



Better
Sooner
More Convenient

Taranaki District Health Board
TARANAKI TOGETHER, A HEALTHY COMMUNITY
TARANAKI WHANUI HE ROHE ORANGA



District



Annual



Plan

2009 - 2010



TABLE OF CONTENTS

1.0	INTRODUCTION FROM THE CHAIRMAN AND CHIEF EXECUTIVE	1
2.0	OBJECTIVES	3
2.1	The District Strategic Plan	3
2.2	Government and Ministerial Priorities	3
3.0	APPROACH	5
3.1	Older People	7
3.2	Children & Young People	8
3.2.1	Screening Activities	9
3.2.2	Immunisation Activities	10
3.2.3	Oranga Kai Oranga Pumau	11
3.2.4	Tobacco	12
3.3	Disability & Access	13
3.4	Chronic Disease Management	14
3.4.1	Mental Health	15
3.5	Elective Services	16
3.6	Clinical Leadership	17
3.7	Collaboration	18
3.7.1	Multi Parent Subsidiaries and Associated Companies	18
3.7.2	Regional Collaboration	19
3.7.3	National Collaboration	19
3.7.4	Intersectoral Collaboration	22
3.8	Workforce Development	24
3.9	Better, sooner, more convenient	25
3.9.1	Shift some secondary services to primary health care	26
3.10	Ensuring safe and high quality services	27
3.11	Reducing Inequalities for those with the poorest health	28
4.0	NOTICES	31
4.1	Significant service change	31
4.1.1	Community Pharmacy Services	31
4.1.2	Community Nursing Services	31
4.1.3	Community Mental Health and Addiction Services	31
4.2	Service coverage expectations	32
4.3	Service issues	32
5.0	MEASURES – DHB Performance Reporting Framework	33
5.1	Health Targets – Summary Reference Table	33
5.2	Level 2: Indicator of DHB Performance 2009/10 (IDP's) – Summary Reference Table	36
5.3	Additional Reporting 2009/10 – Summary Reference Table	40
6.0	FUNDING ACCOUNTABILITY	41
6.1	How is Money Allocated to Taranaki District Health Board?	41
6.2	How Will the District Health Board Prioritise?	41
7.0	Consolidated Financial Summary: 2009 - 2012	43
7.1	Key Points from the Budgeted Financials 2009-2012	44
7.2	Key Financial Risks	46
7.2.1	Taranaki DHB's Funder	46
7.2.2	Taranaki DHB's Hospital Provider	48
7.3	Key Financial Strategies	50
7.4	Key Financial Assumptions	51
7.4.1	Application of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS)	51

DAP 2009/10 Final	
7.4.2	Equity and Borrowing 51
7.4.3	Wages and Operating Cost Growth..... 51
7.5	Taranaki DHB Funder – “Ring Fence Principle” and Application of Surplus/Deficits 52
7.5.1	Mental Health Services..... 52
7.5.2	Mental Health Services and Strategic Initiatives Expenditure.. 52
7.5.3	Interest Rates 52
7.5.4	Asset Revaluation and its Impact 53
7.5.5	Depreciation 53
7.5.6	Capital Charge 54
7.5.7	Leasing..... 54
7.5.8	Financial Covenants and Ratios 54
7.5.9	Changes in Accounting Policies 54
7.5.10	Capital Investment..... 55
7.5.11	Capital Divestment 56
7.5.12	Personnel 56
7.5.13	Capital Expenditure 2009/10 (operating)..... 58
7.6	Major Capital project: Base Hospital Inpatient Facilities Development Programme..... 59
7.6.1	Proposed Capital Outlay:..... 60
7.6.2	Financing Plan for Stage 1: 61
7.7	Efficiency and Productivity Improvements 62
7.8	Debt and Equity 63
7.9	Sensitivity Analysis 64
7.10	DAP Financial Summary..... 66
8.0	Elective Services Plan – 2009/10 – Taranaki DHB 73
8.1	APPENDIX 1 - Taranaki DHB Total Elective Volumes for 2009/10 . 77
8.2	APPENDIX 2 – 2007/08 Raw and Standardised Discharge Rates per 10,000 78
8.3	APPENDIX 3 - Cardio Thoracic Delivery 90
8.4	APPENDIX 4 - Planning Elective Services 2009/10 91
8.5	APPENDIX 5 - Quality Plan 92
8.6	APPENDIX 6 - Taranaki DHB Indicative levels of elective activity... 96
8.7	APPENDIX 7 - The Hospital Work Plan: How Does It All Fit Together? 97
8.8	APPENDIX 8 – Price Volume Schedule Summary 2009/10 101

MINISTERIAL LETTER OF ENDORSEMENT



Office of Hon Tony Ryall

Minister of Health
Minister of State Services

20 JUL 2009

17 JUL 2009

Mr John Young
Chair
Taranaki District Health Board
Private Bag 2016
NEW PLYMOUTH

Dear Mr Young

Taranaki District Health Board: 2009/10 District Annual Plan

This letter advises you that I have signed Taranaki District Health Board's (DHB) 2009/10 District Annual Plan (DAP) for three years and that the Board has my full support for implementing this plan.

I appreciate the efforts your Board and management have put in over the past year to manage your DHB in a sustainable manner. More work lies ahead to achieve long lasting sustainability. Given the severe impact of the international financial situation on the fiscal position, the 2010/11 and out-years funding increase for health will be lower than the FFT and Demographics' planning signals notified in December 2008. At the same time pressures from cost, demand, and technology remain. In this environment it is important that you achieve productivity gains and manage your services within your allocated funding. The Government's priority is for funding to be directed towards front line services.

Your DAP presents as a clear and concise business plan. The use of flow charts is innovative and effectively provides a visual picture of how your intervention logic links to funding, outcome and measures. I note the emphasis your Board has placed on the Government's health targets and priority areas and that your DHB is already performing well in many of these areas, in particular, shorter stays in Emergency Departments and improved access to Elective Surgery.

The Board's commitment to achieving a break even result as expected through robust cost savings measures within your provider and funder arms is noted. I will be monitoring the outcomes of this work closely. I understand that achieving this result will place your DHB in the best possible position to ensure ongoing financial sustainability.

It is strongly recommended that your Board ensures the collaborative approaches outlined in your DAP are implemented. I expect to see examples of this collaboration to include best practice sharing between DHBs, intersectoral cooperation and constructive engagement with non-Government organisations in the sector. In particular I expect to see a high degree of collaboration with other Midland DHBs.

The approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

It is important that you continue to manage your services within your allocated funding. I note the risks outlined in your DAP and the mitigation strategies you have identified. I expect robust financial performance and that you continue to keep the Ministry informed of emerging risks. My approval of your DAP does not mean acceptance of your assumptions in the out years.

My approval of your DAP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the National Capital Committee. Approval of such projects is dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I wish you, your Board and management every success with the implementation of your 2009/10 DAP, and thank you for your contribution and efforts to improve the health of New Zealanders.

Finally, please ensure that a copy of this letter is attached to the copy of your signed DAP held by the Board and to all copies of the DAP made available to the public.

Yours sincerely



Hon Tony Ryall
Minister of Health

NB: At the time of submitting the District Annual Plan for approval the Taranaki DHB Statement of Intent and the Crown Funding Agreement have not been finalised and have therefore not been attached. The Statement of Intent and Crown Funding Agreement will be publicly available via www.tdhb.org.nz as soon as practicable.

1.0 INTRODUCTION FROM THE CHAIRMAN AND CHIEF EXECUTIVE

The 2009/10 financial year marks a crossroads for Taranaki District Health Board. The environment around us is changing rapidly. The global economic downturn not only affects the cost of delivering care to patients, but has also markedly reduced Treasury estimates of future Vote Health funding. Changes to the population based funding formula and Taranaki's slower than national average population growth has lead to a sharp reduction in our share of national funding for the year ahead. Forecast local demographic changes will likely result in a continued reduction in funding share in the future. These economic factors mean that the District Health Board can no longer provide high levels of sustainability funding to our hospital provider and has to reshape services to meet the needs of the population. This includes adjusting funding to the hospital provider while developing new, efficient models of care associated with "Project Maunga" Base Hospital redevelopment. The new Government has indicated that all District Health Board's should focus on hospital services with five area's for particular attention; elective surgery; emergency departments; cancer treatment; clinical staff retention; and clinical leadership. Activity in these areas is reflected in the intervention logic diagrams in this plan.

At the same time there is an expectation that we maintain a strong focus on improving productivity and value for money, with all the priorities signalled being met within existing resources.

Changes in both the hospital and community settings will therefore be necessary if we are to meet all the financial expectations and breakeven.

Of course as far as possible we will also still need to have a view to the longer term future and our overall strategic goals. This will however mean a change in the pace at which we can move towards these goals. When it comes to reviewing the District Strategic Plan, in line with the regional's clinical services planning activity and Ministry of Health's Long Term Sector Framework the goals themselves and associated priority areas may well also need change.

These changes to the environment in which we operate bring with them great opportunities for Taranaki District Health Board. The opportunity to position the District Health Board, its services and the community we serve for the future. The opportunity to ensure that the new hospital that we are planning to be built is based on innovative and affordable models of service delivery. Also the opportunity to play a major role in the planning and delivery of health services across a wider group of District Health Board's, to ensure ongoing and more convenient delivery of services to our community.

Any opportunity brings with it an element of risk and we acknowledge that there are risks inherent in our plans. Change can be uncomfortable, as accepted ways of doing things will be challenged. There is a risk that our clinical staff and our community may not support or understand the need for change. We will mitigate this risk by ensuring that clinical leadership is embedded in planning for the future, by ensuring that our leaders are skilled in leading and facilitating change; and by ensuring that all stakeholders are kept well informed about our plans. There is also a risk that we might lose momentum on progress towards the aims of our District Strategic Plan. However we are confident that the planned hospital focus for 2009/10 will allow progress to be made in key areas of the District Strategic Plan;

and will prepare us for the next phase of service development in primary care the following year.

The Board believes that the potential rewards which should result from our approach justify our ambitious plans for 2009/10. This Annual Plan will deliver better, sooner and more convenient care for Taranaki patients. Our community and our staff will have a much better understanding of the District Health Board, the challenges we face and the need to prepare for the future. The District Health Board will be ready for the future, able to live within our means and prepared to respond to the future health demands of our population.

Fundamentally health care is all about people caring for people and helping people out. In Taranaki we are fortunate in having lots of very skilled and experienced people; not only our District Health Board clinical staff, but our management team, support staff, other health providers and partner organisations both in Taranaki and outside the Province. It is these people that will enable the District Health Board's Annual Plan to become a reality. We encourage everyone to participate in our ambitious plans for 2009/10 as we strive for Taranaki Together, a Health Community, Taranaki Whanui He Rohe Oranga.

SIGNATORIES



John Young
Chairman



Hon. Tony Ryall
Minister of Health



Tony Foulkes
Chief Executive

2.0 OBJECTIVES

This section describes what Taranaki District Health Board is trying to achieve in 2009 to 2012 from the perspective of our District Strategic Plan; and Government and Ministerial priorities.

2.1 The District Strategic Plan

The vision of the District Strategic Plan is: *Taranaki Together, a Healthy Community, Taranaki Whanui He Rohe Oranga.*

To achieve this objective the District Health Board aims to:-

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

2.2 Government and Ministerial Priorities

The Government and Minister of Health have indicated that District Health Boards should prioritise the following areas in 2009/10:

Health Targets:

- Improving immunisation coverage
- Improving oral health
- Improving elective services
- Reducing cancer waiting times
- Reducing ambulatory sensitive hospitalisation
- Improving diabetes services
- Improving mental health services
- Improving nutrition, increasing physical activity
- Reducing the harm caused by tobacco use

Government Priorities:

- Expanding the availability of subsidised medicines, including community pharmaceuticals and pharmaceutical cancer treatments
- Improving the quality of supervision and nursing in rest homes
- Kick-starting the devolution of services to primary care
- Providing dedicated respite care beds
- Ensuring that mothers have the choice of longer post-natal stays

Minister of Health Priorities:

- Maintain core services
- Use demographic increases to increase elective volumes year on year
- Taranaki District Health Board must achieve a financial break-even
- Improve emergency department waiting times
- Improve cancer treatment waiting times
- Improve clinical staff retention
- Foster clinical leadership including development of clinical networks and regional cooperation
- Increase regional cooperation between District Health Boards
- Move resources away from the back office and poor quality spending into frontline services

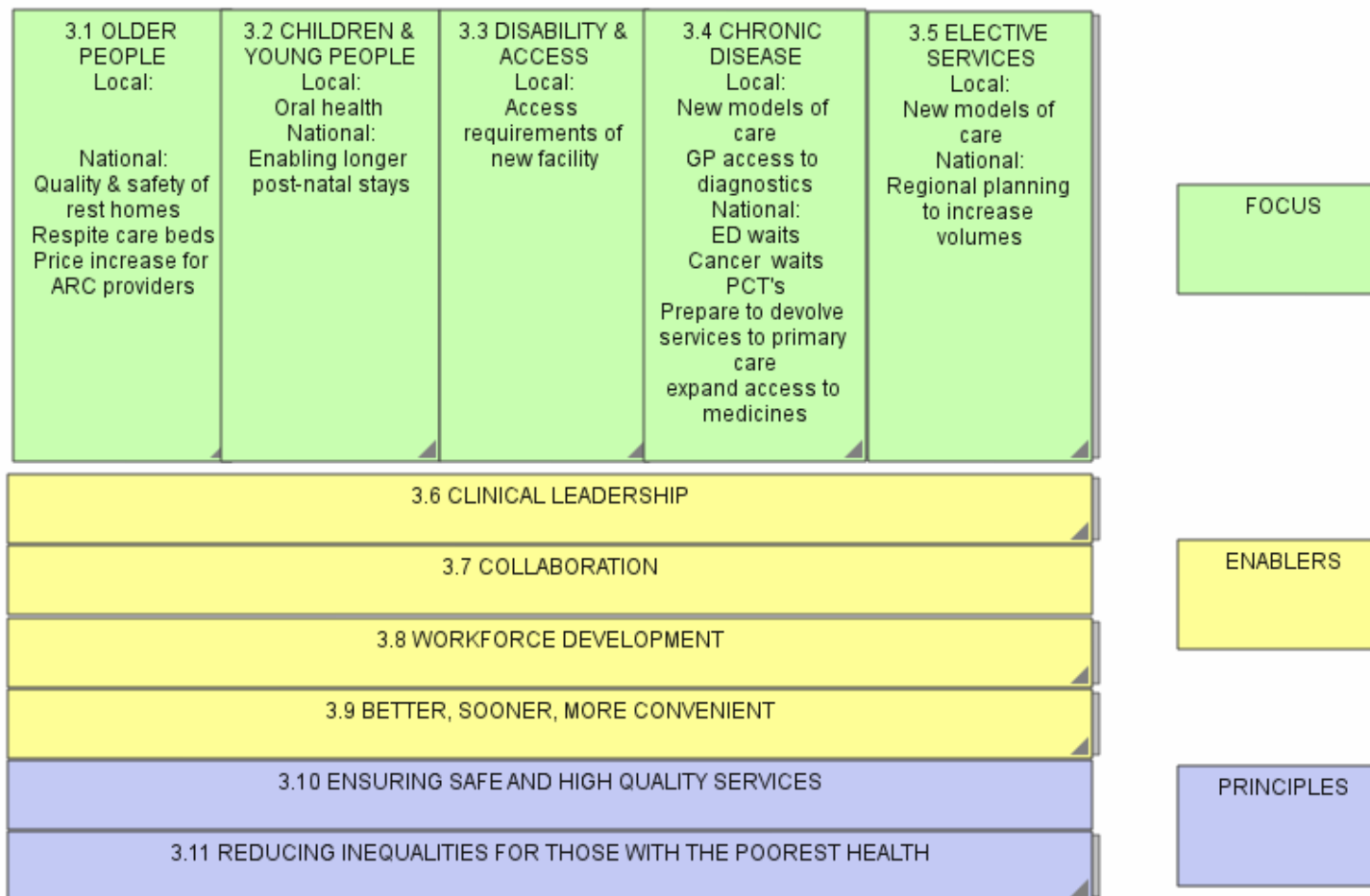
3.0 APPROACH

This section of our Plan describes what activities are planned for 2009/10 and why the DHB believes that these activities will help achieve our objectives. The diagram on page 10 explains how the DHB will approach the task of delivering both local and national objectives.

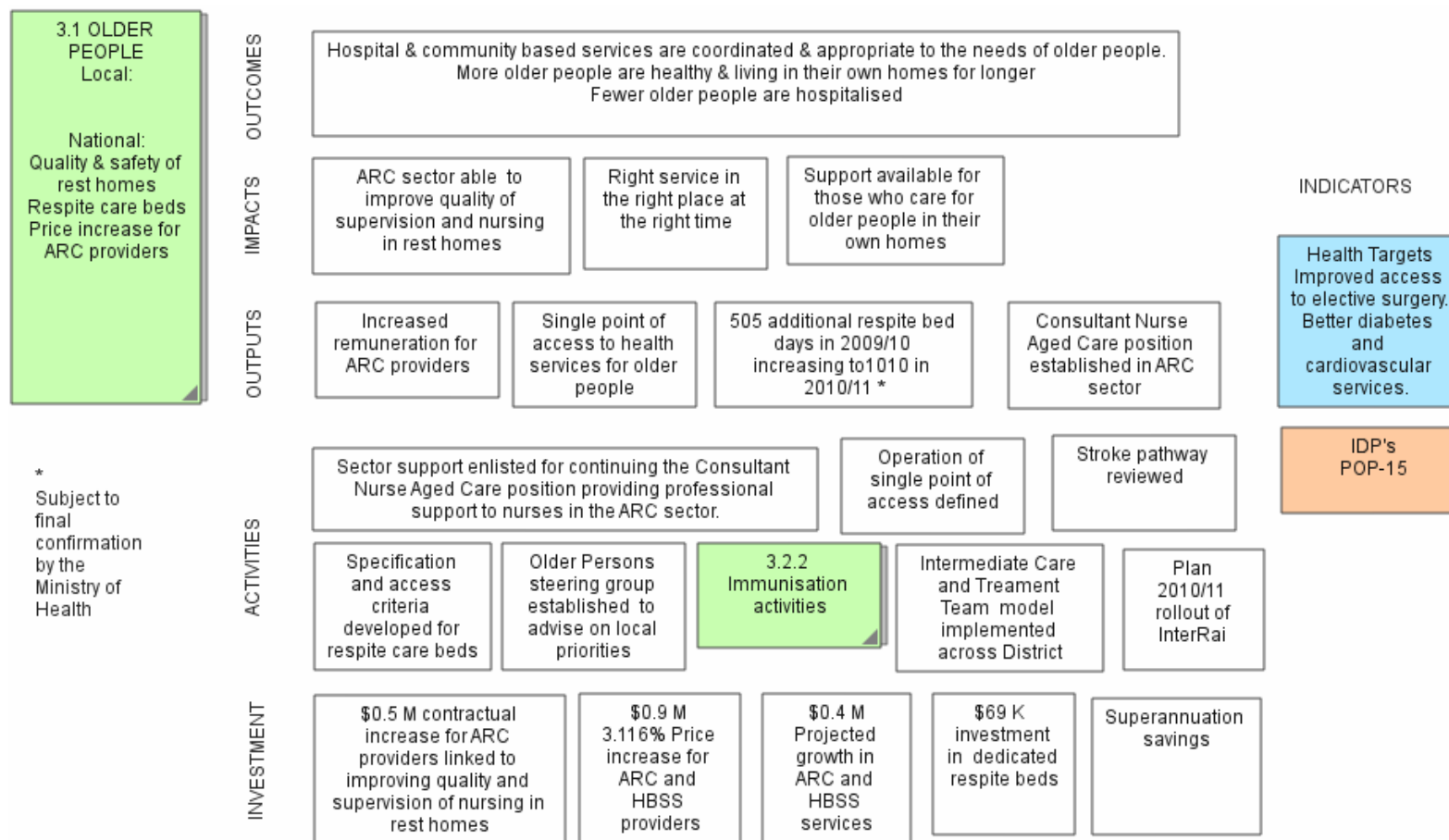
The diagram has three components: Outputs, enablers and principles. The remainder of the section then drills down progressively to give more details on each component. “Focus” refers to activities grouped into the priority areas identified by our District Strategic Plan. “Enablers” are those activities which support all DHB activity. Two “Principles” guide all the activity of Taranaki DHB.

Intervention Logic

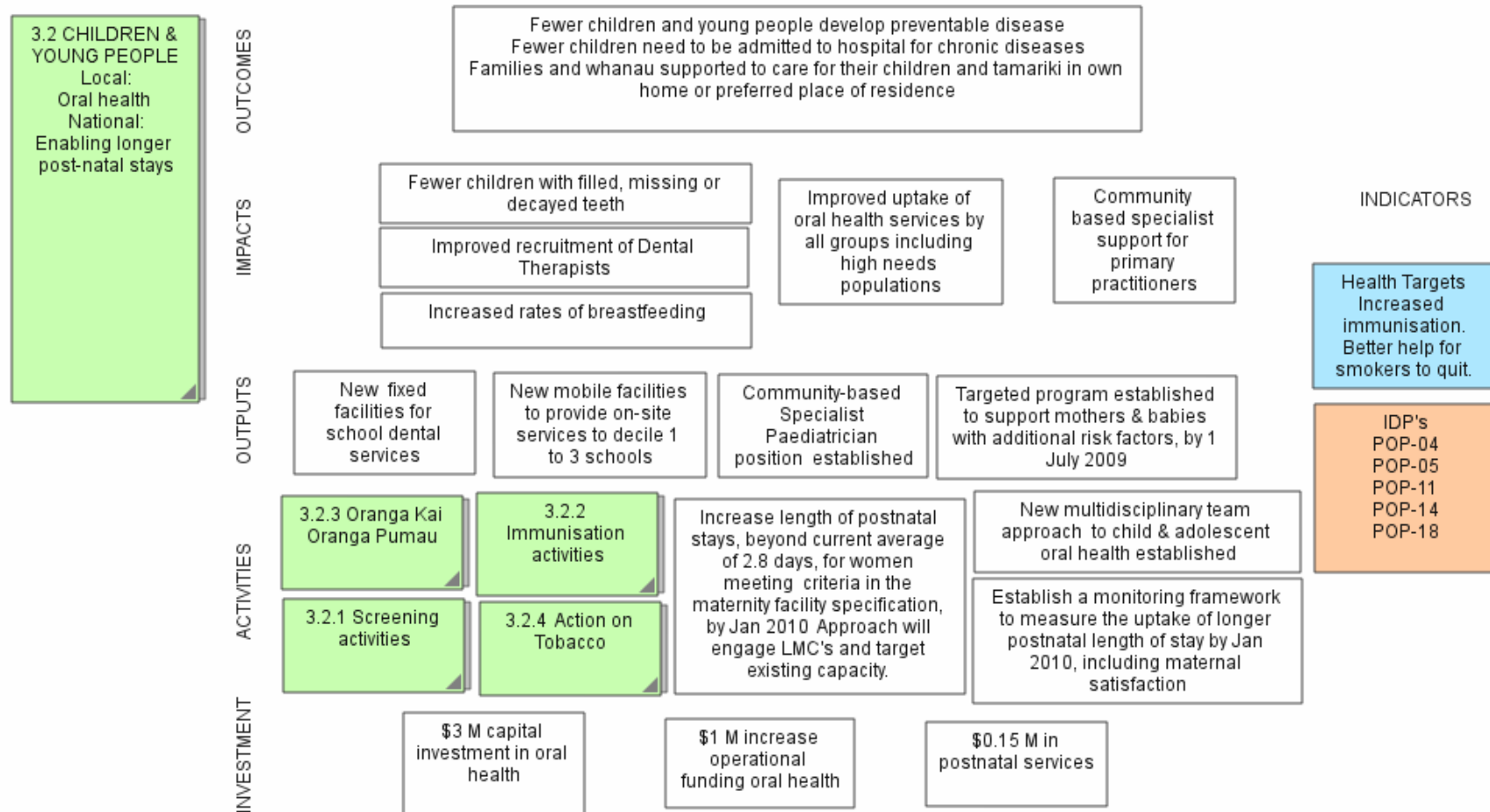
Most detail in this section is in the form of intervention logic diagrams. Each diagram shows a logical series of steps between investment decisions; activities which will be undertaken; the tangible outputs which will result from the planned activities; what impact these outputs are expected to have and what the intended outcome will be. Alongside are the indicators which will be used to track progress. The Indicators are divided into Health Targets and Indicators of DHB Performance (IDP’s). Details of the Health Targets and IDP’s can be found in section 5.



