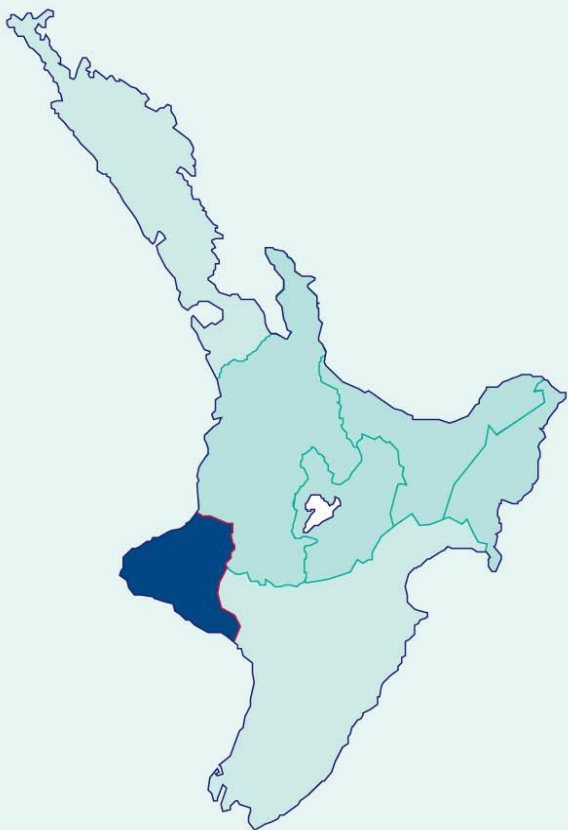




Taranaki District Health Board

**Annual Plan
2013/14**



Our Shared Vision - Te Matakite

Taranaki Together, A Healthy Community
Taranaki Whanui He Rohe Oranga

Our Mission – Te Kaupapa

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

Our Aims

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

Our Values

How We Work Together With Others – Ngā Tikanga

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

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

This document presents our Annual Plan 2013/14 (referred to as the Plan). The Plan is broken into a number of modules that can be extracted for different purposes including presentation of our Statement of Intent 2013/2016. Central to understanding this Plan, is our performance story which sets out our key outcomes (what we are trying to achieve), our impacts (our shorter term contribution to an outcome), our outputs (goods and services supplied), and our inputs (resources).

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

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Private Bag 2016, NEW PLYMOUTH 4342

This document is available on the Taranaki District Health Board website:

www.tdhb.org.nz

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1.0 Module One: Introduction

1.1 Executive Summary

The Taranaki District Health Board is ready to meet the significant challenges of 2013/14 onwards.

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

Our plans and activities for 2013/14 concentrate on supporting service integration and achieving greater efficiency across all health care providers. At a national level this includes collective procurement with our DHBs in conjunction with Health Benefits Limited. At a regional level this includes developing and sustaining a workforce delivering robust clinical pathways for vulnerable services in the Midland Region; and cancer services in the Central Region. Locally, we will continue service integration between the services delivered by the DHB and services delivered by our key primary care partners the Te Kawau Maro Strategic Alliance, the Midland Health Network and the National Hauora Coalition. Our PHO partners have jointly developed and agreed with all the relevant sections of this plan as it relates to their service delivery.

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

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

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

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



Tony Ryall
Minister of Health



Mary K. Bourke
Board Chair



Tony Foulkes
Chief Executive

MINISTER'S LETTER OF APPROVAL



Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

18 JUL 2013

Miss Mary Bourke
Chair
Taranaki District Health Board
Private Bag 2016
NEW PLYMOUTH 4342

Dear Miss Bourke

Taranaki District Health Board 2013/14 Annual Plan

This letter is to advise you I have approved and signed Taranaki District Health Board's (DHB) 2013/14 Annual Plan for three years.

I appreciate the significant work that goes into preparing such a thorough annual planning document and I thank you for your effort. I look forward to seeing your progress over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2013, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Better Public Services (BPS): Results for New Zealanders

The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result areas of reducing the number of assaults on children, increasing participation in early childhood education and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has included step targets in your Annual Plan to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important that your board works closely with other social sector organisations and initiatives, including Whānau Ora.

National Health Targets

Your plan includes a good range of actions that will lead to improved or continued performance against the health targets. The target set has remained stable for 2013/14 allowing you to build on the results from the current year.

Taranaki DHB is performing well in most health target areas. However, in the year ahead I expect Taranaki DHB to particularly focus attention on maintaining the recent pattern of improving performance for the primary care component of the Better help for smokers to quit target, and the More heart and diabetes checks target.

Quality Framework

I recently wrote to DHBs emphasising the need to maintain a focus on the quality and safety of services, both within hospitals and in wider services such as aged residential care and mental health. Ensuring quality will be an on-going focus for us all in the health sector. I expect that DHBs will use the framework that was provided to help shape DHB quality discussions. Also, that DHBs will produce a 'dashboard' of key quality and safety measures to regularly monitor performance and produce Quality Accounts in 2013.

Care Closer to Home

I expect DHBs to increase their focus on integration, particularly with respect to primary care, ensuring the scope of activity is broadened and rate of improvement is increased. I look forward to seeing an integrated approach driving service development, delivery and improved overall system performance; and in preparing to implement integration changes currently under development with the sector.

I am pleased to see an enhanced commitment to tangible actions in your Annual Plan to show how you will achieve real increases in access to diagnostic and treatment services for primary care and service shifts 'closer to home'. I expect DHBs to work in partnership with primary care, using their Alliances to drive service reconfiguration and improved system performance.

I am pleased to see your DHB has developed your Annual Plan jointly with your PHOs, using existing alliances. I look forward to seeing the results of your work to improve the breadth of services primary care has direct access to. In particular, through the implementation of a 'primary options to acute care' programme, increased access to a full range of X-rays and ultrasounds by 3250, direct access to the gastroscopy and minor operations elective surgical booking lists, and formalised arrangements for access to specialist advice for mental health and paediatrics. I look forward to hearing how your National Immunisation Register Services are reconfigured.

Health of older people

The Government expects DHBs to continue to work with primary and community care to deliver integrated services and improve overall quality of care for older people. I am pleased to see that you have developed an Annual Plan which undertakes to meet the Government's expectations for the coming year. Notably, the implementation of a local dementia pathway that follows the national framework, the management of the risk of variable service quality of home and community support services, and proactive use of your HOP specialists to advise and train health professionals in primary and aged residential care. You have also committed to review your wraparound services, roll out the Comprehensive Clinical Assessments in aged residential care facilities, and to establish a fracture liaison service.

Regional and National Collaboration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities. It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions.

Guidance on national entity priorities was provided to all DHBs in April, for inclusion in final 2013/14 Annual Plans, following the successful completion of the Health Sector Forum lead work between the Ministry, national entities and DHBs. I expect that your DHB will deliver on these commitments, as included in your plan financials. Attached is a summary of National Entity Priority Initiatives that shows your DHB's commitments for 2013/14. I look forward to observing progress on the delivery of these priorities.

Living within our means

DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. Improvements through national, regional and sub-regional initiatives are expected to continue to be a key focus for all DHBs.

I note that you are planning for a deficit of \$3.45 million for 2013/14, \$0.94 million for 2014/15 and a small surplus for 2015/16. I will be watching with keen interest your management of financial performance during 2013/14, including the delivery of the improvement initiatives supporting your planned net result.

Budget 2013

The expectation is that you will include a statement in your Annual Plan/SOI to deliver on Budget 2013 initiatives. The Ministry of Health will discuss these more fully with you and develop monitoring arrangements during 2013/14.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

My acceptance of your Annual Plan does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent 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 would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2013/14 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

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

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Tony Ryall', is written over a light blue horizontal line.

Hon Tony Ryall
Minister of Health

1.2 Context

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

This Plan sets out the activities we will undertake in terms of national, regional and local priorities. It describes to Parliament and to the New Zealand public what we intend to achieve in 2013/14, to improve the health of the Taranaki DHB population and to reduce or eliminate health inequalities.

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

We receive funding from Government to undertake our role. The amount of funding is determined by the size of our population, as well as the population's age, gender, ethnicity and socio-economic status characteristics. We are both a funder and provider of health services. In 2013/14 we will receive \$300,694,541 in funding from the Government for most personal health (services to improve the health of individuals), mental health and addictions, Maori health and health of older people services for the Taranaki DHB population.

The Hospital and Specialist Services, our provider division, will receive approximately 52.3 per cent of the service funding with the remaining 47.7 per cent being utilised to fund services including those provided by non-government organisations (NGOs), primary care, pharmacy and laboratories.

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

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

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

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

1.3 Performance Story

The diagrams presented on the following pages provide a high level summary of our performance story and demonstrate the link between our outcomes and our resources. The right hand column of the diagram indicates the relevant module of this Plan for further details.

National Performance Story

Health & Disability System Outcomes	All New Zealanders lead longer, healthier and more independent lives	New Zealand's economic growth is supported	Module 2
Overarching Health Sector Goals	Better, Sooner, More Convenient Health Services for all New Zealanders		



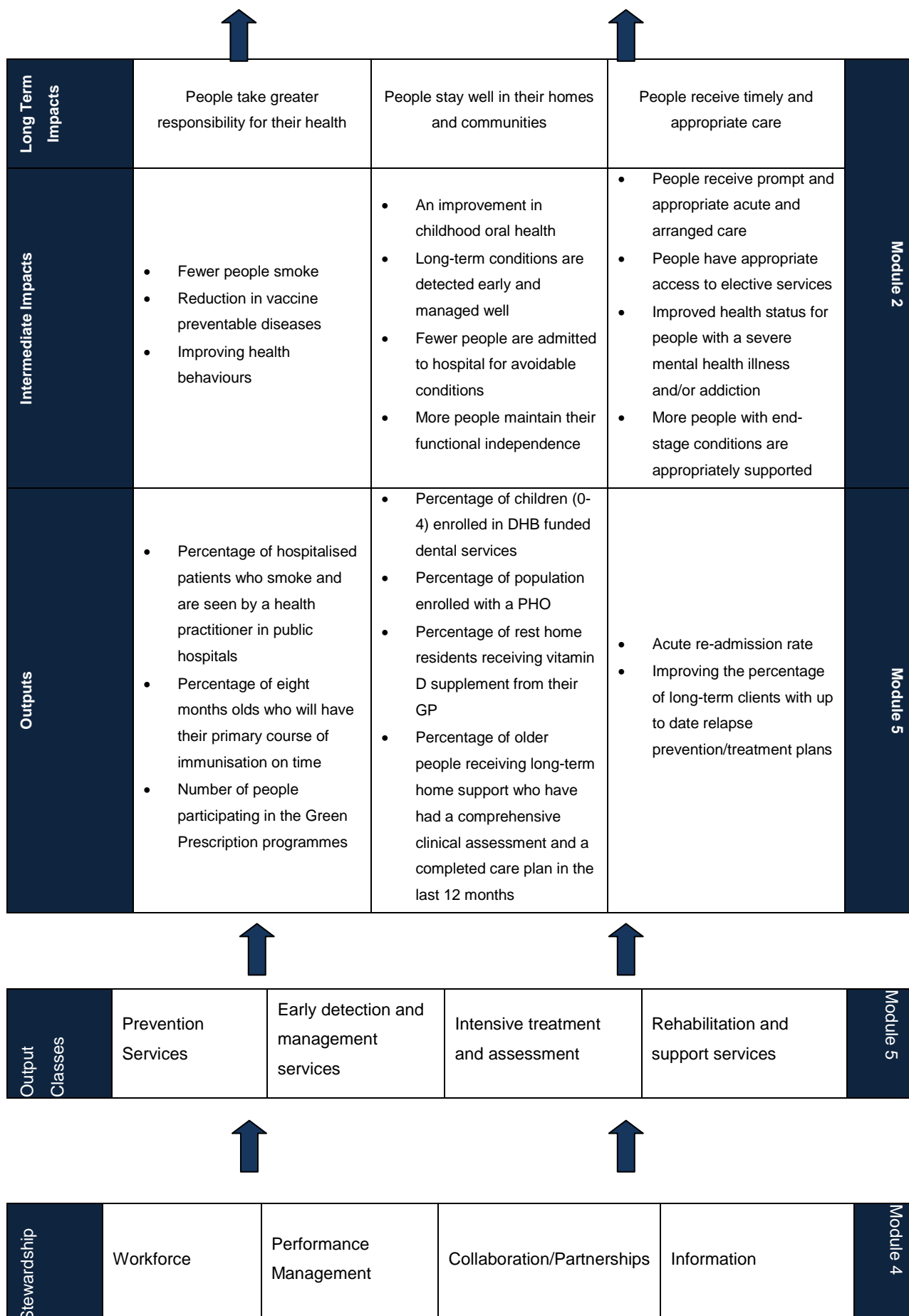
Midland DHBs Performance Story

Midland Vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives					Module 2	
Midland Outcomes	To improve the health of our population		To reduce or eliminate health inequalities				
Regional Strategic Objectives	To build the workforce	Systems integration across the continuum of care	To improve quality access across agreed regional services	To improve clinical information systems	To improve Maori health outcomes		
By focusing on these objectives we will be able to drive change that enables us to live within our means							



Taranaki DHBs Performance Story

Our Vision and Mission	Vision: Taranaki Together, a healthy Community – Taranaki Whanui He Rohe Oranga Mission: Improving Promoting, Protecting and caring for the health and wellbeing of the people of Taranaki					Module 2	
Our Outcomes	To improve the health of our population		To reduce or eliminate health inequalities				
Our Strategic Priorities	Health Targets	Maori Health/Disparities	Health of Older People	Primary Health	Wellness/Chronic Conditions		



1.4 *National Operating Environment*

The Minister of Health with Cabinet and the Government develops policy for the health and disability sector. The Minister is supported by the Ministry of Health and its business units and, advised by the Ministry, the National Health Board, Health Workforce New Zealand, the National Health Committee and other ministerial advisory committees. Accident services are funded by the ACC. Health and disability services in New Zealand are delivered by a complex network of organisations and people. Each has their role in working with others across the system to achieve better, sooner, more convenient services for all New Zealanders. The network of organisations is linked through a series of funding and accountability arrangements to ensure performance and service delivery across the health and disability system.

1.4.1 **Treaty of Waitangi**

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

1.4.2 **Better Public Health Services**

One of the Government's priorities is to ensure New Zealanders can rely on Better Public Services, in tight financial times. This brings an expectation that we will continue to improve performance and find new ways of working to reduce costs and get better traction on difficult issues. The Government has set ten results, in five broad areas, which they expect the public service to achieve over the next five years. Each result has specific and measurable targets. The targets in which the health sector is taking a major role will see us:

- Increase infant immunisation rates so that 95 per cent of eight-month-olds are immunised with three scheduled vaccinations, by 2017.
- Reduce the incidence of rheumatic fever by two-thirds to 1.4 cases per 100,000 by 2017.
- Halt the 10-year rise in children experiencing physical abuse, and reduce the number of children experiencing substantiated physical abuse by over 1000 on projected numbers by 2017.
- Ensure that 98 per cent of children starting school will have participated in Early Childhood Education (ECE) in 2016.

Taranaki DHB is committed to focusing our inputs and outputs as appropriate to contribute to achieving these results.

1.4.3 **Health Sector Challenges and Pressures**

Major, long-term systematic pressures are shaping the way health services will be delivered in the future. These pressures not only impact on New Zealand, but on a majority of health systems across the world, with:

- A changing population – urban growth, rural decline, increasing diversity, an ageing population and evolving family structure
- An increasing burden of chronic conditions
- A reducing rate of funding growth
- Substantial inequalities in health status persisting
- Workforce shortages worsening
- Multiple new technologies being developed
- Public expectations rising

1.5 *Regional Operating Environment*

Taranaki DHB is one of five DHBs that make up the Midland Region. In 2013/14 all five Midland DHBs will continue to progress activities towards regional cooperation in a planned manner. Our region has worked together to develop a Midland DHB Regional Services Plan (RSP) which is available from: www.healthshare.health.nz

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

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

1.6 Local Operating Environment

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

- Two hospital sites
- One mental health inpatient facility
- Five community bases
- Six community mental health residential facilities
- 29 aged related residential care facilities (rest homes)
- 25 pharmacies
- 36 GP practices
- One preferred Maori provider
- Two primary health organisations

1.6.1 Functions of a DHB

As a DHB we will:

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

1.6.2 Our Geography and Population

Our DHB serves a population of 110,258 (extrapolated from the 2006 Census) and covers a geographic area of 723,610 hectares. It stretches from Mokau River in the north to Waitotara River in the south.

Table: Taranaki DHB Map



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

Table: Taranaki DHB projected population by age and ethnicity for 2013/14

Age Group	Ethnicity				
	Maori	Pacific	Asian	Other	Total
00 – 24	10,290	573	1,120	24,250	36,233
25 – 44	4,525	338	1,160	19,970	25,993
45 – 64	3,320	210	690	24,810	29,030
65 – 74	755	43	155	9,375	10,328
75+	420	35	135	8,085	8,675
Total	19,310	1,198	3,260	86,490	110,258

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

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

1.6.3 Health Profile

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

- Around 60% of Taranaki population live in NZDEP2006 Decile 6, 7, and 8 compared to 30% nationally. Non-Maori are over-represented in the wealthiest socio-economic deciles and Maori are over-represented in the lowest socio-economic deciles.
- Within Taranaki, 28% of Maori live in the most deprived 20% of areas compared to 10% of non-Maori. In contrast, 4.2 % of Maori live in 20% of the most affluent areas compared to 12.2% of non-Maori.
- Maori in Taranaki experience a shorter life expectancy than non-Maori. Maori females have a life expectancy of 75.5 years compared to 82.5 years for non-Maori, a difference of 6.9 years.
- Maori males have a life expectancy of 72.4 years compared to 79.0 years for non-Maori, a difference of 6.6 years. This difference is less than that for the general New Zealand population at 7.7 years for females and 7.9 years for males.
- The leading causes of avoidable mortality in Taranaki DHB for non Maori are ischaemic heart disease, cerebro-vascular disease and chronic obstructive pulmonary disease (COPD) and lung cancer. For Maori in the Taranaki District, the leading causes of avoidable mortality are ischaemic heart disease, lung cancer, diabetes and chronic obstructive pulmonary disease (COPD).

In 2011 Taranaki DHB completed a Whānau Ora Health Needs Assessment on the Maori Population in the Taranaki Areas. The following areas were identified as priorities in terms of protective and risk factors and preventative care: smoking, alcohol and drug issues, breastfeeding, immunisation, breast screening and cervical screening. Priority health conditions identified were; diabetes, cardiovascular disease, lung cancer, breast cancer, respiratory disease (i.e. COPD and asthma), oral health, mental health and disability.

2.0 Module Two: Strategic Direction

This module presents an overview of the outcomes we are planning to achieve through a whole of system approach. The outcomes represent what we expect to achieve in the long term (i.e. five plus years) through the actions, initiatives and interventions we are planning and implementing now.

2.1 Maori Health and Reducing Health Inequalities

We are committed to reducing or eliminating the effects of health inequalities through, firstly, identifying them and, secondly, through funding and providing programmes that target inequalities and improve access to services by:

- Implementing Te Matakite 2013/14 (our Maori Health Plan)
- Promoting screening services to hard to reach groups to increase early detection of disease
- Implementing services that target communities with identified health inequalities
- Setting targets by ethnicity or by high needs
- Investing in kaupapa Maori services
- Increasing the capability of the Maori workforce across our district
- Engaging with Te Whare Punanga Korero to provide advice and inform decision making
- Engaging with community health forums and expert advisory groups to provide advice

2.2 National Strategic Outcomes

The following diagram is part of our wider performance story and shows the national strategic direction. The outcomes identified here provide a broad framework for the wider health and disability system. The outcomes are long-term and are influenced by a number of factors and key stakeholders.

Diagram: National Performance Story

Health & Disability System Outcomes	All New Zealanders lead longer, healthier and more independent lives	New Zealand's economic growth is supported
Overarching Health Sector Goals	Better, Sooner, More Convenient Health Services for all New Zealanders	

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

There are two approaches utilised for development of services at a national level; national services and national service improvement programmes. Effective as of 1 July 2013, national services have been identified as:

- Intestinal Failure
- Renal Transplantation
- Hyperbaric Medical Service

During 2013/14 a national service improvement programme is being run around services relating to complex epilepsy. We will continue to support national services and national service improvement programmes.

2.2.1 Minister's Letter of Expectations

The Minister of Health has outlined his expectations for 2013/14 which enables us to plan and prioritise activity for the coming year. The Minister's expectations reinforce the Government's commitment to a public health system that delivers better, sooner, more convenient care and lifts health outcomes for patients within constrained funding increases. Currently the potential areas of priority focus are:

- Better Public Services: Results for New Zealanders
- National Health Targets
- Care Closer to Home
- Health of Older People
- Regional and National Collaboration
- Living Within Our Means

The actions to deliver improved performance (and related measures) against the Minister's expectations are integrated within the information in module three.







HEALTH TARGETS: The six 2012/13 Health Targets are confirmed as continuing into 2013/14:

- Shorter Stays in Emergency Departments
- Improved Access to Elective Surgery
- Shorter Waits for Cancer Treatment
- Increased Immunisation
- Better Help for Smokers to Quit
- More heart and diabetes checks (including stroke)

2.2.2 Nation Wide Health Targets

Improving performance across the sector is fundamental to the Government's goal of Better, Sooner, More Convenient health services for all New Zealanders. One of the mechanisms used to monitor our performance is the nationwide health targets. The following table outlines our target levels for each of the six health targets.

Table: Taranaki DHB Health Targets 2013/14

Health Target	Long Term Target	Taranaki DHB Target
 <p>Shorter stays in Emergency Departments</p>	95 per cent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	95 per cent
 <p>Improved access to Elective Surgery</p>	The volume of elective surgery will be increased nationally by at least 4,000 discharges per year	4,264 total elective surgical discharges
 <p>Shorter waits for Cancer Treatment Radiotherapy</p>	All patients ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.	100 per cent
 <p>Increased Immunisation</p>	90 per cent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 percent by December 2014.	Total 90 per cent
 <p>Better help for Smokers to Quit</p>	<p>95 per cent of patients who smoke and are seen by a health practitioner in public hospitals</p> <p>90 per cent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.</p> <p>Within the target a specialised identified group will include: Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.</p>	<p>Total 95 per cent</p> <p>Total 90 per cent</p>
 <p>More heart and diabetes checks</p>	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.	Total 90 percent

Having a specific focus on these targets will not only impact the chosen areas, but is expected to bring broader benefits such as relieving pressure and lifting performance across the sector.

2.2.3 Better Public Health Services

The Government has set ten results for the public sector to achieve over the next five years. Taranaki DHB is committed to focusing our inputs and outputs as appropriate to contribute to achieving the results. The result that health is taking a lead role in is:

- Result 3: Increase infant immunisation rates and reduce the incidence of rheumatic fever

The results where health is taking a supporting role are:

- Result 2: Increase participation in quality early childhood education
- Result 4: Reduce the number of assaults on children

2.2.4 Non-Financial Monitoring Framework

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

2.3 Regional Strategic Outcomes and Priorities

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

Diagram: Regional Portion of Our Performance Story

Midland Vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives				
Midland Strategic Outcomes	To improve the health of our population		To reduce or eliminate health inequalities		
Midland Strategic Objectives	To build the workforce	Systems integration across the continuum of care	To improve quality access across agreed regional services	To improve clinical information systems	To improve Maori health outcomes
By focusing on these objectives we will be able to drive change that enables us to live within our means					

Our DHB is committed to being an active participant in our regional planning process. This is evidenced by both clinical and management representatives from our DHB being part of the various forums and networks that have been established to guide RSP implementation activities as well as directly funding regional work and positions. HealthShare is tasked with co-ordinating the delivery of regional planning and implementation on behalf of the Midland DHB region. The following table summarises the service and infrastructure priorities in the Midland DHB RSP.

Table: Regional Service Plan Priorities

Service Priorities	Infrastructure Priorities
Vulnerable Services <ul style="list-style-type: none"> • Maternity services • Renal services • Rural Health • Health of older people • Radiology 	<ul style="list-style-type: none"> • Midlands Region IS Plan has been developed and is to be progressed by HealthShare Ltd) as outlined in the RSP). Areas in this Plan include: <ul style="list-style-type: none"> ○ Clinical data reporting ○ Clinical workstations ○ e-Medicines reconciliation • Building the workforce • Maori Health
National Priority Services <ul style="list-style-type: none"> • Cardiac services • Cancer control • Elective services • Stroke services 	Key Enablers <ul style="list-style-type: none"> • Health Quality and Safety Commission • National Health Committee • Asset Planning
Regional activities <ul style="list-style-type: none"> • Mental health and addictions • Smokefree • Trauma 	

In addition to the areas of work outlined in the RSP, the Midland DHB region Chairs and Chief Executives recently agreed to focus on two additional areas being:

- Children's Services
- Health of Older People

2.4 Local Strategic Outcomes and Priorities

To contribute to achieving the outcomes at a national and regional level, we have identified our local strategic intent for 2013/14. Our strategic intent represents a continuation from previous years, as they are not short term issues easily resolved within a 12 month period.

Diagram: Local Portion of Our Performance Story

Our Vision and Mission	Vision: Taranaki Together, a healthy Community – Taranaki Whanui He Rohe Oranga Mission: Improving Promoting, Protecting and caring for the health and wellbeing of the people of Taranaki				
Our Outcomes	To improve the health of our population		To reduce or eliminate health inequalities		
Our Strategic Priorities	Health Targets	Maori Health/Disparities	Health of Older People	Primary Health	Wellness/Chronic Conditions

Our local strategic outcomes align directly to the regional strategic outcomes. At a local level, we will be monitoring the following outcome indicators and will link into regional work as appropriate.

Our priorities areas and a short description are outlined in the following table.

Table: Our 2013/14 Priorities

Strategic Priority	Description
Health Targets	Taranaki DHB is committed to meeting the Health Targets. Improving our performance requires a 'whole of system' approach with a combination of focused attention, clinical leadership and system integration.
Maori Health/Disparities	<p>Improving Maori health and enabling a Whānau Ora approach to the health and wellbeing of Maori living in Taranaki, are priorities for the Taranaki DHB.</p> <p>Understanding of the implications of the Whānau Ora Health Needs Assessment was considered necessary in order to determine the priority areas for service planning for Maori. This in turn will lead to improved health outcomes and reduced inequalities in health.</p>
Health of Older People	<p>We have a growing aging population and generally this population requires a larger proportion of health funding as it ages. To support the management of the services delivered to this group we will focus on the below for 2013/14;</p> <p>Improving quality care in aged residential care through the support the delivery of InterRAI to the ARCC sector A regional model of home and community support services Improving the quality of care in aged residential care Supporting primary care to identify people with dementia and early referral to support Development of clinical pathways relating to delirium, fracture liaison services, advanced care planning Expanding access to interRAI assessment information for hospital and primary care clinicians to support better clinical decision making Development of alternative services to support older people to remain at home or in the community as an alternative to being admitted to hospital Re-alignment of HOP NASC services to work more closely with primary care and older people with the highest risk and need Reduce the readmissions for older people Review initiatives used to minimize inappropriate admissions into long term aged residential care and share regionally</p>
Primary and Community Health Services	Primary and community health services deliver the majority of health and disability services to our population. Closer integration with hospital services will enable even more care to be delivered closer to home.
Addressing Chronic Conditions	Long term conditions are the leading cause of ill health and premature death in New Zealand. They disproportionately affect low income earners, Maori and Pacific people thus contributing significantly to health inequalities.
Financial Performance	Ensuring delivery on agreed financial forecasts and the ability to live within our means, while delivering budget 2013 initiatives.
2013 Budget Initiatives	The DHB will work to deliver the budget 2013 Initiatives and will discuss with the Ministry of Health these more fully in order to develop monitoring arrangements during the 2013/14 year.

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

2.5 Key Risks and Opportunities

Table: Key Risks and Opportunities

Factor	Description	Our Response
Living Within Our Means	The global economic outlook has continued to deteriorate. This, together with the Government's goal of returning to surplus in 2014/15 and the financial impact of hospital redevelopment has driven an even stronger focus on improving fiscal management. There are significant and increasing cost pressures for all providers and very limited scope for new strategic investment.	We will implement a range of practical options including continued management of workforce and non-staff costs within the hospital and specialists services; and the reconfiguration of services, with the aim of delivering care closer to home whilst reducing the overall system costs of service delivery.
Managing in a Changeable Environment	Capacity of the executive and staff to properly manage day-to-day activity while: <ul style="list-style-type: none"> Reconfiguring and integrating services both regionally and locally Implementing new models of care and transferring services to the new hospital 	<p>We will ensure active management and prioritisation of work so that critical outputs are maintained and workloads are balanced to minimise stress and work pressure on staff.</p> <p>We will ensure effective communication and engagement with staff, including provision of the Employee Assistance Programme. Contingency plans will be developed for key roles.</p>
Regional Integration	Integration with other DHBs can assist our DHB with both financial and clinical sustainability.	We will work collaboratively with the other Midland DHBs and actively participate in the development and implementation of the Regional Services Plan.
Integrated Care	Evidence shows that integrating primary care with other parts of the health system leads to better management of long term conditions as well as enabling the whole system to absorb the demands of an aging population.	We will plan and implement new models of care that bring services closer to home. Our key partners in this work will be the Midland Health Network and the National Hauora Coalition.
Health Inequalities	The benefits of improved health may not be shared equitably across population groups. The current pattern of unhealthy lifestyles e.g. obesity, and broader socio-economic changes, such as increased unemployment, suggest that a 'second wave' of health inequalities may develop.	<p>We are committed to reducing or eliminating the effects of health inequalities through:</p> <ul style="list-style-type: none"> Identification Funding, providing and supporting the development of provider led innovations that target inequalities and improve access to services Monitoring the effectiveness of our programmes by ethnicity and for high needs populations
Health Workforce Shortages	Workforce shortages, particularly in rural and provincial areas, are a key threat to the health system's ability to provide a full range of accessible, high-quality health services.	<p>We will work to strengthen the Taranaki health workforce through collaboration with:</p> <ul style="list-style-type: none"> Health Workforce New Zealand Midland Regional Training Network Local partners, e.g. Western Institute of Technology, the Whakatipuranga Rima Rau Trust and other Government agencies

2.6 Key Impacts and Measures of Performance

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

Long Term Impacts	People are supported to take greater responsibility for their health	People stay well in their homes and communities	People receive timely and appropriate care
Intermediate Impacts	<ul style="list-style-type: none"> Fewer people smoke Reduction in vaccine preventable diseases Improving health behaviours 	<ul style="list-style-type: none"> An improvement in childhood oral health Long-term conditions are detected early and managed well Fewer people are admitted to hospital for avoidable conditions More people maintain their functional independence 	<ul style="list-style-type: none"> People receive prompt and appropriate acute and arranged care People have appropriate access to elective services Improved health status for people with a severe mental health illness and/or addiction More people with end-stage conditions are appropriately supported

2.6.1 Long Term Impact One (1) – People are Supported to Take Greater Responsibility for Their Health

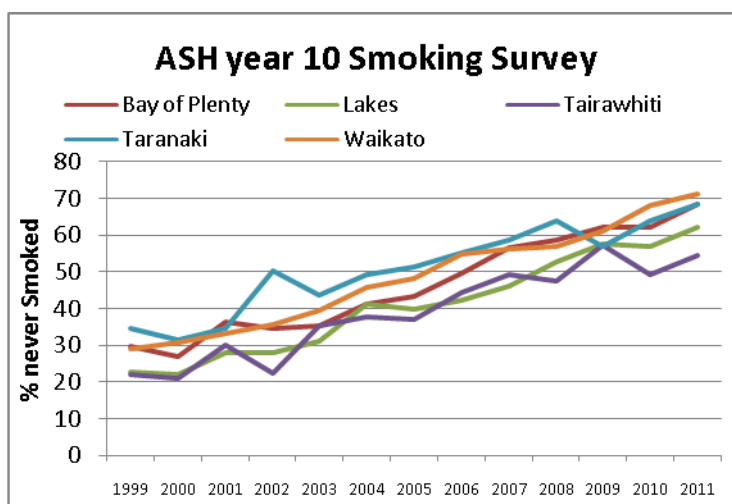
Expectation

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

Why is this outcome a priority?

