



# **Statement of Intent**

## **2013/14—2015/16**



## **Statement of Intent 2013/14-2015/16**

Name of DHB: Taranaki District Health Board

Address: Private Bag 2016  
NEW PLYMOUTH 4342  
New Zealand

Telephone number: +64 6 753 6139

Website: [www.tdhb.org.nz](http://www.tdhb.org.nz)

### **Taranaki DHB Vision**

Taranaki Together, a healthy community  
Taranaki Whanui He Rohe Oranga

In 10 years:

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

### **Taranaki DHB Values**

We work together by:

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

## Contents

<b>1.0</b>	<b>Introduction.....</b>	<b>6</b>
1.1	Executive Summary .....	6
1.2	Context.....	7
1.3	Performance Story .....	8
1.4	National Operating Environment .....	10
1.4.1	Treaty of Waitangi .....	10
1.4.2	Better Public Health Services .....	10
1.4.3	Health Sector Challenges and Pressures .....	10
1.5	Regional Operating Environment .....	11
1.6	Local Operating Environment.....	11
1.6.1	Functions of a DHB .....	11
1.6.2	Our Geography and Population .....	12
1.6.3	Health Profile.....	13
<b>2.0</b>	<b>Strategic Direction .....</b>	<b>14</b>
2.1	Maori Health and Reducing Health Inequalities .....	14
2.2	National Strategic Outcomes .....	14
2.2.1	Minister's Letter of Expectations .....	15
2.2.2	Nation Wide Health Targets.....	15
2.2.3	Better Public Health Services .....	16
2.2.4	Non-Financial Monitoring Framework .....	17
2.3	Regional Strategic Outcomes and Priorities.....	17
2.4	Local Strategic Outcomes and Priorities .....	18
2.5	Key Risks and Opportunities.....	20
2.6	Key Impacts and Measures of Performance .....	21
2.6.1	Long Term Impact One (1) – People are Supported to Take Greater Responsibility for Their Health .....	21
2.6.2	Long Term Impact Two (2) - People Stay Well in Their Homes and Communities.....	24
2.6.3	Long Term Impact Three (3) - People Receive Timely and Appropriate Care .....	27
<b>3.0</b>	<b>Stewardship.....</b>	<b>31</b>
3.1	Managing Our Business.....	31
3.1.1	Our People.....	31
3.1.2	Organisational Performance Management.....	32
3.1.3	Funding and Financial Management.....	33
3.1.4	Health Benefits Limited.....	33
3.1.5	Risk Management.....	33
3.1.6	Performance and Management of Assets .....	34
3.1.7	Shared Decision-Making.....	34
3.2	Building Capability.....	35
3.2.1	HealthShare Limited .....	35
3.2.2	Information Communications Technology .....	36
3.2.3	Integrated Contracting .....	36
3.2.4	Collaboration .....	37
3.2.5	Long Term Demand Forecasting .....	37
3.3	Strengthening Our Workforce .....	38
3.3.1	Regional.....	38

3.3.2	Local .....	39
3.4	Quality and Safety.....	42
3.5	Organisational Health.....	44
3.5.1	Governance.....	44
3.5.2	Providing Health and Disability Services.....	45
3.5.3	Planning and Funding Health and Disability Services .....	46
3.6	Reporting and Consultation.....	47
3.6.1	Consultation with the Minister and the Ministry of Health .....	47
3.6.2	External Reporting.....	47
3.7	Ownership Interests .....	48
4.0	Statement of Forecast Service Performance.....	49
4.1	Output Classes .....	49
4.2	Guide to Reading the Statement of Service Performance.....	49
4.3	People are Supported to Take Greater Responsibility for Their Health .....	50
4.3.1	Fewer People Smoke .....	50
4.3.2	Reduction in Vaccine Preventable Diseases.....	51
4.3.3	Improving Health Behaviours.....	52
4.4	People Stay Well in Their Homes and Communities.....	52
4.4.1	An Improvement in Childhood Oral Health.....	53
4.4.2	Long-Term Conditions are Detected Early and Managed Well.....	53
4.4.3	Fewer People are Admitted to Hospital for Avoidable Conditions.....	54
4.4.4	More People Maintain their Functional Independence .....	55
4.5	People Receive Timely and Appropriate Care .....	56
4.5.1	People Receive Prompt and Appropriate Acute and Arranged Care .....	56
4.5.2	People Have Appropriate Access to Elective Services.....	57
4.5.3	Improved Health Status for those with Severe Mental Illness and/or Addictions.....	58
4.5.4	More People With End Stage Conditions are Supported Appropriately .....	59
4.6	Support Services.....	59
5.0	Financial Performance .....	60
5.1	Key Points from the Budgeted Financials 2013-16 .....	60
5.2	Key Risk.....	62
5.2.1	Taranaki DHB's Funder Operations .....	62
5.2.2	Taranaki DHB's Hospital Provider Operations .....	63
5.3	Key Financial Assumptions .....	64
5.3.1	Application of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).....	64
5.3.2	Equity and Borrowing .....	65
5.3.3	Operating Expenditure.....	65
5.4	Taranaki DHB Funder – “Ring Fence Principle” and Application of Surplus/Deficits.....	66
5.4.1	Mental Health Services.....	66
5.4.2	Mental Health Services and Strategic Initiatives Expenditure.....	66
5.4.3	Interest Rates.....	66
5.4.4	Asset Revaluation and its Impact.....	67
5.4.5	Depreciation .....	67
5.4.6	Capital Charge .....	67
5.4.7	Leasing .....	67
5.4.8	Financial Covenants and Ratios .....	67
5.4.9	Changes in Accounting Policies.....	68

5.4.10	Capital Investment.....	68
5.4.11	Capital Divestment .....	69
5.4.12	Personnel.....	70
5.5	Capital Expenditure 2013/14 (Strategic) .....	71
5.5.1	Community Oral Health Project .....	71
5.5.2	Base Hospital Inpatient Facilities Development Programme .....	72
5.6	Cost and Efficiency Initiatives .....	72
5.7	Debt and Equity .....	74
5.8	Sensitivity Analysis: Plan 2013/14.....	74
5.9	Statement of Comprehensive Income .....	76
5.10	Consolidated Statement of Financial Position.....	78
5.11	Consolidated Statement of Cashflows .....	79
5.12	Consolidated Statement of Movement In Equity .....	80
6.0	Appendices.....	81
6.1	Glossary of Terms.....	81
6.2	Output Class Revenue and Expenditure .....	85
6.3	Output Measure Rationale .....	85

## 1.0 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 Statement of Intent 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*.



Mary K Bourke  
**Board Chair**



Peter Catt  
**Deputy Chair**



Tony Foulkes  
**Chief Executive**

## 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 Statement of Intent, 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.