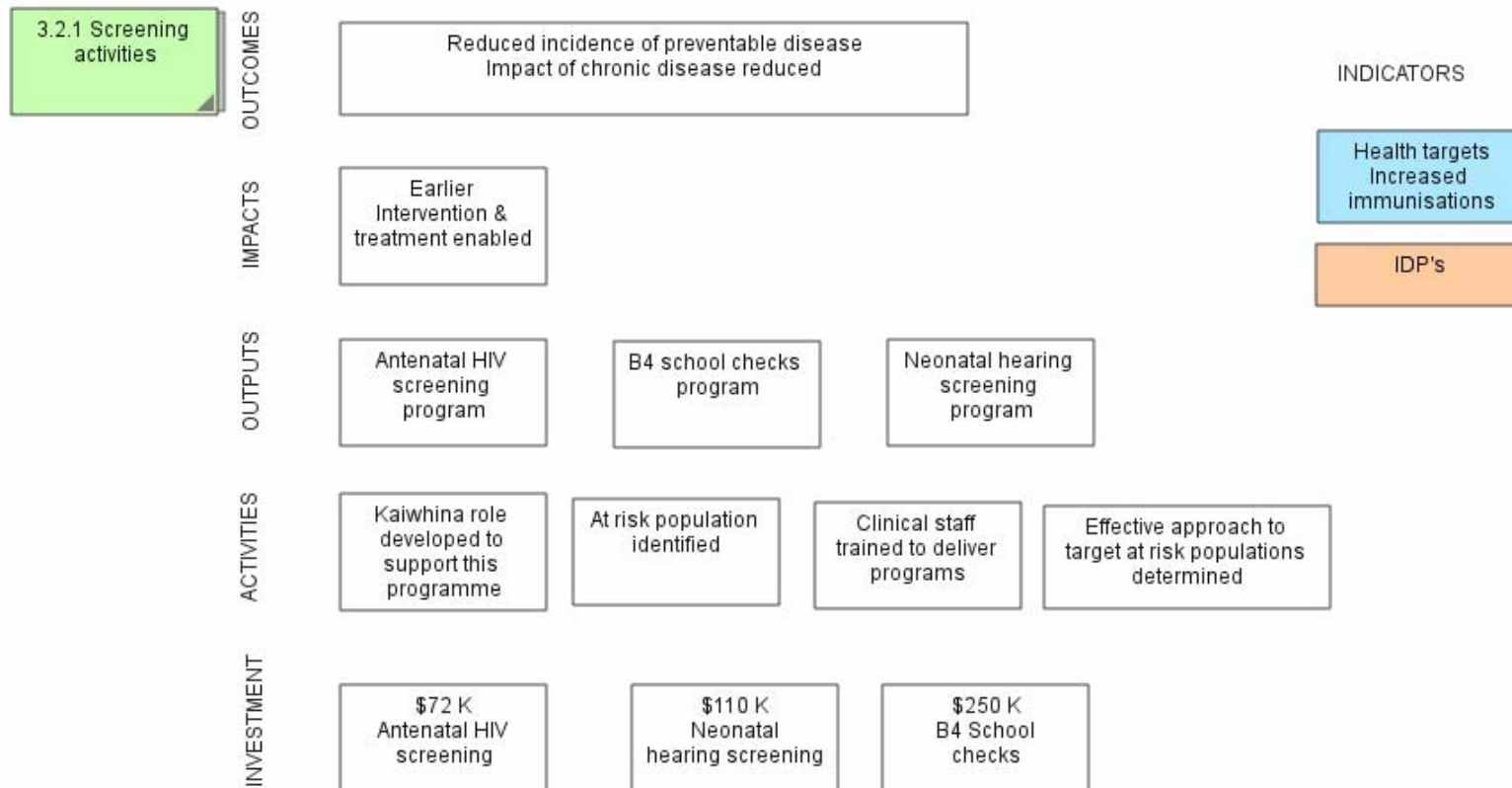
3.1 Older People



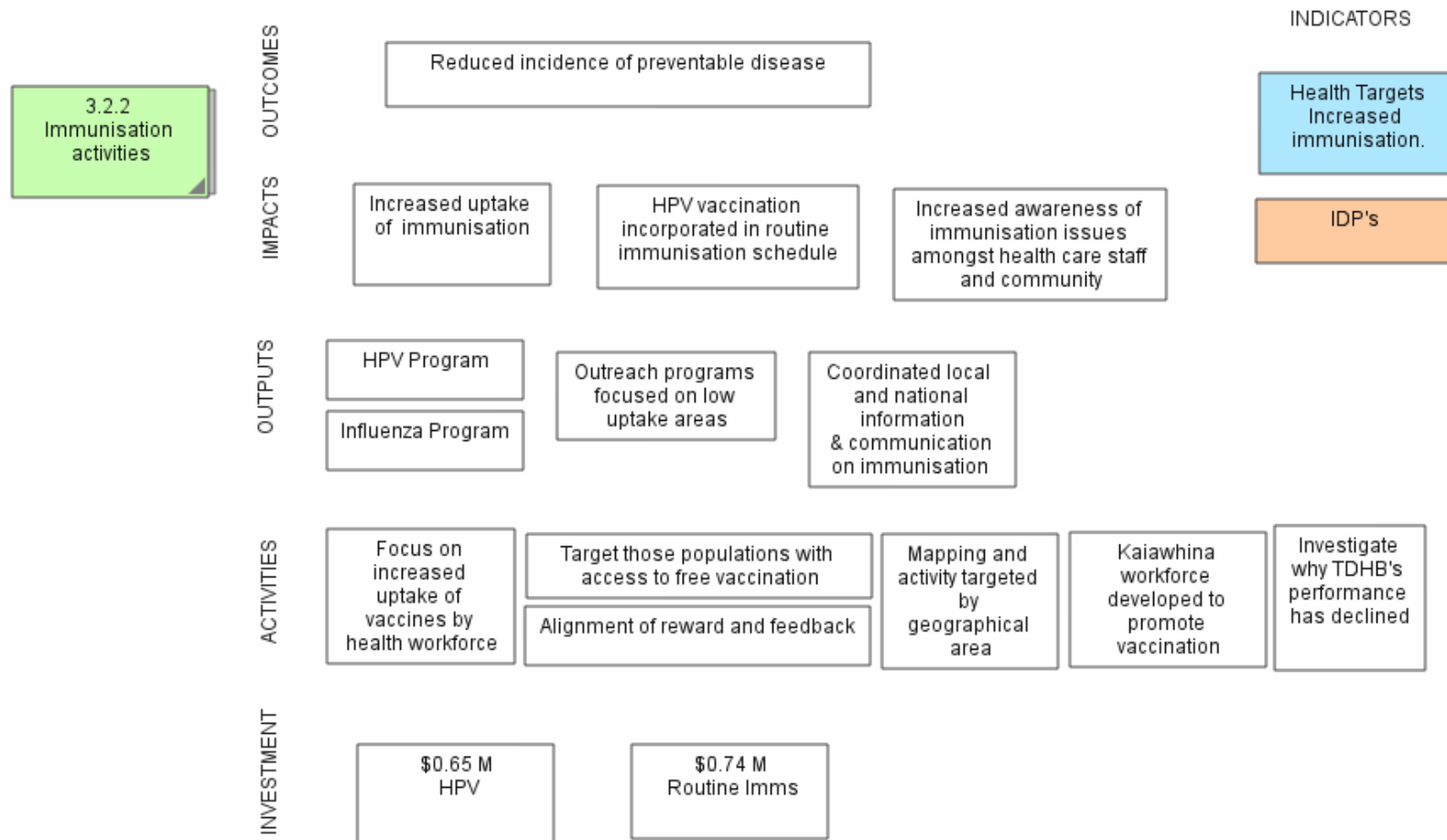
3.2 Children & Young People



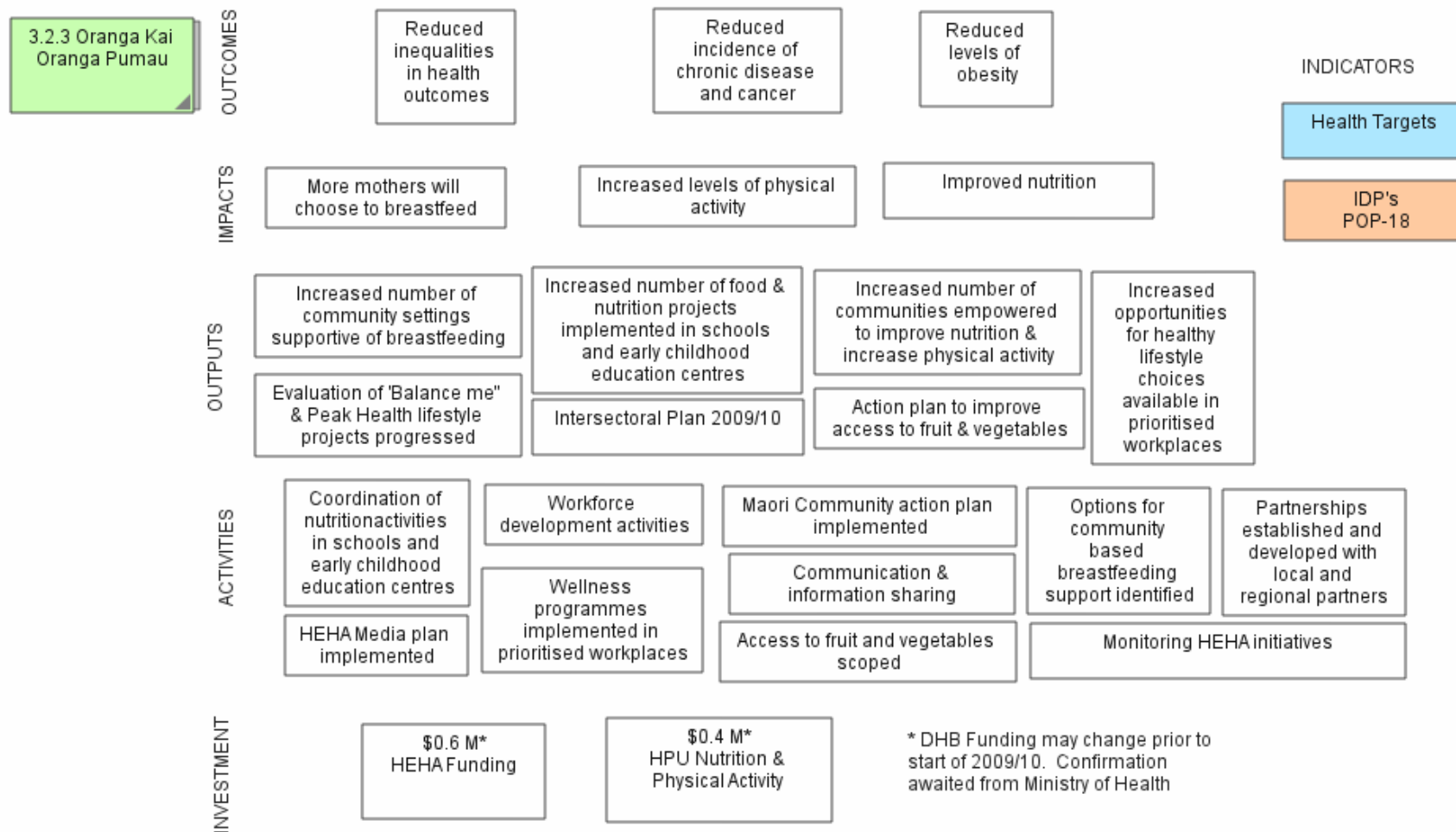
3.2.1 Screening Activities



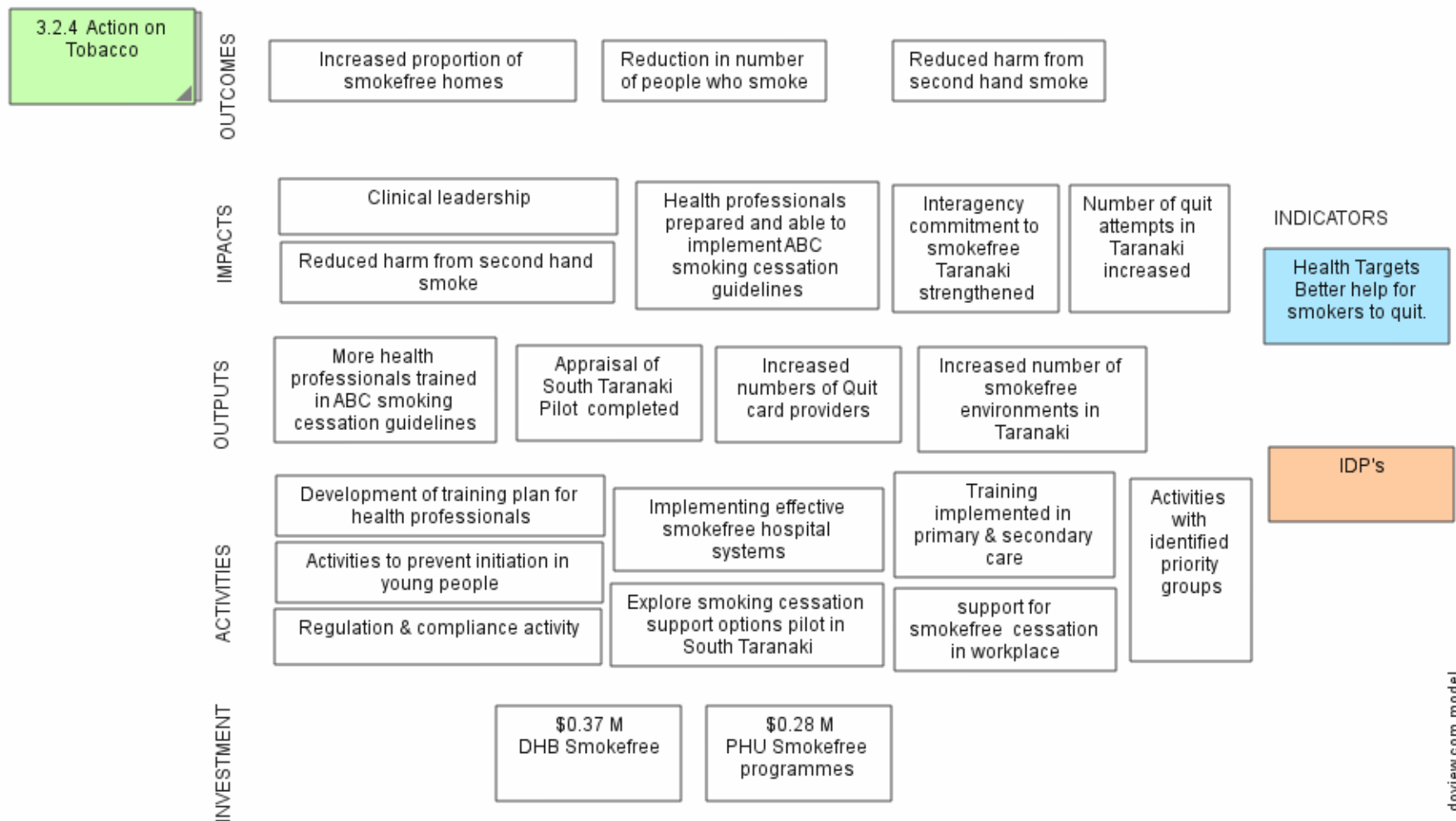
3.2.2 Immunisation Activities



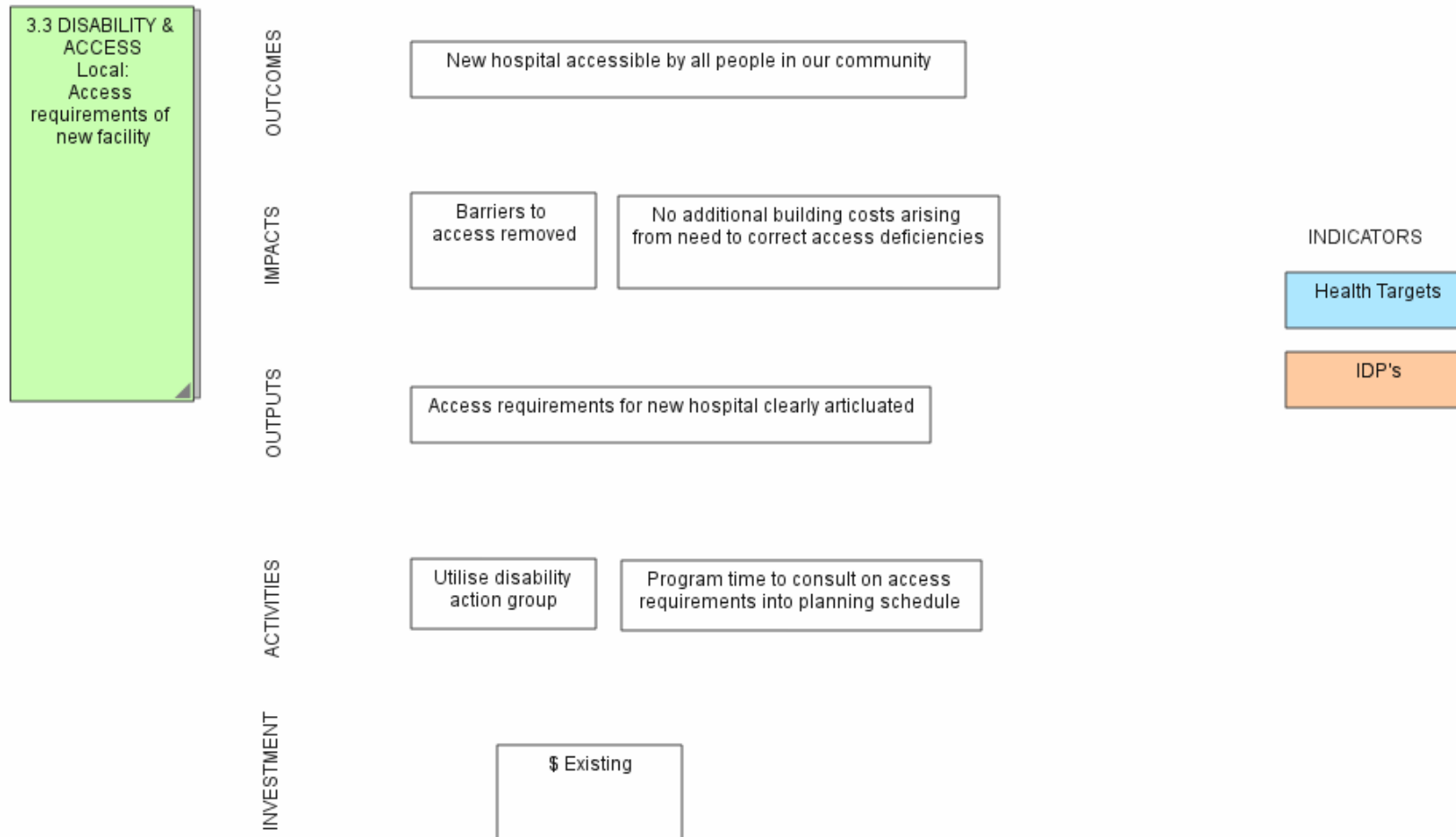
3.2.3 Oranga Kai Oranga Pumau



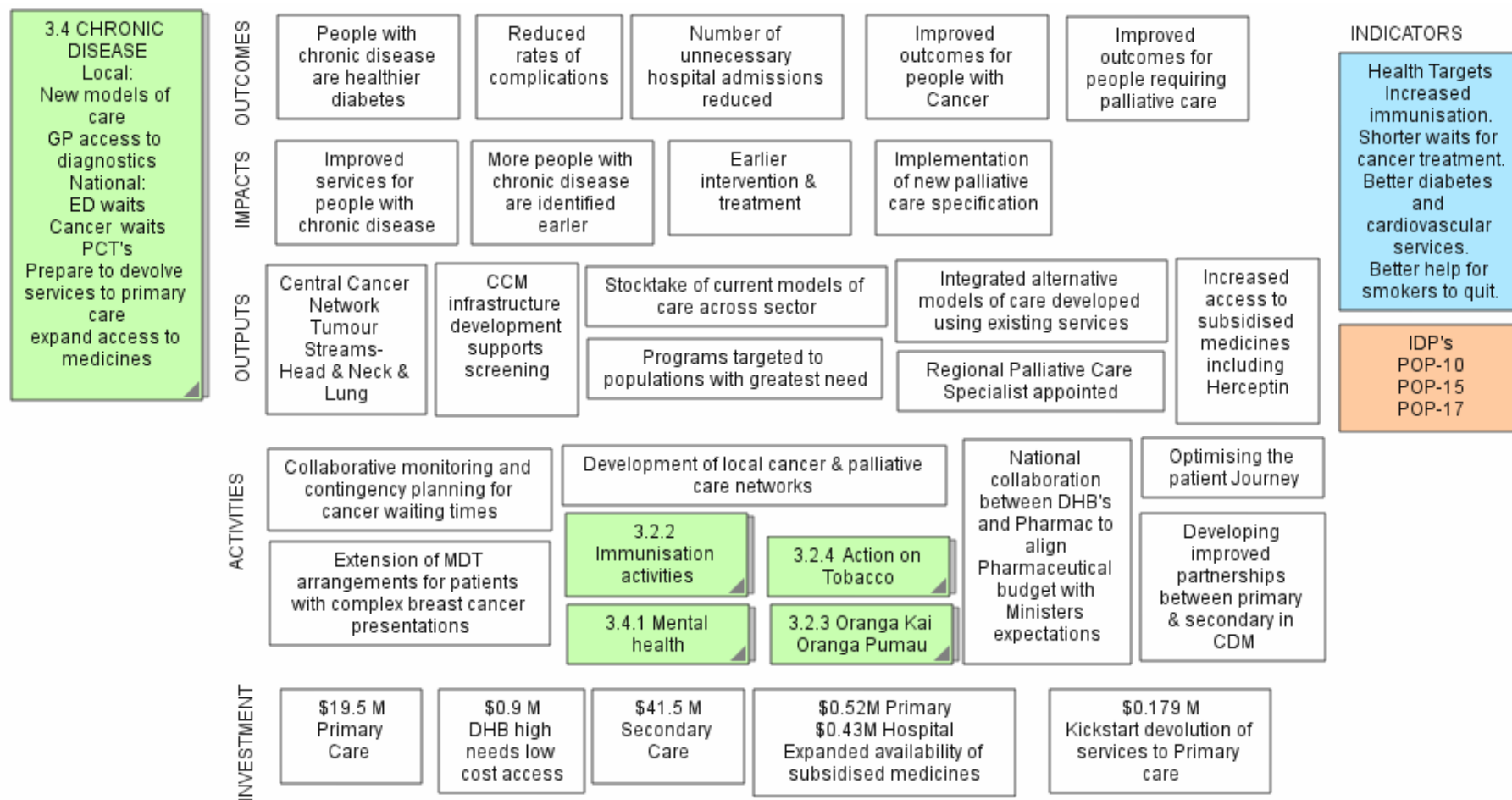
3.2.4 Tobacco



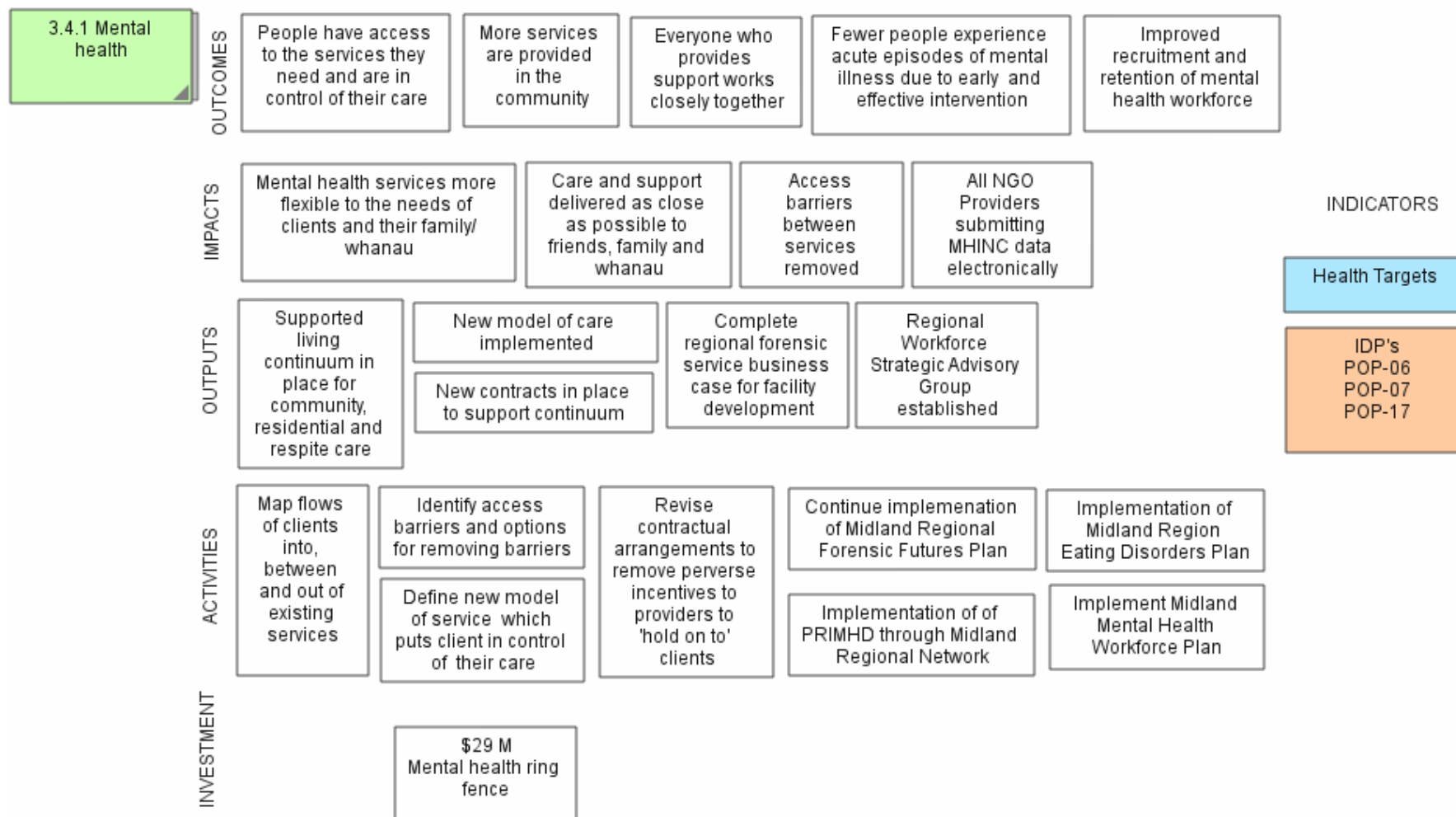
3.3 Disability & Access



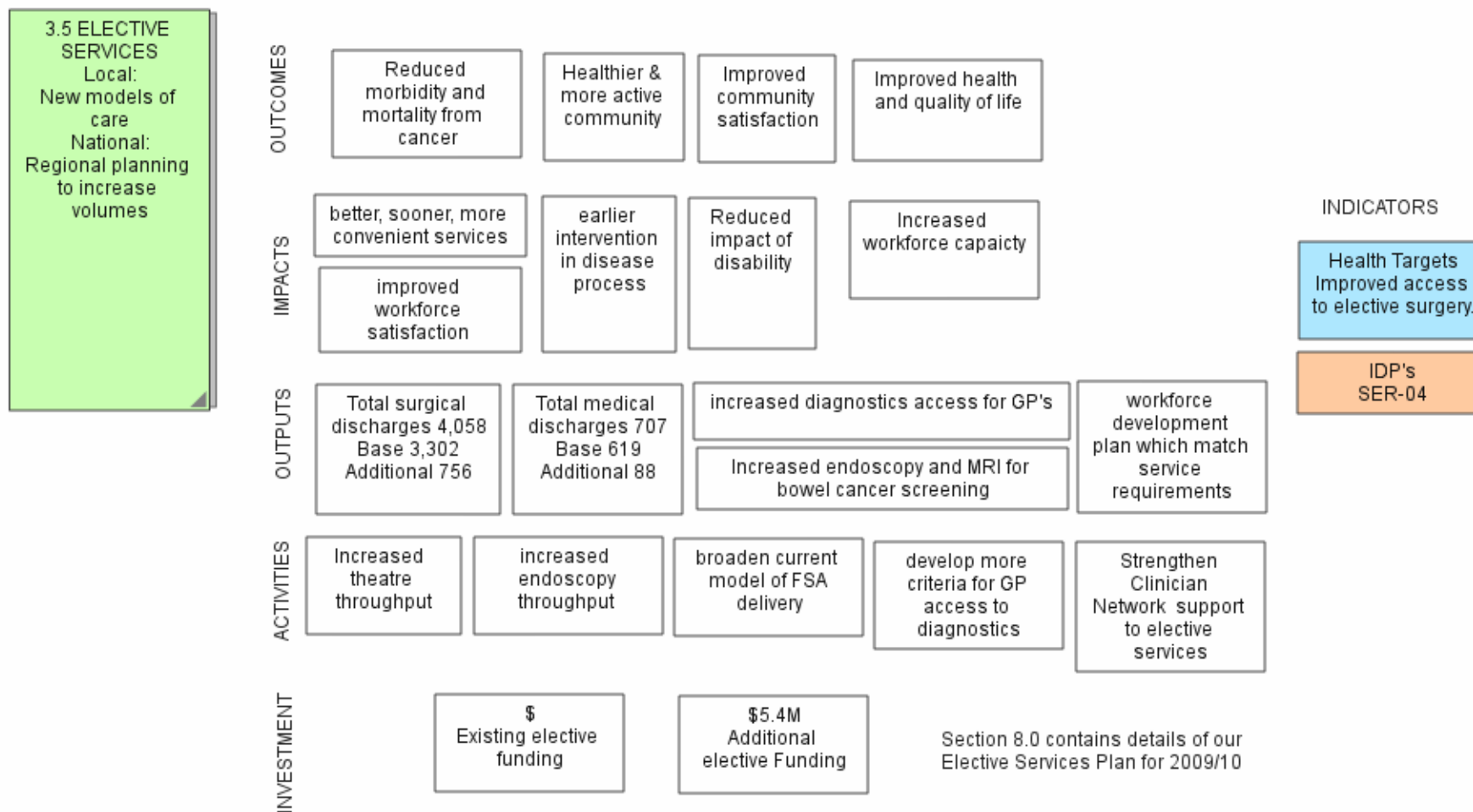
3.4 Chronic Disease Management



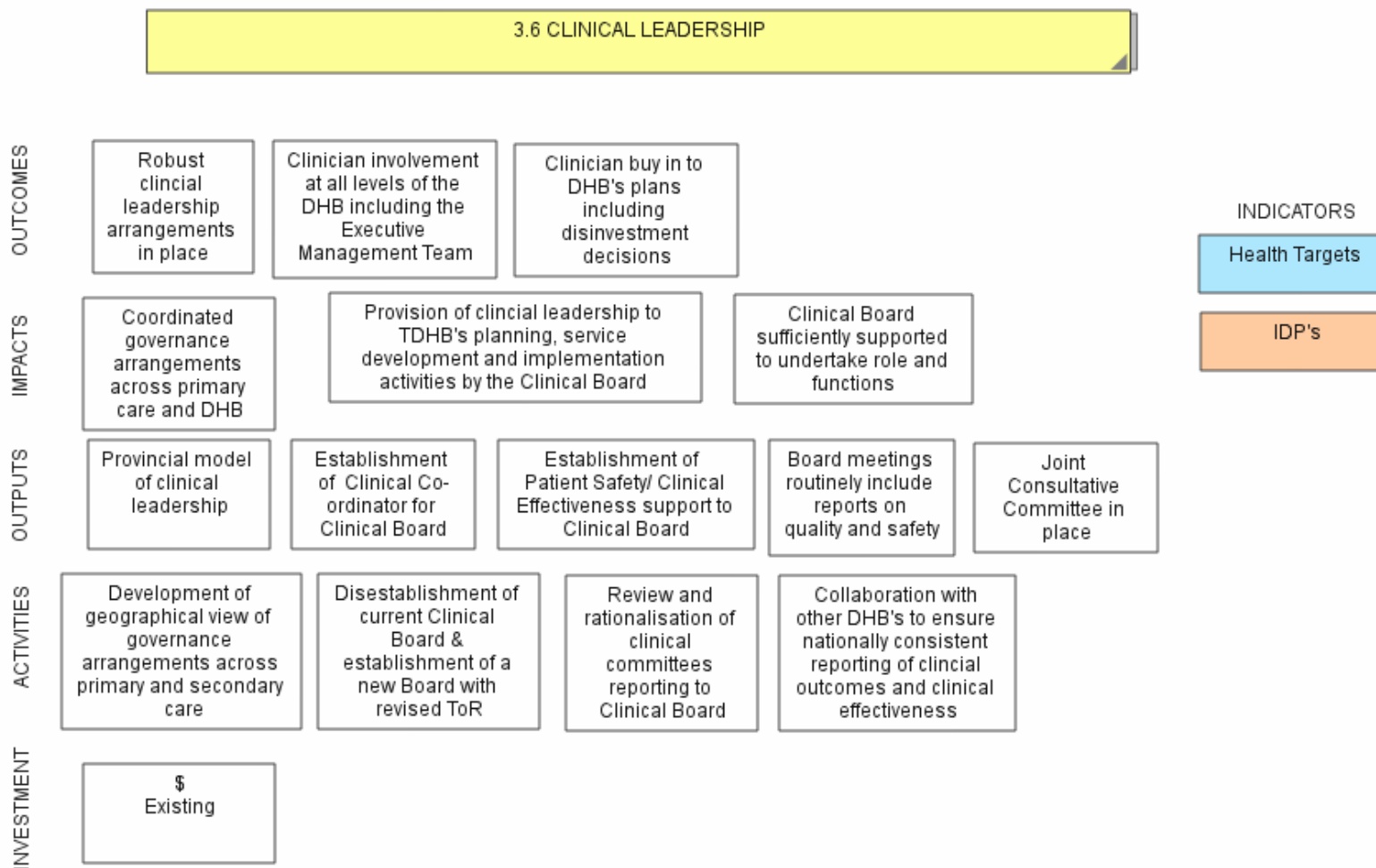
3.4.1 Mental Health



3.5 Elective Services



3.6 Clinical Leadership



3.7 Collaboration

Taranaki District Health Board recognises that by working collaboratively with others more can be achieved for our local population. The District Health Board therefore collaborates extensively with a range of partners both within the health sector and with others able to influence the wider determinants of health.

3.7.1 Multi Parent Subsidiaries and Associated Companies.

HIQ Ltd

HIQ is a wholly owned entity focused upon providing operational and strategic information systems support to Taranaki DHB. Through HIQ the DHB will be able to progress our Information Systems Strategic Plan including the required technology for the new hospital development.

HIQ also provides a good opportunity for further Inter DHB collaboration and shared information technology improvements. In the coming year HIQ will provide support to four other DHB's, on shared projects and also contribute to achieving national goals in this area.

HIQ support the Health Information Strategy for New Zealand. In particular, key initiatives are:

National Network Strategy: Through our ICT service provider, Health Intelligence, we are participating in the selection and implementation of a secure data network between regional DHBs.

eLabs: Implementation of a laboratory results repository accessible by multiple stakeholders in the region.

Chronic Care and Disease Management: We are actively investigating tools and decision support systems that will support chronic care initiatives.

National Collections/Strategies: TDHB have implemented the National Non-admitted Patient Collection (NNPAC) and are actively participating in the Primary Health Care Strategy workshops.

Allied Laundry Services Ltd

Allied Laundry Services Ltd is a shared services arrangement between four District Health Boards for the provision of laundry and linen services. The participating District Health Boards are Hawkes Bay, MidCentral, Taranaki and Wanganui. This collaborative arrangement enables cost savings to be achieved in the delivery of laundry and linen services to the participating District Health Boards.

Fulford Radiology Services Ltd

Taranaki District Health Board has a 50% investment in Fulford Radiology Services which provides a comprehensive range of imaging services to the Taranaki population.

HealthShare

Each of the five Midland DHBs has a participatory interest in HealthShare Limited, a DHB joint venture company that specialises in both routine and issues-based quality-audit of service providers. The five DHB Chief Executives are Board members. The service level agreement between the five DHBs and HealthShare sets out the principles, targeted performance standards, and operational guidelines that underpin

HealthShare's audit programme and framework ensuring alignment with both national and regional requirements.

HealthShare reports back to the participating DHBs throughout the year ensuring contractual obligations and standards are met by contracted providers.

HealthShare also manages the primary health regional fees review process for the Midland DHBs.

3.7.2 Regional Collaboration

Midland Region District Health Board's

Taranaki District Health Board is been an active participant in work undertaken by the Midland District Health Boards. A number of Regional Plans have been developed for specific clinical services including: mental health and addiction, diabetes and cardiac services.

The Midland group of DHBs have recently embarked on a Regional Clinical Services Plan. The Plan is sponsored by all 5 Chief Executives in the Midland region and focuses on what we intend to do clinically as a region in meeting the health needs of the regional population. The Plan describes a set of principles eg patient centric, targeting at risk groups, providing services close to the population so long as they are clinically and financially viable which provide the focus for the collaboration. The Plan also acknowledges that within the region and outside it there are current cooperative ventures that need to be supported. Further, planning needs to be flexible to take in to account this approach in the future. The Plan is congruent with the Ministry's Long Term Sector Framework vision of greater regional collaboration

Central Region District Health Board's

Taranaki District Health Board is an active participant in the Central Region Cancer Network.

3.7.3 National Collaboration

ACC District Health Board Relationship

ACC and DHBs are working together at district and national levels on projects of mutual interest and advantage to common clients as expressed in the Charter of Collaboration, which seeks to progress the relationship and seek opportunities to improve health outcomes for common clients.

In Taranaki the ACC and the Taranaki DHB engages on number of items and projects of interest to the hospital provider arm. Joint ACC-DHB prioritising of projects occurs yearly and in 2008/09 has included the provision of and changes to ACC Elective surgery; Mental Health project; Public Health Acute Services workshops and discussion; rewriting the Provider Handbook and DHB/ACC "Accident Services Who Pays?" guidelines; TDHB representatives on the Pain Contracts Workshops in order to rewrite more effective pain services contracts.

Future priorities might include updating equipment provision processes; further progress with electronic invoicing and reporting and ongoing collaboration in clinical pathway projects.

