Wairarapa District Health Board

District Annual Plan

2008/2009

Wairarapa DHB

Wairarapa District Health Board

Te Poari Hauora a-rohe o Wairarapa

Wairarapa District Health Board's vision is:

Well Wairarapa –Better health for all
Wairarapa ora – Hauora pai mo te katoa

Our mission is:

To improve, promote, and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices.

Wairarapa District Health Board Treaty of Waitangi Statement

The Wairarapa DHB recognises and respects the Treaty of Waitangi, and the principles of partnership, participation and protection, in the context of the New Zealand Public Health and Disability Act 2000.

The Wairarapa District Health Board will continue to work with the Te Iwi Kainga to ensure Maori participation at all levels of service planning, and service delivery for the protection and improvement

of the health status of Maori.

Wairarapa District Health Board Values

The values that underpin all of our work are:

- **Respect - Whakamana Tangata**
  According respect, courtesy and support to all

- **Integrity – Mana Tu**
  Being inclusive, open, honest and ethical

- **Self Determination - Rangatiratanga**
  Determining and taking responsibility for ones actions

- **Co-operation - Whakawhanaungatanga**
  Working collaboratively with other individuals and organisations

- **Excellence – Taumatatanga**
  Striving for the highest standards in all that we do

CONTENTS

1 EXECUTIVE SUMMARY

This District Annual Plan (DAP) sets out the Wairarapa DHB's objectives and targets for 2008/09. It shows how we will:

- Address the Minister of Health's expectations
- Make progress towards national and local DHB strategic priorities
- Manage risks
- Allocate funding; provide services; measure, monitor and report performance.

Expectations and Objectives for 2008/09

The Minister of Health's Letter of Expectations for 2008/09 requires DHBs to demonstrate progress in:

- Value for money
- Getting ahead of chronic conditions
- Reducing disparities
- Child and youth health
- Primary health
- Infrastructure
- Health of older people

The DHB's strategic priorities and themes align well with the Minister of Health's expectations

Key Achievements in 2007/08

- Achieved significant increases in both elective and acute service volumes
- Maintained full compliance on all ESPIs
- Established new services – paediatric surgery, ophthalmology, Incredible Years programme
- Increased primary health services in community settings – schools, marae, and outreach facilities
- Continued development of Long Term Conditions (chronic care) Management System across all PHO providers and initiated CVD/diabetes risk assessments
- Established The Patient Journey programme
- Increased the number of older people supported to live in the community through a variety of initiatives
- Continued to shift focus of service delivery towards population based approaches to reducing the incidence of long term illness
- Achieved positive progress overall against Health Targets
- Began to see reductions in disparities across a range of health indicators

Wairarapa DHB Strategic Priorities

The DHB's Strategic Plan for 2005-2015 sets out seven priorities for improving health and reducing inequalities in Wairarapa:

- Improving the health of Maori
- Improving the health of people in low socio-economic groups
- Improving the health of older people
- Improving the health of children and youth
- Reducing the incidence and impact of chronic disease (*now called long term conditions)*
- Reducing the incidence and impact of mental illness and addictions
- Reducing the incidence and impact of cancer

Actions to Achieve Expectations and Objectives for 2008/09

The table following summarises the activities we will undertake in 2008/09 to achieve the Minister's expectations and our local DHB objectives.

DHB Priorities and actions for 2008/09	
Increasing collaboration	• Further develop inter-agency work through HEHA, Healthy Homes, Violence Free Wairarapa, aged care service planning and other initiatives • Continue and increase participation in Central region planning and service development through Regional Clinical Services Plan, Regional Mental Health Strategy, Regional Cancer Network, Renal, Plastics and Cardiology groups, and Keeping Well (the Wellington region public health plan).
Reducing Inequalities • Maori • Pacific • Lower socio-economic groups	• Complete new Maori Health Plan for Wairarapa DHB • Complete Wairarapa Maori cultural competency framework • Develop new contracts with Maori providers that enable flexible delivery of whanau ora • Continue to support development of Pasifika Wairarapa • Expand range of servicers provided at Cameron Centre • Deliver targeted health promotion and public health interventions to areas of high deprivation • Continue support for Healthy Homes project • Continue to fund free health clinics in low decile schools
Healthy Lifestyles • Healthy Eating Healthy Action • Reducing Family Violence • Preventing Suicide	• Complete and implement social marketing strategy • Establish single inter-sectoral governance group over all health lifestyles programmes • Implement Wairarapa Smokefree plan • Complete training of all hospital staff in screening for risk of violence and abuse • Improve interface between health services and CYF • Continue focus on building resilience and social inclusion • Develop Suicide prevention action plan for Wairarapa
Children and youth • Oral health	• Continue to provide free primary care for children under six • Implement Before School Checks for four year olds • Continue to improve immunisation and breastfeeding rates • Continue to fund free clinics in low decile high schools • Implement new model of service provision in school dental services • Increase sexual health promotion targeted at youth
Older People	• Implement recommendations from AT&R review • Establish dedicated stroke service • Increase capacity of residential care services • Establish specialist gerontology nurse position • Complete plan to address mental health needs of older people
Primary Care	• Complete CVD/diabetes risk measurement across all target groups and establish intervention protocols • Establish Family Nurse practitioner position • Implement new pharmacy services – health promotion and medicines use reviews • Implement training and structure for generalist palliative care • Increase use of Green prescriptions

DHB Priorities and actions for 2008/09	
Long Term(chronic) conditions	• Develop single point of entry to support services in alignment with DSS • Maintain high rates of vaccination against influenza • Review and refine Care Plus • Promote use of best practice guidelines and common care pathways across Wairarapa District Health Board • Establish protocols for stroke management in older and younger people
Cancer • Palliative care	• Increase access to radiotherapy services • Establish and appoint to specialist oncology nurse position • Continue implementation of district cancer plan • Work with regional network to assess case for provision of chemotherapy in Wairarapa District Health Board • Implement new palliative care framework and services
Mental illness and addictions	• Implement local and regional foster family services for youth • Re-establish inter-agency management forum • Implement new consumer advocacy service • Implement outcome measurement in clinical services • Establish support service for people with alcohol/drug induced disability • Establish position to address mental health needs of older people
Elective Services	• Maintain and improve performance on all elective services performance indicators • Improve primary care access to radiology • Further develop specialised nurse roles in outpatient services, including ophthalmology, and urology
Hospital efficiency	• Review utilisation of acute assessment unit • Develop strategies to reduce unnecessary hospital admissions • Complete and implement new model of staffing for junior doctors • Change practices in ED to ensure patients are not recalled to ED if can be followed up in primary care • Develop protocols for acute event management in rest homes • Increase use of home IV service
Infrastructure • Workforce • Information technology and systems • Quality and safety • Facilities	• All DHB provider staff trained in screening for family violence and disability awareness • Wairarapa DHB training programme instituted for middle managers • MECAs settled within bargaining parameters agreed by DHB CEOs • Complete implementation of electronic referrals • Continue progress to implementation of new Patient Administration System (PAS) • Develop IT/IS for school dental service • Implement new financial management system • Roll-out medicines reconciliation project in Wairarapa hospital • Provide training in adverse event management and open disclosure for clinical staff • Implement cultural competency framework in at least two hospital services • Implement Infection Control plan and report progress quarterly • Local mortality reviews reported to Clinical Board quarterly • Library/Learning centre completed

DHB Priorities and actions for 2008/09	
Value for Money	• Continue to use transparent prioritisation and funding allocation processes • Increase use of outcome measures, particularly in mental health services • Review and evaluate school clinics and flexible packages of care service for older people • Streamline primary care practitioners' access to imaging diagnostics • Achieve savings in expenditure on supplies through participation in Lower North Island Buying Group, and national procurement initiatives

Financial Forecasts

Wairarapa DHB will achieve breakeven in 2007/08 and again in 2008/09. Forecasts for the out-years also show breakeven. This continues the Wairarapa pattern of strong financial management and performance that has been demonstrated in recent years.

Maintaining financial breakeven in 2008/09 and beyond, will be an increasing challenge, requiring careful management of all expenditure, risks and expectations. Current levels of service provision and access are not sustainable within the DHB's expected future funding allocation.

Currently the DHB provider is over-delivering against contract by about 5% ($2M pa). Pressures on DHB expenditure are increasing sharply due to growth in both service volumes and input prices. Growth in wage and salary rates across the health sector is considerably greater than growth in DHB funding, and nationally hospital costs overall are rising by over 7% per annum, while DHB funding grows at around 3-4% per annum. This is not sustainable financially.

Projections indicate that aged care service needs will increase by 4% to 5% per annum over the next few years; offset by much smaller annual growth in the DHB's demographic funding adjustment as the DHB's share of total population is declining relative to the rest of New Zealand. The growth of new technologies (including pharmaceuticals), the increase in national prices for inter district services above the rate of DHB funding growth, and the need for all Central region DHBs to increase their investment in regional specialty services such as radiotherapy create additional pressures.

The financial plan presented in this DAP assumes efficiencies continue to be realised and that the DHB will find new ways of meeting needs and managing demand so that expenditure on services rises more slowly than growth in service needs.

Key Risks and Challenges

All DHBs face ongoing challenges as they try to balance community demands and needs for more and better services against the requirements to ensure clinical safety and increasing investment in clinical governance and quality assurance systems, sustainability of the clinical workforce, financial prudence, and organisational health (including being a good employer).

In 2008/09 management of the growing pressures for increasing expenditure will require considerable restraint and sharpened focus on productivity improvements and increased workforce flexibility.

The biggest risks facing us in 2008/09 relate to:

- Ensuring clinical safety and quality
- Increasing costs from new multi-employer collective agreements negotiated nationally
- Managing delivery of acute services within budget
- Maintaining performance in delivery of elective services
- Capacity within residential services for older people
- Expenditures on IDFs and other regional services
- Expenditures on pharmaceuticals (including cancer drugs) and pharmacy services
- Realisation of further efficiency gains

These risks arise from a mix of internal and external factors. Wairarapa DHB is confident of its ability to manage the internal factors. However risks due to external factors cannot be managed fully by Wairarapa DHB actions alone as they require co-operative actions with several DHBs and/or the Ministry of Health.

Internal risks

Ensuring clinical safety and quality

In 2008/09 Wairarapa DHB will further develop its clinical governance and quality systems and increase investment in this area.

Managing delivery of hospital acute services within budget

Several projects are being implemented to address this.

Maintaining performance in delivery of elective service

Any failure to meet targets for elective services carries a significant financial penalty. We address this risk through strong management of the elective services work programme.

Maintaining the workforce at full establishment

Maintaining the full establishment of clinical staff is an ongoing challenge as there are national and international shortages across the health workforce. This risk is shared with other DHBs and is managed through our active participation in regional recruitment strategies.

Realisation of further efficiency gains

Over the past four years Wairarapa DHB has achieved huge efficiency gains through introduction of new facilities and work practices, more effective procurement of both services (eg laboratories) and inputs (eg petrol). The hospital workforce has demonstrated considerable productivity growth. While further efficiencies are now becoming harder to find we are maintaining our focus on continual efficiency gains and overall system improvements.

External risks

MECAs

National and regional wage settlements continue to create significant threats to the financial status of the DHB as salary expectations and market rates are growing more strongly than the DHB's baseline funding. Given the expectations of the health workforce, relativity issues, full employment, and serious labour shortages across the health sector there is significant risk of industrial action in 2008/09 and Wairarapa DHB being pressured to agree to MECAs that would make it impossible to reach our financial targets. We will work with national programmes to avoid this.

Aged Residential Care services

There are significant risks regarding continuity and future sufficiency of provision of aged residential care services in Wairarapa:

- Growth in service need is rising faster than DHB funding
- Small local service providers who are not financially viable

We are managing these risks by working locally with service providers to find and implement effective local solutions, and with other DHBs and the Ministry of Health to address those aspects that require a national approach.

IDF and Regional service risks

We are vulnerable to increasing pressures and risks in IDF expenditure due to:

- The volatility of IDF flows
- National increases in prices for highly specialized services, greater than FFT
- Increasing application of new technologies.

Expenditure on out of district services is growing much faster than DHB funding due to:

- Growth in the disease burden – for example numbers of patients needing renal dialysis increasing 8% per annum
- Application of new technologies – for example expenditure on cancer treatment drugs is growing 30-40% per annum
- Increasing specialization and growth of new areas such as cardiac electro-physiology

We are managing this risk by increasing the range of services provided within Wairarapa, as far as possible and working with other Central region DHBs on shared regional service planning.

Pharmaceuticals and Pharmacy Services

There is a risk the DHB's uncapped, fee-for-service expenditure on pharmaceuticals and pharmacy services will exceed budget. There are many drivers of this expenditure growth external to the DHB. This risk will be addressed by working closely with:

- Other DHBs and pharmacy groups to develop new agreements for pharmacy services and manage growth in fees for pharmacy services
- Other DHBs, PHARMAC, and the primary health care sector, to plan and manage expenditure on pharmaceuticals.

Our Commitment to Succeed

As for previous plans, the Wairarapa DHB is totally committed to planning for and delivering the range and mix of services that best meets the needs of Wairarapa people, within the funding made available to us by Government, and achieving a breakeven financial outcome.

Although we are confident this can be delivered in 2008/09, we are very concerned that, due to growing external factors, we will face increasing difficulty in achieving this result in 2009/10and 2010/11. We are very committed to working collaboratively with the Ministry of Health and other DHBs, to find ways to overcome the issues and risks we face.

In pursuit of break-even results for 2008/09 and beyond we will seek Ministry and regional support for joint problem solving, prioritising and implementing necessary services changes, and support regarding industrial action.

SIGNATORIES

Janine Vollebregt
Deputy Chair

David Meates
Chief Executive

Hon David Cunliffe
Minister of Health

2 NATIONAL HEALTH TARGETS

<table>
<tr><th>Health Target</th><th>Indicator</th><th>Wairarapa Targets 2008/09</th></tr>
<tr><td>Improving immunisation coverage</td><td>Progress towards the national target of 95% of two year olds</td><td>Percentage of children fully immunised:
Maori 91%
Total 89%</td></tr>
<tr><td>Improving oral health</td><td>Progress is made towards 85% adolescent oral health utilisation</td><td>81%</td></tr>
<tr><td rowspan="2">Improving elective services</td><td>Each District Health Board will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs)</td><td>
<table>
<tr><td>ESPI - 1</td><td>100%</td><td>ESPI - 5</td><td>4.0%</td></tr>
<tr><td>ESPI - 2</td><td>1.0%</td><td>ESPI - 6</td><td>5.0%</td></tr>
<tr><td>ESPI - 3</td><td>3.0%</td><td>ESPI - 7</td><td>4.0%</td></tr>
<tr><td>ESPI - 4</td><td>N / A</td><td>ESPI - 8</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>Each DHB will set an agreed increase in the number of elective services discharges, and will provide the level of service agreed</td><td>
<table>
<tr><th></th><th>Base</th><th>Add.</th><th>Total</th></tr>
<tr><td>Elective CWD</td><td>1,897</td><td>262</td><td>2,159</td></tr>
<tr><td>Estimated Elective Discharges</td><td>1,576</td><td>158</td><td>1,734</td></tr>
</table>
</td></tr>
<tr><td>Reducing cancer waiting times</td><td>All patients will wait less than 6 weeks between their first specialist assessment and the start of radiation oncology treatment.
This excludes category D patients.</td><td>Wairarapa patients will wait less than 6 weeks between their first specialist assessment and the start of radiation oncology treatment.
This excludes category D patients</td></tr>
<tr><td>Reducing ambulatory sensitive (avoidable) hospital admissions</td><td>There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged:
0-4, 45-64, and 0-74 years across all population group

No targets are set for Pacific People due to low population numbers

Targets based on National Discharge Ratio – Year End June 2007</td><td>
<table>
<tr><th>Ethnicity</th><th>Age Group</th><th>Target</th></tr>
<tr><td rowspan="3">Maori</td><td>0-4 years</td><td>Not to exceed more than 15% above national level</td></tr>
<tr><td>45-64 years</td><td>Not to exceed more than 18% above national level</td></tr>
<tr><td>0-74 years</td><td>Not to exceed more than 16% above national level</td></tr>
<tr><td rowspan="3">Other</td><td>0-4 years</td><td>Not to exceed more than 12% above national level</td></tr>
<tr><td>45-64 years</td><td>Not to exceed more than 6% above national level</td></tr>
<tr><td>0-74 years</td><td>Not to exceed more than 15% above national level</td></tr>
</table>
</td></tr>
<tr><td rowspan="2">Improving diabetes services</td><td>There will be an increase in the percentage of people in all population groups:
➢ Estimated to have diabetes accessing free annual checks
➢ On the diabetes register who have good diabetes management
No targets are set for Pacific People due to low population numbers</td><td>
<table>
<tr><th>Maori</th><th>Pacific</th><th>Other</th><th>Total</th></tr>
<tr><td>80%</td><td>- -</td><td>80%</td><td>78%</td></tr>
<tr><td>72%</td><td>- -</td><td>75%</td><td>75%</td></tr>
</table>
</td></tr>
<tr><td>There will be improved equity for all population groups in relation to diabetes management.</td><td>Continue to work towards improved equity by providing free primary care and diabetes support services to Maori and Pacific groups, and specialist diabetes clinics at Marae and a Pacific community centre</td></tr>
<tr><td>Improving mental health services</td><td>100% of long-term clients have an up to date relapse prevention plan
(NMHSS criteria 16.4)</td><td>% of long term clients who have an up to date relapse prevention plan
<table>
<tr><th></th><th>Maori</th><th>Non Maori</th></tr>
<tr><td>Child & Youth</td><td>98%</td><td>98%</td></tr>
<tr><td>Adult Mental Health</td><td>98%</td><td>98%</td></tr>
<tr><td>Addiction Services</td><td>98%</td><td>98%</td></tr>
</table>
</td></tr>
<tr><td>Improve nutrition
Increase physical activity
Reduce obesity</td><td>Wairarapa DHB activity supports achievement of national health sector targets:
➢ Proportion of infants exclusively and fully breastfed:
74% at six weeks, 57% at three months, 27% at six months
➢ Proportion of adults (15+ years) consuming at least three servings of vegetables per day, and proportion of adults (15+ years) consuming at least two servings of fruit per day:
70% for vegetable consumption and 62% for fruit consumption</td><td>Implement actions in the Wairarapa MAP for HEHA:
➢ Complete accreditation for the Baby Friendly Community Initiative
➢ Implement social marketing programme
➢ Support school gardens
➢ Continue to work with Pacific Island churches to encourage healthy eating
➢ Implement Momona marae challenge</td></tr>
<tr><td>Reduce the harm caused by tobacco</td><td>Wairarapa DHB activity supports achievement of national health sector targets:
➢ Increase the proportion of ‘never smokers’ among Year 10</td><td>Implement activities in the Wairarapa DHB Tobacco Control Plan:
➢ Establish DHB wide Smokefree Network to promote and</td></tr>
</table>

	students by at least 3 percent (absolute increase) over 2007/08 (baseline 57.9%) ➢ An increasefor both Maori Year 10 'never smokers' and Pacific Year 10 'never smokers' that is greater than that for European Year 10 'never smokers' ➢ To reduce the prevalence of exposure of non-smokers to SHS inside the home to less than 5% (baseline 2006 12.5%, 2007 7.5%) and ➢ A reduction in the prevalence of exposure of non-smokers to SHS inside the home for Maori (baseline 2007 16.1%) and for Pacific (baseline 2007 16.4%) that is greater than that for European (baseline 2007 6.5%).	maintain collaboration between providers ➢ Increase screening, brief advice and referral to cessation services in contacts with primary and secondary health services ➢ Increase the number of people using Nicotine Replacement Therapy

3 INTRODUCTION

3.1 About the District Annual Plan

A District Annual Plan (DAP) is required under Section 39 of the New Zealand Public Health and Disability Act, and describes the Board's intentions for the coming year (July 2008 – June 2009), including how it will advance the implementation of its District Strategic Plan and meet the expectations and requirements of the Minister of Health.

The DAP should be read in conjunction with the DHB's Statement of Intent (SOI). The SOI in addition to summarising the DHB's key financial and non-financial objectives and targets, also provides summary information about Wairarapa health needs and priorities, the DHB's organisation and structure, and the national policy environment within which the DHB operates. The DAP provides detail on how the DHB intends to achieve its objectives and targets and the outputs/activities proposed for the year ahead. The DAP includes more operational performance measures and targets as well as those stated in the SOI.

The DAP is designed to show:

- The DHB's intended outputs for 2008/09 and how these relate to the DHB's District Strategic Plan (DSP)
- The funding proposed for those intended activities and outputs
- The expected performance of the DHB's provider arm
- Expected capital investment
- Financial and performance forecasts
- How performance will be monitored, measured and reported

The DAP has been developed through an iterative process of discussions with stakeholders and where possible includes shared outcomes and joint responsibilities for achievement of objectives.

3.2 Wairarapa District Health Board

The Wairarapa District Health Board (DHB) was formed upon the enactment of the New Zealand Public Health and Disability Act 2000, and is responsible for funding and providing health and disability support services in the Wairarapa District.

Wairarapa DHB is responsible for working, within the funding allocated to it, to improving, promoting and protecting the health of the Wairarapa population, and for promoting the independence of people with disabilities, and improving access to services for all those in the district. The DHB has developed its Board Committees and organisation structure to enable it to carry out these responsibilities efficiently and effectively.

Role of the Board

The Board provides governance of the Wairarapa DHB and is responsible for the organisation's performance to this plan. The Board has eleven members. Seven members are elected by the community, and four members are appointed by the Minister of Health. There are two Maori members with one of these Maori board members sitting on each Committee of the Board. The Maori members maintain close working relationships with iwi, hapu, and the Board's Director of Maori Health.