#### 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	



#### Midland DHBs Performance Story

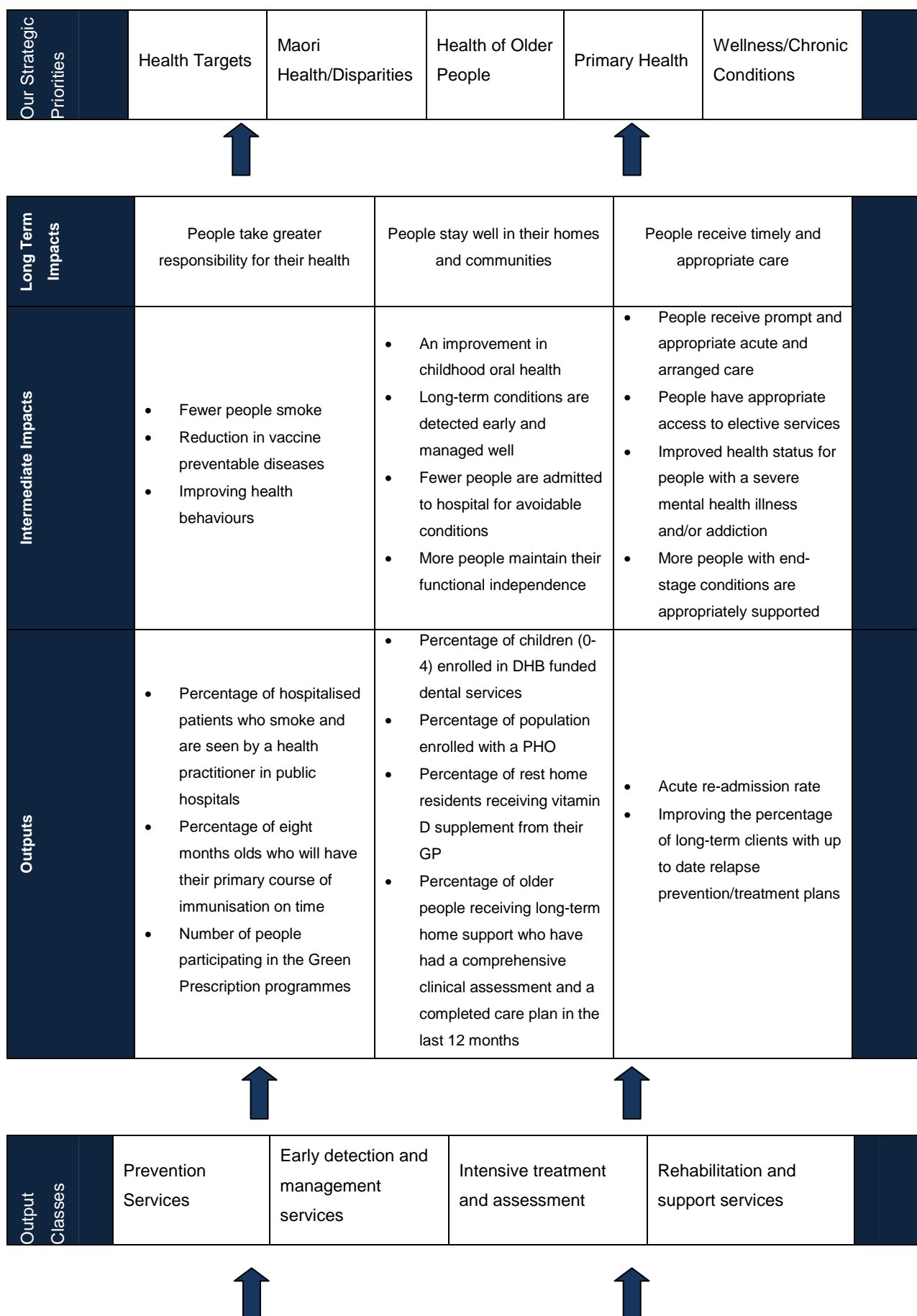
Midland Vision	All residents of Midland District Health Boards lead longer, healthier and more independent lives				
Midland Outcomes	To improve the health of our population		To reduce or eliminate health inequalities		
Regional Strategic Objectives	To build the workforce	Systems integration across the 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	
Our Outcomes	To improve the health of our population	To reduce or eliminate health inequalities





Stewardship	Workforce	Performance Management	Collaboration/Partnerships	Information	
-------------	-----------	------------------------	----------------------------	-------------	--

## 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](http://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:

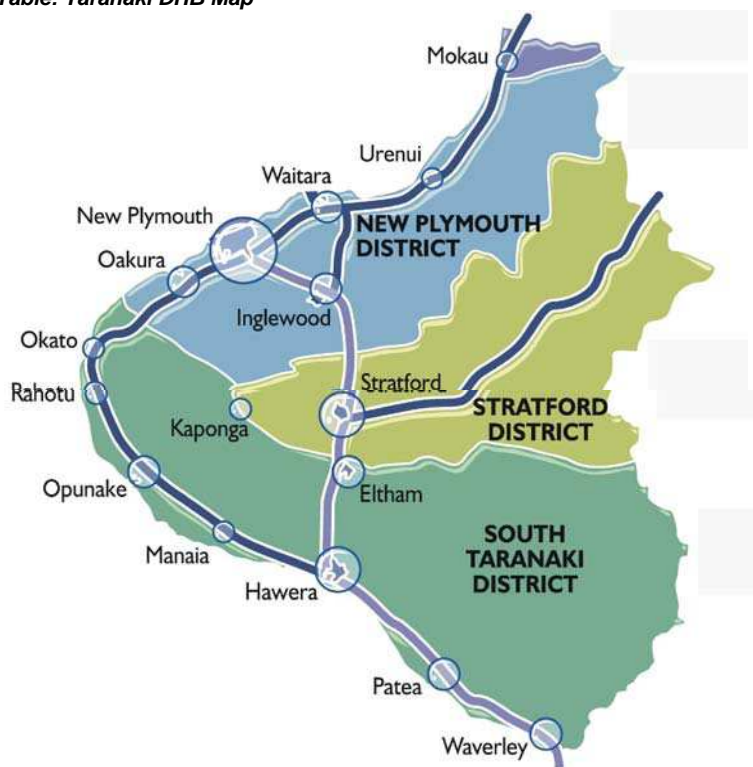
- Plan in partnership with key stakeholders, the strategic direction for health and disability services
- Plan regional and national work in collaboration with the National Health Board and other DHBs
- Fund the provision of the majority of the public health and disability services in our district, through 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 Strategic Direction

This section 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 specific actions to deliver improved performance (and related measures) against the Minister's expectations are described in the DHB's Annual Plan 2013-14.







**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 percent
 <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 percent
 <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 percent
 <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 percent</p> <p>Total 90 percent</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 the Statement of Intent.

## 2.3 Regional Strategic Outcomes and Priorities

The Midland DHBs have produced a Regional Services 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"> <li>• Maternity services</li> <li>• Renal services</li> <li>• Rural Health</li> <li>• Health of older people</li> <li>• Radiology</li> </ul>	<ul style="list-style-type: none"> <li>• 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"> <li>○ Clinical data reporting</li> <li>○ Clinical workstations</li> <li>○ e-Medicines reconciliation</li> </ul> </li> <li>• Building the workforce</li> <li>• Maori Health</li> </ul>
National Priority Services <ul style="list-style-type: none"> <li>• Cardiac services</li> <li>• Cancer control</li> <li>• Elective services</li> <li>• Stroke services</li> </ul>	Key Enablers <ul style="list-style-type: none"> <li>• Health Quality and Safety Commission</li> <li>• National Health Committee</li> <li>• Asset Planning</li> </ul>
Regional activities <ul style="list-style-type: none"> <li>• Mental health and addictions</li> <li>• Smokefree</li> <li>• Trauma</li> </ul>	

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 RoheOranga 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	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.  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.
Health of Older People	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;  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 minimise inappropriate admissions into long term aged residential care and share regionally
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.

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 Statement of Intent.

