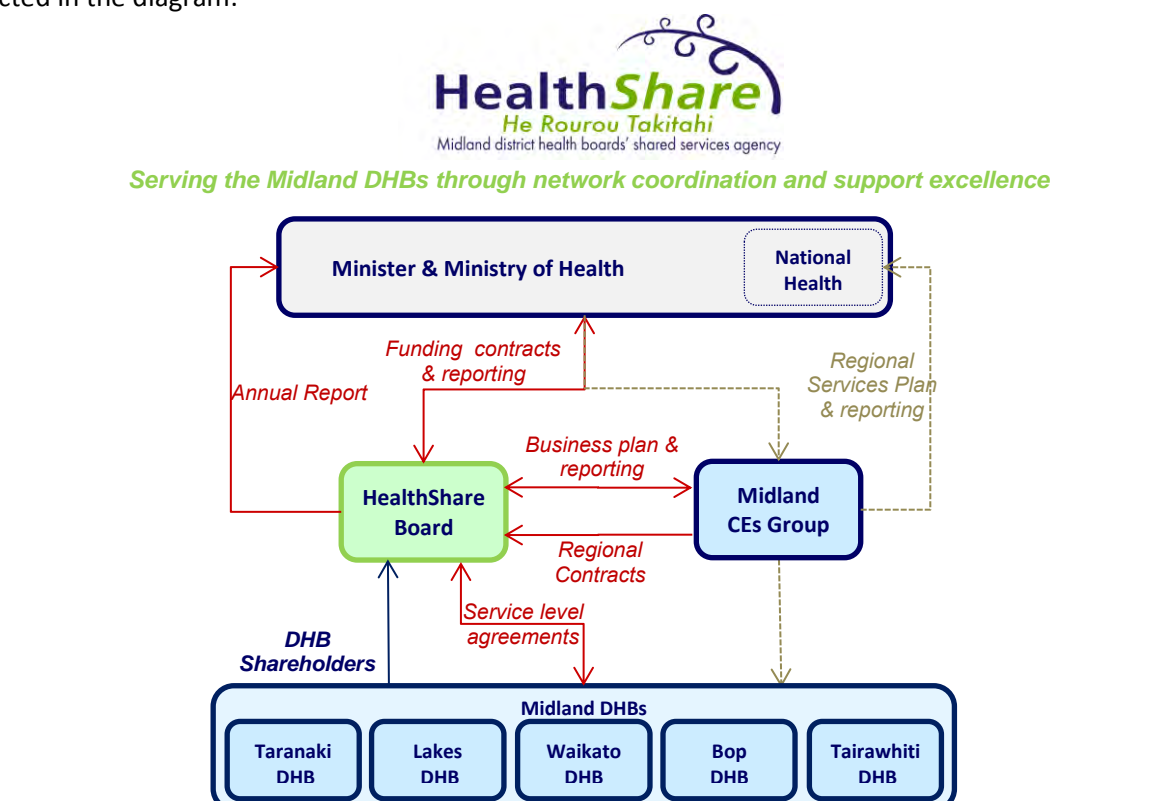
The Midland region DHBs determine the services that HSL will provide, and the level of these services, on an annual basis. These determinations are made through the Regional Services Plan (RSP) and regional business case processes.

Categories of possible regional service delivery include:

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

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

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



### 5.2.2 Information Communications Technology

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

The process of prioritising the ICT work effort is done via the IS executive group which is comprised of clinical leaders and business leaders from each of the Midland DHBs. This group reviews the programmes of work and provides recommendations to the regional capital committee for funding decisions.

The regional deployment of the CSC ePharmacy application that underpins the regional medication management programme was planned to be live in early 2014/15. Technical and contractual challenges have slowed the delivery of the ePharmacy programme and this will be live for the start of the 2015/16 year.

The other major programme currently underway is the establishment and deployment of the Orion CWS application within the Midland region. This project has commenced with the deployment into Lakes DHB and this will be followed by deployment into the remaining Midland DHBs over a two year period. Currently the Midland DHBs are working through the local, regional and national approval processes to support this programme of work.

Further information is available in the Midland DHBs RSP for 2015/16.

### 5.2.3 Integrated Contracting

As part of the Better Public Services Programme we will focus on delivering better results and improved services by streamlining contracts that Social Sector ministers identify as a priority for simplified contracting arrangements within the DHB role. We will work with the Ministry of Business Innovation and Enterprise (MBIE) to implement the Streamlined Contracting with Non-Governmental Organisations (NGO) Programme. We recognise that the streamlined contracting framework will benefit funders and NGOs by having a single contract that provides streamlined reporting, audits and contract management. For funders, this will mean resources currently invested in duplicating contract management practices with other funding agencies can be focused on increasing efficiencies and improving results for clients.

We have been working with our local Preferred Provider of Maori Health Services (Te Kawau Maro Alliance) to progress a Whānau ora service delivery model within the contracting framework. This involves ensuring our current services are responsive and quality focused and sustainable. We (the DHB and its primary care partners) are also utilising the Results Based Accountability framework in order to assist in identifying the appropriate population and performance indicators that we can use to ensure that changes made are actually helping improve the health and well-being of our people.

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

### 5.2.4 Capital and Infrastructure Development

Capital expenditure is planned and prioritised at both a Midland regional and local level. DHBs capital intentions, which span 10 years, are consolidated to form a regional view. Large clinical investments are collaborated with the aim of achieving best fit for the region.

The Midland region capital committee meets regularly to consider and approve business cases requiring regional sign-off. Business cases are prepared and approved at a local Board level before submission to the regional capital committee for approval.

At a local level, our long term financial model 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.