The wider DHB is also involved in projects such as the Implementation of the InterRAI Assessment Tool; encouraging DHBs to involve ACC in primary care after hours planning; joint funding of falls prevention programmes for elderly in the community and establishment of the ACC, Ministry and Police joint venture for Sexual Abuse Assessment and Treatment services.

The National Ambulance Sector Office (NASO), a joint venture between the Ministry of Health and ACC is charged with managing all ambulance related work for the two Crown agencies. There is ongoing work between NASO and the Taranaki DHB owned ambulance service towards determining linkages between the draft New Zealand Ambulance Strategy and other pieces of work such as the Inter Hospital Transfers project.

The ongoing commitment is that ACC and Taranaki DHB will continue to engage openly about opportunities that will benefit common clients and advance mutual outcomes.

Quality Improvement Committee (QIC) Programme

There are five priority project areas in the QIC programme. Below is a description of what is planned for 2009/10.

This is Year two of a multi-year programme. The expected outputs are therefore focused on progressing the projects at DHB level.

1. **DHB collective commitment to the National Quality Improvement Programme:** Taranaki DHB will continue to work at both the national collective level and at the DHB level to deliver the QIC programme over the next 2-3 years.

Taranaki DHB continues with its commitment to actively work with the national collective to support the lead DHBs and to ensure that we as a DHB are prepared in terms of planning and resourcing to implement the results of these projects as they become available. We expect to be ready to start implementing outputs as we move into the implementation phase of 2009/10.

We note that many of the projects have a significant IT component that is yet to be funded. We will continue working with the Ministry of Health at the national collective level to ensure investment decisions are made in a timely manner.

2. **DHB Activity at the Local Level for 2009/10:** The following table sets out a range of deliverables for the 2009/10 financial year. The table has two columns, the second contains paragraphs that we believe will be the minimum DAP requirements for DHBs. Common to all of the projects will be our ongoing commitment to contribute to applicable evaluation processes.

	DHB Local Activity for the National Quality Improvement Programme
1	Optimising the Patient Journey
a)	The DHB will continue to actively participate in the national collaborative processes.
b)	Progress our own patient journey related initiatives: delivery of acute care, maternity services and oral health.
2	Management of Healthcare Incidents
a)	The DHB will continue to actively participate in the national collaborative processes.
b)	Ensure that our DHB Reportable Events Policy is in line with the national Management of Healthcare Incidents Policy.
c)	The DHB will continue to market/promote the national programme across the DHB
d)	The DHB will release staff for the comprehensive training programme on incident management that is scheduled for July 2009.
3	Infection Prevention and Control
a)	The DHB will continue with the implementation of the Hand Hygiene Project Stage 2 Rollout.
b)	The DHB will continue to participate in the national learning sessions with DHBs to educate local teams on the guidelines, the implementation strategy, improvement method and achieving change.
c)	The DHB will implement the infection prevention and control strategies as they become available
4	National Mortality Review Systems
a)	The DHB will continue to work with the National CEO Group (via the Lead CEO) and the Ministry of Health to assist other DHB's in the establishment of a local Child and Youth Mortality Review Committee
	DHB Local Activity for the National Quality Improvement Programme
5	Safe Medicines Management
a)	The DHB will continue to actively participate in the applicable working groups.
b)	The DHB will consider becoming a pilot site for the medication reconciliation project.
c)	The DHB will implement the medication safety project outcomes and strategies as they become available.

3. **Framework for consolidated reporting - as per QIC Oversight Arrangements Chart:** DHBs have agreed on structures and processes to manage the National Quality Improvement Programme at both the local and collective levels. The Lead DHB CEOs will steer the project and produce a regular consolidated report that will be used to update DHBs, Ministry of Health and the Quality Improvement Ministerial Committee.
4. **Performance measures which will be put in place to track the targets you set to implement the QIC programmes:** Taranaki DHB will respond to the Performance Measures set out in the Crown Funding Agreement (CFA).
5. **Reporting milestones for the achievement of these targets:** These will be included in the CFA.

3.7.4 Intersectoral Collaboration

Future Taranaki

Taranaki DHB is an active participant of the Future Taranaki Facilitation Group (FTFG) which was formed in 2004 out of a collaborative regional partnership between a wide and varied range of agencies. The FTFG member organisations currently comprise:

Taranaki District Health Board
Ministry of Social Development
Te Puni Kokiri
Venture Taranaki Trust
New Plymouth District Council
Stratford District Council
South Taranaki District Council
Taranaki Regional Council

The purpose of the group is to provide a framework through which these and other organisations can be encouraged to collaborate to deliver the seven community outcomes identified for the Taranaki region. These outcomes are:

Secure and Healthy: Region is a safe, healthy and friendly place to live, work or visit

Sustainable: Region appreciates its natural environment and its physical and human resources in planning, delivery and protection

Prosperous: Regional economy sustainable, resilient and innovative, prospering with the natural and social environment

Together: Region is caring and inclusive, works together and enables people to have a strong and distinctive sense of identity

Vibrant: Region provides high quality and diverse cultural and recreational experiences, and encourages independence and creativity

Connected: Region has accessible and integrated infrastructure, transport and communication systems that meet the needs of residents, businesses and visitors

Skilled: Region values and supports learning so all can play a full and active role in social, cultural and economic life

Three key projects are being undertaken by FTFG, all of which link to Taranaki DHB's strategic aims:

Working Together for a Smokefree Taranaki: Taranaki DHB is the lead agency for this project, which aims for Taranaki to become the first Smokefree province in New Zealand by Smokefree Day 2009

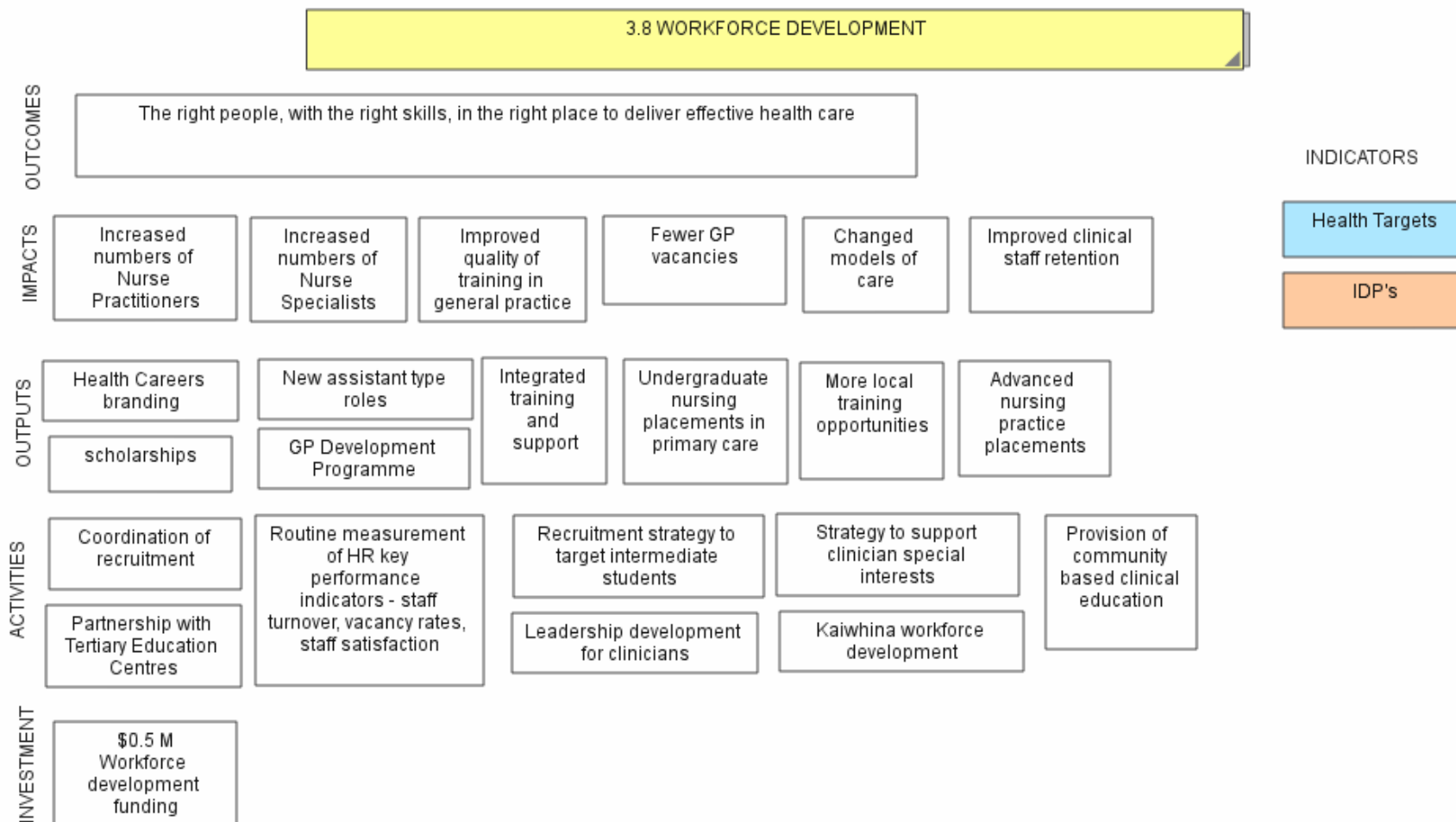
Safer Families, Safer Communities – Eliminating Family Violence in Taranaki: The Ministry of Social Development is the lead agency for this project, which aims to provide intervention, education and support in workplaces

Regional Skills Strategy: This project is led by Venture Taranaki Trust, with the New Plymouth District Council. The aim is to ensure that the region's supply of labour meets its potential demand

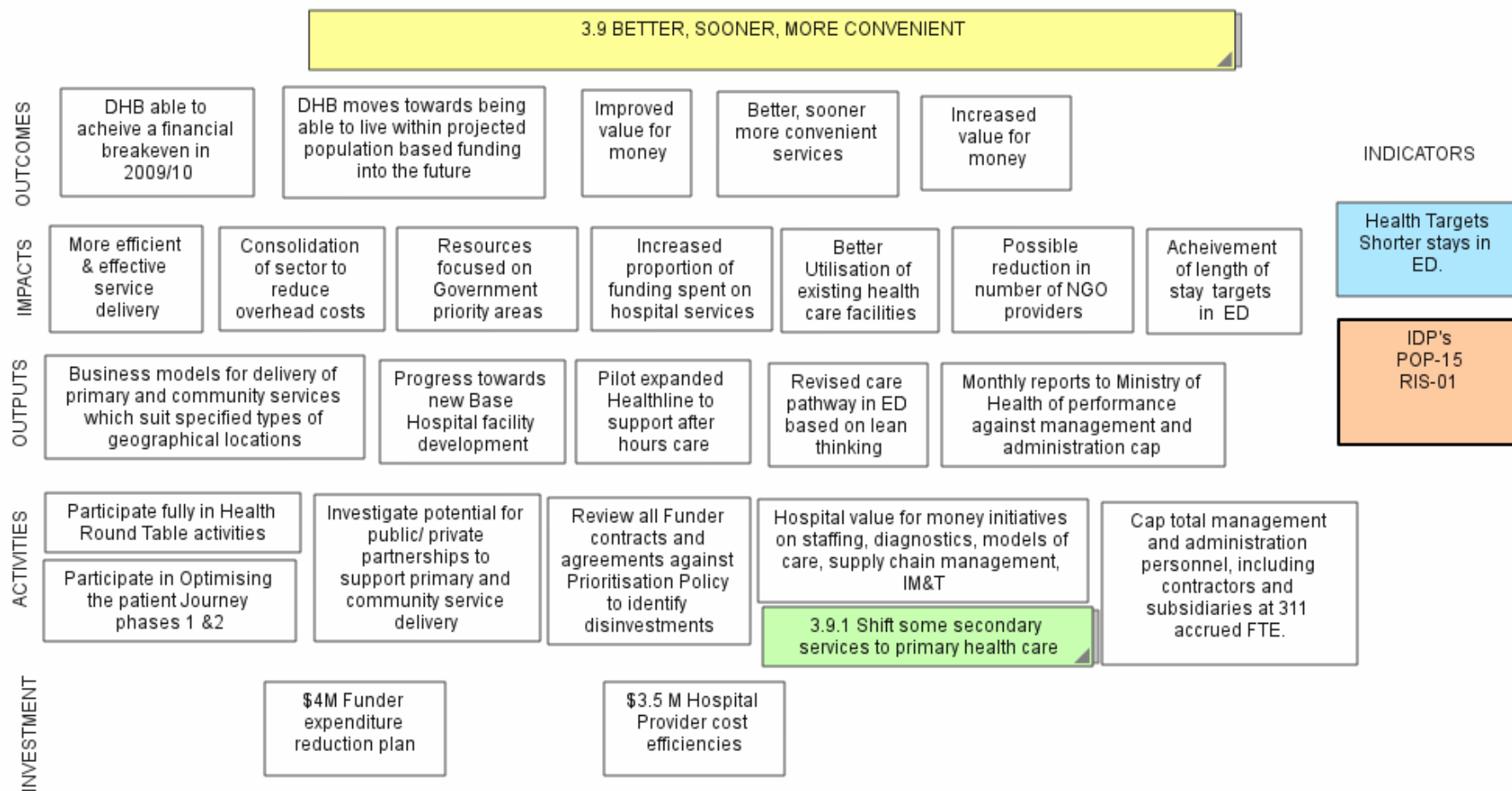
Taranaki Strategic Forum

The Taranaki Strategic Forum comprises Taranaki DHB, Ministry of Social Development and the Accident Compensation Corporation. The forum provides an opportunity for the major funders in the district to come together to share information, knowledge and expertise, identify duplications and gaps with a view to pooling resources to achieve greater gains.

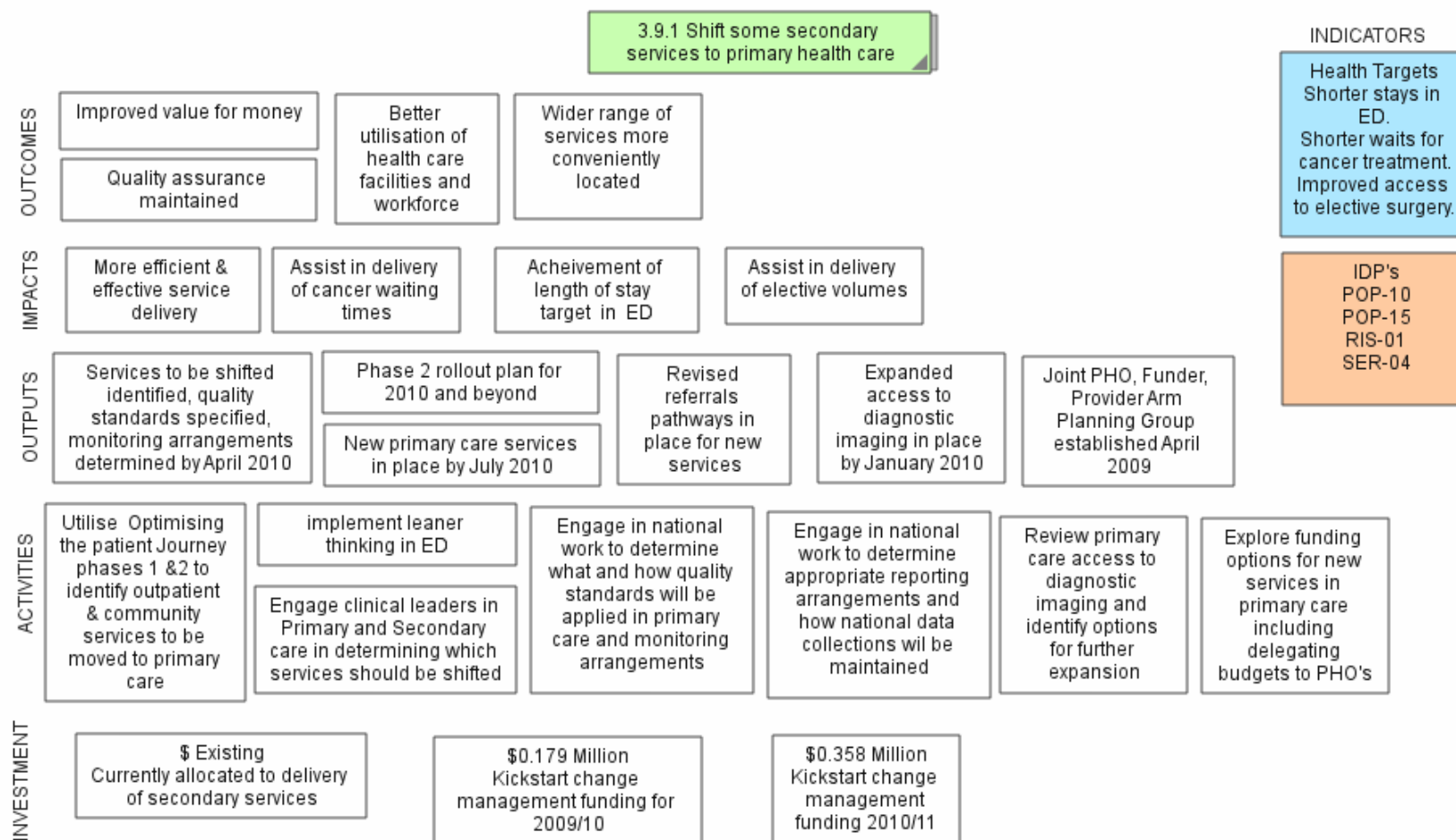
3.8 Workforce Development



3.9 Better, sooner, more convenient



3.9.1 Shift some secondary services to primary health care



3.10 Ensuring safe and high quality services

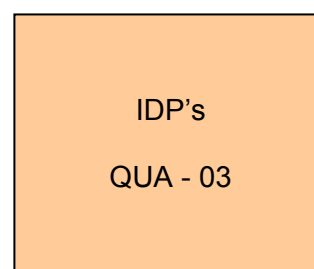
The Taranaki DHB is committed to the delivery and funding of quality services by all health and disability providers within the district. Quality assurance systems and procedures are in place to ensure services undergo performance measurement (usually focused on service content, delivery specifications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

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

The annual Taranaki DHB Quality and Risk Plan facilitates the progressive achievement of the Taranaki DHB's vision by monitoring and continuously improving all services, processes and activities relevant to the quality of care and the service provided or funded. It outlines organisation wide goals and links into the Taranaki DHB's District Annual Plan and the Ministry of Health's IQ Action Plan: Supporting the Improving Quality Approach, provides direction for all health and disability services in Taranaki, building upon that successfully applied in the Taranaki DHB Provider services.

Key areas of focus within the Taranaki DHB Quality & Risk Plan for this DAP period will be addressing our corrective actions and recommendations received from our recent certification and accreditation audit/survey respectively; progressing our commitment to the National Quality Improvement Committee Programme and progressing the recommendations from the Review of the Clinical Board Report received earlier this year.

Indicators



3.11 Reducing Inequalities for those with the poorest health

The 2005 Taranaki Health Needs Assessment confirmed previous findings that Māori people have poorer health than the rest of the population, dying on average eight years earlier than people who are non-Māori. The incidence of chronic diseases such as cardiovascular disease, diabetes and respiratory disease in Māori people is twice that of non-Māori. A higher proportion of Māori are overweight or smoke which are risk factors for chronic diseases. Māori people are therefore a priority because they have more illness and use health services more than the rest of the people of Taranaki. A third Taranaki Health Needs Assessment was published in 2007. This report confirmed the previous findings and in addition identified that breast cancer particularly in Māori women, melanoma, sexually transmitted illness and hazardous drinking were issues for our community.

Our approach to reducing inequalities for those with the poorest health status therefore focuses on addressing the needs of our Māori people.

Te Tiriti o Waitangi is widely acknowledged as the founding document of New Zealand and is often referred to in overarching strategies and plans throughout all sectors. The Taranaki District Health Board is one of many organisations that value its importance in the context of the work that we do.

Central to the Treaty relationship and the acknowledgement of the Treaty principles, is a common understanding that Māori will have an important role in developing and implementing health strategies for Māori.

He Korowai Oranga – Māori Health Strategy, emphasises that the relationship must be based on:

Partnership: working together with whanau, hapu, iwi and Māori communities to develop strategies for improving the health status of Māori.

Participation: involving Māori at all levels of the sector in planning, development and delivery of health and disability services that are put in place to improve the health status of Māori.

Protection: ensuring Māori well-being is protected and improved as well as safeguarding Māori cultural concepts, values and practices.

The Taranaki District Health Board is committed to the application of these Treaty obligations.

As a crown agency, the Taranaki District Health Board (TDHB) considers the Treaty of Waitangi principles to be implicit conditions of the nature in which the Taranaki District Health Board responds to Māori health issues.

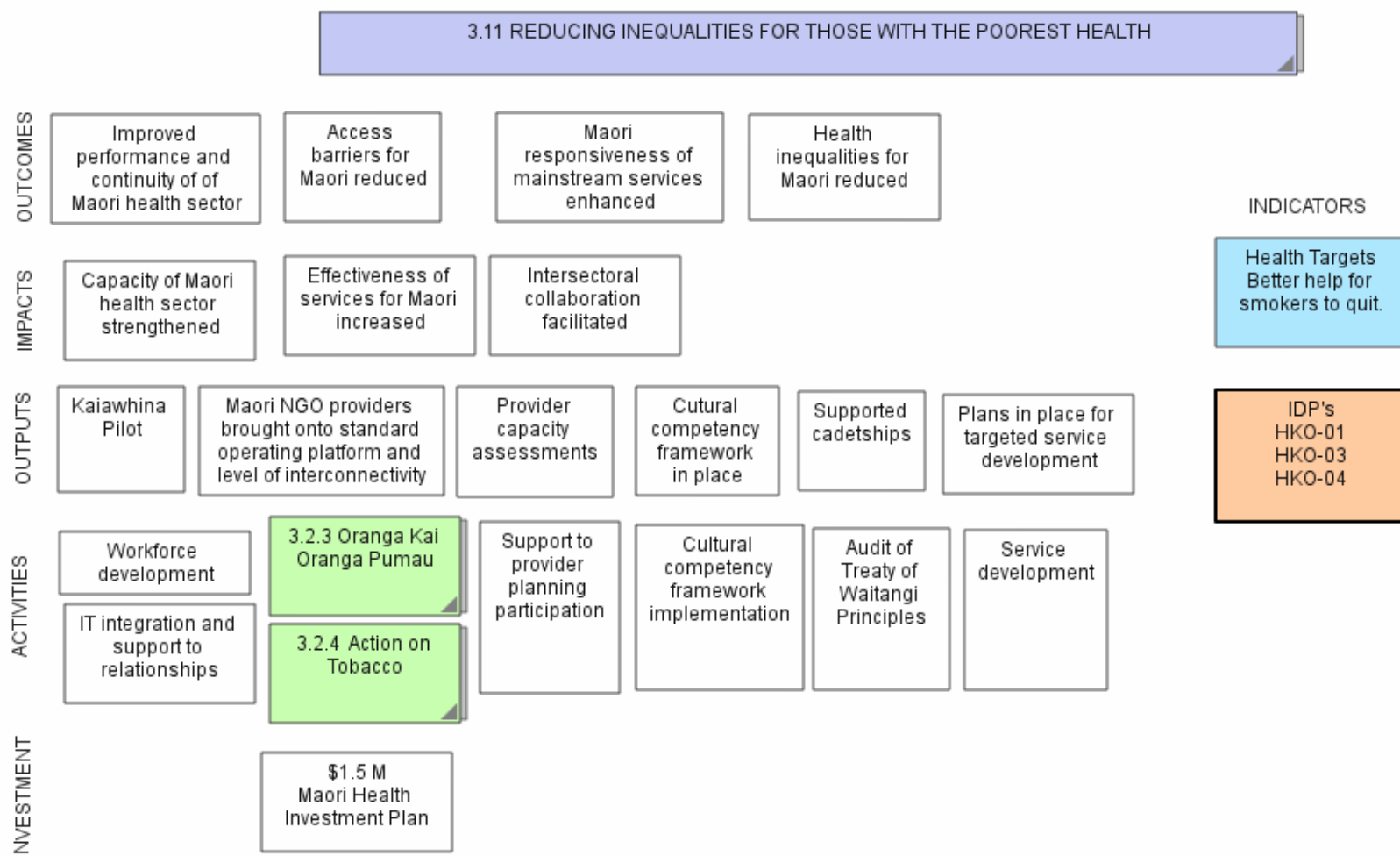
TDHB is committed to operationalise the Treaty of Waitangi and do so by working in partnership with the regional Māori governance body “Te Whare Pūnanga Kōrero” (TWPK). The Memorandum of Understanding between TDHB and TWPK provides for Māori input into decision-making and performance monitoring at the governance level.

In addition, the TDHB has strong operational relationships with Tui Ora, the regional Māori Development Organisation that is the umbrella body for 13 Māori provider organisations, as well as with the iwi-based provider organisations Ngati Ruanui and Nga Ruahine in the south, and Te Atiawa in the north. These relationships are essential for facilitating the practical expression of Treaty of Waitangi obligations on a day-to-day basis.

The application of Treaty obligations is an organisation wide responsibility that sits on the shoulders of all persons throughout the Taranaki DHB, as well as all other organisations involved in delivering health services to Taranaki communities.

Planned actions for reducing inequalities are described in the form of an intervention logic diagram in this section.

Reducing Inequalities



4.0 NOTICES

4.1 Significant service change

Forecast demographic changes suggest that Taranaki will continue to experience lower population growth than the national average. As a consequence the DHB will experience a continued decline in our funding share in the future. The DHB cannot afford to deliver services in the same way. In 2009/10 and into 2020/11 a series of service reviews will be undertaken to ensure that our population continue to have access to a comprehensive range of health and disability support services, which are delivered through new, more efficient models of care, and which are affordable into the future. Consultation with key stakeholders will take place in relation to reviews as may be necessary.

4.1.1 Community Pharmacy Services.

The DHB will also consult on a new funding and contracting framework for community pharmacy services. The current funding and contracting framework has remained largely unchanged for a number of years. The potential benefit of pharmacist involvement in reducing medication error and wastage remains unrecognised and potential health gain and financial savings from wider pharmacist roles unrealised. Meanwhile dispensing volumes have grown significantly impacted on by a mix of STAT and monthly prescribing, variable use of close control, a significant shift in copayments and underlying volume growth. These factors are not under the direct control of DHBs or pharmacy and they have created funding pressure on the system. With a period of static dispensing fees there has been an increasing tension in the sector between the pressures on community pharmacy and the funding growth pressure on DHBs. In this environment both DHB's as funder and Pharmacy as providers have been experiencing sustainability pressure.

We have worked collectively with thirteen other DHBs to support the development of a discussion paper regarding funding model and contracting options for community pharmacist services. The discussion paper has been developed following a series of meetings with the Pharmaceutical Society, the Pharmacy Guild and representatives of DHBs involved. Our aim is to enable full realisation of the contribution pharmacist services can make to the health and wellbeing of patients and the community as a whole.

4.1.2 Community Nursing Services

A review will be undertaken of all nursing services delivered to people in their own homes or in a community setting. The aim is to integrate nursing services, deliver better outcomes for patients and target services at those people with the greatest need for nursing care. Particular emphasis will be placed on the health and disability support needs of those people living in rural locations.

4.1.3 Community Mental Health and Addiction Services

The DHB will review the mental health and addiction support needs of our population, current configuration of services, consumer and family/whanau views of current service delivery, barriers to clients moving along a recovery pathway and options for reconfiguration. This work will include full engagement with all stakeholders and is expected to result in a new configuration of community mental health and addiction services. The new configuration will provide a continuum of services to meet the full

range of client needs and will enable clients to move freely between services according to their needs and the requirements of clients and their families/ whanau.

4.2 Service coverage expectations

Taranaki District Health Board meets the requirements of the national service coverage document as specified in the Operational Policy Framework and Service Coverage Schedule. At the time of writing, Taranaki District Health Board has not identified any exceptions to the Service Coverage Schedule for 2009/10.

4.3 Service issues

As an input to vulnerable services planning, the Midland region completed a process in April 2009 to identify publicly funded services within the region with short term vulnerability issues (up to June 2010). Our focus for the first year is on hospital services given the government's interest in this area. Vulnerable services are those where significant workforce shortages challenge the viability of the service, create an inability to maintain safe and appropriate quality services, and/or are jeopardised by a lack of critical mass.

The vulnerable services identified have been categorised and assigned to the level (district, regional, national), that should take a lead in ongoing management of the service issues identified. We have also prioritised the services identified according to the risk and impact of service failure, and agreed to an overall priority order within the region.

The Midland region will, over 2009/10, provide regular reports to the Ministry regarding these services including:

- a current action plan for securing ongoing access to these services within the region

- the criteria used to assess vulnerability

- barriers to implementation of longer term, more enduring solutions, where these are apparent.