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

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



2.6.1.1 Fewer People Smoke

Why is this important?

Smoking is a major contributor to preventable illness and long term conditions, such as cancer, respiratory disease, heart disease and strokes. Cancer is the leading cause of death in New Zealand (29.8%), and is a major cause of hospitalisation and driver of cost. Cancer also highlights continuing inequalities, with Maori experiencing a higher incidence (20%+), higher mortality and higher stage at presentation. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say “no” to tobacco smoking is our foremost opportunity to target improvements in the health of our population and to reduce health inequalities for Maori.

Key findings from the 2009 NZ Tobacco Use Survey identify that one in five adults aged 15-64 years (21.0%) and around one in five (18.0%) youth aged 15-19 years are current smokers. While, nationally, we are seeing a decline in smoking rates, we want to reduce the incidence even further. Notably, 80.0% of current smokers aged 15-64 years said “they would not smoke if they had their life over again”.

How will we know we are succeeding?

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

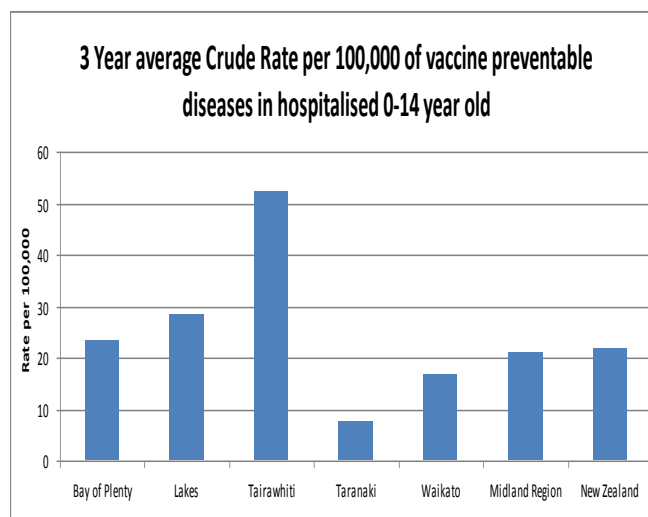
Fewer People Smoke	Actual	Target	Target	Target
	2012	2013	2014	2015
% never smoked	71.1	>71.1	Increase	

2.6.1.2 Reduction in Vaccine Preventable

Diseases

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

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



How will we know we are succeeding?

We will know we have succeeded when we identify a reduction of admissions for vaccine preventable diseases.

Reduction in vaccine preventable diseases	Actual	Target	Target	Target
	09/10 to 11/12	11/12 to 13/14	12/13 to 14/15	13/14 to 15/16
3 Year average Crude Rate per 100,000 of vaccine preventable diseases in hospitalised 0-14 year old	7.36	<7.36	Decrease	

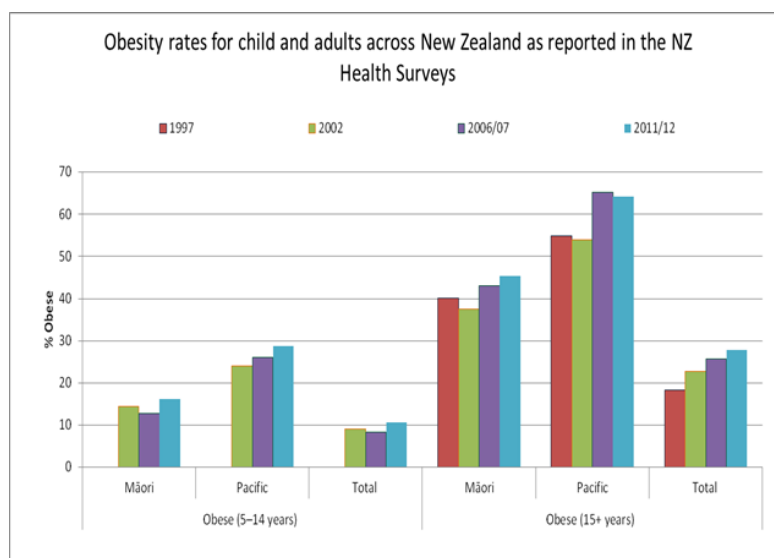
2.6.1.3 Improving Health Behaviours

Why is this important?

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

How will we know we are succeeding?

By seeing a reduction in obesity, a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence people to make healthier choices.



Improving Health Behaviours	Actual	Target		
	11/12	2016/17		
% Obese of New Zealand 5 -14 years population	10.7	reduce rate of increase		
% Obese of New Zealand 15+ years population	27.8	reduce rate of increase		

2.6.2 Long Term Impact Two (2) - People Stay Well in Their Homes and Communities

Expectation

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

Why is this outcome a priority?

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

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

With an ageing population, the Midland Region will require a strong base of primary care and community support, including residential care, respite and home-based support. If long-term conditions are managed

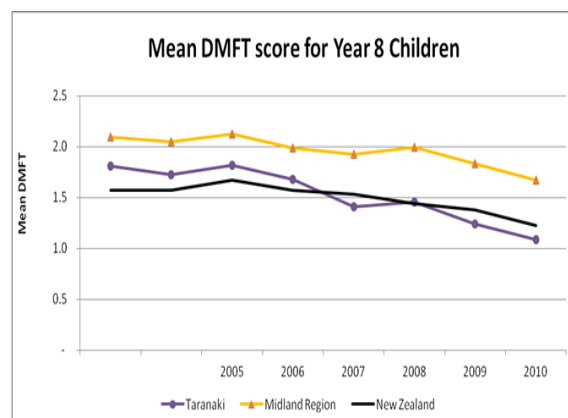
effectively, crises and deterioration can be reduced and health outcomes improved. Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence.

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

2.6.2.1 Children and Adolescents Have Better Oral Health

Why is this important?

Good oral health demonstrates early contact with health promotion and prevention services and reduced risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights. Oral health is also an integral component of lifelong health and impacts a person's comfort in eating (and ability to maintain good nutrition in old age), self esteem and quality of life. Maori children are three times more likely to have decayed, missing or filled teeth, and improved oral health is a proxy measure of equity of access and the effectiveness of mainstream services in targeting those most in need.



How will we know we are succeeding?

With the continued decrease in the DMFT score of year 8 children.

Mean Diseased, Missing or Filled Teeth (DMFT) for permanent teeth.

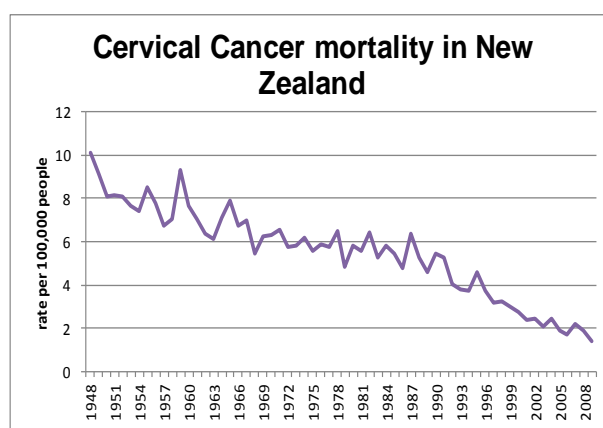
DMFT is a count of Diseased, Missing or Filled Teeth in permanent dentition (permanent teeth) in a person's mouth. By Year 8, children's teeth should be their permanent teeth and any damage at this stage is life long, so the lower a child's DMFT, the more likely that their teeth will last a life time.

Children and adolescents have better oral health	Actual	Target	Target	Target
	2011	2013	2014	2015
Mean DFMT Year 8	1.11	0.91	reduce	

2.6.2.2 Long-Term Conditions are Detected Early and Managed Well

Why is this important?

If we are to empower people to take greater responsibility for their health, to improve the health of our population and if we are to "contain costs" we have a significant opportunity by detecting conditions early. Early detection will lead to either successful treatment, or delaying or reducing the need for secondary and specialist care, enabling more people to stay well in their homes and communities for longer. Our greatest opportunity to do this is to manage Cardiovascular Disease (CVD or heart disease). It is one of the largest causes of death in New Zealand, and disproportionately higher for Māori. Often by the time heart problems are detected, the underlying cause of atherosclerosis (arterial



disease) is usually well advanced. Our aim is to either prevent the disease by modifying risk factors such as healthy eating, exercise and avoiding smoking, or early detection and management. See also Health Targets. Another major cause of death in New Zealand is cancer. If people are encouraged and supported to participate in screening programmes, this will lead to earlier detection and an increased likelihood of successful treatment.

How will we know we are succeeding?

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

Cervical Cancer mortality in New Zealand	Actual	Target	Target	Target
	2009	2013	2014	2015
Aged Standardised rate for NZ	1.4	Decrease		

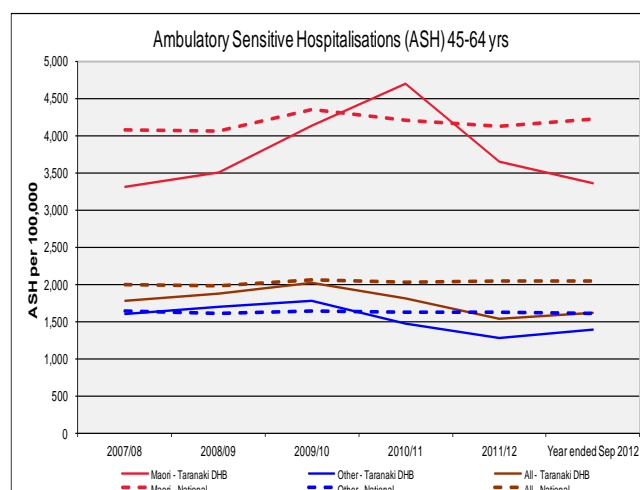
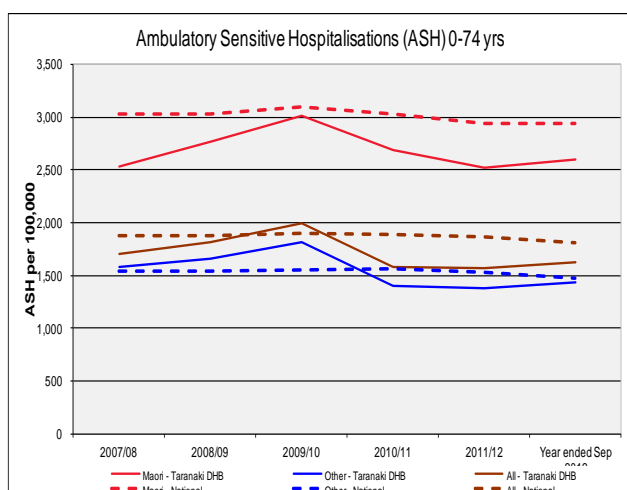
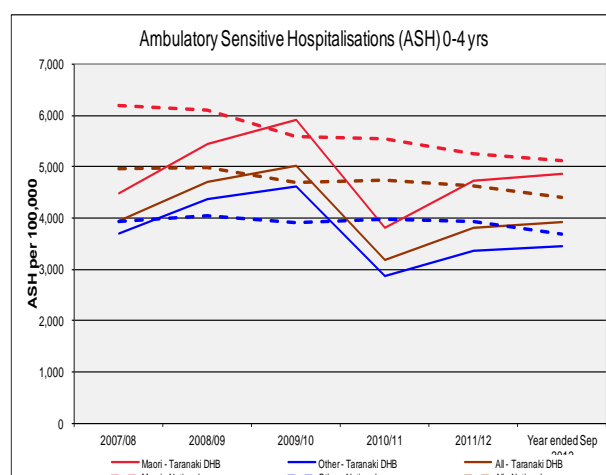
2.6.2.3 Fewer People are Admitted to Hospital for Avoidable Conditions

Why is this important?

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

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

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



How will we know we are succeeding?

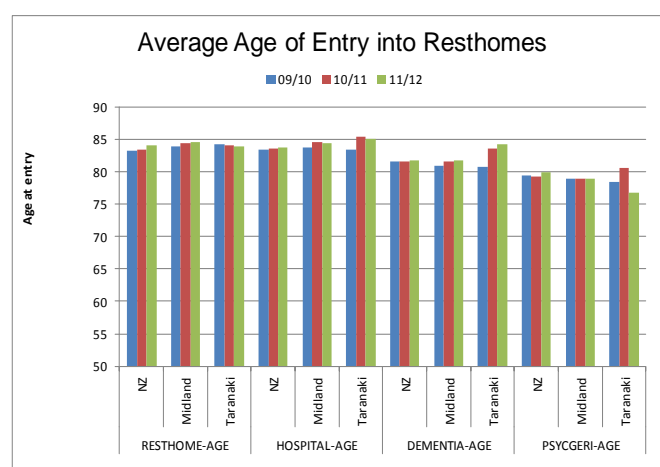
We will know when we have succeeded when we reduce the ratio of actual to expected avoidable hospital admissions for our population (Total and Māori).

Fewer people are admitted to hospital for avoidable conditions	Actual	Target	Target	Target
	Year ended Sep 2012	2013	2014	2015
ASH rate per 100,000 Taranaki DHB 0-74 year olds Total	1,628	<1,628	Decrease	
ASH rate per 100,000 Taranaki DHB 0-74 year olds Maori	2,600	<2,600	Decrease	

2.6.2.4 People Maintain Functional Independence

Why is this important?

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



How will we know we are succeeding?

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

Average Age of Entry to Aged Related Residential Care	Actual	Target	Target	Target
	11/12	13/14	14/15	15/16
Rest Home	83.94	Increase		
Dementia	84.35	Increase		
Hospital	85.14	Increase		

2.6.3 Long Term Impact Three (3) - People Receive Timely and Appropriate Care

Expectation

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

Why is this outcome a priority?

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

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

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

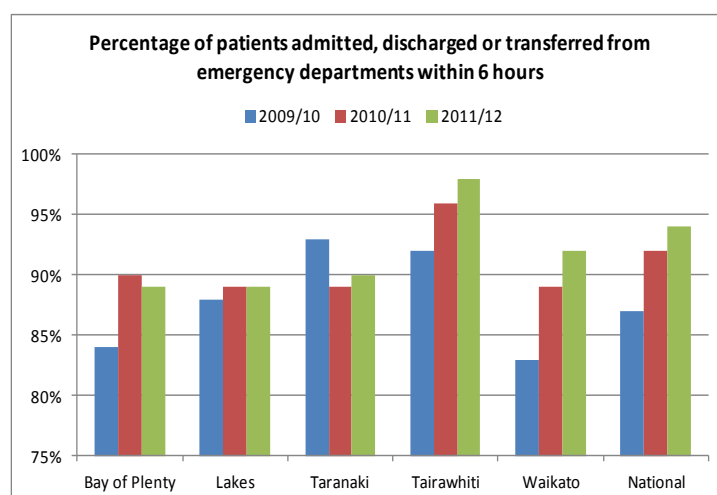
This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the Midland Region has the capacity to provide for the complex needs of its population now and into the future.

2.6.3.1 People Receive Prompt and Appropriate Acute Care

Why is this important?

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

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



How will we know we are succeeding?

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

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

Percentage of patients admitted, discharged or transferred from emergency departments within 6 hours	Actual	Target	Target	Target
	11/12	13/14	14/15	15/16
	90%	95%	95%	95%

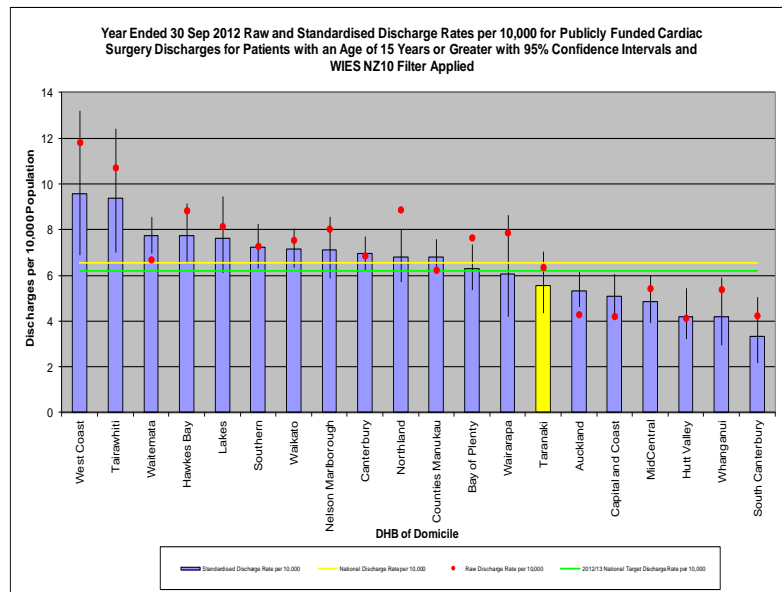
2.6.3.2 People have Appropriate Access to Elective Services

Why is this important?

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

How will we know we are succeeding?

We have chosen cardiac procedures as an impact measure, as the cardiac pathway requires a 'whole of system' approach to achieve an improvement. The inference is that lessons learnt in this service are utilised in others. This includes the effective management of the referral process, increased number of First Specialist Assessments completed, which then leads to improved access to actual cardiac procedures being undertaken, which in turn improves outcomes for patients. To meet the appropriate level of access, we want to ensure that our Standard Intervention Rates (SIRs) meet national expectations for cardiac procedures.

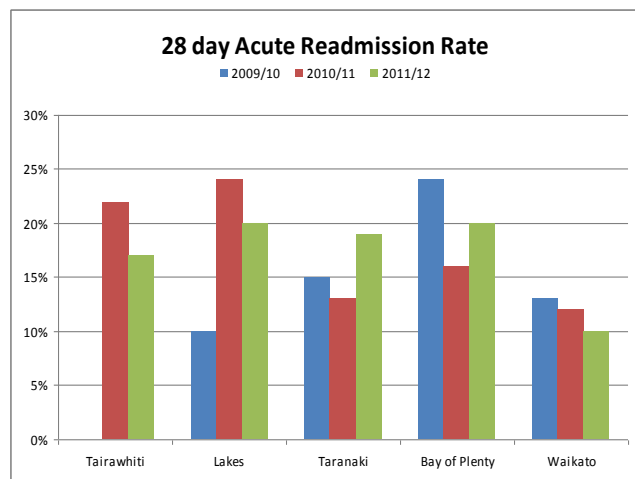


Standardised Discharge Rates per 10,000 for Publicly Funded Cardiac Surgery Discharges	Actual	Target	Target	Target
	11/12	13/14	14/15	15/16
	5.55	≥6.5	≥6.5	≥6.5

2.6.3.3 Improved Access to Mental Health Services

Why is this important?

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



How will we know we are succeeding?

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

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

28 day acute re-admission rates	Actual	Target	Target	Target
	11/12	13/14	14/15	15/16
	19%	≤15%	Decrease	

2.6.3.4 More People with End-Stage Conditions are Appropriately Supported

Why is this important?

For people in our population who have end stage conditions, it is important that they, their family and Whānau are supported to cope with the situation. Our focus is on ensuring that the patient is able to live comfortably, without undue pain or suffering. Early identification and recognition of end-of-life choices heavily influence the quality of life an individual experiences during the dying process. Rehabilitation and Support Services contribute to this impact. Programmes include palliative care, aged residential care, respite care and home based support services.

How will we know we are succeeding?

Palliative care is being accessed, but we want to target those with greatest need. The Palliative Care Council has identified inequalities of access to palliative care based on diagnosis (evidence of under-utilisation by those with non-malignant conditions), with a lack of suitable service provision for children and young people. We would like to see an increase in palliative support for this group.

3.0 Module Three: Delivering on Priorities and Targets

This module outlines the actions that are planned to be delivered to improve the performance of the health system in 2013/14 as well as how we will be measuring success. The actions in this module highlight what the health system will be doing to give effect to the overarching goal of Better Sooner More Convenient Health Services for all New Zealanders. Sections of this module have been developed in collaboration with our primary care partners, the Midland Health Network and the National Hauora Coalition.

The actions and measures presented in this module show:

- How we are implementing Government priorities
- How we are contributing to the activities in the Midland Region Service Plan
- How we plan to improve performance in terms of our local priorities

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

- 3.1** Prime Minister's Youth Mental Health Project
- 3.2** Maternal and Child Health:
 - 3.2.1 Supporting Vulnerable Children
 - 3.2.2 Other Maternal and Child Health
- 3.3** Service Development:
 - 3.3.1 Improving Access to Cancer Services
 - 3.3.2 Achieve Identified Diagnostic Services Waiting Time Targets
 - 3.3.3 Increasing Access to Elective Services
 - 3.3.4 Improving Access to Cardiac Services
 - 3.3.5 Working with Primary Care to Drive Clinical Integration
 - 3.3.6 Implementing the Mental Health and Addictions Service Development Plan
 - 3.3.7 Supporting Whānau Ora Provider Collectives
- 3.4** Acute and Unplanned Care:
 - 3.4.1 Working with Primary Care to Reduce the Impact of Cardiovascular Disease and Diabetes
 - 3.4.2 More Smokers Make More Quit Attempts
 - 3.4.3 Improved Access to Acute Services
 - 3.4.4 Long Term Conditions / Stroke
 - 3.4.5 Wrap around Services for Older People
- 3.5** Living within Our Means

3.1 Prime Minister's Youth Mental Health Project

3.1.1 Context

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

3.1.2 Our Approach

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

3.1.3 Linkages

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

3.1.4 Action Plan

Objective	Actions to Deliver Improved Performance	Measured by: (baselines/dates of delivery for all measures)	Reporting Requirements (expectation of quarterly reporting)
Maintaining and Expanding School Based Health Services (SBHS)	<ul style="list-style-type: none"> • Use of pharmaceutical savings to increase coverage and quality of SBHS in decile 1, 2 and 3 secondary schools, teen parent units and alternative education facilities. Service delivery and checks completed for decile 3 schools by December 2013. • SBHS are delivered as per the service expectations previously advised under the SBHS Crown Funding Agreement variation and draft School Based Health Services Specification. • National Hauora Coalition and TDHB will explore how the successes of the School Based Health Service and Youth Health Practitioner Service can be replicated across the wider Taranaki networks. 	<ul style="list-style-type: none"> • All Taranaki secondary schools rated decile 1, 2 and 3, teen parent units and alternative education facilities with School Based Health Services will receive HEADSSS. • All SBH'S will be delivered Registered Nurses with approved HEADSSS training. • By September of 2013 school year, 75% of the students eligible are completed. • By December of the 2013 school year, 100% of students eligible are completed. • By March of the 2014 school year, 25% of the students eligible are completed. • By June of the 2014 school year, 50% of the students eligible are completed. 	<ul style="list-style-type: none"> • Quarterly reporting on School Based Health Services as outlined in the OPF, including identification of schools with School Based Health Services.
Expanding the Use of HEEADSSS Wellness Checks in Schools and Primary Care Settings	<ul style="list-style-type: none"> • HEEADSSS is a wellness check that is part of SBHS, as noted above. Expansion of the services and checks completed by December 2013 for decile 3 schools. 	<ul style="list-style-type: none"> • Increased numbers of Year 9 students receiving HEEADSSS assessment from nurses in decile 1-3 schools. • Increased HEEADSSS 	<ul style="list-style-type: none"> • Quarterly reporting as per national reporting on School Based Health Services.

	<ul style="list-style-type: none"> Promotion of psychosocial assessment tools such as HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and depression, Safety) as identified in the evidence-based best practice guideline Identification of Common Mental Disorders and Management of Depression in Primary Care (2008) in School Based Health Services and wider primary care settings. 	<p>assessment training to clinicians working in primary care.</p> <ul style="list-style-type: none"> All nurses providing school based health services have completed HEADSSS training. By September of 2013 school year, 75 of the students eligible are completed. By December of the 2013 school year, 100% of the students eligible are completed. By March of the 2014 school year, 25% of the students eligible are completed. 	
Expanding Primary Mental Health Services to all Youth in the 12-19 Year Age Group and Their Families	<p>By September 2013</p> <ul style="list-style-type: none"> Alignment of Midland Health Network services with Primary Mental Health Initiative (PMHI) to provide greater consistency in service delivery across localities and to support development and future application of stepped care model. Integration of child and youth services who use existing PMHI service delivery. <p>Expansion of services into schools. Development of a school based programme for primary mental health which includes:</p> <ul style="list-style-type: none"> Ensuring appropriately trained primary care practitioners as funding for the primary mental health service increase for Taiohi. Adoption of responsive services to meet the unique needs for the youth population 12-19 years in schools. Ensuring services are culturally competent and provided to meet the health needs of Maori and Pacific populations. Identification of points of access in the community and development of referral systems into the primary mental health service, to ensure comprehensive coverage for all youth within the 	<ul style="list-style-type: none"> Standard reporting template as per contractual requirements. Increased primary mental health interventions. Number of schools receiving PMH interventions. <ul style="list-style-type: none"> Refer reporting as per implementation of Taiohi Health Strategy Implementation. 	<ul style="list-style-type: none"> Quarterly and six monthly reporting via PHO contract. Quarterly reporting of progress against the implementation of the Taiohi Health Strategy.

	<p>DHB region including:</p> <ul style="list-style-type: none"> - A clear two-way system between SBHS and the primary mental health service 		
<p>Improve the Responsiveness of Primary Care to Youth</p>	<ul style="list-style-type: none"> • Implementation of the Taranaki Taiohi Health Strategy 2013 – 2016. Supporting Youth 12 – 24 years. • Build on multi-agency stock take undertaken as part of the development of the Taranaki Taiohi Health Strategy to include other agencies/organisations such as Police, Youth Courts, Youth Social Services and Private Counselling Services. • Development and implementation of youth health teams that utilise and build on the current youth specialist expertise that exists and addresses gaps identified through the expansion of the stock-take by March 2014. • Using young people in the design and development of service provision. • As outlined in the Taranaki Taiohi Health Strategy, work with PHOs to reduce cost for access to General Practice and to become more youth friendly. • 75% of identified professionals working with youth are trained in providing smoking cessation programmes by June 2014. • Encourage and support agencies to sign up to a multi-agency/organisational alliance charter. • Work with schools and alternative education providers on the implementation for model of care for Youth Health Teams supporting schools. 	<ul style="list-style-type: none"> • Youth Health Teams developed and implemented – March 2014. • Reducing costs accessing GP – December 2013 • Youth Forum for participation embedded implementation of the Strategy July 2013. • Stock take of additional agency/organisational services completed by December 2013. • Increase in the number of professionals trained to deliver smoking cessation programmes to youth (on-going). • Number of agencies/organisations signed up to a multi-agency charter. • Number of schools and alternative education providers engaged and supported in implementation of Youth Health Teams. • Smoking cessation training – increase of 25% of those working with youth are trained by December 2013. Baseline July 2013 = 0. • By June 2014 75% of identified professionals working with young people are trained. 	<ul style="list-style-type: none"> • Quarterly reporting.
<p>Review and Improve the Follow-Up Care for those Discharged from CAMHS Youth AOD Services</p>	<ul style="list-style-type: none"> • Improve the follow-up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction services through providing follow-up care plans to primary care providers. 	<ul style="list-style-type: none"> • Reporting progress against key milestones identified through pathway development. <p>By September 2013</p> <ul style="list-style-type: none"> • Establishing a pathway for primary care liaison with Primary Care / PHOs. 	<ul style="list-style-type: none"> • Bi-Monthly progress through Local Advisory group.

		<p>By December 2013</p> <ul style="list-style-type: none"> • The follow-up care plans should be provided with the expectation that they are activated by the primary care provider within three weeks of discharge from secondary services ensuring services are culturally competent and provided to meet the health needs of Maori and Pacific populations. • Refine data collection systems and collect baseline data of the percentage of youth discharged from CAMHS and Youth AOD services in primary care being provided with follow up care plans, by 30 June 2014. • Implementation of the Choice and Partnership Approach (CAPA) in CAMHS services by December 2013. 	
Improve Access to CAMHS and Youth AOD Services through Wait Time Targets and Integrated Case Management	<p>By March 2014</p> <ul style="list-style-type: none"> • Development of a plan for implementation of phased waiting time targets that by 2015 that will enable: 80 percent of youth to access services within three weeks; 95 percent to access services within eight weeks of contact. 	<ul style="list-style-type: none"> • Delivery to agreed targets through (PP8). • Monitoring of milestones and activities against implementation plan. • Participation in the CAMHS KPIs benchmarking projects and setting of local quality improvement initiatives. 	<ul style="list-style-type: none"> • Progress in delivery to agreed targets (PP8).

3.2 *Maternal and Child Health*

This section contains the following components:

- 3.2.1 Supporting vulnerable children
- 3.2.2 Other maternal and child health

Each of these components has a separate set of information and action plan in this section.