The Board's key responsibilities include:

- Setting a long-term strategic direction that is consistent with the government's objectives
- Developing the District Annual Plan and other accountability documents

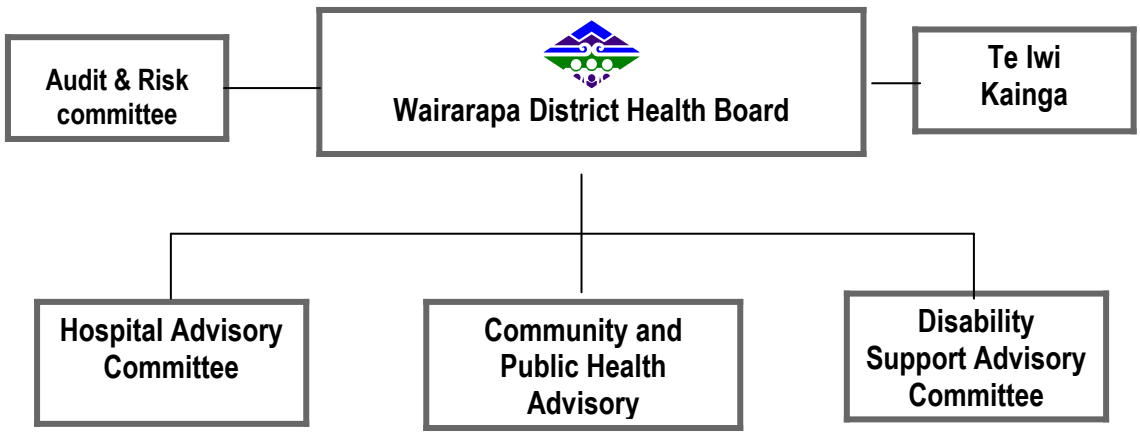
- Monitoring the performance of the organisation and appointing its Chief Executive
- DHB governance
- Maintaining appropriate relationships with the Minister of Health, Parliament, Maori and the public.

Board committees

The Board has established a Maori partnership committee, three statutory advisory committees and an audit and risk committee:

- *Te Oranga O Te Iwi Kainga:* Te Iwi Kainga provides advice to the Board on the improvement of health outcomes for Maori and the reduction of disparities between Maori and non-Maori, and advises on all aspects of Maori health service development and provision.
- *Community and Public Health Advisory Committee*: The Community and Public Health Advisory Committee provide advice and recommendations to the Board on the health needs of the resident population. It also advises the Board on priorities for the use of the health funding provided. The committee membership is comprised of eight Board members.
- *Disability Support Advisory Committee:* The Disability Support Advisory Committee provides advice and recommendations to the Board on the disability support needs of the resident population. It also provides advice and recommendations to the Board on priorities for the use of the disability support funding provided. The membership of this Committee consists of five Board members and two representatives from the Wairarapa disability community.
- *Hospital Advisory Committee*: The Hospital Advisory Committee monitors, advises and provides recommendations to the Board on the financial and operational performance of Wairarapa Hospital and related services provided by the Wairarapa District Health Board. Seven board members make up this Committee.
- *Audit and Risk Committee:* Monitors and records risk and advises the Wairarapa District Health Board in discharging its responsibilities in terms of the integrity of financial reporting, risk management and regulatory conformance. The committee membership is comprised of four board members.

These committees meet regularly throughout the year and are supported by the Board and Committee Secretaries, and members of the senior management team as appropriate. The diagram that follows shows how each of these committees provides input to the DHB.



Shared Decision Making

While the final responsibility for DHB strategy rests with the Board, and the Chief Executive is responsible for operational decisions, the Board and Chief Executive ensure that their strategic and operational decisions are fully informed through the appropriate involvement of Maori at all levels of the decision-making process.

Partnership with Maori is assured through the appointment of two Maori to the Board, Te Iwi Kainga (representing Iwi) and Maori Health Committee. Involvement of clinicians occurs through the Clinical Board.

Te Iwi Kainga and Maori Health Committee

Te Iwi Kainga represents the two local Iwi, Ngati Kahungunu and Rangitaane and advises the Wairarapa DHB at governance level. Wairarapa DHB and the Te Iwi Kainga first signed a formal partnership agreement in March 2003. This agreement was revised and renewed during 2006/07 and a new agreement signed formally in December 2007.

The Maori Health Committee advises DHB management on the planning, development, delivery and monitoring of services for Maori within the hospital provider arm. The Maori Health Committee membership is representative of Maori across the health sector in conjunction with Maori practitioners working in the sectors that complement health. This committee also has the benefit of having kaumatua, Maori Women's Welfare League, consumers and representation from the Maori community either as designated members or official supporters and observers in attendance at their bi-monthly meetings.

Clinical Board and Clinical Governance

The Wairarapa Clinical Board was established in 2003. It provides a multi-disciplinary clinical forum to be the focus of clinical leadership and lead the development of clinical governance for Wairarapa DHB. The Clinical Board is a multidisciplinary clinical forum that provides advice and oversight of clinical activity to the DHB Board and Chief Executive.

The Clinical Board is responsible for:

- Oversight of systems and processes to assure clinical safety and the management of clinical risk
- Oversight and monitoring of credentialing, required by the Health Practitioners' Competency Assurance Act
- Provision of clinical advice to the DHB Board, Chief Executive, and management
- The development and leadership of clinical governance

For further information about the Clinical Board and Clinical Governance see Section 5.21

Planning and Funding Arm

The primary responsibility of the Planning and Funding Directorate is to plan and fund health and disability services for the district. The Planning and Funding Directorate assesses the health and disability needs of the communities and plans the mix, range and volume of services. Planning and funding staff also manage agreements with providers of services, initiate specific health improvement projects with different communities and build partnerships with the community, providers and other DHBs.

The Planning and Funding Directorate is also responsible for ensuring Wairarapa people have access to specialist services that are not delivered in the district and monitoring and managing the flow of funds for these out of district services.

The Planning and Funding Directorate's core activities are:

- Determining the health and disability needs of the population.
- Prioritising and operationalising national health and disability strategies in relation to local need.
- Involving the community through consultation and participation.
- Undertaking service contracting.
- Monitoring and evaluation of service delivery, including audits.

In 2008/09 Wairarapa DHB will continue to have Service Agreements with a wide range of service providers and/or enter new Agreements with service providers to ensure the services required are provided for its population, in line with the aims and objectives set out in this plan.

Provider Arm

Wairarapa DHB's hospital and community health services are provided mainly from Wairarapa Hospital and Choice Health. Services are also delivered from out-reach clinics, including several held at Marae. The Wairarapa DHB's provider arm will continue to deliver outpatient, community, day programmes, and inpatient services as funded by the DHB through its Planning and Funding Team and as required by other DHBs and purchasers including ACC, across the following services:

- Medical and Surgical Services
- Child Health
- Oral Health Services
- Obstetrics and Women's Health
- Clinical Support services – laboratory, pharmacy, imaging and allied health services
- Mental Health Services
- Rehabilitation services
- Public Health services
- Community health services
- Ambulance

Working with other providers

In addition to Wairarapa DHB provider arm, there are a range of other providers who provide a variety of health services and disability services for people in the district. These providers are a mix of private, religious, welfare and other non-governmental organisations. The services they provide include mental health residential and support, rest homes, primary care (GP and nursing services, community workers, pharmacists, laboratories, pharmaceuticals etc), maternity, public health, Well Child, and Kaupapa Maori services. Hutt Valley DHB, in partnership with Wairarapa Public Health Unit, provides Regional Public Health Services for the Wairarapa.

PHOs are a key vehicle in implementing the Primary Care Strategy, achieving improvements in health outcomes and reductions in inequalities. The Wairarapa is fortunate to have one PHO that encompasses the whole district. The DHB has a close working relationship with Wairarapa Community PHO.

Public Health Partnerships

Public Health Services are funded and contracted for by the Ministry of Health. Wairarapa DHB's public health unit provides most public health services locally, and Regional Public Health in Hutt Valley provides a range of other public health services to Wairarapa, Hutt and Capital and Coast districts. These three DHBs have worked with the Ministry to complete a Public Health Strategic Plan for the greater Wellington region. This plan provides a framework for shared decisions with the four parties meeting regularly to review progress. The plan is being updated currently.

Treaty of Waitangi

The New Zealand Public Health and Disability Act requires DHBs to take active steps to reduce health disparities by improving health outcomes for Maori and to assist the Crown in fulfilling its obligations under the Treaty of Waitangi. DHB's are required to establish and maintain processes to enable Maori to participate in, and contribute towards strategies for Maori Health improvement.

In fulfilment of these responsibilities, Wairarapa DHB works with the Te Iwi Kainga and Maori Health Committee, and has an active Treaty of Waitangi Policy. The application of this policy by all services provided or funded by the DHB ensures that not only Maori health gain and development is achieved but that each partner is proactive and jointly responsible for improving Maori health.

The Wairarapa DHB employs a Director of Maori Health who is a member of the senior management team. This position is supported by a Maori Health Coordinator who works with the Wairarapa DHB's provider services to ensure that services are culturally relevant for Maori, staff development programmes include Tikanga Maori, and that Tikanga Maori is respected within the organisation.

3.3 Priorities for 2008/09

Wairarapa DHB Strategic Priorities and Directions

DHBs are expected to advance national priorities and strategies in ways that best meet the needs of their local communities, and maximize health gain for district populations. This is described in the DHB's Strategic Plan (DSP). Wairarapa DHB's DSP sets out the specific local population priorities and outcomes Wairarapa DHB intends to progress towards as it implements national policies and strategies.

The DHB's Strategic Plan for 2005-2015 sets out seven priorities for improving health and reducing inequalities in Wairarapa:

Wairarapa health gain priorities

1. Improving the health of Maori
2. Improving the health of people in low socio-economic groups
3. Improving the health of older people
4. Improving the health of children and youth
5. Reducing the incidence and impact of chronic disease
6. Reducing the incidence and mental illness and addictions
7. Reducing the incidence and impact of cancer

Wairarapa strategic directions

The Strategic Plan sets five overarching strategic directions or themes that will be followed to achieve progress in the priorities:

1. Increased connectedness between all health and social services across the continuum
2. Development of more holistic approaches by all services
3. Addressing common risk factors through healthier lifestyles
4. Increasing community wide collaborations across sectors
5. Continually improving quality and safety of services.

The DHB's priorities, targets and actions for 2008/09 have been determined from consideration of both national and local priorities to provide a plan that advances achievement of both Government and local goals.

National Strategic Context

In determining their population outcomes and priority actions for each year DHBs are required to address specific priority areas related to the New Zealand Health Strategy and the New Zealand Disability Strategy, as set out in the annual Minister's Letter of Expectations.

National Priorities for 2008/09

The Minister of Health's Letter of Expectations for 2007/08 requires DHBs to demonstrate progress in:

1. Value for money – better value provides more health care for more New Zealanders
2. Reducing the chronic disease burden, including implementing the Healthy Eating Healthy Action Strategic Framework, the Cancer Control Strategy and the Tobacco Control Strategy.
3. Reducing disparities, especially for Maori and Pasifika populations

4. Child and Youth health – implement current programmes and build on the well child review
5. Primary Health Care – improve the interface, through planning and working together with PHOs
6. Infrastructure – especially workforce development and co-ordinated information systems
7. Health of older people – continue to give priority to new service models

3.4 Prioritisation and Decision Making Principles

The Wairarapa DHB's task is to make decisions about what health and disability services or interventions to fund, for the benefit of the people of the Wairarapa, within the resources available. This requires prioritisation as health sector funding will never meet the unlimited demands for expenditure.

The DHB policy on prioritisation[1] outlines the decision-making principles to be applied to competing demands for limited resources. The agreed principles on which prioritisation decisions are based are:

- Effectiveness — the extent to which a proposed service will produce the desired outcome
- Cost — the total economic cost of a service proposal, and its affordability within available funding
- Equity — the extent to which a proposal is expected to reduce disparities in health status and outcome
- Maori Health — the expected impact of a proposal on Maori participation, partnership and protection, including development of Maori provider capability and capacity
- Acceptability — extent to which a specific service proposal is desired by the local community
- Consistency — with the New Zealand Health and Disability Strategies

The health equity assessment tools developed by the Ministry of Health are used to assist prioritisation decisions. These include: HEAT (the Health Equity Assessment Tool), the Health Equity Intervention Framework, and the Whanau Ora Health Impact Assessment toolkit.

3.5 Socio-economic status

Overall the Wairarapa shows rising socio-economic status with a smaller percentage of the population falling in the most deprived deciles at each successive census, and growing numbers in the least deprived deciles. However the gap between rich and poor may be increasing. The inequalities in life expectancy between different neighbourhoods in Wairarapa are greater than those found in most other DHBs.

3.6 Wairarapa Health Status and Needs

Wairarapa DHB regularly reviews information about the status of health in Wairarapa. The most recent Wairarapa Health Status Report, completed in 2005, indicates that the key issues for Wairarapa people are:

- *Maori health*: Maori have much worse health status than non-Maori, across nearly all indicators. However it is very pleasing to note that the most recent information shows some reductions in disparities in health indicators between Maori and non-Maori. For example, in 2007/08, rates of child vaccination are higher for Maori than for non-Maori, and Maori diabetes patients are showing greater gains than non-Maori diabetes patients.

[1] Wairarapa District Health Board Policy Prioritisation Principles and Process available on the DHB website

- *Mental health:* particularly alcohol and drug issues: In recent years Wairarapa has had rates of suicide above the national average, and has higher rates of intentional self harm/suicide attempt, and higher levels of hazardous drinking.

- *Cancer*: Cancer rates in Wairarapa are similar to those for New Zealand as a whole and
    - Rates of colorectal, breast, cervical and lung cancers are increasing faster in Wairarapa than nationally.
    - Lung cancer is much more prevalent in Maori
    - Prostate cancer is the most commonly diagnosed cancer.

- *Cardiovascular disease, diabetes and respiratory disease:*
  Wairarapa has:
    - High rates of ischaemic heart disease
    - High hospitalisation rates for stroke, congestive heart failure and ischaemic heart disease
    - High rates of hospitalisation and deaths due to diabetes, although diabetes case detection and management has improved significantly since 2001
    - High rates of respiratory diseases and deaths.

- *Child and Youth Health*
  There has been improvement overall in Wairarapa's child health indicators since 2001, particularly for Maori, but Wairarapa still has worse outcomes than national averages on several child health indicators, including:
    - Higher infant mortality
    - Higher rates of admission to hospital for avoidable conditions
    - More burns and poisonings in young children.

Overall
- Most deaths are from avoidable causes – heart disease, cancer, respiratory disease, and road traffic accidents. Wairarapa has higher rates of death from these causes than all New Zealand.
- Wairarapa has above average rates of hospitalisations from potentially avoidable causes and this is increasing.
- There are high rates of falls in those aged 65 years and above (29% above national rates)
- Wairarapa teenage birth rate has been falling but continues to be above the national rate
- Road traffic accidents are the top causes of death and hospitalisation for youth

Wairarapa shows better than average outcomes for:

- Hearing – fewer children fail the hearing test at school entry
- Oral health – less decay in children's teeth at year 8.
- Immunisations – very high rates achieved for both child immunisations and flu vaccination.

3.7 Monitoring and Reporting Performance

The DHB monitors and reports its performance against its District Annual Plan through a wide range of monthly, quarterly and annual reports.

Our performance monitoring and reporting systems relate to:

- Internal management and reporting to the DHB Board
- External reporting of financial performance against the three output classes
- External reporting of the population's health and other indicators – including quarterly reporting to the Ministry of Health of progress against the national Health Targets and Indicators of DHB Performance (IDPs).

The DHB's approach to managing each of these is:

Internal Management

A balanced mix of financial and non-financial indicators covering the whole range of the organisation's operations are measured and reported monthly to senior management and the Board.

Areas of focus in the internal measurements of performance are:

- Financial: Ensuring that finances are well managed and performance against budget is reviewed
- Consumers: Ensuring we are doing the right things to meet the DHBs consumer's needs – through regular surveys of consumer satisfaction and monitoring of complaints and compliments.
- Internal Processes and Systems: Ensuring that the things we do meet contractual requirements, and the objectives set out in this District Annual Plan, are performed efficiently, and accurately, and done on time.
- People, Learning and Growth: Ensuring the people in the organisation possess the core competencies, skills and knowledge to be able to deliver agreed objectives.

Performance is monitored monthly at multiple levels throughout the organisation, variances to target are accounted for and corrective actions embarked upon where appropriate.

External Reporting of Financial Performance

Financial reporting complies with the Ministry of Health's reporting guidelines including the monthly reporting of financial performance. These guidelines specify separate reporting requirements for each output class and a consolidation for the whole DHB.

External Reporting of the Population's Health and Other Indicators

The Wairarapa DHB reports to external parties on the Health Targets and IDPs set by the Ministry[2]. These indicators focus on measuring non-financial DHB performance in the Governments priority areas, as identified in the New Zealand Health Strategy and the Ministers stated annual expectations.

The current set of Health Targets and IDPs focus on national priority areas where the DHB is responsible as the funder. In addition, other aspects of financial and provider arm performance are reported quarterly through the Balanced Scorecard.

The DHB reports to its community and other stakeholders through its Annual Reports and other ad hoc publications.

3.8 Consulting with the Wairarapa Community

Community engagement and consultation are fundamental to good decision-making and development of effective plans. Consultation is both a process towards, and a key component of, community engagement. The Wairarapa DHB aims to fulfil its obligations to consult in positive ways that result in decisions leading to better or more appropriate services, improved health outcomes, and increased value for money.

The main purpose of consultation is to enhance the quality of planning and decision-making by enabling the community to review and contribute to these processes. Consultation should also contribute to increased community understanding of the role of the Wairarapa DHB, the parameters and constraints within which it operates, and the overall direction of national health policies and strategies.

[2] Performance measures and other indicators are shown in Appendix 7 of this plan

The Wairarapa DHB consultation policy[3] covers both formal and informal consultation processes. These include: advisory groups, focus groups, hui, public meetings, workshops, surveys, informal communication with individuals and groups, and provision of written information for comment and submissions. The choice of process or processes used for any particular project or issue is dependent on the purpose of the consultation, the groups that are affected, the complexity of the issues involved, and the significance of the consequences of the decisions to be made – how many people will be affected and to what extent.

We recognise that there are also specific requirements for consultation with disabled people. Consultation must occur in accessible settings and a variety of communication methods are used.

Specific groups have been established to facilitate the consultation process including:

Te Iwi Kainga

There are specific requirements for consultation with Maori. Te Iwi Kainga meets with the Board at a minimum of four times a year, and works in association with the Maori Health Committee, and the Director of Maori Health, to advise on and guide the DHBs plans and processes for consulting with Maori. This consultation recognizes the Wairarapa DHB's Treaty partnership with Mana Whenua but is also inclusive of mataa waka.

Service Advisory Groups

In addition to its consultation policy, the Wairarapa DHB has a number of processes in place to enable engagement with the community and special interest groups. A number of groups meet regularly with Wairarapa DHB staff. These include:

- Mental health local advisory group
- Local diabetes team
- Respiratory services advisory group
- FOCUS advisory group, and
- Health of the Older Person advisory group.

During 2008 an advisory group for Child health will be established.

Intersectoral Working Groups

Wairarapa DHB staff also meet regularly with other groups and organisations including: Strengthening Families, Youth Offending Team, Violence Free Wairarapa, Wellington Region Leaders Forum, and Wairarapa Territorial Local Authorities Chief Executives group, Healthy Homes, Masterton Safe and Healthy Community Council, and the Wairarapa Safe and Healthy Community Council.

Pacific Participation

The Wairarapa DHB must ensure that the needs and issues of the growing numbers of Pacific people are considered and responded to effectively and appropriately. The Wairarapa's Pacific population is small and diverse and currently comprises only 1.7% of the population with an estimate that this will grow to 1.9% over the next ten years. There are no Pacific service providers, and Pacific people, like Maori, are very under-represented among the staff of mainstream providers. The Wairarapa DHB is working with the PHO to develop its links with Pacific communities to ensure they have opportunities to participate in planning.

In early 2008 Pasifiika Wairarapa was established as a community trust. This is a huge step forward for the Pacific community in Wairarapa. The trust will provide a Pacific voice and advocacy for Pacific needs.

[3] Wairarapa District Health Board Consultation Policy is available on the DHB website

Proposals for ensuring improvements in secondary service responsiveness to Pacific people are discussed and developed jointly with other DHBs. Pacific services in Hutt, Wellington, and Porirua provide liaison, advice and support on cultural matters to Wairarapa mainstream services that have Pacific clients.

3.9 Achieving Service Coverage and National Consistency

The Ministry of Health's Service Coverage Schedule specifies the minimum access, scope and eligibility to publicly funded services that the population can expect. Wairarapa DHB is committed to meeting the national service coverage requirement and does not expect any exceptions to this to occur for residents of Wairarapa during 2006/07.

Not all services are available locally within Wairarapa and travel to publicly funded services in other districts is required for a range of services.

Services Provided for Wairarapa by Other District Health Boards *:*

- Regional Cancer Centre – mostly MCDHB
- Tertiary services for treatment of cardiovascular diseases- mostly C&CH Renal dialysis services C&CDHB
- Specialist mental health and forensic services C&CDHB
- Outsourced Acute Mental Health Services HV & MC DHBs
- Specialist child and neonatal services C&C & ADHB
- Termination of Pregnancy Services in second trimester C&CDHB
- Residential Psychogeriatric Services provided by various districts
- Retinal Screening Services through WIPA.

The Wairarapa DHB recognises the need for national consistency across services and wherever possible, uses the National Service Framework when funding services, including use of national service specifications, purchase units and standard contract forms. The DHB at all times observes the mandatory requirement that all services it funds must comply with the Provider Quality Specifications set out in the National Service Framework.

Wairarapa DHB cannot ensure provision of all services within the district. Some services, particularly those that are very specialised are only available on a regional or national basis. For services that cannot be provided within Wairarapa, the DHB has funding arrangements with other DHBs, so that services provided by other DHBs to Wairarapa DHB domiciled residents that are funded appropriately by Wairarapa. Wairarapa DHB also has an MOU with Hutt Valley DHB that promotes sharing of staff and resources between the two DHBs.