## 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"> <li>• Reconfiguring and integrating services both regionally and locally</li> <li>• Implementing new models of care and transferring services to the new hospital</li> </ul>	<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"> <li>• Identification</li> <li>• Funding, providing and supporting the development of provider led innovations that target inequalities and improve access to services</li> <li>• Monitoring the effectiveness of our programmes by ethnicity and for high needs populations</li> </ul>
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"> <li>• Health Workforce New Zealand</li> <li>• Midland Regional Training Network</li> <li>• Local partners, e.g. Western Institute of Technology, the Whakatipuranga Rima Rau Trust and other Government agencies</li> </ul>

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

### 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

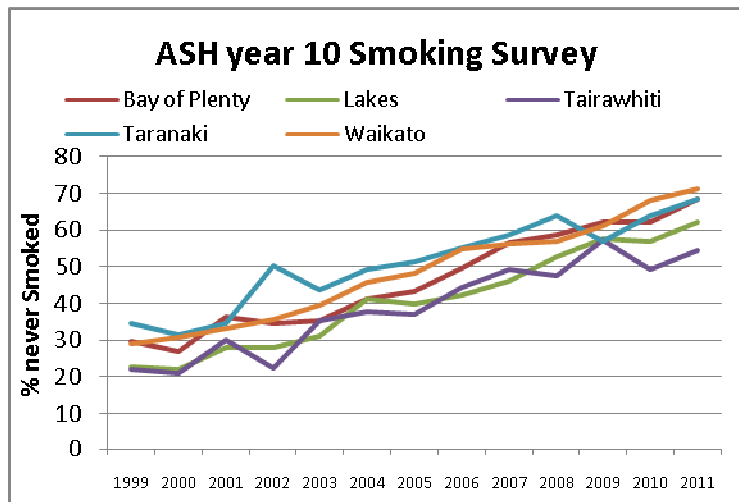
communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say “no” to tobacco smoking is our foremost opportunity to target improvements in the health of our population 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?

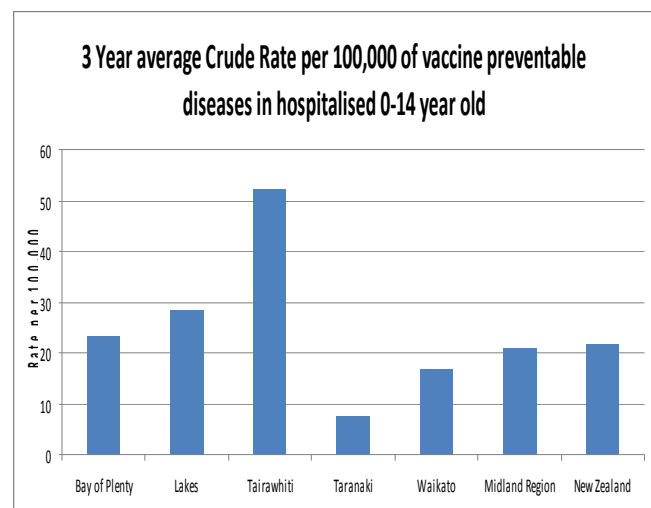
In order to have the greatest impact, we will prevent people from taking up smoking in the first place (Year 10 students), working our way through the continuum from prevention, to detection (identifying adults who smoke and offering them cessation advice – see Health Targets), and ultimately reducing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

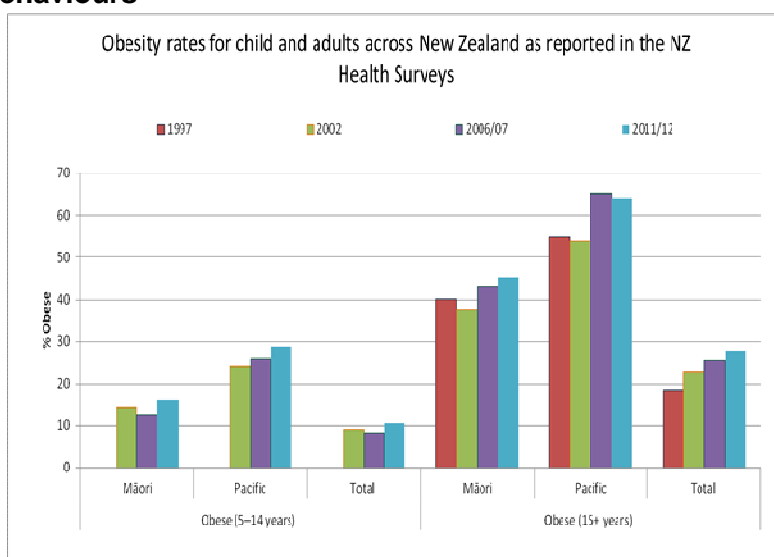
### 2.6.1.3 Improving Health Behaviours

#### 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.

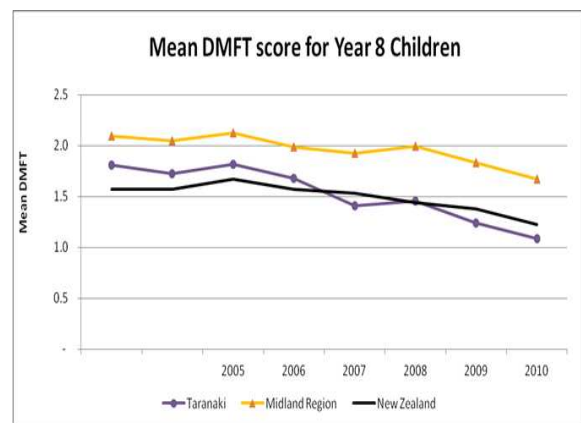
With an ageing population, the Midland Region will require a strong base of primary care and community support, including residential care, respite and home-based support. If long-term conditions are managed effectively, crises and deterioration can be reduced and health outcomes improved. Even where 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.

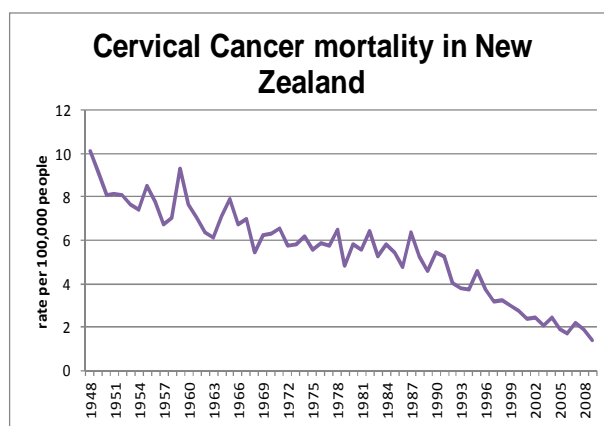
DMFT is a count of Diseased, Missing or Filled Teeth in permanent dentition (permanent teeth) in a person's mouth. By Year 8, children's teeth should be their permanent teeth and any damage at this stage is life long, so the lower a child's DMFT, the more likely that their teeth will last a life time.