3.2.1 Supporting Vulnerable Children

3.2.1.1 Context

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

3.2.1.2 Our Approach

Through collaboration with Midland Health Network and other DHBs, we have financially supported the development of an IT Platform (Catch 18) to identify all children/tamariki at birth:

- Support them to enrol with a GP and Well Child provider as early as possible
- Alert health providers when a child or young person is due for a health milestone
- Better inform all providers about the progress of a child or young person

Catch 18 will be piloted in Waikato DHB during 2014/14 including the set-up of a co-ordination service. Taranaki DHB will have access to the system and co-ordination service in 2014/15.

During 2013/14 we will continue our focus on meeting the increased immunisation health target. There are many stakeholders from across the sector whose individual work forms part of the 'greater whole' in terms of the approach to childhood immunisation in this district. The results against the health target for our district reflect the combined effort of all these stakeholders.

3.2.1.3 Linkages

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

3.2.1.4 Action Plan

Objectives	Actions to Deliver Improved Performance	Measured By: (baselines/dates of delivery for all measures)	Reporting Requirements (expectation of quarterly reporting)
Increase Infant Immunisation Rates	<ul style="list-style-type: none"> Maintain an immunisation steering group that includes all the relevant stakeholders for the DHB's immunisation services including the Public Health Unit and that participates in regional and national forums and progresses actions from the TISG Strategic Plan. Work with primary care partners to implement newborn enrolment policy and monitor newborn enrolment rates. Monitor immunisation coverage at DHB, and PHO level manage identified service delivery gaps. Monitor and target clusters of children who decline or who are overdue through OIS. Identify immunisation status of children presenting at hospital and refer for immunisation if not up to date. This is carried out through regular status reports undertaken each day in the wards. These are then sent to Immunisation team for follow up as necessary. In collaboration with primary care stakeholders develop systems for seamless handover of mother and child as they move from: maternity care services to general practice and WCTO services. Taranaki does not have any plans to implement changes in the configuration of National Immunisation Register Services during 2013-14. Discussion will continue with PHOs, Outreach Immunisation Providers and the DHB on the optimal configuration of NIR services during 	<ul style="list-style-type: none"> 85% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014). 95% of newborns enrolled on the NIR at birth (measure NIR). 100% of newborns enrolled with general practice (measured at 6 weeks, measure B code uptake). Narrative report on DHB and interagency activities to promote immunisation week . 90% of 6 week immunisations are completed (measured through the completed events report at 8 weeks). Monthly monitoring of Dashboard reporting. Increase uptake of immunisations for Maori and reduce inequalities between total and Maori not less than 5%. A decision will be made regarding NIR configuration by end of the 1st Quarter 2014. Following the above decision, we will either: implement the agreed plan, or confirm no 	<ul style="list-style-type: none"> Progress against Health Target. Progress on specific actions through TISG. Monitoring and Progress through Taranaki DHB Immunisation Dashboard. Quarterly report/update.

	<p>2013-14.</p> <p>By March 2014</p> <ul style="list-style-type: none"> In collaboration with NGOs and government agencies, develop initiatives to that increase working across agencies to increase immunisation coverage. 	<p>further changes required to the service configuration.</p>	
Supporting the Children's Action Plan Implementation	<p>By September 2013</p> <ul style="list-style-type: none"> Establishment of a Taranaki Child Health (multi-agency/organisational) Advisory group to support current and new initiatives and programmes for children. The Advisory Group to be kept informed of developments in the demonstration sites and provide advice and support as needed. The Advisory Group will be responsive to further guidance and expectations from Government on planning and progressing implementation for Taranaki. <p>By June 2014</p> <ul style="list-style-type: none"> Agree the local Perinatal Client Pathway by September 2013. Implementation Plan developed for Pathway by December 2013. Lower threshold for access & entry to services for those with higher vulnerability. Priority response from CMH intake coordinator to referrers and forwarding to clinics for assessment. Support for access to parenting groups, including Great Fathers, and perinatal programmes. Increased collaboration across primary and secondary and perinatal and specialist child health teams through the implementation of the local Perinatal Client Pathway. 	<ul style="list-style-type: none"> 6 monthly monitoring of milestones against ongoing guidance and actions as released by the Government. Quarterly month reporting against milestones. 50% of the Implementation Plan for the Perinatal Client Pathway is completed by March 2013. 100% of the Implementation Plan for the Perinatal Client Pathway is completed by June 2014. 	6 monthly

Reduce the Number of Assaults on Children/Implement the Children's Action Plan	<ul style="list-style-type: none"> Implementing CAP initiatives. All DHBs are expected to contribute to the successful implementation of the CAP (including supporting the DHBs in the Children's Teams demonstration sites as needed). This includes ensuring DHB staff and local primary and community health partners are regularly kept up-to-date with CAP developments and have opportunities to contribute to its implementation. Children's Teams are expected to be progressively rolled out in other Health Board districts. To prepare to implement the 'wrap around care' for vulnerable children envisaged under the CAP, DHBs will need to undertake service and development planning so that a continuum of services across primary and referred health services are well positioned to meet the needs of vulnerable pregnant women, children and families, including for referrals from Children's Teams and Child Youth and Family (for children in state care). 	<ul style="list-style-type: none"> Taranaki DHB has representation on New Zealand Paediatric Society Special Interest Group (NZPS SIG CP) in discussions on DHB Children's Teams. There are two DHB pilot sites. We are advised to wait for feedback from DHB pilot sites and a plan going forward will be developed at a later date through the PSNZ. From 1 July 2013 Establish governance arrangements and engagement processes within the DHB and with primary and community partners regarding implementation of the Children's Action Plan. By December 2013 Undertake a stock take of services for vulnerable pregnant women, children and parents across the care continuum identify service coverage, wait times, capacity issues and gaps By March 2014 Use findings from the stock take to inform the steps that will be taken towards ensuring the right mix and intensity of services to support vulnerable pregnant women, children and parents for inclusion in 2014/15 planning. The DHB will demonstrate that its service planning is linked with the implementation of the Mental Health and Addiction Service Development Plan (Ministry of Health 2012) and Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand (Ministry of Health, 2012). The DHB will demonstrate that its systems for identifying and responding to child maltreatment continue to 	Quarterly against milestones.
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		<p>be developed and strengthened, including:</p> <ul style="list-style-type: none"> • National Child Protection Alert System (NCPAS). The monitoring and evaluation of NCPAS implemented April 2012. • The Taranaki DHB systems were approved 26 March 2013 to replace NCPAS • The identification, assessment and referral responses to vulnerable children and their families through Violence Intervention Programmes in designated services: Child Health, Sexual Health, Emergency Departments, Mental Health & Addiction Services with training being rolled out to Maternity in July 2013. • Policy & Procedures, systems, supports and training align with Ministry of Health Family Violence Intervention Guidelines: Partner and Child Abuse. • Intersectoral collaboration through: Multi-agency Safety Planning Meeting Prior to Discharge forum, local meetings under MOU between Police, Child Youth and Family and DHB. Monitoring of this MOU will be undertaken by key stakeholders including CYF, Police and TDHB to guide interagency partnerships for child protection issues. • Continual progression of training of DHB professionals to recognise signs of abuse and maltreatment in designated services. This has been ongoing since 2009 supported by coordination of partner abuse and child abuse and neglect including child protection to support increased identification of 	
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		<p>vulnerable children.</p> <ul style="list-style-type: none"> • Regional implementation and monitoring of the MOU with Child Youth and Family, Police and Taranaki DHB including Schedules 1 and 2 through quarterly meetings. • Family, Police and DHBs for interagency collaboration for child protection and Schedules 1 and 2 to support better integration across health and social services for vulnerable families. • Shaken Baby Prevention Programme (SBPP) within Taranaki DHB launched 23 April 2012. Invitation to all DHB staff, Primary Health, non-government organisations, Child Youth and Family, Police. SBPP continue to be included in DHB FVIP core training. 	
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<p>Contribute to Increased Participation in Quality and Early Childhood Education</p>	<ul style="list-style-type: none"> • Working with primary and community based health services to raise awareness of the importance of early childhood education in improving health and wellbeing and education outcomes and guided by Ministries of Education and Health. • Strengthening connections between frontline health services working with families with young children and early childhood education • Contributing to initiatives that help to locate, engage and retain vulnerable children in quality early childhood education, including for example integration projects and initiatives stemming from the Children's Action Plan • An expectation that primary and community based services will raise awareness of early childhood education and be able to connect families with ECE is consistent with, for example, the expectations set out for Well Child providers in the Well Child National Schedule. <p>By June 2014</p> <ul style="list-style-type: none"> • DHB and MOE actively working together on dissemination of agreed information and development of local pathways from health services to ECE services. 	<ul style="list-style-type: none"> • The Ministry will work with the Ministry of Education in 2013/14 to further consider how we could monitor referrals to ECE using a mix of education and health sector data, such as Well Child and B4SC data. • Quarterly reporting process, on the actions taken to encourage PHOs and DHB employed/contracted frontline workers (such as public health nurses) to routinely provide information about ECE, ask and know how to connect parents to local ECE providers in their communities. • Quarterly progress on DHB/MOE working together to progress milestones. 	<p>Quarterly updates on actions to support improved participation rates</p>
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Reduce the Incidence of Rheumatic Fever	<ul style="list-style-type: none"> TDHB will develop and implement a rheumatic fever prevention plan by 1 October 2013 in line with the MOH template and proportionate to the low prevalence of Rheumatic Fever in the DHB. <p>This may include:</p> <ul style="list-style-type: none"> Ensuring that primary care providers and other health professionals likely to see high risk children follow the National Heart Foundation Sore Throat Management Guidelines. Ensuring people with Group A streptococcal infections are treated appropriately within 7 days of developing symptoms. Ensuring that all cases of acute rheumatic fever are notified to the Medical Officer of Health within 7 days of hospital admission. Reviewing all cases of rheumatic fever to identify any identifiable risk factors and system failure points. Ensuring patients with a past history of rheumatic fever receive monthly antibiotics not more than 5 days after due date. National Hauora Coalition will support their providers with CME/CNE on prevention and treatment of rheumatic fever. 	<ul style="list-style-type: none"> TDHB's Hospitalisation rate at 0.8per 100,000 total population for acute rheumatic fever is lower than the national average over the last 3 years (measured by National Minimum Data Set). The national 2013/14 targets for DHBs are: <table border="1"> <thead> <tr> <th colspan="3">2013/2014 Target rheumatic fever number and rate reductions, 10% below 3-year average</th></tr> <tr> <th>DHB</th><th>Number</th><th>Rate</th></tr> </thead> <tbody> <tr><td>Northland</td><td>15</td><td>9.5</td></tr> <tr><td>Waitemata</td><td>11</td><td>2.0</td></tr> <tr><td>Auckland</td><td>15</td><td>3.2</td></tr> <tr><td>Counties Manukau</td><td>64</td><td>12.4</td></tr> <tr><td>Northern Region</td><td>105</td><td>6.2</td></tr> <tr><td>Waikato</td><td>12</td><td>3.3</td></tr> <tr><td>Lakes</td><td>8</td><td>7.3</td></tr> <tr><td>Bay of Plenty</td><td>7</td><td>3.4</td></tr> <tr><td>Tairāwhiti</td><td>4</td><td>8.4</td></tr> <tr><td>Taranaki</td><td>1</td><td>0.8</td></tr> <tr><td>Midland Region</td><td>32</td><td>3.8</td></tr> <tr><td>Hawke's Bay</td><td>6</td><td>3.9</td></tr> <tr><td>MidCentral</td><td>3</td><td>2.0</td></tr> <tr><td>Whanganui</td><td>2</td><td>2.9</td></tr> <tr><td>Capital and Coast</td><td>8</td><td>2.8</td></tr> <tr><td>Hutt</td><td>6</td><td>4.4</td></tr> <tr><td>Wairarapa</td><td>0</td><td>0.0</td></tr> <tr><td>Central Region</td><td>26</td><td>2.9</td></tr> <tr><td>Southern Region</td><td>5</td><td>0.5</td></tr> <tr><td>New Zealand</td><td>168</td><td>3.7</td></tr> </tbody> </table> <ul style="list-style-type: none"> TDHB will monitor rates. 	2013/2014 Target rheumatic fever number and rate reductions, 10% below 3-year average			DHB	Number	Rate	Northland	15	9.5	Waitemata	11	2.0	Auckland	15	3.2	Counties Manukau	64	12.4	Northern Region	105	6.2	Waikato	12	3.3	Lakes	8	7.3	Bay of Plenty	7	3.4	Tairāwhiti	4	8.4	Taranaki	1	0.8	Midland Region	32	3.8	Hawke's Bay	6	3.9	MidCentral	3	2.0	Whanganui	2	2.9	Capital and Coast	8	2.8	Hutt	6	4.4	Wairarapa	0	0.0	Central Region	26	2.9	Southern Region	5	0.5	New Zealand	168	3.7	6 monthly
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3.2.2 Other Maternal and Child Health

3.2.2.1 Context

Better Sooner More Convenient Health Services for mothers, babies and children and their families means families do not have to navigate multiple systems in order to access the services they need.

Maternity services are identified as a vulnerable service area in our RSP. Maternity is the lynchpin of acute services in provincial areas, and obstetrics was clearly identified as a vulnerable service early in the development of regional planning. HealthShare through the Midland Maternity Action Group are leading the development and implementation of regional actions focusing on opportunities to strengthen quality improvement activities regionally.

Helping women who smoke during pregnancy to quit has significant health impacts; reducing the risk of foetal abnormality, placental insufficiency, miscarriage, preterm birth and infant mortality and provides a smoke free environment for the child.

3.2.2.2 Our Approach

TDHB is a smokefree hospital and actively promotes quitting smoking in the child maternal health areas. All women and their families are asked about their smoking status at their booking for secondary care or with an LMC. If they do smoke they are given active support in the form of education, counselling and pharmaceutical support, e.g. patches, to quit. Family members are also given counselling and advice to quit smoking. All actions are documented in the patients notes. In addition to the above there are posters supporting quitting in all patient and public areas. Identification of smoking and reduced smoking rates are also targets for our Maternity Quality and Safety Committee. This committee includes members of the public and primary maternity groups.

3.2.2.3 Linkages

- Minister's Letter of Expectation
- Health Target – Better Help for Smokers to Quit
- Our Performance Story Impact: People stay well in their homes and communities

3.2.2.4 Action Plan

Objectives	Actions to Deliver Improved Performance	Measured By: (baselines/dates of delivery for all measures)	Reporting Requirements (expectation of quarterly reporting)
Higher Coverage and More Equitable Access to Universal Services and Primary Care TDHB is Committed to Ensuring the B4 School Check Coverage Maintained or Improved	<ul style="list-style-type: none"> • Increase number of women who register with an LMC by week 12 of their pregnancy. • (This will be achieved by focussed communication with within vulnerable groups around the importance of registering with an LMC early). • Communication is delivered by public health nurses, GPs, Kaiawhina, early education groups, and schools. 	<ul style="list-style-type: none"> • Establish baseline measure for phased plan for improvement. • Women are supported to maximise their health and the health of their baby during pregnancy. • At least 90% of all eligible children receive a B4 School Check, including at least 90% of children in most deprived regions. 	<ul style="list-style-type: none"> • Report quarterly on progress towards achieving as close as possible to 100% coverage of under-six access to free after hours primary care and where the DHB is not achieving this, report quarterly on proposed actions to improve coverage. • Contract Reporting quarterly.

	<ul style="list-style-type: none"> Geographical monitoring of gaps in uptake of B4 School Checks. Targeted clinics in response to gaps analysis. Work with primary care partners to ensure every pregnant woman is enrolled with a PHO and registered with a GP. Ensure universal access to the core WCTO services and equitable access to additional WCTO contacts. B4 School Check coverage maintained or improved. Work with Midland Health Network and National Hauora Coalition to ensure as close as possible to 100% of under-sixes have access to free after hours primary care. Pregnant women, who smoke receive advice and support to quit, measured as per the health target – refer to the Tobacco Health Target. 	<ul style="list-style-type: none"> Decrease in ASH rates for 0 – 4 year olds. (Refer SI: 1). National quarterly reporting 	<ul style="list-style-type: none"> National reporting quarterly
	<ul style="list-style-type: none"> Work with LMCs and within maternity services to enable clinicians to support pregnant women who smoke to quit. 		Quarterly
	<ul style="list-style-type: none"> Ensure pregnancy and parenting education meets the needs first time mothers with a focus on the needs of vulnerable groups such as teen parents and families where English is a second language. Review and implement pregnancy and parenting education in line with MOH service specification (to be released) with a view to improving access for vulnerable women and whānau. Immunisations, breastfeeding and oral health promotion are 	<ul style="list-style-type: none"> Progress report detailing on action to improve access to DHB funded parenting and pregnancy education and to ensure parenting and pregnancy education meets the needs of vulnerable families. Providers will begin delivering ... services in line with new specifications once contracts are formalised and implemented from June 2014 or earlier of service specifications are introduced significantly earlier. 	<p>Quarterly through contract reporting.</p> <p>Quarterly Monitoring Report.</p>

	<p>mandatory components of pregnancy and parenting course curriculum.</p> <ul style="list-style-type: none"> Support the implementation of the Breastfeeding Community Support Service by Tui Ora Limited which includes implementation of Breastfeeding Friendly Community Initiative (BFCI) and the Breastfeeding Peer Support initiative. Maintenance and extension of BFCI accreditation with current 4 organisations. Training of 6 new Peer Support Counsellors using existing framework. Delivery of Peer Support Counsellor Service to 120 new referral. 	<ul style="list-style-type: none"> Consistent increases in breastfeeding rates by 30 June 2014 at: 6 weeks towards the target of 74% 3 months towards the target of 57% 6 months towards the target of 27% Annual education standards (over 2 financial years) are achieved by all 4 organisations by 30 June 2015. 6 new PCS's completed training by 30 June 2014 Receive 120 new PSC referrals by 30 June 2015. 	<p>Quarterly Report Monitoring</p> <p>Quarterly Report Monitoring</p> <p>Quarterly Report Monitoring</p> <p>Quarterly Monitoring</p>
Improved Oral Health	<ul style="list-style-type: none"> Increasing the enrolment of pre-school children in publicly funded child oral health programmes. Increase communication to schools on the free oral health services for adolescents. 	<ul style="list-style-type: none"> PP11 and PP13 Increased uptake of adolescent completion rates PP12. 	DHB Quarterly reporting and provider contract reporting.
More Timely Access to Specialist and Referred Services	<ul style="list-style-type: none"> Demonstrate improved access to maternal/ perinatal mental health services for pregnant and postpartum women. <p>Actions include:</p> <ul style="list-style-type: none"> Application of a local perinatal client pathway including roll out of education for staff around the use of the tool. Lower threshold for access and entry. Assertive outreach by perinatal clinicians. Support for access to parenting groups. Collaborative primary 	<ul style="list-style-type: none"> Reduced DNA rates 	<ul style="list-style-type: none"> Performance against measures (tbc). Performance against local wait times measures (as developed in 2012/13). Progress on specific actions to address access to services with significant wait times.

	<p>and secondary services.</p> <ul style="list-style-type: none"> Improved access to child specialist services by focussing on Maori DNA rates by increasing the number of community based clinics. Monitor timeliness of access to referred services following WCTO referral and B4SC assessment and implements actions required to expedite service delivery. 	<p>for Maori from 17%</p> <ul style="list-style-type: none"> No waiting times when LMCs and DHBs refer women for maternal/perinatal mental health services. All infants and children identified as requiring referral for specialist advice or care receive timely access to appropriate services. Children referred following a B4 School Check are seen before their fifth birthday. 	
Quality Improvement Across all Services	<ul style="list-style-type: none"> Improved quality and safety of maternity services including improved access, outcomes and consumer satisfaction. Consolidate the Maternity Quality and Safety programme, and identify actions for 2013/14 to embed MQSP as business as usual by June 2015. Support quality improvement of the B4 School Check programme including high quality data collection and reporting. Incorporate Quality Improvement Framework (in development 2012/13) across all WCTO services including B4SC. By June 2014 Process established for the rollout of CATCH18 in the 2014/15 year. 	<ul style="list-style-type: none"> As monitored against the Maternity Quality and Programme Safety milestones. Findings of B4SC quality improvement letters. Quality of B4SC service delivery improves. Implementation of the WCTO Quality Improvement Plan, building on national and local reviews. Unnecessary variation in the delivery of WCTO is reduced. Access to WCTO and associated services is improved. Progress report on incorporating the findings of the B4 School quality improvement letters to improve service delivery Progress report on specific actions to implement the Quality Improvement Framework 	<ul style="list-style-type: none"> Maternity Quality and Safety Programme Strategic Plan in place as soon as possible in 2013/14. Second annual Maternity Quality and Safety Programme report by 30 June 2014 Progress on specific actions to locally implement the Quality Improvement Framework. Quarterly

3.3 Service Development

This section contains the following components:

- 3.3.1 Improving Access to Cancer Services
- 3.3.2 Achieve Identified Diagnostic Services Waiting Time Targets
- 3.3.3 Increasing Access to Elective Services
- 3.3.4 Improving Access to Cardiac Services
- 3.3.5 Working with Primary Care to Drive Clinical Integration
- 3.3.6 Implementing the Mental Health and Addictions Service Development Plan
- 3.3.7 Supporting Whānau Ora provider collectives to transform to a Whānau-centred integrated approach to deliver improved Whānau health and other social outcomes

Each of these components has a separate set of information and Action Plan in this section.

3.3.1 Improving Access to Cancer Services

3.3.1.1 Context

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

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

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

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

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

3.3.1.2 Our Approach

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

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

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

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

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

3.3.1.3 Linkages

- Minister's Letter of Expectations
- National Cancer Programme Work Programme
- Midland DHBs Regional Services Plan 2013/14
- Central Cancer Network Strategic Plan
- Hei Pā Harakeke Action Plan
- Health Target – Shorter Waits for Cancer Treatment
- Our Performance Story Impact: People receive timely and appropriate specialist care

3.3.1.4 Action Plan

Key Objective / Planning Approach	Actions to Deliver Improved Performance	Measured By	Reporting Requirements
Shorter Wait Times for Cancer Treatment	<ul style="list-style-type: none"> • Sustain performance against the radiotherapy and chemotherapy wait time targets by more efficient use of existing resources; and investing in workforce and capacity as required. • Report against the shorter waits for cancer treatment target on a monthly basis. • Implement priority areas identified in the national (developed by Oct 2013) and regional (developed by Apr 2013) radiation oncology capital and service plans. • Implement the priority areas identified in the National Medical Oncology Models of Care Implementation Plan 2012/13, including continuing to progress e-prescribing. 	<ul style="list-style-type: none"> • All patients ready for treatment, wait less than four weeks for radiotherapy or chemotherapy. • Increased standardisation in Medical Oncology processes, procedures and workforce across the region. 	Monthly report on progress against measures
Implement the Faster Cancer Treatment (FCT) Work Programme	<p>Deliver against the Regional FCT Implementation plan 2012/13, which has Ministry funding through to October 2013 (total funding for plan \$335K over 2012/13 and 2013/14). Action areas include:</p> <ul style="list-style-type: none"> • Identify and implement actions to improve faster cancer treatment data collection systems to support service improvements along 	<ul style="list-style-type: none"> • DV1: Faster cancer treatment (establishment of baseline). Including the following: • 62 day indicator - proportion of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days. 	Quarterly report on progress against measures

	<p>cancer patient pathway - continued improvement to processes implemented as enabled by CRISP and national IT developments.</p> <ul style="list-style-type: none"> • Improve the functionality and coverage of multidisciplinary meetings (MDMs) across the region – Regional MDM Plan delivered to improve infrastructure and technology support for MDMs. • Begin implementing the national tumour standards of service provision – identify and plan to address gaps against prioritised tumour standards. • Enable and support cancer nurse coordinators attendance at national and regional training and mentoring forums. • Implement priorities identified in the Prostate Cancer Quality Improvement Plan, through the establishment of a Regional Prostate Cancer Steering Group to identify and address regional priorities. 	<ul style="list-style-type: none"> • <i>14 day indicator</i> - proportion of patients referred urgently with a high suspicion of cancer who have their first specialist assessment within 14 days. • <i>31 day indicator</i> - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision-to-treat. <p>MDM Indicators:</p> <ul style="list-style-type: none"> • % patients accessing MDMs (by tumour stream, DHB, ethnicity) • MDM interconnectivity across the region. <p>Tumour Standards:</p> <ul style="list-style-type: none"> • An audit of one of the Tumour Standard of service provision is completed. 	
Improve Waiting Times for Diagnostic Services: Colonoscopy	<ul style="list-style-type: none"> • Support the implementation of the Endoscopy Quality Improvement (EQI) Programme. • The aim of the EQI programme is to provide safe, patient-focused endoscopy services that are efficient, accountable and sustainable. (Led by national endoscopy leads). 	<p>DV2: Improving waiting times for diagnostic services: Colonoscopy as per the diagnostic waiting time indicator (colonoscopy) template</p> <p>Diagnostic Colonoscopy : 50% of people accepted for an urgent diagnostic colonoscopy receive their procedure within two weeks (14 days).</p> <p>50% of people accepted for a diagnostic colonoscopy received their procedure within six week (42 days).</p> <p>Surveillance Colonoscopy: 50% of people accepted for a surveillance colonoscopy receive their procedure within twelve weeks (84 days) of the planned date</p>	Quarterly report on progress against measures
Improving Palliative Care	<p>Implementation of the Taranaki Palliative Care Plan (2013/16).</p> <ul style="list-style-type: none"> • Develop care pathways between Hospice Taranaki 	<p>Palliative Care Plan implemented:</p> <ul style="list-style-type: none"> • Care pathways developed and 	Quarterly report on progress against measures

	<p>and other specialist services to improve access to specialist palliative care.</p> <ul style="list-style-type: none"> • Undertake a Taranaki wide needs assessment for palliative care training and develop training plan for primary palliative care providers. • TDHB to formally contract in-reach palliative care services provided by Hospice Taranaki to Taranaki Base Hospital and Hawera Hospital • Develop and promote the Hospice Taranaki website as a key site for accessing information about palliative care. • Needs assessment for short-term palliative care to be undertaken by DHB according to regional consistent criteria. 	<p>circulated</p> <ul style="list-style-type: none"> • Needs assessment completed and training plan developed. • Formal contract between TDHB and Hospice Taranaki signed. • Hospice Taranaki website development completed. 	
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3.3.2 Achieve Identified Diagnostic Services Waiting Time Targets

3.3.2.1 Context

Better Sooner More Convenient Health Services in relation to diagnostic services means delivering shorter waiting times for diagnostic tests to ensure patients are treated faster to provide the right services at the right time. This also includes primary care direct-referral to diagnostics which can speed up diagnosis and delivers efficiency and productivity gains to secondary care services by making smarter use of specialists' time, allowing them to treat more people sooner.

3.3.2.2 Our Approach

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

3.3.2.3 Linkages

- Minister's Letter of Expectation
- Our Performance Story Impact: People stay well in their homes and communities
- Our Performance Story Impact: People receive timely and appropriate specialist care

3.3.2.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Diagnostic Services	<ul style="list-style-type: none"> • Work with regional and national clinical groups to contribute to development of improvement programmes. • Support and participate implementation as required. • Ensure internal data collection systems are in place to facilitate accurate reporting. • Patients access diagnostic services in accordance with priority. • Increasing the volume and improving the management of primary referred diagnostics through defined referral criteria. • Ensure budget volumes are sufficient to meet targets. • Implementation of regionally consistent patient centred criteria for access to diagnostics and laboratory investigation. • Additional electives funding providing for community radiology diagnostic procedures. TDHB has planned to increase funding to Community Radiology testing by a further \$300K to improve access and reduce waiting times. • Increased funding for cardiac diagnostics access by a further \$170K • Increased funding for access to colonoscopies by a further \$200K (which equates to approximately another 200 procedures p.a.). 	<p>Refer also DV2: Improving waiting times for diagnostic services:</p> <ul style="list-style-type: none"> • CT and MRI – 85% of accepted referrals for CT and 75% for MRI scans will receive their scan within six weeks (42 days). • Diagnostic colonoscopy – 50% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); and 50% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days). • Surveillance/Follow up colonoscopy – 50% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date • Coronary angiography – 85% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days). • Waiting times for community referred radiology tests reduced. • Measured by compliance with elective services performance indicators. 	Monthly reporting DHB to MoH

3.3.3 Increasing Access to Elective Services

3.3.3.1 Context

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

3.3.3.2 Our Approach

Managing patient length of stay is important to sustaining our elective service in terms of capacity. It is also important for good patient health outcomes; reducing length of stay is a quality and effectiveness issue and can lead to better outcomes for the patient. Reducing length of stay is also critical to providing and efficient optimal use of our health budget.

Also linked to sustainable and efficient elective services is reduced diagnostic delays (see 3.3.2.4).

Taranaki DHB is working regionally with other Midland DHBs and moving towards greater integration of each DHBs elective services. Purchasing appropriate regional volumes will allow sustainable service improvement. Service improvement will be supported by regional referral pathways, clinical networks and consistently applied access criteria.

3.3.3.3 Linkages

- Minister's Letter of Expectation
- Health Target – Improved Access to Elective Services
- Midland DHBs Regional Services Plan 2013/14
- Our Performance Story Impact: People receive timely and appropriate specialist care

3.3.3.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Achieve Taranaki's Contribution to the Health Target regarding Electives	<ul style="list-style-type: none"> • Electives funding will be allocated to support increased levels of elective surgery, specialist assessment, diagnostics, and alternative models of care. 	<ul style="list-style-type: none"> • Delivery against agreed volume schedule, including a minimum of 4264 elective surgical discharges in 2013/14 towards the Electives Health Target. 	Quarterly
Standardised Intervention Rates Will be Used as a Tool to Assist in Determining the Appropriate and Equitable Level of Access	<ul style="list-style-type: none"> • Standardised intervention rates or other mechanisms will be used to assess areas of need for improved equity of access. 	<ul style="list-style-type: none"> • Refer to SI4: Elective services standardised intervention rates. 	Quarterly
Implement the Government's Expectations on Improving Waiting Times for Elective Services	<ul style="list-style-type: none"> • Patient flow management will be improved to ensure reduced waiting times for electives, so that no patient waits longer than five months during 2013/14, and progress is made toward 	<ul style="list-style-type: none"> • Elective Services Patient Flow Indicators expectations are met, and all patients wait five months or less for first specialist assessment and treatment from June 2013. 	Quarterly

	managing patients within four months.		
Actions to Support Improvements in Access to Electives	<p>To support improvements in access to electives we will:</p> <ul style="list-style-type: none"> Continue to increase the theatre capacity (Project Maunga) and outpatient clinic capacity. Review the management of follow-ups – utilising more non-medical alternatives such as nurse led clinics. Review referral management guidelines. TDHB will introduce the Map of Medicine. Locally agreed pathways will be developed for direct GP access to: <ol style="list-style-type: none"> gastroscopy minor operations list Patients will be prioritised for treatment using national, or nationally recognised, tools, and treatment will be in accordance with assigned priority and time waiting. Patients will have access to streamlined preadmission processes (Preadmission Process Redesign) which better assess fitness for surgery. Improved scheduling processes and timeliness of list starts will increase the number of available minutes for operating (TPOT). 	<ul style="list-style-type: none"> Regional productivity and efficiency gains and better, sooner, more convenient. Return of patients to primary care in a timely manner in line with clinical best practice. Management of waiting times. Identified level of service integration with primary care / community by September 2013. Map of Medicine implemented by September 2013. Local pathways agreed and implemented by September 2013. Increased uptake of latest national CPAC tools to improve consistency in prioritisation decisions. Reduction in day of surgery cancellations from 7%. Increased theatre capacity from 77%. 	Quarterly
			Monthly
			Monthly
			Quarterly

3.3.4 Improving Access to Cardiac Services

3.3.4.1 Context

Better Sooner More Convenient Health Services for New Zealanders in relation to cardiac – secondary services means improved and timelier access to cardiac services. Improving access to cardiac services will help New Zealanders to live longer, healthier and more independent lives.