5.0 MEASURES – DHB Performance Reporting Framework

5.1 Health Targets – Summary Reference Table

Area	Long term Target	2009/10 National target		2009/10 DHB target	
Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	95%	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	95%	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Improved access to elective surgery	Increase the National volume of elective surgery by an average of 4,000 discharges per year (compared with the recent average increase of 1400 per year).	129,000	additional elective surgical discharges	3,969	additional electives surgical discharges
Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.	100%	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).	100%	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).
Increased immunisation	85 percent of two year olds are fully immunised by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012	85%	of two year olds are fully immunised by July 2010	79%	of two year olds (Maori) are fully immunised by July 2010
				79%	of two year olds (Total) are fully immunised by July 2010

Area	Long term Target	2009/10 National target		2009/10 DHB target	
Better help for smokers to quit	80 per cent of hospitalised smokers are provided with advice and help to quit by July 2010; 90 per cent by July 2011; and 95 per cent by July 2012. Introduce similar target for primary care from July 2010 or earlier, through the PHO Performance Programme.	80%	of hospitalised smokers are provided with advice and help to quit by July 2010	80%	of hospitalised smokers are provided with advice and help to quit by July 2010
Better diabetes and cardiovascular services NB All four of these targets are based on an increase of 2% of the actual achieved percentage this year not an increase on the targets set for 2008/2009. Ongoing discussions between the MOH, PHO's & Taranaki DHB to compare PHO Patient Management System data and the Laboratory Warehouse data	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	Baseline 47.1%	49.2%	Increased percent of the eligible adult population (Maori) have had their CVD risk assessed in the last five years (suggestion is 2%)
			Baseline 50%	52%	Increased percent of the eligible adult population (Pacific) have had their CVD risk assessed in the last five years (suggestion is 2%)
			Baseline 66.9%	69%	Increased percent of the eligible adult population (Other ethnicity) have had their CVD risk assessed in the last five years (suggestion is 2%)
			Baseline 62.8%	64.8%	Increased percent of the eligible adult population (All ethnicities) have had their CVD risk assessed in the last five years (suggestion is 2%)

Area	Long term Target	2009/10 National target		2009/10 DHB target	
Better diabetes and cardiovascular services cont'd	Increased percent of people with diabetes attend free annual checks	Increased percent of people with diabetes attend free annual checks	Baseline 41%	59%	Increased percent of people with diabetes (Maori) attend free annual checks
			Baseline 21%	28%	Increased percent of people with diabetes (Pacific) attend free annual checks
			Baseline 59%	71%	Increased percent of people with diabetes (Other Ethnicity) attend free annual checks
			Baseline 56%	69%	Increased percent of people with diabetes (All Ethnicities) attend free annual checks
	Increased percent of people with diabetes have satisfactory or better diabetes management	Increased percent of people with diabetes have satisfactory or better diabetes management	Baseline 73%	74%	Increased percent of people with diabetes (Maori) have satisfactory or better diabetes management
			Baseline 81%	62%	Increased percent of people with diabetes (Pacific) have satisfactory or better diabetes management
			Baseline 81%	85%	Increased percent of people with diabetes (Other ethnicity) have satisfactory or better diabetes management
			Baseline 80%	83%	Increased percent of people with diabetes (All ethnicities) have satisfactory or better diabetes management

5.2 Level 2: Indicator of DHB Performance 2009/10 (IDP's) – Summary Reference Table

DHB Performance Reporting Framework		Level 2: Indicators of DHB Performance 2009/10				
		09/10 Target	Reporting occurring in Quarter			
			Quarter 1	Quarter 2	Quarter 3	Quarter 4
HKO – 01	Local Iwi/Maori are engaged and participate in DHB decision-making and the development of strategies and plans for Maori health gain	Reporting against 7 measures		✓		✓
HKO-03	Improving mainstream effectiveness	Reporting against 2 measures		✓		✓
HKO-04	DHBs will set targets to increase funding for Maori Health and disability initiatives	Reporting against 3 measures				✓
POP-04	Oral health – Mean DMFT score at year 8	Maori Fluoridated - 1.74 Maori Non-fluoridated - 1.94 Other Fluoridated - 1.26 Other non-fluoridated – 1.25			✓	
POP-05	Oral health – Percentage of children caries free at age 5 years	Maori Fluoridated – 47% Maori Non-fluoridated - 37% Other Fluoridated – 69% Other non-fluoridated – 60%			✓	

DHB Performance Reporting Framework		Level 2: Indicators of DHB Performance 2009/10				
		09/10 Target	Reporting occurring in Quarter			
			Quarter 1	Quarter 2	Quarter 3	Quarter 4
POP-06	Improving the health status of people with severe mental illness	0 – 19 years Maori 3.1% * 0 – 19 years Other 3.2% 20 – 64 years Maori 5.2% 20 – 64 years Other 3.5% Over 65 years Maori 3.6% Over 65 years Other 3.6% *This target is aspirational but reflects our intend priority		✓		✓
POP-07	Alcohol and other drug service waiting times	Reporting by ethnicity against 5 measures		✓		✓
POP-10	Chemotherapy treatment waiting times	Maximum 6 week wait for chemotherapy	monthly	monthly	monthly	Monthly
POP-11	Family violence prevention	Overall score of 70/100 in AUT audits for child abuse and partner abuse responsiveness				✓
POP-14	Utilisation of DHB funded dental services by adolescent from Year 9 up to and including age 17 years	Maori – Data not available All – 72% NB There are difficulties in obtaining an accurate baseline figure for 2008/09 and therefore this target may not be achieved.				✓
POP-15	Ambulatory sensitive (avoidable) hospital admissions	Remain below 95% of national average for Maori and other ethnicities for all age groups		✓		✓
POP-17	Improving mental health services	90% all long term consumers in all population groups will have up to date relapse prevention plans.		✓		✓

DHB Performance Reporting Framework		Level 2: Indicators of DHB Performance 2009/10				
		09/10 Target	Reporting occurring in Quarter			
			Quarter 1	Quarter 2	Quarter 3	Quarter 4
POP-18	Improving exclusive and fully breastfeeding rates	6 weeks Maori - 70.3% 6 weeks total - 74% 3 months Total - 54% 6 months Total – 22%	✓	✓	✓	✓
QUA-03	Improving the quality of data provided to National Collections Systems (NCS) – 09/10	NHI duplications less than or equal to 3% Ethnicity not stated in the NHI less than or equal to 4% Standard v specific descriptor ratio of 5.0 or greater NMDS timeliness less than 5% records late		✓		✓
RIS- 01	Service Coverage	Report progress towards resolution of exceptions to service coverage identified in DAP		✓		✓
SER-04	Continuous Quality Improvement – Elective Services	Target minimum intervention rates per 10,000 population: Elective surgical 280 Target minimum intervention rates per 100,000 population: Major joint replacement 210 Hip replacement 105 Knee replacement 105 Cataract procedures 270	✓	✓	✓	✓

DHB Performance Reporting Framework		Level 2: Indicators of DHB Performance 2009/10				
		09/10 Target	Reporting occurring in Quarter			
			Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Continuous Quality Improvement – Elective Services (cont'd)	Cardiac procedures 59 Percutaneous revascularisation - maintain current rate				
SER-07	Low or reduced cost access to first level primary care services	Reporting against 2 measures	✓	✓	✓	✓

5.3 Additional Reporting 2009/10 – Summary Reference Table

DHB Performance Reporting Framework	Additional Reporting 2009/10			
	Reporting occurring in Quarter			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Reducing inequalities achievements (self assessment)		✓		✓
Oral Health			✓	
Delivery of DAP in key priority – confirmation and exception report		✓		✓
DHB Self Evaluation – Provider Arm Efficiency	✓	✓	✓	✓
Update report on delivery of Te Kokiri: the Mental Health and Addiction Action Plan			✓	
Delivery of Personal Health Services and Mental Health Service volumes	✓ mental health only	✓	✓ mental health only	✓
DHB confirmation and exception reports – risk management		✓		✓
Status Updates – Service changes and management of service risks	✓	✓	✓	✓
Global Trigger Tools	✓			✓
Longer Post Natal Stays		✓		✓
Primary Secondary Devolution		✓		✓

6.0 FUNDING ACCOUNTABILITY

6.1 How is Money Allocated to Taranaki District Health Board?

Funding to District Health Boards is allocated on the basis of a Population Based Funding Formula (PBFF). This is a mathematical formula that determines the share of funding to be allocated to different districts in the country, based on the population living in each district. The aim of the PBFF is to fairly distribute available funding between DHB's, according to the relative needs of their populations and the cost of providing health and disability services to meet those needs. Each year the PBFF is reviewed to ensure that it fairly reflects the relative costs of providing health care to different populations.

The key factor in PBFF is the size of the population. However, PBFF takes account of population factors such as age, sex, ethnicity and levels of social deprivation and unmet need, and other factors such as rural areas and numbers of overseas visitors. Every year the population forecast is recalculated and used in the revised PBFF. Changes to PBFF and Taranaki's slower than national average population growth has lead to a sharp reduction in our funding share for the year ahead. Forecast local demographic changes will result in a continued reduction in funding share in the future. These economic factors mean that the District Health Board can no longer provide high levels of sustainability funding to the hospital provider. Similarly health services across the sector will need to be reshaped to meet the needs of the population within the funding available.

Therefore planning and prioritisation has to take place to determine which health and social needs will be met by publicly funded services and which will remain unmet. Our clear focus is to allocate funding to achieve significant health gain in our population and reduce inequalities for those with the poorest health status.

6.2 How Will the District Health Board Prioritise?

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

The health sector is continually changing, sometimes in accordance with changes in health needs, or accepted clinical practice or medical technology. Services which were funded with the intention of reducing health inequalities may not prove to be as effective as originally anticipated. Established services can change, sometimes expanding in an unplanned or uncontrolled way. Growth in expenditure in any service is always at the expense of other services, since health resources are constrained. If the District Health Board does not intervene when unplanned changes are inconsistent with the strategic direction, this leads to prioritisation through inertia. The risk is that major prioritisation decisions are made in this way rather than through a considered prioritisation process.

Taranaki DHB faces the double challenge of delivering and contracting for services which will deliver health improvements for our communities and reduce inequalities, whilst bringing our overall costs within that affordable under our share of PBFF. This will only be achieved through the systematic review of new and existing health investments using an accepted prioritisation and inequalities tool. In 2009/10 the tool

will be used to identify \$4 million disinvestment to enable the Funder to meet known cost pressures.

When considering prioritisation decisions Taranaki District Health Board will apply the following criteria:

Effectiveness: This relates to the extent to which services produce improvements in health status or reduce or prevent a decline in health status. Higher priority will be given to services which produce the greatest improvement to the health status at a population level.

Affordability: This relates to the cost of services and the impact on overall health expenditure relating to achievement of that health gain, to ensure that funding achieves maximum gain.

Equity: This refers to both access and outcome. Can the service be accessed by the target population and does it improve the health status of those with the worst health?

Māori Health: This refers to the degree to which Māori will take up and benefit from the proposal, whether it is appropriate and acceptable to Māori and whether it will reduce disparities between Māori and Non-Māori.

Strategic Fit: This relates to the delivery of health gain in the strategic focus areas outlined in the Taranaki DHB District Strategic Plan 2005-2015, or with the delivery of services required by the Ministry of Health under the Service Coverage Schedule.

Timing of Benefits: This refers to how quickly the benefits will be realised. Highest priority will be given to those proposals which deliver benefits most quickly.

Taranaki District Health Board would like to make all decisions based on good epidemiological data and evidence on outcomes. However, this type of information is not always available and sometimes decisions will have to be made on the best information available. In this situation the Board commits to ensuring fair and accurate representation of the need and benefit; and reasonable estimation of the relative importance or value of proposals. It is also acknowledged that on occasions prioritisation decisions will take place outside the control of the DHB. e.g. through national policy setting or direction from the Minister of Health.

Through the consistent application of these criteria, to all funding decisions, Taranaki DHB aims to deliver both an improvement in health status of the population and affordability of services within the PBFF. The Planning and Prioritisation Panel of the District Health Board provide advice on investment and disinvestment decisions. The Chief Medical Advisor and Director of Nursing are members of this Panel and provide clinical leadership into the deliberations of the Panel.

7.0 Consolidated Financial Summary: 2009 - 2012

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)	2007/08 audited	Year 0 2008/09 forecast		Year 1 2009/10 plan	Year 2 2010/11 plan	Year 3 2011/12 plan
Hospital Provider + Governance Funding (including other income)	156,290	158,647		166,434	171,577	177,359
Non Hospital Provider Funding (NGO)	115,268	128,380		131,988	136,080	140,707
TOTAL FUNDING	271,558	287,027		298,422	307,657	318,066
Hospital Provider + Governance Operating Expenses	159,507	166,252		172,534	177,045	181,149
Payments to Non Hospital Providers (NGO)	112,751	121,030		125,790	130,550	136,424
TOTAL OPERATING EXPENSES & PAYMENTS	272,258	287,282		298,324	307,595	317,573
Hospital Provider + Governance Operating Surplus/(Deficit)	(3,217)	(7,605)		(6,100)	(5,468)	(3,790)
TDHB Funder - Surplus/(Deficit)	2,517	7,350		6,198	5,530	4,283
OPERATING RESULT FOR THE FISCAL PERIOD	(700)	(255)		98	62	493
<i>Expenditure against prior period surpluses (TDHB Funder)</i>						
* Mental Health services	-	-		(837)	(364)	-
* Workforce Development	(562)	(300)		(500)	(233)	(100)
* Māori Health	(31)	(50)		(864)	(1500)	(500)
inequalities project	-	-		-	(100)	(100)
* Hospital Provider strategic projects						
NET CONSOLIDATED SURPLUS/(DEFICIT)	(1,293)	(605)		(2,103)	(2,135)	(207)

Notes:

A: The net consolidated financial result is AFTER recognising the:

- I. expenditure against ring fenced Mental Health surpluses carried forward from prior financial periods,
- II. expenditure on account of Workforce Development initiatives (an appropriation against retained surpluses),
- III. expenditure on Māori Health gains project (an appropriation against retained surpluses), and
- IV. expenditure on strategic Hospital Provider projects (an appropriation against retained surpluses)

The consolidated operating result BEFORE the appropriations against prior period retained surpluses is a financial breakeven position , with an operating surplus of \$0.098M, \$0.062M and \$ 0.49M for the plan periods 2009/10, 2010/11 and 2011/12 respectively.

B: Expenditure against prior period surpluses: These relate to short to medium term investment in strategic services and operations viz. Workforce development (\$ 2.5 Million) and Maori Health inequalities (\$ 3.0 M). These investments were committed by the Board, and will span more than one financial period, and are outside the core annual operating budget. The investment is to be funded out of carried forward surpluses from prior periods. Due to timing, if this committed outlay does not eventuate or is less than what was planned for the period, the financial results of the DHB Funder operations will be favourable to that extent, as also the DHB consolidated result. The Mental Health (MH) expenditure relates to ring fenced surpluses arising from MH services in prior periods that are being expended from carried forward surpluses/reserves (Please also refer to 7.5.1).

C: It is also to be noted that expenditure (\$ 1.44M towards capital charge and depreciation) incidental to the revaluation of assets (per FRS3 - land and buildings) carried out on 30 June 2008 is charged against the hospital provider. This extraordinary expenditure has had a material impact on TDHB's financial and cash positions. No confirmation or commitment for funding this expenditure has been received (this was funded on a cost neutral basis during previous revaluation exercises). The corresponding funding if/when received will improve the hospital provider and also the consolidated financial results by \$ 1.44M in each of the financial periods 2008/09 and plan years 2009/2012 - a significant improvement in the financial results of the DHB.

D: These financial results are to be read with the accompanying notes and assumptions.

7.1 Key Points from the Budgeted Financials 2009-2012

In principle, the Board has planned for a consolidated financial breakeven result in each year of the plan period. However, this financial breakeven goes against the emerging trend across the entire planning period 2009-2012, which clearly indicates that cost growth in the hospital provider operations is significantly in excess of funding received, leaving residual operating deficits. The consolidated surplus is primarily on account of the surpluses generated in the Funder operations during each of the fiscal periods under consideration.

1. The Hospital Provider Arm is facing a budgetary cost to funding gap resulting in operating deficits in each year covered by this plan. This financial gap could increase to \$8.40M in 2009/10 if other identified risks and associated costs (estimated at \$ 2.30M) were to materialise fully. With the residual risk estimated at \$1.70M, the resultant financial gap could be in the region of \$7.75M. (Please refer to the “Sensitivity Analysis” section for details).
2. In applying the stated budgetary assumptions, it is evident that current cost structures in the Hospital Provider have little to offer by way of savings, unless there are structural changes in some of its services, workflows and staffing levels. In view of the increasing cost pressures and risks, the financial budget for the provider arm hinges on the delivery of a number of efficiency initiatives, service changes and staffing movements, which are expected to generate approximately \$3.5M of reduced operating costs during 2009/10. (Please refer the “Efficiency & Productivity Improvements” section for details).
3. Additionally, it is carrying unbudgeted financial risks in many of its cost structures that are likely to materialise in part or full during the plan period. (Please refer to the “Sensitivity Analysis” section for details).
4. The Board therefore recognises that the operating cost to funding gap in the Hospital Provider operations will need to be addressed through options that could result in changes to service configurations, models of care and re-alignment of services within funding available. It acknowledges these changes are essential if the hospital services arm is to remain financially viable and sustainable when faced with increased costs on several fronts.
5. In context of increasing cost structures and continuing operating deficits, it is to be noted that Taranaki DHB is about to embark on a staged redevelopment of the Base Hospital inpatient facilities. There are several compelling reasons to undertake the redevelopment, but none more compelling than the fact that the current hospital layout and structures are not conducive for delivery of complex clinical pathways and modern models of care. Consolidation of specialist services and improved models of care and pathways will result in more efficient use of clinical resources and thereby reduction in core operating costs. The redevelopment will pave the way for a recovery plan for the hospital services to align itself more efficiently – both clinically and financially. The impact will be evident post redevelopment of the base hospital facilities.
6. Likewise, the DHB Funder operations is planning disinvestments totalling \$4 million to enable the DHB Funder operations to manage its costs down and deliver the operating surplus planned for 2009/10. It is also faced with an overall exposure in its contracts estimated at around \$1.0M for 2009/10, with a probability factor leaving a residual risk equating to about \$0.50M. This is in addition to the financial risks carried by the Hospital Services operations. (Please refer the “Sensitivity Analysis” section for details).
7. In the final tally, though the Board is planning a financial breakeven it is faced with:
 - a. a significant cost to funding gap in its Hospital provider operations for 2009/10 (and out years),
 - b. additional financial exposure in its expense budgets which could materialise in part or full

- c. the possibility of having to change or re-align service configurations in its hospital service operations to manage the gap and other potential risks
- d. the financial recovery plan for its hospital provider operations being largely dependent on the redevelopment of the hospital facilities
- e. its Funder operations having to significantly reduce investment in additional services, besides carrying financial risks, and
- f. its consolidated residual financial exposure (besides the hospital provider operating deficit) being circa \$2.20M for the planning period 2009/10, the overall exposure being around \$3.30M

Recognising that additional risks continue to be carried both within and outside the financial budget, Taranaki District Health Board's financial risk assessment of the current District Annual Plan is potentially "medium to high risk" under the assumptions and risks as stated.

7.2 Key Financial Risks

7.2.1 Taranaki DHB's Funder

1. Taranaki DHB will receive an increase in funding of 4.37% for 2009/10, which is the minimum set for all DHB's. (The maximum level of increase for DHBs is set at 7%.) This increase comprises an inflationary rise (forecast funding track), demographic funding of 1.678% and additional revenue as a contribution to ensure that Government commitments are met.
2. Taranaki DHB will receive transitional funding in 2009/10 as population share of minimum set for all DHB's. (The maximum level of increase for DHBs is set at 7%.) funding is lower than historical funding share. Transitional funding was calculated at the funding necessary to take the new PBFF share to the historical funding level plus an increase to cover cost growth. This was then reduced by 1% in line with other "larger" DHBs to provide an incentive for the DHB to move costs towards the PBFF share.
3. The Taranaki DHB share of population based funding has fallen from 2.8% in 2008/09 to 2.76% in 2009/10. Current Ministry calculations project this to decline further to 2.75% in 2010/11 and 2.73% in 2011/12. However future changes to the PBFF could significantly increase the rate of decline in population based funding, as is the case for 2009/10.
4. Overall the funding envelope shows an increase of \$11.43 million over the December 2008 baseline. The increase includes \$7.9 million FFT, \$3.2 million funding to advance Government priorities and \$18,678 demographic growth.
5. Other than FFT, Taranaki DHBs entire increase in funding for 2009/10 is required to be invested in advancing five Government priorities. These are:
 - a. Expanding the availability of subsidised medicines
 - b. Improving the quality of supervision and nursing in rest homes
 - c. Devolution of services to primary care
 - d. Dedicated respite-care beds
 - e. Post-natal stays

Therefore unlike previous years Taranaki DHB has no flexibility in the use of additional funding over and above FFT.

6. Indicative funding increases which are significantly lower than 2009/10, have been advised for out-years:
 - a. 2010/2011 3.1% revenue growth including 2.67% FFT.
 - b. 2011/2012 3.4% revenue growth including 2.67% FFT
7. The starting point used for the local allocation of funding was the 2008/09 allocation, net of IDF inflow and outflow revenue. FFT was been added to at 3.116% and advised allocations for Emergency Ambulance, Primary Maternity and SMO Funding were allocated to the appropriate funding stream. 2009/10 IDF inflow revenue was then added to the corresponding revenue stream and the IDF outflow costs included under planned NGO expenditure. The allocation of funding to advance Government priorities, was also made to the appropriate revenue stream. Finally an assessment of projected demand for services in the NGO sector was made and revenue matched to projected expenditure. The remainder of the funding allocation being that which was considered available for investment in the DHB's strategic priorities and any DHB provider arm increase. However the proposed 2009/10 ISLA allocation to the Provider Arm was \$2 million less than current forecast deficit for 2008/09. No investment was available to advance the DHB's strategic priorities.
8. Unlike 2008/09, there is no funding available in 2009/10 to be held by the Funder as a risk reserve. This will severely limit the Funder's ability to respond to any unexpected demands in-year.
9. Ministry of Health pharmaceutical cancer treatment cost estimates are based on 1 months data. It is assumed that claw back of Herceptin funding by the Ministry of Health will reflect our population share, however this could be higher based on actual usage. (Risk: \$350,000; Probability: 50%)
10. NGO Pharmaceutical budget was reduced by \$200,000 from expenditure estimates in line with available funding (Risk: \$ 200,000; Probability: 50%)
11. IDF plan set by Ministry of Health on actual activity 2 years prior. As at January 2009 there was a \$650,000 shortfall between the IDF plan and actual relating to additional elective activity. This level of additional activity may have to be delivered by Provider Arm if tertiary providers are unable to deliver planned volumes. Costs would be incurred by the Provider Arm ahead of IDF funding wash-up at year end.
12. Taranaki DHB may be unable to meet any imposed targets relating to the new elective cardiac surgery initiative, due to the low number of patients currently on the waiting list at Waikato DHB. (Risk un-quantified)
13. As a consequence of the level of risk identified within the proposed funding allocation, the DHB has determined that reductions in both costs and expenditure are required in 2009/10. The DHBs Funding Prioritisation Policy will be used to identify \$4 million of disinvestments to enable the DHB Funder operations to manage its costs down and deliver the operating surplus planned for 2009/10

In summary, the level of funding allocation may prove insufficient to cover all risks that have been identified. Therefore robust management and monitoring of potential risks will be required and revised management proposals developed if the level of risk rises above that manageable within the funding regime.

7.2.2 Taranaki DHB's Hospital Provider

1. The FFT allocation for 2009/10 is 3.116%. However, the real cost growth in hospital provider services is well in excess of this inflation adjustor. The year on year cost movements across several expenditure lines are on an average between 5% and 7%. This gap between FFT and real cost growth has resulted in a budgetary deficit of \$6.1M after considering all current efficiencies and cost savings. This growth is particularly evident in the following:
 - a. wages – primarily MECA settlements.
 - b. outsourced clinical staff – primarily locum doctors and psychiatrists
 - c. diagnostics
 - d. blood costs, pharmaceuticals, air ambulance retrieval costs
 - e. acute services such as renal, intensive care, mental health inpatient services, emergency services
 - f. increasing cost impacts of statutory compliances, financial standards, quality and accreditation deficits and adherence to a number of new legislative requirements
 - g. general overhead costs – primarily outsourced labour, fuel, materials and utilities.
 - h. Flow on cost impact arising from the depreciation of the NZ\$ on imports primarily clinical equipment, clinical supplies and maintenance items.

Overall, the Hospital Provider's financial plan for the three year period is highly geared and has no flexibility to accommodate unplanned cost movements. On the basis of current trends in expenditure, the issues requiring tight management and efficiency gains are:

Payroll costs make up 60 % of total operating expenditure (excluding interest and depreciation) and have increased significantly over the recent periods. The flow on impacts of MECA agreements together with increase in base rates are in excess of FFT parameters and presents budgetary risks. We estimate this impact to be \$ 0.38M, to be managed to the extent possible through strict FTE planning, attrition and deferment of staff vacancies.

Outsourced clinical staffing costs – mainly locum doctors and psychiatrists. The increasing cost of locums to cover vacancies has been one of the primary contributors to recent period deficits. Whilst it is acknowledged that this is a national issue, the impact on costs at a local level is perhaps more significant. The financial exposure in the 2009/10 budget is estimated at \$0.60M, with best efforts being directed towards more aggressive and extensive recruitment initiatives to fill vacancies and reduce the dependence on locums.

Diagnostic budget – the financial exposure in both radiography services and pathology budgets against current year costs are

estimated at \$0.23M, which is expected to be managed by initiatives to contain volume growth in agreement with our service providers, reduce duplication and enforce clinical access protocols.

The hospital **pharmaceutical** budget has not provided fully for the increasing trends in usage and introduction of expensive new drugs. This exposure, estimated at \$0.10M, is expected to be managed through measures to reduce medication errors, inventory management and operating within dispensing guidelines.

Cost of **clinical supplies and treatment consumables** have been steadily increasing for a variety of reasons. The budgetary risk carried for 2008/09 is expected to be managed by contract re-negotiations and pricing gains generated from the Value for Money (VFM) procurement projects at the local and national level. A point to note is the impact of the depreciating NZ\$ on imports as a risk factor that has the potential to materially influence costs across a spectrum ranging from capital items to clinical supplies.

General operating overheads including travel, training, conferences, stationery, transport, general repairs and such other discretionary costs have once again been subjected to annual reduction in costs through cost control measures. These expense lines are currently budgeted at minimum levels, with a very high probability to exceed the budgetary outlay. Cost growth in most of these lines is driven by external influences. These lines are highly vulnerable to small movements in prices, rates or increase in service levels. Estimated exposure is around \$0.30M, which is expected to be managed through internal controls, contract re-negotiations and cost management processes.

The overall impact is a financial exposure close to \$ 2.30M, with a probability factor leaving \$1.66M as a real and potential risk.

2. In applying the budgetary assumptions we have recognised ongoing quality improvements and those **compliance costs** of which TDHB has been aware. The financial budget is vulnerable to small movements in costs over stated assumptions or increased costs resulting from unforeseen clinical safety and legislative compliance expectations.
3. The Hospital Services Provider is fully dependent on sustainable revenue streams. With over 90% of its revenue derived from health funding (via Taranaki DHB and the Ministry of Health), the Hospital Provider has few alternate income streams for significant revenue growth opportunities. In the 2009/10 budget, there is greater dependence on realising increased revenues from non MOH income streams such as ACC, donations, private patient, interest and other miscellaneous sources.
4. In view of the increasing cost pressures, the financial budget for the provider arm continues to hinge on a number of efficiency gains, which are expected to generate approximately \$3.5M of reduced operating costs during 2009/10. (Please refer the “Efficiency & Productivity Improvements” section for details).

In summary, the gap between funding and the realistic cost model for services has resulted in a very sensitive financial budget for the planning period 2009/10 and out years. In financial terms the budgetary gap in the draft hospital provider budget presented for the period 2009/10 is around \$ 6.1M. The hospital provider will have to

bridge this budgetary gap + realise the efficiency gains and cost reductions targeted if it is to achieve a financial breakeven result.

7.3 Key Financial Strategies

- a. The Hospital Provider Arm is faced with an operating deficit of \$ 6.1M in its 2009/10 operating budget + other financial risks. The hospital provider has identified a number of areas and developed a framework for effecting change. These include, amongst others, plans for:

Integration of Health centre services/facilities with primary care and other providers.

Selective capital investment in Information Technology aimed at improving work flows and processes and releasing FTEs.

Development of regional networks to support effective local service delivery of vulnerable services.

Effective and robust clinical pathways for after hours care.

Focus on chronic disease management strategies.

Service reviews.

Staffing reviews aimed at improving productivity and reduction in core FTEs.

Overall the approach will be to explore a range of practical options including re-configuration of services and facilities with the primary aim of reducing the overall cost of service delivery whilst maintaining access of core services to the people of Taranaki.

- b. These options are being considered in conjunction with the redevelopment of the inpatient facilities at the Base Hospital. The facilities redevelopment is expected to deliver greater workflow efficiencies and an overall reduction in costs in several areas of its operations. Underpinning this redevelopment is the need to configure the facilities to meet the services profile for the future and achieve maximum efficiency and effectiveness of service delivery.
- c. Considering the trends in demand for health services, it is obvious that longer term sustainability, both clinical and financial, will continue to be the key focus for Taranaki DHB. To achieve this balance, Taranaki DHB has embarked on the development of strategies and processes that involve:
- identifying and evaluating referred options to match costs with funding
 - alignment towards a more sustainable clinical services model in line with funding
 - internal cost controls and closer monitoring of operating budgets
 - achievement of systems and process improvements, initiatives and efficiency gains
 - technology driven solutions
 - Sustained focus on longer term strategic plans, whilst continuing to proactively address immediate and medium term risks and issues
- d. Investment and cash outlay for committed strategic initiatives such as Workforce Development, Māori Health Gains and Hospital Provider services projects will continue to be funded below the line using prior period retained surpluses.

- e. Primary sector cost pressures will be mitigated through management of demand driven services and integration of services with providers, while the secondary services align itself.
- f. The hospital provider services will continue to pursue operational efficiencies through initiatives and measures to further reduce its service costs and/or increase non DHB funded revenue.
- g. Cost containment together with focus on cost reduction in primary costs across the hospital provider operations such as staffing and operational overheads will continue to be pursued and managed through a Cost Management Plan.
- h. During the plan period 2009/12, baseline capital expenditure is expected to be contained within annual depreciation accruals, so that additional equity injection or borrowing is not required. The only exception will be funding to support the stages of the hospital redevelopment programme in line with approvals received.

7.4 Key Financial Assumptions

The following key assumptions have been employed in the preparation of the financial statements for the three-year planning period 2009/12.

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

The DAP financial template for the plan period 2009/12 and comparative years have been prepared in accordance with NZIFRS.

7.4.2 Equity and Borrowing

- The District Annual Plan 2009/12 has not assumed any additional Crown equity, other than the capital funding approved to undertake the rollout of the community oral health project (\$ 3.04M) which is being treated as equity.
- Term borrowing from the Crown Health Financing Agency (CHFA) to fund the first stage of the capital redevelopment programme proposed for the inpatient facilities at the Base Hospital has been included in the DAP 2009/12. Approval for Stage 1 (estimated cost: \$ 80M) of the redevelopment was received in July 2008, which includes a CHFA funded borrowing of \$ 45M.
- With the exception of the capital outlay envisaged on inpatient facilities redevelopment as noted above, base line capital expenditure outlay is expected to be contained within the level of depreciation for 2009/10 and the two years following
- Taranaki DHB is on “standard monitoring” status on the performance monitoring scale, and it is assumed that monthly funding will continue to be received in advance.

7.4.3 Wages and Operating Cost Growth

1. Wage costs: in principle, wage budgets for employee groups covered by national MECA settlements are essentially in accordance with the agreement (s) and in line with collective DAP assumptions agreed nationally.

2. Clinical supplies: average 3.0% for 2009/10 + estimated on activity levels + reduced for efficiencies and value for money (vfm) gains.
3. General operating expenditure: average 3.0% for 2009/10 + confirmed outflows + reduced for efficiencies and value for money (vfm) gains.
4. Value for Money (VFM) impacts: the potential impact of efficiencies and cost reductions generated by the national VFM programme has been estimated and built into the relevant operating budgets and expense lines. Other potential gains from local initiatives and projects have also been considered in the relevant expense budgets.

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

7.5.1 Mental Health Services

In keeping with the guidelines received from the MOH on treatment of “Mental Health Ring fence surplus” the amount of any under-expenditure will be reported as a surplus in Taranaki DHB’s Statement of Financial Performance in the year the surplus is generated. Further, the surplus arising will be applied to mental health operating expenditure in the following year and possibly the out years. Accordingly:

1. The forecast financial result reflects separately the impact of mental health expenditure against mental health surplus carried forward from previous years. The forecast spend in 2009/10 is \$837K (partially expending the accumulated surplus as at 30 June 2009), with the carried forward surplus of \$ 364K to be expended in 2010/11.
2. Accordingly, the draft financial budget result for 2009/10 has assumed the impact of mental health surpluses and expenditure against ring fenced surpluses carried forward from prior financial periods.

7.5.2 Mental Health Services and Strategic Initiatives Expenditure

Expenditure on strategic projects and initiatives viz. Workforce Development, Māori Health Gains and Hospital Services Strategic Projects are being funded from prior period retained surpluses and is in line with the strategic direction set by TDHB. In principle, this strategic spend being outside the 12 month fiscal period may result in a financial deficit for the period, however no additional funding or deficit support is being requested by Taranaki DHB to progress these long term initiatives.