### 5.2.5 Collaboration

We are proactively engaging to collaborate with Government agencies, Primary Care Partners, 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. To help deliver on our vision; and Ministerial priorities such as the Children's Teams and Social Sector Trials; and driving the IHS we continue to engage and collaborate.

Through these collaborative efforts, we ensure that services are well 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 wastage across the whole of the health system to achieve the best health outcomes for our community. These principles underline the focus of streamlined contracts.

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.

#### 5.2.5.1 Regional Collaboration

##### Midland Regional Public Health Network

The Midland Regional Public Health Network (the Network) was established in 2010 to provide leadership for and strengthen the performance and sustainability of the Midland public health units. The Network provides an avenue for public health units to work together on public health issues affecting the Midland region.

Leadership of the Network comprises the manager and clinical director from each of the four public health units in the Midlands region: Toi Te Ora - Public Health Service (Bay of Plenty and Lakes District Health Boards); Population Health (Waikato District Health Board); Population Health, Te Puna Waiora (Tairāwhiti District Health Board) and Public Health Unit (Taranaki District Health Board).

The Network continues to develop and/or strengthen relationships with the Midland Regional Clinical Networks to ensure a public health perspective is considered within their planning. At a national level the Network is a member of the National Public Health Clinical Network (NPHCN), whose membership comprises clinical leader and manager from each public health unit and representatives from the Ministry of Health.

The goals of the Midland Regional Public Health Network are to:

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

The Network's work to date has included collaborative annual planning, business continuity planning, supporting the development of Midland position statements on key health issues, setting up a mechanism for a regional approach to health intelligence work, standardising of communicable disease control processes, peer review, staff orientation programmes and support of sole practitioners.

Three key work streams are in place to support a consistent approach to common areas of work:

- Workforce development;

- Communicable diseases;
- Public health intelligence.

Future work streams will be determined based on the need to increase the focus on a particular public health issue. For instance, the Network has been discussing its possible approach to climate change. In addition, the NPHCN's work plan for 2015 will mean a collective focus on the reduction of alcohol related harm.

In determining its direction for 2015/16, the Network will consider alignment to the Ministry of Health's new five core functions of public health (Health Assessment and Surveillance, Public Health Capacity Development, Health Promotion, Health Protection, and Preventive Interventions) and the following key themes identified in the 2014 Briefing to the Incoming Minister of Health<sup>12</sup>:

- Better integration of services within health and across the sector;  
The Midland public health units are continuing to explore new ways to work more closely together to share resources and expertise and to support each other. The Network is also advocating for a stronger public health focus within each of the other Midland clinical networks.
- Improvement in the way services are purchased and provided;  
All public health units are moving to contracting with the Ministry of Health based on the new five core functions which enable great clarity and flexibility around the delivery of services purchased.
- Lifting of quality and performance;  
The Network has established a peer review process which enables a public health unit to request support from others to review an aspect of its work.
- Supportive leadership and capability for change;  
The Network contributes to the NPHCN with formal representation on the steering group rotating annually. The Network has been engaging with HealthShare to bring greater public health influence to regional clinical service planning.

In line with the wider health sector goal of better, sooner, more convenient health services for all New Zealanders, emphasis for the Network will continue to be on effective and efficient working and service delivery.

Taranaki DHB Public Health Unit also maintains key linkages with the Central North Island Drinking Water Assessment Unit (CNIDWU) for drinking water assessment and continues to participate in developing the network.

#### 5.2.5.2 Local Collaboration

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 up-skilling and developing the Maori Health and Disability workforce in Taranaki. This is an innovative multi agency and multi funder model which introduces a range of initiatives to address Maori workforce development through collaboration.

Other examples of intersectoral collaboration include:

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

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<sup>12</sup> Ministry of Health. (2014). *Briefing to the Incoming Minister of Health*. [www.health.govt.nz](http://www.health.govt.nz)

- Strengthening Families
- Accident Compensation Corporation and DHB relationship
- Healthy Homes initiatives

#### **5.2.5.6 Health Quality and Safety Commission's Quality and Safety Markers**

We are committed to implementing and evaluating patient safety initiatives specified by the Health Quality and Safety Commission including, but not limited to, the National Patient Safety 'Open for Better Care' Campaign focuses, Quality and Safety Markers, our Quality Accounts document and Patient Experience Indicators. For further details see Section 2.4, *Improving Quality*.

## **5.3 WORKFORCE**

The health and disability sector continues to face increased demand for services along with rising public expectations as to how services are delivered. There is also a strong requirement for simpler, more standardised ways of doing things to release resources for better use elsewhere and build a platform to develop a workforce with more generic skills that is flexible and able to work in integrated service models across hospital and community settings.

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

We continue to operate in a changing environment within a large and complex workforce. This requires sound strategic planning in order to meet our current obligations however this must be delivered within fiscal constraints.

Given the impact of affordability and availability factors, New Zealand faces a critical challenge in maintaining a clinically skilled health workforce. Improving supply within the health workforce is only part of the answer. To find enduring solutions service providers will need to strengthen innovation, explore new ways of working, and to develop workforces that are sustainable into the future.

Staff engagement and organisational health is central to ensure the provision of high quality and effective services that meet the health needs of our community. TDHB engages staff and unions in forums in change management, transformational initiatives and policy development. Staff involvement is important to achieve productivity gains and foster continuous improvement.

Collaboration and connectedness locally, regionally and nationally is imperative for TDHB to continue to attract and retain people to Taranaki with emphasis on supporting the national Kiwi Health Jobs brand and leading the regional recruitment work plan.

By working closely with our union partners, we will ensure organisational improvement, continuous improvement and productivity enhancements. In return we will ensure the terms and conditions of our peoples employment are in line with the state sector expectations.

The fostering of a performance culture ensures that the aims and objectives of the organisation are being met at all levels within the organisation.