4 KEY ASSUMPTIONS, ISSUES, AND RISKS IN 2008/09

4.1 Assumptions

In putting together this plan and budget for 2008/09 Wairarapa DHB has made the following assumptions:

1. All pressures for additional expenditures must be managed within Wairarapa's total revenue for 2008/09 of $106M.

2. The DHB's funding allocation from Government includes the FFT (forecast funding track) annual increase in DHB funds, which for 2008/09 allows for price inflation of 2.8%,
   a. Less 0.5% for the efficiency gains expected of DHBs
   b. Plus 0.5% for expenditures on new/additional technologies, including higher IDF prices
   c. Plus 0.25% for expenditure on hospital quality improvement initiatives to support the national QIC programme
   d. Plus 0.25% to meet the costs of collective procurement initiatives.

3. Large efficiency gains will continue to be made by the DHB to offset the costs of previous MECA settlements that are greater than FFT. Further ongoing efficiencies will be realised to offset costs of any future MECAs settled above FFT.

4. The price increase to be agreed by DHBs collectively for national contracts will be no greater than FFT. This includes all prices in DHBs' service agreements with providers of:
   a. Primary health care services
   b. Aged residential care services
   c. Oral health services
   d. Pharmacy services
   e. Blood and blood products

5. Volume growth in key demand driven areas of service provision will be:
   a. 7% in number of prescriptions dispensed
   b. 5% in aged residential care
   c. 0-2% in acute presentations to Wairarapa hospital

6. Costs of new initiatives required by Government in 2008/09 will be fully funded by specific additional funding allocations to the DHB. This includes the roll-out of Before School Checks; and possible introduction in 2008/09 of hearing screening for newborn babies; HPV vaccination against cervical cancer; and reduction in patient co-payments for dispensing of scripts written by hospital doctors.

7. Interest and foreign exchange rates will remain within the bounds of Treasury forecasts as at January 2008.

8. Wairarapa DHB will retain early payment status

9. The impact on the DHBs' cash flow of moving to payment in advance for IDFs will be able to be managed within the DHBs' overdraft limits and will not impact adversely on the DHBs' facility development and capex programmes.

10. Government will fully fund the costs to the DHB of implementing Kiwisaver

11. The growth in expenditure on pharmaceutical cancer treatments in 2008/09 will be $200,000 based on Wairarapa utilising its population share of the projected national increase of $20M.

4.2 Key Risks

All DHBs face pressure from additional expenditure which must be managed within allocated funding. For 2008/09 management of expenditure pressures will require considerable restraint, and focused exploration of productivity improvements. In employment negotiations there will be continued focus on increased workforce flexibility, increased productivity, and fair and reasonable wages that are affordable. The DHB will have to manage staff numbers to appropriate levels and implement changes to service configuration. These efforts will be prioritised within the DHB's service review and development priorities for 2008/09 – hospital acute and rehab services.

Broadly speaking, the DHB faces two types of risks: those we can manage by ourselves – those internal to the DHB itself - and external risks that fall more broadly across central region DHBs, and/or the DHB sector as a whole. We can only manage these external risks by working jointly with other DHBs.

The biggest risks facing the DHB going into 2008/09 relate to:

- Clinical safety and quality
- increasing labour costs from new multi employer collective agreements (MECAs)
- managing delivery of acute services within budget,
- maintaining performance on elective services
- services for older people
- IDFs and regional services
- expenditure on pharmaceuticals and pharmacy services

Internal risks

Clinical Safety and Quality

Our greatest risk is that we fail to maintain clinically safe services. This risk is increasing due to increasing shortages in the health workforce, heavy reliance on locum staff, increasingly complex technologies, growing reliance on IT, and the increasing need to achieve productivity gains to remain within budget. The challenge of balancing the need to improve access and outputs against the need to maintain clinically safe and sustainable services within budget is increasing sharply.

To meet this challenge and manage the risk, as well as investing in direct patient care, we must also increase our investment in clinical governance, quality systems and internal audit to ensure we continue to meet standards and recognise and manage increasing pressures on the clinical workforce. This risk is managed through our clinical board (responsible for clinical safety) and quality management and infection control departments. In 2008/09 we will give increased focus to further development and strengthening of clinical governance and increase staffing in the quality department.

Increasing labour costs from new multi employer collective agreements (MECAs)
Achieving efficiencies and ensuring value for money

Costs of MECAs are an internal risk to the extent that they need to be offset by increasing efficiencies. Over the past three years Wairarapa DHB has been exceptionally successful in realising efficiencies in the delivery of its hospital services. In 2007/08 there have been very large increases in productivity as new models of care became fully operational. This has enabled the costs of very large MECAs agreed in 2006/07 to be met, and the DHB's financial targets to be achieved, however finding further large efficiencies as we go forward is becoming much more difficult. We manage this risk through our ongoing focus on value for money, strong management, review and performance monitoring.

Managing demand for hospital acute services

In 2006/07 and 2007/08 provision of hospital acute services has continued to increase and is now above financially sustainable levels. The DHB needs to reduce acute admissions to hospital and expenditure back to budget. This is a key challenge for 2008/09. Several projects are in place to reduce pressure on hospital services.

Maintaining Green status on all electives services indicators and delivering elective services volumes to plan

The DHB needs to stay green on all indicators to maintain its early payment status. If early payment status is not maintained the DHB cannot achieve financial breakeven. Also, to access funding for additional elective services, the DHB must maintain green status and deliver service volumes as planned and agreed with the Ministry of Health. Ability to deliver services to plan is dependent on maintaining the clinical staff required, which is at risk through reliance on locums and visiting specialists. The electives services manager engages in detailed workforce planning to minimise this risk.

Changing capacity and capability

Although change processes implemented over the past three years have provided excellent outcomes, this needs to remain a key focus for the DHB. Ongoing active management of resources and continuing passion for improving outcomes are required to ensure that the DHB continues to deliver services effectively and efficiently. DHB operational objectives cannot be achieved unless there are continuing changes in organisational culture, behaviour and capability. This is addressed through ongoing training, consultation and communication with staff – see workforce section of this plan.

Ability to recruit and retain clinical workforce

While issues regarding the need to maintain a stable workforce are not unique to Wairarapa, the impact on Wairarapa of any workforce gaps is significantly higher than for larger DHBs due to the lower establishment numbers of any one type of clinical staff. We manage this risk through effective human resource management, judicious use of locums, and participation in national and regional workforce development and recruitment initiatives. As the workforce continues to change this risk will increase.

Aged Residential Care services

There are significant risks regarding continuity and future sufficiency of provision of aged residential care services in Wairarapa:

- Growth in service need is outstripping growth in funding
- Small local service providers may not be financially viable.

While to some extent these risks are common to all DHBs, there are some aspects unique to Wairarapa. Wairarapa has an older population than other DHBs and is aging more rapidly. In addition Wairarapa has more very small providers of aged care residential facilities than other DHBs. These small providers cannot achieve the economies of scale necessary to assure ongoing viability. We are managing these risks by working locally with service providers to find and implement effective local solutions, and with other DHBs and the Ministry of Health to address those aspects that require a national approach.

External risks

MECAs

The future costs of implementing recently agreed wage and salary settlements are a very serious financial risk to the DHB sector, with existing settlements projected to outstrip sector revenue growth by $350M within three years. In addition there are several more wage negotiations still to be resolved in 2008 and 2009 which will increase this number substantially.

Continuing wage and salary growth at affordable rates is the DHB's biggest financial risk in 2008/09. Employee remuneration expectations need to be brought into line with Government's expectations for health sector funding and productivity growth. This is being addressed by DHBs collectively through a series of sector–wide negotiations with different workforce groups.

The flow-on impact of DHB wage and salary agreements to the DSS and NGO sectors is also a significant risk in terms of price increase expectations and sustainability of community and disability support services. This is being managed both locally through close communication with the DSS and NGO sector, and, where appropriate, nationally through collective DHB negotiation of nation-wide service agreements.

A 1% change in DHB personnel costs has a financial impact of $306k per annum

IDF and Regional service risks

Wairarapa experiences significant volatility in IDF costs. We manage the volatility risk by keeping a contingency fund. The risk is increased in 2008/09 as, due to other pressures on expenditure the size of the contingency fund has had to be reduced.

We are face increasing pressures on IDF expenditure due to:

- National increases in prices for highly specialized services, greater than FFT
- Increasing application of new technologies.

A specific risk in 2008/09 is increasing expenditure on radiotherapy services as the third linear accelerator at Capital and Coast comes on stream. This has been budgeted. Another additional risk in 2008/09 arise from the unbundling of pharmaceutical cancer treatment costs from other oncology treatment costs. Pharmaceutical treatments for cancer (PCTs) are now a separate payment line in IDFs. Due to data limitations there is a large element of uncertainty about the amount that has been budgeted for PCTs (see below).

Central region DHBs are agreed that IDF issues should be addressed jointly and that each DHB can more effectively and efficiently meet its obligations to its local population by working together on shared regional approaches. This risk will be managed by active engagement and dialogue with neighbouring DHBs, and strong advocacy.

A 1% change in net IDF costs has a financial impact of $190k per annum.

Pharmaceutical cancer treatments

For 2008/09 pharmaceutical cancer treatment (PCT) costs have been unbundled from other cancer treatment costs and will be billed for separately. There are serious doubts about the robustness of the calculations and a risk that the amount estimated is around $10M less than the actual expenditure in 2007/08. In addition there are huge growth pressures on PCTs. We have budgeted $200k for extra expenditure on PCTs in 2008/09 (our population share of $20M) in the expectation that $20M will be sufficient to meet additional PCT costs nationally. However this is based on another assumption – that Wairarapa's need for PCTs reflects its share of the national population. This may be an under estimate as Wairarapa's population is older and rates of some cancers in Wairarapa are above national averages,

Pharmaceuticals and Pharmacy Services

There are several drivers of the DHB's uncapped, fee-for-service expenditure on pharmaceuticals and pharmacy services and significant risk that it will exceed budget. A major driver is the increasing focus on population health screening as the diabetes and CVD risk programmes roll out, another driver is the aging population. This risk will be addressed by working closely with:

- Other DHBs and pharmacy groups to develop new agreements for pharmacy services and manage growth in fees for pharmacy services

- Other DHBs, PHARMAC, and the primary health care sector, to plan and manage expenditure on pharmaceuticals

A 1% change in pharmaceutical demand driven costs has a financial impact of $114k per annum

Quantification of Major Risks

The table below shows estimates of the financial impacts of meeting service growth pressures over the next three years, so as to maintain current levels of access to services. The total financial impact of all risks for 2008/09 greatly exceeds the available contingency fund, however we are assuming we can manage these risks in 2008/09 so as to remain within budget and achieve break-even. Figures in the column headed 'Risk 2008/09' indicate the financial impact if this is not achieved.

For 2008/09 and 2009/10 we consider that further growth in aged care needs and volumes, pharmaceutical expenditure (including new cancer drugs), and expenditure on regional services, including IDFs, will add further risks. Managing these risks within the available funding for 2008/09 and 2009/10 will be a considerable challenge.

The projected required growth in Aged Care volumes is estimated at 2% and 2.5% above the 2% 'affordable' increase in each year, the affordable increase being that which can be funded through the DHB's expected demographic funding adjustment.

Volume and price pressures for increased expenditure on out of district services are growing strongly. The planned increases in linear accelerator capacity and other new technologies will impact further on IDF arrangements for 20009/10 and 2010/11.

Risk	**Risk 2008/09**	**Risk 2009/10**	**Risk 2010/11**
Failure to maintain green status on ESPIs, with subsequent loss of access to additional funds	$692k	$692k	$692k
Failure to meet DHB performance requirements and subsequent loss of early payment	$420k	$430k	$430k
Wage growth above FFT 1% increase in wages costs DHB provider $290k – flow to NGO sector in out-years	$290k	$556k	$556k
Industrial action – extra costs incurred in maintaining minimum services	$200k		
Aged Care risks, provider failure and volume growth above rate of demographic funding increase.	$200k	$300k	$400k
Pharmaceutical expenditure, PCTs, and community pharmaceuticals	$230k	$250k	$540k
Baseline growth in IDFs and Regional Services as new services and treatment regimes come on stream – Radiotherapy, Brachytherapy, Cardiology	Minor - manageable within contingency fund	$570k	$760k
Implementation of InterRAI		$133k	$70k
TOTAL	**$2.03M**	**$2.93M**	**$3.45M**

Major Risks Affecting Wairarapa DHB in 2008/09

Risk	Why a concern	Strategy to address
1. MECAs – settlements in excess of FFT	• DHB funding path assumes settlements are no greater than the growth in the labour cost index • Higher settlements mean DHB cannot achieve financial targets • Risk of industrial action and service disruption	• Joint strategy with other DHBs to negotiate settlements within DHB funding parameters • Escalate issues appropriately, including informing Ministry of Health
2. Identification and mitigation of clinical risk	• Clinical competency systems required • Ability to learn from adverse events • Assurance that clinical practice complies with best practice guidelines • Complexity of health care regime • Robust systems in place to mitigate risk	• Reportable Event Group • Credentialling • Professional Recognition Development Programme • Monitoring of events – Clinical Board • Mortality & morbidity meetings • PQAA policy and associated reporting requirements • Complaint systems • Policy development • Clinical audit • Open disclosure policy • Clinical Audit programme
3. Workforce recruitment and retention	• Difficulties in attracting appropriately skilled clinical staff – Provider arm requires staff with high level generalist and specialist skills, who are able to practice autonomously	• Work with national and regional recruitment initiatives • Continue to support development of local nurse workforce through UCOL and NETP programmes • Develop succession planning initiatives and relevant skills in managers. • Develop workplace environments that encourage retention.
4. Viability and sustainability of regional services	• Risk of loss of service coverage and access if regional specialty closes down. • Increased pressure on travel and accommodation budget if patients referred outside the region	• Work with other regional DHBs to identify and analyse issues • Work collaboratively with other regional DHBs to agree services required and sustainable funding path for them • Negotiate exceptions to service coverage, if required
5. Achievement of new efficiencies	• Achieving breakeven requires realisation of all planned efficiencies	• Strong project management and control • Regular reporting and monitoring of progress • Strong internal communications
6. Inter District Flows (IDFs) – net outflow greater than expected	• Greater than expected use of specialist services of other DHBs and application of wash-up provisions create unexpected drain on Wairarapa funds. • IDF patient/service flows are uncontrolled • Small DHB has less capacity to absorb volatility in high cost patient numbers than larger DHBs	• Maintain contingency fund • Implement IDF budget management strategy with all referrers • Contain/reduce IDF outflows by maintaining greater skill base at Wairarapa hospital.
7. Workforce culture, capability and capacity – loss of momentum as change processes wind down	• Ongoing changes in DHB provider workforce are critical to realisation of: • Best practice and new models of care • Achieving efficiencies • Ongoing changes required in both numbers of staff and ways of working • Recognition that leadership and management competencies are vital to organisational capability	• Continue comprehensive service development and change management programmes • Ongoing consultation and engagement with staff in all disciplines • Focus on a comprehensive training programme for existing and aspiring managers at all levels in leadership and management skills
8. DSS Provider failure – due to financial viability and/or staffing issues	• Prices do not cover costs • Scale diseconomies - Most Wairarapa providers are very small scale • Service providers could exit suddenly – leaving vulnerable patients stranded • Questionable clinical viability of some services in face of staffing difficulties	• Maintain close liaison with providers and identify early warning signs • Participate in national working groups to identify sustainable solutions • Encourage providers to work together to share costs as far as possible • Maintain contingency plans • Escalate issues appropriately, including informing Ministry of Health
9. Insufficient supply of Aged Residential Care services to meet future needs	• Total current residential care capacity is fully utilised • Shortages impact on operational efficiency of Wairarapa Hospital	• Continue to analyse and quantify needs • Work with providers to develop short and longer term solutions including home support options for people with very high need levels • Escalate issues appropriately, including informing Ministry of Health
10. Provider failure – due to poor contract performance	• Indications of serious inadequacies in service provision can arise suddenly, necessitating contract exit and rapid development of alternative arrangements for service delivery	• Effective monitoring and audit programmes in place • Early identification of concerns • Develop tailored solutions to address specific concerns • Exit contracts where resolution not achieved
11. Growth in expenditure on pharmaceuticals and pharmacy services	• Expenditure on pharmaceuticals is demand driven and uncontrolled • Expenditure on pharmaceuticals and Pharmacy services is rising faster than DHB funding	• Continue to work with local pharmacists and Wairarapa Community PHO to achieve effective management of prescribing and expenditure
12. Carer support for older people	• Regional increase in Carer Support allowance to cover FFT from 2003 – 2008 • Ministry action plan for Implementation of Carer Support Strategy – all DHBs	• Quantify amount and compare with Ministry allowance rates for younger people with disabilities • Agree DHB actions in principal, but these will not be cost neutral.

4.3 DHB funding for 2008/09

The Crown Funding Envelope

The DHB expects to receive $99,589,231 in revenue through its Funding Agreement with the Crown, and $2,838,149 for provision of services to residents of other DHBs, giving a total funding envelope of $102,427,381. Wairarapa DHB expects to pay other DHBs $19,010,788 for services they provide to Wairarapa residents, leaving $83,416,592 available to operate the DHB and fund services for Wairarapa residents within Wairarapa.

After allowing for funding increases for specific adjustments, in 2008/09 Wairarapa DHB will receive about $4.5M more in its funding envelope than in 2007/08. This increase is comprised of the adjustments for the Future Funding Track (FFT) and demographics.

FFT is an annual adjustment by government to enable DHBs to accommodate increases in costs of services due to movements in the consumer price increase (CPI) the labour cost index (LCI) and technological growth, after allowing for efficiency gains.

Other sources of funds

Revenue from sources other than the Crown Funding Agreement is expected to be $9m. This funding includes revenue from ACC, the Clinical Training Agency, Elective Services funding and other funding from the Ministry of Health not included in the Crown Funding Agreement as it has yet to be devolved.

Contingency Fund

In each of the last two years the DHB has set aside a sum to meet any unplanned contingencies that may arise. This has been invaluable in enabling unexpected swings in IDFs and faster than expected growth in demand driven expenditures to be accommodated without reduction of planned expenditure in other areas. We have again budgeted for a contingency fund in 2008/09.

4.4 Allocation of funds

The tables below shows the allocation of the DHB's revenue in 2006/07, 2007/08, and that planned for 2008/09. All figures are GST exclusive. Table 1 shows the allocation of the Crown Funding Envelope revenue.

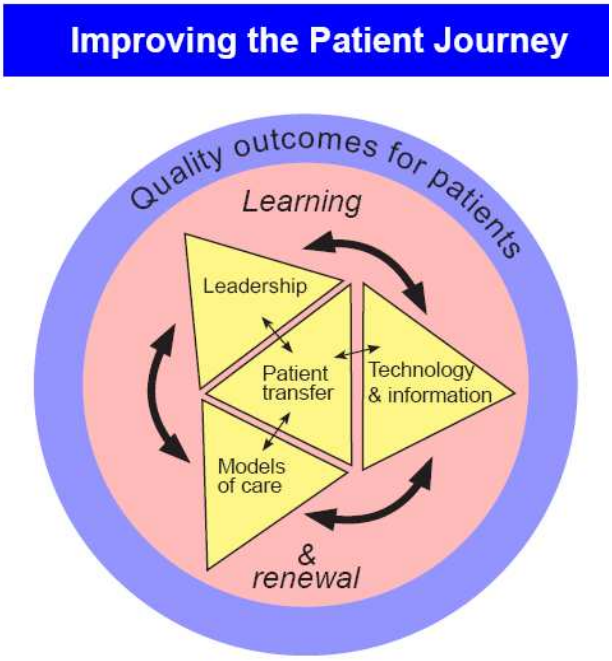
Table 1: Crown Funding Envelope Allocation

Expenditure category	2006/07 $	2007/08 $	2008/09	Comment
DHB provider total	38,727,647	39,505,472	42,783,449	Increased by $33m or 8% mainly due to costs rising >7% and increased volumes for acute demand.
DHB governance and administration	1,600,000	1,736,898	1,731,228	
Demand driven primary care items	9,738,727	11,022,598	11,361,043	Main expense is pharmaceuticals, growing at 7% per annum. Budget includes $200k for PBF share of Pharmaceutical Cancer Treatments (PCT's) and $200k for Value Added Services.
Services purchased from other DHBs (IDFs)	15,936,765	14,223,517	15,774,106	Increase due to change in national prices (eg CWD price up 6.6% on 07/08). Volumes based on 06/07 actuals.
DSS –residential aged care	8,803,883	8,627,902	9,577,606	5% volume increase plus FFT.
DSS – aged care – non residential	1,468,959	2,313,681	2,422,485	FFT increase for prices, plus 3% for volume growth
Medlab Central	0	3,157,500	3,257,000	Laboratory services as per contract (started 1/3/07).
Wairarapa PHO	4,441,043	6,878,477	6,492,386	FFT increase applied to 07/08 forecast actual costs. Primary MH initiatives to be funded directly by the MOH in 08/09 (est $201k).
Other personal health NGO's	716,207	1,464,832	1,261,893	.
Maori Health NGO's	543,931	566,525	575,472	FFT increase.
Mental Health NGO (includes Maori provider)	2,994,793	3,521,303	3,825,209	Includes FFT increase plus $199,000 Blueprint funding.
Contingency for risks	648,737	676,745	527,354	
TOTAL	**85,620,692**	**93,695,450**	**99,589,231**	

5. PRIORITY ISSUES AND ACTIONS FOR 2008/09

In 2008/09 Wairarapa DHB will continue to be guided by its District Strategic Plan and pursue the same overarching goals and strategic directions as in 2007/08, but with increased focus on the seven priorities set out on the Minister's Letter of Expectations for 2008/09.