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		

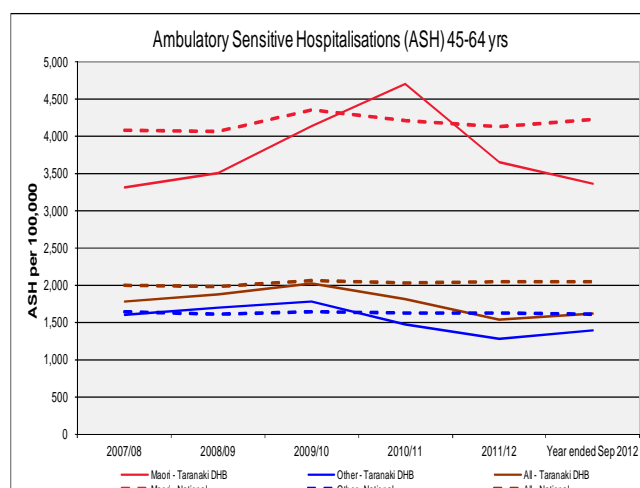
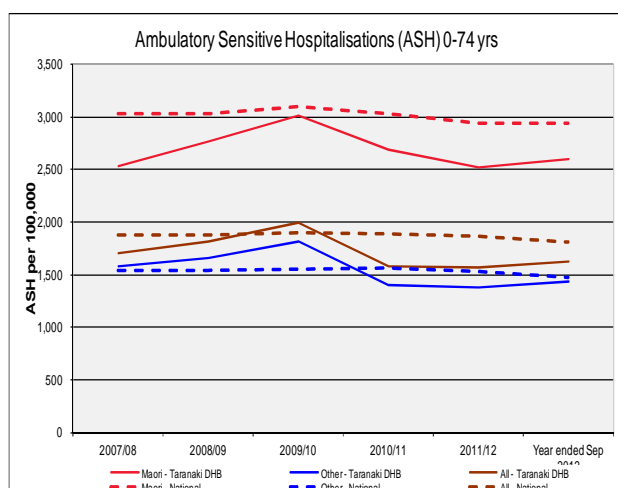
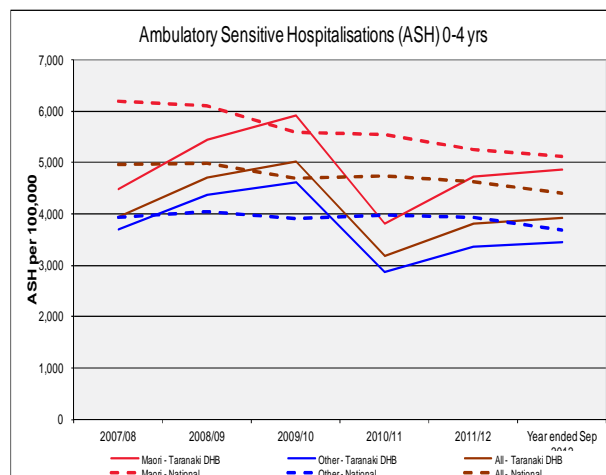
### 2.6.2.3 Fewer People are admitted to Hospital for Avoidable Conditions

#### 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?

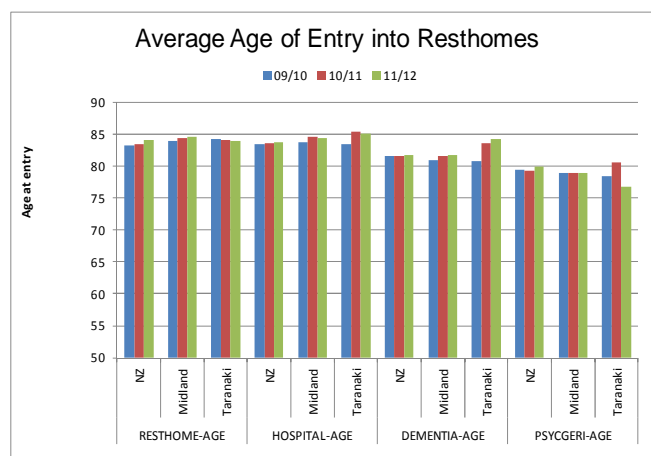
We will know when we have succeeded when we reduce the ratio of actual to expected avoidable hospital admissions for our population (Total and Māori).

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.

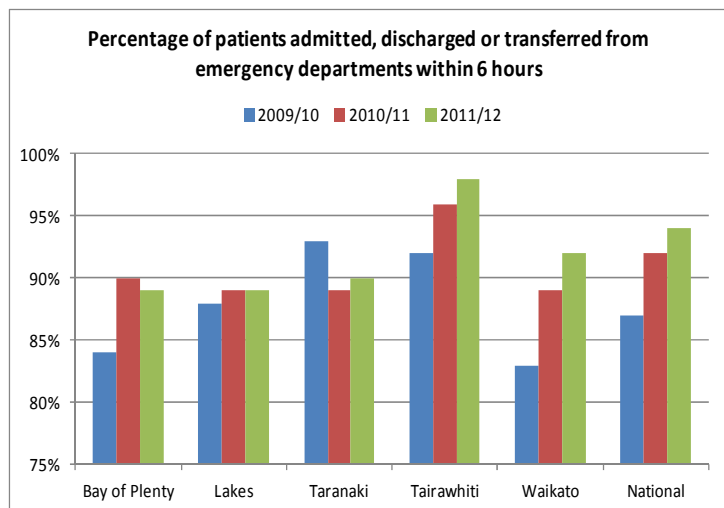
### 2.6.3.1 People Receive Prompt and Appropriate Acute Care

#### 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.

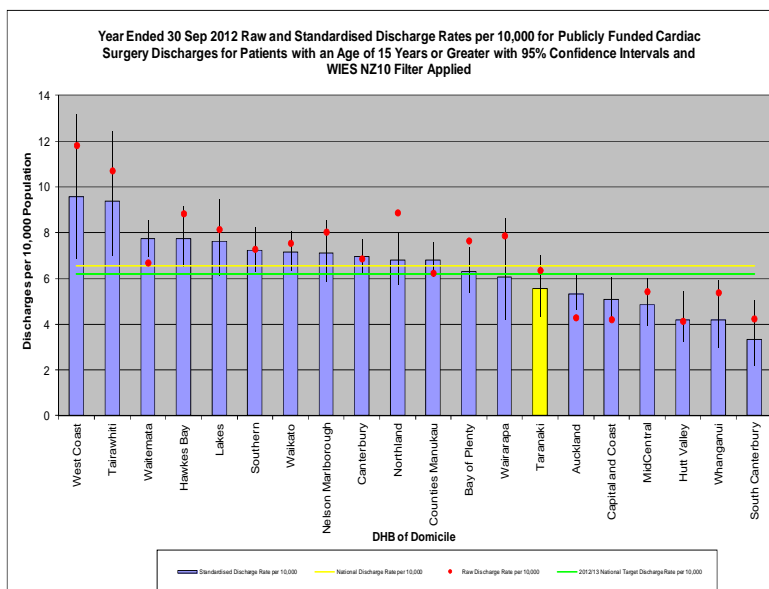
Improved performance against this measure will not only improve outcomes for our population, but will improve the public's confidence in being able to access services when they need to.

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?

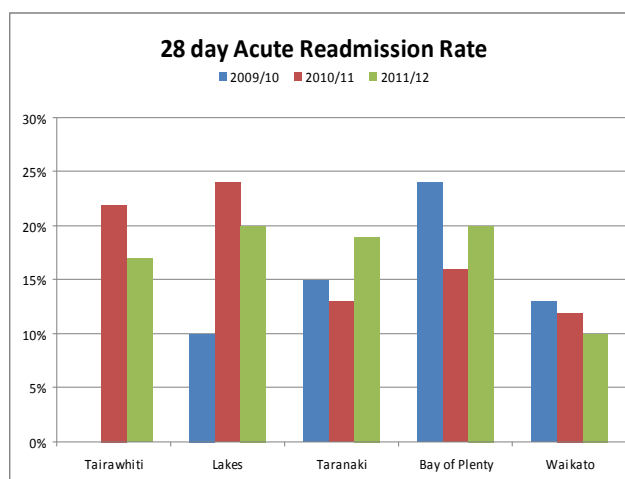
We have chosen cardiac procedures as an impact measure, as the cardiac pathway requires a 'whole of system' approach to achieve an improvement. The inference is that lessons learnt in this service are utilised in others. This includes the effective management of the referral process, increased number 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. 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 Stewardship

### 3.1 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 section 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
-------------	-----------	------------------------	----------------------------	-------------

#### 3.1.1 Our People

The central part of our capability is our people. Providing health and disability services now and into the future depends on having a workforce that is well matched to the health needs of the community and appropriately skilled and located. Key points of note about our workforce (as at 31 December 2012) are:

- We employed 1,199.82FTE 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

### **3.1.2 Organisational Performance Management**

Our performance is assessed on both non-financial and financial measures. Our overall planned performance as a funder and provider of health services for 2013/14 is outlined in this Statement of Intent and will be reported to our Executive Team, Finance and Audit Committee, Board and the Ministry of Health on a regular basis.