### **5.3.2 Strengthening Our Workforce**

Health Workforce New Zealand (HWNZ) was setup to provide strategic leadership for a sector-wide response to New Zealand's workforce challenges. 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. HWNZ has adopted a siloed professional-by-profession approach to forecasting and they believe this will deliver greater benefits to New Zealanders. HWNZ is focusing on a number of key areas that together contributes to building a sustainable workforce:

- Developing workforce intelligence
- Demonstrating innovative roles
- Recruitment, retention and distribution initiatives
- Managing the medical and nursing pipelines
- Developing the non-regulated workforce
- Increasing number of targeted training positions

## **Regional**

Workforce continues to be a key enabler both within both the Ministry of Health's Guidance for DHB Annual Planning Priorities and the Regional Services Plan (RSP) Guidelines for 2015/16. Within the Midland RSP, that provides a framework for the five Midland DHBs, we aim to continue to develop the principles of culture, capability, capacity and change leadership. We recognise that there are longstanding gaps and weaknesses in our knowledge around the current workforce, particularly relating to the capability and capacity. Critically evaluating the workforce as a number (headcount / FTE) does not provide sufficient evidence to enable clinical networks to develop new models of healthcare delivery.

The regional director of workforce (RDoW) role working alongside General Managers – human resources (GM-HR) provides the link between HWNZ, workforce and training. Alignment of strategic planning between these entities is essential to develop the workforce required within our region in the near future, whilst providing a long-term platform for developing a sustainable model of training and workforce development. The RSP identifies that GM-HRs will work in tandem with the RDoW in workforce and training planning. Midland region is currently re-evaluating its training hub (Midland Region Training Network – MRTN) to gain the required traction from this body.

This RSP recognises the continued national collaboration between District Health Board – Shared Services (DHB-SSER) and Health Workforce New Zealand (HWNZ) to align the national workforce priorities of the GMs-HR. This collaboration will support collection and collation of workforce intelligence and training data, thus enabling the Midland region to extract and critique credible and reliable data around its workforce (DHB-SS) and funded training positions (HWNZ), and support development of health practitioner workforces to deliver new models of care.

## **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 of Health has highlighted the expectation for DHBs to have embedded in place strong clinical leadership and engagement, and the integration of primary care with other parts of the health service.

Capability and capacity will be addressed by the implementation of initiatives that include supporting new service models across within the hospital setting with senior leadership roles, the delivery of the Long Term Conditions contracts that will enhance the interface between primary and secondary settings, and management of employment and cost growth and use of the workforce.

We have a continued commitment to:

- High quality clinical leadership and the development of strong, high performing clinical/management partnerships. This will drive engagement and accountability at all levels as we strive to live within fiscal constraints and to manage change.
- Progression of the Care Capacity Demand Management project system along with the "Releasing Time to Care" project, which drives the way we work. This provides a whole of organisation view to meeting service demand with quality care, providing a healthy and safe work environment, and delivering service efficiencies.
- Meet or exceed its good employer obligations by maintaining a safe, supportive and healthy environment for staff, where a strong culture of leadership, accountability, health, safety and wellbeing is fostered.

- Building on our strong “Grow Our Own” programme targeting graduates, opportunities to attract vocational trainees back to Taranaki and a well-known health education scholarship programme.
- Continue to strengthen TDHB’s “Behaviours in the Workplace” initiative that was introduced in collaboration with unions.

Embed a culture of learning that is critical to building capability and capacity, and we will support the development of shared learning resources across the region. We will work with staff on the development of their career and supporting them through a wide range of development opportunities aligned to their career.

### 5.3.3 Safe and Competent Workforce

Priorities to provide a safe and competent workforce, and to strengthen and support vulnerable areas are:

1. Developing and delivering training sessions which will increase capability and build capacity for making quality and productivity improvements including the use of information and analysis. This allows for consistent development and application of quality improvement skills across TDHB staff and both enhance the depth of improvement science skills within the DHB and also the breadth of skills leading to an accelerated pace of improvement.
2. Continue to encourage clinicians to lead initiatives and build on service design and system changes that will include:
  - Delivering a clinical and communication skills programme to increase early identification of acutely deteriorating patients supplemented by simulation which will include members of medical, nursing and allied health staff. The aim is to improve earlier detection of the sickest patients in the hospital and to foster great team working in the inpatient environment.
  - The Clinical Lead at the Hawera Hospital developing a proposal to change the model of service that will provide seamless care in a rural hospital setting.
  - Clinicians in internal medicine and radiology lead the development of the angiography suite made possible as a result of the building redevelopment.
  - Clinical Directors work closely with senior management and the Taranaki District Health Board members to provide clinical advice on the strategic direction of services in the District to improve the efficiency and effectiveness of clinical services.
3. Build on activity that integrates primary care with other parts of the health services to move closer to home, that includes:
  - Clinicians in primary and secondary services developing the Map of Medicine that uses best clinical evidence to develop agreed pathways across primary and secondary services and localise them to Taranaki. This will reduce inappropriate diagnostic testing and reduce variation in the clinical management of patients.
  - A Multi Disciplinary Team managing long term conditions of diabetes and COPD that includes social workers, pharmacists, dietitians and general practitioners. This will support the patient in the community to reduce admitting rates to the hospital.
  - Redirection of patients of low acuity from the Base Hospital Emergency Department and St. Johns ambulance service to re-engage with their general practitioner or accident and medical centres.
4. Continue to investigate the feasibility to establish in partnership with the University of Auckland Medical School a 5th Year programme that focuses on rural and GP immersion to meet the future workforce needs in these areas or a Training Internship Programme. Early exposure of medical trainees is likely to improve recruitment into future primary and secondary services in the District.
5. Achieving workforce equity for Maori by:
  - Continuing to work closely with the Whakatipuranga Rima Rau Trust (WRR) to expose rangatahi Maori to career opportunities in the health sector
  - Increase the percentage of WRR registrants who are on an education pathway, enrolled for tertiary studies

- Identifying positions that influence positive health outcomes for Maori and ensuring Maori participation and perspective to recruitment and selection processes. Our goal is to increase Maori participation in our workforce up to 10%.