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

3.3.4.2 Our Approach

In 2013/14 we will be continuing the work around the acute coronary syndrome (ACS) project, which is a major focus for our region. We will continue to engage with our primary care partners in the planning and implementation activities that occur in this area.

3.3.4.3 Linkages

- Minister's Letter of Expectations
- Midland DHBs Regional Services Plan 2013/14
- Our Performance Story Impact: People receive timely and appropriate specialist care

3.3.4.5 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Cardiac Services	<ul style="list-style-type: none"> • A target intervention rate for cardiac surgery will be set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access. • Improve access to cardiac diagnostics to facilitate appropriate treatment referrals, including angiography, echocardiograms, exercise tolerance tests, etc. • Manage waiting times for cardiac services, so that no patient waits longer than five months for first specialist assessment or treatment. Reduce waiting times to a maximum of four months by the end of December 2014. • Undertake initiatives locally to ensure population access to cardiac services is not significantly below the agreed rates. This includes cardiac surgery, percutaneous revascularisation and coronary angiography. • Participation in regional cardiology network activities • Implementation of local cardiology project recommendations 	<ul style="list-style-type: none"> • Agreement to and provision of a minimum of 84 total cardiac surgery discharges for local population in 2013/14. • Refer DV2: Improved access to diagnostics. 85% of people will receive elective coronary angiograms within 90 days. • Elective Services Patient Flow Indicators: all patients wait five months or less for first specialist assessment and treatment from June 2013. • Refer SI4: Standardised Intervention Rates. • Cardiac surgery: 6.5 per 10,000 of population. • Percutaneous revascularisation: 11.9 per 10,000 of population. • Coronary angiography: 33.9 per 10,000 of population. 	<p>Quarterly</p> <p>Quarterly</p> <p>Monthly</p> <p>Quarterly</p>
Acute Coronary Syndrome	<ul style="list-style-type: none"> • Taranaki DHB will implement the Cardiac ANZACS Q1 and Cardiac Surgical registers once further information is to hand • Q1 actions – implementation of cardiology project recommendations including change of catheter lab 	<ul style="list-style-type: none"> • Indicator 1. >70% of high risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission=Day 0) (TDHB baseline currently 40%). 	Performance reported against health target

	<p>schedule.</p> <ul style="list-style-type: none"> • Q2 actions – introduction of new process to facilitate acute angiograms locally. • Q3 actions – CME meeting coordinated by Waikato on regional guidelines. 	<ul style="list-style-type: none"> • Indicator 2 >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS Q1 ACS and Cath/PCI registry data collection. 	
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3.3.5 Working with Primary Care to Drive Clinical Integration

3.3.5.1 Context

Policy work currently underway to drive clinical integration by strengthening primary care including:

- PHO roles, functions and results
- Strengthen accountability and align with Government priorities
- Financial incentives
- Non-financial incentives
- Shifting services closer to home

Further detail will be provided upon completion of policy work and engagement with the sector

3.3.5.2 Our Approach

Primary care services in Taranaki are delivered by two Primary Health Organisations (PHOs) and by one GP practice that is not a member of a PHO. The majority of general practices in the province are part of the Midland Health Network. Te Atiawa Medical Centre in New Plymouth, the Ngati Ruanui Medical Centre in Hawera and the Te Oranganui Medical Centre in Waverley are members of the National Hauora Coalition. Dr Blayney in Hawera is not a member of a PHO.

Taranaki DHB is a member of the Alliance Leadership Teams of both the Midland Health Network and the National Hauora Coalition. The DHB is an active partner in clinical integration activity by both PHOs which aims to bring services closer to home. This clinical integration activity is reflected in actions throughout this Plan.

3.3.5.3 Linkages

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

3.3.5.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Primary Care Integration	<ul style="list-style-type: none"> • TDHB to consult with Midlands Health Network, National Hauora Coalition and Te Kawau Maro on the options for the management of NIR in Taranaki. • Implementation of the Community Hub for Referrals from Primary Health Care for the top 2% of people living with Long Term Conditions • Establish capacity for a Multi Disciplinary Team to provide services to the Primary Health sector. DHB to fund \$369,656 for 4.1 FTE. For Social Work and Dietetics. • The National Hauora Coalition will undertake register ethnicity data audit (baseline) and register data improvement to increase the accuracy and quality and improve PHO enrolment rates. • TDHB will introduce the Map of Medicine. Locally agreed pathways will be developed for direct GP access to: <ol style="list-style-type: none"> 1. gastroscopy 2. minor operations list • TDHB will introduce the Map of Medicine and implement locally agreed pathways to identify which two surgery booking lists and which specialist services GP's will have direct access to. • TDHB will introduce two specialist advice services to support GPs in their management of patients in the primary care envelopment. These services are Mental Health and Paediatrics. • Increasing primary access to general radiology by 3250 RVU. • Rural Taranaki Communities First Aid Courses. • Rural Taranaki Communities Mental Health First Aid. • Taranaki DHB and the MHN are working together to develop a Primary Options 	<ul style="list-style-type: none"> • Consultation completed by September 2013. • Discussion and decision on the management of NIR for Taranaki with all partners complete by December 2013. • Community Referral Hub operational by December 2013. • 4.1FTE Social Worker and Dietetics to provide Packages of Care for Primary Health in the community established by 30 December 2013. • Ethnicity data. • Map of Medicine implemented by September 2013. • Local pathways agreed and implemented by September 2013. • Specialist services pathways developed by Quarter 1, 2014. • Specialist services pathways implemented by Quarter 2, 2014. • Increase in primary access by 3250 RVU's by 30 June 2014. • Number of First aid Courses provided in Rural Taranaki Communities. • Number of Mental Health First Aid Courses provided in Rural Taranaki Communities 	<p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p>

	Model of Care appropriate for the Taranaki population.	<ul style="list-style-type: none"> • Agreement of Model for Care for Taranaki by Quarter 1. • Implementation of Primary Options by Quarter 3. 	Quarterly Quarterly
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3.3.6 Implementing the Mental Health and Addictions Service Development Plan

3.3.6.1 Context

The Mental Health and Addiction Service Development Plan clearly articulates prioritised service developments for the next five years. The Plan aims to ensure that across the spectrum of health promotion, primary, specialist treatment and support services access and responsiveness will be enhanced; integration will be strengthened while improving value for money and delivering improved outcomes for people using services.

Actions relating to the following Government work programmes have been integrated into the action table (3.3.6.4):

- Drivers of Crime (see objective: Cement and build on gains for the most vulnerable and Deliver increased access for all age groups)
- Implementation of the Suicide Action Plan (see objective: Cement and build on gains for the most vulnerable)
- Welfare Reforms (see objective: Cement and build on gains for the most vulnerable and Deliver increased access for all age groups)

3.3.6.2 Our Approach

A number of the planned actions in this area have been developed in association with the other four DHBs in our region.

The actions we are planning in terms of primary mental health and addictions are presented in 3.1.

3.3.6.3 Linkages

- Minister's Letter of Expectations
- Mental Health and Addiction Service Development Plan
- Our Performance Story Impact: People receive timely and appropriate specialist care

3.3.6.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Make Better Use of Resources / Value for Money	By June 2014 <ul style="list-style-type: none"> • Taranaki DHB (Provider Arm and NGO partners) will continue to participate in key performance indicator (KPI) forums. • KPI data is used by Taranaki MH&A sector to improve performance with Provider Arm and NGO 	<ul style="list-style-type: none"> • Improving the health status of people with severe mental illness PP6. 	Quarterly updates – PP6 & PP8 Taranaki monthly KPI meetings

	<p>sector implementing at least one quality improvement activity each 6 months</p> <p>By June 2014</p> <ul style="list-style-type: none"> Support and fund participation in the Taranaki Suicide Prevention Co-ordination Group. Partner with local stakeholders and wider community for events aligning to the World Suicide Prevention Day (Week). <p>By December 2013</p> <ul style="list-style-type: none"> Roll out of the ASIST programme workshops with focus on taiohi. Workshops to have broad participation across education, health and other people working with youth and wider community. <p>By June 2014</p> <ul style="list-style-type: none"> Provider Arm quality improvement project is completed. Midland Regional Planning and Funding Portfolio Managers will identify five purchase units for benchmarking. A process for benchmarking will be developed and agreed with the Regional Clinical Governance Network. Planning and Funding will obtain benchmarking data. <p>By June 2014</p> <ul style="list-style-type: none"> Midland Regional Portfolio Managers will submit a report to GM's Planning and Funding regarding benchmarking findings and implications for future contracting. <p>By December 2013</p> <ul style="list-style-type: none"> Complete RFP process for crisis/planned respite services for Adult (North Taranaki), Adult (South and Central Taranaki). Implementation of new Crisis Planned Respite service model completed by 	<table border="1"> <tr> <td colspan="2"></td><td>Total</td></tr> <tr> <td colspan="2"></td><td>3.78%</td></tr> <tr> <td colspan="2"></td><td>Maori</td></tr> <tr> <td colspan="2"></td><td>3.78%</td></tr> <tr> <td>Age 0-19</td><td></td><td></td></tr> <tr> <td colspan="2"></td><td>Total</td></tr> <tr> <td colspan="2"></td><td>4.02%</td></tr> <tr> <td colspan="2"></td><td>Maori</td></tr> <tr> <td colspan="2"></td><td>5.34%</td></tr> <tr> <td>Age 20-64</td><td></td><td></td></tr> <tr> <td colspan="2"></td><td>Total</td></tr> <tr> <td colspan="2"></td><td>3.46%</td></tr> <tr> <td>Age 65+</td><td></td><td></td></tr> </table> <ul style="list-style-type: none"> Expand access and decrease waiting times PP8 <table border="1"> <tr> <th colspan="3">Mental Health Provider Arm</th></tr> <tr> <th>Age</th><th><= 3 weeks</th><th><=8 weeks</th></tr> <tr> <td>0-19</td><td>70%</td><td>95%</td></tr> <tr> <td>20-64</td><td>80%</td><td>95%</td></tr> <tr> <td>65+</td><td>80%</td><td>95%</td></tr> <tr> <td>Total</td><td>80%</td><td>95%</td></tr> <tr> <th colspan="3">Addictions (Provider Arm and NGO)</th></tr> <tr> <th>Age</th><th><= 3 weeks</th><th><=8 weeks</th></tr> <tr> <td>0-19</td><td>70%</td><td>95%</td></tr> <tr> <td>20-64</td><td>70%</td><td>95%</td></tr> <tr> <td>65+</td><td>70%</td><td>95%</td></tr> <tr> <td>Total</td><td>70%</td><td>95%</td></tr> </table> <ul style="list-style-type: none"> Taranaki MH&A Services report on quality improvement project is provided at KPI forum. Raised awareness of suicide and suicide prevention identified through HEADSSS assessments. Number of workshops held and numbers of participants. 			Total			3.78%			Maori			3.78%	Age 0-19					Total			4.02%			Maori			5.34%	Age 20-64					Total			3.46%	Age 65+			Mental Health Provider Arm			Age	<= 3 weeks	<=8 weeks	0-19	70%	95%	20-64	80%	95%	65+	80%	95%	Total	80%	95%	Addictions (Provider Arm and NGO)			Age	<= 3 weeks	<=8 weeks	0-19	70%	95%	20-64	70%	95%	65+	70%	95%	Total	70%	95%	<p>December 2013</p> <p>December 2013</p> <p>Quarterly reporting through CMS and DHB Quarterly volume accountability reporting.</p> <p>Quarterly updates by Provider Arm.</p>
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	<p>December 2013.</p> <ul style="list-style-type: none"> Implementation of an Alcohol and Drug Detoxification bed. Documented continuum of care and contract in place. <p>By December 2013</p> <p>The MH&A sector to have developed a model of service delivery for:</p> <ul style="list-style-type: none"> Ageing clients, clients that are like in age and interest and those with severe and enduring with co-morbidities. Adult recovery-rehab bed configuration; and Whole of system approach for South Taranaki. <p>By March 2014</p> <ul style="list-style-type: none"> Sign off of proposed reconfiguration. Process for reconfiguration (RFP for preferred provider) agreed. <p>By July 2014</p> <ul style="list-style-type: none"> For services described above (ageing clients, recovery– rehabilitation and South Taranaki). Where a preferred provider(s) process was undertaken and a provider identified- a contract to be put in place. Improving effectiveness and efficiency by reducing number of contracts held across mainstream services. 	<ul style="list-style-type: none"> Service audits will be submitted to Planning and Funding by December 2013. Final audits submitted to Planning and GM Maori by May 2014. Enhanced service provision and monitoring of access and utilisation of new services and reduced occupancy to inpatient ward. Preferred provider identified, contract in place. Enhanced and more effective service models to support the gap in service provision that relates to the model of care. Improved mental health wellbeing, physical health and social inclusion. More effective use of funding supporting MH&A services. 	<p>Quarterly tracking of progress.</p>
<p>Improve Primary, Secondary Integration</p>	<ul style="list-style-type: none"> Regionally agreed process to obtain input from young people into planning and delivery of specialist mental health and AoD services. Midland Region to hold a regional youth summit. Are incorporated in Regional and Local service planning documentation by June 2014. Continued evaluation of the Taranaki Psychiatrist / General Practice telephone consult liaison service. <p>By March 2014</p> <ul style="list-style-type: none"> Taranaki MH&A and Primary Care sector (Midlands Health Network and National Hauora Coalition) to have agreed activities to support both 	<ul style="list-style-type: none"> Report submitted to GMS Planning and Funding regarding outcomes of the Midland Youth Summit by May 2014. Evaluation results shared and any issues addressed. Key actions prioritised to ensure increased integration, collaboration and responsive to tangata whaiora and the needs of the MH&A and primary care workforce. Reducing the barriers to accessing and enrolling with General practice. Improving the health status of people with severe mental illness Expand access and decrease waiting times 	<p>May 2014 Report</p> <p>Six monthly reporting to sector.</p> <p>Quarterly reporting to stakeholders (TLAG) – against SDP reporting template.</p>

	Children and Young People <ul style="list-style-type: none"> Review best practice models for support for children and young people who have parents that have Mental Health and Addictions issues. Development of a pathway for access to service provision. 		
Deliver Increased Access for All Age Groups	<ul style="list-style-type: none"> Reduce the use of seclusion and restraint by: Development of strategy to further reduce the use of seclusion and restraint Participation in national forum Implementation of strategy and measure progress Review and improve actions taken when responding to Did Not Attend (DNAs) across all MH&A services. Youth forensics – Court Liaison and Community Advisor. Meeting of local forensics advisory group on 3 monthly basis. <p>By April 2014</p> <ul style="list-style-type: none"> In collaboration with primary care development of processes to enhance responsiveness to physical health needs of MH&A clients. <p>By December 2013</p> <ul style="list-style-type: none"> Planning completed to move CAMHS services to ICAMHS – whole of sector approach, Provider Arm and NGO within a WhanauWhanau ora framework. 	<ul style="list-style-type: none"> Use of seclusion reduces by 20% as compared with 2012/13 year Improving the health status of people with severe mental illness PP6 Expand access and decrease waiting times PP8 Reporting from Know the People Planning (KPP) Monitoring of the local analysis of Outcomes Reporting. Increased access to supports and assessments for young people within the Taranaki Courts. Increased wellness checks for physical health need of tangata whaiora. Reporting against planning milestones 	<p>Quarterly reporting from regional service provider.</p> <p>Quarterly reporting via regional provider contract.</p>

3.3.7 Supporting Whānau Ora Provider Collectives

3.3.7.1 Context

The vision for Taranaki Maori is Whānau Ora – Whānau enabled to achieve their maximum health and wellbeing.

The Whānau Ora philosophy articulated by the Whānau Ora Taskforce, as it relates to health, provides the philosophical base for the TDHBs approach to Whānau Ora. This is echoed in the Taranaki DHBs 20-year Maori Health Strategy “Te Kawau Maro”, which draws on the Maori health promotion model “Te Pae Mahutonga” to describe the key dimensions of Maori health and wellbeing: **Mauri Ora** – participating fully in te ao Maori, **Waiora** – living in harmony with the environment, **Toiora** – living healthy lifestyles, **Te Oranga** - positive participation in all aspects of society, **Te Mana Whakahaere** – autonomy and self-determination, and **Nga Manukura** – exercising leadership at Whānau, hapu, iwi and all other levels of society.

The philosophical underpinning described above is supported by He Korowai Oranga, national Maori Health Strategy as a framework for Whānau Ora implementation, based on the rationale that:

- Whānau Ora is the over-arching aim of He Korowai Oranga – Whānau supported to achieve their maximum health and wellbeing;
- The framework is known and understood by Maori health stakeholders;
- It places Whānau at the centre of public policy;
- The four pathways for action provide the core of a Whānau Ora monitoring framework.

Within this framework and at the core of the Taranaki DHB’s approach is to support Whānau ownership over their own development. The implication is that every service offered or funded by the DHB should contribute to Whānau being empowered to understand and act to prevent or manage health conditions. The transfer of knowledge and skills to enable this to happen is a key function of Whānau Ora health service provision.

3.3.7.2 Our Approach

The system to support Whānau Ora will work in a range of ways, influenced by the approach the Whānau choose to take. It is not a one size fits all approach. It needs to be flexible and dynamic to meet the changing and varied needs of Whānau and families.

Taranaki DHB will continue to support Whānau Ora through ongoing engagement at a strategic level with health and inter-sectoral initiatives that aim to address the socio-economic determinants of health. Supporting the relationships within primary health care, at the primary / secondary interface of health services, and at the interface between health services and those driven by or in conjunction with other sectors, are a critical focus.

Taranaki DHB region has three significant initiatives engaged in the development and delivery of services within a Whānau Ora context. These are the TPK-led Whānau Ora provider collective “Taranaki Ora” consisting of the Tui Ora Ltd and Tu Tama Wahine O Taranaki joint venture, Te Kawau Maro Alliance, the Taranaki DHB’s preferred provider of services for Maori in Taranaki which is developing a Whānau Ora system approach, the National Hauora Coalition PHO with its Whānau Ora Centre developments under the Better, Sooner More Convenient strategy and taking a leading role in Whānau Ora system developments, and. The DHB’s support for each initiative is relative to the contribution of DHB-funded health services and health systems support. Briefly summarised in financial terms this involves \$1.04M per annum to the National Hauora Coalition PHO, and \$7.7M to Te Kawau Maro Alliance activities. Alliance activities include provision of back-office support. Tui Ora’s contribution to the Taranaki Ora Whānau Ora provider collective is the provision of back-office support and the vehicle for Taranaki DHB’s indirect support of that collective.

The Taranaki DHB is keen to support the full alignment of the three key initiatives, with each other, with the intent of having a common, comprehensive and robust Whānau Ora system geared to working with

families to be able to self-determine and self-manage the attainment of agreed outcomes. To this end Taranaki DHB will:

- Provide advice and support to the Ministry of Health with regard to Taranaki Ora collective endeavours
- Work with the Taranaki Ora provider collective to support the implementation of the collective's programme of action
- Work with the Taranaki Ora provider collective to support implementation of its information systems strategy
- Engage with and support te Tai Hauauru Regional Leadership Group activities as they relate to Taranaki Ora provider activities

3.3.7.3 Linkages

- Minister's Letter of Expectations
- Our Performance Story Impact: People stay well in their homes and communities

3.3.7.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Building Capacity and capability of Providers	<ul style="list-style-type: none"> Work with the Taranaki Ora provider collective to agree areas of infrastructure development that the DHB will support through the Maori Provider Development Scheme Work with Te Kawau Maro alliance to identify and pursue opportunities for intersectoral capacity and capability development 	<ul style="list-style-type: none"> Opportunities identified are pursued to successful funding outcomes 	Annual
		<ul style="list-style-type: none"> Opportunities identified are pursued to successful outcomes 	Quarterly
Being Outcome Focused	<ul style="list-style-type: none"> Support the implementation of the Taranaki Ora provider collective Information System Strategy to support delivery against and monitoring of the collectives programme of action Establish the framework for monitoring performance accountabilities and outcomes under Te Kawau Maro integrated contract. Work with the Taranaki Ora provider collective to agree common outcomes for Taranaki Whānau. 	<ul style="list-style-type: none"> Information system strategy successfully implemented or in progress of implementation Monitoring framework established and routinely reporting to key stakeholders. Common outcomes agreed with the Taranaki Ora provider collective 	Quarterly 1 st Quarter 2013/14 Annual
Supporting Strategic Change	<ul style="list-style-type: none"> Continue to participate and support the activities of Te Tai Hauauru Regional Leadership Group Strategic planning with the DHB includes participation of the Whānau ora collectives Building and maintaining relationships with agencies implementing Whānau Ora 	<ul style="list-style-type: none"> The outcome of the Whānau Ora approach in health will be improved health outcomes for Whānau through quality services that are integrated (across social sectors and within health), responsive and patient/Whānau centred (Refer S15: Delivery of Whānau ora) Quarterly narrative reports on progress 	

3.4 *Acute and Unplanned Care*

This section contains the following components:

- 3.4.1 Working with primary care to reduce the impact of cardiovascular disease and diabetes
- 3.4.2 More smokers make more quit attempts
- 3.4.3 Improved access to acute services
- 3.4.4 Long term conditions / stroke
- 3.4.5 Wrap around services for older people

Each of these components has a separate set of information and action plan in this section.

3.4.1 Working with Primary Care to Reduce the Impact of Cardiovascular Disease and Diabetes

3.4.1.1 Context

Better Sooner More Convenient Health Services for our population in relation to cardiovascular disease (CVD) and diabetes means all people with, or at risk of CVD / diabetes are identified, assessed and managed well. They are referred promptly between primary, secondary and tertiary care for assessment and management where appropriate and they are supported to self manage their own condition in order reduce the impact on their health.

These conditions account for a significant number of potentially preventable presentations at emergency departments and admissions to hospital and specialist services. With an ageing population this burden is expected to increase. New models of care and care pathways are essential to shift how we maintain and look after people with these conditions in community settings to ensure they are able to manage their conditions themselves.

3.4.1.2 Our Approach

Taranaki DHB recognises that the key to improvement in this area is greater collaboration and co-ordination between primary and secondary care. Our primary care partners are leading development of a 'diabetes care improvement package' to improve the health outcomes for the people in their populations with diabetes. Our primary care partners use the allocated funding to support and incentivise performance of their practices. This approach is intended to contribute to the achievement of our outcomes of improving the health status of our population and reducing or eliminating health inequalities.

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

3.4.1.3 Linkages

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

3.4.1.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
More Heart and Diabetes Checks	<p>In agreement with our primary care partners, we will identify actions that will improve performance on 'More heart and diabetes checks' provided in primary care including actions in the following areas:</p> <ul style="list-style-type: none"> Identifying eligible populations (including any demographic changes). Proactively contact / invite people due for CVD risk assessment. Efficient recall systems in place to ensure people attend CVD risk assessments. Te Kawau Maro (TDHBs Preferred Provider of Maori Health Services) to work towards an agreed outcome of Whanau living well with a Long Term Condition. This framework will be agreed and established within a contract and performance measures identify the need to monitor and increase the number of CVD risk assessments. Ensuring the expertise, training and tools they need to successfully complete the CVD risk assessment to meet clinical guidelines. Development of effective services tailored to the needs of targeted patients. Clinical champions have been identified as the Clinical Directors of each PHO. Taranaki DHB will work with the PHO's to improve the % of eligible people who have had their cardiovascular disease (CVD) risk assessed in the last five years. NHC will work with GP practices to establish a register of prioritised list patients for CVD risk assessment. Implementation of a Community Referral Hub for people living in the community with a Long Term Condition (which includes diabetes and cardiovascular disease). TDHB to fund \$458,720 to support GP access to podiatry, social workers, dietetics and clinical pharmacist in order to more effectively manage diabetic and CVD patients within the community setting. This includes contribution from these service providers to an extend Long Term Conditions Community MDT. 	<ul style="list-style-type: none"> 80% of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years by March 2014. 90% of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years by June 2014. By September 2013. RBA contract in place by 1 July 2013. Establish referrals to the Community Hub by 1 September 2013. Case Managers providing navigational services for patients by December 2013. By 1 September 2013. 	<p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p>

	<ul style="list-style-type: none"> • GPs to be linked into results of the MDT outcomes, while also maintaining oversight and care of all other patients with diabetes and CVD. Access to the patients care. • Risk stratification tools will be available to GPs. • Retinal screening will be maintained and undertaken by specialist ophthalmology service in order to provide direct access to specialist services when the need is identified rather than waiting for additional referral processes to occur. • Continue to support the PHO Performance Programme to ensure that reporting on CVD risk assessments is more timely and that PPP reports can be incorporated into discussions between the DHB and PHO through the Taranaki Alliance Leadership Team (TALT). 	<ul style="list-style-type: none"> • Risk stratification tools available to MHN GP Practices from 1 July 2013. • Maintenance and on-going. • TALT meetings reflect PHO Quality Plans in place by September 2013. 	Quarterly
Diabetes Care Improvement Packages	<ul style="list-style-type: none"> • Improving the skills and knowledge of the diabetes clinical workforce in primary care through increased uptake of the Level 7 Diabetes Management Courses. • People at risk of diabetes will be identified and will undertake regular diabetic reviews. • MHN to introduce risk stratification tools for GP Practices to commence from 1 July 2013 (see CVD/Diabetes as above also). • Ensuring the care provided to people with diabetes is consistent with the guidance contained in the New Zealand Primary Care Handbook 2012. • The DHB is providing incentive funding of \$355,600 from our Population Based Funding for GPs/PHOs to utilise the Risk Stratification, Assessment and Care Planning tools for patients with diabetes and CVD. • GP Teams will have access to podiatry, social work, dietetics and clinical pharmacist to support all patients with diabetes within the community. The top 2% of 	<ul style="list-style-type: none"> • Reviews in place by September 2013. <p>Clinical indicators to be collected in 2013/14 are:</p> <ul style="list-style-type: none"> • Achieving < Hb1Ac for 70% of people with a diagnosis across all ethnicities. • Maintain or improve appropriate management of microalbuminuria or overt nephropathy in patients with diabetes. • By September 2013, MHN Quality Plans in place to support uptake of GP Practices uptaking and utilising the Risk Stratification Assessment and Care Planning Tools. • Number of GP Practices up-taking and utilising the Risk Stratification Assessment and Care Planning Tools. 	<p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p>

	high needs Long Term Conditions patients referred to the Community Hub for assessment by the MDT and appropriate referral.	<ul style="list-style-type: none"> MDT established by September 2013. Introduction of "Manage My Health" into GP practices to support patient self management available from 1 July 2013. 	Uptake reported Quarterly
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3.4.2 More Smokers Make More Quit Attempts

3.4.2.1 Context

Better Sooner More Convenient Health Services for New Zealanders in relation to tobacco means more smokers make more quit attempts, leading to more successful quit attempts and a reduction in smoking prevalence. A renewed impetus is required in order to achieve the Government's aspirational goal of a Smokefree New Zealand by 2025. Increased integration into all other aspects of health is critical to achieving Smokefree Aotearoa 2025. Supporting smokers to quit needs to be integrated into all primary, secondary and maternity health services and DHBs have a leading role.

3.4.2.2 Our Approach

Our children and tamariki need to grow up free of the risk of becoming addicted to tobacco and the effects of second-hand smoke. For 2013/14 the investment of funding targeted to smoking reduction will be applied with an approximate split of 20% secondary care, 30% primary care, 30% smoking in pregnancy and 20% co-ordination and supportive activities. The allocation of funding for 2013/14 will be approximately \$500K.

We meet regularly with our primary care partners and share information about the health target as well as monitoring actual performance against planned performance.