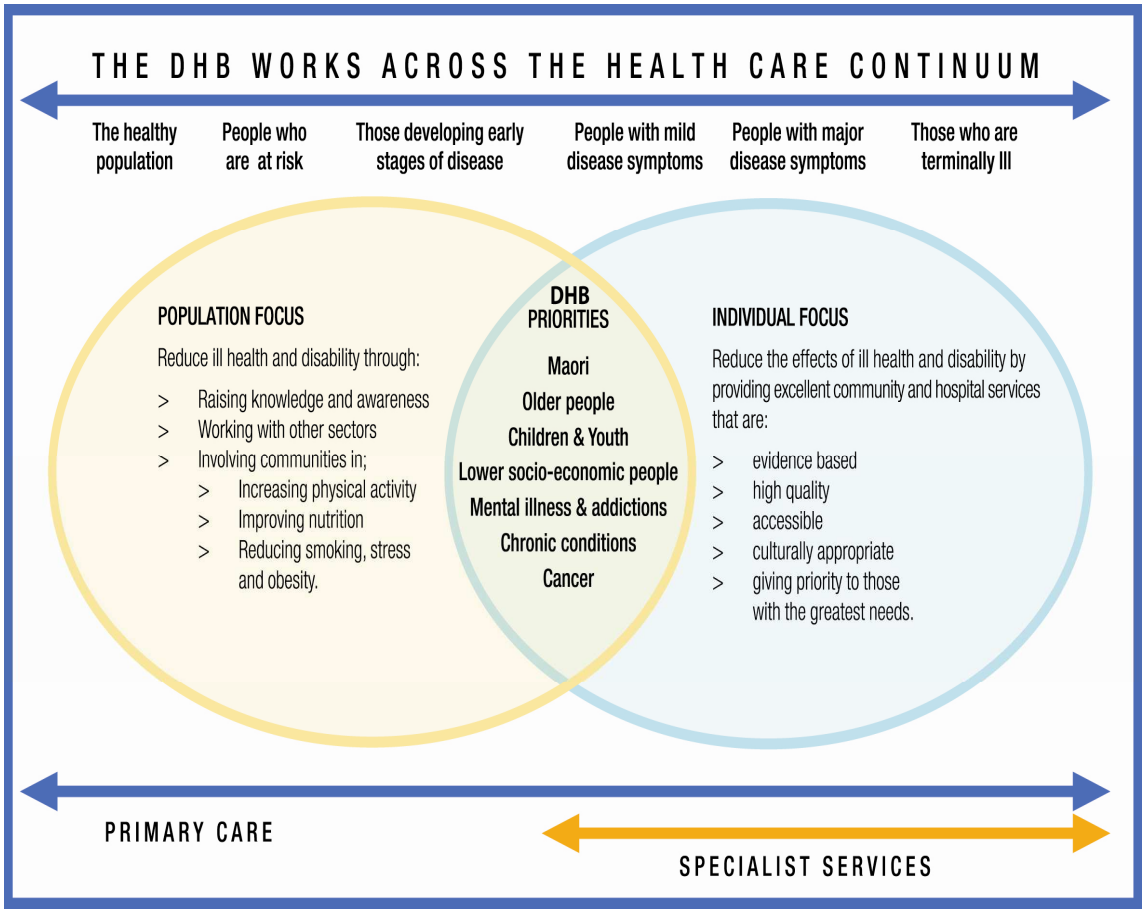
During 2007/08 Wairarapa DHB introduced a major new programme to improve the patient journey. Eventually the programme will cover the entire patient experience through primary care, outpatients, inpatient services, and support services. This is a continuous quality improvement programme that will be ongoing. It is a journey, not a destination. It will cover all aspects of DHB activity.



This project underpins and is closely associated with several QIC initiatives, and with the strengthening of clinical governance in Wairarapa DHB and roll out of the Wairarapa Maori cultural competency framework. The cultural competency framework is a tool being developed by Wairarapa iwi to enable health services to measure their responsiveness to Maori.

Implementing the District Strategic Plan

As detailed in section 1.3, Wairarapa DHB's strategic plan sets the DHB's overarching strategic directions, or themes, for addressing each of the DHB's priority outcomes. The DHB's priorities and strategic directions align well with those of government. The DHB approach is to work with others across the whole continuum of need, using both population and individual approaches, with increasing emphasis on health promotion and disease prevention. This is summarised in the following diagram.



The sections that follow outline the DHB's achievements and plans for each DHB priority and Ministerial expectation.

5.1 Increasing Collaboration

It is a function of DHBs:
"To actively investigate, facilitate, sponsor and develop collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion in society and independence of people with disabilities".

New Zealand Public Health and Disability Act, 2000

"The DHB's vision and goals can only be achieved through joint working with a wide range of other agencies and individuals ….. It is fundamental to our plans and strategies that they are shared and supported by other agencies, both within and beyond the health sector. Without broad support from other sectors and agencies health initiatives and strategies will achieve only limited success".

Wairarapa District Strategic Plan 2005

Working collaboratively with others, across sectors, and increasing connections between health and social services are key themes in the District Strategic Plan. Wairarapa DHB actively progresses collaboration at several levels. The DHB maintains effective formal relationships and collaborations with a large number of agencies and groups. The full list of these is appended. There are also many informal relationships and links.

Working with our local communities

Over recent years the DHB has build sound collaborative relationships with local government and key community groups. There is widespread community ownership of the DHB's vision and goals and growing understanding of the societal determinants of health – that health is everybody's business. This is encouraged to develop further through a strongly consultative approach to development of new strategies and initiatives, with hui and open community meetings held to debate significant issues and new developments.

Wairarapa DHB has strong relationships with the three local territorial authorities and contributes to some joint planning processes with them. Examples of this include the Active Wairarapa Plan, LTCCPs and the Regional Land Transport Strategy.

In 2006/07 and 2007/08 Healthy Eating Healthy Action was the main focus of collaborative action within the district. The Wairarapa approach to HEHA already has strong cross sectoral and local government support and involves stakeholders from all parts of the community, including all three mayors and the regional commissioner for the Ministry of Social Development.

Working with other sectors and Government agencies

The DHB works with Work and Income, the Ministry of Social Development, ACC, SPARC and the education sector to identify and use opportunities for shared approaches to common problems. This is particularly important in progressing implementation of 'whole of government' strategies such as the National Suicide Prevention Strategy, and the New Zealand Disability Strategy. Work and Income staff sit on the DHB's Health of Older People Advisory Group and Family Violence Steering Group, and are involved in implementation of the DHB's programme to provide low cost emergency dental care to people on low incomes. Relationships with ACC and SPARC revolve around shared strategies for reducing falls, improving balance, and increasing physical exercise, in conjunction with implementation the multi-agency active Wairarapa plan.

Working with the PHO and other local health and disability service providers

Further development of primary health care, increasing focus on population health approaches, and a more cohesive interface between primary and secondary services are essential to the development of better health care and improvements in health status. Wairarapa DHB and Wairarapa Community PHO work together to agree their joint annual plans and objectives.

Working with other DHBs

For the Wairarapa, strong co-operative regional and sub-regional relationships are essential to ensure that full and efficient service coverage is maintained for Wairarapa residents through access to the services provided and/or funded by other DHBs, and to provide and promote specialist back-up and peer review for services delivered in the Wairarapa. Particularly close links have been established with Hutt Valley DHB. Wairarapa and Hutt Valley DHBs have a memorandum of understanding to work together. Services that have benefited from this agreement include ENT, plastics, general surgery, mental health and public health.

The Wairarapa DHB is committed to:

- Sharing of resources with neighbouring DHBs and with other providers
- Working collaboratively with all central region district health boards
- Working collaboratively with the Ministry of Health
- Working collaboratively with DHBNZ.

CENTRAL REGION DHB COLLABORATION

Collaboration with other DHBs is essential to assist achieving effective, efficient and high quality services. Central Region DHBs (Capital and Coast, Hutt Valley, Wairarapa, Whanganui, MidCentral, Hawke's Bay) work closely together on a number of endeavours and continue to invest in their shared service agency, Central Region Technical Advisory Service Limited (TAS) to support much of this work. TAS is jointly owned by the six District Health Boards in the Central region and each District Health Board participates in its governance through the board structure.

A service level agreement is negotiated each year and outlines the work programme which typically includes the following components; health information and analysis, service planning (mental health and personal health), audit services and administrative and coordination support for regional groups. Investment into regional work increased over 2007/08 following the decisions to progress Cardiology Project implementation and develop a Clinical Services Plan for the Central Region.

What progress was made in 2007/08?

The Central Cancer Network (CCN) is one of four Ministry of Health funded regional networks established in line with the Cancer Control Strategy and is being led by MidCentral DHB. In addition to the Central Region DHBs the CCN encompasses Taranaki, Tairawhiti, and Nelson/Marlborough to reflect referral flows in the region. The Network consists of broad representation of clinicians, consumers, Pasifika, Māori and DHB representatives. Two clinical director positions have been established to provide clinical leadership and advice across the continuum of care. The positions report to the chair of the network and have been established in the two treatment centres in Wellington and MidCentral.

The Network has progressed an annual programme of work aimed at achieving the reduced incidence and impacts of cancer. Central to this programme of work is the establishment of multidisciplinary clinical teams to address patients' needs in a timelier and clinically appropriate manner.

Core technical work continued at TAS with the focus being on the Health Needs Assessment (HNA) analysis work to be used as input into local DHB HNA documents. For the first time a Central Region HNA has also been produced to provide a summary document of the region's strategic health needs.

A regional computer network now links all regional DHBs and TAS. This network is an enabler for the sharing of clinical information such as medical images and administrative information such as service contracts.

Service Initiatives

Regional service development work concentrated on progressing the implementation of the recommendations of the prior Plastics & Burns and Cardiology service reviews and a review of Renal Services.

- The Plastic & Burns project established a Service Leadership Group (SLG) and work is progressing in four work streams; Head and Neck Cancer Services, Breast Surgery, Workforce, and Improving the Patient Experience.
- An Implementation Plan for Cardiology was approved mid 2007 and a regional Clinical Director and Project Manager have been appointed to lead the three year work programme. The high priority initiative to increase the Cardiac Technicians workforce commenced in October with an expected completion date of April 2008.
- The Renal Services Project completed a review of renal services over the first half of the year. Recommendations included intervening earlier in the course of Chronic Kidney Disease and increasing the number of kidney transplants performed at Wellington Hospital. A Renal Network is being formed to advance this work.

The Regional Mental Health Service Plan was completed and endorsed in mid 2007. This plan provides the framework for all local and regional mental health service development across the Central region. TAS undertook a gaps analysis between the current state of Mental Health services and the desired future state. A prioritised action plan will now be developed for progressive implementation of the Regional Mental Health Service Plan over the next three years.

Regional Clinical Services Plan

Following a decision at the 2007 Combined Boards meeting, a project to develop a Regional Clinical Services Plan (RCSP) was initiated in July 2007. The RCSP will provide the framework for the region's future service development and investment. This significant project has required a high level of participation from DHBs, particularly at the senior management and clinician level. Development of the plan has involved a research and evidence based component (horizon scan and data analysis) and a series of strategic planning workshops. The combination of material will be used to develop a range of models for delivering services in the Central Region, which will form the core of the RCSP.

Although the scope of the RCSP is limited to hospital services (excluding Mental Health) the involvement of other stakeholders such as consumers and primary health is particularly important so the plan can give consideration to the wider continuum. This wider involvement is being achieved in a variety of ways such as workshop participation, stakeholder forums and communication approaches. The Ministry of Health are also contributing to ensure the project is linked with national objectives.

The draft RSCP will include a decision-making process to support the use of the RCSP and will be considered by the Combined Boards in May 2008.

What is planned for 2008/09?

Central Region DHBs will progress a range of collaborative initiatives in 2008/09 including:

- implementing the work programmes for the service development initiatives already underway:
  - Plastics, Burns and Maxillofacial Surgery
  - Cardiology Services
  - Renal Services

- complete establishment of CCN work streams in the following areas; prevention, early detection and screening, diagnosis and treatment, support and rehabilitation, palliative care and research and surveillance and tumour specific steering groups. Implementation of the CCN Work Plan including development of Local Cancer Networks against CCN guidelines, development of a shared operations framework and a regional strategic plan
- progression of the recommendations of the 2004 ENT (Otorhinolayngology, Head and Neck Services) review
- implementation of a communications plan focusing on wide engagement and consultation on the draft RCSP
- developing an implementation plan for key priorities identified in the RCSP
- progression of the shared learning Acute Demand Project aimed at identifying successful strategies and tools to assist DHBs to manage acute demand
- implementation of the Mental Health Service Plan
- finalisation of the Regional Information Systems Strategic Plan based on the priorities identified in the RCSP
- data warehousing and improvements in information management and reporting capabilities
- regional repository of medical images (regional PACs)
- audit and assurance (ongoing programme)
- sharing information relating to the implementation of the Quality Improvement Committee (QIC) Programme at DHB level with possible cooperation of a range of regional and sub regional initiatives e.g. medicines reconciliation
- progressing a regional approach towards the implementation of the NZNO MECA Partnership Agreement
- progressing a regional approach and response to clinical and workforce initiatives and issues
- developing a regional leadership development programme

5.2 Reducing Inequalities

The objectives of DHBs include:

- To reduce health disparities by improving health outcomes for Maori and other population groups
- To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other new Zealanders.

New Zealand Public Health and Disability Act 2000

Wairarapa DHB's Health Needs Assessment report 2005 (HNA), and the Ministry of Health report 'Monitoring Health Inequality Through Neighbourhood Life Expectancy' both indicate there are significant inequalities in health between different population groups within Wairarapa, and that the degree of inequality in Wairarapa is high relative to the rest of New Zealand.

The DHB's strategic plan shows a strong focus on reducing inequalities with particular emphasis on improving the health status of Maori, poor people, older people, and children and youth. In each of these groups HNA data shows health outcomes in Wairarapa lag behind those achieved elsewhere in New Zealand.

The HNA raised awareness of equity issues and inequalities and increased commitment to address them. The DHB and Wairarapa PHO both use the 'equity lens' in assessing and deciding on programmes and interventions. Across all services there is increasing measurement of utilisation and outcomes by ethnicity, age, and deprivation decile.

Wairarapa DHB routinely assesses its efforts against the Ministry's Health Equity Intervention Framework to ensure that interventions are being pursued at all levels.

Past year achievements

Level 1 – Structural

- New Relationship Agreement signed between Te Oranga O Te Iwi Kainga and Wairarapa DHB
- Community consultation hui with Maori to establish service needs and priorities
- PHO focus groups with Maori, Pacific and 'other' groups to discuss service needs and priorities for people living with long term conditions
- DHB support for the development of *Pasifika Wairarapa*, a community trust for the Wairarapa Pacific community

Level 2 – Intermediary pathways

- Continued work with Maori, low income groups, and older people, to increase physical exercise, improve nutrition, and housing – through a range of programmes delivered by Maori providers, the PHO and joint initiatives, such as Tai Chi, and Healthy Homes
- Wairarapa Pacific Festival
- Maori Women's Welfare League delivery of Healthy Eating Healthy Action activities
- Development of a Smokefree Wairarapa Plan

Level 3 – Health and disability services

- Continued development of community outreach clinics for Maori and Pacific
- Establishment of, and recruitment to, a Maori outreach/liaison role to work across primary care
- Increasing transparency and equity of access to health and disability services through the establishment of a single point of entry

Level 4 – Impact

- Significantly reduced disparity in diabetes management through increased collaboration and improved access to health services
- Provision of bariatric services for cases selected on need including social determinants
- Ministry of Social Development primary mental health pilot for people on sickness or invalid benefits

Plans for the year ahead

Level 1 – Structural

- DHB Maori Health Plan reviewed and updated
- District Strategic Plan priorities reviewed/reconfirmed in light of 2008 HNA.

All DHB Board members will receive Treaty of Waitangi training

- Maori health provider contracts reviewed and updated
- WDHB staff across public health, mental health, the provider arm, and Maori providers undertake training in the Whanau Ora Health Impact Assessment Tool

Level 2 – Intermediary pathways

- Increased promotion of healthy lifestyles through expansion of community outreach clinics
- Implementation of a targeted social marketing programme aimed at improved lifestyle choices for Maori and Pacific families and whanau
- Implementation of the targeted initiatives within the HEHA and Smokefree Wairarapa plans

Level 3 – Health and disability *services*

- Scheduled reviews of pathways of care for Maori
- Wairarapa PHO will work with practices and Maori providers to improve breast and cervical cancer screening rates for Maori
- On-going evaluation and development of services to increase access for Maori, Pacific and other high needs groups
- Maori input is provided across service planning and review processes; Specialist Palliative Care Services, Podiatry services, Pharmacy services

Level 4 – Impact

- Improved access to culturally appropriate palliative care services for Maori and Pacific
- Early implementation of B4School checks for Maori and Pacific children and children from low income families

For further information on plans to reduce inequalities see sections 4.2, 4.3, 4.4 and 4.5.

5.3 Maori Health

Why is health of Maori a priority?

- Maori have poorer health than any other group
- Some gaps between health of Maori and health of non-Maori are reducing but in some areas, such as asthma, they are increasing
- Despite having greater needs, Maori are less likely to access primary health services
- Maori are an increasing proportion of the total Wairarapa population and will place increasing demand on health services
- Maori health is a national priority
- DHBs have statutory responsibilities to advance Maori health and to reduce disparities between Maori and non-Maori

Increasing recognition and understanding of the cultural determinants of health is of specific relevance to Maori. Whanau is central to Maori health and well-being. Service developments for Maori must support whanau ora and Maori models of health. He Korowai Oranga, the national strategy for Maori health, sets out pathways for the achievement of whanau ora.

Wairarapa District Strategic Plan 2005

He Korowai Oranga

He Korowai Oranga: the Maori Health Strategy sets the national direction for Maori health development. The overall aim is whanau ora – Maori families supported to achieve their maximum health and wellbeing. He Korowai Oranga sets out four pathways for action. Whakatataka Tuarua is the national action plan for implementing He Korowai Oranga over the period 2006--2011. Together He Korowai Oranga and Whakatataka Tuarua provide the framework for actions taken by DHB's at a local level.

Past year achievements

- Renewed Te Oranga O Te Iwi Kainga / WDHB relationship agreement
- Maori Health Committee reviewed the Maori pathways of care in rehabilitation, maternity and FOCUS
- Maori strategic input on HEHA lead group
- Maori provided advice to the DHB at governance, operational and advisory levels including the PHO, in the development of the Palliative Care Plan, Smokefree Wairarapa plan, violence intervention plan, health promotion plan,
- Maori advice and input was provided across all review and audit processes; the AT&R Review, Colposcopy service audit, EQuIP Accreditation process, Pharmacy strategic options review
- Ethnicity Data collection processes increased in provider arm
- Reducing inequalities data integrated within reporting processes
- Increased delivery of clinics at Marae and Maori communities such as the Kura Kaupapa, Te Rangimarie, Pirinoa and Papawai.

The activities and actions outlined in this plan are also guided by the DHB's Maori Health Plan for 2005 – 2008, *Te Kaupapa Hauora Maori o Wairarapa*. Significant achievements have been made through determining the goals and actions held within the Maori Health Plan 2005-2008. We have increased service responsiveness for Maori across primary and secondary services, increased Maori access to primary services and elective services and increased ethnicity data collection practices. We are at present working with Iwi, Maori health providers and the Wairarapa community to establish the next set of goals and action points for increasing Maori health gain in the Wairarapa. *Te Kaupapa Hauora Maori O Wairarapa* 2008-2011 will be completed during 2008.

Mechanisms and processes to involve Iwi and Maori in DHB decision-making and monitoring of progress

Te Oranga O Te Iwi Kainga monitors and reviews progress against the Maori Health Action Plan and He Korowai Oranga, through the annual review processes specifically associated with the DAP and monitoring of the Maori health plan. Iwi Kainga is representative of local Iwi; Ngati Kahungunu Ki Wairarapa and Rangitane o Wairarapa and is the main mechanism for monitoring of health service developments and progress. The Maori Health Committee comprises representatives from Wairarapa Maori health providers, and other local Maori health stakeholders. The Maori Health Committee is tasked with monitoring and reviewing the Maori pathways of care within the DHB hospital provider arm.

The committee also provides a forum for evaluation at an operational level of health services for Maori in the Wairarapa.

Plans for the year ahead

Maori participation in the provision and development of health services in Wairarapa will continue to be underpinned at governance level by the relationship between the Board and Te Iwi Kainga.

Key activities for Te Iwi Kainga and the Maori Directorate in 2008/09 will include:

Past year achievements cont…

- Supported application of Treaty of Waitangi policy through all contracted services
- Implemented Tikanga Best Practice tool across DHB Services and residential care homes
- Ensured SIA funding is focussed on reducing inequalities in Maori health
- Maori Provider Te Hauora have established weekly clinics within a General Practice
- Rongoa Service Review conducted
- Supported Maori provider development in IT and systems design
- PHO establishment of a Maori Liaison role to work across General Practice and Maori Providers
- Increased numbers of Maori accessing FOCUS
- The Cultural Competency Framework initiated and further developed

- Actively engage Maori participation and ensure Maori worldviews are incorporated in all levels of service planning and delivery
- Continued development and provision of mainstream provider policy development, guidelines and training
- Support Iwi Kainga in the development of the WDHB Cultural Competency Framework
- Assist in Maori Provider development of capacity and capability
- Extend outreach and marae based clinics to improve access to primary and specific health needs
- Utilise all opportunities and forums to build and maintain strong relationships within and between mainstream and Maori health providers, other agencies and the wider community
- Assist Maori Providers to continue to develop the whanau ora concept.

In the coming year the Maori Health Committee will:

- Review the pathways of care for Maori patients across 3 provider arm services
- Oversee a 'by Maori for Maori' HEHA initiative
- Continue to collaborate with the PHO to increase accessibility and responsiveness of primary health services

Maori access both mainstream health and disability services, and services that are specifically for Maori. Most of the service provision for Maori occurs through mainstream services. Maori in Wairarapa make up 15% of the population but within mainstream services Maori account for 18% of admissions to Wairarapa hospital, and about 10% of primary health care (PHO) consultations

The table below summarises actual and planned expenditures on services that are specifically targeted to Maori.