#### **5.3.4 Child Protection Policies**

Taranaki DHB seeks to achieve a safe, supportive and healthy environment for staff, patients and their family/whanau. The Vulnerable Children's Act requirements will be implemented using current and proposed policy and procedures.

Collaboration between Quality and Risk, Human Resources, Violence Intervention Coordinator and Child Protection Coordinator, Violence Intervention Coordinator will ensure that a Children Protection Policy is adopted as soon as practicable from 1 July 2015 to meet the requirements of section 17 of the Vulnerable Children Act.

To strengthen our procedures we will:

- Make the policy available to all
- Develop a 3 Yearly Review cycle
- Require contracted independent people to adopt a child protection policy

#### **5.3.5 Children's Worker Safety Checking**

The purpose of the children's worker safety checks as part of the Vulnerable Children's Act 2014 is to reduce the risk of harm to children by requiring people employed or engaged in work that involves regular or overnight contact with children to be safety checked.

TDHB policy states all new employees, students, volunteers and contractors must undergo a police vetting procedure, and organisational pre-screening questions and letters inform all candidates of this requirement. All relevant policies and procedures will be updated as appropriate to ensure all aspects of a worker safety check is completed.

A procedure in the HRIS has been implemented to record the date the safety check has been completed, which enables all children workers to be checked on a 3 yearly basis.

The children's workforce is being confirmed and a planned approach will be implemented to complete safety checks for all existing employees, that include confirmation of identity, use of appropriate questions at interviews and reference checking procedures.

All contracts and funding arrangements for services are now required to adopt and implement child protection policies, and have a system for worker safety checks to meet the requirements of the Vulnerable Children's Act 2014.

As required of the Act any exemptions or compliance issues are reported to the Chief Executive.

### **5.4 ORGANISATIONAL HEALTH**

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

#### **5.4.1 Governance**

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

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

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

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

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

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

#### **5.4.2 Providing Health and Disability Services**

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

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

They include:

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

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

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

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

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

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

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

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

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

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

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

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

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

- Ministry of Health
- National Health Board
- Midland DHBs
- Other DHBs

- Clinical leaders
- Primary Health Organisations
- Our primary care alliance partners
- Iwi / Maori
- Non-Government Organisations
- Clinical advisory groups
- Expert advisory groups
- Community health forums

## 5.5 REPORTING AND CONSULTATION

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

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

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

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

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

### 5.5.2 External Reporting

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

Table: External Reporting Framework

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

## Module 6

# Service Configuration



## MODULE 6: SERVICE CONFIGURATION

### 6.1 SERVICE COVERAGE

Taranaki DHB acknowledges that it has responsibility to fund other services outside the district, and will do so accordingly. The impact of this responsibility in the 2015/16 funding environment will largely be limited to:

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

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

- Well Child services through Plunket, health camps etc
- National contracts (Organ transplants and new services purchased nationally)
- Emergency ambulance services
- Strengthening Families
- Family Start
- Primary response in medical emergencies (PRIME)

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

### 6.2 SERVICE CHANGE

Service coverage exceptions and service changes must be formally approved before they are included in Annual Plans. The DHB had not signaled any significant proposed service changes for the 2015/16 year prior to the deadline established by the Ministry of Health of February 2015.

### 6.3 SERVICE ISSUES

The following table identifies emerging service issues other than what is already covered this plan or described within the context of the Midland Regional Service Plan. TDHB wishes to signal its intention to review and/or evaluate these in the coming year.

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

**Table: Approved Service Issues 2015/16**

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



## Module 7

# Performance Measures



## MODULE 7: NON-FINANCIAL PERFORMANCE MEASURES

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

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

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

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – Establishment of baseline (no target/performance expectation is set)

Performance Measure	2015/16 Performance Expectation/Target		
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	Total	3.78%
		Maori	3.78%
	Age 20-64	Total	4.02%
		Maori	5.34%
	Age 65+ Maori	Pending	
	Age 65+ Total	3.46%	
PP7: Improving mental health services using transition (discharge) planning and employment	Long term clients		Provide a report as specified
	Child and Youth with a Transition (discharge) plan		At least 95% of clients discharged will have a transition (discharge) plan.
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm		
	Age	<= 3 weeks	<=8 weeks
	0-19	80%	95%
	Addictions (Provider Arm and NGO)		
	Age	<= 3 weeks	<=8 weeks
	0-19	80%	95%
PP10: Oral Health - Mean DMFT score at Year 8	Ratio year 1		0.9
	Ratio year 2		0.88
PP11: Children caries-free at five years of age	Ratio year 1		64%
	Ratio year 2		64%
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1		85%
	% year 2		85%
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1		90%
	0-4 years - % year 2		95%
	Children not examined 0-12 years		6%
	% year 1		
	Children not examined 0-12		5%

	years % year 2	
PP20: improved management for long term conditions (CVD, diabetes and Stroke) Focus area 1: Long term conditions	Report on delivery of the actions and milestones identified in the Annual Plan.	
Focus area 2: Diabetes Care Improvement Packages and Diabetes Management (HbA1c)	Narrative quarterly report on DHB progress towards meeting its deliverables for Diabetes Care Improvement Packages (DCIP) identified in the 2015/16 annual plans  Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	Improve or maintain
Focus area 3: Acute coronary syndrome services	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')	70%
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	95%
	Over 95 percent of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge.	95%
	Report on delivery of the actions and milestones identified in the Annual Plan, including actions and progress in quality improvement initiatives to support the improvement of ACS indicators as reported in ANZACS-QI	
Focus area 4: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed	6%
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
	Report on delivery of the actions and milestones identified in the Annual Plan.	