3.4.2.3 Linkages

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

3.4.2.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Better Support for Smokers to Quit in Secondary Care	<ul style="list-style-type: none"> TDHB are committed to sustain performance against the secondary Care target. Continue to fund the TDHB Hospital Provider Services to deliver a range of activities to support the achievement of the Tobacco Health Target including: <ul style="list-style-type: none"> - Reviewing the Tobacco Health Target Action & Training plan by 31 August 	<ul style="list-style-type: none"> Maintain 95% of hospitalised patients who smoke and are seen by a health practitioner are offered brief advice and support to quit smoking. Maintain 95% of hospitalised Maori patients who smoke are seen by a health practitioner are offered 	Quarterly Reporting

	<p>2013</p> <ul style="list-style-type: none"> - Develop and implement the ABC Induction E-Learning module by 31st August 2013 • Review and strengthen TDHB Smokefree/Auahi Kore Workplace and Environment Policy. • Continue the Implementation of the Secondary Care Tobacco Health Target Action Plan and training and education Plans. • Undertake audit and evaluation plan including routine feedback on health target performance by ward and ethnicity. • Develop sustainable systematic quality systems. • Strengthen clinical and managerial leadership in Secondary Care by <ul style="list-style-type: none"> - determining roles and responsibilities for the Smokefree champions and providing training and support - Establishing quarterly meetings with department Link Nurses • Continue to promote use and access of Nicotine Replacement Therapy and Smoking Cessation medicines within the hospital. • Improve referral systems between the Quit Group and Smoking Cessation Providers • Continue to strengthen systems and linkages between Secondary and Primary Care by establishing a smoking cessation network by 31 Dec 2013. • Work collaboratively developing systems, linkages and communications with Smokefree/Auahi Kore services and stakeholders. • Direct funding for Smoking Cessation Activity from the Tobacco Action Plan for 2013/14 is estimated to be \$95K for Secondary Care (Not exceeding 20% total funding) 	<p>brief advice and support to quit smoking.</p>	
<p>Better Support to Quit in Primary Care (PHOs) General Practice</p>	<ul style="list-style-type: none"> • Continue to fund the Primary Care Midland Regional Health Network to deliver agreed local activities to support the achievement of the Tobacco Health Target. • Implement the Midland Health Network and Tobacco Health 	<ul style="list-style-type: none"> • 90% of patients who smoke aged 15 years and over and are seen in General Practice by a health practitioner are offered brief advice and support to quit smoking. • Make progress toward 	<p>Quarterly Reporting</p>

	<p>Target Action Plan , and Implementation of training and Education Plan including the following deliverable by 30 June 2014.</p> <ul style="list-style-type: none"> • All MHN practice to have a Smoking Cessation Plan developed by 31 December 2013. • Identify core components to be included in practice based smoking cessation plans, and include these as part of the 2013-14 PHO quality plan process • All practices have an identified smoking cessation champion and can describe the implementation of a range of leadership activities. • Maintain a data reminding and decision making support tool is available to all Taranaki MHN Medtech practices. • A pregnancy pathway implemented and evaluated to ensure that help and support to quit is given to mothers at the time of the confirmation of pregnancy within PHOs. • Extend and Promote Smokefree Environments in Primary Care Settings. • Work collaboratively PHO developing systems, linkages and communications with Smokefree/Auahi Kore services and stakeholders. • Implementation dedicated specialist cessation service to support quit attempts in Primary Care setting in line with priority groups and areas. <p>By June 2014</p> <ul style="list-style-type: none"> • To progress activities with National Hauora Coalition to support health target performance. • To facilitate communication and updates to PHO from DHB and MOH. • Direct funding associated with Smoking Cessation Activity from Tobacco Action Plan for 2013/14 is estimated to be: • \$150K to Primary Care PHOs (approx 30% of total funding) 	<p>90% of pregnant women who identify as smokers at the time of confirmation of pregnant in general practice are offered advice and support to quit.</p> <ul style="list-style-type: none"> • 95% of all Practice based staff trained to the appropriate level of ABC Approach by 30 June 2014. • Each practice to have a Smoking Cessation plan developed by 31 December 2013. • All local MHN sites Smokefree/Auahi Kore by June 2014. • All MNH practice have a data reminding and decision making support tool available. • Audit and evaluation of Pregnancy Pathway completed by 30 June 2014. ▪ All MHN sites to have a Smokefree/Auahi Kore policy by June 2014. • A minimum of 667 patients provided with support to quit specification by 30 June 2014 in new service model. 	
Better Support for Pregnant Women to Quit	<ul style="list-style-type: none"> • Ensure continued ABC implementation for hospital based maternity services. • TDHB Hospital Service to work with Te Kawau Maro (Smoking in Pregnancy Services) and PHOs to inform ways in which the 	<ul style="list-style-type: none"> • Progress towards 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in General Practice or booking with Lead Maternity Carer are offered advice and 	Quarterly Reporting

	<p>Hospital Services can improve its cessation advice service for pregnant women.</p> <ul style="list-style-type: none"> • To work with Te Kawai Maro to grow existing services within the alliance to engrain smoking cessation knowledge within their respective collaborative systems to promote sustainability support the implementation of smoking in pregnancy service including by 30 June 2014. • Te Kawai Maro to train and support health and community professional working with pregnant women and their whānau to apply ABC in practice every day and encourage referral to smoking cessation support services. • To develop a team of five Whānau Champions to be trained to deliver a Train-the-Trainers programme to whānau champions to actively support smokefree pregnancy. • Provide smoking cessation / behavioural support group interventions to pregnant women and their partners/Whānau • Direct funding associated with Smoking Cessation Activity from the Tobacco Action Plan for 2013/14 is estimated to be: \$160K for Maternity Initiatives (32% total funding allocated). 	<p>support to quit. (Awaiting Information from MOH on final definitions.)</p> <ul style="list-style-type: none"> • To deliver training and awareness activities to all staff within the Te Kawai Maro Alliance by December 2013. • 12 professional community champions identified and trained by March 2014. • Five whānau champions trainers will be recruited and trained to deliver the Train-the-Trainers programme by 30 June 2014. • Five whānau champions will be recruited and complete the Train-the-trainers programme by 30 June 2014. • 25 pregnant women provided with support to quit through intervention by December 2013. • 50 pregnant women provided with support to quit through intervention by March 2014. • 75 pregnant women provided with support to quit through intervention by June 2014/ 	
Regional Collaboration – implement the 2012-13 actions in the Midland Smokefree 2025 Five Year Programme of Action 2010-15	<ul style="list-style-type: none"> • Ongoing monitoring and prioritisation of Taranaki Tobacco Action Plan. • To align and implement agreed local actions from the review of the Midland Smokefree Programme Regional Action Plan . • Direct funding associated with Smoking Cessation Activity from Tobacco Action Plan for 2013/14 is estimated to be: \$105K via Planning and Funding to allocate toward regional and other supportive and co-ordination activity (representing approx. 20% of total funding). 	<ul style="list-style-type: none"> • Review of Taranaki Tobacco Action Plan by June 2014 	Annually by June 2014

3.4.3 Improved Access to Acute Services

3.4.3.1 Context

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

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

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

3.4.3.2 Our Approach

Taranaki DHB growth in acute demand can only be managed through initiatives focused across the whole of the health system which includes:

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

3.4.3.3 Linkages

- Minister's Letter of Expectations
- Health Target – Shorter stays in Emergency Departments
- Midland DHBs Regional Services Plan 2013/14
- Our Performance Story Impact: People receive timely and appropriate specialist care

3.4.3.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Shorter Stays in Emergency Department	<ul style="list-style-type: none">• Structure created through formation of Acute Pathway Working Group reporting through the COO as Project Sponsor and through to TDHB Board. The group comprises senior clinicians and managers working in partnership.• Whole of organisation focus, with demonstrable support from senior managers and clinicians.	<ul style="list-style-type: none">• 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.	Quarterly Performance against the health target Progress on specific actions

	<p>Key activities include:</p> <ul style="list-style-type: none"> • Diagnostic/analysis work to identify the main factors impacting on ED length of stay. • We will align resource levels with patterns of demand by forecasting staffing levels, managing sick and annual leave through the HWS tools. • Resource allocation will be reviewed across the ED disciplines to maximise utilisation and improve the process of streaming within the ED. • Restructure of ward rounds, early completion of discharge paper work, clear identification of expected discharge date on post acute ward rounds, nurse facilitated discharge and introduction of rapid rounds will all support this KPI. • Appropriate resources placed on the most significant bottlenecks and constraints identified in the diagnostic analysis work. • Actions spanning the whole system – pre ED, within the ED, and post-ED. • Whole of organisation focus, with demonstrable support from senior managers and clinicians. 		
Sustainable Services for Unplanned and Acute Care	<ul style="list-style-type: none"> • We will maintain the current GP after-hours services within the Taranaki region. Funding has been allocated to enhance access to GP service for under sixes after hours. • Review and support viable proposals as presented by PHOs for Primary Options for Acute care. 	<ul style="list-style-type: none"> • PHO Performance Monitoring Reports. • PHOs to report utilisation of services provided to under sixes after hours to measure effectiveness in reducing demand for ED services. 	Quarterly

3.4.4 Long Term Conditions/Stroke

3.4.4.1 Context

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

Stroke services are identified priority area in our RSP. HealthShare through the Midland Stroke Action Group are leading the development and implementation of regional actions.

While this section focuses on identified expectations in terms of long term conditions and stroke services, it is linked to initiatives outlined in the following sections in this module:

3.3.1 to 3.3.4

3.4.1 to 3.4.3

3.4.4.2 Our Approach

Implement a defined stroke unit and clinical care pathways. We believe adoption of agreed best-practice pathways will drive improved quality of care and better health outcomes.

A regional model of home and community support services for long term conditions.

Increase access to community rehabilitation services for people with long term physical impairments.

3.4.4.3 Linkages

- Midland DHBs Regional Services Plan 2013/14
- Our Performance Story Impact: People stay well in their homes and communities
- Our Performance Story Impact: People receive timely and appropriate specialist care

3.4.4.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Long Term Conditions	<p>Identification of targets to improve the acute demand curve including:</p> <ul style="list-style-type: none"> • 75+ readmissions, ED presentation, length of stay and bed days. • TDHB to fund the introduction and ongoing licensing costs of Map of Medicine. • Clinical Pathway development. • Implementation of a Community Referral Hub for people living in the Community with Long Term Conditions. • TDHB to fund \$458,720 for an extended LTC Community MDT • MDT assessment and referral of people referred to the Community Hub for case management and appropriate treatment. • Risk stratification for Community Hub referrals by GP's. • GP's to be linked in and maintain oversight of the patients care. • Midlands Regional Health Network Charitable Trust (MRHNCT) GP practices will have "Manage My Health" patient management system with a patient portal to enable 	<ul style="list-style-type: none"> • Reduction in avoidable hospital admissions. • Acute readmission rate for over 75 yr olds $\leq 8.66\%$. • Clinical Pathway development. • Number of referrals to the Community Hub. • Additional 5.1FTE capacity of Allied Health employed and working in Community and with the Referral Hub. • Case managers providing navigational services for patients by December 2013. • Risk stratification tools available to MHN GP Practices from 1 July 2013 • Manage My Health available from 1 July 2013. • Uptake will be measured over the year. 	<p>Quarterly performance against the acute demand targets</p> <p>Progress on specific actions</p>

	them to access their own health information and improve health literacy.		
Stroke Services	<ul style="list-style-type: none"> • Dedicated areas for management of people with stroke, acute transient attack services and rehabilitation. • Participate in regional feasibility for access to thrombolysis services for small population groups. • National and regional clinical stroke networks to implement actions to improve outcomes for people who have had a stroke 	<ul style="list-style-type: none"> • 80% of stroke patients admitted to a stroke unit or organised stroke services with a demonstrated stroke pathway. • Current baseline is 45/51 (88%). Target is to maintain or improve. • 6 percent of potentially eligible stroke patients thrombolysed • Current baseline is 0/44 ischemic strokes thrombolysed (0%). Target is 6%. 	Quarterly

3.4.5 Wrap Around Services for Older People

3.4.5.1 Context

The population is ageing and this will have a significant impact on our DHB. The increase in the number of older people will drive an increase in demand for acute personal health and long-term disability support services. DHB services for older people will work in partnership with primary care and non-government organisation providers to achieve a continuum of care that can be easily accessed by the older person and provide positive outcomes.

Health of older people is one of the vulnerable service priority areas identified in our RSP. Consistency in service capacity and availability is maintained through national linkages. During 2013/14 we will continue to work with our primary care partners and regional DHBs to develop and refine integrated services that will address the needs of older people with basic needs to those whose needs have a greater complexity.

3.4.5.2 Our Approach

The increasing demand on our health system from an aging population and the increasing burden of chronic conditions means that we need to strengthen the ability of primary care to effectively manage more patients in community settings.

This will mean ensuring that primary care has improved access to diagnostic and specialist services – particularly those that will support their ability to care for older people, and for people with long term conditions. It is anticipated that enhancing the capacity of primary care in this way will lead to a reduction in acute demand pressures on our hospital services.

The DHB also need to ensure that other community providers of care and support services for older people (e.g. aged residential care providers, home and community support providers) are funded and supported in a way that promotes sustainability and meets the changing needs of older who people who require flexible and responsive service provision to meet their increasingly complex needs.

The DHB will participate in a home-based support services costing exercise through the HoP Steering Group led by the lead DHB CE for HoP.

The DHB is working in partnership with Midland DHBs to develop a regional model of home and community support services that includes a shift to the delivery of restorative home support supported by new, sustainable funding models.

Improving the quality of care in aged residential care through:

- Supporting the implementation of InterRAI assessment / care planning tools
- Increasing access, visits, education and advice from specialist gerontology nurses / aged care nurse consultant
- Supporting the development of electronic sharing of client information with other health professionals e.g. E referrals, interRAI assessments
- Implementing standardised processes to implement Elder Abuse, Neglect and Prevention guidelines
- Continue the promotion of Vitamin D supplements to reduce the risk of injury from falls
- Supporting primary care to identify people with dementia and early referral to support, information/advice for person and carers through the Dementia Clinical Pathway.
- Expanding access to interRAI assessment information for hospital and primary care clinicians to support better clinical decision making.
- Development of alternative services to support older people to remain at home or in the community as an alternative to being admitted to hospital, such as access to intermediate care/step down services, home and community support services following acute events and access to short term residential respite care.
- Continuing to strengthen relationships between Community Support Service (Older Persons NASC) Care Management service and locality based GP practices working with older people with complex needs.
- Continue to explore strategies to reduce ED and hospital readmissions for older people.
- Review initiatives used to minimise inappropriate admissions into long term aged residential care and share regionally.

3.4.5.3 Linkages

- Minister's Letter of Expectation
- Midland DHBs Regional Services Plan 2013/14
- Our Performance Story Impact: People stay well in their homes and communities
- Our Performance Story Impact: People receive timely and appropriate specialist care

3.4.5.4 Action Plan

Key Objective / Planning Approach	Actions to Deliver Improved Performance	Measured By	Reporting Requirement
Wrap Around Services for Older People	<ul style="list-style-type: none"> • Monitor the investment in smarter services for older people living at home to reduce acute admission and readmissions, including rapid response and discharge management teams and processes. 	<ul style="list-style-type: none"> • Review of rapid response and discharge management services / teams by 30 June 2014. 	Quarterly report on progress against measures.
	<ul style="list-style-type: none"> • Benchmark readmission rates for the DHB 65+ population. 	<ul style="list-style-type: none"> • Readmission rates for 65+ population benchmarked against other DHBs. 	Quarterly report on progress against measures.
	<ul style="list-style-type: none"> • Expand use of Enhanced Intermediate Care Service to include older people living in 	<ul style="list-style-type: none"> • Enhanced Intermediate Care Service scope 	Quarterly report on progress against

	<p>the community with the aim of reducing avoidable hospital admission. (Service currently only accepts referrals of patients post discharge from hospital). The decision to admit older people living in the community would be made on a case by case basis, following a geriatrician based MDT process.</p> <ul style="list-style-type: none"> Develop a proposal for an OPHRS Specialist Response Service for ED aimed at identifying elderly with complex co-morbidities and optimising their management to maintain functional independence and reduce likelihood of re-presentation to ED or avoidable hospital admission. The Business Case will be developed by a Project Steering Group that includes Geriatricians, Clinical Nurse Specialists and Allied Health representatives. 	<p>expanded and includes community admissions with the addition of two Transitional Care Beds (increase from 4 to 6 beds) by 30 June 2014.</p> <ul style="list-style-type: none"> Proposal and Business Case to be developed by 30 June 2014. 	<p>measures</p> <p>Quarterly report on progress against measures.</p>
Community Support Services for Older People	<p>Actively manage the risk of variable service quality and service failure in Home and Community Support Services, including any contracting and costing issues related to the provision of services in rural areas:</p> <ul style="list-style-type: none"> Follow the national framework for processing client complaints and assessing client satisfaction, including implementation plan, impact and risk assessment and communications plan (once advised as complete by the H&CSS Working Group – Strengthening Quality Assurance Project). Implement a Regional model of Home and Community Support Services that includes a shift to the delivery of restorative home support supported by a case mix/case weight based funding model. All H&CSS contracts for 2013/14 identify need for providers to meet HCSS standards and include termination plan for any provider not meeting the standards. Ensure reporting requirements in H&CSS contracts include core quality measures for H&CSS 	<ul style="list-style-type: none"> Evidence of proactive risk management including: National framework followed for 100% of client complaints. Regional approach to contracting and funding of H&CSS services is implemented as per agreed regional plan. All contracted H&CSS services hold NZS 8158 2012 by 1 September 2013. Evidence DHB is utilising core quality measures at each level of management. 	<p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures.</p>

	<p>identified by the DHB Health of Older People Steering Group.</p> <ul style="list-style-type: none"> Midland Regional Clinical Action Network / Health Share to collate DHB baselines regionally for core quality measures and data utilised for benchmarking within Midland. 	<ul style="list-style-type: none"> Established baselines for core quality measures are benchmarked with other DHBs. 	<p>Quarterly report on progress against measures providing evidence of benchmarking with other DHBs by 30 June 2014.</p>
Comprehensive Clinical Assessment in Residential Care	<ul style="list-style-type: none"> Identify and implement actions that will support aged residential care facilities to Implement Comprehensive Clinical Assessments in their facilities. DHB engaged with Central TAS to bring forward funding to support implementation of the InterRai LTCF from 2014/15 to 2013/14. TDHB Aged Care Nurse Consultant to undertake iLTCF training to provide additional support to aged residential care facilities using iLTCF. Initiate Vitamin D prescription for all new residential care residents through TDHB Standing Order initiative Ensure all patients discharged into residential care have Vitamin D prescription on discharge. 	<ul style="list-style-type: none"> All aged residential facilities in DHB have trained or have a plan in place to train their nurses to use InterRai LTCF assessment tool by 30 June 2014. Funding to support implementation of the InterRAI LTCF form from 2014/15 to 2013/14 has been arranged through Central TAS. TDHB Aged Care Nurse Consultant training completed. 90% of aged residential care residents are receiving Vitamin D by 30 June 2014 . 100% of patients discharged to aged residential care with Vitamin D prescription. 	<p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures</p> <p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures.</p>
Dementia Pathway	<p>Taranaki DHB has applied best practice in dementia care locally, by developing a Dementia Care Pathway, implemented in 2011 that provides clarity of access to services across the continuum as set out in the National Dementia Care Pathway Framework (2013). This initiative will be consolidated in the coming year by the following actions:</p> <ul style="list-style-type: none"> Review and updating of supporting documentation for Taranaki Dementia Pathway. Update visits to all GPs to provide information and training to support use of Taranaki Dementia Pathway. Delivery of 2 Living Well programmes aimed at people with dementia and their carers. Undertake an evaluation of the In-Home Dementia Respite Service. 	<ul style="list-style-type: none"> Review and updates completed. Visits to all GPs undertaken. Living Well programmes delivered In-Home Dementia Respite Service evaluated 	<p>Quarterly report on progress against measures</p> <p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures.</p>
Community Specialist HOP Teams	<ul style="list-style-type: none"> Proactive use of DHB specialist Health of Older People Services 	<ul style="list-style-type: none"> Number of hours specialist HOP services consult with health 	<p>Quarterly report on progress against measures.</p>

	<p>(geriatricians, gerontology nurse specialists) to advise and train health professionals in primary care and aged residential care.</p> <ul style="list-style-type: none"> DHB has established a baseline for inappropriate admissions to hospital (i.e. where an older person is simply observed, rather than given an intervention) from the community and residential care. TDHB Aged Care Nurse Consultant to deliver targeted training and support to aged residential care facilities to improve quality of care, including delivery of following: <ul style="list-style-type: none"> Two Gerontology Study Days for ARC Registered Nurses Clinical Refresher Days for care staff and nursing staff 1 Enrolled Nurses Study Day Monthly Forums for isolated RNs working in ARC 	<p>professionals in primary care and aged residential care is increased. (Baseline = 221 hours per quarter.</p> <ul style="list-style-type: none"> A baseline for inappropriate admissions is established. All study days and monthly forums take place. 	<p>Quarterly report on progress against measures.</p> <p>Quarterly report on progress against measures</p>
Elder Abuse Guidelines	<ul style="list-style-type: none"> DHB Family Violence Intervention Programme (VIP) to implement the Elder Abuse Guidelines (2007) in 2011/12. 	<ul style="list-style-type: none"> Elder Abuse guidelines were implemented in 2011/12. Requires on-going maintenance and monitoring of the programme to ensure outcomes achieved. 	<p>Quarterly report on progress against measures</p>
Fracture Liaison service	<ul style="list-style-type: none"> TDHB to establish a multidisciplinary review team to assess the viability and effectiveness of such a programme. 	<ul style="list-style-type: none"> Outcomes as determined by the group are available by December 2013. Recommendations implemented by June 2014. 	<p>Six monthly</p>

3.5 *Living within Our Means*

3.5.1 Context

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

3.5.2 Our Approach

Taranaki DHB recognises it faces significant challenges in delivering services within available resources. We have outlined in Module 7 our financial forecast to 2015/16. In order to achieve those targets this Annual Plan contains cost containment strategies that align with our targets of a \$3.45m deficit in 2013/14, \$0.95m deficit in 2014/15 and a return to breakeven/surplus in 2015/16.

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

3.5.3 Linkages

- Minister's Letter of Expectation
- Strategic aim for the Midland DHB region
- Module 4: Stewardship

3.5.4 Action Plan

Key Objective	Actions to Deliver Improved Performance	Measured By	Reporting Frequency
Health Benefits Limited	<ul style="list-style-type: none">• Continue the implementation of Shared Services actions aligned with Health Benefits Limited (HBL) work programmes	<ul style="list-style-type: none">• Regular progress report on actions aligned with HBL work programmes as part of financial reports	Quarterly
Reduce demand for acute hospital services	<ul style="list-style-type: none">• Increase in service outputs delivered within a primary care and/or community setting, relative to hospital delivery, and reduction in demand for acute hospital services	<ul style="list-style-type: none">• See Acute and unplanned Care Section - 3.4	Quarterly
Financial Recovery Plan	<ul style="list-style-type: none">• Our financial recovery plan has been discussed with the National Health Board and is incorporated in Module 7.	<ul style="list-style-type: none">• Expected Financial results are identified in Module 7 in line with approved plans.	Monthly
Efficiency Projects	<ul style="list-style-type: none">• Provide Clinical leadership and strategic direction and Planning and Funding input to implement a coordinated and integrated approach to Health of Older People Services across the Midland DHB Region• Proactive management of employment cost growth and improved use of workforce	<ul style="list-style-type: none">• Regional approach to contracting and funding of Home and Community Support Services is implemented as per agreed regional plan (see 3.4.5 also).• FTE reports	Quarterly

4.0 Module Four: Stewardship

4.1 *Managing Our Business*

As detailed earlier, the environment we operate in is changing and there are a number of pressures and challenges DHBs face. The level of our success over the next few years will depend on our ability to adapt to the changing environment.

This module describes how we intend to perform our functions and conduct our operations to achieve the outputs and impacts we seek to deliver. It provides further detail on the stewardship portion of our performance story.

Stewardship	Workforce	Performance Management	Collaboration/Partnerships	Information
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4.1.1 Our People

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

Key points of note about our workforce (as at 31 December 2012) are:

- We employed 1,199.82 FTE of staff
- almost 82% of staff were female
- We have a multi cultural workforce with 37 different ethnicities working together to provide health services in many settings
- The Maori workforce make up around 7% of the overall staffing numbers with around 30% in support roles
- Maori are underrepresented in the medical workforce however the proportion of Maori registrars is gradually increasing
- New Zealand non-Maori make up the largest single ethnic group of employees (approximately 64 per cent)
- Our workforce is older than the New Zealand labour force
- In some areas more than 58% of our workforce is over the age of 46 years

Taranaki DHBs workforce consists of the following (as at 31 December 2012)

Workforce	Subgroup	FTE
Medical	SMO	67.86
	RMO	68.11
Nursing		514.76
Allied		239.89
Non Health Support		77.05
Management/ Administration		232.14
Total		1,199.81

4.1.2 Organisational Performance Management

Our performance is assessed on both non-financial and financial measures. The table in section 4.6.2 of this module provides an overview of the external reporting. Our overall planned performance as a funder and provider of health services for 2013/14 is outlined in this plan and will be reported to our Executive team, Finance and Audit Committee, Board and the Ministry of Health on a regular basis.

4.1.2.1 Non-Financial Performance Reporting

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

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

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

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

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

4.1.2.2 Financial Performance Reporting

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

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

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

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

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

4.1.3 Funding and Financial Management

The following table sets out our key financial indicators:

	2011/12 \$M ACTUAL	2012/13 \$M FORECAST	2013/14 \$M PLANNED	2014/15 \$M PLANNED	2015/16 \$M PLANNED
Revenue (after adjustments)	319	326	329	335	341
Net Surplus/(Deficit)	0	(1)	(3)	(1)	0
Total Fixed Assets	130	168	163	155	147
Net Assets	75	73	69	67	66
Term Borrowings and Provisions	58	73	75	75	75

4.1.4 Health Benefits Limited

Health Benefits Limited (HBL) was established in July 2010. HBL's role is to facilitate and lead initiatives that result in savings and efficiencies for District Health Boards (DHBs) on non-clinical initiatives. The actions we will undertake to support HBL and improve performance are presented in module seven.

4.1.5 Risk Management

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

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

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

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

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

4.1.6 Performance and Management of Assets

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

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

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

4.1.7 Shared Decision-Making

4.1.7.1 Clinical Governance

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

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

4.1.7.2 Maori Participation

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

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

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

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

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

4.1.7.2 Community Input

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

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

4.1.7.2 Primary Health Alliance Leadership Teams

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

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

4.2 Building Capability

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

4.2.1 HealthShare Limited

HealthShare (HSL), established in 2001, is a regional Share Services Agency jointly owned by Waikato, Bay of Plenty, Lakes, Taranaki and Tairāwhiti District Health Boards.

From August 2011 HSL has taken on an expanded role as a regional provider of service and now provides operational support in a number of areas identified as benefiting from a regional solution.

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

Agreed regional services are planned for in HSL’s Statement of Intent which specifies the company’s performance framework; the services to be provided; and the associated performance measures. HealthShare’s Business Plan details, at a service level, the activities that have been purchased by the shareholding DHBs.

The following regional support services are expected to be provided from HealthShare in 2013/14:

- Regional service planning and reporting facilitation
- Clinical Service Network development facilitation including:
 - Regional Clinical Networks
 - Midland Cancer
 - Mental Health and Addictions
- Clinical Service Network development including:
 - Maternity services
 - Renal
 - Cardiac
 - Rural
 - Elective
 - Health of Older People
 - Radiology
 - Stroke
- Midland Region Training Network
- Workforce development support
- Regional Information Services plan implementation
- Shared services including:

- Third party provider audit and assurance service
- Regional internal audit service (Waikato, Lakes, Taranaki, Tairāwhiti)
- Midland Smokefree programme.

4.2.2 Information Communications Technology

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

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

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

4.2.3 Integrated Contracting

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

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

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

4.2.4 Collaboration

We collaborate with other health and disability organisations, stakeholders and our community to decide what health and disability services are needed and how to best use the funding we receive from Government. These collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of the health system to achieve the best health outcomes for our community.

Taranaki DHB will monitor the progress of Lakes DHB's activities and relationships in its capacity as Pilot Site for the introduction of the Children's Action Plan (arising from The White Paper recently released). TDHB will assist where possible to ensure the successful implementation of this programme across the region and nationally.

Local

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

Whakatipuranga Rima Rau Trust (WRR) is an inter-agency trust established by Taranaki District Health Board, Ministry of Social Development, Te Puni Kōkiri and Te Whare Pūnanga Kōrero. WRR was created to build an integrated approach focusing on the common objective of up-skilling and developing the Māori Health and Disability workforce in Taranaki. This is an innovative multi agency and multi funder model which introduces a range of initiatives to address Māori workforce development through collaboration.

In 2013/14 we will explore stronger collaboration between the DHB Public Health Unit and Maori Health Promotion Providers.

Other examples of intersectoral collaboration include:

- Whānau Ora Integrated Contracts
- Long-term Community Council Plans
- Strengthening Families
- Accident Compensation Corporation and DHB relationship
- Healthy Homes initiatives

4.2.5 Long Term Demand Forecasting

We are experiencing an increasing mismatch of health service demand, supply and affordability. The health sector cannot continue to operate in the same way as it has been if we expect to be clinically and financially sustainable into the future.

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

- Programmes like the better, sooner, more convenient health care initiatives
- expectations for closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals
- Regional service planning
- Facility Change Management – supporting staff in lean process redesign and change management for the completion of Project Maunga (New Plymouth Base Hospital campus redevelopment)

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

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

4.3 Strengthening Our Workforce

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

We regularly scan HWNZ activities to ensure alignment of the DHBs direction and to ensure that there is no duplication of effort.

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

4.3.1 Regional

Responding to workforce challenges requires multiple strategies across a range of service and workforce determinants. The Midland DHBs Regional Services Plan (RSP) provides a framework for the five Midland DHBs to continue to plan and work cooperatively, while still acknowledging the unique challenges of individual DHBs.

Our RSP outlines how Midland DHBs are responding to changing patterns of demand and delivery of health services, now and into the future, to ensure we have a health and disability workforce that meets the needs of the population. As part of the RSP, the Regional Director of Training and the Midland Regional Training Network, identifies the regions training needs, and develops collaborative programmes to meet the needs of the workforce. Taranaki DHB will support the Regional Director of Training by contributing to the development of regional training plans and then participating in the implementation of the regional training initiatives.

Taranaki DHB will contribute to the following RSP capacity and capability workforce activities by participating in the leadership group that oversees the RSP activities, and by contributing resources to the development and implementation of the regional activities. Each DHB has committed to being a lead on at least one specific initiative, and Taranaki DHB will be the lead for developing and implementing strategies for the management of the aging workforce.

Further detail is provided in our RSP on the following regional workforce activities for 2013/14:

- Care assistant development (HCAs, orderlies, therapy assistants)
- Strategies around the management of the aging workforce
- Recruitment and retention strategies for rural vulnerable workforces
- Implementation of the Midland Training Network action plan
- Kia Ora Hauora – promotion of Maori Health as a career
- Strategies around alternative workforces that add value and cost less or are cost neutral

The DHBs have revised how regional workforce programmes are delivered. Regional workforce projects will be completed by the DHBs using a collaborative model. The collaboration process involves each DHB agreeing to a common approach for each project area first and then one DHB commits internal resource to develop the products for each DHB to select from. The decision about the strategy is made early to reduce the likelihood of redundant work and duplication. It also allows for the fact that each DHB has evolved to respond to its unique situation which has resulted in differences in the nature of services delivered, systems, processes, policies etc. The factors which have resulted in these differences remain today.

At regional level we would expect to see:

- The development and implementation of regionally coordinated HR processes
- Implementation and promotion of programmes that address regional workforce challenges
- Action to address workforce priorities which support the delivery of service plan, integrating IT and capital planning

4.3.2 Local

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

TDHB will maintain local relationships that will enhance the development of needed skills within the region particularly with the local tertiary provide, Western Institute of Technology Taranaki WITT), the Whakatipuranga Rima Rau Trust and other government agencies.