Expenditure on Maori Health

		2005/06 Actual	2006/07 Actual	2007/08 (Est)	2008/09 Budget	2009/10 Target	2010/11 Target
1	Mainstream PHO services for Maori	85,000	185,000	190,500	190,500		
2	Maori providers (incl Mental Health Services)	1,367,000	1,264,000	1,349,000	1,356,000		
3	Maori specific in mainstream	414,000	514,000	625,300	668,200		
4	Maori workforce development	13,000	44,000	50,500	65,000		
	Iwi PHO			-	-	-	
6	Funding increase					60,000	60,000
	TOTAL EXPENDITURE	1,879,000	2,007,000	2,215,300	2,279,700	2,324,700	2,384,700

Key to lines:

1. Specific service initiatives for Maori put in place by Wairarapa PHO (a mainstream service)
2. Services provided by organisations that have Maori governance and a Maori kaupapa.
3. Services that target Maori clients, and may be provided by Maori staff, but within an organisation that has mainstream ownership/governance, the DHB provider's Maori mental health team is an example of this.

DSP Priority	Maori			
	He Korowai Oranga			
Objectives	Pathway 1 – development of whanau, hapu and iwi and Maori communities	Pathway 2 – Maori participation in the health and disability sector	Pathway 3 – effective health and disability services	Pathway 4 – working across sectors
	Wairarapa District Strategic Plan			
	Maori provider development and whanau ora	Maori participation increased	Services more effective for Maori	Healthier environments for Maori
DSP Themes in Action • *Increase connectedness* • *Holistic approaches* • *Address common risk factors* • *Community wide collaborations* • *Quality and safety*	• Iwi Kainga provides oversight of all DHB Maori health service planning and delivery • DHB Treaty of Waitangi policy is a key component in the delivery of all health services in Wairarapa • Maori Health Committee works across the DHB to ensure opportunities to improve health outcomes for Maori are maximised • Work with Maori communities to develop local infrastructures that support the delivery of health initiatives • Work with Te Hauora o te Karu o te Ika and individual Maori health providers to develop workforce capability and capacity • Provide Maori participation across the DHB recruitment processes, mainstream staff development and the redevelopment of provider arm services • Work with WCPHO and other community providers to maintain positive relationships and increase access for Maori to services • Improved integration between Maori and mainstream health and social services			
Planned Actions	Facilitate strategic planning with the collective - Te Hauora o Te Karu o Te Ika. Work with Maori Health providers to: • Further develop whanau ora approaches in their service delivery • Provide Maori providers advice and support during contract review processes • Improve management systems • Further develop programmes for tangata whaiora • Increased linkages and collaborative approaches with provider arm mental health services • Increased integration of Rongoa service with General Practice • Further develop whanau case management practice • WDHB – Iwi Kainga training in implementing the Treaty at governance level	Facilitate 2 hui a iwi Maori Health Committee runs Maori consumer focus groups in provider arm services Continue to develop the 'Momona Marae' 'by Maori for Maori' HEHA project Continue to strengthen Te Iwi Kainga/WDHB relationship through scheduled combined meetings Te Iwi Kainga - WDHB to facilitate and host a Central Region Maori Relationship Board Hui Work with Human Resources to develop a training programme for the Cultural Competency Framework	High level of input into the development of the DHB's child health strategy Continue to develop the Cultural Competency Framework and implement within a provider arm service Training is conducted with staff from Maori providers, public health, mental health and provider arm services in the use of the Whanau Ora Health Impact Assessment Tool Extend the marae based clinics to support the long term conditions project Ensure the HEAT Tool is implemented in any service development Work with Te Iwi Kainga to monitor and increase ethnicity data questions 2008-09 Maori Health Committee reviews of pathways of care within the hospital provider arm: • Paediatrics services • Medical Surgical Services • Mental Health Services Maori input is ensured on the Violence Intervention Steering Committee and protocols are strengthened for whanau Maori within the hospital provider arm	Provide Maori leadership on the HEHA Lead Group Ensure Maori input on all HEHA project groups In conjunction with the Needs Assessment agency FOCUS, develop and subsequently evaluate, a needs assessment tool that is sensitive to Maori needs Continue to support Maori nursing through implementation of thee Nurse Educator (Maori Mentor) pilot at UCOL. Monitor and evaluate the Nursing Mentorship Pilot Programme Work with the PHO and MSD to increase service responsiveness for Maori sickness beneficiaries Support the establishment of a governance structure for Wairarapa East side development

Outcome Measurements	*IDPs* HKO 01 – Local iwi/Maori are engaged and participate in DHB decision-making and the development of strategies and plans for Maori health gain HKO 02 – Development of Maori health workforce and Maori health providers HKO 03 – improving mainstream effectiveness HKO 04 – increase in funding for Maori health and disability initiatives POP 13 – avoidable hospital admissions (for Maori)	*DHB Indicators:* Number of Maori nursing graduates employed by WDHB Number of assessed eligible Maori whanau have homes insulated *PHO targets for Maori and Pacific:* • At least 30% SIA funding for Packages of Care • At least 20% of PHO primary mental health care programme participants • At least 50% of care coordination clients • At least 35% of PHO free sexual health consultations.

5.4 Pacific People

The small number of Pacific people in Wairarapa makes it difficult to draw reliable conclusions about their health needs from local data. National data shows that Pacific people generally are in low socio-economic groups, and have poor health outcomes compared with non-Maori and non-Pacific groups.

In Wairarapa there are no Pacific health provider organisations and Pacific people are not represented in DHB decision-making. A DHB priority for the immediate future is to establish a Pacific people's advisory group.

Wairarapa District Strategic Plan 2005

Past year achievements

- Pasifika Wairarapa established
- Inaugural Pasifika festival held in Masterton
- Pacific Community Health Worker works with health and social services to increase access for Pacific people
- Te Awhina community clinic increases access to primary care for Pacific people
- Focus group held to increase the responsiveness of services for Pacific people with long term conditions
- Health newsletter designed for Pacific communities

Plans for the year ahead

Pacific people make up less than 2% of the Wairarapa population, with the 2006 Census reporting that 846 people identifying as of Pacific ethnicity. Due to the small numbers it is difficult to analyse health data and gain a picture of the health status for the group. However Pacific people have not historically been specifically provided for by health services, and anecdotally many Wairarapa Pacific people suffer from poor health.

During 2006 a Pacific community health worker position was established within the Wairarapa Public Health Unit. This position has been successful in providing a bridge between community and health services and has provided an initial basis for the assessing and meeting of community needs. A community based health clinic with nurse and GP services is supported by the community health worker and has helped to reduce the cost and cultural barriers to accessing primary care. A PHO focus group for Pacific people living with long term conditions will provide a basis for ensuring that primary care can be responsive to this group.

In early 2008 Pasifika Wairarapa was established with the support of the DHB. This community Trust will provide a focus and mechanism for community development initiatives and consultation with the Pacific community. The inaugural Pasifika Festival also provided a focus for the community as well as an opportunity for health education and promotion.

These recent developments have provided a platform for an increased focus on health promotion, access to services, and the health outcomes for Pacific people living in Wairarapa. During 2008/09 the DHB and health service providers intend to continue to focus on a community development approach, particularly in Masterton East. Specific initiatives that are planned include:

- Healthy lifestyle initiatives centred on the existing community clinic, including smoking cessation for Pacific clients and implementation of learnings from training in Pacific nutrition
- Through the Long Term Conditions project, increased screening and management of long term conditions for Pacific people
- Continued support for Pasifika Wairarapa

5.5 Lower Socio Economic Groups

People who live in relatively deprived areas (the highest deciles) are twice as likely to die early from avoidable diseases. They are also much more likely to be admitted to hospital for diabetes, asthma and other chronic conditions, compared with the rest of the population. They face greater barriers to accessing health services – user charges and transport pose greater difficulties – than for people in better off groups. About 12% of the total Wairarapa population lives in the most deprived areas (Deciles 9 and 10).

People in deciles 9 and 10 are:

- Twice as likely to die early from avoidable diseases
- More likely to be hospitalised
- Less likely to use primary care
- More likely to live in homes that are poorly insulated and damp
- More likely to smoke
- 12% of Wairarapa's total population
- 23% of Wairarapa Maori
- 28% of Wairarapa Pacific people

Wairarapa District Strategic Plan 2005

This population group has been given priority across all sections of the DAP because of this group's poor health outcomes relative to others. Inequalities can be found in almost all aspects of health and disability services provision, including access to services, utilisation of services, incidence of health risk factors and disease, and clinical interventions provided.

All sections in this DAP therefore include activity that illustrates how the DHB targets the health needs of those people in lower socio-economic groups.

Plans for the year ahead

Efforts to ensure increasing access to health services and improve the health status of people in the lower socio-economic groups will continue.

Past year achievements

- Increased subsidised services:
- Transportation to clinics and services
- More free school based health services in low decile schools
- More healthy homes
- Comprehensive health and social assessments of new entrants and year nine students
- Increased number of people on Care Plus scheme
- 'First Steps' Evaluation of health clinics in low decile schools
- Implementation of the PHO Long Term Conditions programme across all GP practices in the District

These include:

- Develop single point of entry to support services in alignment with DSS
- Ensure HEHA implementation has a strong focus on low socio-economic groups
- Increase the focus of Health Promotion for this group of people, especially with regard to serious skin infection and gastroenteritis.
- Subsidised services (e.g. transport to services, driving assessments, sexual health services, and home-help). Subsidised services also include increasing fee and script subsidies for primary health (decreasing costs for the patient).
- Initiatives for Chronic disease prevention and management (HEHA initiatives, Outreach clinics, Kura clinic, College Health Clinics, Care Plus).
- Multi-sectoral projects which promote a holistic approach to healthy lifestyles and the needs of people with a low socio-economic status. (e.g. Healthy Homes project)

- Promotion of healthy lifestyles will occur through a variety of approaches. Implementation of the Wairarapa Physical Activity Plan ("Active Wairarapa") will focus on low or no cost activity opportunities.
- Establishment of the PHO Long Term Conditions programme based on best practice, to enable more active management of those people with chronic disease (a significant portion being of lower socio-economic status).
- Continuation of services which are deemed to be cost effective in achieving health outcomes for people in low decile groups and reducing health inequalities.
- Explore opportunities for Community Pharmacists to further their role in Health Promotion and Education projects

Along with the many and various DHB-wide initiatives to increase access for those people of lower socio-economic status, a key focus will remain on ensuring alliance with other sectors (e.g. Local Councils, Wellington Regional Council, Work and Income, Housing NZ, Energy Smart). This will occur through advocating for appropriate parallel approaches by other sectors, participating in multi-sectoral projects, and contributing to future planning by other agencies.

DSP Priority:	**People in low socio economic groups**			
	Objectives	**Actions**	**Target Date**	**Responsibility**
Increase connectedness between services	**Lower barriers to access to primary health care and support services**	• Primary health care will be available to people of lower socio-economic status through a variety of SIA initiatives	All Quarters	PHO
		• All Wairarapa practices offer free care for under sixes	All quarters	PHO
		• Complete the establishment of a single point of entry for support services for older people	Quarter 2	General Manager Community Health Services, Manager District Nursing, Manager FOCUS (NASC), Planning and Funding
Promote more holistic approaches in services	**Healthier environments**	• Continued multi-sector approach to healthy lifestyles and enabling those of low socio-economic status to access services, including home insulation	Quarter 1	PHO, Planning and funding, Public Health
		• Implement a framework of community action to address the social determinants of the low socio economic population of Masterton East	All Quarters	Wairarapa Public Health

<table>
<tr><td rowspan="4">Community wide collaborations</td><td rowspan="4">Fewer avoidable hospital admissions</td><td>• Early intervention, appropriate referral and care coordination, improved through roll-out of CVD and diabetes risk screening</td><td>Quarter 4</td><td>Planning and funding Aged Care Providers, PHO, Hospital Managers, General Manager Community Health Services, FOCUS (NASC)</td></tr>
<tr><td>• Initiate a serious skin infections project in primary care</td><td>Quarter 2</td><td>Planning and funding, PHO, Public Health</td></tr>
<tr><td>• Identification of repeat admissions and promotion of care management.</td><td>Quarter 3</td><td>Hospital Managers, Patient Journey Project, PHO, NGO Providers</td></tr>
<tr><td>• Increase use of IV at Home Service</td><td>All Quarters</td><td>Hospital Managers, Community Health Services Managers</td></tr>
<tr><td rowspan="3">Improve quality and safety of services</td><td rowspan="3">Achieve equitable outcomes for high need communities</td><td>• Healthy Homes Nursing intervention including assessment of family health needs, health education and referral to other agencies as appropriate</td><td>All Quarters</td><td>Wairarapa Public Health</td></tr>
<tr><td>• Establish modular ‘Jigsaw’ Health Promotion Training for service providers, especially Maori and Pacific Island people</td><td>All Quarters</td><td>Wairarapa Public Health</td></tr>
<tr><td>• Free access to Health Clinics in low decile (low socio-economic)schools</td><td>All Quarters</td><td>PHO, Public Health, Planning and Funding</td></tr>
<tr><td>Outcome Measurements</td><td colspan="2">IDPs:
Improving health outcomes for people 0 –4 years
Improving health outcomes for people 45 – 64 years
Improving health outcomes for people 0 – 74 years</td><td colspan="2">DHB Indicators:
Reducing Ambulatory sensitive (avoidable) admissions from 2007 – 08 rates
1.5% reduction for Maori 0 – 4 yrs
1.5% reduction for Others 0 – 4 yrs

5% reduction for Maori 45 – 64 yrs
1.5% reduction for Others 45 - 64 yrs

5 % reduction for Maori 0 =- 74 years
2.5% reduction for Others 0 – 74 years

Community Health and Support services accessed through a single point of entry.</td></tr>
<tr><td>Health Target</td><td colspan="4">Reducing Ambulatory sensitive (avoidable) admissions – 2008 – 09 Targets (based on Q2 results)
<table>
<tr><td>0 – 4 years</td><td>Maori</td><td>Not to exceed more than 15% above national level</td></tr>
<tr><td></td><td>Pacific Island</td><td>N/A (insufficient numbers)</td></tr>
<tr><td></td><td>Others</td><td>Not to exceed more than 12% above national level</td></tr>
<tr><td>45 – 64years</td><td>Maori</td><td>Not to exceed more than 18% above national level</td></tr>
<tr><td></td><td>Pacific Island</td><td>N/A (insufficient numbers)</td></tr>
<tr><td></td><td>Others</td><td>Not to exceed more than 6% above national level</td></tr>
<tr><td>0 – 74 years</td><td>Maori</td><td>Not to exceed more than 16% above national level</td></tr>
<tr><td></td><td>Pacific Island</td><td>N/A (insufficient numbers)</td></tr>
<tr><td></td><td>Others</td><td>Not to exceed more than 15% above national level</td></tr>
</table></td></tr>
<tr><td>Outcome Measurements</td><td colspan="2">IDPs:
Number of homes insulated through Healthy Homes project</td><td colspan="2">DHB Indicators:
Retrofitting home insulation for people in the lower socio-economic group, with long term health conditions</td></tr>
<tr><td>Health Target</td><td colspan="4">75 homes to be insulated in 2008-09</td></tr>
</table>

5.6 Healthy Lifestyles (HEHA)

Lifestyle factors

Smoking, diet, drug and alcohol consumption and exercise are major determinants of health status and outcomes. Compared with all New Zealand, Wairarapa people have:

- A higher percentages of smokers
- More obesity
- More hazardous drinking
- Similar levels of marijuana use
- Similar fruit and vegetable consumption
- Similar levels of physical activity

(Ministry of Health, Public Health Intelligence, 2005)

Past year achievements

- Completed Phase 1 of HEHA plan (MAP)
- Developed Smokefree Wairarapa Plan
- Combined Governance structure for HEHA, Active Wairarapa and Smokefree Wairarapa for co-ordinated nutrition, physical activity and smoking cessation initiatives
- Developed a social marketing strategy for Wairarapa
- Appointed a HEHA Education Co-ordinator
- Funded new position for community dietitian
- Introduced "Walk the Talk" culture to DHB
- Funded Maori Womens Welfare League to provide HEHA promotion for Maori

Although these priority areas may be at different stages in the development of strategies and implementation, synergies have been identified that will enable effective interventions to be developed and delivered across the whole suite of priority areas together.

A social marketing strategy for Healthy Lifestyles in the Wairarapa has been developed that will adopt a whole society, whole family/whānau approach to integrate nutrition and physical activity, smoking cessation and mental health. Health risks accumulate over life and there are interactions between the risk factors.

Plans for the year ahead

During 2007/08 Wairarapa DHB initiated a move towards a broad population health focus that links a variety of health promotion strategies including Healthy Eating, Healthy Action, tobacco control and suicide prevention. This shift in focus will govern the activities in the year to come. The 'joined up' approach to population health is consistent with the Wellington Region Strategic Plan for Population Health, "Keeping Well 2008-12". This is a plan is to improve the health of people in the Wellington region (Capital & Coast, Hutt Valley and Wairarapa) and increase the performance of the population health system. The goals are to reduce health inequalities, support the development of healthy communities and reduce the health impact of chronic illness in an ageing population. The "Keeping Well" plan suggests that while working to improve the determinants of health, efforts need to be unequally focussed on the determinants for high needs populations. The plan proposes that effort should be concentrated on high needs populations and support functional whanau/family structures. Eight population health priority areas are identified.

Population health priority areas

- Equal opportunity to good health
- Smokefree living
- Healthy eating healthy action
- Mental wellbeing
- Lives free from harm due to drugs and alcohol
- Control of infectious diseases
- Living conditions that nurture human health
- Families enjoying violence free lives

There is limited information available on current behaviours, attitudes and beliefs surrounding healthy eating and nutrition for most of the priority populations in Wairarapa. Although the determinants of fruit and vegetable consumption lie largely outside the health sector, the strategy will collect district level information by conducting the Behaviour Change indicator survey (HSC national survey) in the Wairarapa. This will provide a benchmark for behaviour change among Wairarapa parents and caregivers of children aged 5-16.

While it is acknowledged that measurable benefits to the population will take some time to be evident, the DHB is committed to increasing the collaborative approach to HEHA to achieve both immediate and ultimately, long term health gains, including:

- Reduce smoking rates
- Reduce the prevalence of obesity and overweight, particularly among children
- Reduce obesity related elective procedures
- Improve oral health
- Reduce the incidence of chronic conditions including cancer
- Reduce avoidable hospital admissions
- Reduce the impact and the incidence of diabetes
- Improve the mental wellbeing of the community and reduce the incidence and impact of depression and suicidal ideation.
- Improve rates of exclusive breastfeeding until baby 6 months old
- Reduce family violence

Details of implementation for these initiatives are covered in related sections of this plan.

Planned Actions for 2008/09

DSP Goal:	Reduce obesity, reduce impact of diseases such as Type 2 diabetes and cardiovascular disease, improve health status especially for high needs population groups	
Objective	**Actions**	**Performance Measure**
HEHA District-wide Plan (MAP)	• Implement HEHA District-wide plan • Support the prevention and detection of long term conditions through the promotion of adopting a healthy lifestyle, eating a healthy diet, maintaining a healthy weight, increasing physical activity and being smokefree	• Evidence of increase in initiatives to reduce obesity and long term conditions • Reduced incidence of long term (chronic) conditions including cancer
Increase collaboration & co-ordination of initiatives	• Combine the governance of Healthy Eating, Healthy Action, Active Wairarapa and Smokefree Wairarapa with multi-agency, intersectoral membership • Identify synergies that will enhance collaboration and co-operation between community partners • Continue collaboration with community partners, and associated health disciplines including oral health, mental health and child and youth health	• Evidence of increased intersectoral and multi-agency collaboration
Reduce smoking rate	• Implementation of the Wairarapa Smokefree Plan (WSFP) by smokefree co-ordinator appointed in 2007/2008 • Target high priority groups – Maori, Pacific people, pregnant women, rangatahi, mental health consumers, young people and parents who smoke • Implementation of the Smokefree Wairarapa network • Increase collaboration between smoking cessation providers and health promotion services to promote routine screening, brief intervention and linking of services	• Evidence of reduction in number of young people taking up smoking • Reduced disparity in smoking rates between Maori, Pacific and other ethnic groups • Evidence of increase in smoking cessation packages provided
Increase breastfeeding rates	• Implement Baby Friendly Community Initiative following accreditation • Implement National Breastfeeding Promotion strategy • Improve linkages between support agencies	• Evidence of increase in exclusive breastfeeding to 6 weeks and 6 months • Increased awareness of benefits of breastfeeding
Reduce childhood obesity	• Support implementation of Food & Nutrition Guidelines and Food & Beverage Classification System in schools and Early Childhood Education Services • Stimulate and support innovative initiatives to improve nutrition through applications to the HEHA Nutrition Fund • Support the development of School Travel Plans • Work collaboratively with Sport Wairarapa to increase the number of Active Schools	• Evidence of nutrition modules incorporated into school curricula • Number of applications to the Nutrition Fund • Number of Health Promoting Schools
Reduce adult obesity	• Support Bariatric Surgery initiative • Increase access to weight loss programs • Promote Green Prescriptions • Increase access and opportunities for physical activity • Promote and support community initiatives to improve nutrition	• Outcomes from Bariatric Surgery program • Green Prescription uptake • Increase in physical activity initiatives • Enrolments in physical activity programs
Reduce inequalities	• Work with Te Oranga O Te Iwi Kainga to develop initiatives that are culturally appropriate for Maori and support the development of a Cultural Competency Framework • Target Maori, Pacific and low-income groups to prevent people taking up smoking and provide smoking cessation programs for current smokers • Support initiatives to prevent obesity and improve	• Reduction in obesity and increase in physical activity • Reduced disparity in smoking rates between Maori, Pacific and other ethnic groups

	nutrition through the Community Obesity Prevention Funding for Maori • Support the implementation of the Healthy Lifestyle Initiative delivered by Whaiora Whanui • Support the promotion of healthy eating and activity in Outreach health clinics for Maori, Pacific and low-income people • Support a Pacific advisory group • Work with the Maori Womens' Welfare to promote HEHA in Maori communities	
Research information on current behaviours, attitudes & beliefs surrounding healthy eating, nutrition and physical activity	• Conduct, analyse and interpret Behaviour Change Indicator Survey (BCI) in Wairarapa to establish meaningful baseline for behaviour change • Interpret results of Wairarapa Physical Activity Survey • Develop interventions based on information from surveys	• Baseline data recorded • Benchmark established for future follow-up
Increase awareness of importance and impact of healthy eating, physical activity and being smokefree	• Implement the Social Marketing Strategy developed in 2007/2008 • Adopt a whole society, whole family, whole whanau approach • Combine healthy eating, healthy action and being smokefree in a healthy lifestyle package. • Identify promotional synergies with other priority areas / groups and develop these	• Increased awareness assessed by surveys
A healthy workforce – "Walk the Talk"	• Implement Wairarapa DHB Nutrition Policy • Implement Wairarapa DHB Physical Activity Policy • Implement Wairarapa Smokefree workplace strategy • Develop opportunities for staff to participate in programmes to improve nutrition and increase physical activity • Explore opportunities to extend current initiatives	• Changes in food provided by DHB for patients and staff • Increased opportunities to participate in physical activity
Build capacity	• Increase the range of skills and knowledge of the nutrition and physical activity workforce by providing education and professional development opportunities • Develop and support workforce development e.g. Pacific Nutrition Certificate	• Increases in workforce and skill level

5.7 Reducing family violence

The Campaign for a Violence Free Wairarapa

'Rise Above It' is a Wairarapa wide community response to violence based on four principles:

- **Partnerships:** strengthening the many positive relationships within our community.
- **Changing Attitudes:** encouraging the whole community to realise that violence is not an answer to any of our problems.
- **Improving Wellbeing:** increasing the sense of belonging within our community and improving the quality of life for everyone.
- **Improving Coordination:** agencies and groups working together to provide services.