PP21: Immunisation coverage	IPIF Healthy Start - Percentage of two year olds fully immunised	95%
	Percentage of five year olds fully immunised	90% by end 2015/16 95% by end 2016/17
	Percentage of eligible girls fully immunised with three doses of HPV vaccine	65% for dose three
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.	Improvement on current performance
	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan	Provision of data that demonstrates an improvement on current performance
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP25: Prime Minister’s youth mental health project	<p>Initiative 1: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities.</p> <ol style="list-style-type: none"> <li>1. quarterly quantitative reports on the implementation of SBHS, as per the template provided.</li> <li>2. quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.</li> </ol> <p>Initiative 3: Youth Primary Mental Health</p> <ol style="list-style-type: none"> <li>1. quarterly narrative progress reports with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: <ul style="list-style-type: none"> <li>• early identification of mental health and/or addiction issues</li> <li>• better access to timely and appropriate treatment and follow up</li> <li>• equitable access for Maori, Pacific and low decile youth populations.</li> </ul> </li> </ol> <p>Initiative 5: Improve the responsiveness of primary care to youth.</p> <ol style="list-style-type: none"> <li>1. quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements.</li> <li>2. quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB’s youth population (for the 12-19 year age group at a minimum) by</li> </ol>	

	addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.	
PP26: The Mental Health & Addiction Service Development Plan	Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2015/16 and for any actions which are in progress/ongoing.	
PP27: Delivery of the children's action plan	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing Rheumatic fever	As a low incidence DHB, TDHB will provide an exception report only against DHBs' rheumatic fever prevention plan	
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 55% lower than the average over the last 3 years	0.4 per 100,000
PP29: Improving waiting times for diagnostic services	1. Coronary angiography – 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
	2. CT and MRI – 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)	95% CT 85% MRI
	3. <u>Diagnostic colonoscopy</u> – a. 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive) 100% within 30 days b. 65% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 120 days	75% 65%
	<u>Surveillance colonoscopy</u> c. 65% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days	65%
PP30: Faster cancer treatment (details of expectations to be confirmed)	Part A: Faster cancer treatment – 31 day indicator	< 10 percent of the records submitted by the DHB are declined.

	Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat.
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	TBC
	Age 45-64	TBC
	Age 0-74	TBC
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region ( the report includes local DHB actions that support delivery of regional objectives	
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage	
SI4: Standardised Intervention Rates (SIRs)	major joint replacement	21.0 per 10,000
	cataract procedures	27.0 per 10,000
	cardiac surgery	6.5 per 10,000
	percutaneous revascularization	12.5 per 10,000
	coronary angiography services	34.7 per 10,000
SI5: Delivery of Whānau Ora	Provision of a qualitative report identifying progress within the year that shows that the DHB has delivered on its planned Whānau Ora activity and what the impact of the activity has been	
SI6: IPIF Healthy Adult - Cervical Screening	80% of eligible women have received cervical screening services within the last 3 years	
OS3: Inpatient Length of Stay	Elective LOS	1.53 days
	Acute LOS	2.69 days
OS8: Reducing Acute Readmissions to Hospital	total pop	improvement on baseline performance
	75 plus	improvement on baseline performance
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections  Focus area 1: Improving the quality of identity data	New NHI registration in error A. Greater than 2% and less than or equal to 4% B. Greater than 1% and less than or equal to 3% C. Greater than 1.5% and less than or equal to 6%	>1% ≤3%
	Recording of non-specific ethnicity Greater than 0.5% and less than or equal to 2%	>0.5% ≤2%

	Update of specific ethnicity value in existing NHI record with a non-specific value Greater than 0.5% and less than or equal to 2%	>0.5% ≤2%
	Invalid NHI data updates %TBC	%TBC
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS Greater than or equal to 97% and less than 99.5%	≥97% <99.5%
	National collections file load success Greater than or equal to 98% and less than 99.5%	≥98% <99.5%
	Standard vs edited descriptors Greater than or equal to 75% and less than 90%	≥75% <90%
	NNPAC timeliness Greater than or equal to 95% and less than 98%	≥95% <98%
Focus area 3: Improving the quality of the programme for Integration of mental health data (PRIMHD)	PRIMHD data quality	Routine audits undertaken with appropriate actions where required
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: <ul style="list-style-type: none"> <li>a) five percent variance (+/-) of planned volumes for services measured by FTE,</li> <li>b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and</li> <li>c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan</li> </ul>	
Developmental measure DV4: Improving patient experience	No performance target set	