Taranaki DHB engages with staff by working with them on the development of their career plan when they begin working at the DHB, and supporting them through the appropriate training to ensure their development is aligned to their career plan. Staff will have access to resources within the DHB who will be able to provide the appropriate advice and guidance.

Staff will be able to contribute through forums and project groups in the development of the following workforce initiatives for 2013-2014:

Initiatives	Measure
Promoting opportunities where there are known workforce gaps including maternity services, rural medicine, health of the older person, general practice, filling all contracted medical placements developing career plans and encouraging participation on the Ministry of Health's Voluntary Bonding Scheme (VBS) for hard-to-staff communities and / or specialties.	<ul style="list-style-type: none"> Reduced level of vacancies Increase in length of service for those occupation groups
Continue with our "Grow Our Own" strategies to support the Hawera Hospital workforce development, the General Practice Education programme (GPEP), Scholarship Programme to attract young health professionals back to Taranaki targeting rural areas and Maori, and the continued development of leaders targeting all areas and levels of the organisation.	<ul style="list-style-type: none"> Recruitment vacancy rates, Turnover rates, Allocation of scholarships Recruitment of previous scholarship recipients
Create a Maori health workforce that is better representative of the population by exposing Rangatahi Maori to health professionals and encouraging them to take science subjects, and collaborating with initiatives like Kia Ora Hauora, Whakatipuranga Rima Rau and the Incubator Programme. Priorities for Maori workforce development in 2013 are participation of all Taranaki secondary schools in Incubator, enhanced support for all Year 13 students that participate on the Incubator programme and taster science programmes to be run for Year 9, 10 and 11 students.	<ul style="list-style-type: none"> Percentage of secondary schools participating in Incubator Participation numbers in Kia Ora Hauora for the Taranaki region Participation numbers for the Incubator programme
New entrants into the health workforce will be introduced to manage the attrition of those workers retiring. We will increase the number of nurse graduates, target medical vocational trainees to return to the DHB to manage the senior medical officer future workforce and maintain links with secondary schools and tertiary education providers.	<ul style="list-style-type: none"> Nurse Graduate volumes compared to previous years Volume of medical vocational trainees returning to TDHB
A Flexible Working Policy recognises the requirement of some employees who may want to vary their hours, days or place of work to care for people and achieve a work and life balance. On a case by case basis we will consider phased retirement options that will enable planning for retirement and we have the online Future Lifestyle Planning Programme for Retirement to support employees	<ul style="list-style-type: none"> Turnover Staff satisfaction survey results
There will be a strong emphasis on new models of care and the development of both secondary and primary led services. Project Maunga has provided opportunities to re-model the service including: <ul style="list-style-type: none"> The Productive Operating Theatre designed to balance and manage acute and elective patient demand on theatres and staff resources; Intermediate Care Assessment and Treatment Team (ICATT) designed to facilitate transition from hospital to home and from medical dependence to functional independence; and Continuing to implement the TDHB E-Pharmacy vision focussing on the E-Prescribing and Medicines Reconciliation pilot projects 	<ul style="list-style-type: none"> Turnover Staff satisfaction survey results Clinical Board KPIs
Focus on workforce management during 2013/14 with an emphasis on how supplementary staffing is utilised for the Nursing, Allied Health and Administration workforces. This ensures we have both planned and optimal staffing while ensuring accountability for results, budgets, staff and services rested with the appropriate leaders and managers	<ul style="list-style-type: none"> Turnover Staff satisfaction survey Number of Quality Improvements identified and implemented
Commitment to high quality clinical leadership and the development of strong, high performing clinical/management partnerships that will drive engagement and accountability at all levels as we strive to live within.	<ul style="list-style-type: none"> Staff satisfaction survey Clinical Board KPIs

TDHB participated in the clinical engagement survey conducted by the Otago University in 2012. A focus will be to support clinical leadership by the Chief Medical Advisor, Heads of Department and Clinical Directors, in provision of clinically appropriate and cost effective services	<ul style="list-style-type: none"> • Feedback from clinical leaders
TDHB will implement the Safe Staffing Healthy Workplaces DHB and Care Capacity Demand Management Implementation Programme (CCDM). These projects have provided further opportunity for staff engagement, building commitment to new ways of working and improving care.	<ul style="list-style-type: none"> • Staff satisfaction survey • Number of Quality Improvements identified and implemented
We will continue to develop as an attractive employer with good inducting and orienting of new employees, which will use current e-recruitment technology to connect new employees to the organisation in the shortest possible time. The outcomes sought will be consistency in messaging, a more productive employee, increased retention and cost savings.	<ul style="list-style-type: none"> • Successful implementation of project • Feedback from new staff via the post entry survey
TDHB participates as a member of the Midland Regional Training Network to support coordination and optimal solutions for post entry education and training of the health workforce, via the shared service organisation Health Share Limited. Key priorities for 2013 standardisation of PGY1 and PGY2 programmes implement new and emerging roles in health and strengthen clinical leadership by coordinating leadership training.	<ul style="list-style-type: none"> • Regional PGY1 and PGY2 programmes implemented • Regional leadership training programmes implemented • Feedback from programme participants
Taranaki shares a regional e-learning platform and we will participate in the development of a list of regional DHB courses in 2013 and 2014. Locally we will promote opportunities to employees to participate in leadership development programmes and deliver fit for purpose workshops that will enhance the skills and knowledge of managers using "toolkits" as the primary source of information.	<ul style="list-style-type: none"> • To have an increase in the volume of employees completing e-learning courses • Training feedback on the e-learning courses • To have implemented leadership development programmes at TDHB
<p>Taranaki will work with the MRTN to ensure mentoring and career planning will take account of service needs of the population, reinforcing the 70/20/10 programme. This will include:</p> <ul style="list-style-type: none"> • Review career planning arrangements • Contribute to the central resource for career planning information and resources • Implementing regional reporting mechanisms • Involvement in the regional mentoring process 	<ul style="list-style-type: none"> • Complete career plans for trainees • Regional resources implemented to support the trainees with their career plans

Staff engagement and organisational health is central to ensure the provision of high quality and effective services that meet the health needs of our community. TDHB engages staff in regards to change management and policy development, particularly during times of organisational change and transformation.

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

- Learning and development framework that establish a culture where learning is actively supported and removes barriers to learning
- Talent management framework that focuses on Talent Identification - sourcing, recruitment and talent management, Talent Planning – workforce and succession planning, and Talent Development and Retention – learning and development, and retention strategies.
- Fair and transparent recruitment processes and automated candidate management systems
- Zero-tolerance of harassment and bullying with policy and bipartite forum action focused on achieving this outcome
- Recognition within the workforce of the aspirations and needs of Maori, other ethnic or minority groups, women and people with disabilities

- Equitable training and development opportunities, leadership and professional, for all employees
- Compliance training
- The management and disclosure of adverse events to ensure a safe quality working environment
- Commitment to DHB values and treating our people with respect and dignity

4.4 Quality and Safety

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

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

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

- Quality and risk framework
- Strategic objectives
- Dimensions of quality and our associated goals
- Quality and Risk committee structure
- Staff responsibilities
- Links into the Health Quality and Safety Commission's areas of focus identified in their Statement of Intent (June 2012)

The following table outlines the Taranaki DHB's high level actions and outcomes for the 2013/14 year in relation to our key quality improvement projects including the four areas of focus identified by the Health Quality & Safety Commission as part of the national Patient Safety Campaign.

Programme	Expected Actions	Outcomes
Medication safety	Progressive roll out of e-medications (reconciliation and prescribing) across the hospitals as agreed to by the Commission and National Health IT Board and detailed in the project plan. E-medications programme monitoring and evaluation actions continue.	Results from our monitoring measures, identified in the project plan for e-medications, meet or exceed agreed targets resulting in the reduction of the number, type and harm from medication related events. Productivity and efficiency gains.
Reducing healthcare associated infections	Hand Hygiene Train more Gold Auditors Meet the required hand hygiene moments observed and submitted each quarter. Increase our compliance rate to equal to or more than 70% Central Line Associated Bacteraemia (CLAB) Continue with the implementation and	Rate of <0.1 per thousand bed-days of Staphylococcus aureus bacteraemia. Rate maintained at <1 per 1000 line days in ICU. Rate of infection is <5% in surgeries surveyed.

	<p>monitoring of the programme.</p> <p>Surgical Site Infection Surveillance</p> <p>Continue with the Taranaki DHB's existing process until a national solution becomes available.</p>	
Falls reduction	Progressive implementation of our Falls Prevention Steering Group Work Plan.	<p>Rate of patients having had a falls risk assessment is 100%.</p> <p>Rate of high quality individualised care plans in place for those patients assessed as high risk is 100%.</p> <p>Reduction in the number of hospital falls by 10%.</p> <p>Reduction in the number of patient falls with a serious/sentinel outcome by 10%</p>
Surgical safety	<p>Continue to monitor and feedback use of the Surgical Safety Checklist by specialty.</p> <p>Progressive implementation of the 'productive operating theatre' programme.</p>	<p>Percentage of operations where all three parts of the surgical checklist was used is 100%</p> <p>Percentage of operations where venous thromboembolism was considered as part of the surgical checklist is 100%</p>
Increasing consumer participation	Development and implementation of a patient and family –centred care framework and toolkit for hospital and specialist services, and, in due course, for all of Taranaki DHB.	Increased consumer participation across the DHB identified through evaluation.
Reportable event process /analysis enhancement	<p>Explore options for an electronic reportable events system.</p> <p>Complete a business case and submit for approval and prioritisation.</p>	Improved analysis and reporting of events and trends to the Taranaki DHB.

Evaluation of our key quality programmes will be occur and be reported in our Quality Accounts document for 2013-14.

4.5 Organisational Health

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

4.5.1 Governance

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

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

composition of the board is 11 members, seven elected and four appointed by the Minister of Health. As required, the Board has two Maori members.

Three statutory (mandatory) advisory committees and three non-statutory committees have been established to assist the Board to meet its responsibilities. The membership of these committees is comprised of a mix of Board members and community representatives who meet regularly throughout the year. It includes both clinical and Maori members who contribute clinical and cultural experience and understanding to decision making.

The Board has not approved delegations to committees. All matters are recommended to the Board through the minutes of the relevant committee.

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

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

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

4.5.2 Providing Health and Disability Services

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

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

Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic and rehabilitative services.

Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services.

Emergency Department services including triage, diagnostic, therapeutic and disposition services.

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

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

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

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

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

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

4.5.3 Planning and Funding Health and Disability Services

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

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

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

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

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

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

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

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

4.6 Reporting and Consultation

4.6.1 Consultation with the Minister and the Ministry of Health

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

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

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

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

4.6.2 External Reporting

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

Table: External Reporting Framework

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

4.7 *Ownership Interests*

Taranaki DHB is a Crown Entity with ownership of:

- Taranaki Base Hospital delivering a full range of secondary services. These are New Zealand Role Delineation Model Level 4 for Emergency Medicine, General Medicine, Maternity and Neonates, Paediatrics, Health of Older Persons and Specialist Rehabilitation; and Level 3 for Oncology and Haematology, and Surgical Services.
- Hawera Hospital delivering New Zealand Role Delineation Model Level 2 services in Emergency Medicine, Medicine, Surgery, Maternity and Older Adult Services; and Level 1 Paediatrics.
- Mental Health and Addiction Services with acute inpatient facilities and community facilities in New Plymouth.
- Public Health Unit providing a range of Health Promotion, Health Protection and Medical Officer of Health services in New Plymouth.
- HIQ – a wholly-owned subsidiary delivering operational and strategic information systems support to the DHB.
- Allied Laundry Services Ltd – ownership shared with Hawke's Bay, MidCentral, and Whanganui DHBs for the provision of laundry and linen services.
- Fulford Radiology Services Ltd – joint ownership with Taranaki Radiologists Ltd, providing a comprehensive range of imaging services to the district.
- HealthShare – ownership shared with Bay of Plenty, Lakes, Tairāwhiti, and Waikato DHBs for the provision of routine and issues-based quality audit of service providers.
- Health Centres at Patea, Mokau, Opunake, Stratford and Waitara, delivering community and outpatient services.

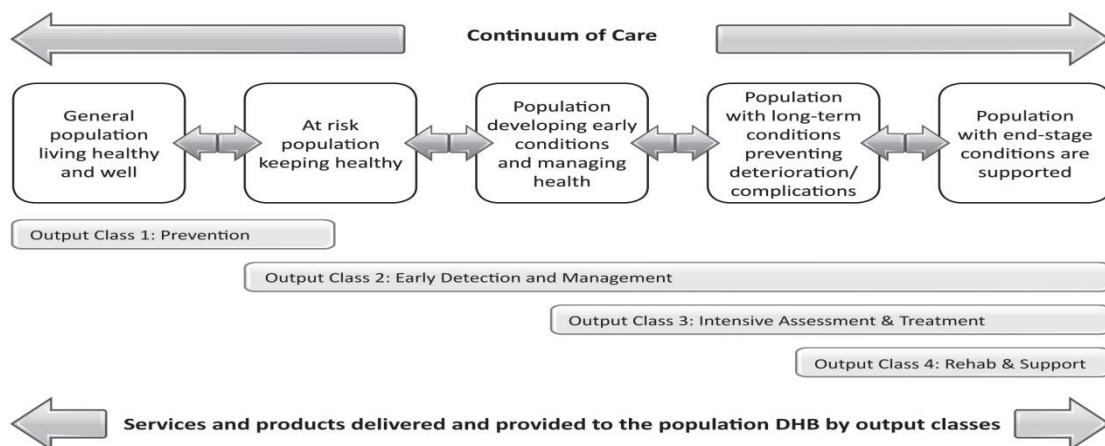
5.0 Module Five: Statement of Forecast Service Performance

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Forecast Service Performance (SFSP) in which we provide measures and forecast standards of our output delivery performance. The actual results against these measures and standards will be presented in our Annual Report 2013/14. The performance measures chosen are not an exhaustive list of all of our activity, but they do reflect a good representation of the full range of outputs that we fund and / or provide. They also have been chosen to show the outputs which contribute to the achievement of national, regional and local outcomes (see modules 2 and 3). Where possible, we have included with each measure past performance as baseline data.

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

5.1 Output Classes

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used in our statement of forecast service performance are also reflected in our financial measures and are described in Module Nine (9.3). The four output classes that have been agreed nationally are defined in Module Nine (9.2). They represent a continuum of care, as follows:



5.2 Guide to Reading the Statement of Service Performance

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

- Further detail of the performance story logic and rationale is contained in section 2.6
- Baseline and National/Regional Result figures for the output performance measures are for the 2011/12 financial year unless otherwise stated
- In the performance measures table and where available the average column presents the national or regional average for the output performance measure
- Most measures have been adopted regionally
- Some measures fall across more than one impact. Where this is the case they have only been included once.
- Measurement type key: qn = Quantity t = Timeliness ql = Quality

- There are some services we provide that support the rest of the health system so we have included these in a “Support Services” section of our performance story
- Detailed information about various programme definitions and rationale for each output measure is provided in Module Nine (9.4).
- National data collections will be occurring during 2013/14 through the Quality and Safety Commission’s National patient Safety Campaign. Further baseline data for future quality markers will be available for the 2014/15 Annual Plan and TDHBs Quality Programme Outcomes will be presented in our 2013/14 Quality Account Report.

5.3 *People are Supported to Take Greater Responsibility for Their Health*

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

5.3.1 Fewer People Smoke

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result	
Percentage of hospitalised smokers offered advice to quit (Health Target & MHP)	1	qn/t			National	Regional
Maori			91%	95%	93%	91%
Non-Maori			90%	95%	94%	92%
Total			90%	95%	94%	92%
Percentage of Primary Health Organisations enrolled smokers offered advice to quit (Health Target & MHP)	1	qn/t			National	Regional
High Needs			45%	90%	34%	40%
Total						

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit (Health Target and MHP)	1	qn/t			
Maori			New Measure	90%	New Measure
Non-Maori				90%	
Total				90%	

5.3.2 Reduction in Vaccine Preventable Diseases

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
Percentage of eight month olds fully immunised (Health Target & MHP)	1	qn/t			National Regional
Maori			83%	90%	83% 79%
Non-Maori			88%	90%	91% 87%
Total			87%	90%	89% 84%
Percentage of the population >65 years who have received the seasonal influenza immunisation (PHO Performance Programme & Maori Health Plan)	1	qn/t			National
High Needs			66%	75%	63%
Total			68%	75%	64%

5.3.3 Improving Health Behaviours

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
Percentage of infants who are fully or exclusively breastfed at 6 months (Maori Health Plan)	1	qn/t			National
Maori			10%	27%	16%
Non-Maori			23%	27%	27%
Total			20%	27%	25%

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
The number of referrals to the GRx (Green Prescription) programmes (Local Contract) Adult Children	1	qn/t	New Measure	967 35	New Measure
Reduce the teen birth rate per 10,000 Maori Non-Maori Total	1	qn/t	339 160 203	<339 <160 <203	National Regional 415 428 123 149 186 247
Reduce the rate of teenage terminations of pregnancy per 10,000 Maori Non-Maori Total	1	qn/t	194 142 154	<194 <142 <154	National Regional 158 163 123 116 186 133

5.4 People Stay Well in Their Homes and Communities

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

5.4.1 An Improvement in Childhood Oral Health

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result	
Percentage of children (0-4) enrolled in DHB funded dental services (Policy Priority 13)	2	qn			National	Regional
Maori			55%	85%	41%	31%
Non-Maori			85%	85%	67%	66%
Total			75%	85%	60%	58%
Percentage of enrolled pre-school and primary school children (0-12) overdue for their scheduled dental examination (Policy Priority 13)	2	qn/t	3%	3%	National	Regional
					11%	12%
Percentage of adolescent utilisation of DHB funded dental services (Policy Priority12)	2	qn	71%	85%	National	Regional
					68%	68%

5.4.2 Long-Term Conditions are Detected Early and Managed Well

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result	
Percentage of population enrolled with a PHO (Maori Health Plan)	2	qn			National	Regional
Maori			86%	96%	87%	93%
Non-Maori			99%	96%	98%	99%
Total			97%	96%	96%	98%
Percent of the eligible population will have had their cardiovascular risk assessed in the last five years (Health Target & Maori Health Plan)	2	qn			National	Regional
Maori			54%	90%	48%	47%
Non-Maori			60%	90%	49%	61%
Total			59%	90%	49%	58%
Maintain or improve appropriate management of microalbuminuria or overt nephropathy in patients with diabetes (Policy Priority 20)	2		New Measure	Improve or where high, maintain	New Measure	

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result	
Percentage of eligible women (20-69) have a cervical cancer screen every 3 years (Maori Health Plan)	1	qn/t			National Regional	
Maori			73%	80%	63%	63%
Non-Maori			87%	80%	79%	83%
Total			85%	80%	77%	79%
Percentage of eligible women (50-69) have a breast screen in the last 3 years (Maori Health Plan)	1	qn/t				
Maori			56%	70%	64%	57%
Non-Maori			72%	70%	72%	67%
Total			70%	70%	71%	66%
Increase the number of packages of care available to youth under the Primary Mental Health Initiative	2		New Measure		New Measure	
Maori				63		
Non-Maori				187		
Total				250		

5.4.3 Fewer People are Admitted to Hospital for Avoidable Conditions

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result	
Percentage of Rest Home residents receiving vitamin D supplement from their GP	4	qn	63%	70%	Not Available	
Triage level 4 & 5s presenting to the Emergency Department as a percentage of the total population	2&3	qn	23%	<23%	National Regional	
					11%	15%
Percentage of eligible population who have had their B4 school checks completed	1	qn/t			National Regional	
High Needs					82%	91%
Total					79%	83%

5.4.4 More People Maintain their Functional Independence

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months (Policy Priority 18)	4	qn/t	30%	66%	Not Available
For those with aged related and chronic health conditions we aim to reduce the rate of rest home level of residential care to home based support and respite funding	4	qn	ARRC:HBSS/ Respite 2.45:1	2.19:1	Not Available
Increased number of clients accessing respite services	4	qn	25	100	Not Available
Percentage of patients aged 75 and over (Maori and Pacific Islanders 55 and over) that are given a falls risk assessment	3	ql	91%	100%	Not available

5.5 People Receive Timely and Appropriate Care

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

5.5.1 People Receive Prompt and Appropriate Acute and Arranged Care

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result	
Acute Re-admission rate (Ownership Dimension 8)	3	qn/t/ql	5.22%	≤5.22%	National 8.03%	Regional 7.09%
Acute Re-admission rate 75+ years (Ownership Dimension 8)	3	qn/t/ql	8.66%	≤8.66%	National 11.50%	Regional 10.40%
Acute inpatient average length of stay (Ownership Dimension 3)	3	qn/t	4.86 days	4.86 days	National 4.52 days	
Percentage of patients who require radiation or chemotherapy are treated with 4 weeks (Health Target)	3	qn/t	100%	100%	100%	
Faster Cancer Treatment – Proportion of patients with a confirmed diagnosis of cancer who receives their first cancer treatment with 31 days (Developmental Measure 2)	3	qn	New Measure	100%	New Measure	
Arranged Caesarean deliveries without catastrophic or severe complication as a % of total primary and secondary deliveries	3	ql	18%	<18%	National 17%	Regional 15%

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
Percentage of operations where venous thromboembolism (blood clot) was considered as part of the surgical checklist	3	ql	91%	100%	Not available

5.5.2 People Have Appropriate Access to Elective Services

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
Percentage of patients waiting longer than five months for their first specialist assessment (Elective Service Performance Indicator 2)	3	qn/t	1.2%	0%	National 4.0% Regional 3.6%
Number of surgical discharges under the elective initiative (Health Target)	3	qn	4,967*	4,264	N/A
Elective inpatient length of stay (Ownership Dimension 3)	3	qn/t	3.43 days	3.21 days	3.43 days
Did-not-attend percentage for outpatient services (Maori Health Plan)	3	qn/t			National Regional
Maori			19%	<9%	13% 16%
Non-Maori			7%	<9%	6% 7%
Total			9%	<9%	7% 9%

*The number of surgical discharges performed during 2011-12 was greater than Plan. We expect that during 2013-14 we will manage the volumes to meet the Plan live within our means

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

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
Percentage of people referred for non-urgent mental health or addiction services are seen within 3 weeks (Policy Priority 8)	3	qn/t			National Regional
Mental Health					
0-19 yr olds			60%	70%	63% 63%
20-64 yr olds			83%	80%	84% 80%
65+ yr olds			87%	80%	78% 80%
Addictions					
0-19 yr olds			61%	70%	67% 52%
20-64 yr olds			64%	70%	74% 55%
65+ yr olds			64%	70%	82% 65%
Improving the percentage of long-term clients with up to date relapse prevention/treatment plans (Policy Priority 7)	3	qn/t/ql			
<20 yr olds					
Maori			100%	95%	Not Available
Non-Maori			96%	95%	
Total			97%	95%	
20+ yr olds					
Maori			100%	95%	
Non-Maori			97%	95%	
Total			98%	95%	
Average length of acute inpatient stays (KPI 8)	3	qn/t/ql	16 days	14-21 days	Not Available
Rates of post-discharge community care (KPI 18)	3	qn/t/ql	52%	90-100%	Not Available

5.5.4 More People With End Stage Conditions are Supported Appropriately

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
A reduction in the percentage of palliative care clients who have had an Emergency Department presentation	3		11%	≤11%	Not Available

5.6 Support Services

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
Improved wait times for diagnostic services - accepted referrals receive their scan within 42 days (Developmental Measure 2)	2		New Measure		New Measure
Computed Tomography (CT) Magnetic Resonance Imaging (MRI)				85% 75%	
Non-urgent community laboratory tests are completed and communicated to practitioners within the relevant category timeframes: Category 1: Within 24 hours Category 2: Within 96 hours Category 3: Within 72 hours	2		95% 95% 90%	90% 90% 90%	N/A
Number of community pharmacy prescriptions	2		1,087,761	<1,087,761	N/A

6.0 Module Six: Service Configuration

6.1 Service Coverage

Taranaki DHB acknowledges that it has responsibility to fund other services outside the district, and will do so accordingly. The impact of this responsibility in the 2013/14 funding environment will largely be limited to:

- Determining alternative levels of services purchased from those indicated by Ministry of Health forecasts where there have been indications that volumes need to be increased or decreased in line with need and prioritisation
- Funding any additional acute inpatient activity to meet demand
- Purchasing services previously provided within the district from outside the district should local provision be disrupted.

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

- Well Child services through Plunket, health camps etc
- National contracts (Organ transplants and new services purchased nationally in 2012/13)
- Emergency ambulance services
- Strengthening Families
- Family Start
- Primary response in medical emergencies (PRIME)

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

6.2 Service Change

The following table describes possible service areas that TDHB wishes to signal it's intention to review and/or evaluate in the coming year. It has yet to be determined that there is a proven need for a change to take place. Should the DHB consider in due course that a change is warranted, a formal service change process as outlined under the Operating Policy Framework (OPF) will be followed to ensure service coverage and the Minister's and the Ministry's requirements are met.

Table: Approved Service Changes 2013/14

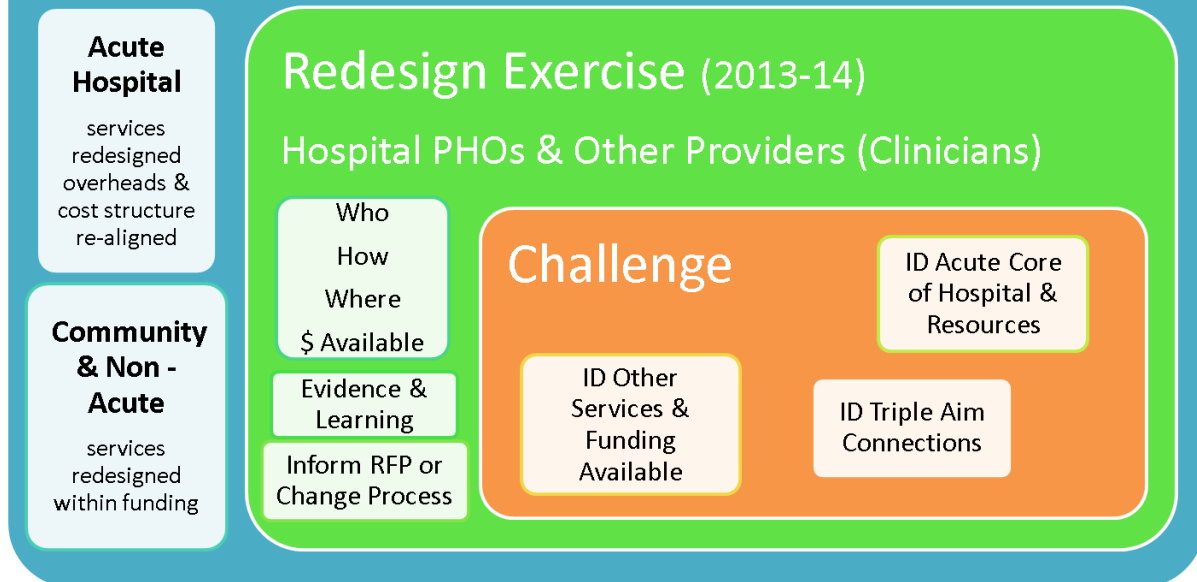
Type of Change	Description of Change	Benefits of Change	Link to Lower Funding Path	Change Due to Local, Regional, or National Reasons
Midland Regional Clinical Services Plan	As part of the Regional Clinical Services planning process clinical action groups or networks have been established for identified areas.	<ul style="list-style-type: none">• Reduce duplication of effort enabling DHBs to collectively develop sustainable solutions.• Develop integrated approach to recruitment and retention within the global marketplace.• Standardised planning, evaluation and procurement of new technology solutions within a clinical environment.	Yes	This work is consistent with the national expectation of an increased focus on regional approaches, and with the strong focus on regionalisation agreed across the Midland DHBs.

Type of Change	Description of Change	Benefits of Change	Link to Lower Funding Path	Change Due to Local, Regional, or National Reasons
Reconfiguration	<ul style="list-style-type: none"> Consolidation of Home and Community Support Services. 	<ul style="list-style-type: none"> Provider able to meet new Service Specification. Regional constancy Sustainability of services. 	Yes	Regional
	<ul style="list-style-type: none"> Consolidation of residential mental health services and crisis respite services. 	<ul style="list-style-type: none"> Greater sustainability of services. Facilitates demand for and from DHB inpatient facility. Reduced proportion of expenditure on overheads. 	Yes	Local
	<ul style="list-style-type: none"> Explore most appropriate model of maternity services for rural Taranaki. 	<ul style="list-style-type: none"> Clinical sustainability. Improved cost effectiveness. Fewer women delivering who are not registered with an LMC. 	Yes	Local
	<ul style="list-style-type: none"> Expansion of intermediate care for older people. 	<ul style="list-style-type: none"> Reduced inpatient LOS. Reduced proportion of older people entering permanent rest home care. Care closer to home. 	Yes	Regional
	<ul style="list-style-type: none"> New options for acute demand and urgent primary care. 	<ul style="list-style-type: none"> Support achievement of ED Health Target. Increase options available in primary care after hours. Increased enrolment of patients with PHOs. 	Yes	Local

Taranaki Integrated Health System

A major piece of work will be undertaken over the next 12-16 months on the redesign of non-acute services. This will involve many stakeholders working together to redesign the Taranaki Integrated Health System. A key to this will be the collective effort of local providers and communities, together with lessons from elsewhere, developing new ways and potentially new locations for services to be delivered within the resources available. The following diagram describes the approach, starting in the centre with the Challenge, moving over the next 12-18 months to the redesign exercise and resulting in a new Taranaki Integrated Health System.

Taranaki Integrated Health System (2014-16)



This work may result in service change from 2014/15 and the out-years.

6.3 Service Issues

We have no emerging service issues other than what is already covered in this section or described within the context of the Midland Regional Service Plan.