#### **3.1.2.1 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 identified in the Ministry of Health's Non-Financial reporting framework. 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.

#### **3.1.2.2 Financial Performance Reporting**

As part of our planning process we submit a set of financial templates to the Ministry of Health. The templates inform the tables and narrative presented in Section Five. 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.



### 3.1.3 Funding and Financial Management

The following table sets out our key financial indicators:

	2011/12	2012/13	2013/14	2014/15	2015/16
	\$M	\$M	\$M	\$M	\$M
	ACTUAL	FORECAST	PLANNED	PLANNED	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

### 3.1.4 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 Section Five.

### 3.1.5 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.

### 3.1.6 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.

### 3.1.7 Shared Decision-Making

#### 3.1.7.1 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.

#### 3.1.7.2 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. 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.

### **3.1.7.2 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.

### **3.1.7.2 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.

## ***3.2 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.

### **3.2.1 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.

### **3.2.2 Information Communications Technology**

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

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

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 document their IT capacity planning and action; bringing together the National Health IT Plan and regional priorities.

### **3.2.3 Integrated Contracting**

We have been working with our local Preferred Provider of Maori Health Services (Te Kāwau Maro 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

### 3.2.4 Collaboration

We collaborate with other health and disability organisations, stakeholders and our community to decide what health and disability services are needed and how to best use the funding we receive from Government. 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 Kokiri and Te Whare Punanga Korero. WRR was created to build an integrated approach focusing on the common objective of up-skilling and developing the Maori Health and Disability workforce in Taranaki. This is an innovative multi agency and multi funder model which introduces a range of initiatives to address Maori workforce development through collaboration.

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

### 3.2.5 Long Term Demand Forecasting

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

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

### *3.3 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.

#### **3.3.1 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

### **3.3.2 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"> <li>• Reduced level of vacancies</li> <li>• Increase in length of service for those occupation groups</li> </ul>
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"> <li>• Recruitment vacancy rates,</li> <li>• Turnover rates,</li> <li>• Allocation of scholarships</li> <li>• Recruitment of previous scholarship recipients</li> </ul>
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"> <li>• Percentage of secondary schools participating in Incubator</li> <li>• Participation numbers in Kia Ora Hauora for the Taranaki region</li> <li>• Participation numbers for the Incubator programme</li> </ul>
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"> <li>• Nurse Graduate volumes compared to previous years</li> <li>• Volume of medical vocational trainees returning to TDHB</li> </ul>
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"> <li>• Turnover</li> <li>• Staff satisfaction survey results</li> </ul>
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"> <li>• The Productive Operating Theatre designed to balance and manage acute and elective patient demand on theatres and staff resources;</li> <li>• Intermediate Care Assessment and Treatment Team (ICATT) designed to facilitate transition from hospital to home and from medical dependence to functional independence; and</li> <li>• Continuing to implement the TDHB E-Pharmacy vision focussing on the E-Prescribing and Medicines Reconciliation pilot projects</li> </ul>	<ul style="list-style-type: none"> <li>• Turnover</li> <li>• Staff satisfaction survey results</li> <li>• Clinical Board KPIs</li> </ul>
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	<ul style="list-style-type: none"> <li>• Turnover</li> <li>• Staff satisfaction survey</li> <li>• Number of Quality</li> </ul>



Initiatives	Measure
and services rested with the appropriate leaders and managers	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"> <li>• Staff satisfaction survey</li> <li>• Clinical Board KPIs</li> </ul>
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"> <li>• Feedback from clinical leaders</li> </ul>
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"> <li>• Staff satisfaction survey</li> <li>• Number of Quality Improvements identified and implemented</li> </ul>
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"> <li>• Successful implementation of project</li> <li>• Feedback from new staff via the post entry survey</li> </ul>
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"> <li>• Regional PGY1 and PGY2 programmes implemented</li> <li>• Regional leadership training programmes implemented</li> <li>• Feedback from programme participants</li> </ul>
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"> <li>• To have an increase in the volume of employees completing e-learning courses</li> <li>• Training feedback on the e-learning courses</li> <li>• To have implemented leadership development programmes at TDHB</li> </ul>
<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"> <li>• Review career planning arrangements</li> <li>• Contribute to the central resource for career planning information and resources</li> <li>• Implementing regional reporting mechanisms</li> <li>• Involvement in the regional mentoring process</li> </ul>	<ul style="list-style-type: none"> <li>• Complete career plans for trainees</li> <li>• Regional resources implemented to support the trainees with their career plans</li> </ul>

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

### *3.4 Quality and Safety*

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

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

Our Strategic Quality and Risk plan facilitates the progressive achievement of the DHB's vision by assisting us to meet the challenge of continuously improving service provision and quality of care by ensuring patient safety and robust systems and processes. 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	<p>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.</p> <p>E-medications programme monitoring and evaluation actions continue.</p>	<p>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.</p> <p>Productivity and efficiency gains.</p>
Reducing healthcare associated infections	<p>Hand Hygiene</p> <p>Train more Gold Auditors</p> <p>Meet the required hand hygiene moments observed and submitted each quarter.</p> <p>Increase our compliance rate to equal to or more than 70%</p> <p>Central Line Associated Bacteraemia (CLAB)</p> <p>Continue with the implementation and 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>	<p>Rate of &lt;0.1 per thousand bed-days of Staphylococcus aureus bacteraemia.</p> <p>Rate maintained at &lt;1 per 1000 line days in ICU.</p> <p>Rate of infection is &lt;5% in surgeries surveyed.</p>
Falls reduction	<p>Progressive implementation of our Falls Prevention Steering Group Work Plan.</p>	<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>

Programme	Expected Actions	Outcomes
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	Explore options for an electronic reportable events system.  Complete a business case and submit for approval and prioritisation.	Improved analysis and reporting of events and trends to the Taranaki DHB.

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

### 3.5 *Organisational Health*

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

#### 3.5.1 Governance

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](http://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

### **3.5.2 Providing Health and Disability Services**

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

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

They include:

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

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

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

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

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

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

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

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

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

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

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

## 3.6 *Reporting and Consultation*

### 3.6.1 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

### 3.6.2 External Reporting

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

**Table: External Reporting Framework**

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

### *3.7 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.



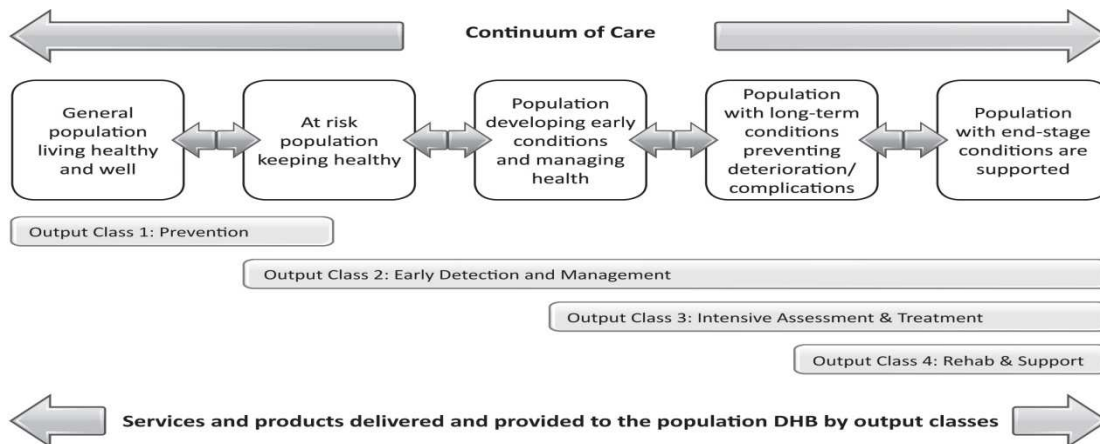
## 4.0 Statement of Forecast Service Performance

We have worked with other DHBs in the Midland region, our primary care partners as well as other key stakeholders to develop the Statement of Forecast Service Performance (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. Where possible, we have included with each measure past performance as baseline data.