## Module 8

## Appendices



## MODULE 8: APPENDICES

### 8.1 GLOSSARY OF TERMS

TERM	MEANING
<b>Activity</b>	What an agency does to convert inputs to Outputs.
<b>Capability</b>	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver the outputs required to achieve the Government's goals.
<b>Cost Containment</b>	Reducing costs or cost growth in general, whether through improved efficiency, or other means such as contract negotiation/consolidation, changes to budget management, changes in structure etc.
<b>Crown Agent</b>	A Crown entity that must give effect to government policy when directed by the responsible Minister. One of the three types of statutory entities (see also Crown entity; autonomous Crown entity and independent Crown entity)
<b>Crown Entity</b>	A generic term for a diverse range of entities within one of the five categories referred to in section 7(1) of the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
<b>Crown Entity Subsidiary</b>	A crown company is a company that is incorporated under the <u>Companies Act 1993</u> that are controlled by Crown entities and that are: (a) a subsidiary of another Crown entity under <u>sections 5 to 8</u> of the Companies Act 1993; or (b) a multi-parent subsidiary of 2 or more Crown entities <u>New CE Act 2013 s7 1(c)</u>
<b>Efficiency</b>	Reducing the cost of inputs relative to the value of outputs.
<b>Effectiveness</b>	The extent to which objectives are being achieved. Effectiveness is determined by the relationship between an organisation and its external environment. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
<b>Impact</b>	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency. E.g., the change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations. (Public Finance Act 1989)
<b>Impact Measures</b>	Impact measures are attributed to agency (DHBs) outputs in a credible way. Impact measures represent near-term results expected from the goods and services you deliver; can be measured after delivery, promoting timely decisions; reveal specific ways in which managers can remedy performance shortfalls.
<b>Input</b>	The resources such as labour, materials, money, people, information technology used by departments to produce outputs, that will achieve the Government's

	stated outcomes.
<b>Intervention</b>	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
<b>Intervention Logic Model</b>	<p>A framework for describing the relationships between resources, activities and results. It provides a common approach for integrating planning, implementation, evaluation and reporting. Intervention logic also focuses on being accountable for what matters – impacts and outcomes</p> <p>(Refer State Services Commission ‘Performance Measurement – Advice and examples on how to develop effective frameworks: <a href="http://www.ssc.govt.nz">www.ssc.govt.nz</a>)</p>
<b>Intermediate Outcome</b>	See Outcomes
<b>Living within Means</b>	Providing the expected level of outputs within a break even budget or NHB agreed deficit step toward break even by a specific time.
<b>Management Systems</b>	Are the supporting systems and policies used by the DHB in conducting its business.
<b>Measure</b>	A measure identifies the focus for measurement: it specifies what is to be measured
<b>Multi-Parent Subsidiary</b>	<p>A company (incorporated under the Act) is a multi-parent if, under <u>sections 5 to 8 of the Companies Act 1993</u>,—</p> <ul style="list-style-type: none"> <li>• (a) the company is not a subsidiary of any one Crown entity; but</li> </ul> <p>(b) if 2 or more Crown entities were treated as 1 entity (a <b>combined entity</b>), with their rights, entitlements, and interests in relation to the company taken together, the company would be a subsidiary of the combined entity (<u>New CE Act s7(1 – 2)</u>)</p>
<b>Objectives</b>	Is not defined in the legislation. The use of this term recognises that not all outputs and activities are intended to achieve “outputs”. E.g., Increasing the take-up of programmes; improving the retention of key staff; Improving performance; improving Governance...etc are ‘internal to the organisation and enable the achievement of ‘outputs’.
<b>Outcome</b>	<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.</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>
<b>Output Agreement</b>	<p>Output agreement/output plan - See Purchase Agreement</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</p>

	standards, terms, and conditions under which the Crown entity will deliver and be paid for the specified outputs. Responsible Minister may set standards, terms, and conditions in respect of certain classes of outputs.
<b>Output Classes</b>	<p>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>
<b>Outputs</b>	Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).
<b>Ownership</b>	<p>The Crown's core interests as 'owner' can be thought of as:</p> <p>Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown;</p> <p>Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future;</p> <p>Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively.</p>
<b>Performance Measures</b>	Selected measures must align with the DHBs Regional Service Plan and Annual Plan. Four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2014/15) and show intended results for the three subsequent financial years.
<b>Priorities</b>	Statements of medium term policy priorities.
<b>Productivity</b>	Increasing outputs relative to inputs (i.e.: either more outputs produced with the same inputs, or the same output produced using fewer inputs)
<b>Purchase Agreement</b>	A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs.
<b>Regional Collaboration</b>	<p>Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist.</p> <p>Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB</p> <p>Midland: Bay of Plenty DHB, Lakes DHB, Tairāwhiti DHB, Taranaki DHB and Waikato DHB</p> <p>Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB</p>

	<p>Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB</p> <p>Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network contains eight DHBs, Taranaki DHB and Tairāwhiti DHB in addition to the Central Region DHBs.</p>
<b>Results</b>	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.
<b>Standards of Service Measures</b>	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.
<b>Statement of Performance Expectations (SPE)</b>	Government departments and Crown entities are required to include audited statements of objectives and statements of performance expectations with their financial statements. These statements report whether the organisation has met its service objectives for the year.
<b>Statement of Service Performance (SSP)</b>	Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year.
<b>Strategy</b>	See Ownership
<b>Sub Regional Collaboration</b>	Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalised with an agreement e.g., Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (central Alliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.
<b>Targets</b>	Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.
<b>Values</b>	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos.
<b>Value for Money</b>	The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

## 8.2 OUTPUT CLASS DEFINITIONS

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

Output Class		Category of Output Class	
2	<b>Early Detection and Management</b> <p>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.</p> <p>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.</p>	6	<b>Primary Healthcare and GP Services</b> <p><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></p>
		7	<b>Oral Health Services</b> <p><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></p>
		8	<b>Primary Community Care Programmes</b> <p><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></p>
		9	<b>Pharmacy Services</b> <p><i>These services include the provision and dispensing of medicines and are demand-driven, i.e. by patients and prescribers (nurse specialists, GPs and specialists). As long term conditions become more prevalent, we are likely to see an increased dispensing of medicines. Success is measured by (a) medication management for people on multiple medications to reduce potential negative interactive effects and (b) maintaining or reduction the level of prescribed medicines.</i></p>