7.0 Module Seven: Financial Performance

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

(\$'000)	2011/12 audited	Year 0 2012/13 Forecast		Year 1 2013/14 plan	Year 2 2014/15 plan	Year 3 2015/16 plan
Hospital Provider + Governance Funding (including other income)	170,495	173,384		174,355	177,413	180,688
Non Hospital Provider Funding (NGO)	148,358	152,182		154,621	157,505	160,389
TOTAL FUNDING	318,853	325,566		328,976	334,918	341,077
Hospital Provider + Governance Operating Expenses	179,420	184,544		187,806	188,352	190,420
Payments to Non Hospital Providers (NGO)	139,235	141,972		144,621	147,501	150,505
TOTAL OPERATING EXPENSES & PAYMENTS	318,655	326,516		332,427	335,853	340,925
Hospital Provider + Governance Operating Deficit	-8,925	-11,160		-13,451	-10,939	-9,732
TDHB Funder surplus	9,123	10,210		10,000	10,004	9,884
CONSOLIDATED FINANCIAL RESULT	198	-950		-3,451	-935	152

The net consolidated financial projection for the planning period 2013-16 is:

- 2013-14: Deficit \$ 3.45M
- 2014-15: Deficit \$ 0.94M
- 2015-16: Surplus \$ 0.15M

These are draft financial projections, as work continues on targeted initiatives and action plans to provide any further improvements to the financial results.

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

7.1 Key Points from the Budgeted Financials 2013-16

- The Board has planned for a consolidated financial deficit for Year 1 and Year 2 of the planning period 2013-16, with a financial breakeven targeted for Year 3.
- These financial projections reflect a common trend across the entire planning period 2013-16, clearly indicating that cost growth in the hospital provider operations is significantly in excess of funding received, leaving residual operating deficits. The relatively better consolidated financial result is solely

on account of the surpluses generated in the Funder operations during each of the fiscal periods under consideration.

- Stage 1 of the hospital redevelopment programme (Project Maunga) is scheduled for completion in December 2013, with the Clinical Block housing theatres and patient wards planned for occupation in July/August 2013.
- The hospital provider (and consolidated) financial result in Year 1 is materially influenced by the cost impacts of Project Maunga coming on-stream in August 2013. Increased depreciation (\$ 3.01M), interest cost of borrowing (\$ 1.46M) , loss of interest income on deposits (\$ 1.20M) and increased cost of utilities (\$ 0.40M) has resulted in \$ 6.10M addition to operating expenditure in 2013-14. The annual impact is \$ 6.53M (Year 2 & 3).
- The hospital provider budget for Year 1 (2013-14) has built in \$ 4.03M in savings to be generated from cost reduction and efficiency initiatives. These savings are arising from improved service level management, monitoring of contracted volumes, reduced staffing costs, demand and capacity management amongst a range of other initiatives. (Please refer to the “Cost & efficiency initiatives” section for details).
- Likewise, the DHB Funder operations is planning to reprioritise funding and drive initiatives to enable the DHB Funder operations to manage its costs down and deliver the operating surplus planned for 2013/14 and years following.
- It is not practical to estimate with certainty the likely costs and benefits to this DHB from Health Benefit Limited (HBL) driven business cases as these are either in their development stages (Finance, Procurement and Supply Chain) or yet to progress to the business case stage (Food, Laundry and Facilities). However, TDHBs share of capital investment and operating expenditure net of benefits on the basis of information made available have been provisioned.
- Indicative savings through reduced pricing from collective procurement projects, All of Government (AOG) initiatives and other collaborative efforts have been factored into clinical supply and consumable costs over the plan period. Likewise, operating expenditure outflow to support some of these initiatives have been recognised.
- Likewise, TDHBs share in supporting the Midland regional projects and contribution to HealthShare (the regional shared services entity) has also been recognised.
- The impact for TDHB arising from HBL, the multiple central agencies business cases and regional involvement for 2013-14 is an additional operating expenditure outflow of circa \$ 0.50M. Capital investment required by TDHB to support the HBL initiatives in 2013-14 is \$ 0.41M.
- The operating budget is severely constrained to absorb these new costs arising on different fronts.
- The Hospital Provider Arm is facing a significant cost to funding gap resulting in operating deficits in each year covered by this plan. This gap could increase if other identified risks and associated costs (estimated at \$2.00M) were to materialise fully. With the residual risk at \$1.20M, the resultant financial gap could be in the region of \$14.70M. Likewise, the DHB Funder is also faced with exposure estimated at around \$8.90M for 2013/14, with a 50% residual risk equating to about \$4.45M. (Please refer the “Sensitivity Analysis” section for details).
- The Board recognises that the operating cost to funding gap in the Hospital Provider operations will need to be addressed through options that could result in significant changes to models of care, service configurations and re-alignment of services within funding available. It acknowledges these changes are essential if the Hospital Services arm is to remain financially viable when faced with increased costs on several fronts, in particular Project Maunga.
- It is expected that the gains from Project Maunga will materialise in future periods - Years 2 and 3 on wards. Consolidation of specialist services and improved models of care and pathways will result in more efficient use of clinical resources and thereby reduction in core operating costs. The

redevelopment will pave the way for a recovery plan for Hospital Services to align itself more efficiently – both clinical and financial.

In the final analysis, the Board is faced with:

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

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

7.2 Key Risks:

7.2.1 Taranaki DHB's Funder Operations

1. The 2013/14 Funding Envelope indicates growth increases of \$6 million over the 2012/13 Funding Package. The increase includes \$3.4 million demographics and \$2.6 million as a contribution to cost pressures. Whilst this increase is welcome, it is not as great as the general funding and expenditure pressures being experienced by the DHB.
2. The Government has made no decision on funding for 2013/14 and 2014/15. Taranaki DHB has therefore prepared the Annual Plan on the assumption that funding increases for cost growth in out years will be of the same nominal value as 2013/14.
3. Taranaki DHB's share of population based funding for 2013/14 is 2.73%, a reduction on the 2.74% allocated in 2012/13. This reflects the slower population growth of Taranaki in comparison to other parts of the country.
4. The Funding Envelope advice indicates that there may be some further additional funding made available to DHB's from non-devolved funding held by the Ministry of Health for 2013/14. Further advice on devolution of funding is awaited. However, it is assumed that any funding would already be committed to contracts currently held by the Ministry and which would be transferred to DHB's.
5. General hospital and specialist services delivered by the DHB's own Provider Arm will be paid in a composite of National IDF prices and local prices acknowledging affordability and capacity issues. Mental health services delivered by the DHB's Provider Arm are funded by a local price mechanism. Significant reconfiguration of the DHB's hospital and specialist services is planned over the next three years to bring the cost of service delivery closer to the funding available.
6. In order to offset planned deficits in the Provider Arm, whilst service reconfiguration is undertaken to a lower cost base, the Funder is required to achieve significant surpluses over the next three years to. In 2013/14 and 2014/15 the planned Funder surplus is \$10 million, reducing to \$9.9 million in 2015/16. Delivery of these surpluses will present a significant challenge for Funder.

7. The absence of a risk reserve will severely limit the Funder's ability to fund transition costs of new models of care and respond to unexpected demands in year.
8. In order to deliver a net \$10 million surplus the Funder plans to deliver further service configuration signalled in Section 6.2. These changes are transformational in nature and it is believed will deliver the same or better health outcomes for less cost.

7.2.2 Taranaki DHB's Hospital Provider Operations

The funding contribution for cost pressure in 2013/14 is 0.89%. However, the real cost growth in hospital provider services is well in excess of this adjustor. The year on year cost movements across several expenditure lines are on an average between 3% and 5%. This gap between funding and real cost growth has resulted in a budgetary deficit of \$13.50M after considering all current efficiencies and cost savings, including new costs totalling \$ 6.10M related to Project Maunga. Net of Project Maunga cost impact, the hospital provider carries a core structural deficit of circa \$ 11M.

Cost pressures are particularly evident in the following areas:

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

Overall, the Hospital Provider's financial plan for the three year period is highly geared and has no flexibility to accommodate unplanned cost movements. Its operating budget carries financial risks and it is highly dependent on the realisation of targeted savings within planned timelines to meet its 2013/14 and out year financial targets.

In applying the budgetary assumptions we have recognised ongoing quality improvements and those compliance costs of which TDHB has been aware. The financial budget is vulnerable to small movements in costs over stated assumptions or increased costs resulting from clinical compliance expectations and legislative changes (such as increased employer contributions to Kiwi Saver (+\$0.95M)).

The Hospital Services Provider is dependent on sustainable revenue streams. With over 93% of its revenue derived from health funding (via DHB Funder and the Ministry of Health), the Hospital Provider has few alternate income streams for revenue growth. There is a marginal increase (+\$ 0.33M) in ACC revenues planned for 2013/14 arising from increased theatre capacity post Project Maunga. Miscellaneous income also assumes \$ 3.0M to be raised through community donations.

In view of the increasing cost pressures, the financial budget for the Provider Arm continues to hinge on a number of efficiency initiatives, which are expected to generate approximately \$4.03M of reduced operating costs during 2013/14. (Please refer to the "Cost & Efficiency initiatives "section for details).

During the plan period 2013-16, baseline capital expenditure is expected to be contained within depreciation provisions, so that additional equity injection or borrowing is not required despite operating deficits.

In summary, the gap between funding and the realistic cost model for services + the cost impact of Project Maunga has resulted in a very sensitive financial budget for the planning period 2013/14 and out years.. Due to funding constraints, the hospital provider will have to bridge this budgetary gap in a

decisive and time sensitive manner through a range of initiatives comprising rationalisation of services, workforce management, regional co-operations and realisation of gains from ongoing projects. These measures will have to be undertaken in order to exit costs and reduce the deficit in a planned manner to realistic funding levels. From an realistic view point, the quantum of cost savings required from the hospital services will likely span a 3 year planning horizon – if existing services and levels are to be maintained.

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 2013/16.

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

The DAP financial template for the plan period 2013-16 and comparative years has been prepared in accordance with NZ GAAP. They comply with the NZ equivalent to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit.

7.4.2 Equity and Borrowing

The District Annual Plan 2013-16 has not assumed any additional Crown equity.

Term borrowing from the Crown Health Financing Agency (DMO/MOH) 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 2013-16. Approval for Stage 1 (estimated cost: \$80M) of the redevelopment was received in July 2008, which includes a DMO/MOH funded borrowing of \$45M. The construction has commenced and is scheduled for completion by December 2013, with the inpatient block comprising theatres and wards becoming operational in July/August 2013.

With the exception of the capital outlay envisaged on inpatient facilities redevelopment as noted above, base line capital expenditure is expected to be contained within the level of depreciation for 2013/14 and the two years following.

Taranaki DHB was moved from “performance watch” to “intensive monitoring” status on the performance monitoring scale in February 2013. It was advised that monthly funding will continue to be received in advance, no change to this methodology has been assumed.

7.4.3 Operating Expenditure

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.

Clinical supplies: average around 3.5% for 2013/14 + estimated on increased activity levels + reduced for local efficiencies and procurement gains.

General operating expenditure: average 2.0% for 2013/14 + confirmed outflows + reduced for local efficiencies and procurement gains.

Value for Money (VFM) impacts: Cost reductions and gains likely to ensue from the collective procurement contracts undertaken by HBL/ National VFM programmes have been recognised in the DAP financials. No cost savings have been assumed from the shared services initiatives currently being

progressed by HBL (FMSC, FMSS, HRIS etc) since indicative business cases point to upfront capital investment and costs required to generate cost benefits further down the line. Equally, costs related to implementation (FPSC only) have been considered to the extent information is available. Due to indicative timelines and budgetary constraints these will have to be managed within existing budgets, and as and when they occur. Gains from local initiatives and projects have been built into the relevant expense budgets.

Other expenditure reductions: the 2013/14 expense budget assumes efficiencies and cost reductions arising from the following:

- Prioritised service levels
- Length of stay and patient throughput
- FTE management + reduced staffing costs
- Contract tracking + monitoring
- Demand and capacity management

The sum total of \$ 4.03M is recognised by way of cost reduction arising from the above.

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

7.5.1 Mental Health Services

In keeping with the guidelines on treatment of “Mental Health Ring fence surplus” the amount of any under-expenditure carried forward from previous accounting periods has been reported as a surplus in Taranaki DHB’s Statement of Financial Performance in the year the surplus is generated. The ring fenced surpluses as at the beginning of FY 2012/13 have been fully applied to Mental Health Services either in the Hospital Provider or community during the year. Based on expenditure to date and forecasts, there is no surplus likely to remain on 30 June 2013. No surpluses from Mental Health services are envisaged during the 2013-16 plan period and, if any surpluses do eventuate, these will be ring fenced and expended in the year(s) following.

7.5.2 Mental Health Services and Strategic Initiatives Expenditure

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

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. Interest on DMO/MOH loans are as per the loan drawdown schedule.

	Overdraft	DMO/MOH Loans (existing)	DMO/MOH Loans (new)	Deposits	Equity
Year 1 (2013/14)	4.50%	7.02%	3.80%	4.00%	8.00%
Year 2 (2014/15)	5.50%	7.02%	3.80%	5.00%	8.00%
Year 3 (2015/16)	6.50%	7.02%	3.80%	6.00%	8.00%

Notes:

1. DMO/MOH total approved facility is \$74M, with \$72M utilised by 30 June 2013, and the remaining \$ 2M utilised in February 2014, when Project Maunga is fully commissioned. This is inclusive of the \$43M new term debt from DMO/MOH approved for Stage 1 of the Base Hospital redevelopment project.
2. TDHB currently has transactional banking arrangements with ASB bank. The shift to the DHB collective banking and transactional arrangement with West Pac is expected to be completed by 30 June 2013.
3. TDHB currently has short term deposits with West Pac, Kiwi Bank and ASB Bank being the funding set aside for Project Maunga.

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.

No provision has been made in the 2013/14 financials arising from any impacts of asset revaluation as on 30 June 2013. It is assumed that there will be no material movements requiring an adjustment to the current asset base. Conversely, should there be a material movement, it is assumed that any related capital charge increase will be funded/base line adjusted in accordance with current Treasury guidelines. The impact of the new hospital redevelopment on current building values has been factored in the recent revaluations (as at 30 June 2012) and treated appropriately.

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 funds. A schedule has been agreed with the Ministry of Health for payment of an earlier outstanding arising from the revaluation of assets.

7.5.7 Leasing

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

7.5.8 Financial Covenants and Ratios

There are no specific financial covenants stipulated by the Crown Health Financing Agency (DMO/MOH) for its term lending to TDHB. No financial covenants have been stipulated by ASB for transactional banking.

The following are some key financial ratios as derived from the consolidated financial statements for the period 2013-16.

Financial Ratios	TDHB 2012/13	TDHB 2013/14	TDHB 2014/15	TDHB 2015/16
	Forecast	Plan	Plan	Plan
1 Revenue to net funds employed	2.21	2.33	2.50	2.64
2 Operating margin to revenue	4%	3%	4%	4%
3 Operating return on net funds employed	9%	8%	10%	11%
4 Interest cover ratio	6.79	3.39	3.89	4.23
5 Debt to debt equity ratio	50%	53%	55%	58%

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 any changes brought about by the adoption of NZIFRS in the financial statements. All policies have been applied on a basis consistent with the previous period. These are detailed in the Statement of Intent for 2013/14.

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 (\$'000)	Year 1 (2013/14)	Year 2 (2014/15)	Year 3 (2015/16)	Total (2013/2016)
<u>Operating</u>				
Clinical Equipment	2,000	2,000	2,000	6,000
Other Equipment	450	450	450	1,350
Motor Vehicles	50	50	50	150
Minor Site Redevelopment (excluding prior year WIP)	500	500	500	1,500
SUB - TOTAL	3,000	3,000	3,000	9,000
Information Technology	4,000	4,000	4,000	12,000
TOTAL	7,000	7,000	7,000	21,000
<u>Strategic</u>				
Community Oral Health Project	-	-	-	-
Base Hospital redevelopment project	3,000	-	-	3,000
TOTAL	3,000	-	-	3,000
GRAND TOTAL	10,000	7,000	7,000	24,000
Sources of Funding				

Capital Outlay (\$'000)	Year 1 (2013/14)	Year 2 (2014/15)	Year 3 (2015/16)	Total (2013/2016)
Crown Equity	0	0	0	0
Bank Borrowing	0	0	0	0
DMO/MOH Term Loans	2,000	0	0	2,000
Internal Cash Accruals	8,000	7,000	7,000	22,000

Note: Capital outlay on Information and Communication Technology (ICT) is in relation to capital investment in HIQ Ltd.

7.5.11 Capital Divestment

The disposal of surplus assets proposed during the period 2013-16 is as follows:

Asset	Book value (\$)	Realisable Value (\$)	Gain/(loss) On sale (\$)	Timing
* Miscellaneous equipment (discarded/obsolete)	0	Not material	0	2013/16
* Surplus land	0	0	0	n/a
* Vehicles	0	Not Material	0	2013/15
Total	0	0	0	

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

The TDHB Board has approved that HIQ Ltd (a 100% subsidiary of TDHB) that provides ICT services to TDHB be dissolved on 30 June 2013. All services provided by HIQ Ltd will transfer to TDHB effective 01 July 2013.

- There will be no impact on Balance Sheet of TDHB. The share investment is covered by values in assets, liabilities, intercompany accounts, payroll accruals, retained earnings etc. These balances will offset and cancel out from an accounting perspective.
- There will be no impact on the operating budget since HIQ Ltd is fully funded by TDHB.
- Current staff within HIQ Ltd will transfer to TDHB contracts. All leave and other entitlements will be carried over
- Third party revenues will continue to be received by TDHB (as is the case at present). This line of revenue is cost neutral, and will have no impact should it subsequently move to HealthShare Ltd, the Midland regional shared services entity. Other miscellaneous revenues will be retained by TDHB.
- There will be considerably less administrative effort by bringing the operations in-house. Payroll, budgets, banking, capital management, operating costs etc will be common with TDHB operational processes and controls.
- The annual external audit of HIQ Ltd will cease - savings in audit fees (\$ 30K).
- Better alignment with TDHB objectives and goals.
- Some legal fees incidental to winding up processes will result - one off and not deemed material.

Overall, HIQ Ltd being a 100% subsidiary of TDHB will have negligible financial impact if dissolved. On the other hand, there are inherent benefits in administration costs, operational efficiencies and budgetary control.

7.5.12 Personnel

a) Paid / Contracted / Core FTEs:

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

CONTRACTED

	Forecast 2012-13	Yr 1 2013-14	Yr 2 2014-15	Yr 3 2015-16
PROVIDER				
Medical Personnel	145	147	145	144
Nursing Personnel	550	535	525	515
Allied Health Personnel	230	228	226	225
Support Personnel	87	90	90	90
Management & Administration	223	221	221	220
	1,235	1,221	1,207	1,194
GOVERNANCE	17	17	17	17
INFORMATION TECH UNIT (EX-HIQ Ltd)	50	42	38	38
TOTAL	1,302	1,280	1,262	1,249

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

An initiative/project has been underway utilising proprietary workforce allocation and real-time monitoring software to actively manage supplementary staff costs arising from use of casuals, backfills, overtime and locums across the whole of the organisation – code named Project Whakapai. The manner in which the workforce is profiled and rostered will initially reflect in increase of core FTE's, but with an overall reduction in the wage bill (\$) – primarily because of reduction in use of casuals, overtime, backfills, leave rosters and other marginal costs that tend to drive wages disproportionate to staff numbers deployed. This is an interactive workforce management tool and has inbuilt levels of authority and decision matrixes with a centralised allocations unit. Project Whakapai is expected to promote a significant change in the traditional methods of workforce allocation and management with resultant slowing down of the annual wage bill and optimised allocation of available workforce.

Medical FTE count will increase on the assumption that vacancies are likely to be filled over the coming period in lieu of locum cover (with corresponding drop in locum costs). Nursing staff are expected to stabilise over the 3 year plan period due to more efficient management of staffing (Project Whakapai) and reductions likely from services reconfigurations. Movements in Allied Health and support staff are likely to remain steady, whilst Management and Administration staff are also expected to be remain at current levels, with possible reduction in back office and administration staff arising from efficiency reviews and reduction in staff managed through attrition. Reduction of FTEs is a primary goal to reduce operating costs and the deficit, and the service reconfiguration changes proposed for 2013/14 and the two years following are expected to contain growth in FTEs besides bringing FTE reductions across nursing and related areas arising from closer internal monitoring of FTE movements and deferment vacancies.

Taranaki DHB is currently tracking below the Ministerial cap set for Management and Administration staff having made significant reductions over the recent period through internal reviews and restructures, and is expected to remain below the cap over the plan period.

HIQ Ltd (a fully owned subsidiary of Taranaki DHB) staffing is likely to decrease over the plan period, mainly due to completion of design and infrastructure planning in relation to Project Maunga. Outer years will see containment of IT personnel due to regional shared structures coming on stream.

In principle, the personnel budget has not planned for FTE increases – rather a phased reduction in FTEs to manage the overall wage bill carried by the DHB. Though there will be movements due to workforce profiling, vacancies, increases in clinical activity and service specifications, reductions planned in other staff lines should result in net decrease in the core FTE base. There will also be likely reductions from changes to services and models of care that are planned for 2013/14 incidental to the hospital redevelopment project. The overall strategy is to cap and reduce core FTEs; however it is acknowledged that there is likely to be demand for clinical resources due to an expected increase in normal activity levels – both acute and elective. Additionally, as the current year statistics indicate, there has been an increase in specialising patients (one-on-one care) in ICU and Mental Health inpatient admissions. With introduction of management tools such as Project Whakapai, TDHB will continue to aggressively pursue measures and initiatives to increase productivity of existing staff and reduce the demand for locums and casual staff within the hospital and specialist services.

b) Accrued FTEs:

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

ACCRUED

	Forecast	Yr 1	Yr 2	Yr 3
	2012-13	2013-14	2014-15	2015-16
PROVIDER				
Medical Personnel	144	158	156	154
Nursing Personnel	573	567	540	530
Allied Health Personnel	232	246	248	240
Support Personnel	89	98	98	98
Management & Administration	275	236	236	235
	1,313	1,305	1,278	1,257
GOVERNANCE	18	18	18	18
INFORMATION TECH UNIT (EX-HIQ Ltd)	54	45	42	42
TOTAL	1,385	1,368	1,338	1,317

7.6 Capital Expenditure 2013/14 (Strategic)

7.6.1 Community Oral Health Project

The capital expenditure related to the rollout of the Community Oral Health Project is being separately funded by the MoH in line with an approved business case. The total capital outlay is \$3.04M to be invested in fixed and mobile dental facilities, and related clinical equipment. Construction of all fixed facilities has been completed.

7.6.2 Base Hospital Inpatient Facilities Development Programme

The business case for Stage 1, the redevelopment of the Base Hospital inpatient facilities was approved in July 2008. Construction commenced in August 2011. The Acute Services Block comprising theatres and inpatient wards is expected to be ready for occupation by August 2013, and the project fully completed by December 2013. Total capital outlay is \$ 80M.

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.

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

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

Notes:

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

An updated Schedule of Capital Intentions has been submitted.

7.7 *Cost and Efficiency Initiatives*

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

The strategy is to continuously progress short term initiatives and service reviews to provide immediate gains, while progressing a series of more strategic changes in conjunction with regional services planning to achieve longer term sustainability. The latter is needed to rationalise the growth in demand for services and operating costs, besides the need to arrest and reduce the financial deficit.

The following key initiatives are planned during 2013/14 within the Hospital Provider operations to generate efficiency gains and reduce operating costs:

Initiative	Proposal	Potential (\$)	Impact
GAINS (2013-14) Prioritise service levels (2012-13 flow on impact)	Maintain contracted volumes for all services.	\$0.12M	Reduce service cost
FTE management + workforce allocation (2012-13 flow on impact)	Use of alternative staffing models Where clinically appropriate	\$0.37M	Contain cost growth + FTE reduction
Length of stay + patient Throughput (2012-13 flow on impact)	Ensure patient length of stay is appropriate.	\$0.25M	Reduce service cost
Contracts tracking + monitoring (2012-13 flow on impact)	Ensuring contracts for services are delivered and monitored	\$0.81M	Reduce service cost
Laboratory efficiencies (2013-14)	Operational efficiencies encompassing a range of initiatives including increased collaboration	\$ 0.33M	Reduce pathology Lab costs
After hours acute demand (2013-14)	Managing acute demand	\$ 0.099M	Reduce service cost
Targeted strategies – LOS Demand and capacity Mgt Service Efficiencies etc (2013-14)	Operational efficiencies – range of initiatives	\$ 2.65M	Reduce service cost
INVESTMENT (2013-14) (increased opex cost) HBL, National agencies and contribution to Midland regional Projects and shared services.	Operating expenses required to Support HBL, national agencies business cases + regional shared services	(\$ 0.50M)	Increased operating Cost (outflow)
* Non Acute services redesign Project	Project costs – preliminary and Developmental costs	(\$0.10M)	Increased operating Cost (outflow)
NET GAIN (2013-14)		\$4.03M	

The Annual Plan 2013/14 has identified the above major initiatives and recognised the same as cost reduction measures in its financial budget. The services initiatives commenced in 2013-14 will also generate cost savings in Year 2 & 3 and future periods, and have been recognised in the out years.

The DHB share of contribution to HBL, National agency projects and business cases is net of any operating gains identified. A schedule of the expected operating gains and outflows have been included in the NHB financial templates. TDHB also has to contribute its share to HealthShare (the Midland regional shared services entity) towards operating costs and expenses for projects. Other miscellaneous gains from local initiatives and cost reduction measures have been built into the relevant expense budgets.

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

In parallel, the immediate focus is on the successful delivery of Project Maunga and transition of the services to the new building across July/August 2013. A significant aim of this project is to generate efficiencies and improvements to prevalent models of care through consolidation of hospital services and systems into a more compact footprint. This will in turn lend more flexibility and efficiency to operations. Overall, the project should generate more permanent and sustainable results post 2013-14.

7.8 Debt and Equity

The debt profile of Taranaki DHB expected as at 1 July 2013 is term loans totalling \$72M with the Debt Management Office (DMO)/MOH, drawn down against an approved loan limit of \$74M. The primary assumptions carried in the financial plan 2013/14 are:

- Overdraft facilities (as per OPF guidelines) are assumed to be available under the DHB collective banking arrangement with West Pac.
- The draft Annual Plan 2013/14 has not budgeted for any additional equity. It is expected that base line capital expenditure will be contained within the level of depreciation for 2013/14. Remainder of \$2M against the approved borrowing limit will be drawn down in February 2014 incidental to commissioning of Project Maunga.
- No additional equity or deficit support is envisaged.

7.9 Sensitivity Analysis: Plan 2013/14

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

DHB Hospital Provider Operations

Unbudgeted financial risk	Est. risk (\$M)	75% risk (\$M)	50% risk (\$M)	25% risk (\$M)	Probability factor (% risk)
FTE + wage budget	0.50	0.38	0.25	0.13	50%
Outsourced locum costs	0.50	0.40	0.25	0.13	75%
Diagnostic costs	0.20	0.15	0.10	0.05	75%
Clinical supplies	0.30	0.22	0.15	0.08	50%
General overheads	0.50	0.40	0.25	0.13	50%
Likely impact on 2013/14 planned financial result	\$2.00M	\$1.50M	\$1.00M	\$0.50M	\$1.20M

The analysis estimates an overall exposure of circa **\$2.00M** for 2013/14, which could arise from a combination of cost drivers as identified above. The overall probability factor is estimated to be around 60% leaving a residual risk equating to about **\$1.20M**. The risk is expected to be managed through a mix of:

1. Internal cost controls
2. Management of FTEs
3. Operational savings in discretionary expense lines through capped budgets
4. Gains from National procurement programmes and initiatives
5. Achievement of internal efficiency projects and service reviews

DHB Funder Operations

Unbudgeted financial risk	Estimated risk (\$'M)	75% risk (\$'M)	50% risk (\$'M)	25% risk (\$'M)	Probability factor (% risk)
Funder savings plan	3.50	2.63	1.75	0.88	50%
Elective Volumes	1.00	0.75	0.50	0.25	50%
IDF inflows/outflows	1.00	0.75	0.50	0.25	50%
Provider Arm expenditure	3.00	2.25	1.50	0.75	50%
Income in Advance	0.60	0.45	0.30	0.15	50%
Potential impact on 2013/14 planned financial result	9.10M	6.68M	4.50M	2.23M	4.50M

The overall exposure is estimated at around **\$9.10M** for 2013/14, while the probability factor is estimated to be around 50% leaving a residual risk equating to about **\$4.5M**.