7.5.3 Interest Rates

Interest rates have been assumed along current monetary indicators and commitments and averaged as appropriate over the mix of funding streams and options as follows:

	Overdraft	CHFA loans (existing)	CHFA loans (new)	Deposits	Equity
Year 1 (2009/10)	8.00%	6.85%	-	4.00%	8.00%
Year 2 (2010/11)	8.25%	6.85%	5.50%	4.50%	8.00%
Year 3 (2011/12)	8.50%	6.85%	6.00%	5.00%	8.00%

Notes:

1. CHFA existing facility limit is \$ 31M, with \$ 29M drawn down. This is besides the \$ 43M new term debt for Stage 1 of the base hospital redevelopment project approved by CHFA.
2. TDHB has transactional banking arrangements with ASB bank. Approved overdraft facilities are available on stand by basis (uncommitted) with ASB. No financial covenants have been stipulated by ASB for transactional banking and stand by overdraft arrangements.
3. TDHB currently has \$ 29M in term deposits with Kiwi Bank and ASB Bank, which are available to bridge any shortfalls in working capital if required.

7.5.4 Asset Revaluation and its Impact

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

TDHB was required to revalue its land and buildings as @ 30 June 2008 and take into consideration the future carrying values of its buildings incidental to the redevelopment of its base hospital inpatient facilities. The impact of the revaluation was a net increase of \$ 9.01M in its current land and building values, resulting in an increase in capital charge (\$ 740K) and depreciation (\$ 700K). The impact (\$ 1.44M) is already being carried in the financial statements of 2008/09 (Year 0) with no corresponding funding from the MOH (as was provided on a cost neutral basis for previous revaluations).

The impact of the valuation continues to be recognised in the financial statements for 2009/10 with no corresponding increase in funding. The corresponding funding if/when received will improve the hospital provider and also the consolidated financial results by \$ 1.44M in each of the financial periods 2008/09 and plan years 2009/2012 - a significant improvement in the financial results of the DHB.

Since assets have been fully revalued as @ 30 June 2008, it is assumed that any movement in the asset base as at 30 June 2009 is not likely to be material, and accordingly no provision for changes in asset values and related costs have been made.

7.5.5 Depreciation

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

7.5.6 Capital Charge

Capital charges have been calculated in line with existing methodology, adjusted for monthly movements in operating results and closing balance of shareholders fund. There are no capital charge payments outstanding, with the exception of capital charge (full year: \$ 740K) arising from the revaluation of assets as @ 30 June 2008. This fact has been communicated to MOH, the primary reason for withholding this payment being non receipt of funding or other adjustments to the capital charge regime to meet this expenditure.

7.5.7 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.

7.5.8 Financial Covenants and Ratios

There are no specific financial covenants stipulated by the Crown Health Financing Agency (CHFA) for its term lending to TDHB. No financial covenants have been stipulated by ASB for transactional banking and stand by overdraft arrangements. The following are some key financial ratios as derived from the consolidated financial statements for the period 2009 to 2012.

	Financial ratios	TDHB 2008/09	TDHB 2009/10	TDHB 2010/11	TDHB 2011/12
		forecast	plan	plan	plan
1	Revenue to net funds employed	4.57	2.85	2.08	2.16
2	Operating margin to revenue	4%	4%	3%	4%
3	Operating return on net funds employed	10%	10%	7%	8%
4	Debt to debt equity ratio	28%	28%	50%	50%
5	Interest cover ratio	4.57	5.08	5.10	6.09

7.5.9 Changes in Accounting Policies

There have been no changes from the accounting policies adopted in the last audited financial statements other than the changes brought about by the adoption of NZIFRS in the financial statements. All policies have been applied on a basis consistent with the previous period. These are detailed in the Statement of Intent for 2009/10.

7.5.10 Capital Investment

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

Capital Outlay	Year 1 (2009/2010)	Year 2 (2010/2011)	Year 3 (2011/2012)	Total (2009/2012)
Clinical Equipment	1,600	1,600	2,000	5,200
Other Equipment	500	350	450	1,300
Motor Vehicles	50	50	50	150
Minor Site Redevelopment (excluding prior year WIP)	1,350	500	500	2,350
Major Site Redevelopment: (Base Hospital - inpatient facilities)		See separate section for details	See separate section for details	
SUB - TOTAL	3,500	2,500	3,000	9,000
Information Technology (100% subsidiary - HIQ Ltd)	2,000	2,000	2,000	6,000
TOTAL (operational)	5,500	4,500	5,000	15,000
Community Oral Health Project	2,871	171	-	3,042
Base Hospital redevelopment project	-	40,000	40,000	80,000
GRAND TOTAL	8,371	44,671	45,000	98,042
Source of Funding				
Crown Equity	2,871	171	0	3,042
Bank Borrowing	0	0	0	0
CHFA Term Loans	0	40,000	5,000	45,000
Internal Cash Accruals	5,500	4,500	40,000	50,000

Note: Effective 01 July 2009, HIQ Ltd the JV between Capital & Coast DHB and Taranaki DHB (50/50 shareholding) for delivery of ICT services will change its structure and become a fully owned subsidiary of TDHB. Outlay on Information and Communication Technology (ICT) is related to capital investment in HIQ Ltd as a 100% subsidiary of TDHB.

7.5.11 Capital Divestment

The disposal of surplus assets proposed during the period 2009/12 is as follows:

Asset	Book value (\$)	Realisable Value (\$)	Gain/(loss) On sale (\$)	Timing
Miscellaneous equipment	50,000	50,000	-	2009/10
Total	50,000	50,000	-	2009/10

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.

7.5.12 Personnel

A: Paid / contracted / core FTEs:

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

	2008/09 forecast	2009/10 plan	2010/11 plan	2011/12 plan
Medical	117	129	129	130
Nursing	504	492	492	485
Allied Health	244	242	240	240
Support	90	89	89	87
Management & Admin	245	233	230	228
Average worked FTE's	1200	1185	1180	1170
Subsidiary: HIQ Ltd (Category: Mgt & admin)	30	33	33	33
Oral health + other national projects	0	10	15	15

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

There is an overall decrease in total worked FTE planned for 2009/10 relative to 2008/09. Medical FTE count will increase on the assumption that vacancies are likely to be filled over the coming period in lieu of locum cover. Reduction in nursing staff is primarily due to service reviews + review of nursing support for one on one care and the use of casuals. Movements in allied health and support staff are incidental to the outcome of service reviews that would result in reduction of FTEs. Likewise, reduction in Management and Administration

staff are aimed at reduction in back office and administration staff arising from efficiency reviews currently being progressed.

Effective 01 July 2009, HIQ Ltd (currently a JV with Capital & Coast DHB with equal shareholding) will become a fully owned subsidiary of Taranaki DHB, and accordingly the FTE component of HIQ is indicated separately. Likewise, the likely FTE's related to the Community Oral Health project and other national initiatives (HPV and B4 school etc) are indicated.

The baseline average worked FTE count is 1,185 FTE, 1,180 FTE and 1,170 FTE for the plan periods 2009/10, 2010/11 and 2011/12 respectively.

In principle, the personnel budget has not planned for FTE increases – rather a phased reduction in FTEs to manage the overall wage bill carried by the DHB. Though there will be movements relating to vacancies, specific increases in clinical activity (additional elective services) and changes in service specifications, reductions planned in other staff lines should result in net decrease in the core FTE base. Whilst the strategy is to cap FTE growth, it is acknowledged that there is likely to be demand for clinical resources due to an expected increase in normal activity levels – both acute and elective. Additionally, as the current year statistics indicate, there has been an increase in specialising patients (one on one care) in ICU and mental health inpatient admissions. Measures and initiatives are being worked through to increase productivity of existing staff and reduce the demand for locums and casual staff within the hospital and specialist services

B: Accrued FTEs:

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

	2008/09 forecast	2009/10 plan	2010/11 plan	2011/12 plan
Medical	131	144	144	146
Nursing	526	514	514	506
Allied Health	252	249	247	247
Support	92	91	91	89
Management, admin & DHB P&F	249	237	234	232
Average Accrued FTE's	1250	1236	1231	1220
Subsidiary: HIQ Ltd (Category: Mgt & admin)	32	34	34	34
Oral health + other national projects	0	11	16	16

7.5.13 Capital Expenditure 2009/10 (operating)

The capital expenditure for Year 2009/10 envisages an outlay of \$5.50M. The capital expenditure movement against the outlay for 2008/09 is:

(\$'000)	2008/09 (Plan)	2009/10 (Plan)	Movement (+/-)
Clinical equipment	1,800	1,600	- 200
Other equipment	500	500	-
Motor Vehicles	100	50	- 50
Site redevelopment (minor)	1,800	1,350	-450
SUB TOTAL	4,200	3,500	-700
Information Technology. (HIQ Ltd)	1,800	2,000	+ 200
TOTAL	6,000	5,500	--500
Contingency	1,000	1,000	-

Overall capital expenditure is budgeted to decrease marginally in 2009/10 vis-a-vis the current financial year, with small movements between the expenditure lines.

Capital outlay on Information Technology is tipped to increase in the coming year

The capital expenditure budget (\$5.50M) is prioritised to remain within the base line depreciation for 2009/10 (\$8.50M), enabling it to be financed through internal cash accruals whilst leaving sufficient contingency funds for unplanned capital expenditure and improving residual cash reserves

Minor site redevelopment activity in 2009/10 will trend down in view of the redevelopment of the inpatient facilities. The plan envisions a host of minor work across the site, primarily in clinical wards to improve work flows, meet compliance deficits, strengthening of structures, ventilation etc. Some capital works in progress during the current year is also likely to spill over to the next financial year. The Board will continue to seek financial support from local community trusts to progress some of the redevelopment activities proposed during the plan period 2009/12.

The proposed outlay on clinical equipment is \$1.6M, mainly replacement of obsolete and unsafe clinical equipment and continuation of a phased programme for replacement of expensive theatre equipment and beds.

Proposed outlay on non clinical equipment is along similar lines as the current year.

Capital outlay proposed for Information Technology investment in HIQ Ltd (JV with CCDHB for provision of ICT services) is increased to \$ 2.0M. The major costs relate to the ongoing programme for replacement of desktop hardware, software upgrades, new applications and storage devices. Additionally, an outlay of \$0.2M is earmarked specifically towards strengthening the Disaster Recovery (DR) capabilities to balance risks against loss of computing services or in the event of a natural disaster.

Capital outlay on motor vehicles has reduced significantly upon completion of the vehicle replacement programme (commenced in 2005/06) for the transport fleet.

The capital expenditure related to the rollout of the community oral health project is being separately funded by the MOH in line with an approved business case. The outlay of \$ 2.87M in 2009/10 is towards fixed and mobile dental facilities, and related clinical equipment.

In summary, the year 2009/10 will reflect levels of capital spending within internal cash resources. In parallel, Taranaki DHB has commenced planning for the re-development of its inpatient facilities at Base Hospital in New Plymouth for which approval has been received. This is discussed in more detail below.

7.6 Major Capital project: Base Hospital Inpatient Facilities Development Programme

The Base Hospital located in New Plymouth, like many of other contemporary hospitals across New Zealand is a conglomeration of buildings spread across the site with little relationship to patient flows and clinical processes. This coupled with capacity constraints and the urgent need to bring existing structures to the standards found in hospitals elsewhere in New Zealand as also in line with modern practices in clinical safety and patient care is the primary reason supporting the case for capital investment.

In addition, the key drivers that supplement this case are:

1. Theatre capacity – which will allow contracted volumes to be met and for models of care that optimise Day Surgery flows.
2. Ambulatory/outpatient service development – which will consolidate services and allow for the best models of care to be used.
3. Seamless integration between the primary and secondary healthcare settings – which will link primary and secondary models of care.
4. Consolidation of Emergency and Acute Assessment services – which will provide for the best models of care for disposition of ED patients between the primary and secondary sectors.
5. Services for the elderly/rehabilitation models – which will support early entry for assessment and discharge using modern models of care.
6. Consolidation of specialist services (Maternity, Paediatrics and NNU) – which will enable co-location of services and allow optimum efficiencies to be realised by bringing patients closer to the theatre area for urgent surgery situations.
7. Upgrade of inpatient accommodation and provision of sufficient beds over the next 10-15 years – which will enable modern models of care in purpose built inpatient wards.
8. The age and design features of the Clinical Services building indicate that their seismic performance is expected to be significantly below that required by current standards, and therefore it is quite likely that the building is Earthquake Prone. Legally, the Territorial Local Authorities are empowered by the Act to order strengthening or closing down of such buildings.

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

7.6.1 Proposed Capital Outlay:

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

	Stages	Comprising	Estimated Cost	Construction Timeline	Status
1	STAGE 1	Theatres, Ambulatory, Inpatient wards	\$80M	Start: Jul 2010 Finish: Jun 2012	Approval received in July 2008.
2	STAGE 2	Maternity, Neonatal, Paediatrics, ED	\$37M	Tentative: Jul 2013	Supplementary business case will be progressed later
3	STAGE 3	OPD, Laboratory, CSD, Administration	\$28M	Tentative : Jul 2014	Supplementary business case will be progressed later
	TOTAL		\$145M	Jul 2010 – Dec 2015	

Notes:

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

7.6.2 Financing Plan for Stage 1:

The plan for financing Stage 1 is as follows:

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

Notes:

Project capital cost:

1. The cost of the project is based on the concept design, with the cost estimate prepared by Rider Levett Bucknall (Quantity Surveyors) as at August 2007.
2. The project capital includes the cost of site preparations, construction, building infrastructure, design and consultant fees, project management, fit-outs and the costs associated with decanting.
3. The above costs exclude capitalised interest. Interest will be capitalised at the relevant cost of borrowing up to the date of commissioning the facilities.
4. This cost estimate has an assessed accuracy under current building cost market conditions of +/- 20%, which is considered acceptable in the absence of detailed design drawings, projected timelines and architectural inputs.
5. This cost estimate has been independently reviewed and revisions incorporated as appropriate.

Internally generated funds:

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

Net external borrowing and source:

8. It is TDHB's intention to borrow \$45M in the form of debt financing. Financial analysis indicates that with the current CHFA financed debt (\$ 29M) + fresh borrowing (\$ 45M); the debt equity ratio (currently 28%) is able to be maintained within an acceptable range.
9. CHFA has advised TDHB that the term loan of \$43m (with the balance \$ 2M to come from the unutilised limit with CHFA) has been approved by their Board and draft loan facility and related documents have been forwarded for TDHB to review and complete. The loan documents also include tentative timelines for draw down of the approved facility, which subject to final peer review and approval of the detailed design, is expected to commence around July 2010. The lending quantity surveyor (LQS) appointed by CHFA has completed a site visit and has communicated his satisfaction of the progress to date.

Key dates and timelines

Project planning and related activities have commenced. The tentative dateline for construction to commence is July 2010.

Asset Management Plan (AMP)

The first AMP for Taranaki DHB was completed and forwarded for review in October 2005, with subsequent reviews and updates. An inpatient facilities redevelopment programme has been developed to support the planned clinical and health services by the secondary services and linkages with primary services. Stage 1 of the programme has been given approval to proceed, with allocation of funding to support the redevelopment. Whilst the AMP is an evolving document and strategic in content, it will be matched against the projected financial capability of the DHB to support the development programme, besides integration and co-ordination with the capital investment plans of regional and neighbouring DHBs. An updated AMP will be provided by May 2009.

7.7 Efficiency and Productivity Improvements

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope. In addition, it has to balance its long-term strategies with short-term objectives while continuing to provide a clinically safe and quality service. The DHB will also be faced with managing the redevelopment of its base hospital facilities scheduled to commence in the 2010/11 fiscal year. Under this capped environment, with increasing operating costs and demand for services, the hospital provider arm will need to achieve sustainability – both clinical and financial. Taranaki DHB recognises the need for continuous service improvements and efficiency gains while it attempts to re-position itself continually to meet the challenge.

The strategy is to pursue short term initiatives to provide immediate gains, while progressing a series of longer term initiatives to achieve sustainability.

The following key initiatives are expected to result in efficiency gains and reduced operating costs within the hospital provider arm during 2009/10:

	Initiative	Proposal	Potential (\$)	Impact
1	Reduction of outsourced services costs	Bringing in-house services currently outsourced	\$ 300K	Reduce service cost
2	Manage Clinical supply costs.	Efficiency reviews + contract negotiations + VFM initiatives	\$ 300K	Contain cost growth
3	Staffing reviews and alignment of services to funding + FTE's.	Efficiency & process reviews + reduction of FTE's	\$ 1,800K	Contain cost growth + FTE reduction
4	Reduce General Operating overheads	Internal cost controls + capped budgets	\$ 200K	Contain cost growth
5	Management of FTE's through vacancies	Active review and FTE reduction by attrition.	\$ 900K	Contain cost growth + FTE reduction
	TOTAL		\$ 3,500K	

The DAP 2009/10 has recognised the efficiency and reduced cost impacts of the above initiatives in the financial budget. The gains from these initiatives are also expected to flow into future periods and have been recognised in the out years.

In parallel, the focus is on the redevelopment of the facilities. The primary aim of this project is to generate efficiencies and improvements to prevalent models of care through consolidation of hospital services and systems into a more compact footprint. This will in turn lend more flexibility and efficiency to operations. Overall, the project should generate more permanent and sustainable results.

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

7.8 Debt and Equity

The current debt profile of Taranaki DHB is four term loans totalling \$29M with the Crown Health Financing Agency (CHFA), drawn down against an approved loan limit of \$31M. The primary assumptions carried in the financial plan 2009/10 are:

- a) No overdraft borrowing for working capital requirements is envisaged (though a backup facility with ASB is available if required – financial covenants will be stipulated only upon utilisation of this facility), on the assumption that TDHB will remain under “standard monitoring” and continue to receive it's funding in advance.
- b) The draft DAP 2009/10 has not budgeted for any additional equity (other than capital funding of \$ 3.04M in total for the community oral health project which is being treated as equity injection) or debt. It is expected that base line capital expenditure will be contained within the level of depreciation for 2009/10. Additional borrowing from CHFA (\$ 45M) to partially finance the first stage of the Base Hospital redevelopment has been approved, and subject to final reviews and costings of the final design is planned to be drawn down over the 2010/11 and 2011/12 plan periods.
- c) The operating budget of the Board for 2009/10 has planned for a consolidated financial breakeven, before recognising the impact of expenditure against prior period surpluses in mental health services, workforce development and strategic projects. The financial breakeven is assumed in context of the

financial risks and sensitivity indices highlighted in the plan, and exploration of options to manage the financial risks carried in both the Hospital provider and the DHB Funder operations.

- d) It is assumed that from an operational perspective, the timing for realisation of all the efficiency gains and cost reductions contemplated may extend beyond a 12 month financial planning framework. Any residual operating deficit (in addition to the deficit arising from expenditure on Mental Health and strategic projects and initiatives) arising from a timing perspective will be managed from internal cash reserves. No additional equity or deficit support is envisaged.

7.9 Sensitivity Analysis

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:

For DHB Hospital Provider operations:

Unbudgeted financial risk	Est. risk (\$M)	75% risk (\$M)	50% risk (\$M)	25% risk (\$M)	Probability factor (% risk)
General Wages + MECA impacts	0.50	0.38	0.25	0.13	75%
Outsourced locum costs	0.80	0.60	0.40	0.20	75%
Diagnostic costs	0.30	0.23	0.15	0.08	75%
Pharmaceuticals	0.20	0.15	0.10	0.05	50%
General overheads	0.40	0.30	0.20	0.10	75%
Quality & compliance costs	0.10	0.08	0.05	0.03	50%
Likely impact on 2009/10 planned financial result	\$2.30M	\$1.73M	\$1.15M	\$0.58M	\$1.66M

The analysis estimates an overall exposure of circa **\$2.30M** for 2009/10, 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 **\$1.66M**. The risk is expected to be managed through a mix of:

Internal cost controls,
 Management of FTEs,
 Operational savings in discretionary expense lines,
 Achievement of initiatives and efficiency projects,
 Other options (under consideration).

Likewise, for DHB Funder operations:

Unbudgeted financial risk	Est. risk (\$'M)	75% risk (\$'M)	50% risk (\$'M)	25% risk (\$'M)	Probability factor (% risk)
IDF Outflows	0.50	0.38	0.25	0.13	50%
Pharmaceutical Cancer Treatments	0.35	0.27	0.18	0.09	50%
Other Pharmaceuticals	0.20	0.15	0.10	0.05	50%
Likely impact on 2009/10 planned financial result	1.05	0.80	0.50	0.25	0.53M

The overall exposure is estimated at around **\$1.0 M** for 2009/10, while the probability factor is estimated to be around 50% leaving a residual risk equating to about **\$0.50M**.

Other areas of risk which cannot be quantified have also been identified, and include:

- Over delivery of volumes by the Provider Arm
- Failure to meet cardiac surgery targets impacting on overall funding of additional elective activity

This risk is expected to be managed within funding parameters and through efficiency gains from current NGO contracts.

7.10 DAP Financial Summary

TARANAKI DISTRICT HEALTH BOARD

DISTRICT ANNUAL PLAN : 2009/12

	Year -1	FORECAST		Year 0	(\$'000)					Year 1	%
	Consolidated Audited 2007/08	Hosp+Gov Forecast 2008/09	Funder Forecast 2008/09	Consolidated Forecast 2008/09	Provider Plan 2009/10	Govt Plan 2009/10	Hosp+Gov Plan 2009/10	Funder Plan 2009/10	Consolidated Plan 2009/10	change	
REVENUE											
* MOH funding	133961	141377		141377	149982	0	149982		149982	6.1%	
	115268		124376	124376				127983	127983	2.9%	
* Funding & Governance	2094	2163		2163	0	2230	2230		2230	3.1%	
* ACC Revenue	8316	7828		7828	8629	0	8629		8629	10.2%	
* CTA revenue	1274	1518		1518	1512	0	1512		1512	-0.4%	
* Other revenue	10645	5761	4004	9765	4081	0	4081	4005	8086	-17.2%	
TOTAL REVENUE	271558	158647	128380	287027	164204	2230	166434	131988	298422	4.0%	
EXPENDITURE											
Personnel costs											
- medical	19483	21636		21636	24171	0	24171		24171	11.7%	
- nursing	36705	36509		36509	36598	0	36598		36598	3.1%	
- allied health	14636	15405		15405	15981	0	15981		15981	3.7%	
- support	3617	3854		3854	4137	6	4143		4143	7.5%	
- mgt & admin	13208	14150		14150	13788	1364	15152		15152	7.1%	
total	86649	90554	0	90554	94675	1370	96045	0	96045	6.1%	
Outsourced services											
- clinical services	18955	19396		19396	18140	0	18140		18140		
- other outsourced	3976	2948		2948	2158	200	2358		2358		
total	22931	22344	0	22344	20298	200	20498	0	20498	-8.3%	
Clinical supplies											
- treatment disposables	7182	7177		7177	7229	0	7229		7229	0.7%	
- diagnostic supplies	1140	1218		1218	1214	0	1214		1214	-0.3%	
- instruments & equip	586	670		670	680	0	680		680	1.5%	
- patient appliances	1066	1151		1151	1123	0	1123		1123	-2.4%	
- implants & prostheses	2571	2779		2779	2596	0	2596		2596	-6.6%	
- pharmaceuticals	3669	4422		4422	6576	0	6576		6576	48.7%	
- other clinical & client costs	2237	2346		2346	2325	0	2325		2325	-0.9%	
total	18451	19763	0	19763	21743	0	21743	0	21743	10.0%	

Infrastructure & other op.costs									
- hotel services & laundry	2872	3196	3196	3450	0	3450	3450	7.9%	
- facilities	3107	3149	3149	3407	0	3407	3407	8.2%	
- transport	1103	1101	1101	1325	50	1375	1375	24.9%	
- IT systems & telecom	5583	6529	6529	3410	0	3410	3410	-47.8%	
- professional fees	1561	1283	1283	1401	166	1567	1567	22.1%	
- other op.expenses	1978	1193	1193	2085	72	2157	2157	80.8%	
- democracy	340	268	268	4	314	318	318	18.7%	
- depreciation	7599	8350	8350	10444	0	10444	10444	25.1%	
- interest	2036	2171	2171	2045	0	2045	2045	-5.8%	
- associate company income	-24	0	0	0	0	0	0		
- Payment to - NGO providers									
- personal health	74265	79896	79896			83182	83182		
- mental health	6747	8444	8444			8368	8368		
- disability support services	30253	30619	30619			31994	31994		
- public health	32	203	203			301	301		
- maori health	1454	1868	1868			1945	1945		
total	138906	27240	121030	27571	602	28173	125790	153963	3.8%
TOTAL OPERATING EXPENSES	266937	159901	121030	164287	2172	166459	125790	292249	4.0%
SURPLUS before capital charge	4621	-1254	7350	-83	58	-25	6198	6173	
- Capital charge	5321	6351	6351	6075	0	6075	6075	6075	-4.3%
SURPLUS (before strategic exp)	-700	-7605	7350	-6158	58	-6100	6198	98	
STRATEGIC EXPENDITURE									
Mental health Ring-fenced surplus	0	0	0			837	837		
Workforce Development	562	300	300			500	500		
Maori Health Gains Project	31	50	50			864	864		
Hospital Provider Strategic Projects	0	0	0			0	0		
NET SURPLUS/(DEFICIT) (after strategic expenditure)	-1293	-7605	7000	-6158	58	-6100	3997	-2103	
Interest Cover ratio									
Interest Cover ratio	4.10		4.57				5.08		
Revenue to Net Funds employed									
Revenue to Net Funds employed	2.59	1.52	2.75	1.57			2.85		
Operating margin to Revenue ratio									
Operating margin to Revenue ratio	3%	2%	4%	4%			4%		
Op. return on Net Funds employed									
Op. return on Net Funds employed	8%	3%	10%	6%			10%		

DAP 2009/10 Final
TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2009/12

	Year 2				%	change	Year 3				%	change
	Provider	Govt	Funder	Consolidated			Provider	Govt	Funder	Consolidated		
	Plan 2010/11	Plan 2010/11	Plan 2010/11	Plan 2010/11			Plan 2011/12	Plan 2011/12	Plan 2011/12	Plan 2011/12		
REVENUE												
* MOH funding	154629	0	131950	154629 131950	3.1%		159894	0	136454	159894 136454	3.4%	
* Funding & Governance	0	2299		2299	3.1%		0	2377	0	2377	3.4%	
* ACC Revenue	8888	0		8888	3.0%		9155	0	0	9155	3.0%	
* CTA revenue	1557	0		1557	3.0%		1604	0	0	1604	3.0%	
* Other revenue	4203	0	4129	8333	3.0%		4330	0	4253	8583	3.0%	
TOTAL REVENUE	169278	2299	136080	307657	3.1%		174982	2377	140707	318066	3.38%	
EXPENDITURE												
Personnel costs												
- medical	24896			24896	3.0%		25643	0		25643	3.0%	
- nursing	37696			37696	3.0%		38827	0		38827	3.0%	
- allied health	16462			16462	3.0%		16956	0		16956	3.0%	
- support	4261	6		4267	3.0%		4389	6		4395	3.0%	
- mgt & admin	14202	1405		15607	3.0%		14628	1447		16075	3.0%	
total	97517	1411	0	98928	3.0%		100443	1453	0	101896	3.0%	
Outsourced services												
- clinical services	18684			18684			19245	0		19245		
- other outsourced	2223	206		2429			2289	212		2502		
total	20907	206	0	21113	3.0%		21534	212	0	21746	3.0%	
Clinical supplies												
- treatment disposables	7525			7525			7751	0		7751		
- diagnostic supplies	1250			1250			1288	0		1288		
- instruments & equip	700			700			721	0		721		
- patient appliances	1157			1157			1191	0		1191		
- implants & prostheses	2674			2674			2754	0		2754		
- pharmaceuticals	6773			6773			6976	0		6976		
- other clinical & client costs	2395			2395			2467	0		2467		
total	22474	0	0	22474	3.4%		23149	0	0	23149	3.0%	

Infrastructure & other op.costs										
- hotel services & laundry	3554			3554		3617	0		3617	
- facilities	3509			3509		3114	0		3114	
- transport	1365	52		1416		1406	53		1459	
- IT systems & telecom	3512			3512		3618	0		3618	
- professional fees	1443	171		1614		1486	185		1671	
- other op.expenses	2146	74		2220		2274	76		2350	
- democracy	4	323		328		4	333		337	
- depreciation	10444			10444		10444	0		10444	
- interest	2026			2026		2011	0		2011	
- associate company income	0			0		0	0		0	
- Payment to - NGO providers										
- personal health			86664	86664			91183		91183	
- mental health			8628	8628			8919		8919	
- disability support services			32954	32954			33946		33946	
- public health			310	310			319		319	
- maori health			1993	1993			2056		2056	
total	28002	620	130550	159172	3.4%	27974	648	136424	165046	3.7%
TOTAL OPERATING EXPENSES	168901	2237	130550	301688	3.2%	173100	2313	136424	311837	3.4%
SURPLUS before capital charge	377	62	5530	5969		1882	64	4283	6229	
- Capital charge	5907	0		5907	-2.8%	5736	0	0	5736	-2.9%
SURPLUS (before strategic exp)	-5530	62	5530	62		-3854	64	4283	493	
STRATEGIC EXPENDITURE										
Mental health Ring-fenced surplus			364	364				0	0	
Workforce Development			233	233				100	100	
Maori Health Gains Project			1500	1500				500	500	
Hospital Provider Strategic Projects			100	100				100	100	
NET SURPLUS/(DEFICIT) (after strategic expenditure)	-5530	62	3333	-2135		-3854	64	3583	-207	
Interest Cover ratio				5.10					6.09	
Revenue to Net Funds employed	1.15			2.08		1.19			2.16	
Operating margin to Revenue ratio	4%			3%		5%			4%	
Op. return on Net Funds employed	5%			7%		6%			8%	

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2009-12

CONSOLIDATED STATEMENT OF FINANCIAL POSITION

(\$'000)

	2007/08 audited	2008/09 forecast		2009/10 plan	2010/11 plan	2011/12 plan
CURRENT ASSETS						
* Bank Account	5971	3104		3704	8704	13704
* Prepayments +ST investments	23142	30147		35147	35147	147
* Debtors (net of provision)	10167	10150		10150	11150	12150
* Inventory	2352	2395		2395	2495	2595
	41632	45796		51396	57496	28596
CURRENT LIABILITIES						
* Creditors & other payables	18365	19940		18830	10782	11581
* Term Loans (current portion)	216	244		244	244	54
* Provisions	18146	17257		18457	18957	19457
	36727	37441		37531	29983	31092
WORKING CAPITAL	4905	8355		13865	27513	-2496
NON CURRENT ASSETS						
* Net Fixed Assets	94760	90684		85740	114996	144752
* Investments	4681	4597		4597	4597	4597
* Trust funds	671	671		671	671	671
	100112	95952		91008	120264	150020
NET FUNDS EMPLOYED	105017	104307		104873	147777	147524
NON CURRENT LIABILITIES						
* Provisions - non current	592	580		580	580	580
* Finance Leases (Term portion)	480	387		185	53	7
* Term Loans	29000	29000		29000	74000	74000
	30072	29967		29765	74633	74587
CROWN EQUITY						
* Crown Equity	23898	23898		26769	26940	26940
* Reserves	52559	52576		52576	52576	52576
* Retained earnings	-1512	-2134		-4237	-6372	-6579
	74945	74340		75108	73144	72937
NET FUNDS EMPLOYED	105017	104307		104873	147777	147524
Debt: Debt equity ratio	28%	28%		28%	50%	50%

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2008-11

CONSOLIDATED STATEMENT OF CASHFLOWS

(\$'000)