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

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

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

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

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

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

### 8.3 OUTPUT CLASS REVENUE AND EXPENDITURE

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

**Table: Output Class Revenue and Expenditure**

Output Class	Planned Revenue (\$000s)*	Planned Expenditure (\$000s)*
Prevention	7,637	7,636
Early Detection and Management	86,572	86,562
Intensive Assessment and Treatment Services	206,837	206,117
Rehabilitation and Support	53,593	53,586
<b>TOTAL</b>	<b>354,639</b>	<b>353,902</b>

## 8.4 OUTPUT MEASURE RATIONALE

Measure	Rationale	Output class / Category	Dimension of Performance
Percent of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt	Prevention Services/Health Promotion and Education	Quantity
Percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking	Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt	Prevention Services/Health Promotion and Education	Quantity
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit	Pregnancy is a period during which women are motivated to quit smoking, and evidence-based tobacco cessation programmes can significantly increase the likelihood of this. Reducing smoking in pregnancy would be well supported by New Zealanders, is easy to understand and leads to significant positive outcomes across the whole of life span	Prevention Services/Health Promotion and Education	Quantity
Percentage of eight month olds fully immunised	Immunisation can protect against harmful infections, which can cause serious complications, including death. It is one of the most effective, and cost-effective medical interventions to prevent disease	Prevention Services/ Immunisation	Quantity
Percentage of population over 65 years who are immunised against influenza		Prevention Services/ Immunisation/Well Child	Quantity/ Timeliness
		Prevention Services/ Immunisation/Well Child	Quantity/ Timeliness
Percentage of infants fully and exclusively breastfeed at six months	Breastfeeding is the unequalled way of providing ideal food for the healthy growth and development of infants and toddlers. This measure supports the sector to get ahead of the chronic disease burden. (Includes partial breastfeeding at six months.)	Prevention Services / Health Promotion and Education	Quantity/ Timeliness
The number of referrals to the GRx (Green Prescription) programmes	A Green Prescription (GRx) is a health professional’s written advice to a patient to be physically active, as part of the patient’s health management. Research published in the New Zealand Medical Journal indicates that a Green Prescription is an inexpensive way of increasing activity.	Prevention Services / Health Promotion and Education	Quantity
Reduce the teen birth rate	Having babies at a very young age can increase maternal risk factors such as high blood pressure and preeclampsia. There is also the increased likelihood of those without parental/guardian support receiving less pre-natal support.	Prevention Services/Health Promotion and Education	Quantity
Reduce the rate of teenage terminations of pregnancy	Teenage pregnancy is associated with difficulties in psychological, sexual and overall health. We also want to measure both teen pregnancy and termination rates to ensure that one does not increase while the other decreases.	Prevention Services/Health Promotion and Education	Quantity
Percentage of children under five years of age (i.e. aged 0 – 4 years of age inclusive) who are enrolled with DHB-funded oral health services	Research shows that improving oral health in childhood and adolescence has benefits over a lifetime.	Early Detection and Management Services/Oral Health	Quantity
Percentage of pre-school and primary school children (0 – 12 years) who are overdue for their planned recall period			Quantity

Measure	Rationale	Output class / Category	Dimension of Performance
Percentage of adolescents accessing DHB funded oral health services			Quantity
Percentage of population enrolled with a primary health organisation	Access to primary care has been shown to have positive benefits in maintaining good health. It can reduce the economic cost of ill health by intervening early.	Early Detection and Management Services/ Primary Healthcare	Quantity
Percentage of people who are enrolled with a primary health organisation and have had their cardiovascular risk assessed in the last five years	By increasing the percentage of people being checked for long-term conditions ensures these are identified early and managed appropriately, and aid in the promotion and protection of good health and independence.	Early Detection and Management Services/ Primary Healthcare	Quantity
Maintain or improve appropriate management of microalbuminuria or overt nephropathy in patients with diabetes			
Percentage of eligible women (20-69) have a cervical cancer screen every 3 years	Cervical cancer is one of the most preventable of all cancers. Having regular cervical smears can reduce a woman's risk of developing cervical cancer by 90 percent	Prevention Services/ Population Based Screening	Quantity
Percentage of eligible women (50-69) have a breast screen in the last 3 years	Breast screening is a proven way for finding breast cancers early to reduce the risk of dying of breast cancer	Prevention Services/ Population Based Screening	Quantity
Increase the number of packages of care available to youth under the Primary Mental Health Initiative	Primary mental health initiative is funded to increase the availability of services in Primary Health Organisations for patients with mild to moderate mental health issues. In line with our Taiohi Health Strategy and the Prime Minister's Youth Mental Health project we are expecting the actions in our Annual Plan will result in an increase in youth accessing these services.	Early Detection and Management Services/ Primary Mental Health and Addictions	Quantity
Percentage of Rest Home residents receiving vitamin D supplement from their GP	Vitamin D supplementation has been demonstrated to improve mineral bone density and reduce falls.	Prevention Services/Health Promotion and Education	Quantity
Percentage of all Emergency Department presentations who are triaged at levels 4&5	Emergency department services utilise a scale of one to five triage, with one being the most urgent. Triage category four and five may more appropriately be seen in primary care.	Intensive Assessment and Treatment Services/Acute Services	Quantity
Percentage of eligible children have their B4 School Checks completed	A nationwide programme offering a health and development check for four year olds	Prevention Services/ Well Child	Quantity
Hospitalisation rates per 100,000 for acute rheumatic fever	Rheumatic fever arises as a result of a throat infection with Group A Streptococcal bacteria. It predominantly affects children between 5 and 14 years of age. In New Zealand, evidence points to poorer housing conditions (especially overcrowding) and general social deprivation as risk factors for rheumatic fever.	Prevention Services/ Well Child	Quantity
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months	More consistent and comprehensive assessment of the older person which enables determination of service capacity and service planning information	Rehabilitation and Support Services/Needs Assessment and Service Coordination	Quantity
For those with aged related and chronic health conditions we aim to reduce the rate of rest home level of residential	By focusing the models of care in community services such as home based support and respite services to have a more restorative approach we expect that the proportion of	Rehabilitation and Support Services / Age Related Residential Care Services	Quantity