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

### 4.1 Output Classes

DHBs must provide measures and standards of output delivery performance under aggregated output classes. Outputs are goods and services that are supplied to someone outside our DHB. Output classes are an aggregation of outputs, or groups of similar outputs of a similar nature. The output classes used (and referenced to) within our statement of forecast service performance are described in Section Six (6.2). These four output classes have been agreed nationally. They represent a continuum of care, as follows:



### 4.2 Guide to Reading the Statement of Service Performance

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

- Further detail of the performance story logic and rationale is contained in Module Two
- 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 Section Six (6.3).
- 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 SOI, and TDHB’s Quality Programme Outcomes will be presented in our 2013/14 Quality Account Report.

### 4.3 *People are Supported to Take Greater Responsibility for Their Health*

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

#### 4.3.1 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				90%		

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%	

#### 4.3.2 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%

### 4.3.3 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%
The number of referrals to the GRx (Green Prescription) programmes (Local Contract)	1	qn/t	New Measure		New Measure
Adult				967	
Children				35	
Reduce the teen birthrate per 10,000	1	qn/t			National Regional
Maori			339	<339	415 428
Non-Maori			160	<160	123 149
Total			203	<203	186 247
Reduce the rate of teenage terminations of pregnancy per 10,000	1	qn/t			National Regional
Maori			194	<194	158 163
Non-Maori			142	<142	123 116
Total			154	<154	186 133

## 4.4 People Stay Well in Their Homes and Communities

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

#### 4.4.1 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%

#### 4.4.2 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%
Percentage 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%

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result
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
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	

#### 4.4.3 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%

Outputs	Output Class	Measure Type	Baseline	Target 2013/14	National/Regional Result	
Percentage of eligible population who have had their B4 school checks completed	1	qn/t	94%	80%	National Regional	
High Needs					82%	91%
Total					79%	83%

#### 4.4.4 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

## 4.5 People Receive Timely and Appropriate Care

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

### 4.5.1 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

#### 4.5.2 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

### 4.5.3 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	

#### 4.5.4 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

#### 4.6 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

## 5.0 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
<b>TOTAL FUNDING</b>	<b>318,853</b>	<b>325,566</b>		<b>328,976</b>	<b>334,918</b>	<b>341,077</b>
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
<b>TOTAL OPERATING EXPENSES &amp; PAYMENTS</b>	<b>318,655</b>	<b>326,516</b>		<b>332,427</b>	<b>335,853</b>	<b>340,925</b>
Hospital Provider + Governance Operating Deficit	-8,925	-11,160		-13,451	-10,939	-9,732
<b>TDHB Funder surplus</b>	<b>9,123</b>	<b>10,210</b>		<b>10,000</b>	<b>10,004</b>	<b>9,884</b>
<b>CONSOLIDATED FINANCIAL RESULT</b>	<b>198</b>	<b>-950</b>		<b>-3,451</b>	<b>-935</b>	<b>152</b>

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.

### 5.1 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.

## **5.2 Key Risk**

### **5.2.1 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 Statement of Intent 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 the Annual Plan. These changes are transformational in nature and it is believed will deliver the same or better health outcomes for less cost.

### **5.2.2 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, and 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 on-going 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 on-going 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 three year planning horizon – if existing services and levels are to be maintained.

### *5.3 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.

#### **5.3.1 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.

### **5.3.2 Equity and Borrowing**

The Statement of Intent 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.

### **5.3.3 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.

## *5.4 Taranaki DHB Funder – “Ring Fence Principle” and Application of Surplus/Deficits*

### **5.4.1 Mental Health Services**

In keeping with the guidelines on treatment of “Mental Health Ring fence surplus” the amount of any under-expenditure carried forward from previous accounting periods has been reported as a surplus in Taranaki DHB’s Statement of Financial Performance in the year the surplus is generated. The ring fenced surpluses as at the beginning of FY 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.

### **5.4.2 Mental Health Services and Strategic Initiatives Expenditure**

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

### **5.4.3 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.

	<b>Overdraft</b>	<b>DMO/MOH Loans (existing)</b>	<b>DMO/MOH Loans (new)</b>	<b>Deposits</b>	<b>Equity</b>
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.

#### 5.4.4 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.

#### 5.4.5 Depreciation

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

#### 5.4.6 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.

#### 5.4.7 Leasing

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

#### 5.4.8 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%

#### 5.4.9 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.

#### 5.4.10 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)
<b><u>Operating</u></b>				
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
<b>SUB - TOTAL</b>	<b>3,000</b>	<b>3,000</b>	<b>3,000</b>	<b>9,000</b>
Information Technology	4,000	4,000	4,000	12,000
<b>TOTAL</b>	<b>7,000</b>	<b>7,000</b>	<b>7,000</b>	<b>21,000</b>
<b><u>Strategic</u></b>				
Community Oral Health Project	-	-	-	-
Base Hospital redevelopment project	3,000	-	-	3,000
<b>TOTAL</b>	<b>3,000</b>	<b>-</b>	<b>-</b>	<b>3,000</b>
<b>GRAND TOTAL</b>	<b>10,000</b>	<b>7,000</b>	<b>7,000</b>	<b>24,000</b>
<b>Sources of Funding</b>				
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.

#### 5.4.11 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.

### 5.4.12 Personnel

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

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

<b>CONTRACTED</b>				
	<b>Forecast</b>	<b>Yr 1</b>	<b>Yr 2</b>	<b>Yr 3</b>
	2012-13	2013-14	2014-15	2015-16
<b>PROVIDER</b>				
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
	<b>1,235</b>	<b>1,221</b>	<b>1,207</b>	<b>1,194</b>
<b>GOVERNANCE</b>	17	17	17	17
<b>INFORMATION TECH UNIT (EX- HIQ Ltd)</b>	50	42	38	38
<b>TOTAL</b>	<b>1,302</b>	<b>1,280</b>	<b>1,262</b>	<b>1,249</b>

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:

<b>ACCRUED</b>				
	<b>Forecast</b>	<b>Yr 1</b>	<b>Yr 2</b>	<b>Yr 3</b>
	2012-13	2013-14	2014-15	2015-16
<b>PROVIDER</b>				
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
	<b>1,313</b>	<b>1,305</b>	<b>1,278</b>	<b>1,257</b>
<b>GOVERNANCE</b>	18	18	18	18
<b>INFORMATION TECH UNIT (EX- HIQ Ltd)</b>	54	45	42	42
<b>TOTAL</b>	<b>1,385</b>	<b>1,368</b>	<b>1,338</b>	<b>1,317</b>

## 5.5 Capital Expenditure 2013/14 (Strategic)

### 5.5.1 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.

### 5.5.2 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 <b>STAGE 1</b>	Theatres, Ambulatory, Inpatient wards	\$80M	Start: Aug 2011 Finish: Dec 2013	In progress. Completion by Dec 2013.
2 <b>STAGE 2</b>	Maternity, Neonatal, ED	\$37M	Tentative: July 2017	Supplementary business case to be progressed.
3 <b>STAGE 3</b>	OPD, Laboratory, CSD, Administration	\$28M	Tentative : July 2020	Supplementary business case to be progressed.
<b>TOTAL</b>		<b>\$145M</b>	<b>Aug 2011 – June 2021</b>	

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.