	2007/08 audited	2008/09 forecast		2009/10 plan	2010/11 plan	2011/12 plan
<u>OPERATING ACTIVITIES</u>						
* MOH funding	250479	269571		281707	289536	299427
* Other revenue	15951	14740		15355	15820	16864
total receipts	266430	284311		297062	305356	316291
* Payment of salaries & operating exp.	150282	157539		160377	166451	170165
* Payment to providers & DHB's	112366	121236		129614	140559	136654
total payments	262648	278775		289991	307010	306819
NET CASHFLOW FROM OPERATIONS	3782	5536		7071	-1654	9472
<u>INVESTING ACTIVITIES</u>						
* Interest Received	3010	2852		1360	1401	875
* Sale of fixed assets etc	40	0		50	0	0
* (Increase) / decrease in investments	-4408	-6990		-5050	0	35000
* Capital expenditure	-4471	-4200		-5500	-39700	-40200
NET CASHFLOW FROM INVESTING	-5829	-8338		-9140	-38299	-4325
<u>FINANCING ACTIVITIES</u>						
* Equity injections / repayments	-853	0		2871	171	0
* Private sector borrowings	333	0		0	45000	0
* Payment of debts	-20	-65		-202	-218	-147
NET CASHFLOW FROM FINANCING	-540	-65		2669	44953	-147
Total cash in	265890	284246		299731	350309	316144
Total cashout	-268477	-287113		-299131	-345309	-311144
NET CASHFLOW	-2587	-2867		600	5000	5000
Add: Cash (opening)	8558	5971		3104	3704	8704
CASH (CLOSING)	5971	3104		3704	8704	13704

TARANAKI DISTRICT HEALTH BOARD
DISTRICT ANNUAL PLAN : 2009-12

CONSOLIDATED STATEMENT OF MOVEMENT IN EQUITY

	2008/09 forecast		2009/10 plan	2010/11 plan	2011/12 plan
EQUITY AT THE BEGINNING OF PERIOD	74945		74340	75108	73144
* Net results for the period	-605		-2103	-2135	-207
* Revaluation of Fixed assets	0		0	0	0
* Equity Injections / (repayments)	0		2871	171	0
* Other	0		0	0	0
EQUITY AT THE END OF THE PERIOD	74340		75108	73144	72937

8.0 Elective Services Plan – 2009/10 – Taranaki DHB

Outcome	Supporting Information required:	Actions	Timeframes	Measures	Accountability
Minimum Service Requirements					
<p>A 3.3 percent increase over total planned elective services in 2008/09; or A 20 percent increase over base, including minimum joint, cataract and cardiac surgery increases And A 5 percent increase in first specialist assessments (FSAs)</p>	<p>Regional agreement for IDF volumes Private arrangements for additional capacity Any issues related to ESPI compliance or follow ups</p>	<p>TDHB have submitted the additional electives initiative template describing 21% increase in additional elective discharges over and above the 05/06 base volumes. This amounts to an additional 844 discharges above the base of 3,921. See appendix 1 below This template also outlines plan to increase FSA's by 5%. No further private arrangements are required to assist us in meeting these targets. ESPI compliance remains outstanding and our intention is to maintain this.</p>	12 months	20% increased delivery in electives discharges and 5% increase in FSAs	Provider Arm of TDHB
Identified service level increases, including type and mix of procedure	<p>Clinical endorsement of plans Marginal analysis / local knowledge SIR evidence Identified access constraints</p>	<p>The documentation following this table received from the MoH, (appendix 2) identifies that TDHB is at or above the National Discharge Rate per 10,000 for all services with the exception of cardiac and Plastics. We have addressed the issue of cardiac by increasing expected case weighted volume and FSAs over the 2005/06 base. Plastics is driven by IDF to tertiary hospital(s), we intend to review the demand and referrals within this service over the coming year. As a result we have spread the expected additional volumes across the following services: General Surgery (cwd & FSA) , ENT (cwd), Orthopaedics (cwd & FSA from 08/09 delivery), Endoscopy procedures, Urology (FSA), Cardio Thoracic – modest increase over 2005/06 base to partially meet MoH requirement for</p>	12 months	Evidence of increase applied to the various services as outlined	Provider Arm of TDHB

Outcome	Supporting Information required:	Actions	Timeframes	Measures	Accountability
		<p>increase to this service area.</p> <p>As per advice received from MoH we have built this plan on the assumption that if IDFs under perform we are able utilise the available funding to ask our Provider Arm to contribute to the overall additional elective volumes.</p> <p>See Appendix 3 for clinical endorsement letter. See appendix 4 for the clinical engagement plan.</p>			
Capacity					
Capacity Analysis completed, to identify actual capacity, and potential capacity (including surplus capacity)	Barriers and incentives identified	<p>TDHB have embarked on a theatre throughput project to establish capacity onsite. This project covers many aspects. Establishing capacity for new lists and re-integration of lists currently provided in private, have been two of these.</p> <p>ENT surgery has been delivered using private capacity for the past twelve months. We have withdrawn from this contract, commencing 1 July 2009 in line with the capacity created by the above project.</p> <p>TDHB have also entered into a private arrangement for General Surgery on a case by case basis. The increase in General Surgical FTE, currently in the recruitment phase, should alleviate the need for this option.</p> <p>At this stage of planning it is difficult to predict the need for private capacity before the new facility is commissioned. However, should this be necessary, TDHB will undertake to ensure all delivery is within national pricing frameworks.</p>	Analysis of capacity within region by start of 2009/10.	Delivery of regional analysis/plan	Regional Planning and Funding Teams across Midland.

Outcome	Supporting Information required:	Actions	Timeframes	Measures	Accountability
Capacity Initiatives implemented, specifically in the following areas: <ul style="list-style-type: none"> - productivity improvement - increased staffing - increasing physical capacity - utilisation of regional capacity through improved collaboration 	Clinical and primary care agreement Regional agreements	Theatre rostering review has taken place. Adjustment of nursing hours to align with Surgeons and Anaesthetists has taken place. We are looking at a similar alignment of Anaesthesia Technicians for similar productivity gains. New facility plans include increased theatres (from 4.5 theatres currently to 6.0 in the new facility) Once regional capacity review analysed regional capacity will be identified.	On-going local capacity and capability adjustment. Regional capacity plan by July 2009	Production of capacity plan and implementation of recommendations.	Regional Planning and Funding Teams across Midland.
Quality					
Three clinical quality standards identified: <ul style="list-style-type: none"> - current performance against clinical quality standards - target performance in 2009/10 against standards - plans to achieve targets identified 	Benchmark standards Unit of measure Data collection method	Centralised Booking Process review to establish single point of entry for referrals. Theatre Management Group (TMG) is a collaborative representation of clinical and management staff. The TMG has a key role in improving theatre utilisation. Centralising endoscopy services as a unit (currently split over surgical & medical)	12 months 12 months 6 months	See appendix 5 for details on the Quality Plans	Provider Arm of TDHB Provider Arm DHB Provider Arm DHB
Sustainability					
Indicative volume increases for 10/11 and 11/12 of at least 3.3% over previous year		Taranaki DHB will maintain a similar plan in 2010/11 and 2011/12 as the current year's plan already meets the base volumes required. Variation to the plan would generally be guided by SIR changes or identified demand changes. It is our intention to therefore maintain a 3.28% year on year increase as required by the Ministry of Health. See Appendix 6.	Annual review during planning phases for DAP.	Identified increase of 3.28% discharges.	Joint Provider Arm and Planning and Funding of TDHB

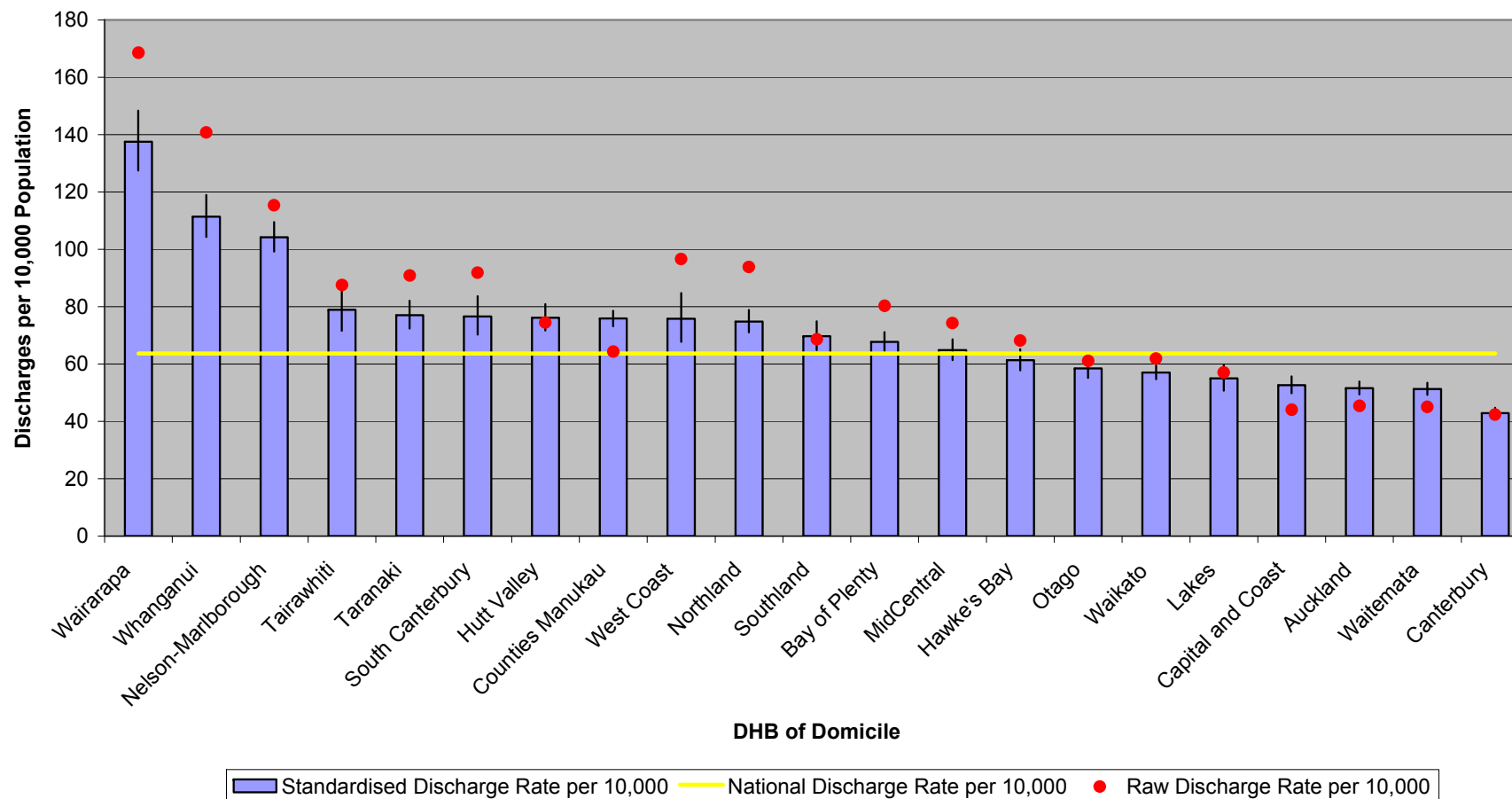
Outcome	Supporting Information required:	Actions	Timeframes	Measures	Accountability
Analysis of future capacity requirements, including: <ul style="list-style-type: none"> - productivity improvements - staffing requirements - facility requirements - other capacity (DHB or private) 		See above regarding electives initiative and see also Taranaki DHBs business Plan for future Hospital site redevelopment See Appendix 7 for TDHB Capacity and Constraints workplan.	On-going local capacity and capability adjustment. Facility build is a phased approach over several years		Regional Planning and Funding Teams across Midland. TDHB

8.1 APPENDIX 1 - Taranaki DHB Total Elective Volumes for 2009/10

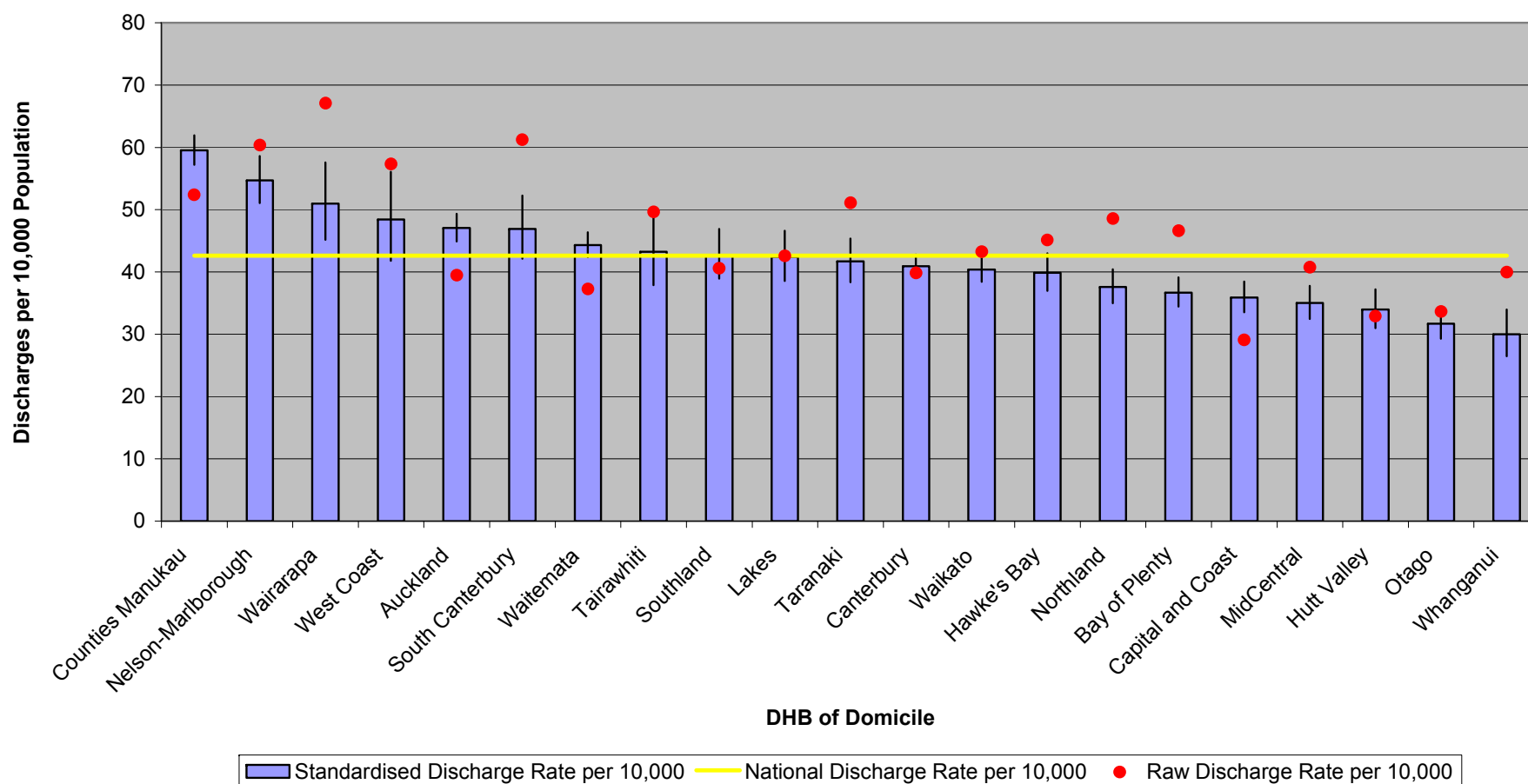
Taranaki DHB Total Elective Volumes for 2009/10						
	Base		Additional		Total 09/10	
	CWD	Discharges	CWD	Discharges	CWD	Discharges
Inpatient Dental	197.34	416	0	0	197.34	416
Cardiology	186.55	203	81	88	267.55	291
Total Non-Surgical Elective Volumes	383.89	619	81	88	464.89	707
General surgery	1502.68	1163	237	183	1,739.68	1,346
Cardiothoracic	172.67	26	67.13	10	239.8	36
ENT	280.68	445	164	260	444.68	705
Gynaecology	361.34	395	0	0	361.34	395
Neurosurgery	38.67	20	22	11	60.67	31
Ophthalmology	278.76	512	39	72	317.76	584
Orthopaedics	942.36	456	545	192	1,487.36	648
Paed Surgical	48.13	28	0	0	48.13	28
Plastics	45.96	29	0	0	45.96	29
Urology	244.87	224	30.13	28	275	252
Vascular	28.68	4	0	0	28.68	4
Total Surgical Elective Volumes	3,944.80	3,302.00	1,104.26	756.00	5,049.06	4,058.00
Total Elective Volumes 09/10	4,328.69	3,921.00	1,185.26	844.00	5,513.95	4,765.00

8.2 APPENDIX 2 – 2007/08 Raw and Standardised Discharge Rates per 10,000

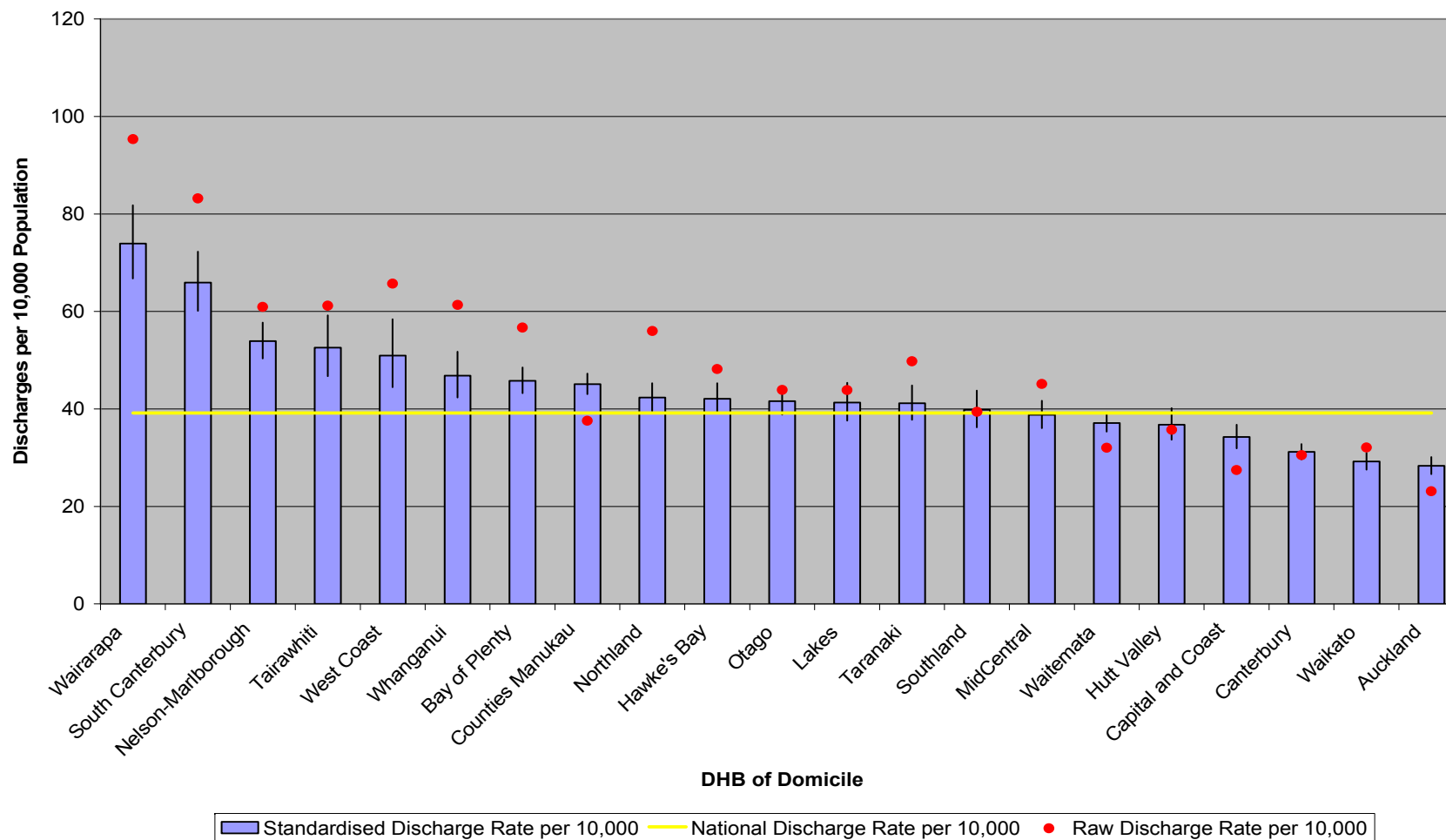
2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the General Surgery SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)

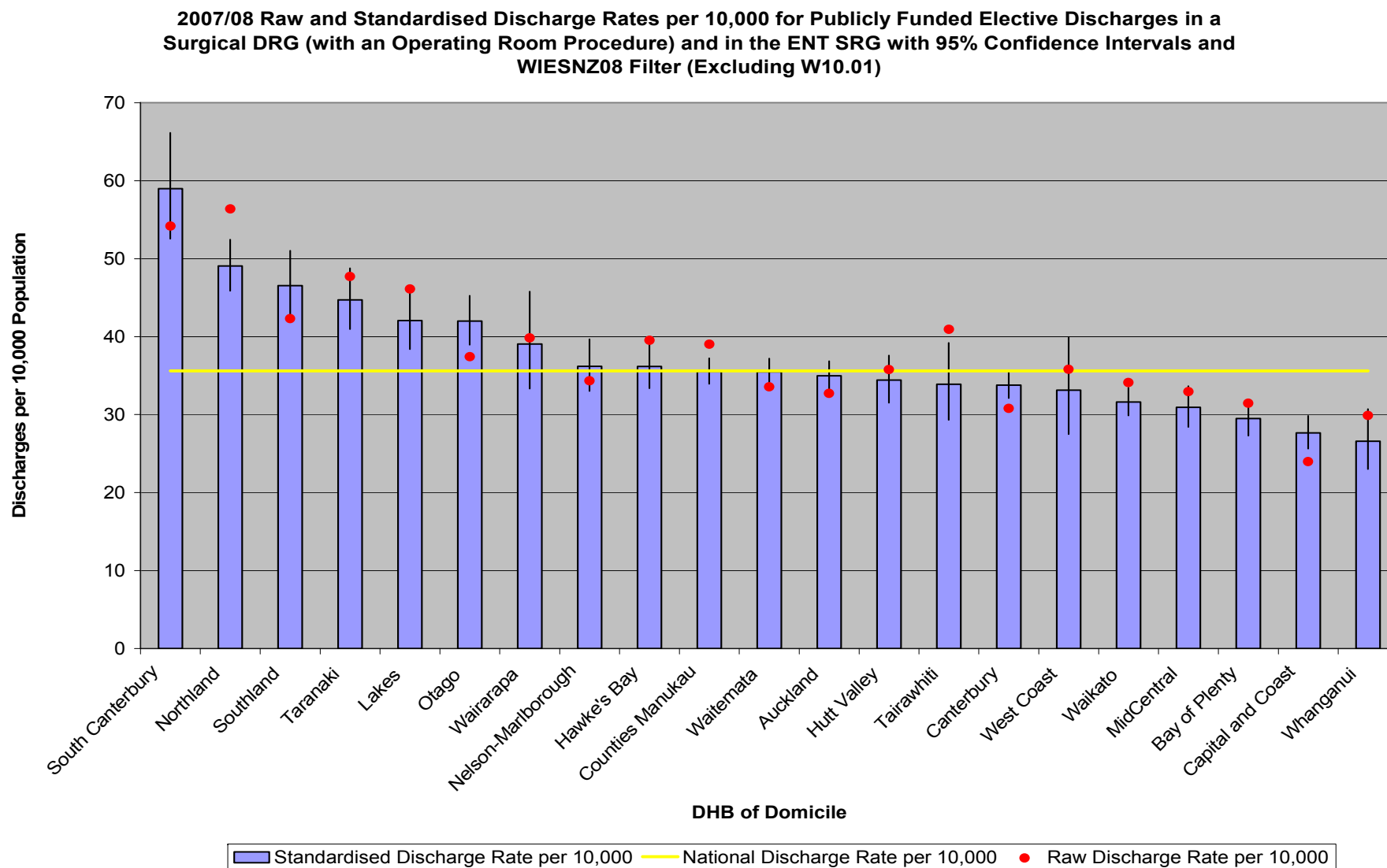


2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Eye SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)

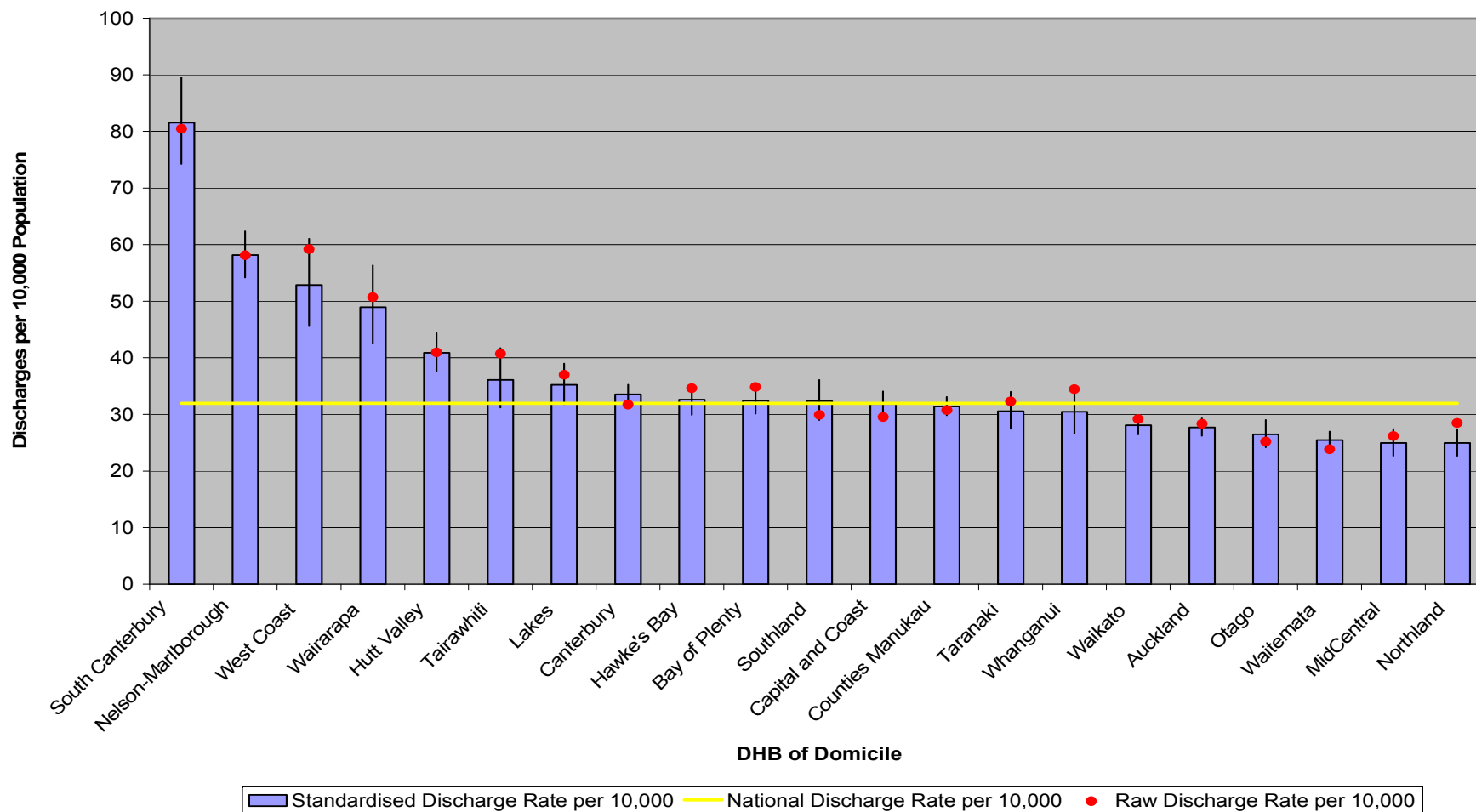


2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Orthopaedics SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)