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

7.10 Statement of Comprehensive Income

TARANAKI DISTRICT HEALTH BOARD										
STATEMENT OF COMPREHENSIVE INCOME										
DISTRICT ANNUAL PLAN 2013-16										
	Year -1	FORECAST		Year 0		(\$'000)				Year 1
	Consolidated Audited 2011/12	Hosp+Gov Forecast 2012/13	Funder Forecast 2012/13	Consolidated Forecast 2012/13	Provider Plan 2013/14	Governor Plan 2013/14	Hosp+Gov Plan 2013/14	Funder Plan 2013/14	Consolidated Plan 2013/14	
REVENUE										
* MOH funding	154498	159453		159453	160839	0	160839		160839	
	143716		147809	147809				150404	150404	
* Funding & Governance	2370	2597		2597	0	2040	2040		2040	
* ACC Revenue	4393	3724	41	3765	4056	0	4056	81	4137	
* CTA revenue	1904	1854		1854	1586	0	1586		1586	
* Other revenue	11972	5756	4332	10088	5834	0	5834	4136	9970	
TOTAL REVENUE	318853	173384	152182	325566	172315	2040	174355	154621	328976	
EXPENDITURE										
Personnel costs										
- medical	27372	27609		27609	29265	0	29265		29265	
- nursing	41518	42655		42655	40539	0	40539		40539	
- allied health	14688	14938		14938	15211	0	15211		15211	
- support	4015	3876		3876	4333	0	4333		4333	
- mgt & admin	19004	17719		17719	17055	1233	18288		18288	
total	106597	106797	0	106797	106403	1233	107636	0	107636	
Outsourced services										
- clinical services	19426	18371		18371	17123	0	17123		17123	
- other outsourced	2777	2502		2502	2398	0	2398		2398	
total	22203	20873	0	20873	19521	0	19521	0	19521	
Clinical supplies										
- treatment disposables	9260	8938		8938	8848	0	8848		8848	
- diagnostic supplies	1219	1388		1388	1389	0	1389		1389	
- instruments & equip	1045	1139		1139	1182	0	1182		1182	
- patient appliances	1032	1053		1053	1076	0	1076		1076	
- implants & prostheses	2483	2400		2400	2877	0	2877		2877	
- pharmaceuticals	4468	4045		4045	4457	0	4457		4457	
- other clinical & client costs	3635	3585		3585	2830	0	2830		2830	
total	23142	22548	0	22548	22659	0	22659	0	22659	
Infrastructure & other op.costs										
- hotel services & laundry	3212	3324		3324	3323	1	3324		3324	
- facilities	3182	3590		3590	3939	0	3939		3939	
- transport	1043	934		934	908	40	948		948	
- IT systems & telecom	3120	2634		2634	1394	0	1394		1394	
- professional fees	2041	2078		2078	2412	9	2421		2421	
- other op.expenses	2297	1795		1795	1388	334	1722		1722	
- democracy	272	286		286	10	377	387		387	
- depreciation	10193	11767		11767	14700	0	14700		14700	
- interest	1824	1868		1868	3265	0	3265		3265	
- cost & efficiency initiatives	0	0		0	0	0	0		0	
- Payment to - NGO providers										
- personal health	61343		62797	62797				63824	63824	
- mental health	8346		9045	9045				9341	9341	
- disability support services	34531		35890	35890				35211	35211	
- public health	222		591	591				415	415	
- maori health	1988		2508	2508				2465	2465	
- IDF's	32805		31141	31141				33365	33365	
total	161825	28276	141972	170248	31339	761	32100	144621	176721	
TOTAL OPERATING EXPENSES	313767	178494	141972	320466	179922	1994	181916	144621	326537	
SURPLUS before capital charge	5086	-5110	10210	5100	-7607	46	-7561	10000	2439	
- Capital charge	6164	6050		6050	5890	0	5890		5890	
NET SURPLUS/(DEFICIT)	-1078	-11160	10210	-950	-13497	46	-13451	10000	-3451	
OTHER COMPREHENSIVE INCOME										
* Gain/(Loss) on asset revaluation	0	0		0	0				0	
* Gain/(Loss) on sale of assets	0	0		0	0				0	
* Share of surplus/(loss) from associates	1276	0		0	0				0	
Total Other Comprehensive Income	1276	0	0	0	0	0	0	0	0	
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	198	-11160	10210	-950	-13497	46	-13451	10000	-3451	
Interest Cover ratio	6.70			6.79					4.45	
Revenue to Net Funds employed	2.39	1.18		2.21	1.20				2.28	
Operating margin to Revenue ratio	4%	1%		4%	3%				5%	
Op. return on Net Funds employed	9%	2%		9%	3%				10%	

TARANAKI DISTRICT HEALTH BOARD									
STATEMENT OF COMPREHENSIVE INCOME									
DISTRICT ANNUAL PLAN 2013-16									
					Year 2		Year 3		
	Provider Plan	Governan: Plan	Funder Plan	Consolidated Plan	Provider Plan	Governan: Plan	Funder Plan	Consolidated Plan	
	2014/15	2014/15	2014/15	2014/15	2015/16	2015/16	2015/16	2015/16	
REVENUE									
* MOH funding	164093		153190	164093 153190	167349		155974	167349 155974	
* Funding & Governance		2081		2081		2122		2122	
* ACC Revenue	4737		83	4820	5632		85	5717	
* CTA revenue	1618			1618	1650			1650	
* Other revenue	4884		4232	9116	3935		4330	8265	
TOTAL REVENUE	175332	2081	157505	334918	178566	2122	160389	341077	
EXPENDITURE									
Personnel costs									
- medical	29427			29427	29846			29846	
- nursing	39145			39145	39240			39240	
- allied health	15377			15377	15684			15684	
- support	4419			4419	4507			4507	
- mgt & admin	17396	1257		18653	17744	1281		19025	
total	105764	1257	0	107021	107021	1281	0	108302	
Outsourced services									
- clinical services	17465			17465	17814			17814	
- other outsourced	2447	0		2447	2496	0		2496	
total	19912	0	0	19912	20310	0	0	20310	
Clinical supplies									
- treatment disposables	9025			9025	9206			9206	
- diagnostic supplies	1417			1417	1445			1445	
- instruments & equip	1206			1206	1230			1230	
- patient appliances	1098			1098	1120			1120	
- implants & prostheses	2935			2935	2994			2994	
- pharmaceuticals	4546			4546	4637			4637	
- other clinical & client costs	2055			2055	1812			1812	
total	22282	0	0	22282	22444	0	0	22444	
Infrastructure & other op.costs									
- hotel services & laundry	3389	1		3390	3457	1		3458	
- facilities	4018			4018	4098			4098	
- transport	926	41		967	945	42		987	
- IT systems & telecom	1422			1422	1450			1450	
- professional fees	2460	9		2469	2509	9		2518	
- other op.expenses	2116	432		2548	2159	440		2599	
- democracy	10	293		303	10	299		309	
- depreciation	14974			14974	14974			14974	
- interest	3432			3432	3432			3432	
- cost & efficiency initiatives	0			0	0			0	
- Payment to - NGO providers									
- personal health			65068	65068			66396	66396	
- mental health			9524	9524			9717	9717	
- disability support services			35916	35916			36635	36635	
- public health			424	424			433	433	
- maori health			2514	2514			2564	2564	
- IDF's			34055	34055			34760	34760	
total	32747	776	147501	181024	33034	791	150505	184330	
TOTAL OPERATING EXPENSES	180705	2033	147501	330239	182809	2072	150505	335386	
SURPLUS before capital charge	-5373	48	10004	4679	-4243	50	9884	5691	
- Capital charge	5614			5614	5539			5539	
NET SURPLUS/(DEFICIT)	-10987	48	10004	-935	-9782	50	9884	152	
OTHER COMPREHENSIVE INCOME									
* Gain/(Loss) on asset revaluation	0			0	0			0	
*Gain/(Loss) on sale of assets	0			0	0			0	
*Share of surplus/(loss) from associates	0			0	0			0	
Total Other Comprehensive Income	0	0	0	0	0	0	0	0	
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	-10987	48	10004	-935	-9782	50	9884	152	
Interest Cover ratio				5.09				5.41	
Revenue to Net Funds employed	1.23			2.35	1.26			2.41	
Operating margin to Revenue ratio	4%			5%	5%			6%	
Op. return on Net Funds employed	5%			12%	6%			13%	

7.11 Consolidated Statement of Financial Position

TARANAKI DISTRICT HEALTH BOARD							
DISTRICT ANNUAL PLAN 2013-16							
CONSOLIDATED STATEMENT OF FINANCIAL POSITION							
(\$'000)							
	2011/12 audited	2012/13 forecast		2013/14 plan	2014/15 plan	2015/16 plan	
CURRENT ASSETS							
* Bank Account	3433	1255		1305	1355	1405	
* Prepayments +ST investments	33656	3700		3750	8750	16750	
* Debtors (net of provision)	9780	9950		10450	10950	11450	
* Inventory	2654	2750		2850	2900	2950	
	49523	17655		18355	23955	32555	
CURRENT LIABILITIES							
* Creditors & other payables	27217	21239		20310	19168	19860	
* Term Loans (current portion)	0	0		0	0	0	
* Provisions	20701	19741		20433	21087	21753	
	47918	40980		40743	40255	41613	
WORKING CAPITAL	1605	-23325		-22388	-16300	-9058	
NON CURRENT ASSETS							
* Net Fixed Assets	129932	167915		163215	155241	147267	
* Investments	1163	2107		2514	2581	2581	
* Trust funds	729	729		729	729	729	
	131824	170751		166458	158551	150577	
NET FUNDS EMPLOYED	133429	147426		144070	142251	141519	
NON CURRENT LIABILITIES							
* Provisions - non current	1098	1150		1250	1325	1400	
* Retentions	392	1046		0	0	0	
* Term Loans	56800	72000		74000	74000	74000	
	58290	74196		75250	75325	75400	
CROWN EQUITY							
* Crown Equity	26042	25083		24124	23165	22206	
* Reserves	52634	52634		52634	52634	52634	
* Retained earnings	-3537	-4487		-7938	-8873	-8721	
	75139	73230		68820	66926	66119	
NET FUNDS EMPLOYED	133429	147426		144070	142251	141519	
Debt: Debt equity ratio	43%	50%		52%	53%	53%	

7.12 Consolidated Statement of Cashflows

TARANAKI DISTRICT HEALTH BOARD DISTRICT ANNUAL PLAN 2013-16						
CONSOLIDATED STATEMENT OF CASHFLOWS						
(\$'000)						
	2011/12 audited	2012/13 forecast	2013/14 plan	2014/15 plan	2015/16 plan	
OPERATING ACTIVITIES						
* MOH funding	301273	311160	314339	320482	326595	
* Other revenue	14395	12947	13777	13576	13622	
total receipts	315668	324107	328116	334058	340217	
* Payment of salaries & operating exp.	166968	172443	172829	172462	174357	
* Payment to providers & DHB's	138831	149293	145185	148880	150211	
total payments	305799	321736	318014	321342	324568	
NET CASHFLOW FROM OPERATIONS	9869	2371	10102	12716	15649	
INVESTING ACTIVITIES						
* Interest & Dividends Received	1886	1250	360	360	360	
* Sale of fixed assets etc	14	0	0	0	0	
* (Increase) / decrease in investments	-2185	29056	-407	-5067	-8000	
* Capital expenditure	-38339	-49750	-10000	-7000	-7000	
NET CASHFLOW FROM INVESTING	-38624	-19444	-10047	-11707	-14640	
FINANCING ACTIVITIES						
* Equity injections / repayments	927	-959	-959	-959	-959	
* Borrowings	27800	15200	2000	0	0	
* Payment of debts	392	654	-1046	0	0	
NET CASHFLOW FROM FINANCING	29119	14895	-5	-959	-959	
Total cash in	344787	339002	328111	333099	339258	
Total cashout	-344423	-341180	-328061	-333049	-339208	
NET CASHFLOW	364	-2178	50	50	50	
Add: Cash (opening)	3069	3433	1255	1305	1355	
CASH (CLOSING)	3433	1255	1305	1355	1405	

7.13 Consolidated Statement of Movement In Equity

TARANAKI DISTRICT HEALTH BOARD									
DISTRICT ANNUAL PLAN 2013-16									
CONSOLIDATED STATEMENT OF MOVEMENT IN EQUITY									
					2012/13 forecast		2013/14 plan	2014/15 plan	2015/16 plan
EQUITY AT THE BEGINNING OF PERIOD					75139		73230	68820	66926
* Net results for the period					-950		-3451	-935	152
* Revaluation of Fixed assets					0		0	0	0
* Equity Injections / (repayments)					-959		-959	-959	-959
* Other					0		0	0	0
EQUITY AT THE END OF THE PERIOD					73230		68820	66926	66119

8.0 Module Eight: Monitoring Performance

Summary Table: 2013/14 Performance expectations

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

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

It is intended that the structure of the framework and associated reports assists stakeholders to 'see at a glance' how well DHBs are performing across the breadth of their activity, including in relation to legislative requirements, but with the balance of measures focused on government priorities. Each performance measure has a nomenclature to assist with classification as follows:

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

Performance Measure	2013/14 Performance Expectation/Target			
PP1: Workforce – Improving clinical leadership	Report progress of DHB work to improve clinical leadership and engagement across all levels of the DHB and the Regional Training Hubs.			
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19		Total	3.78%
			Maori	3.78%
	Age 20-64		Total	4.02%
			Maori	5.34%
	Age 65+		3.46%	
PP7: Improving mental health services using relapse prevention planning	Child and Youth		95%	
	Adult 20+		95%	
PP8: Shorter waits for non-urgent mental health and addiction services	Mental Health Provider Arm			
	Age	<= 3 weeks	<=8 weeks	
	0-19	70%	95%	
	20-64	80%	95%	
	65+	80%	95%	
	Total	80%	95%	
	Addictions (Provider Arm and NGO)			
	Age	<= 3 weeks	<=8 weeks	
	0-19	70%	95%	
	20-64	70%	95%	

	65+	70%	95%
	Total	70%	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1		0.91
	Ratio year 2		0.91
PP11: Children caries-free at five years of age	Ratio year 1		68%
	Ratio year 2		68%
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1		85%
	% year 2		85%
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1		85%
	0-4 years - % year 2		85%
	Children not examined 0-12 years % year 1		3%
	Children not examined 0-12 years % year 2		3%
PP18: Improving community support to maintain the independence of older people	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan		66%
PP20: improved management for long term conditions (CVD, diabetes and Stroke)	>70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')		>70
Focus area 1: Cardiovascular Disease	>95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection.		95%
Focus area 2: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed		6%
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway		80%
Focus area 3a: Diabetes – Management (MICROALBUMINURIA AND ON AN ACEi OR ARB)	Improve and maintain appropriate management of microalbuminuria in patients with diabetes.		Improve or maintain or improve appropriate management of microalbuminuria in patients with diabetes
Focus area 3b: Diabetes – Management (HbA1c)	Improve or, where high, maintain		Improve or, where

	the proportion of patients with good or acceptable glycaemic control.	high, maintain the proportion of patients with good or acceptable glycaemic control.
PP21: Immunisation coverage (previous health target)	95 per cent of two year olds are fully immunised	95%
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP25: Prime Minister's youth mental health project	Provide a written stock take, gaps analysis and actions being considered,	
PP26: The Mental Health & Addiction Service Development Plan	Provide gaps analysis and report against SDP milestones	
PP27: Delivery of the children's action plan	Demonstration site DHBs to report on actions and progress to support the successful establishment and on-going operation of Children's Teams	<p>All DHBs to report on stock take of service , gaps analysis and actions being considered across the care continuum to support vulnerable pregnant women, children and parents</p> <p>All DHBs to provide updates on actions to help reduce child assaults identified in the Annual Plan</p>
PP28: Reducing Rheumatic fever	Provide a progress report against DHBs' rheumatic fever prevention plan	
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 10% lower than the average over the last 3 years	0.8 per 100,000
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	<95%
	Age 45-64	<95%
	Age 0-74	<95%
SI2: Delivery of Regional Service Plans	A single progress report on behalf of the region agreed by all DHBs within that region	

SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage	
SI4: Standardised Intervention Rates (SIRs)	major joint replacement	An intervention rate of 21.0 per 10,000 of population
	cataract procedures	An intervention rate of 27.0 per 10,000
	cardiac surgery (a target intervention rate of 6.5 per 10,000 of population) If previous rate of 6.5 per 10,000 or above -maintain this rate.	6.5 per 10,000
	Percutaneous revascularization (a target rate of at least 11.9 per 10,000 of population)	11.9 per 10,000
	coronary angiography services (a target rate of at least 33.9 per 10,000 of population)	33.9 per 10,000
SI5: Delivery of Whānau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers.	
OS3: Inpatient Length of Stay	Elective LOS	3.21 days
	Acute LOS	4.86 days
OS8: Reducing Acute Readmissions to Hospital	% total pop	≤5.22%
	% 75 plus	≤8.66%
OS10: Improving the Quality of Data Submitted to National Collections	National Health Index (NHI) duplications - Greater than 3.00% and less than or equal to 6.00%	>3%≤6%
	Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI. - <i>Greater than 0.50% and less than or equal to 2%</i>	>0.5%≤2%
	Standard vs. edited descriptors -Greater than or equal to 75.00% and less than 90.00%	≥75%<90%
	Timeliness of NMDS data - Greater than 2.00% and less than or equal to 5.00% late	>2%≤5%
	NNPAC Emergency Department admitted events have a matched NMDS event - <i>Greater than or equal to 97.00% and less than</i>	≥97%<99.5%

	99.50%	
	PRIMHD File Success Rate - Greater than or equal to 98.0% and less than 99.5%	≥98%<99.5%
Output 1: Mental health output Delivery Against Plan	<p>Volume delivery for specialist Mental Health and Addiction services is within:</p> <p>a) five percent variance (+/-) of planned volumes for services measured by FTE,</p> <p>b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and</p> <p>c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan</p>	

9.0 Module Nine: Appendices

9.1 Glossary of Terms

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

departments to produce outputs, that will achieve the Government's stated outcomes.
(<http://www.ssc.govt.nz/glossary/>)

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

Output Classes	<p>Are an aggregation of outputs. (Public Finance Act 1989)</p> <p>Outputs can be grouped if they are of a similar nature. The output classes selected in your non-financial measures must also be reflected in your financial measures (s 142 (2) (b) CE Act 2004). Are groups of similar outputs (Public Finance Act 1989).</p>
Outputs	<p>Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).</p>
Ownership	<p>The Crown's core interests as 'owner' can be thought of as:</p> <p>Strategy - the Crown's interest is that each state sector organisation contributes to the public policy objectives recognised by the Crown;</p> <p>Capability - the Crown's interest is that each state sector organisation has, or is able to access, the appropriate combination of resources, systems and structures necessary to deliver the organisation's outputs to customer specified levels of performance on an ongoing basis into the future;</p> <p>Performance - the Crown's interest is that each organisation is delivering products and services (outputs) that achieve the intended results (outcomes), and that in doing so, each organisation complies with its legislative mandate and obligations, including those arising from the Crown's obligations under the Treaty of Waitangi, and operates fairly, ethically and responsively. (Refer http://www.ssc.govt.nz/glossary/)</p>
Performance Measures	<p>Selected measures must align with the DHBs DSP and DAP. Four or five key outcomes with associated outputs for non-financial forecast service performance are considered adequate. Appropriate measures should be selected and should consider quality, quantity, effectiveness and timeliness. These measures should cover three years beginning with targets for the first financial year (2010/11) and show intended results for the two subsequent financial years. (Refer to www.ssc.govt.nz/performance-info-measures)</p>
Priorities	<p>Statements of medium term policy priorities.</p>
Productivity	<p>Increasing outputs relative to inputs (i.e.: either more outputs produced with the same inputs, or the same output produced using fewer inputs)</p>
Purchase Agreement	<p>A purchase agreement is a documented arrangement between a Minister and a department, or other organisation, for the supply of outputs. Some departments piloting new accountability and reporting arrangements now prepare an output agreement. An output agreement extends a purchase agreement to include any outputs paid for by third parties where the Minister still has some responsibility for setting fee levels or service specifications. The Review of the Centre has recommended the development of output plans to replace departmental purchase and output agreements. (Refer</p>

<http://www.ssc.govt.nz/glossary/>

Regional Collaboration	<p>Regional collaboration refers to DHBs across geographical 'regions' for the purposes of planning and delivering services (clinical and non-clinical) together. Four regions exist.</p> <p>Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB</p> <p>Midland: Bay of Plenty DHB, Lakes DHB, Tairāwhiti DHB, Taranaki DHB and Waikato DHB</p> <p>Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB</p> <p>Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB</p>
	<p>Regional collaboration for some clinical networks may vary slightly. For example Central Cancer Network contains eight DHBs, Taranaki DHB and Tairāwhiti DHB in addition to the Central Region DHBs.</p>
Results	<p>Sometimes used as a synonym for 'Outcomes'; sometimes to denote the degree to which an organisation successfully delivers its outputs; and sometimes with both meanings at once.</p> <p>(http://www.ssc.govt.nz/glossary/)</p>
Standards of Service Measures	<p>Measures of the quality of service to clients focus on aspects such as client satisfaction with the way they are treated; comparison of current standards of service with past standards; and appropriateness of the standard of service to client needs.</p>
Statement of Service Performance (SSP)	<p>Government departments, and those Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of objectives and statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year. (http://www.ssc.govt.nz/glossary/)</p>
Strategy	<p>See Ownership</p> <p>(http://www.ssc.govt.nz/glossary/)</p>
Sub Regional Collaboration	<p>Sub regional collaboration refers to DHBs working together in a smaller grouping to the regional grouping. Typically this is groupings of two or three DHBs and may be formalised with an agreement e.g., Memorandum of Understanding. Examples include DHBs in the Auckland Metropolitan area, MidCentral and Whanganui DHBs (central Alliance), Capital and Coast, Hutt Valley and Wairarapa DHBs and Canterbury and West Coast DHBs.</p>
Targets	<p>Targets are agreed levels of performance to be achieved within a specified period of time. Targets are usually specified in terms of the actual quantitative results to be achieved or in terms of productivity, service volume, service-quality levels or cost effectiveness gains. Agencies are expected to assess progress and manage performance against targets. A target can also be in the form of a standard or a benchmark.</p>

Values	The collectively shared principles that guide judgment about what is good and proper. The standards of integrity and conduct expected of public sector officials in concrete situations are often derived from a nation's core values which, in turn, tend to be drawn from social norms, democratic principles and professional ethos. (http://www.ssc.govt.nz/glossary/)
Value for money	The assessment of benefits relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

9.2 Output Class Definition

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

Output Class		Category of Output Class	
2	Early Detection and Management <p>Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings, including general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule), child and adolescent oral health and dental services.</p> <p>These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.</p>	6	Primary Healthcare and GP Services <p><i>These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at delivering Better, Sooner and More Convenient services and improving, maintaining or restoring our population's health. Success is measured by high levels of enrolment with our PHOs (Primary Health Organisations) as it indicates engagement, accessibility and responsiveness of primary healthcare services.</i></p>
		7	Oral Health Services <p><i>These services are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. While high levels of enrolment, timely access and treatment are important, ultimately success is measured by results – children who are caries-free, and reducing the number of decayed, missing or filled teeth.</i></p>
		8	Primary Community Care Programmes <p><i>These services are offered in local community settings by teams of healthcare professionals (other than general practitioners (GPs), registered nurses, nurse practitioners) aimed at delivering Better, Sooner and More Convenient services and improving, maintaining or restoring our population's health. Success is measured by rates of participation.</i></p>
		9	Pharmacy Services <p><i>These services include the provision and dispensing of medicines and are demand-driven, i.e. by patients and prescribers (nurse specialists, GPs and specialists). As long term conditions become more prevalent, we are likely to see an increased dispensing of medicines. Success is measured by (a) medication management for people on multiple medications to reduce potential negative interactive effects and (b) maintaining or reduction the level of prescribed medicines.</i></p>

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

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

Output Class	Category of Output Class
<ul style="list-style-type: none"> outpatient, district nursing and day services across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services Emergency Department services including triage, diagnostic, therapeutic and disposition services <p>On a continuum of care these services are at the complex end of treatment services and focused on individuals, rather than groups.</p>	<p>14 Acute (Emergency Department/Inpatient/Outpatient) Services</p> <p><i>These are services that have an abrupt onset, are often short in duration and rapidly progressive, for which the need for care is urgent. They may lead to a hospital admission. Hospital-based services include Emergency Departments (ED), short-stay acute assessments and intensive care services. Success is measured by (a) timeliness (waiting times), (b) productivity (length of stay), (c) outcome measures such as readmission rates, to indicate quality of service provision, and (d) managing demand by either maintaining or reducing the number of ED presentations, which is indicative of a strong primary/secondary integration.</i></p>
	<p>15 Maternity Services</p> <p><i>These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in the home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include specialist obstetric, lactation, anaesthetic, paediatric and radiology services. Success is measured by (a) ensuring that our proportion of caesarian deliveries¹ is consistent with the national average; and (b) that we maintain our post natal length of stay (days).</i></p>
	<p>16 Assessment Treatment and Rehabilitation</p> <p><i>These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to GPs, home and community care providers, aged residential care (ARC) facilities and voluntary groups. Success is measured by an increase in the rate of people discharged home with support, rather than to ARC or hospital environments (where appropriate).</i></p>

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

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

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

9.3 *Output Class Revenue and Expenditure*

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

Table: Output Class Revenue and Expenditure

Output Class	Planned Revenue (\$000s)*	Planned Expenditure (\$000s)*
Prevention	10,700	10,812
Early Detection and Management	80,182	81,023
Intensive Assessment and Treatment Services	192,646	194,667
Rehabilitation and Support	45,448	45,924
TOTAL	328,976	332,427

9.4 Output Measure Rationale

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

Measure	Rationale	Output class / Category	Dimension of Performance
children (0 – 12 years) who are overdue for their planned recall period			
Percentage of adolescents accessing DHB funded oral health services			Quantity
Percentage of population enrolled with a primary health organisation	Access to primary care has been shown to have positive benefits in maintaining good health. It can reduce the economic cost of ill health by intervening early.	Early Detection and Management Services/ Primary Healthcare	Quantity
Percentage of people who are enrolled with a primary health organisation and have had their cardiovascular risk assessed in the last five years	By increasing the percentage of people being checked for long-term conditions ensures these are identified early and managed appropriately, and aid in the promotion and protection of good health and independence.	Early Detection and Management Services/ Primary Healthcare	Quantity
Maintain or improve appropriate management of microalbuminuria or overt nephropathy in patients with diabetes			
Percentage of eligible women (20-69) have a cervical cancer screen every 3 years	Cervical cancer is one of the most preventable of all cancers. Having regular cervical smears can reduce a woman's risk of developing cervical cancer by 90 percent	Prevention Services/ Population Based Screening	Quantity
Percentage of eligible women (50-69) have a breast screen in the last 3 years	Breast screening is a proven way for finding breast cancers early to reduce the risk of dying of breast cancer	Prevention Services/ Population Based Screening	Quantity
Increase the number of packages of care available to youth under the Primary Mental Health Initiative	Primary mental health initiative is funded to increase the availability of services in Primary Health Organisations for patients with mild to moderate mental health issues. In line with our Taiohi Health Strategy and the Prime Minister's Youth Mental Health project we are expecting the actions in our Annual Plan will result in an increase in youth accessing these services.	Early Detection and Management Services/ Primary Mental Health and Addictions	Quantity
Percentage of Rest Home residents receiving vitamin D supplement from their GP	Vitamin D supplementation has been demonstrated to improve mineral bone density and reduce falls.	Prevention Services/Health Promotion and Education	Quantity
Percentage of all Emergency Department presentations who are triaged at levels 4&5	Emergency department services utilise a scale of one to five triage, with one being the most urgent. Triage category four and five may more appropriately be seen in primary care.	Intensive Assessment and Treatment Services/Acute Services	Quantity
Percentage of eligible children have their B4 School Checks completed	A nationwide programme offering a health and development check for four year olds	Prevention Services/ Well Child	Quantity
Hospitalisation rates per 100,000 for acute rheumatic fever	Rheumatic fever arises as a result of a throat infection with Group A Streptococcal bacteria. It predominantly affects children between 5 and 14 years of age. In New Zealand, evidence points to poorer housing conditions (especially overcrowding) and general social deprivation as risk factors for rheumatic fever.	Prevention Services/ Well Child	Quantity
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a	More consistent and comprehensive assessment of the older person which enables determination of service capacity and service planning information	Rehabilitation and Support Services/Needs Assessment and Service Coordination	Quantity

Measure	Rationale	Output class / Category	Dimension of Performance
completed care plan in the last 12 months			
For those with aged related and chronic health conditions we aim to reduce the rate of rest home level of residential care to home based support and respite funding	By focusing the models of care in community services such as home based support and respite services to have a more restorative approach we expect that the proportion of funding required to allocate to rest home residential care to comparatively reduce.	Rehabilitation and Support Services / Age Related Residential Care Services	Quantity
Increased number of clients accessing respite services	In line with community services for older people having a more restorative approach and a focus on meeting the needs of informal carers we expect the number of clients accessing respite services will increase.	Rehabilitation and Support Services	Quantity
Percentage of patients aged 75 and over (Maori and Pacific Islanders 55 and over) that are given a falls risk assessment	Falls in the elderly contribute to a reduction in the quality of life including loss of independence, early entry into Rest Home residence and premature death. To ensure that the risk of inpatient falls in the elderly is minimised we aim to provide a risk assessment to all eligible patients.	Intensive treatment and assessment.	Quality
Acute re-admission rate	Unplanned readmissions will usually present to emergency departments, and may result in admission to hospital for further treatment. This puts pressure on emergency departments and inpatient hospital capacity, efficiency and productivity. An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services.	Intensive Assessment and Treatment Services/Acute Services	Quality
Average length of inpatient stay	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, we will positively impact hospital productivity through freeing up beds and other resources so it can provide more elective surgery, reduce waiting times in the emergency department or make savings. Supporting patients to return home sooner may, in part, be achieved by reducing the rate of patient complications and better use of the time clinical staff spend with patients. Patients will also be less at risk of contracting nosocomial infections.	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quality
Percentage of patients who require radiation or chemotherapy are treated with 4 weeks	Specialist cancer treatment and symptom control is essential in reducing the impact of cancer	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quantity
Faster Cancer Treatment – Proportion of patients with a confirmed diagnosis of cancer who receives their first cancer treatment with 31 days	Implementation of Faster cancer treatment supports the overarching goal of Better, Sooner, More Convenient Health Services for New Zealanders. The key 2013/14 (strategic) planning considerations of integration, regionalisation and value for money are all supported by implementation of these indicators.	Intensive Assessment and Treatment Services/Elective Services	Quantity
Arranged Caesarean deliveries without catastrophic or severe	The longer-term aim is to reduce the risks associated with an unnecessary Caesarean section, reduce the number of women at risk of	Intensive Assessment and Treatment Services/Elective Services	Quantity

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

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

9.5 Maori Health Plan Summary of Indicators of Performance

	National Priorities	National Indicators		Target	Baseline (TDHB)	
					Māori	Non-Māori
1	N1-Data Quality	Ethnicity data accuracy		Audit tool to be implemented in 2013/14		
2	N2-Access to Care	Percentage of Māori enrolled in PHOs		98%	86%	99%
3		ASH rates per 100,000	0-4yr 45-64 0-74y	<111% <165% <143%	4,896 3,371 2,600	4,403 2,042 1,815
4		N3-Maternal Health	Percentage of infants exclusively and fully breastfed at:		74%	57%
	Six weeks		57%	41%	58%	
	Three months		27%	10%	23%	
5	N4-Cardiovascular Disease & Diabetes	High-risk patients that receive an angiogram within 3 days of admission		>70%	New measure	
6		>95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection.		>95%	New measure	
7		Percentage of the eligible population who have had their CVD risk assessed in the last 5 years		90%	58%	68.3%
8	N6-Cancer	Breast screening rate among the eligible population (50-69yrs)		70%	61%	75%
9		Cervical screening rate among the eligible population aged between 25-69		80%	72.8%	87.7%
10	N7-Smoking	Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit		95%	93%	93%
11		Percentage of smokers in primary care who are provided with advice and help to quit		90%	37%	38%
12	N8-Immunisation	Percentage of 8 month olds fully immunised (by July 2014 90%, by December 2014 95%)		90%	83%	88%
13		Seasonal influenza immunisation rates for Māori aged 65 years and over –		75%	66%	68%
14	N9-Rheumatic Fever	2013/2014 rheumatic fever target – number and rate reductions, 10% below 3-year average –		0.8	1	
	Local Priorities					
15	L1-Access to Services	Did-Not-Attend (DNA) rate for outpatient appointments –		<9%	19%	7%
16	L2-Oral Health	Pre-school dental enrolment		68%	59.1%	74.6%
17	L3-Sudden Unexplained Death of Infants Syndrome	SUDI mortality rate per 1,000 live births of Māori infants –		0.75	1.10	0.8
18	L4-Primary Mental Health	Access by Taiohi Maori to packages of primary mental health Care		25% increase	No baseline available.	