Masterton District Council, 2002

Past year achievements

- Review of DHB approaches to implementing the Family Violence Guidelines including addressing the recommendations from the Ministry audit conducted in July 2006
- Family Violence co-ordinator established from September 2007
- DHB policies and procedures updated in January 2008.
- MOU established between Police, CYFs and DHB to improve collaboration regarding child abuse and neglect with regular meetings held
- New Multi agency steering group formed
- Regional Public Health Family Violence Coordinator offers Regional support with resource development
- Public Health facilitated an education focus group as part of the evaluation of the Rise Above It campaign

Wairarapa has a unique approach to reducing family violence within the region that has been identified nationally as a leading light in its field. The intersectoral *Rise Above It* campaign was launched in 2002 in response to community concerns about levels of violence particularly involving children. The DHB is represented at the Governance and operational levels of this campaign.

DHB staff are actively involved in community initiatives incorporated in this campaign that focus primarily on raising awareness and community education. White Ribbon Week was a high profile event locally well supported by the community.

The DHB is currently reviewing its Family Violence Intervention (FVI) service following a gap in service provision. We now have a new coordinator who has completed a scoping exercise and we are looking to strengthen the service by a further appointment of an appropriately qualified individual. We have also established strong links with the National FVI lead.

A steering group has been established with wide external membership and chaired by the practice leader from CYFS. From this 4 subgroups are being formed to review:

- Policies and procedures
- Staff training
- Publicity
- Cultural appropriateness and sensitivity of all the above.

Considerable new resources for FVI have been made available and the steering group is helping to inform how best this should be used

The next AUT audit will provide a new baseline from which to move forward. This will help to identify what resources the DHB needs to develop to meet the needs of the community in the identification and prevention of violence and abuse.

The implementation of policies, procedures and training throughout Wairarapa hospital will be the focus for 2008/09 with the aim of improving the DHB's responsiveness to both Partner and Child abuse situations when we are re-audited in 2009.

Our focus to date has been on establishing partnerships developing trust and effective communication with all agencies. Other service providers have skills and networks that we need to tap into and build on if we are to provide effective multiagency support and provide timely intervention to prevent serious abuse occurring.

We are optimistic that this approach will pay dividends over the coming months and create a safer environment and ensure that where family violence is suspected or does occur all agencies can react speedily, collaboratively and effectively to protect our community.

The Wairarapa Organisation for Older Person's (WOOPs) has been contracted to provide Elder Abuse Prevention, to promote awareness of Elder Abuse in the Community, and provide linkages to services for both victims and perpetrators as required.

In 2008/09 the DHB's Health Promoting Schools service will assist Student Councils in Wairarapa schools to address issues associated with bullying.

Outcome Measurements	*IDPs:* *POP 11 – Family Violence Prevention*	*DHB Indicators:* *Progress in taking a systemic approach towards the identification and intervention of child and partner abuse*
Health Target	An overall score of 59/100 in the audits for child abuse and 49/100 for partner abuse responsiveness	
Outcome Measurements	*IDPs:* POP 11 – Family Violence Prevention	*DHB Indicators:* Progress in taking a systemic approach towards the identification and intervention of child and partner abuse
Health Target	An overall score of 70/100 in the audits for child abuse and partner abuse responsiveness	
Outcome Measurements	*IDPs:* POP 11 – Family Violence Prevention	*DHB Indicators:* Progress in taking a systemic approach towards the identification and intervention of child and partner abuse
Health Target	An overall score of 70/100 in the audits for child abuse and partner abuse responsiveness	

5.8 Suicide Prevention

The vision for suicide prevention activity in Wairarapa is a society where all people:

- Feel valued and nurtured
- Value their own life
- Are supported and strengthened if they experience difficulties
- Do not want to take their lives or harm themselves

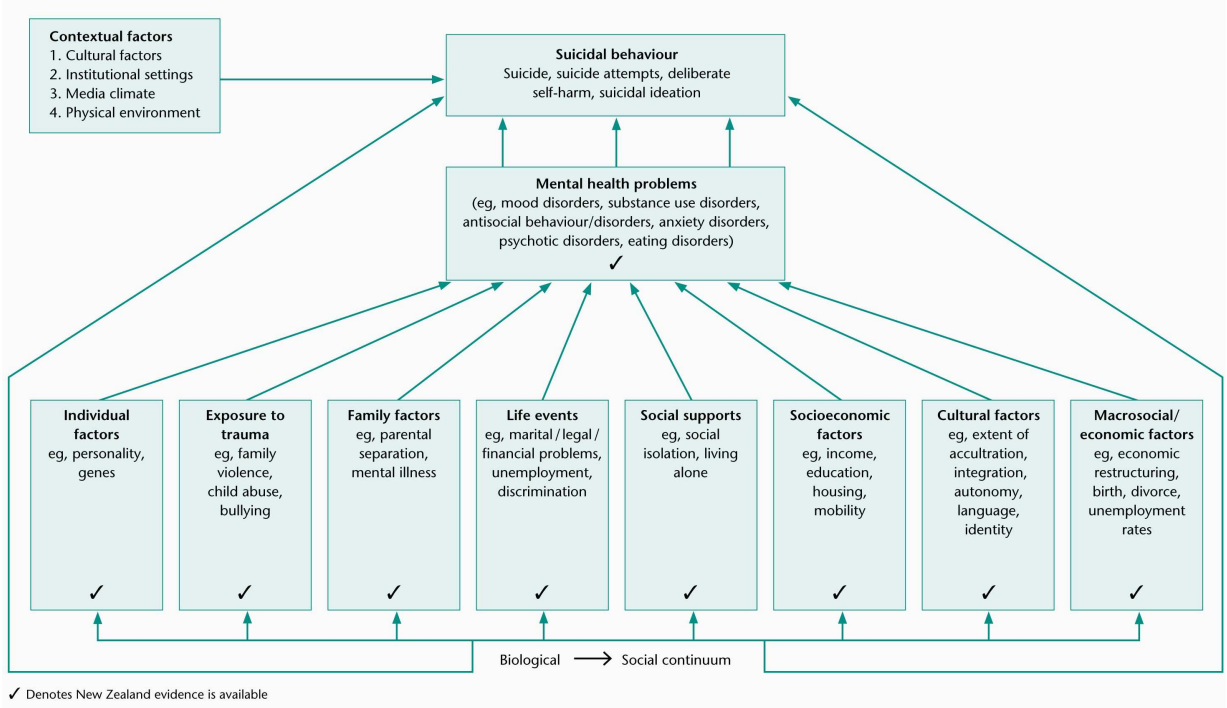
New Zealand Suicide Prevention Strategy, 2006

Suicide and self harm are significant issues for Wairarapa. Rates of suicide and self harm in Wairarapa in recent years have been higher than in other districts.

Mental disorders are the major contributor to suicidal behaviour. Supporting the public to recognise and be more responsive to people experiencing depression (the most common mental disorder) is an objective of the National Depression Awareness Initiative which commenced in October 2006. During 2008 a new web based resource: The Lowdown, has been rolled out specifically to assist young people affected by depression, and there are many self-help tools available on websites. Wairarapa DHB is building on and promoting these initiatives at the local level.

Suicidal behaviour is complex, with many and varied contributing factors. Effective prevention of suicide requires a multi sectoral approach that integrates both individual and population level programmes. The community needs to own suicide prevention activities and take an active role in their planning and development, in the same way as is happening for HEHA. Experience of successful community-wide planning elsewhere shows this requires an identified group responsible for leadership and co-ordination and the utilisation of existing community structures and initiatives.

Pathways to suicidal behaviour



Source: *New Zealand Suicide Prevention Strategy 2006–2016* (Associate Minister of Health 2006)

Past Year Achievements

- Increased access to primary mental health services through 'To Be Heard ' programme
- Increased holistic focus in medical practices, with mental health support accessible directly within one medical centre
- Increased access to specialist mental health services, particularly for youth
- Health promoting schools and HEHA programmes promote resilience and mental-wellbeing
- Growth in Maori and Pacific services promoting cultural identity
- ED-Mental Health services collaborative project commenced (in association with New Zealand Guidelines Group)
- Two SPINZ workshops held in Wairarapa for health promotion staff and other health and social services personnel

The Year Ahead

In 2008/09 a Suicide Prevention co-ordinator will be employed (with pilot project funding from Ministry of Health) to work with the DHB, the Wairarapa community, and other sectors to develop and implement an inter-agency suicide prevention action plan for Wairarapa, informed by the national action plan to be published shortly..

There will be continued focus on building resilience and mental well-being through HEHA and other programmes associated with health lifestyles. International literature demonstrates that mental well-being is improved through increasing social connection, improving nutrition and increasing physical activity.

While the main focus in 2008/09 will be the development of a comprehensive Wairarapa action plan, the actions listed in the table below will be implemented in the meantime.

National Suicide Prevention Strategy Goal	Wairarapa DHB actions for 2008/09
1. Promote mental health and well-being and prevent mental health problems	Continue to implement HEHA action plans Continue 'To Be Heard' programme
2. Improve care of people experiencing mental disorders associated with suicidal behaviour	Increase awareness of effective interventions, including self-help strategies – provide CME for primary health services in use of National Depression Guidelines. Promote awareness of The Lowdown website. Work with PHO and CAMHS to increase recognition of, and response to self harming behaviours
3. Improve care of people who make non-fatal suicide attempts	Complete ED-MHS collaborative project: review Wairarapa hospital treatment, management and after care for people who have attempted suicide and implement recommendations. Develop support systems for families/whanau
4. Reduce access to means of suicide	Work with pharmacies and public health services to reduce poisonings by prescribed medications and paracetamol.
5. Promote safe reporting and portrayal of suicidal behaviour by the media	Work with the media to encourage safe reporting
6. Support families/whanau friends and others affected by a suicide or suicide attempt	Ensure Wairarapa families and communities have access to post-suicide support from the suicide post prevention worker based at Regional Public Health
7. Expand the evidence about rates, causes and effective interventions	Monitor local trends and ensure local actions and strategies are informed by international research findings

5.9 Children and Young People

Why is the health of Children and Youth a priority?

- Childhood and youth have their own age specific health issues, and are also vitally important years in setting the pattern for health in later life. During childhood and adolescence both risk and protective factors are established for many diseases that affect adult health.
- While generally improving, health statistics for children and youth in Wairarapa are below national averages in some key areas
- Wairarapa youth show high levels of risk behaviours – sexual activity, binge drinking, exposure to drugs, unsafe driving
- Children and young people are more likely than adults to live in areas of high deprivation
- Wairarapa children and young people have high rates of hospitalisation
- High use of sexual health services indicates high level of sexual activity among Wairarapa youth
- High and increasing rates of dysfunctional families and child abuse notifications

Wairarapa District Strategic Plan 2006

Past year achievements

- Baby Friendly Community Initiative accreditation
- Increasing immunisation rates, especially for Maori children
- Incredible Years programme introduced
- Food and nutrition guidelines supported in schools
- Child Health Advisory Group established
- Child Health Strategy under development
- Free primary care for all children under 6
- Introduction of ante-natal HIV screening
- Primary mental health services for youth established
- Improved connectedness between health and social services working in secondary schools
- Crisis and planned respite services for youth established
- Intensive AOD programme for secondary school students developed
- 10000 steps in schools programme run
- Smoke-free DHB plan completed

Plans for the year ahead

Children

The focus in recent years has been developing child health services in line with national priorities, across Wellchild / Tamariki Ora providers, primary care, immunisation providers and hospital paediatric services.

We will continue to build on these developments in the 2008/09 year, including:

- Continuing collaborative approaches to ensuring all children are fully immunised
- Working with the PHO to ensure accessible primary health care for children through maintaining no cost primary health care visits for children under 6
- The introduction of the universal offer of ante-natal HIV screening
- Further development of community paediatric outreach services
- Introduction of B4School checks for four year old children
- Work with National Screening Unit and the Implementation Advisory Group to introduce hearing screening for newborns.

The district is on track to reach immunisation targets. A NIR steering group is overseeing projects aimed at identifying and addressing barriers to immunisation uptake and immunisation practitioners meet monthly. Both groups include representatives from primary care.

A major child health project for 2008/09 will be the implementation of B4School checks, a comprehensive health and development check for children aged between four and five years. The initial focus will be to ensure that the families of children not in regular contact with early childhood education and health services are offered the check.

2008/09 will see the continued development of a district wide child health strategy. This strategy builds on national initiatives, including the Well Child review and B4School Checks and focuses on specific Wairarapa priorities including improving outcomes for Maori and Pacific children and reducing hospital admissions for gastroenteritis and respiratory infections. The Strategy also aligns with other national and district strategies including family violence intervention, tobacco control and Healthy Eating, Healthy Action. The DHB will continue to work closely with schools and Sport Wellington to implement Mission On, the Nutrition Fund and Active Wairarapa. These initiatives will support schools as they develop and implement physical activity and nutrition policies.

The DHB has established a Child Health Advisory Group to oversee the development of the child health strategy. This advisory group will also provide oversight for all child health initiatives including immunisation and the implementation of B4School checks.

Youth

Youth health continues to be a high priority for the health sector during the 2008/09 year. 2008/09 is the second full year in the implementation of the DHBs Youth Health Strategy. The first year has seen the successful establishment of school based health services with a model for working in schools now firmly agreed across all providers. The focus for 2008/09 will be on consolidating the school services and working to reach groups of young adults who are no longer in the school system.

During 2008/09 the DHB hopes to be able to assist an initiative led by local iwi representatives to establish a youth health centre in Masterton and provide services for those young adults who are reluctant to access mainstream primary care service and are often difficult to engage with.

Services targeting specific needs will be established. These include smoking cessation programmes and alcohol and drug programmes in school and youth friendly community settings.

Mental health and addiction services for children and young adults

Several initiatives were undertaken in 2007/08 that improve the continuum of care for youth experiencing episodes of mental unwellness in the Wairarapa.

In 2008/09 the newly established Youth Crisis Respite and Recovery Service will work to consolidate its role in the service continuum and align itself to regional initiatives that support respite services for youth in the community.

A budget for primary mental health packages of care was established in 2007/08 to provide increased access to counseling and other services. This will continue to be promoted among school and GP services to ensure that those who are most in need of this type of assistance receive it.

<table>
<tr><td>DSP Priority:</td><td colspan="4">Children and Youth</td></tr>
<tr><td></td><td>Objectives</td><td>Actions</td><td>Target Date</td><td>Responsibility</td></tr>
<tr><td rowspan="5">Increased use of primary and secondary care</td><td rowspan="3">Improved collaboration between providers</td><td>Implementation of B4School checks</td><td>November 2008</td><td>Planning and Funding
WPHU, PHO</td></tr>
<tr><td>Increase immunisation rates for 2 year olds to 85%</td><td>July 2009</td><td>WPHU and Wairarapa Child Health Advisory Group (WCHAG)</td></tr>
<tr><td>Complete Wairarapa Child Health Strategy</td><td>June 2009</td><td>Planning and Funding WCHAG</td></tr>
<tr><td rowspan="2">Increase numbers of young adults in the lower socio economic groups accessing services</td><td></td><td></td><td></td></tr>
<tr><td>Youth AOD services providing more services in schools and community settings</td><td>March 2009</td><td>Planning and Funding
Wairarapa Addiction Service
Te Hauora Runanga O Wairarapa</td></tr>
<tr><td></td><td>Health promotion activities target employers who employ a largely younger workforce</td><td>All Quarters</td><td>WPHU – health promotion</td></tr>
<tr><td rowspan="3">Better mental health of youth</td><td rowspan="3">Increased services across the care continuum</td><td>Local Crisis Respite and Recovery service aligns to regional respite service support programme and network initiatives</td><td>Sept 2008</td><td>Planning and Funding
CAMHS</td></tr>
<tr><td>Increase access to primary care mental health and addiction services for youth</td><td>July 2008</td><td>Planning and Funding
PHO</td></tr>
<tr><td>Introduce AOD programme across secondary schools</td><td></td><td>Planning and Funding Wairarapa Addiction Service
Te Hauora Runanga O Wairarapa, WPHU</td></tr>
<tr><td rowspan="4">Reduction in risk taking behaviours</td><td>Smoking in year 10 students</td><td>Smoking cessation programmes run in secondary schools
DHB and NGO Health Promoters provide education in intermediate and secondary schools</td><td></td><td>WPHU, PHO, Whaiora Whanui</td></tr>
<tr><td>Decrease risk taking behaviour involving motor vehicles and alcohol and drugs</td><td>Support Students Against Driving Drunk in their annual project</td><td></td><td>WPHU - Health Promotion, Community Alcohol Action Group</td></tr>
<tr><td>Reduce the incidence of STIs and pregnancy in teenagers</td><td>Implement National Sexual Health programmes in the Wairarapa</td><td></td><td>WPHU – Health Promotion, PHO</td></tr>
<tr><td>Increased collaboration in health promotion activities</td><td>Utilisation of Keeping Well: the Wellington Region Strategy for Population Health</td><td></td><td>WPHU</td></tr>
<tr><td>Outcome Measurements</td><td colspan="3">IDPs:
POP 08 – Progress towards 95% of 2 yr olds fully immunised
<table>
<tr><th></th><th>DHB Total</th><th>Maori</th><th>Pacific</th></tr>
<tr><td>6 months of age</td><td>71</td><td>60</td><td>N/A</td></tr>
<tr><td>12 months of age</td><td>89</td><td>88</td><td>N/A</td></tr>
<tr><td>18 months of age</td><td>81</td><td>79</td><td>N/A</td></tr>
</table></td><td>DHB Indicators:
• Reduction in teen pregnancy
• Hospitalisation rates for motor vehicle accidents
• Motor vehicle accident fatalities</td></tr>
<tr><td>Health Target</td><td colspan="4">Progress towards the national target of 95% of two year olds
Percentage of children fully immunised:
Maori 85%
Total 84%</td></tr>
<tr><td></td><td colspan="4">Reducing ambulatory sensitive (avoidable) hospital admissions
<table>
<tr><td>Maori</td><td>0-4 years</td><td>Not to exceed more than 15.1% above national level</td></tr>
<tr><td>Other</td><td>0-4 years</td><td>Not to exceed more than 12.7% above national level</td></tr>
</table></td></tr>
<tr><td></td><td colspan="2">Improve nutrition
Increase physical activity
Reduce obesity</td><td colspan="2">➢ Completing accreditation for the Baby Friendly Community Initiative
➢ Increasing resources for lactation advice and support</td></tr>
</table>

5.10 Oral health

The DHBs Oral Health Services Strategic Plan sets five objectives for oral health services;

1. Increase oral health prevention and promotion
2. Increase early intervention opportunities
3. Improve treatment rates for adolescents
4. Increased access to all services
5. Maximize efficiency and effectiveness of existing workforce capacity

Wairarapa DHB 2005

Past year achievements

- DHB business case for oral health services for the 0 – 18s approved
- 98% enrolments of year 8 students with Dental Services
- 79 % adolescents completed treatment (2006)
- Emergency dental service operated within budget and applied access criteria with increased consistency across the Wairarapa

Oral health services for 0 – 18 year olds

Oral health status

In the Wairarapa children living in urban Masterton have the poorest oral health. Although Masterton is Wairarapa's only area with fluoridated water, it also has the greatest numbers of people in high deprivation groups. Consequently oral health is better among those living in non-fluoridated areas. Most recent data shows 60% of all children are caries free at age five in non-fluoridated areas, and only 40% in fluoridated areas. Results are considerably worse for Maori than for non-Maori. Discrepancies are reduced at year 8 but are still large.

Service Development

The DHB aims to reduce inequalities and improve oral health status overall through a mix of strategies to be rolled out over the next 2-3 years. We will increase our focus on areas of high need and implement Maori specific strategies, in consultation with iwi. In 2007 our business case for redevelopment of oral health services was approved by Government. This includes the following strategies:

- Ensuring rural and high risk children have full access to services through mobile clinics
- Ensuring parents can access services for their children through a central hub for oral health services
- Locating the hub in an area close to areas of high deprivation
- Working closely with Maori providers and the PHO to identify high risk families and support enrolment and engagement with oral health services.