## 5.6 Cost and Efficiency Initiatives

Taranaki DHB is faced with the challenge of managing its service delivery within a defined fiscal envelope. In addition, it has to balance its long-term strategies with short-term objectives while continuing to provide a clinically safe and quality service. 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
<b>GAINS</b> (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
<b>INVESTMENT</b> (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)
<b>NET GAIN (2013-14)</b>		<b>\$4.03M</b>	

The Statement of Intent 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 on-going 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.

## *5.7 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.
- We have 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.

## *5.8 Sensitivity Analysis: Plan 2013/14*

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

### DHB Hospital Provider Operations

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

The analysis estimates an overall exposure of circa **\$2M** 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	<b>1.75</b>	0.88	50%
Elective Volumes	1.00	0.75	<b>0.50</b>	0.25	50%
IDF inflows/outflows	1.00	0.75	<b>0.50</b>	0.25	50%
Provider Arm expenditure	3.00	2.25	<b>1.50</b>	0.75	50%
Income in Advance	0.60	0.45	<b>0.30</b>	0.15	50%
<b>Potential impact on 2013/14 planned financial result</b>	<b>9.10M</b>	<b>6.68M</b>	<b>4.50M</b>	<b>2.23M</b>	<b>4.50M</b>

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.

## 5.9 Statement of Comprehensive Income

TARANAKI DISTRICT HEALTH BOARD										
STATEMENT OF COMPREHENSIVE INCOME										
DISTRICT ANNUAL PLAN 2013-16										
(\$'000)										
	Year -1	FORECAST		Year 0						
	Consolidated Audited 2011/12	Hosp+Gov Forecast 2012/13	Funder Forecast 2012/13	Consolidated Forecast 2012/13	Provider Plan 2013/14	Governan: Plan 2013/14	Hosp+Gov Plan 2013/14	Funder Plan 2013/14	Consolidated Plan 2013/14	Year 1
<b>REVENUE</b>										
* MOH funding	154498 143716	159453	147809	159453 147809	160839	0	160839	150404	160839 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	
<b>TOTAL REVENUE</b>	<b>318853</b>	<b>173384</b>	<b>152182</b>	<b>325566</b>	<b>172315</b>	<b>2040</b>	<b>174355</b>	<b>154621</b>	<b>328976</b>	
<b>EXPENDITURE</b>										
<b>Personnel costs</b>										
- 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	
<b>total</b>	<b>106597</b>	<b>106797</b>	<b>0</b>	<b>106797</b>	<b>106403</b>	<b>1233</b>	<b>107636</b>	<b>0</b>	<b>107636</b>	
<b>Outsourced services</b>										
- clinical services	19426	18371		18371	17123	0	17123		17123	
- other outsourced	2777	2502		2502	2398	0	2398		2398	
<b>total</b>	<b>22203</b>	<b>20873</b>	<b>0</b>	<b>20873</b>	<b>19521</b>	<b>0</b>	<b>19521</b>	<b>0</b>	<b>19521</b>	
<b>Clinical supplies</b>										
- 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	
<b>total</b>	<b>23142</b>	<b>22548</b>	<b>0</b>	<b>22548</b>	<b>22659</b>	<b>0</b>	<b>22659</b>	<b>0</b>	<b>22659</b>	
<b>Infrastructure &amp; other op.costs</b>										
- 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	
- <b>Payment to - NGO providers</b>										
- 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	
<b>total</b>	<b>161825</b>	<b>28276</b>	<b>141972</b>	<b>170248</b>	<b>31339</b>	<b>761</b>	<b>32100</b>	<b>144621</b>	<b>176721</b>	
<b>TOTAL OPERATING EXPENSES</b>	<b>313767</b>	<b>178494</b>	<b>141972</b>	<b>320466</b>	<b>179922</b>	<b>1994</b>	<b>181916</b>	<b>144621</b>	<b>326537</b>	
<b>SURPLUS before capital charge</b>	<b>5086</b>	<b>-5110</b>	<b>10210</b>	<b>5100</b>	<b>-7607</b>	<b>46</b>	<b>-7561</b>	<b>10000</b>	<b>2439</b>	
- Capital charge	6164	6050		6050	5890	0	5890		5890	
<b>NET SURPLUS/(DEFICIT)</b>	<b>-1078</b>	<b>-11160</b>	<b>10210</b>	<b>-950</b>	<b>-13497</b>	<b>46</b>	<b>-13451</b>	<b>10000</b>	<b>-3451</b>	
<b>OTHER COMPREHENSIVE INCOME</b>										
* Gain/(Loss) on asset revaluation	0	0		0	0				0	
* Gain/(Loss) on sale of assets	0	0		0	0				0	
* Share of surplus/(loss) from associates	1276	0		0	0				0	
<b>Total Other Comprehensive Income</b>	<b>1276</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	
<b>TOTAL COMPREHENSIVE INCOME FOR THE YEAR</b>	<b>198</b>	<b>-11160</b>	<b>10210</b>	<b>-950</b>	<b>-13497</b>	<b>46</b>	<b>-13451</b>	<b>10000</b>	<b>-3451</b>	
<b>Interest Cover ratio</b>	<b>6.70</b>			<b>6.79</b>					<b>4.45</b>	
<b>Revenue to Net Funds employed</b>	<b>2.39</b>	<b>1.18</b>		<b>2.21</b>	<b>1.20</b>				<b>2.28</b>	
<b>Operating margin to Revenue ratio</b>	<b>4%</b>	<b>1%</b>		<b>4%</b>	<b>3%</b>				<b>5%</b>	
<b>Op. return on Net Funds employed</b>	<b>9%</b>	<b>2%</b>		<b>9%</b>	<b>3%</b>				<b>10%</b>	

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

## 5.10 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	
<b>CURRENT ASSETS</b>							
* 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	
<b>CURRENT LIABILITIES</b>							
* 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	
<b>WORKING CAPITAL</b>	1605	-23325		-22388	-16300	-9058	
<b>NON CURRENT ASSETS</b>							
* 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	
<b>NET FUNDS EMPLOYED</b>	<b>133429</b>	<b>147426</b>		<b>144070</b>	<b>142251</b>	<b>141519</b>	
<b>NON CURRENT LIABILITIES</b>							
* 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	
<b>CROWN EQUITY</b>							
* 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	
<b>NET FUNDS EMPLOYED</b>	<b>133429</b>	<b>147426</b>		<b>144070</b>	<b>142251</b>	<b>141519</b>	
<b>Debt: Debt equity ratio</b>	43%	50%		52%	53%	53%	

## 5.11 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	
<b>OPERATING ACTIVITIES</b>							
* MOH funding	301273	311160		314339	320482	326595	
* Other revenue	14395	12947		13777	13576	13622	
<b>total receipts</b>	<b>315668</b>	<b>324107</b>		<b>328116</b>	<b>334058</b>	<b>340217</b>	
* Payment of salaries & operating exp.	166968	172443		172829	172462	174357	
* Payment to providers & DHB's	138831	149293		145185	148880	150211	
<b>total payments</b>	<b>305799</b>	<b>321736</b>		<b>318014</b>	<b>321342</b>	<b>324568</b>	
<b>NET CASHFLOW FROM OPERATIONS</b>	<b>9869</b>	<b>2371</b>		<b>10102</b>	<b>12716</b>	<b>15649</b>	
<b>INVESTING ACTIVITIES</b>							
* 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	
<b>NET CASHFLOW FROM INVESTING</b>	<b>-38624</b>	<b>-19444</b>		<b>-10047</b>	<b>-11707</b>	<b>-14640</b>	
<b>FINANCING ACTIVITIES</b>							
* Equity injections / repayments	927	-959		-959	-959	-959	
* Borrowings	27800	15200		2000	0	0	
* Payment of debts	392	654		-1046	0	0	
<b>NET CASHFLOW FROM FINANCING</b>	<b>29119</b>	<b>14895</b>		<b>-5</b>	<b>-959</b>	<b>-959</b>	
Total cash in	344787	339002		328111	333099	339258	
Total cashout	-344423	-341180		-328061	-333049	-339208	
<b>NET CASHFLOW</b>	<b>364</b>	<b>-2178</b>		<b>50</b>	<b>50</b>	<b>50</b>	
Add: Cash (opening)	3069	3433		1255	1305	1355	
<b>CASH (CLOSING)</b>	<b>3433</b>	<b>1255</b>		<b>1305</b>	<b>1355</b>	<b>1405</b>	