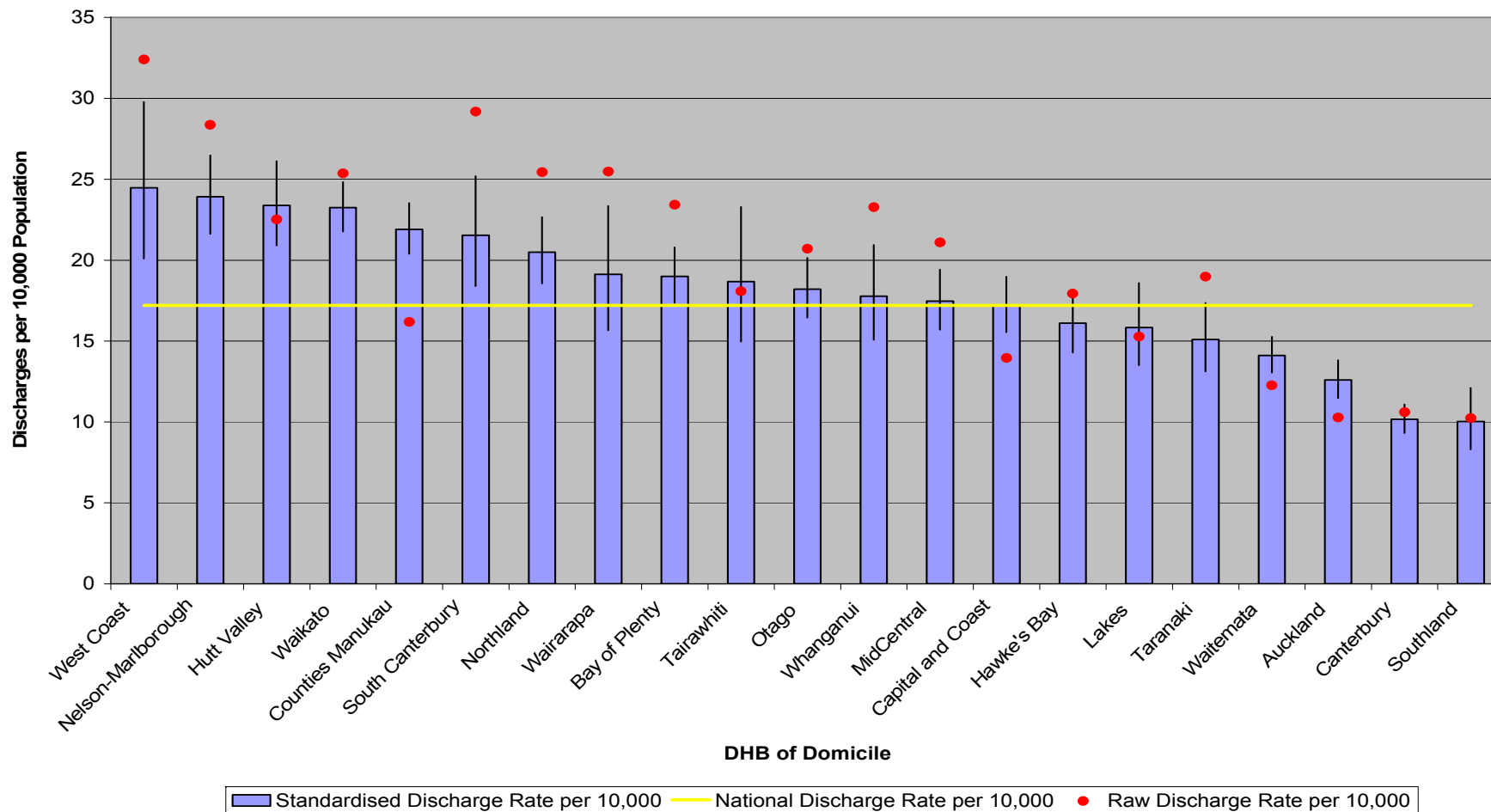




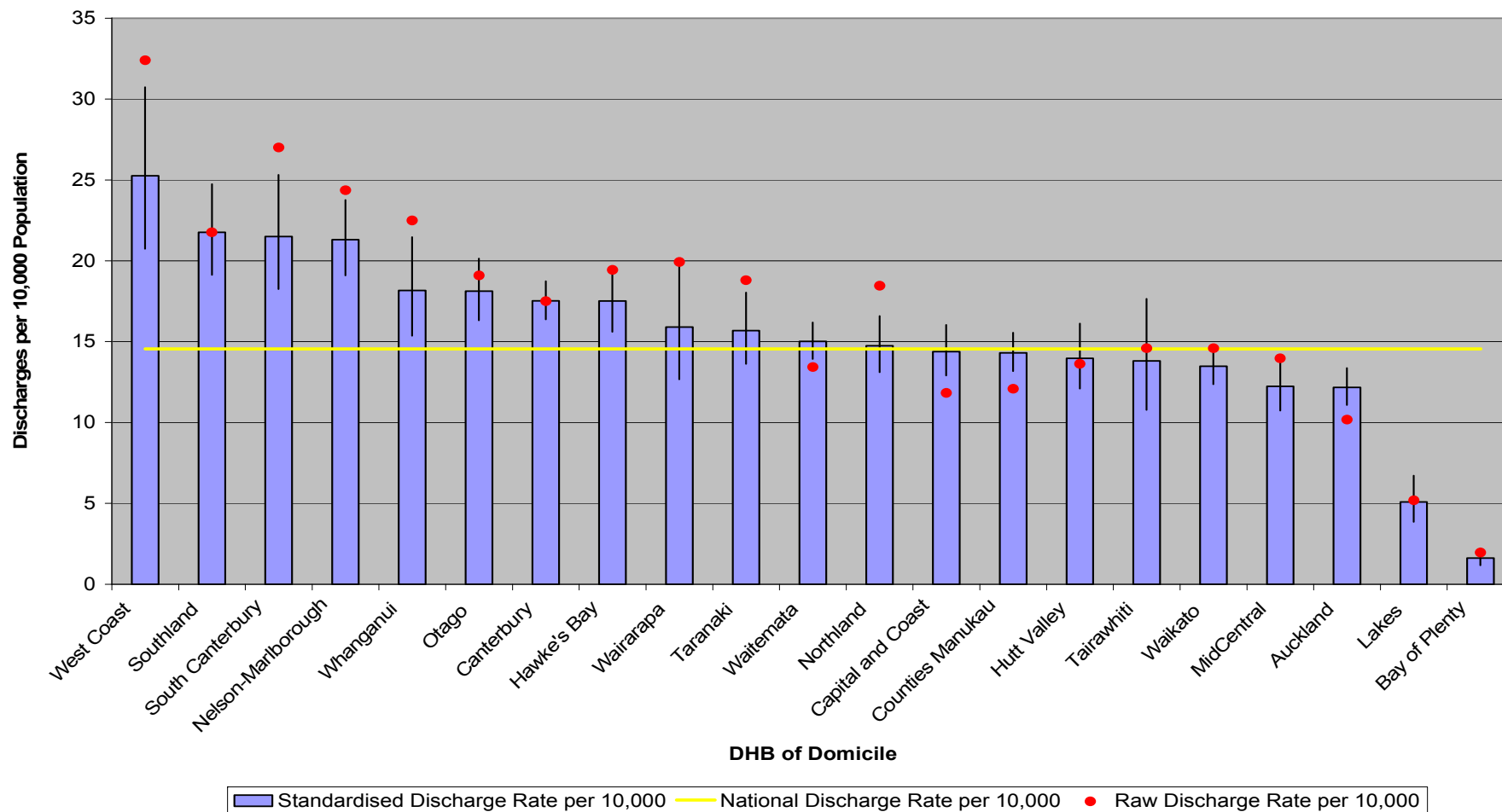
2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Gynaecology SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



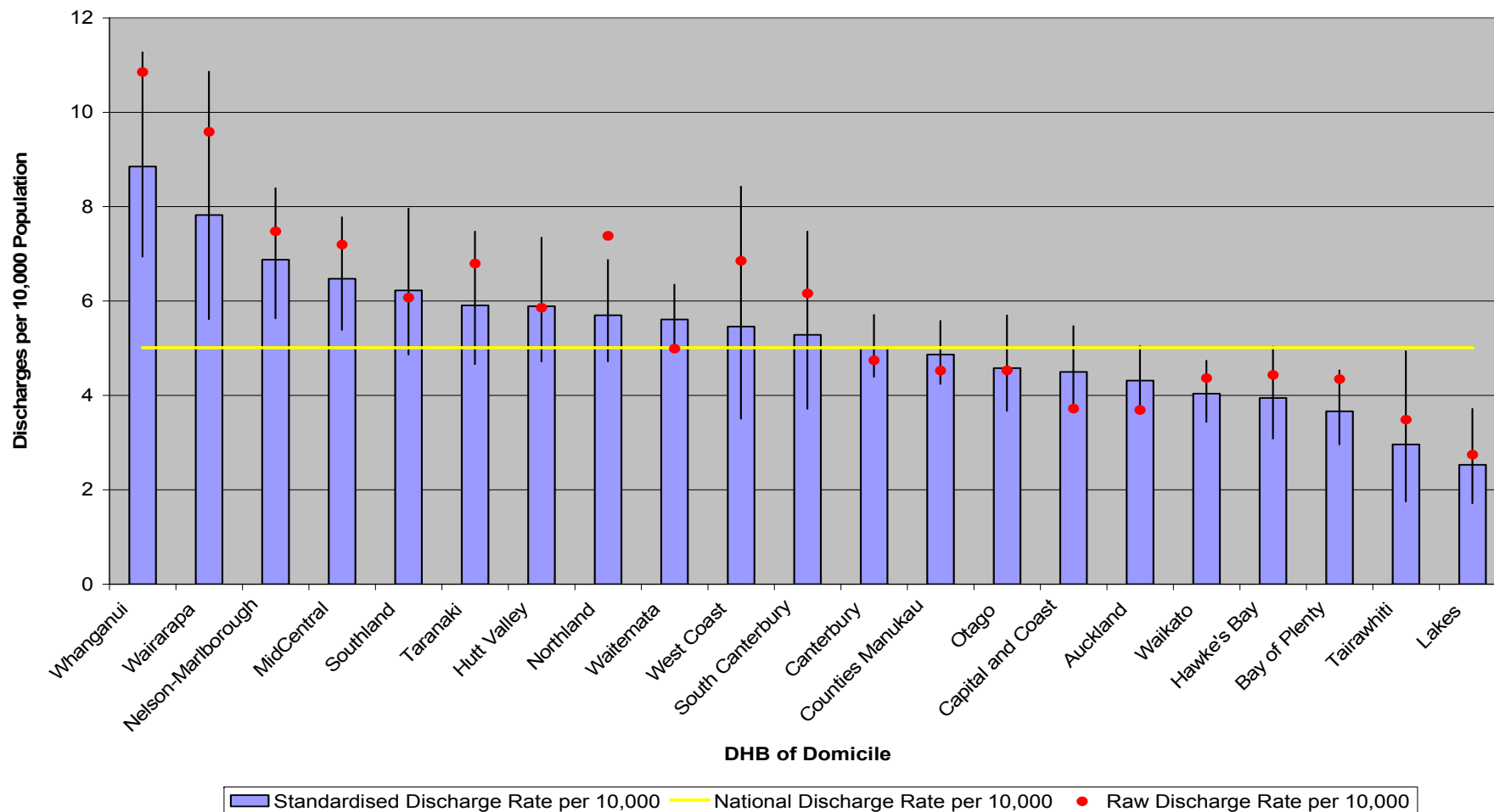
2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Plastics SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



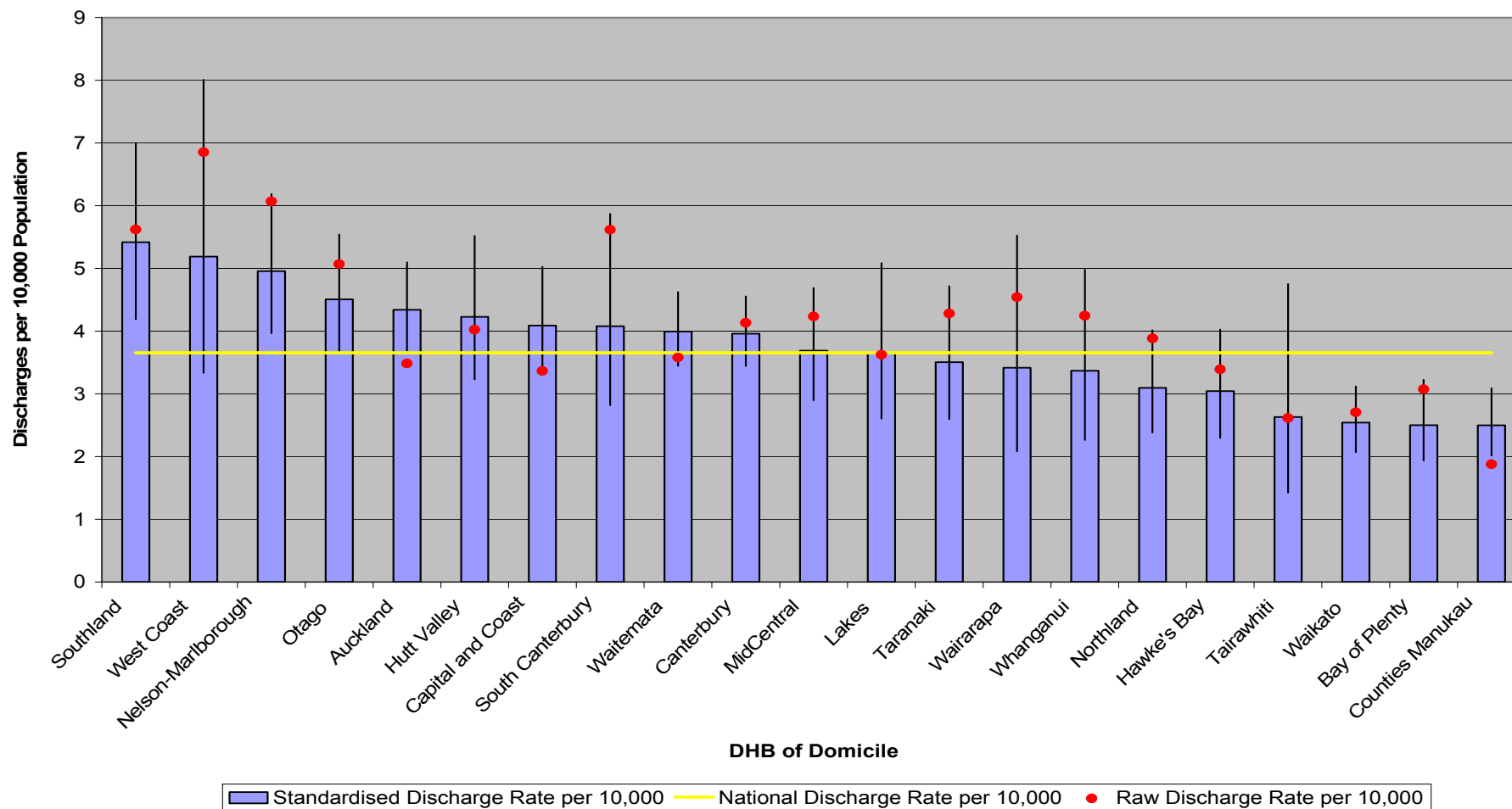
2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Urology SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



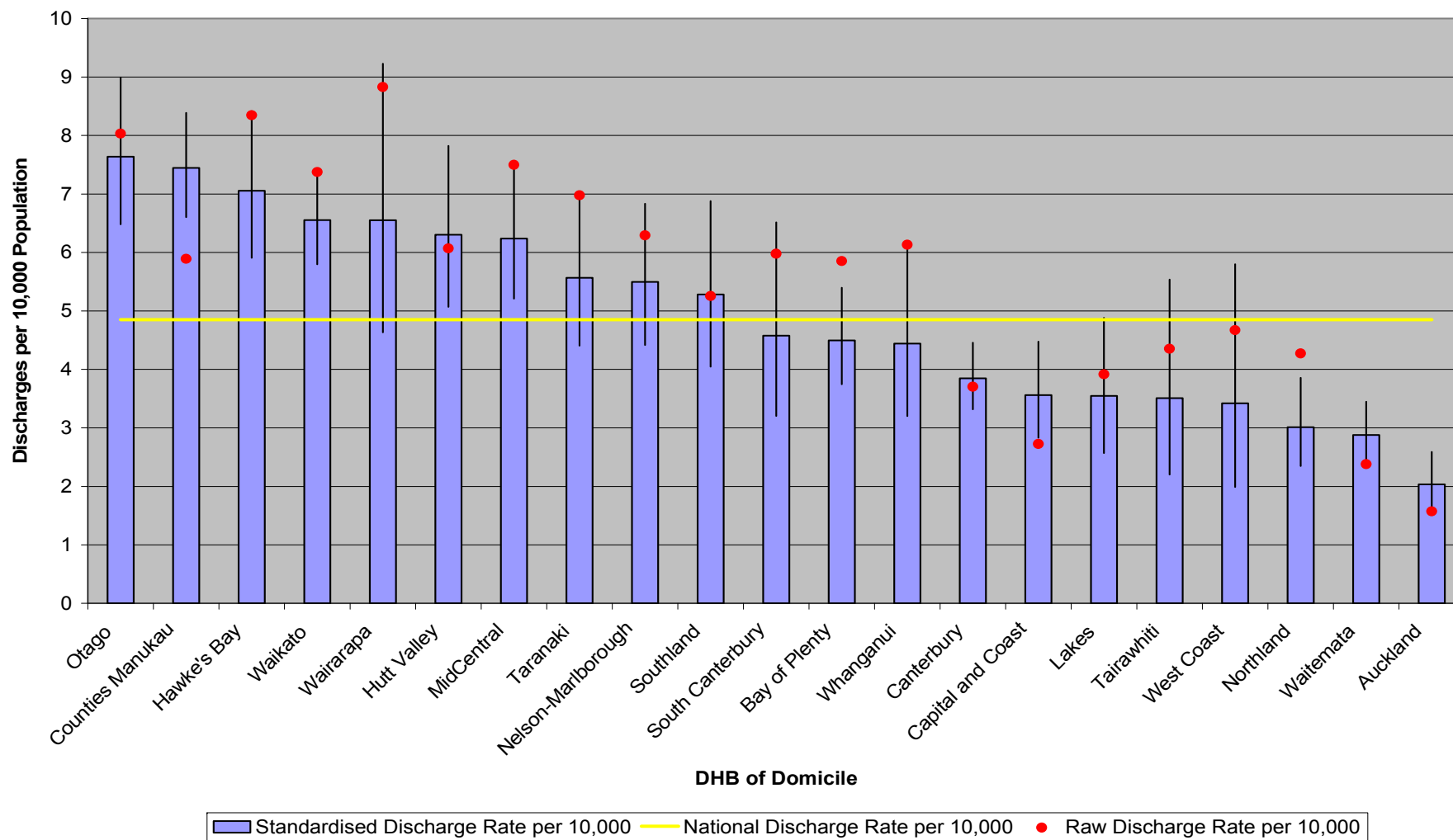
2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Cardiothoracic SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



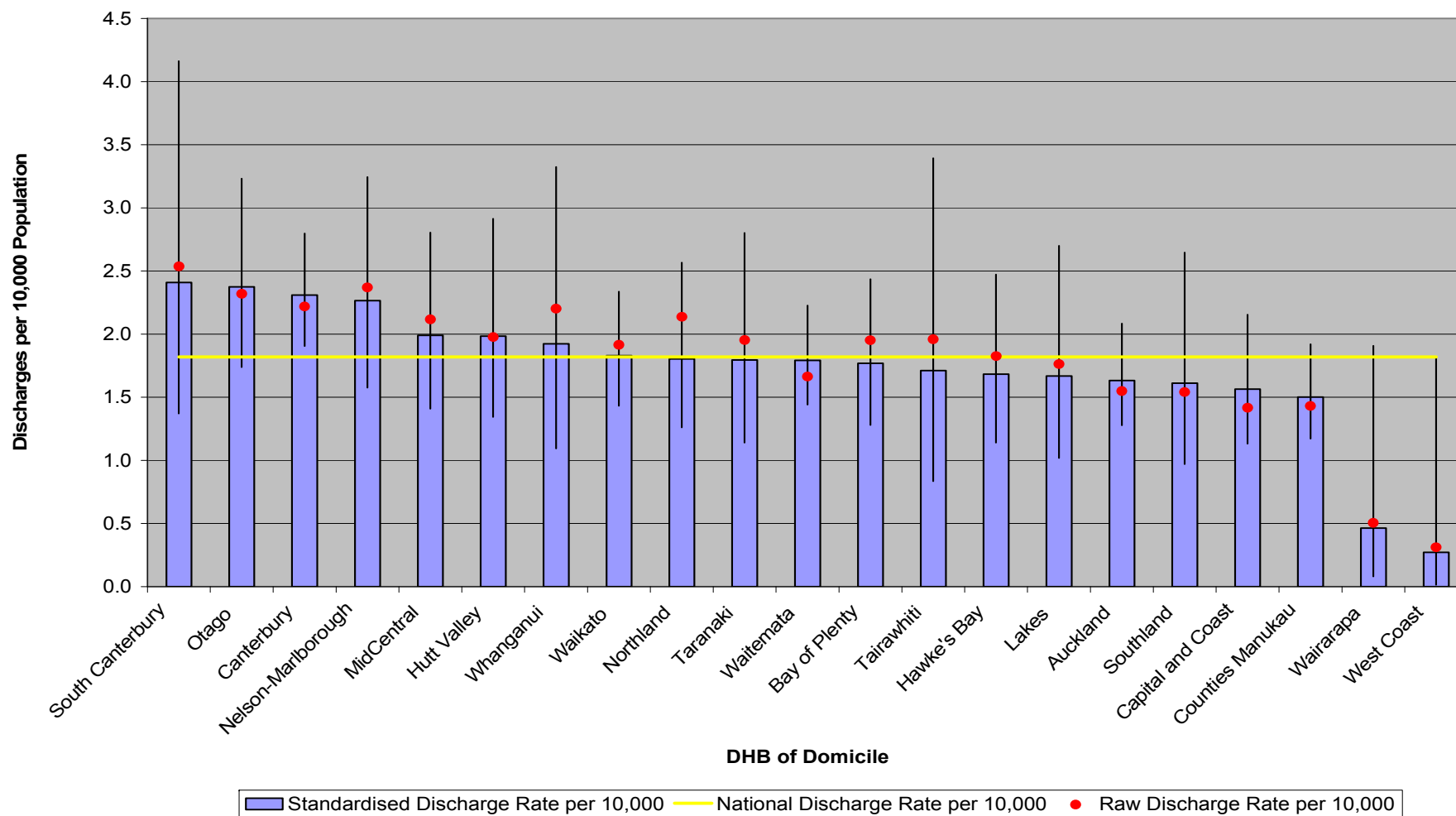
2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Cardiac SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



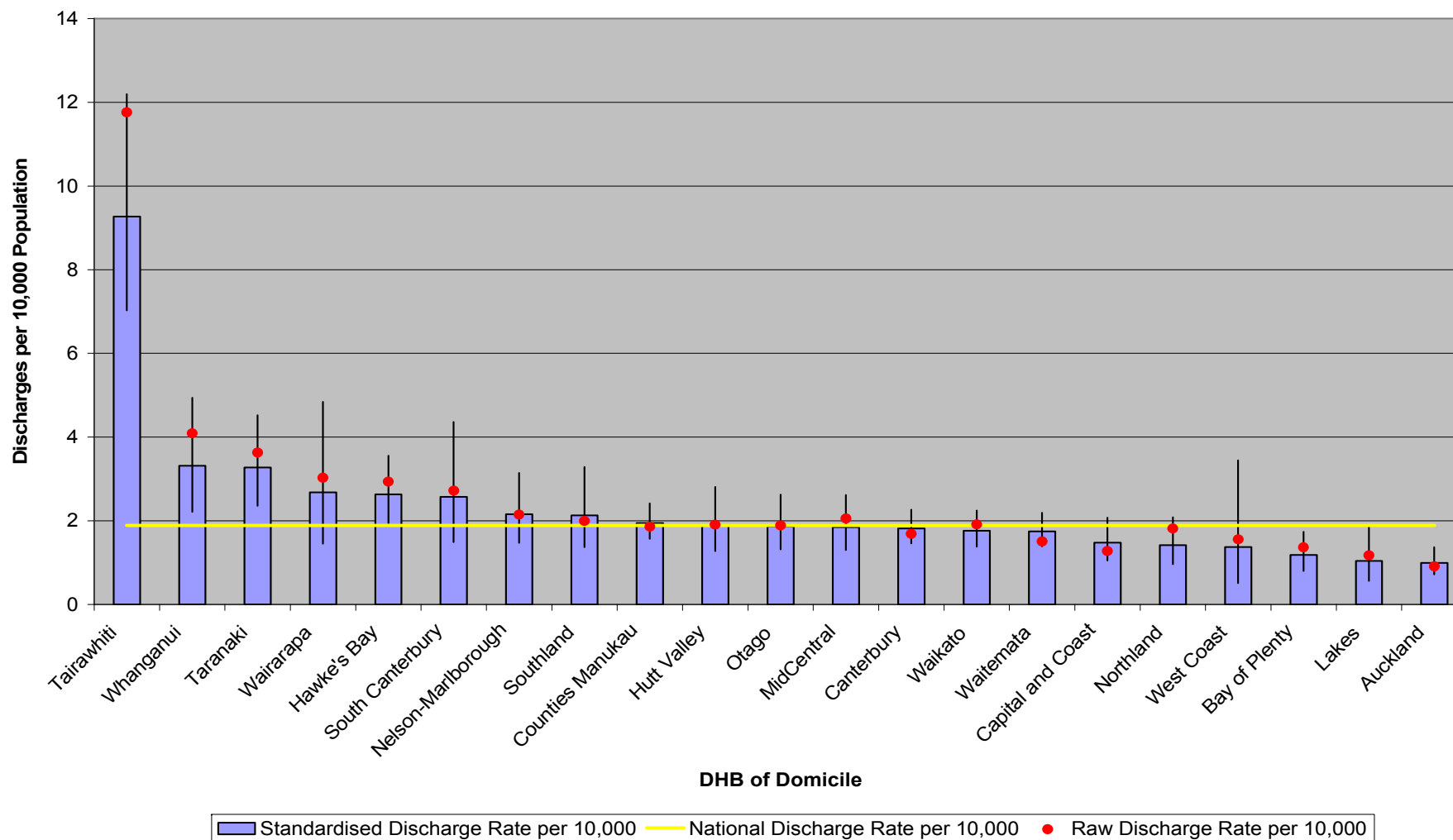
2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Vascular SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Neurosurgery SRG with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



2007/08 Raw and Standardised Discharge Rates per 10,000 for Publicly Funded Elective Discharges in a Surgical DRG (with an Operating Room Procedure) and in the Other Miscellaneous SRGs with 95% Confidence Intervals and WIESNZ08 Filter (Excluding W10.01)



8.3 APPENDIX 3 - Cardio Thoracic Delivery



22 April 2009

Rosemary Clements
Clinical Ambulatory Manager
TARANAKI DISTRICT HEALTH BOARD

Dear Rosemary

Re: Cardio Thoracic Delivery

Taranaki District Health Board
Private Bag 2016
New Plymouth 4620
New Zealand
Telephone 06 753 6139
Facsimile 06 753 7770
Email corporate@tdhb.org.nz
Website www.tdhb.org.nz

Taranaki Base Hospital
Private Bag 2016
New Plymouth 4620
New Zealand
Telephone 06 753 6139
Facsimile 06 753 7710

Hawera Hospital
Post Office Box 98
Hawera
New Zealand
Telephone 06 278 7109
Facsimile 06 278 9910

Stratford Health Centre
Telephone 06 765 7189

Opunake Health Centre
Telephone 06 761 8777

**Patea + Waverley Districts
Health Centre**
Telephone 06 273 8088

Waitara Health Centre
Telephone 06 754 7150

Mokau Health Centre
Telephone 06 752 9723

I have read and contributed to your paper titled "Taranaki District Health Board Referral Patterns for Cardiothoracic Delivery at Waikato District Health Board" dated 3 April 2009, outlining the investigation into the issues for Taranaki when supporting Cardio Thoracic delivery.

I write in support of this paper and the plan to gradually increase the Cardio Thoracic delivery. My endorsement comes with recognition that the 2008/09 delivery was planned to be 283 cwd and in February 2009 TDHB were 62c wd (10 patients) behind in this plan for the reasons you have outlined.

I therefore believe, that support for the plan outlined in your paper alongside a casemix delivery aim for 2009/10 of 240c wd, with graduated increases each following year, is a sensible approach and would be happy to support this clinically. We do not have the cardiology resources to safely double our referrals in one calendar year.

I trust this letter assists with your planning

Cheers and best wishes
Yours sincerely



Dr Ian Ternouth
Consultant Cardiologist
IT:ALC

8.4 APPENDIX 4 - Planning Elective Services 2009/10



Planning Elective Services 2009/10

The GM, Hospital Specialist Services, released a memo to Heads of Department 29 March 2009.

This memo outlined background, current situation and implications of the planning for elective services. This was subsequently discussed at a Heads of Department meeting.

Below is 4.0 of that memo which is timeframed.

Planning Process

An initial meeting with Planning and Funding representatives and the CMA has been held to discuss the above principles as a guide and the planning process.

PROPOSED PROCESS

#	Action	Whom	By When
1	Draft some options for volumes based on this years elective activity	Rosemary Clements (Hospital) Brian Gubb (Planning & Funding)	31 March
2	1:1 discussions with the HOD's and departments on their departmental views. Data re this year activity and SDRs to be provided. Theatre and bed capacity to be reviewed.	Rosemary Clements and team	10 April
3	Incorporate these discussion outcomes into a paper for HODs to consider at next meeting. Send out prior to next meeting (16 April)	Joy Farley GM	13 April

Rosemary and /or members of her team – Adele Blyde and Lee McManus – will make contact with you to undertake these discussions. I appreciate the short timeframes but that is a feature of the central timeframes that are set by this years planning process.

I have had individual discussions with the departments as well as the HOD discussions. Final signoff for delivery will occur once confirmation is received from the Ministry.

8.5 APPENDIX 5 - Quality Plan

Quality Plan

Three clinical quality standards have been identified for progression by TDHB.

1. TDHB Booking Role and Process Redesign

Goal

TDHB's aim is to provide an efficient, effective and safe journey for the patient through their healthcare experience. This project will also contribute to the overall goal of returning the hospital provider to financial health by undertaking an in-depth assessment of the current roles and design of the booking process. It will consider future service delivery requirements and best practice models for all our population needs.

Objectives

Analyse existing roles and booking processes across TDHB, benchmarking information from the MoH and other sources as appropriate

Analyse current service delivery

Identify current and future business requirements considering IT, MIU, ACC and new facility opportunities

Identify barriers for Maori when accessing Hospital Specialist Services and incorporate actions for improvement

Identify systems/process improvements and the roles and FTEs needed to support these

Consider a centralised booking model. The booking process will be consistent and not limited to sites or clinician groups

Propose options for change and associated risks and impacts

Outcome

A booking process and role model redesign in line with the QIC recommendations regarding improving Outpatient processes.

Targets will include:

Patient focused booking by Dec 2010 complete through all specialties by Dec 2012

All communication copied to referrer, GP and the patient commencing Dec 2009 complete through all specialties by Dec 2011

A system in place to check referrals sent to the DHB have been received Commencing Dec 2009 completed through all specialties by Dec 2011

A system in place to ensure each stage of the appointment process has been completed Commencing Dec 2009 throughout all specialties by Dec 2010

Single point of entry for referrals Commencing Dec 2009 Complete through all specialties by June 2010

Referrals logged within 24 hours of receipt and before being sent for prioritisation June 2010 through all specialties

All clinical appointments and referral letters are copied to the patient commencing June 2009 – complete through all specialties by Dec 2009

2009/10 Target

All communication copied to referrer, GP and the patient for 25% of the patients.

Current Position

Current delivery 0%.

Plan

Process to commence Dec 2009 completed for all specialties by Dec 2011.

This target is predicated on the implementation of the referral module in the IBA IT system.

The implementation of this module is set for December 2009

Timeframe

Scope completed

Review completion 30 June 2009

Implementation complete 30 June 2010

2. Theatre Throughput

Goal

The goal of this project is to configure a theatre service that can provide efficient delivery of surgical services over the next ten to fifteen years, within the resources specified. This will be done by incorporating anticipated changes in practice, which may include technical advances or changes in models of care, and where possible, deliver the planned changes prior to the building and relocation of the current theatre service to the new six theatre complex.

Objectives

To build a clear understanding of the theatre service. Highlighting areas of exceptional performance but also identify weaknesses / problems

Establish an Advisory Committee and Project Group with the necessary expertise and resources to progress the overview and make recommendation on future service delivery

Ensure all affected stakeholders are well informed on the progress of the theatre project with appropriate communications

Ensure the focus for the future service delivery and models of care are underpinned by the four principals of the Clinical Service Plan

Develop, in consultation with the workforce a model of service which will improve theatre productivity and streamline the patient pathway

Audit the theatre service by quantitative and qualitative methods of analysis

Make recommendations to improve service delivery, followed by a program of transformation

Plan future workforce requirements and develop a strategy to deliver the theatre service over the next 10 to 15 years

Outcome

A robust consultation process with the workforce

Staff well informed and supportive of the changes that are required for the success of the project

A streamlined patient journey through the theatre pathway

Improved theatre scheduling, introducing additional all day lists, where appropriate

Increased theatre capacity and through-put

Best practice and new technologies are adopted and implemented, where appropriate

Reduction in the unit cost of an operation, by

- *Increasing theatre productivity within the resources available*
- *Eliminating waste and improving cost efficiency*
- *Reducing lists running over, thereby minimising work-overs and associated costs*
- *Ensuring only clinically appropriate cases are operated on after hours*

Reduction in sunk costs, e.g. On the day cancellations.

Increased opportunity savings by improving time & resource management

2009/10 Target

Increase Theatre capacity to include ENT elective surgery which is currently performed at a private facility to 75% by June 2010.

Current Position

Current elective delivery 0%.

Plan

Process to commence July 2009 completed by June 2010

This target is will be achieved with improved theatre scheduling, stream lining the patient pathway and robust consultation and planning with staff

Timeframe

Plan completed

Review completion 30 July 2009

Recommendations 31 August 2009

3. Centralising Endoscopy Services as a Unit

Goal

TDHB's aim is to provide an efficient, effective and safe journey for the patient through their healthcare experience. This project will also contribute to the overall goal of returning the hospital provider to financial health by undertaking an in-depth assessment of the current roles and design of the endoscopy process. It will consider future service delivery requirements and best practice models for all our population needs.