Measure	Rationale	Output class / Category	Dimension of Performance
care to home based support and respite funding	funding required to allocate to rest home residential care to comparatively reduce.		
Increased number of clients accessing respite services	In line with community services for older people having a more restorative approach and a focus on meeting the needs of informal carers we expect the number of clients accessing respite services will increase.	Rehabilitation and Support Services	Quantity
Percentage of patients aged 75 and over (Maori and Pacific Islanders 55 and over) that are given a falls risk assessment	Falls in the elderly contribute to a reduction in the quality of life including loss of independence, early entry into Rest Home residence and premature death. To ensure that the risk of inpatient falls in the elderly is minimised we aim to provide a risk assessment to all eligible patients.	Intensive treatment and assessment.	Quality
Acute re-admission rate	<p>Unplanned readmissions will usually present to emergency departments, and may result in admission to hospital for further treatment. This puts pressure on emergency departments and inpatient hospital capacity, efficiency and productivity.</p> <p>An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services.</p>	Intensive Assessment and Treatment Services/Acute Services	Quality
Average length of inpatient stay	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, we will positively impact hospital productivity through freeing up beds and other resources so it can provide more elective surgery, reduce waiting times in the emergency department or make savings. Supporting patients to return home sooner may, in part, be achieved by reducing the rate of patient complications and better use of the time clinical staff spend with patients. Patients will also be less at risk of contracting nosocomial infections.	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quality
Percentage of patients who require radiation or chemotherapy are treated within 4 weeks	Specialist cancer treatment and symptom control is essential in reducing the impact of cancer	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quantity
Percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016	Implementation of Faster cancer treatment supports the overarching goal of Better, Sooner, More Convenient Health Services for New Zealanders. The key strategic planning considerations of integration, regionalisation and value for money are all supported by implementation of these indicators.	Intensive Assessment and Treatment Services/Elective Services	Quantity
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total deliveries	The longer-term aim is to reduce the risks associated with an unnecessary Caesarean section, reduce the number of women at risk of a subsequent Caesarean section and reduce the number of women who experience difficulties with their second and subsequent births as a consequence of a primary Caesarean section.	Intensive Assessment and Treatment Services/Elective Services	Quantity

Measure	Rationale	Output class / Category	Dimension of Performance
Percentage of operations where venous thromboembolism (blood clot) was considered as part of the surgical checklist	Venous thromboembolism can cause long term debilitating damage so the assessment and appropriate preventative actions to all surgical patients will increase not only the overall quality of life but also reduce the toll of long term ill health or even death.	Intensive Assessment and Treatment Services Acute/ Elective Services	Quality
Percentage of patients waiting longer than four months for their first specialist assessment	Patients have a much better chance of recovering and getting on with their lives where they are diagnosed and treated and returned home in a timely way.	Intensive Assessment and Treatment Services/Elective Services	Quantity/ Timeliness
Number of surgical discharges under the elective initiative	Elective surgery reduces pain or discomfort, and improves independence and wellbeing. Increasing delivery should will improve access and reduce waiting times.	Intensive Assessment and Treatment Services/Elective Services	Quantity
Percentage of people who did not attend (DNA) their scheduled appointment for an outpatient service	Reducing did not attend is a key objective in terms of removing waste in the system	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quantity
Percentage of people referred for non-urgent mental health services are seen within three weeks	Access and shorter waits are very important to patients. Earlier treatment in the progression of illness links to better outcomes as evidenced in international literature. Timeliness is also a key quality indicator in calls for improvement to the health care system.	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Timeliness/ Quality
Improving the percentage of long-term clients with up to date relapse prevention/treatment plans	When long term clients with serious mental illness have agreed relapse prevention plans that enable them to better co-produce their mental health and well-being outcomes	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Quantity
Average length of stay in an adult mental health and addiction inpatient unit	<p>Mental health and addiction services seek to support service users in the least restrictive environment. Performance on this indicator provides some information about the extent to which this is being achieved.</p> <p>Length of stay is the main driver of variation in inpatient episode cost and reflects differences between mental health service organisations resources, service practices and service user case-mix.</p> <p>This indicator, alongside others promotes a more complete understanding off an organisation's overall model of service delivery.</p>	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Quantity
Rates of post-discharge community care	A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. Service users leaving hospital after an admission with a formal discharge plan involving linkages with community services and supports are less likely to need early readmission. Research indicates that service users have increased vulnerability immediately following discharge, including higher risk for suicide.	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Quality
A reduction in the percentage of palliative care clients who have had an Emergency Department presentation	The Taranaki Palliative Care Strategy highlighted the need for an increase in the generalist workforce who are trained and supported by our Specialist Palliative Care	Intensive Assessment and Treatment Services	

Measure	Rationale	Output class / Category	Dimension of Performance
	Provider to provide quality palliative care underpinned by Advanced Care Planning. We expect that delivery of enhanced palliative care pathways, particularly in aged residential care, will lead to a reduction in the percentage of palliative care patients who present to our Emergency Departments.		
Improved wait times for diagnostic services – accepted referrals for CT and MRI receive their scan within 6 weeks (Developmental Measure 2)	Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management.	Intensive Assessment and Treatment Services/Elective Services	Quantity/ Timeliness
Non urgent community laboratory tests are completed and communicated to practitioners within the relevant category time-frames			
Number of community pharmacy prescriptions	The new Community Pharmacy contract will encourage greater efficiency and a more patient focused service. We expect volume of prescriptions to decrease overall	Early detection and management/Pharmacy Services	Quantity