The priority for 2008/09 is to achieve the successful implementation of the business case progressively throughout the year.

As it is anticipated that both the local and national facility development and procurement processes will take some time yet to complete, the DHB intends to implement service models within existing facilities where possible in order to facilitate a seamless transition once full implementation becomes viable. This will include a greater focus on health promotion in early childhood education centres, primary schools and secondary schools, and developing improved linkages between oral health services and the public health nurses, health promoters, school health clinics, Whaiora Whanui, and GP centres.

Emergency Dental Services for low income adults

The DHB reconfigured its Emergency Dental Care service for low income adults sommencing January 2006 with a focus being on ensuring that the funding available was targeted to those who were not able to meet WINZ criteria for financial support for emergency dental services. The reconfigured service required considerable community education and a change in work practices of all providers. There is now greater consistency in the interpretation of access criteria across providers.

Oral Health			
	Actions	**Target Date**	**Responsibility**
Implementation of DHB Business Case for Oral Health Services	Complete local and national processes to build and procure facilities required to deliver the business case: • Hub designed and building commenced • Mobile clinics and equipment purchased as national programme permits	Ongoing	Project Manager PHU Planning and Funding
	Service models described in Business Case are applied to existing facilities as far as possible		Project manager PHU Human Resources
Increase % of adolescents who have treatment completed	Greater linkages between school based health services and the adolescent oral health coordinator and dentists to increase the number of adolescents who have their oral health treatment completed		Adolescent oral health coordinator Public Health PHO Wairarapa Dentists
Equitable access to emergency dental services for low income adults	Ensure equitable access to available funding through well maintained access criteria processes and prioritisation		Planning and Funding Central Dental Practitioners
Outcome Measurements	*IDPs:* POP 04 – Mean DMFT score at year 8 POP 05 – Percentage of children caries free at age 5 years	*DHB Indicators:* Business case implementation milestones are achieved	
Health Target	Percentage of adolescents completing oral health treatment		

5.11 Older People

Why is health of Older People a priority?

- As people get older their health needs usually increase
- Compared with other DHB's, Wairarapa has a greater proportion of older people
- Wairarapa's population is also aging faster – the proportion of people in Wairarapa who are over 65 years will grow from 17% in 2006 to 23% in 2016, and to over 30% in 2026
- The greatest projected increase is in the numbers of people aged 75 years and above – these 'old' older people are the biggest users of health and disability services
- Avoidable admissions for older people are significantly higher in Wairarapa than in New Zealand as a whole
- Older people's problems more complex and the impact more severe and pro-longed
- Older people are disproportionately represented in poorer areas
- Older people are far more likely to suffer from, and die from chronic conditions, than are younger people
- More than half of all people over 65 years have some arthritis

Wairarapa District Strategic Plan 2005

Past year achievements

- Establishment of Support to Live at Home service. This is a flexible, goal focused support service to assist older people with complex needs who wish to remain at home
- Implemented reviews of care need levels of older people in residential care to ensure they were receiving the appropriate level of care.
- Enabled 'slow stream' Health Recovery for clients who need further input before they can safely return to their home setting.
- Assisted transition out of residential care when the older person wished to live in the community
- Progress in establishing a single point of entry for Community and Support Services
- Provided Public Health programme for Older People. Over 100 older people regularly attend monthly social, information and exercise mornings. Specific courses for older people are well attended (e.g. microwave Cooking for One).
- 3 year health promotion contract signed with WOOPS
- WOOPS opened Southern Wairarapa office in Featherston

Past Year Achievements

The DHB has prioritised implementation of the Health of Older People Strategy through its DSP. The "Wairarapa Elder Local Links" (WELL) plan[4] describes the direction the DHB is taking to implement the Strategy.

Plans for the year ahead

Developments for implementing an integrated continuum of care for older people will continue through a range of service developments across the Health and Disability sector. These developments will be aligned with ensuring a smooth transition between services (e.g. hospital, community and other agencies).

The DHB will continue to work towards establishing a single point of entry for Community Health and Support services. This will incorporate entry to services for long term personal health support services disability support services, short term home based support services, District Nursing, Palliative Care services, and long term Mental Health support services. It will be relevant to all people in Wairarapa regardless of their age, ethnicity, and health or disability status. It will enhance the continuum of care through providing seamless transition between funding streams.

[4] Wairarapa Elder Local Links (W.E.L.L.) – Health of Older People Plan, Wairarapa DHB 2004

Achievements continued

- The DHB renewed its contract with The Red Cross for provision of the Wairarapa Community Transport service with nearly all of passengers being aged over 65 years old.
- Processes are in place to ensure that Maori have culturally appropriate assessment processes.
- High rates of the Flu Vaccine for people aged over 65 years (89%).
- NASC Assessor worked closely with the Rehabilitation Team to ensure appropriate support pathways for older people on discharge
- Increased utilization of Primary Mental Health Care by older people
- Increased proportion of all older people receiving funded DHB support services are living in the community (69%)

Promotion of the single point of Entry to Community Health and Support Services will help the DHB inform the community about how older people and their carers can access these services.

Carer Support will be offered through a dedicated NASC resource to enable identification of carers, provide relevant information, and assist carers to use allocated support for their own wellbeing. In addition, clients with early Alzheimer's and their carers will be provided with appropriate Day Activity Support through an NGO contract, in conjunction with Alzheimer's Society.

The DHB will continue to work with ACC and other lead providers to support the implementation of the ACC Injury Prevention Strategy. In conjunction with this strategy, it will incorporate falls prevention activities (strength and balance) within its HEHA plan, and encourage opportunistic strength and balance activities for older people (e.g. through Wairarapa Public Health contract with Wairarapa Organisation for Older Persons (WOOPS))

Improving the mental wellbeing of older people will also be specifically included in the WOOPS Health Promotion contract with Wairarapa Public Health. Mental Health services for older people in the community will continue to be offered through the Primary Health programme "To Be Heard". In addition, specialist Mental Health Service support will be provided to aged residential care facilities who have clients who also have a mental health or addiction diagnosis.

Following the Rehabilitation review in 2007 – 08, the DHB will implement the recommendations of that review. It will develop and promote Rehabilitation service, culture and identity. The service will provide specialist advice, knowledge transfer, consultation/liaison to, or joint clinical management with, other services to enable those services to better meet the needs of their clients with Rehabilitation needs

The DHB will continue to ensure a positive relationship with aged care providers, especially with regard to the medical management of residents, quality improvement, and workforce development. It will identify potential workforce and development opportunities for support workers in conjunction with other providers and agencies.

DSP Priority:	Health of Older People			
	Objectives	**Actions**	**Target Date**	**Responsibility**
Increase connectedness between services	Provision of a continuum of care for older people	• Complete the establishment of a single point of entry for support services for older people	Quarter 3	General Manager Community Health Services, Manager District Nursing, Manager FOCUS (NASC), Planning and Funding
		• Develop clear pathways, entry points into Rehabilitation and defined exit points from the service	Quarter 1	General Manager, Hospital Services, Rehabilitation Manager Patient Journey Coordinator
		• Implement stoke protocols to establish an Organised Stroke Service	Quarter 3	General Manager, Hospital Services, Hospital Service Managers, PHO
Promote more holistic approaches in services	Promotion of healthier lifestyles	• Promote an identifiable support and information service for informal carers.	Quarter 1	Community Health Service Manager, FOCUS (NASC)
		• Work with a range of agencies to promote healthy nutrition and activity of older people (e.g. Active Wairarapa, ACC, HEHA)	All Quarters	Wairarapa Public Health Planning and Funding Project coordinators (e.g. HEHA)
Community wide collaborations	develop flexible, goal focused models of care across the continuum, including dementia care at all levels	• Work with stakeholders to review the DHB Health of Older People Strategic Plan and further develop implementation plan for the Health of Older People Strategy	Quarter 4	Planning and funding Aged Care Providers, PHO, Hospital Managers, General Manager Community Health Services, FOCUS (NASC)
		• Identify potential workforce and development opportunities for support workers in conjunction with other providers and agencies	Quarter 3	Planning and Funding, NGO Providers
		• Enhance opportunities for aging in place through collaboration of DHB, PHO, service providers and community support groups	All Quarters	Planning and Funding, PHO, Community Providers, Wairarapa Public Health
Improve quality and safety of services		• Implement recommendations from Rehabilitation review	All Quarters	General Manager, Hospital Services, Rehabilitation and Clinical Services Managers
		• Establish Rehab/Gerontology Specialist Nurse position as a clinical champion/leader	Quarter 2	General Manager, Hospital Services, Rehabilitation Manager, Director of Nursing,
		• Develop and promote Rehabilitation service, culture and identity.	All Quarters	Rehabilitation Manager and staff, Specialist Nurse
		• Complete plan to address mental health needs of older people	Quarter 4	Planning and Funding, Manager Mental Health Services, FOCUS
Outcome Measurements	*IDPs:* Older people increase their use of primary and preventive care		*DHB Indicators:* Numbers of people aged 65 years and above who have been vaccinated against influenza.	
Health Target	*Percentage achieved 2006/07 – 73%* *Percentage achieved 2006/07 –89%* *Target for 2008/09 – 90% or more*			
Outcome Measurements	*IDPs:* Implementing Aging in Place		*DHB Indicators:* The percentage of people aged 65 years and above, receiving disability support services, who are in their own homes, rather than in residential care	
Health Target	*Percentage achieved 2006/07 – 59%* *Percentage achieved 2007/08 – 68%* *Target for 2008/09 – 70%.*			

5.12 The Primary Care Strategy

Government's Primary Health Care Strategy sets the framework for all developments in primary care, with increasing focus on whole population approaches, health promotion and disease prevention. Further implementation of the Primary Health Care Strategy in conjunction with Healthy Eating, Healthy Action provides the foundation for tackling the growing burden of chronic disease.

Wairarapa is fortunate to have one PHO encompassing all primary medical practices across the whole district. 98.7% of the 2006 census population are enrolled with the PHO. There are seven practices, with at least one practice located in each town. The practices each provide comprehensive first line medical and nursing services and collaborate to provide after hours services jointly. Other PHO services include: sexual health, Care Plus; primary mental health care; services to improve access, and health promotion. PHO utilisation reports show increasing service use since the PHO commenced in January 2004, particularly by Maori, people in low socio-economic groups, and older people.

Past year achievements

- Ruamahanga Health Trust raised $650,000 to build Martinborough Health Centre - opened January 2008
- Family Nurse Practitioner recruited to work across South Wairarapa practices
- Common approach to long term conditions adopted in all practices
- Over 85% of the expected Care Plus population recruited to the programme
- Achieved targets for diabetes management
- Continued development of outreach and youth clinics
- Maori outreach/liaison service established
- Childhood immunisations reach record levels
- Over 89% of eligible people received influenza vaccinations
- School and Outreach Clinics developed
- 300 pneumococcus vaccinations provided
- Access rates for Maori, Pacific and High Deprivation populations increased
- Primary healthcare nursing plan developed
- Referrals to primary mental health services ahead of target

Wairarapa Community PHO and Wairarapa DHB are working together to progress the Primary Health Care Strategy as follows:

Community participation	Community engagement in PHO governance and operations continues to be facilitated by: • Appointments of eight community representatives and a Community Chair to the PHO trust board • Community membership (from a wide range of community organisations) on the PHO services committee that advises on service initiatives, service design, delivery and monitoring • Widely advertised, open, PHO Trust Board meetings and community forums, held at a range of venues across Wairarapa, including Marae. These are well attended by the public. • Reporting to and input from approximately 50 community agencies and Non Governmental Organisations serving the Wairarapa • Formation of the Ruamahanga Health Trust to provide a community owned medical facility and health services in Martinborough and to potentially assist with recruitment and retention issues across the Southern Wairarapa • Regular meetings between Maori health providers and the PHO, and subcontracts with the Maori providers for health promotion, research, liaison and outreach. • Regular media releases inform the community of Primary Care and PHO issues and invite input

Improving health sector performance	Wairarapa DHB Health Needs Assessment information is developed and reviewed in discussion with the PHO and other community providers. Shared priorities for local service developments, including responses to national priorities, are agreed through iterative and collaborative strategic and annual planning processes that ensure PHO and DHB plans are aligned, widely supported and owned by both parties. The PHO through its shared services agency WIPA is developing its capacity to extract and analyse practice information. This is enabling the DHB and PHO to focus on the areas of demonstrated highest need. Wairarapa Community PHO is participating in the national PHO performance management programme. This programme has been successfully adopted in Wairarapa and contributes to ongoing quality improvement across the primary sector. WCPHO has achieved excellent results across the programme indicators.
Reducing inequalities in health outcomes	Research conducted in 2006/07 on kaumatua health provided a picture of inequalities in access and health status at practice level. This has provided a basis for the continued development of services to increase access. This included the introduction of a new Maori liaison/outreach position in collaboration with a Maori health provider. The Health Equity Assessment Tool is used in planning services aimed at reducing health inequalities.
Preventing and managing chronic or long term conditions	Services to Increase Access (SIA) funding is being used effectively to increase service utilisation in all high needs groups. The range of initiatives includes provision of a transport service, and free outreach clinics in areas of high deprivation. A Long Term Conditions (chronic disease management) programme developed in one Wairarapa practice has been implemented across all Wairarapa practices. This programme will provide district wide population health benchmarks and facilitate the identification, screening and management of all people with long term conditions. The programme will also support the introduction of new diabetes and CVD targets. A programme to deliver 300 pneumococcus vaccinations per annum is included in the Long Term Conditions (LTC) project.
Developing new models of service	The Long Term Conditions (LTC) programme will provide a standardised approach to LTC throughout the Wairarapa, consistent with current international best practice and integrated with DHB and Maori provider services. The model of care will include: • opportunistic risk assessment and advice to patients, • development of the role of practice nurses, • designing programmes to actively promote outreach and collaboration, • affiliation with community based organisations and • actively addressing cultural competence. The DHB and PHO are also collaborating to develop a new model of rural primary care through the appointment of a Family Practice Nurse Practitioner from USA to work across South Wairarapa practices. It is envisaged that, over time, the role will become an integral part of the rural practice business model. The project also includes offering scholarships to encourage the development of a local primary care nurse practitioner workforce, to ensure a long term sustainable solution to current general practice workforce issues. School health clinics have been implemented in the Kura Kaupapa since 2005 and two Wairarapa colleges from February 2007. The PHO has contracted with Whaiora Whanui (Maori Provider) to provide outreach support to Practices for high needs whanau who the Practice have difficulty in effectively supporting through existing Practice staff & resources. It is envisaged that this position will work in closely with the Family Practice Nurse Practitioner in the South Wairarapa on a part time basis (the position currently covers the whole Wairarapa), and the PHO is currently endeavouring to gain funding for a second Maori/Pacific outreach position to be based in the Southern Wairarapa on a full time basis.

Wairarapa PHO and Wairarapa DHB develop their strategies and plans collaboratively, and ensure aims and objectives are closely aligned. PHO actions and strategies that support achievement of the DHB's priorities are summarised below.

Maori Health

The PHO trust deed stipulates Maori representation and participation in PHO governance. Maori comprise one third of PHO Board members and are represented on all PHO committees. The Board of the PHO operates very much in partnership with Maori and actively promotes engagement with Maori. Board meetings are held in a variety of community settings including on local Marae. The PHO works closely with Wairarapa's two Maori providers and sub contracts some services to them.

Implementation of the PHO's Maori Health Plan is continuing.

SIA initiatives in the PHO have focused on improving access for Maori and high needs people. A "packages of care" fund has been placed with Whaiora Whanui (Maori Provider), three outreach clinics target Maori and Pacific people, and the Board of the PHO operates very much in partnership with Maori. The PHO indicators as at 31/12/07 are showing a positive trend for Maori in respect of:

- Flu Vax
- Childhood immunisations
- Access to primary care
- Access to sexual health care
- Access to SIA funded visits
- Care Plus

Outreach clinics which target Maori whanau have been set up at the Kura Kaupapa and at local Marae. During 2007/08 the PHO contracted a Maori health provider to provide a Maori liaison /outreach service in conjunction with primary care practices.

The Primary Care Mental Health initiative and Long Term Conditions (Chronic Care Management) Programme are also targeted at Maori people and ensures that the approach adopted is effective for Maori. The LTC project is making people living with long term conditions more "visible" to practice staff and clinicians. This will gradually move practices to a more population based health care delivery.

People in low socio-economic groups

The roll out of access funding across age groups has been supported by WCPHO, with all practices maintaining lower cost fees and all providing free visits for children under six. In addition, the PHO supports increased access and improved health outcomes for people on low incomes by:

- Keeping user part charges as low as possible, and implementing schemes to assist those who have difficulty paying
- Contributing to provision of a free community transport service for people travelling to health appointments
- Providing free outreach clinics in areas of high deprivation
- Packages of Care funded through Services to Increase Access
- Free sexual health service

Older People

Specific PHO initiatives towards achieving increased access and improved health outcomes for older people include:

- Keeping user part charges as low as possible, and implementing schemes to assist those who have difficulty paying

- Contributing to provision of a free community transport service for people travelling to health appointments
- Care Plus and development of the Long Term Conditions programme – see below
- Packages of Care funded through Services to Increase Access

Children and youth

The PHO contributes strongly to improving child and youth health by:
- Implementation of school health clinics in two secondary schools and one primary school
- Successful implementation and use of the NIR in all practices
- Provision of free sexual health services for young people
- Introduction of family nurse practitioner in South Wairarapa

All Wairarapa practices provide free care for under sixes.

Reducing the burden of chronic disease

At January 2008 the PHO is at 85% of its Care Plus target, and is on track to reach the target of 100% by June 2008. During 2007/08 implementation of a standardised approach to Long Term Conditions (chronic care management) was completed in all Wairarapa practices. The programme enables improved monitoring, early intervention and support for people who live with, or are at risk of developing chronic illness. As data is collected it will also provide measures of whole practice population health.

Reducing the burden of mental illness and addictions

The "To Be Heard" pilot service for Wairarapa PHO became fully operational in the 2006/07 year and will continue in 2008/09. As at 31 December 2007 28 providers were signed up to provide services for "To Be Heard" and 181 active Packages of Care (POC) were being provided. An internal review of the programme delivery over the four WIPA supported PHOs, along with the results of the University of Otago evaluation of the pilots nationally, will result in modifications to the operational aspects of the "to be heard" pilot over the next 12 months with the aim of increasing the operational and clinical effectiveness of the programme.

Implementation of the Depression guidelines and an extensive training programme are planned for the eighteen months from January 2008.

Cancer services

- Wairarapa Community PHO has contributed to the development of cancer services and cancer plans for the district
- PHO health promotion funding is being used to help fund a Healthy Eating / Healthy Action programme run by Maori provider Whaiora Whanui.
- WCPHO is committed through the PHO Performance Monitoring framework to obtaining full eligible population uptake of Cervical and Breast Screening.
- WCPHO is working with the DHB to implement improved Palliative Care services for Wairarapa during 2008/09. These services will include an enhanced role for generalist palliative care, including primary care.

Performance Measures

The table below shows the measures we will use in 2008/09 to monitor progress towards improving health outcomes through primary health care services.

Outcome desired	Measure	Target/expectation for 2008/09
Continuous quality improvement	Proportion of pharmaceutical and laboratory transactions with a valid NHI (SER-03)	95%
Increased access to primary care services, particularly for high needs groups	Fee increases above annual statement of reasonable referred to fees review Practices comply with fees committee recommendations PHO practices ensure access to fees information (SER-07)	100%
	Ratio of age standardised GP consultations per high needs person compared to non high needs persons. (SER- 01)	≥1.15
	Proportion of laboratory tests and pharmaceutical transactions with a valid NHI number (SER -03)	95%
	Percentage of PHO enrollees aged 65 years and above who received influenza immunisation	75%
	Percentage of PHO enrolled two year olds fully immunised	84%
Reduction in the burden of chronic conditions	Number of green prescriptions issued	150
	% of PHO enrolled population aged >14 years with smoking status on record (POP-01)	Establish baselines
	Care Plus enrolled population (SER-02)	95%
	Diabetes follow-up	To be determined
	Cervical screening coverage rate	Total population:80% High needs: 75%
	Breast screening coverage (high needs population	70%
	Number who access PHO 'mental health packages of care'	250

5.13 Long Term Conditions

Chronic conditions are any ongoing, long term or recurring health problems that can have a significant impact on a person's life.

- Chronic conditions cover a very wide range of physical and mental conditions including: asthma, diabetes, arthritis, depression, heart disease, stroke, cancer, back and neck pain, and HIV. Many people live with two or more chronic conditions.
- Chronic conditions account for 80% of all deaths and 70% of health services expenditure.
- The numbers of people with chronic conditions are rising dramatically worldwide.
- Chronic diseases are the main cause of the gap in life expectancy between Maori and non-Maori.
- Maori are three times more likely to have diabetes and five times more likely to die from it than non Maori.
- People live with chronic conditions for a long time – this affects all aspects of life for them and their family/whanau.
- Chronic conditions have common risk factors – inactivity, unhealthy diets, obesity, stress, depression, smoking and alcohol mis-use.
- Much chronic illness is preventable.
- People affected by chronic conditions need to be better supported by services that are holistic and better co-ordinated.
- Chronic cardiac and respiratory conditions account for 14% of admissions to Wairarapa Hospital.

Specific chronic conditions we are targeting are

- Diabetes
- Heart disease
- Respiratory conditions, including asthma
- Arthritis and osteoporosis

Wairarapa District Strategic Plan 2005

Past year achievements

- Contributed funding and support to the implementation of Active Wairarapa.
- Smoking cessation services are now offered by all GP practices and Whaiora Whanui and Pacific Community Health worker
- Roll out of the Long Term Conditions data management software across the PHO.
- Achievement above the DHB target of people with diabetes (all ethnicities) who have adequately managed diabetes.