Objectives

Analyse existing roles and booking processes across TDHB, benchmarking information from other sources as appropriate

Analyse current service delivery across both sites (TBH, Hawera)

Identify current and future clinical requirements considering IT and new facility opportunities

Identify barriers for Maori when accessing Hospital Specialist Services and incorporate actions for improvement

Identify systems/process improvements and the roles and FTEs needed to support these

Consider this project in line with the booking role and process redesign

The endoscopy booking process will be consistent and not limited to sites or clinician groups

Propose options for change and associated risks and impacts

Outcome

An endoscopy service which provides consistent processes and treatment across both Taranaki sites.

Targets will include:

Patient focused booking

All communication copied to referrer, GP and the patient

A system in place to check referrals sent have been received

A system in place to ensure each stage of the appointment process has been completed

Single point of entry for referrals

Referrals logged within 24 hours of receipt and before being sent for prioritisation

All clinical appointments and referral letters are copied to the patient

2009/10 Target

All communication copied to referrer, GP and the patient for 20% of the patients

Current Position.

Current delivery 0% increase to 55% within 12 months (Dec 2010)

Plan

Process to commence Dec 2009 completed within 12 months (Dec 2010).

This target is predicated on the implementation of the referral module in the IBA IT system.

The implementation of this module is set for December 2009

Timeframe

Scope completed

Review completion 30 June 2009

Implementation complete 30 December 2009



8.6 APPENDIX 6 - Taranaki DHB Indicative levels of elective activity

Taranaki DHB Indicative levels of elective activity										
	Base		Additional		Total 09/10		Total 10/11		Total 11/12	
	CWD	Discharges	CWD	Discharges	CWD	Discharges	CWD	Discharges	CWD	Discharges
Inpatient Dental	197.34	416	0	0	197.34	416	197.34	416	197.34	416
Cardiology	186.55	203	81	88	267.55	291	267.55	291	267.55	291
Total Non-Surgical Volumes	383.89	619	81	88	464.89	707	464.89	707	464.89	707
General surgery	1502.68	1163	237	183	1,739.68	1,346	1885.73	1,459	1,983.96	1,535
Cardiothoracic	172.67	26	67.13	10	239.8	36	246.461	37	253.122	38
ENT	280.68	445	164	260	444.68	705	456.664	724	473.064	750
Gynaecology	361.34	395	0	0	361.34	395	361.34	395	388.784	425
Neurosurgery	38.67	20	22	11	60.67	31	60.67	31	60.67	31
Ophthalmology	278.76	512	39	72	317.76	584	317.76	584	317.76	584
Orthopaedics	942.36	456	545	192	1,487.36	648	1,487.36	648	1,497.36	653
Paed Surgical	48.13	28	0	0	48.13	28	48.13	28	48.13	28
Plastics	45.96	29	0	0	45.96	29	45.96	29	45.96	29
Urology	244.87	224	30.13	28	275	252	275	252	275	252
Vascular	28.68	4	0	0	28.68	4	28.68	4	28.68	4
Total Surgical Volumes	3,944.80	3,302.00	1,104.26	756.00	5,049.06	4,058.00	5,213.76	4,191.00	5,372.49	4,329.00
% Surgical Increase							3.26%	3.28%	3.04%	3.29%

8.7 APPENDIX 7 - The Hospital Work Plan: How Does It All Fit Together?



The Hospital Work Plan: How Does It All Fit Together?

The Hospital and Specialist Services through the Service Planner role has responsibility for a number of *CORE SERVICE PLANNING PROJECTS*. As of October 2008 there were a total four projects underway at various stages of completion. In addition to these four projects there a number of specific productivity projects at the concept stage or already initiated. This extended suit of initiatives coupled with the nationally led work on "*OPTIMISING THE PATIENT JOURNEY*" have prompted a redevelopment of the Taranaki DHB approach to service development and productivity projects.

With the approval of the new facility these pieces of work serve to inform the models of care that underpin the *FACILITY DEVELOPMENT PROJECT*.

More latterly a number of *SERVICE REVIEWS* have commenced in the pursuit of moving the hospital provider to a break even.

To support the above *LEAN THINKING* methodology has been selected and a team of staff are undertaking training to roll this out to the organisation.

1.0 The four core service planning projects are;

Model of Care Project
Theatre Throughput
Maternity Service Review
Acute Pathway
Dental Service – including Community Oral Health Service implementation

The core projects can be classified as either Productivity Projects (Theatre Throughput, Acute Pathway) or as Service Development (Maternity and Oral Health)

Each project has been initiated (Project Scope developed) and three of the four have completed Project Plans.

All for projects have been planned using the same core structures and approaches the original project management plans describe the approach as a three step process

Service Analysis, which will be a qualitative and quantitative journey of discovery, building a clear understanding of the maternity service. It will highlight areas of exceptional performance but also identify perceived and actual problems, taking into account differing perspectives of the professional groups within the workforce.

The development of a conceptual model, where an evaluation of best practice, clinical delivery trends, and revised models of care will be developed based on the findings from the service analysis. Therefore, enabling workforce and service delivery issues to be identified. The impact (benefits/constraints) on the patient's journey through the services pathway will determine options for future delivery

Program of transformation, which will involve the development of detailed plans which identify future ways of working and preferred service delivery. The impact of new models of care and service delivery will be continually reviewed and the impact on linked services addressed

Each project includes the establishment of a governance structure consisting of a Project Sponsor, Project Steering or Advisory Group and a Project Team. Membership of each group has been designed to balance stakeholder input while making the best use of time from clinical and operational experts.

The methodology to be applied where change has been identified utilises (Plan – Do – Study – Act (PDSA) cycle which is consistent with best practice tools in managing transformational change - i.e.:

Plan what you are going to do, after you have gathered some evidence of the nature and size of the problem.

Do it, preferably on a small scale first.

Study (check) the results. Did the plan work?

Act on the results. If the plan was successful, standardise on this new way of working. If it wasn't, try something else

2.0 The national “**Optimising the Patient Journey**” project led by Counties Manukau DHB has identified the following as key areas for improvement in all DHB's

Outpatients

ED (including bed capacity management)

Inpatient Resources (including diagnostics) standard care pathways

Theatres, including pre-operative care, DOSA.

Discharge and back to the community

These areas are consistent with the two overarching Productivity Projects identified by Hospital and Specialist Services.

With the advent of nationally consistent monitoring data from the Health Round Table, Taranaki DHB has identified two key performance indicators that can be used to guide the Productivity Projects. These indicators are.

1. 85 Percent of Patients able to be discharged are discharged by 1100hrs
2. 85 Percent of Emergency Department Disposition times are six hours or less

These indicators become the high level measures for a number of interlinked initiatives focused on the Emergency Department and the Discharge Pathway as indicated in the diagram attached.

To ensure that each project is supported it is anticipated that key members of staff will act as leaders for each piece of work.

3.0 The facility project.

With the appointment and commencement of our Project Director momentum is well underway on this project. We are setting project structure to try coincide with Model of Care user groups and meetings, further developing the documentation to guide the briefing process and shortly to have the first steering group committee meeting. The composition of the user groups and governance groups is still under development.

4.0 A series of **staff/service** reviews have been initiated to support achievement of our financial targets. All appropriate consultation with our staff and our obligations under employment agreements are being met.

#	Target Area	Function	Formal notification to staff/unions	Draft review scope status	Target date for review completion / 2009
1	Clinical Administration	Staff who undertake support to clinician processes.	Not yet pending PA review completion	Not commenced	Nil
2	Processes associated with booking (base/Hawera hospitals and Health Centres	All booking staff undertaking specialist patient booking across DHB	Due end April	Under development	June 30
3	Allied Health services	Occupational therapy, social workers, SLT, Dieticians, Physiotherapy	Yes	Under development Steering committee formed	June 30
4	Pharmacy	Pharmacists and technician staff.	Yes	Under development Steering committee formed	June 30
5	Laboratory	Administration and implementation of Point of care testing at Hawera.	Due end April	Under development	June 30
6	Hawera	Various	Y	Steering committee formed	December 2009
7	Various units in Hospital	Supply Chain	Not applicable	Y	June 2009

5.0 A total of six management staff are undertaking the six day **Lean health Care** programme workshop based programme focusing on developing hands on skills in deploying proven Toyota Production System (Lean) techniques in healthcare settings.

One of the key drivers for sending a core group of management staff through the health round table programme is to take the opportunity of embedding lean healthcare thinking and tools within the entire Taranaki DHB Hospital Services team and supporting significant systems change to support the new facility build. This will be achieved through the group being trained demonstrating an ability and mandate to make rapid quality improvements and system change that directly facilitate staff having more time to care for patients.

DAP 2009/10 Final

This objective can be best captured as “releasing time to care”

While the direct Health Round Table learning programme will take a single service improvement project from initiation to an embedded continuous quality improvement focused service - in this case the Stroke Pathway - the work undertaken will generate a level of understanding and support from staff across the acute pathway.

This initial enthusiasm will drive further “lean” initiatives and learning for all staff involved both in the hospital and the wider sector.

The problem:

One of the biggest challenges is managing the time to enable all staff and stakeholders to engage in the design briefing process. The workloads at all levels of the organisation are frenetic; clinically the hospital continues to deliver patient care above normal volumes and complexity and additional elective services, undertake development of Models of Care within service planning, complete our work with QIC programme, implement new services as outlined last quarter and initiate a work plan aimed at positioning ourselves to meet the clinical needs of the 2009/10 year.

The key is to fit as much into the existing meeting schedules, that meetings can be used for dual purposes, and staggering some pieces of work.

How to do this?

Joy Farley

GM HOSPITAL & SPECIALIST SERVICES

8.8 APPENDIX 8 – Price Volume Schedule Summary 2009/10**Price: Volume Schedule Summary 2009/10**

<u>Personal Health</u>	Funding 2009/10
Inpatients Total	64,337,971
Outpatients Total	11,676,433
Specific Procedure Total	1,923,722
Allied Health	2,022,192
Programs and Services Total	16,206,540
Maternity Total	5,933,502
Communities Total	8,413,567
Community Referred Diagnostics Total	3,045,755
Adjusters and Premiums Total	3,265,600
CFA or MoH Contract Funded	1,637,193
Total Personal Health	118,462,474
 <u>Mental Health</u>	
Mental Health Base Funding	20,847,198
Total Mental Health	20,847,198
 <u>Health of Older People</u>	
HOP Base Funding	3,824,203
Total Health of Older People	3,824,203
 Total PV Schedule Funding	143,133,876

Personal Health

Service	Service Description	Unit of Measure	Price 2009/10 \$	Agreed Volumes for 2009/10	Funding 2009/10
D01001	Inpatients Dental	CWD	4,315.48	225.33	972,414.15
	Acute/Arranged			15.80	
	Base Elective			183.34	
	Additional Elective			0.00	
	IDF Acute/Arranged			21.31	
	IDF Elective			4.88	
M00001	General Medicine	CWD	4,315.48	5,851.71	25,252,933.63
	Base			4,964.58	
	Hawera			834.54	
	IDF Acute/Arranged			52.59	
	IDF Elective			0.00	
M10001	Cardiology	CWD	4,315.48	133.04	574,131.46
	Base Elective			50.00	
	Additional Elective			81.00	
	IDF Acute/Arranged			2.04	
M55001	Paediatric medicine	CWD	4,315.48	522.50	2,254,842.09
	Base			510.31	
	IDF Acute/Arranged			12.19	
S00001	General Surgery	CWD	4,315.48	3,580.15	15,450,070.19
	Acute/Arranged			1,921.34	
	Base Elective			1,353.00	
	Additional Elective			237.00	
	IDF Acute/Arranged			54.00	
	IDF Elective			14.81	
S25001	Ear Nose and Throat	CWD	4,315.48	455.00	1,963,543.40
	Acute/Arranged			45.69	
	Base Elective			241.00	
	Additional Elective			164.00	
	IDF Acute/Arranged			1.99	
	IDF Elective			2.32	
S30001	Gynaecology	CWD	4,315.48	574.74	2,480,288.21
	Acute/Arranged			241.13	
	Base Elective			326.00	
	Additional Elective			0.00	
	IDF Acute/Arranged			6.49	
	IDF Elective			1.12	
S40001	Ophthalmology	CWD	4,315.48	276.35	1,192,582.90
	Cataract Initiative			0.00	
	Acute/Arranged			21.20	
	Base Elective			214.00	
	Additional Elective			39.00	
	IDF Acute/Arranged			1.59	
	IDF Elective			0.56	
S45001	Orthopaedics	CWD	4,315.48	2,944.57	12,707,234.17
	Orthopaedic Initiative			0.00	
	Acute/Arranged			1,526.62	
	Base Elective			812.36	
	Additional Elective			545.00	
	IDF Acute/Arranged			55.00	
	IDF Elective			5.59	
S70001	Urology	CWD	4,315.48	345.25	1,489,930.60
	Acute/Arranged			102.75	
	Base Elective			210.00	
	Additional Elective			30.00	
	IDF Acute/Arranged			2.50	
	IDF Elective			0.00	
	Inpatients Total			14,908.65	64,337,970.80

DAP 2009/10 Final

	Outpatients				
D01002	Outpatient Dental treatment	Attendance	238.10	4,500.00	1,071,450.00
D01017	Special Dental	Treatment	63,910.06	1.00	63,910.06
M00002	General Medicine - 1st attendance - Total	Attendance	357.13	650.00	232,134.50
M00003	General Medicine - Subsequent attendance	Attendance	251.75	1,600.00	402,800.00
M10002	Cardiology - 1st attendance - total	Attendance	359.73	578.00	207,923.94
M10003	Cardiology - Subsequent attendance	Attendance	265.62	1,200.00	318,744.00
M15002	Dermatology - 1st attendance - Total	Attendance	239.29	393.00	94,040.97
M15003	Dermatology - Subsequent attendance	Attendance	197.96	15.50	3,068.38
M20002	Endocrinology - 1st attendance - Total	Attendance	488.95	200.00	97,790.00
M20003	Endocrinology - Subsequent attendance	Attendance	357.05	400.00	142,820.00
M30002	Haematology - 1st attendance - Total	Attendance	559.94	150.00	83,991.00
M30003	Haematology - Subsequent attendance	Attendance	375.48	700.00	262,836.00
M45002	Neurology - 1st attendance - Total	Attendance	563.95	180.00	101,511.00
M45003	Neurology - Subsequent attendance	Attendance	338.05	180.00	60,849.00
M45004	Neurology Botulinum Toxin Therapy	Attendance	913.57	100.00	91,357.00
M50002	Oncology - 1st attendance - Total	Attendance	651.01	250.00	162,752.50
M50003	Oncology - Subsequent attendance	Attendance	442.94	1,500.00	664,410.00
M55002	Paediatric Medical Outpatient - 1st attendance - Total	Attendance	437.94	1,200.00	525,528.00
M55003	Paediatric Medical Outpatient - Subsequent attend	Attendance	283.33	3,589.50	1,017,013.04
M60002	Renal Medicine - 1st attendance - Total	Attendance	466.17	200.00	93,234.00
M60003	Renal Medicine - Subsequent attendance	Attendance	253.46	1,000.00	253,460.00
M65002	Respiratory - 1st attendance - Total	Attendance	493.81	220.00	108,638.20
M65003	Respiratory - Subsequent attendance	Attendance	338.00	360.00	121,680.00
M70002	Rheumatology (incl immunology) - 1st attendance - Total	Attendance	534.90	160.00	85,584.00
M70003	Rheumatology (incl immunology) - Subsequent attendance	Attendance	284.66	500.00	142,330.00
MS01001	Other Medical Clinics	Attendance	141.22	4,000.00	564,880.00
PC0001	Pain Clinic - 1st attendance - Total	Attendance	553.83	80.00	44,306.40
PC0007	Pain comprehensive assessment (triple assessment) - Additional Funding	Attendance	829.78	55.00	45,637.90
PC0003	Pain Clinic - Subsequent attendance	Attendance	357.66	210.00	75,108.60
S00006	General Surgery - 1st attendance - Total	Attendance	321.35	1,600.00	514,160.00
S00007	General Surgery - Subsequent attendance	Attendance	321.35	2,500.00	803,375.00
S25002	Ear Nose and Throat - 1st attendance - Total	Attendance	262.02	765.00	200,445.30
S25003	Ear Nose and Throat - Subsequent attendance	Attendance	214.67	1,000.00	214,670.00
S30002	Gynaecology - 1st attendance - Total	Attendance	377.72	590.00	222,854.80
S30003	Gynaecology - Subsequent attendance	Attendance	271.59	800.00	217,272.00
S40002	Ophthalmology - 1st attendance	Attendance	206.36	1,080.00	222,868.80
S40003	Ophthalmology - Subsequent attendance	Attendance	155.53	2,980.00	463,479.40
S45002	Orthopaedics - 1st attendance - Total	Attendance	285.14	900.00	256,626.00
S45003	Orthopaedics - Subsequent attendance	Attendance	232.83	3,870.00	901,052.10
S60002	Plastics (incl Burns and Maxillofacial) - 1st attendance	Attendance	234.54	54.00	12,665.16
S60003	Plastics (incl Burns and Maxillofacial) - Subsequent attendance	Attendance	194.32	120.00	23,318.40
S70002	Urology - 1st attendance - Total	Attendance	325.57	750.00	244,177.50
S70003	Urology - Subsequent attendance	Attendance	239.68	1,000.00	239,680.00
	Outpatients Total			42,181.00	11,676,432.95

DAP 2009/10 Final

	SPECIFIC PROCEDURES				
S70005	Urology - Cystoscopy	Procedure	556.11	300.00	166,833.00
S70006	Urology - Lithotripsy	Procedure	5,569.17	20.00	111,383.40
M00006	Blood Transfusions	Attendance	583.67	200.00	116,734.00
M25004	Gastroenterology - ERCP	Procedure	2,028.13	5.00	10,140.65
MS02007	Gastroenterology - Colonoscopy - Total	Procedure	1,037.84	570.00	591,568.80
MS02005	Gastroenterology - Gastroscopy - Total	Procedure	814.48	555.00	452,036.40
M25008	Gastroenterology - Capsule Endoscopy	Procedure	2,559.97	10.00	25,599.70
M65005	Respiratory - Bronchoscopy	Procedure	1,259.65	55.00	69,280.75
S30006	Termination of Pregnancy	Attendance	994.60	322.00	320,261.20
S30009	Termination of Pregnancy - 2nd Trimester	Attendance	1,216.92	28.00	34,073.76
S40005	Eye - laser treatments	Procedure	215.09	120.00	25,810.80
	Specific Procedure Total			2,185.00	1,923,722.46
	ALLIED HEALTH				
AH01001	Dietetics	Contact	139.96	4,000.00	559,840.00
AH01003	Occupational Therapy	Contact	133.42	3,800.00	506,996.00
AH01005	Physiotherapy	Attendance	73.73	8,850.00	652,510.50
AH01006	Podiatry	Contact	91.90	830.00	76,277.00
AH01007	Social Work	Contact	126.72	1,300.00	164,736.00
AH01008	Speech Therapy	Contact	154.58	400.00	61,832.00
	Allied Health Total			19,180.00	2,022,191.50
	PROGRAMS AND SERVICES				
ED04001	Emergency Dept - Level 4	Attendance	282.51	17,000.00	4,802,670.00
ED03001	Emergency Dept - Level 3	Attendance	282.51	5,500.00	1,553,805.00
ED08001	Regional Emergency Planning	Service	95,066.77	1.00	95,066.77
MEOU0000	CQI Co-ordinator	Service	77,852.89	0.20	15,570.58
M55004	Paediatric Acute Assessments	Attendance	439.33	1,400.00	615,062.00
TR0201	Inter Hospital Transfers	Service	1,195,731.65	1.00	1,195,731.65
TR0101	Patient Travel & Accommodation Assistance (Outpatients)	Service	960,746.18	1.00	960,746.18
TR0101	Patient Travel & Accommodation Assistance (Inpatients)	Service	1,356,884.32	1.00	1,356,884.32
D01005	Emergency treatment/essential dental	Treatment	152.03	771.00	117,215.13
M10004	Cardiac Education and Management	Client	219.12	354.00	77,568.48
M20006	Diabetes Education and Management	Client	256.81	1,131.00	290,452.11
M60004	Recurrent Home Based CAPD	Number of Patient	1,727.46	300.00	518,238.00
M60005	Renal Medicine - CAPD Training	New Client	2,308.45	9.00	20,776.05
M60006	Recurrent Home Based Haemodialysis	Number of Patient	2,662.25	84.00	223,629.00
M60008	Renal Medicine - Incentre Dialysis	Attendance	409.57	5,200.00	2,129,764.00
M60010	Renal Medicine - Self managed Dailydialysis Training	New client	3,486.01	4.00	13,944.04
M60011	Renal Medicine - Management of Pre Dialysis Patients	Service	44,310.97	1.00	44,310.97
M65004	Respiratory Education and Management	Client	244.70	700.00	171,290.00
MS02010	Sleep apnoea - assessment	Attendance	1,584.24	88.00	139,413.12
M20007	Diabetes - Fundus Screening	Procedure	99.24	1,565.00	155,310.60
COOC0070	Family Violence Co-ordinator	Service	83,155.00	1.00	83,155.00
COOC0077	Non Provider Arm Hospital Beds for CMI patients (Medical)	Service	82,492.80	1.00	82,492.80
M50012	High Cost Cancer Drugs	Service	1,543,444.33	1.00	1,543,444.33
	Programs and Services Total			34,114.20	16,206,540.13

DAP 2009/10 Final

	MATERNITY				
W08001	Midwifery services (supporting Obstetricians as LMCs)	Programme	226,038.52	1.00	226,038.52
W02001	Maternity Facility - Fee for labour and delivery <199 births	Deliveries in facility	1,635.27	100.00	163,527.00
W02003	Maternity Facility -Fee for labour and delivery 600+ births	Deliveries in facility	795.94	1,096.00	872,350.24
W02004	Maternity Facility -Fee per postnatal <199 births	Postnatal stay	2,452.98	150.00	367,947.00
W02006	Maternity Facility -Fee per postnatal 600+ births	Postnatal stay	1,193.91	888.00	1,060,192.08
W03001	Secondary Maternity	Deliveries in catchment area	1,127.53	1,300.00	1,465,789.00
W08001	Secondary Maternity - outpatients	Programme	99,370.56	1.00	99,370.56
W06002	Neonatal home care	Service	3,770.69	1.00	3,770.69
W06002	Neonatal home care	Service	58,383.97	1.00	58,383.97
W06003	Neonatal Inpatient (DRGs) IDFs	CWD	4,315.48	26.09	112,590.87
W06003	Neonatal Inpatient (DRGs)	CWD	4,315.48	348.41	1,503,542.15
	Maternity Total			3,912.50	5,933,502.08
	COMMUNITIES				
C01010	Well Child - School Aged Services (5-18 years)	Client	984,354.51	1.00	984,354.51
D01003	School dental services	Client	103.59	16,366.00	1,695,353.94
D01004	Adolescent dental services	Client	61.26	2,297.00	140,714.22
DOM101	Community Services - professional services	Contact	88.97	35,500.00	3,158,435.00
DOM102	Community Services - home oxygen	Client	561.72	347.00	194,916.84
DOM103	Community Services - stomal service	Client	2,155.34	249.00	536,679.66
DOM104	Community Services - continence service	Client	550.92	374.00	206,044.08
DOM105	Community Services - home help	Hour	22.23	8,452.00	187,887.96
DOM106	Community Services - meals on wheels	Meal	4.15	14,000.00	58,100.00
DOM107	Community Services - personal care	Hour	24.14	1,600.00	38,624.00
DOM110	Community Services - orthotics	Service	417,537.20	1.00	417,537.20
C01010	Dental Health Educator Services	Service	34,062.68	1.00	34,062.68
C01010	School Based Nursing	Service	139,100.94	1.00	139,100.94
SH01001	Sexual Health - First Contact	Contact	191.21	2,294.00	438,635.74
SH01002	Sexual Health - Follow Up	Contact	155.98	1,174.00	183,120.52
	Communities Total			82,657.00	8,413,567.29
	COMMUNITY REFERRED DIAGNOSTICS				
CS01001	Community Diagnostics Primary Referred Radiology (GP referred)	Relative Value Unit	64.28	8,912.23	572,878.14
CS01001	Community Diagnostics Primary Referred Radiology (Specialist referred)	Relative Value Unit	64.28	10,050.39	646,039.07
CS02001	Laboratory Non Schedule Community Testing	Test	695,508.67	1.00	695,508.67
CS04001	Community referred tests - cardiology	Test	206.18	2,800.00	577,304.00
CS04002	Community referred tests - neurology	Test	365.01	150.00	54,751.50
CS04003	Community referred tests - audiology	Test	130.89	2,100.00	274,869.00
CS04004	Community referred tests - gastroenterology	Test	441.19	180.00	79,414.20
CS04007	Community referred tests - urology	Test	194.30	260.00	50,518.00
CS04008	Community referred tests - respiratory	Test	236.18	400.00	94,472.00
	Community Referred Diagnostics Total			24,853.62	3,045,754.58
	Adjusters & Premiums				
ADJ106	Maori Health Adjuster	Programme	457,257.36	1.00	457,257.36
	Exceptional Circumstances Pool	Programme	154,947.00	1.00	154,947.00
	Government priority - subsidised medicines		433,320.00	1.00	433,320.00
	Government priority - post natal stays		151,800.00	1.00	151,800.00
ADJ111	Sustainability Adjuster	Service	1,416,042.40	1.00	1,416,042.40
	Adjusters & Premiums Total				2,613,366.76

Non Sustainable

Adjusters & Premiums					
	SMO	Service	152,233.00	1.00	152,233.00
	Workforce Development (non recurring) Funding	Service	500,000.00	1.00	500,000.00
	Adjusters & Premiums Total				652,233.00

CFA/MoH Contract Funded					
COAM0002	PRIME		109,350.00	1.00	109,350.00
N-IMMUN	HPV		180,913.67	1.00	180,913.67
N-IMMUN	HPV - Screening		43,028.00	1.00	43,028.00
C01013	B4 School Checks - District Nursing		87,500.00	1.00	87,500.00
C01013	B4 School Checks - Screening		220,401.00	1.00	220,401.00
RM00111	Smokefree		275,000.00	1.00	275,000.00
UNHS-40	Universal Newborn Screening		85,000.00	1.00	85,000.00
RM00105	Violence Intervention		100,000.00	1.00	100,000.00
D01013	Oral Health Strategy (Dental Project)		536,000.00	1.00	536,000.00
	CFA/MoH Contract Funded Total				1,637,192.67

*Total Personal Health**118,462,474.22*

Mental Health & Addiction Service

Service	Service Description	Unit of Measure	Price 2009/10 \$	Agreed Volumes for 2009/10	Funding 2009/10
MHCS01A	Community Alcohol & Drug Services (Other Clinical FTEs)	Other Clinical FTE	102,680.38	10.30	1,057,607.87
MHCS01A	GP Liaison Opioid	Other Clinical FTE	102,680.38	0.50	51,340.19
MHCS01B	Community Alcohol & Drug Services (Senior Medical FTEs)	Senior Medical Clinical FTE	269,230.69	1.00	269,230.69
MHCS01B	Medical Officer Opioid	Senior Medical Clinical FTE	269,230.69	0.10	26,923.07
MHCS06A	Community Mental Health Service (Other Clinical FTEs)	Other Clinical FTE	111,302.30	40.63	4,522,212.32
MHCS06A	Clinical Nurse specialist - Prof Advisor ADoN MH	Other Clinical FTE	111,302.30	1.00	111,302.30
MHCS06A6	High & Complex needs Blueprint 2003/04 (assertive comm FTE)	Other Clinical FTE	111,302.30	2.00	222,604.59
MHCS06A	Mobile clinical wkr	Other Clinical FTE	111,302.30	1.00	111,302.30
MHCS06A	AHBT Mobile clinical Workers	Other Clinical FTE	111,302.30	6.12	681,170.06
MHCR09.2	Mobile support wkr	FTE	75,181.14	0.36	27,065.21
MHCR09.2	AHBT Mobile Support Wkrs	FTE	75,181.14	2.50	187,952.86
MHCS06B	Community Mental Health Service (Senior Medical FTEs)	Other Clinical FTE	269,230.69	4.10	1,103,845.83
MHCS06B	AHBT Community Mental Health Service (Senior Medical FTEs)	Other Clinical FTE	269,230.69	0.65	174,999.95
MHCS08A	Children & Young People Community Services (Other Clinical FTEs)	Other Clinical FTE	111,302.30	16.60	1,847,618.13
MHCS08B	Children & Young People Community Services (Senior Medical FTEs)	Other Clinical FTE	269,230.69	2.00	538,461.38
MHCS18	Community Service - Older People	Clinical FTE	124,128.18	7.30	906,135.72
MHCS06B	Community Service - Older People Snr medical	Other Clinical FTE	269,230.69	1.00	269,230.69
MHCS21	Advocacy/Peer Support - Consumers	FTE	71,885.84	1.00	71,885.84
MHCS22	Advocacy/Peer Support - Family	FTE	71,885.84	1.00	71,885.84
MHCS28	Specialist Maternal Mental Health Service	Clinical FTE	124,128.18	1.50	186,192.27
MHCS29.1	Methadone Treatment - General Practitioner	Case	2,438.32	50.00	121,916.11
MHCS29.2	Methadone Treatment - Specialist	Case	3,045.67	96.00	292,383.85
MHCS48	Child & Youth WRAP around services	Programme	49,968.53	1.00	49,968.53
MHCS49	Child & Youth - Blueprint Funding 2002/03 - Assessment Tool	Programme	12,119.11	1.00	12,119.11
MHIS01	Acute Inpatient Beds - TPW ward 15 beds	Available bed day	715.16	5,475.00	3,915,474.04
MHIS01	Acute Inpatient Beds - TWW Community supported living 4 beds	Available bed day	715.16	1,460.00	1,044,126.41
MHIS02	Older People Inpatient Beds 4 beds	Available bed day	613.09	1,460.00	895,110.58
MHIS09	Intensive Care Inpatient Beds 4 beds	Available bed day	803.71	1,460.00	1,173,415.76
MHRE01	Planned Respite - Elderly	Programme	16,862.49	1.00	16,862.49
MHRE02	Adult Crisis Respite	Programme	115,832.32	1.00	115,832.32
MHRE04	Child & Youth - Blueprint Funding - Planned respite	Programme	22,371.88	1.00	22,371.88
MHRE04	Child & Youth - Kaupapa Maori B/Print funding - Planned respite	Programme	9,137.81	1.00	9,137.81
MHRE04	ADHD Carer support	Programme	11,471.84	1.00	11,471.84
MHRE05	Child & Youth Crisis Respite	Programme	31,412.07	1.00	31,412.07
MHWD01	Workforce Development	Programme	64,479.55	1.00	64,479.55
MHRD01	Oranga Ngatahi Programme	Programme	151,463.47	1.00	151,463.47
MHCR06	Step Programme	Bed day	436,684.92	1.00	436,684.92
MHCS09	Eating Disorder	FTE	110,000.00	0.40	44,000.00

Total Mental Health
20,847,197.85

Health of Older People

Service	Service Description	Unit of Measure	Price 2009/10 \$	Agreed Volumes for 2009/10	Funding 2009/10
HOP226	Environmental Support	Service	78,978.99	1.00	78,978.99
HOP214	ATR Inpatient	Bed day	717.15	4,500.00	3,227,175.00
HOP215	ATR Outpatient - Clinics	Attendance	185.25	196.00	36,309.00
HOP216	ATR Outpatient – Day Hospital & Day Programmes	Day Attendance	206.96	1,300.00	269,048.00
HOP217	ATR Outpatient - domicilliary assessments & education sessions	Visit	184.95	1,150.00	212,692.50

*Health of Older People**3,824,203.49*