### 5.12 Consolidated Statement of Movement In Equity

<b>TARANAKI DISTRICT HEALTH BOARD</b>									
<b>DISTRICT ANNUAL PLAN 2013-16</b>									
<b>CONSOLIDATED STATEMENT OF MOVEMENT IN EQUITY</b>									
					2012/13 forecast		2013/14 plan	2014/15 plan	2015/16 plan
<b>EQUITY AT THE BEGINNING OF PERIOD</b>					<b>75139</b>		<b>73230</b>	<b>68820</b>	<b>66926</b>
* 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
<b>EQUITY AT THE END OF THE PERIOD</b>					<b>73230</b>		<b>68820</b>	<b>66926</b>	<b>66119</b>



## 6.0 Appendices

### 6.1 Glossary of Terms

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

stated outcomes. (<http://www.ssc.govt.nz/glossary/>)

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

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).

**Outputs**

Are final goods and services, that is, they are supplied to someone outside the entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (Crown Entities Act 2004).

**Ownership**

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

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

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

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

**Performance Measures**

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

**Priorities**

Statements of medium term policy priorities.

**Productivity**

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

**Purchase Agreement**

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

**Regional Collaboration**

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

Northern: Northland DHB, Auckland DHB, Waitemata DHB and Counties Manukau DHB

Midland: Bay of Plenty DHB, Lakes DHB, Tairāwhiti DHB, Taranaki DHB and

Waikato DHB

Central: Capital and Coast DHB, Hawkes Bay DHB, Hutt Valley DHB, MidCentral DHB, Waitemata DHB and Whanganui DHB

Southern: Canterbury DHB, Nelson Marlborough DHB, South Canterbury DHB, Southern DHB and West Coast DHB

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

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

## 6.2 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
<b>TOTAL</b>	<b>328,976</b>	<b>332,427</b>

## 6.3 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	Breastfeeding is the unequalled way of	Prevention Services /	Quantity/

Measure	Rationale	Output Class / Category	Dimension of Performance
and exclusively breastfeed at six months	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.	Health Promotion and Education	Timeliness
The number of referrals to the GRx (Green Prescription) programmes	A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active, as part of the patient's health management. Research published in the New Zealand Medical Journal indicates that a Green Prescription is an inexpensive way of increasing activity.	Prevention Services / Health Promotion and Education	Quantity
Reduce the teen birth rate	Having babies at a very young age can increase maternal risk factors such as high blood pressure and preeclampsia. There is also the increased likelihood of those without parental/guardian support receiving less pre-natal support.	Prevention Services/Health Promotion and Education	Quantity
Reduce the rate of teenage terminations of pregnancy	Teenage pregnancy is associated with difficulties in psychological, sexual and overall health. We also want to measure both teen pregnancy and termination rates to ensure that one does not increase while the other decreases.	Prevention Services/Health Promotion and Education	Quantity
Percentage of children under five years of age (i.e. aged 0 – 4 years of age inclusive) who are enrolled with DHB-funded oral health services	Research shows that improving oral health in childhood and adolescence has benefits over a lifetime.	Early Detection and Management Services/Oral Health	Quantity
Percentage of pre-school and primary school children (0 – 12 years) who are overdue for their planned recall period			Quantity
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	Breast screening is a proven way for	Prevention Services/	Quantity

Measure	Rationale	Output Class / Category	Dimension of Performance
women (50-69) have a breast screen in the last 3 years	finding breast cancers early to reduce the risk of dying of breast cancer	Population Based Screening	
Increase the number of packages of care available to youth under the Primary Mental Health Initiative	Primary mental health initiative is funded to increase the availability of services in Primary Health Organisations for patients with mild to moderate mental health issues. In line with our Taiohi Health Strategy and the Prime Minister's Youth Mental Health project we are expecting the actions in our Annual Plan will result in an increase in youth accessing these services.	Early Detection and Management Services/ Primary Mental Health and Addictions	Quantity
Percentage of Rest Home residents receiving vitamin D supplement from their GP	Vitamin D supplementation has been demonstrated to improve mineral bone density and reduce falls.	Prevention Services/Health Promotion and Education	Quantity
Percentage of all Emergency Department presentations who are triaged at levels 4&5	Emergency department services utilise a scale of one to five triage, with one being the most urgent. Triage category four and five may more appropriately be seen in primary care.	Intensive Assessment and Treatment Services/Acute Services	Quantity
Percentage of eligible children have their B4 School Checks completed	A nationwide programme offering a health and development check for four year olds	Prevention Services/ Well Child	Quantity
Hospitalisation rates per 100,000 for acute rheumatic fever	Rheumatic fever arises as a result of a throat infection with Group A Streptococcal bacteria. It predominantly affects children between 5 and 14 years of age. In New Zealand, evidence points to poorer housing conditions (especially overcrowding) and general social deprivation as risk factors for rheumatic fever.	Prevention Services/ Well Child	Quantity
Percentage of older people receiving long-term home support who have had a comprehensive clinical assessment and a completed care plan in the last 12 months	More consistent and comprehensive assessment of the older person which enables determination of service capacity and service planning information	Rehabilitation and Support Services/Needs Assessment and Service Coordination	Quantity
For those with aged related and chronic health conditions we aim to reduce the rate of rest home level of residential 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	Intensive treatment and assessment.	Quality

Measure	Rationale	Output Class / Category	Dimension of Performance
	patients.		
Acute re-admission rate	<p>Unplanned readmissions will usually present to emergency departments, and may result in admission to hospital for further treatment. This puts pressure on emergency departments and inpatient hospital capacity, efficiency and productivity.</p> <p>An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services.</p>	Intensive Assessment and Treatment Services/Acute Services	Quality
Average length of inpatient stay	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, we will positively impact hospital productivity through freeing up beds and other resources so it can provide more elective surgery, reduce waiting times in the emergency department or make savings. Supporting patients to return home sooner may, in part, be achieved by reducing the rate of patient complications and better use of the time clinical staff spend with patients. Patients will also be less at risk of contracting nosocomial infections.	Intensive Assessment and Treatment Services/Elective Services and Acute Services	Quality
Percentage of patients who require radiation or chemotherapy are treated 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 complication as a % of total deliveries	The longer-term aim is to reduce the risks associated with an unnecessary Caesarean section, reduce the number of women at risk of a subsequent Caesarean section and reduce the number of women who experience difficulties with their second and subsequent births as a consequence of a primary Caesarean section.	Intensive Assessment and Treatment Services/Elective Services	Quantity
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	Intensive Assessment and Treatment Services Acute/ Elective Services	Quality



Measure	Rationale	Output Class / Category	Dimension of Performance
	health or even death.		
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 following discharge, including higher risk for suicide.	Intensive Assessment and Treatment Services/Specialist Mental Health and Addiction Services	Quality
A reduction in the	The Taranaki Palliative Care Strategy	Intensive Assessment and	

Measure	Rationale	Output Class / Category	Dimension of Performance
percentage of palliative care clients who have had an Emergency Department presentation	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.	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