Past Year Achievements

Achievements in managing long term conditions over the past year have impacted positively on the health of older people. The DHB has addressed long term conditions through the continuum components of:

- Prevention and early detection
- Diagnosis and treatment
- Support and rehabilitation
- Palliative care

Plans for the year ahead

In line with the DHB Strategic Plan, activity related to long term conditions will focus on healthier lifestyles (reducing smoking, improving nutrition and exercise), increased access to primary care, increased early intervention and improved disease management. Further developments in these areas will be within a multi-sectoral approach and will build on the achievements of the past year. Health Promotion activities through Wairarapa Public Health will progress Healthy Eating, Healthy Action (HEHA) objectives with particular emphasis on improving the food and nutrition environment in schools and Early Childhood

Education services. The appointment of a dietitian who will work across hospital, community and public health environments is expected to contribute significantly to this work.

Wairarapa PHO will also maintain its momentum with outreach clinics and promotion of physical activity through HEHA, Green Prescriptions, and the Active Wairarapa Plan.

However, the main focus of the PHO will be the continuing establishment of their Long Term Conditions (LTC) Project. The software tool being established in GP practices enables more effective identification of disease risk and risk management across the enrolled population of each practice. The project is expected to result in the systematic identification of risk and monitoring for those at risk of, or affected by cardio-vascular disease, diabetes or respiratory disease.

Implementation of the Wairarapa Palliative Care Plan will be a major focus in 2008/09. The Specialist Palliative Care provider will have been selected through an RFP process and will play a central role in the education of the generalist palliative care providers who will take the lead (coordination) role for each individual person needing palliative care. Entry to the service will be through the single point of entry for Community Health and Disability Support. Assessment will be based on a validated palliative care assessment tool and protocols will be developed for the Palliative Care pathway to ensure appropriate input from the Specialist Team as well as effective coordination of services for individuals.

In 2008/09 the DHB's focus on HEHA and reduction of smoking will increase significantly, and the implementation of both the Chronic Care Management project and the Wairarapa Palliative Care Plan will be major undertakings. Other aspects of the continuum for long term conditions will continue to be addressed through ongoing work that has already been established.

DSP Priority:	**Long Term Conditions**			
	Objectives	**Actions**	**Target Date**	**Responsibility**
Increase connectedness between services	Integrated continuum of care for people with long term conditions	• Complete the establishment of a single point of entry for support services for older people	Quarter 1	General Manager Community Health Services, Manager District Nursing, Manager FOCUS (NASC), Planning and Funding
		• Implement Maori Outreach Service to assist GP practices reach their Maori population	All Quarters	PHO, Whaiora Whanui
		• Implement protocols for Stroke management – establish an Organised Stroke Service	Quarter 3	General Manager, Hospital Services, Hospital Service Managers, PHO
		• Flexible home based support, with care coordination for people with complex needs.		Planning and Funding, FOCUS
		• Implement the Patient Journey project, with an emphasis on improving points of transfer	Quarter 4	General Manager, Hospital Services, Hospital Service Managers, Patient Journey Coordinator, FOCUS
Promote more holistic approaches in services	Promotion of healthier lifestyles	• Implement DHB Tobacco Control Plan	All Quarters	Planning and Funding, Wairarapa Public Health, Hospital Managers, DHB Smoke-free Co-

<table>
<tr><td>DSP Priority:</td><td colspan="4">Long Term Conditions</td></tr>
<tr><td></td><td>Objectives</td><td>Actions</td><td>Target Date</td><td>Responsibility</td></tr>
<tr><td></td><td></td><td></td><td></td><td>ordinator, PHO and Community Providers</td></tr>
<tr><td></td><td></td><td>• Work with a range of agencies to promote healthy nutrition and activity (e.g. Active Wairarapa, ACC, HEHA)</td><td>All Quarters</td><td>Wairarapa Public Health
Planning and Funding
Project coordinators (e.g. HEHA)</td></tr>
<tr><td></td><td></td><td>• Investigate establishment of Lifestyle Clinics</td><td>Quarter 2</td><td>Wairarapa Public Health, PHO, Planning and Funding</td></tr>
<tr><td></td><td></td><td>• Support social marketing targeted at people with high CVD risk</td><td>All quarters</td><td>PHO, Wairarapa Public Health, HEHA, Planning and Funding</td></tr>
<tr><td>Community wide collaborations</td><td>Work with the PHO, Wairarapa Public Health and service providers to ensure integrated service development</td><td>• Maintain high rates for influenza vaccination for people over 65 years</td><td>Quarter 3</td><td>PHO, Wairarapa Public Health</td></tr>
<tr><td></td><td></td><td>• Establish the redesigned Wairarapa Palliative Care service</td><td>Quarter 3</td><td>Planning and Funding, FOCUS, Specialist Palliative Care Service, Generalist Providers, PHO</td></tr>
<tr><td></td><td></td><td>• Review and refine Care Plus</td><td>Quarter 4</td><td>PHO, Planning and Funding</td></tr>
<tr><td>Improve quality and safety of services</td><td>Promote implementation of Best Practice guidelines for long term conditions</td><td>• Continue to increase uptake of the Care Plus programme and improve integration of this programme with other health services.</td><td>All Quarters</td><td>PHO, Lead Palliative Carers</td></tr>
<tr><td></td><td></td><td>• Action Implementation plan from AT&R review recommendations</td><td>Quarter 1, Quarter 2</td><td>General Manager, Hospital Services, AT&R and Clinical Services Managers</td></tr>
<tr><td></td><td></td><td>• Continue implementation of the Long Term Conditions (LTC) project</td><td>All Quarters</td><td>Planning and Funding, PHO</td></tr>
<tr><td></td><td></td><td>• Contribute to planning for Regional Renal Services</td><td>All Quarters</td><td>Planning & Funding</td></tr>
<tr><td>Outcome Measurements</td><td colspan="2">IDPs:
Diabetes Detection and Follow-up</td><td colspan="2">DHB Indicators:
Proportion estimated to have diabetes accessing free annual checks</td></tr>
<tr><td>Health Target</td><td colspan="4">2008/09 Target Number of Diabetes Annual Reviews
<table>
<tr><td></td><td>Target % for 2008/09</td><td>Target # People for 2008/09</td></tr>
<tr><td>Mäori</td><td>80%</td><td>190</td></tr>
<tr><td>Pacific</td><td></td><td></td></tr>
<tr><td>Other</td><td>80%</td><td>1,099</td></tr>
<tr><td>Total</td><td>78%</td><td>1,254</td></tr>
<tr><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Outcome Measurements</td><td colspan="2">IDPs:
Diabetes Management</td><td colspan="2">DHB Indicators:
Proportion on the diabetes register who have good diabetes management (HbA1c = 8.0% or less)</td></tr>
</table>

<table>
<tr><td>Health Target</td><td colspan="2">2008 Target Percentage of People having checks with controlled diabetes (HbA1C = or < 8%)
<table><tr><th></th><th>Target % for 2008/09</th></tr><tr><td>Mäori</td><td>72%</td></tr><tr><td>Pacific</td><td></td></tr><tr><td>Other</td><td>75%</td></tr><tr><td>Total</td><td>75%</td></tr></table></td></tr>
<tr><td>Outcome Measurements</td><td>IDPs:
POP-01 Risk reduction - Smoking</td><td>DHB Indicators:
DHB activity supports achievement of these health sector targets</td></tr>
<tr><td>Health Target</td><td colspan="2">The DHB supports improvement in NZ baseline data
• In 2006, the proportion of 14- and 15-year-olds who never smoked was 54 percent.
• 70 percent of homes with one or more smokers and one or more child are smoke free.</td></tr>
<tr><td>Outcome Measurements</td><td>IDPs:
POP-02 Cardiovascular disease</td><td>DHB Indicators:
Cardiac Rehabilitation Programme</td></tr>
<tr><td>Health Target</td><td colspan="2">Baseline to be established.
Long-term, the ideal is that 95% of those who suffer Acute Coronary Syndrome as defined are offered (via referral and follow-up), and utilise the services that are available to them to support the rehabilitation post Acute Coronary Syndrome.</td></tr>
<tr><td>Outcome Measurements</td><td>IDPs:
POP-03 Stroke</td><td>DHB Indicators:
Organised Stroke Services</td></tr>
<tr><td>Health Target</td><td colspan="2">Organised Stroke Service to be established
Long-term, the ideal is that 100% of people, who suffer a stroke event, are admitted to an organised stroke response, either a unit or services, and at least 50% spend the majority of their stay there.</td></tr>
<tr><td>Outcome Measurements</td><td>IDPs:
SER 02 – Care plus enrolled population</td><td>DHB Indicators:
100% or above of eligible PHO enrolees for each ethnic group and people in Deprivation decile 9 and 10.</td></tr>
<tr><td>Health Target</td><td colspan="2">1,800 eligible PHO enrolees
The national goal is that a PHO would have achieved 70% of its expected Care Plus population enrolled in Care Plus by July 2009.</td></tr>
</table>

5.14 Cancer

Cancer covers a very large number of different diseases many of which are increasing as the population ages. While success rates for cancer treatments are improving, the numbers dying from cancer are still increasing as growing numbers of people are affected by cancer.

- Cancer is a leading cause of hospitalisation and death – the second highest cause of death in Wairarapa
- Cancer among Wairarapa Maori is increasing faster than in Maori elsewhere
- Lung, bowel and breast cancers cause the most cancer deaths in Wairarapa
- Cancer survival rates are increasing
- The incidence of cancer is increasing
- Many cancers are potentially preventable
- Many cancers can be eliminated if found and treated early
- With more health promotion and prevention the rates of cancer can be reduced
- More screening, and early treatment can reduce the numbers of people who are affected by cancer for a long time
- More co-ordinated and accessible treatment, support and palliative care services can greatly reduce the impacts of cancer on patients and their families
- Cancer control is a national priority.

Wairarapa District Strategic Plan 2006

Past year achievements

- DHB smoke free coordinator appointed
- All Wairarapa Hospital patients are screened for smoking and their smoking environment status
- All Wairarapa GP practices are utilizing Patient Management Systems to target women who are overdue due for breast and cervical screening
- Breast screening bus visits extended to South Wairarapa venues and located on Whaiora Whanui premises to increase opportunities to engage with Maori women
- Ongoing participation in interagency healthy lifestyle programmes (Active Wairarapa, HEHA)
- Maori women have been targeted for cervical and breast screening through opportunistic and planned health promotion opportunities
- Implementation of Wairarapa Palliative Care Strategy commenced.
- Central Cancer Network is fully operational
- Smoking Cessation offered in Pacific Health Clinic

The Wairarapa Cancer Control Action Plan, 2007 aims to improve all services across the continuum of care for cancer. The priority actions identified in the Plan require ongoing commitment in order to achieve long term reductions in the incidence of cancer and improve outcomes for those living with cancer. Therefore implementing the priorities identified in the Plan will continue to be the DHB's focus in 2008/09.

As a small DHB with no specialist oncology services, integrated and well functioning regional services and alliances are vital to outcomes for Wairarapa people who are living with cancer. Therefore Wairarapa will continue to actively work with the Central Region Cancer Network to plan and improve services and support any initiatives undertaken to ensure waiting times for services provided by the regional cancer centres are kept to a minimum.

The Central Region Cancer Network has identified four types of cancer (lung, colorectal, breast and cervical cancers) for which it will prioritise prevention and screening initiatives in 2008/09. The Wairarapa DHB's local initiatives will align closely with these priorities.

The addition of a third linear accelerator in the Wellington Cancer Centre, early in the 2008/09 year, is expected to decrease the waiting times for radiation therapy treatment across the central region. The DHB will fund increased access and monitor radiation and chemotherapy waiting times for Wairarapa patients and address any issues that emerge.

The DHB will continue to work closely with the Wairarapa Cancer Society to progress projects that will improve the service user's experience of cancer treatments either locally or regionally. Additional cancer control funding which has been allocated to the DHB will be used to implement these priorities, including the establishment of a specialist oncology nurse position.

The DHB will work with Wairarapa Cancer Society to promote healthy lifestyles among the students of Wairarapa schools.

DSP Priority: Cancer			
Wairarapa Cancer Control Action Plan Goals:	**Actions**	**Target Date**	**Responsibility**
Increased primary prevention	Smoke free Wairarapa Plan implemented: • Increased screening and brief intervention in primary care • Increased referral to smoking cessation • Increased use of NRT • Regular meetings of health promoters and smoking cessation service providers	Ongoing	DHB Smokefree Coordinator Whaiora Whanui PHO Wairarapa Public Health
	Increased smoking cessation programmes offered in schools		PHO, Whaiora
	School based anti smoking campaigns run to reduce the number of young adults who take up smoking		Wairarapa Public Health Unit Cancer Society
	Increased access to clinical support for people with high BMIs to reduce these eg dietician led programmes for bariatric surgery, optifast programmes, education and support		Wairarapa Hospital
	Increased programmes in schools to improve eating to prevent cancer		Wairarapa Public Health HEHA Schools Coordinator
Screening and Early Detection	Work with the PHO and Whaiora Whanui to identify and support women who are behind in their cervical or breast screening to participate in the screening programmes		Whaiora Whanui PHO
	Utilise opportunities to increase understanding of cancer, especially among men, through opportunistic advice and education about colorectal prostate and skin cancers		PHO
Diagnosis and Treatment	Work with WINZ to improve the interface between MSD, health services, patients and their families	Qtr 3	Cancer Control Network
Support and Rehabilitation	Monitor cancer treatment waiting times for Wairarapa cancer patients to ensure radiation oncology treatment is received within 8 weeks of Specialist Referral. Manage any wait time variations directly with tertiary provider	Ongoing	Planning and Funding
	Improve the patient journey for people requiring chemotherapy services	Qtr 2	Planning and Funding
	Establish specialist oncology nurse position	Qtr 2	Planning and Funding Wairarapa Hospital
Palliative Care	Refer to section 5.15		
Outcome Measurements	POP 10 Radiation oncology and chemotherapy treatment waiting times Breast screening coverage rate – 65% of high needs population Cervical screening coverage rate – 78% of total population		
Health Target	Reducing cancer waiting times		

5.15 Implementing changes in palliative care

This plan is for the development of a consistent palliative care approach for the Wairarapa District Health Board population. Palliative care will be delivered across our primary and secondary health services, so that the palliative needs of all patients are assessed and their care and support provided in a coordinated way as an integral part of our primary and secondary health services. This district wide generalist palliative care service will be underpinned and overseen by high quality specialist palliative education, advice and services as required to meet more complex needs.

Wairarapa Palliative Care Plan, March 2007

Past year achievements

- Wairarapa Palliative Care Plan completed and approved
- Specialist services contracted from 1 July 2008
- Palliative care coordinator appointed to Focus (single point of entry)
- Training of generalist palliative carers commenced
- Identification of a palliative care assessment tool

The implementation of new palliative care services to Wairarapa will be a major project throughout the 2008/09 year. The focus of the plan is to deliver high quality palliative care across all primary and secondary services, underpinned by specialist services which will provide education advice and support for generalist providers.

During 2007/08 the focus has been on establishing a palliative care coordination role within the needs assessment and service coordination service Focus, developing a service specification for specialist services, and conducting a tender process for the delivery of specialist services. Training of generalist health workers, in particularly district nurses, is underway.

Plans for the year ahead

- On-going development of the care coordination role in FOCUS, including identifying government, NGO and community resources that are available to palliative care patients.
- Implementation of common assessment tool and new care planning processes for all palliative patients. A single assessment process will be contributed to by relevant members of the multi-disciplinary team and a patient held care plan will detail the roles and responsibilities of each agency.
- Implementation of a Lead Palliative Care (LPC) role. For each patient a LPC will be identified to coordinate services and review the care plan as needed.
- Development of the role of primary health services, including additional funding for services provided to palliative care patients.
- Supporting the implementation of a recognized care of the dying pathway across health services.
- A planned programme of palliative care training for generalist providers, provided by the specialist service.

Performance measures	Target for 2008/09
Progress in implementation of new Wairarapa Palliative Care service	New service operational by 1 September 2008
Number of people receiving organised palliative care through the new service	>150 by patients treated by 30 June 2009

5.16 Mental Illness and Addictions

Mental illness, including addiction, is a change in thinking, perception or behaviour that causes significant distress, disability or loss of function.

- Mental illness (including alcohol and drug addiction) is widespread and will affect 1 in 5 people at some point in their lives.
- Mental illness and addiction is rising worldwide, and is a major cause of disability
- Mental illness is estimated to cause about 25% of all disability and will account for 15% of the total global burden of illness by 2020
- Mental illness is very strongly associated with low socio-economic status - unemployment, poor housing, less education, and low income
- Increasing drug abuse, including 'P' is a significant and growing complication in mental illness
- Wairarapa appears to have more drug related problems than many other areas
- Society in general tends to stigmatise and discriminate against those with mental illness – this worsens their problems
- Maori suffer more from mental illness than do non Maori
- Access to mental health services in Wairarapa still falls well short of what is required – several more years of increasing services will be needed
- Wairarapa has high rates of suicide and self harm

Wairarapa District Strategic Plan 2005

Past year achievements

- Mental health promotion activities focussed on youth health; the Wairarapa youth council ran a campaign to reduce exam stress for senior students
- Improved linkages for secondary school students through school heath clinics and a new primary care service for students in high risk secondary schools was piloted
- A single point of entry was established for Mental health needs assessment and service coordination
- Programme for students with alcohol or substance abuse issues developed
- Service continuum for youth reviewed and new primary, support, crisis and planned respite services in place
- Process to review and maintain long term client relapse prevention plans in place
- DHB wide workforce development group established and first initiatives completed
- Two NGO service leaders sponsored to attend Executive Leadership and Management Programme
- Consumer Advocacy and input into service development and delivery reconfigured and now delivered in a community setting
- Kaupapa Maori Service on site daily in one of the Wairarapa GP medical services
- Te Whare Atawhai awarded contract for Mental Health Destigmisation Promotion

The DHB's first Te Kokiri action plan has been well progressed during the 2007/08 year. The Te Kokiri Action Plan for 2008/09 can be found in Appendix II.

In planning for the 2008/09 year stakeholders identify that mental health services across the Wairarapa DHB are valued and are largely meeting community need. The focus for 2008/09 is in ensuring that we continue to build linkages, processes, and systems across services. This will better enable service users to maximise opportunities for their recovery and minimise the effects of mental illness. There is a continued focus on supporting people in the community and decreasing dependency.

A Needs Assessment and Service Coordination service will be operational from July 2008. This service will support service users in the development of their own recovery plans, it also re-establishes the way in which individual's needs are regularly reviewed. and allows for a more responsive approach in meeting the changing needs of clients.

The development and implementation of a cultural assessment tool for Maori and Pacific service users is included in this project, and is intended to increase Maori and Pacific responsiveness across all mental health services.

Past year achievements – regionally

- A Regional Service Gaps Analysis was completed;
- The five regional speciality services increased clinical support to Wairarapa services through training and specialist advice and consultation
- The new MST AOD service for youth has been established during 2007/08 with a Wairarapa youth being one of the first referrals into the programme. AOD providers, police youth aid officers, and the Alternative education service in the Wairarapa have established excellent relationships with the staff of this service and look forward to some successful outcomes in 2008/09
- A regional plan for developing child and youth respite services was developed and early phases of implementation completed
- A regional workforce development coordinator was appointed during 2007/08 and early work to scope regional and local needs completed
- Regional contracts management is in place and providing improved information flow between individual DHBs and regional services
- The first forensic step down residential facility was opened in February 2008 in Wellington
- The Regional Plan for Mental Health and Addiction services for Pacific Island peoples was completed with some initiatives implemented.

Regional mental health planning

Wairarapa DHB continues its commitment to regional service planning and delivery and is actively involved in initiatives and projects to progress this. Initiatives that will be undertaken in 2008/09 include:

- Regional gaps identified will be targeted in the future through regional and local Blueprint funding bids and service development initiatives
- The development of Eating Disorder services in Hutt Valley DHB. The Wairarapa is well placed geographically to ensure that our population has good access to this service and will work to ensure excellent relationships develop
- The Regional Workforce Coordinator will work with the central region DHBs to support regional and local initiatives to develop and support workforce capability. Regional Blueprint funding of $220k per annum is committed to workforce development from July 2008
- A second step down forensic residential facility will be established outside of Wellington
- A regional service to support family respite services will be established
- Te Arawhata Oranga will continue to provide expert advice. This group supported a regional project to assess progress against Te Puawaitanga and will support initiatives that further enhance Maori participation and partnership in service development and delivery, to improve outcomes for tangata whaiora
- The region remains committed to continuing the implementation of the Pacific Peoples Plan. The Wairarapa will remain engaged with this project to ensure that any opportunities for improving services and networks for Pacific Island peoples living in this district are taken up.

Allocation of Blueprint Funds and Ring Fence requirements

The DHB has applied all ring fence requirements to its allocation of mental health funding. In the 2008/09 year FFT has been passed on to those providers that have satisfactorily met contract monitoring requirements and the demographic adjuster has been applied to increasing services required in the extended continuums of care resulting from the allocation of new Blueprint Funding. The table below show the allocation of new Blueprint funding received for 2008/09.

Purchase Unit	PU Description	Volume	Price per Unit	Spend 08/09	Comment
Not yet decided	Community service for older people	0.5FTE	100000	50000	Increased support to aged residential care facilities who have clients who also have a mental health or addiction diagnosis
MHCS01B	Community AOD Snr clinical	0.7FTE	170000	120000	Increased medical input to the methadone service
Blueprint funds 2008/09		**$190000**			

DSP Priority:	Mental Illness			
	Objectives	**Actions**	**Target Date**	**Responsibility**
Healthier Lifestyles	Intersectoral health promotion and education opportunities	• Media campaign for Mental Health Line	Quarter 1	Planning and Funding, DHB Communications
		• Youth focused media campaign – alcohol and other drugs	Quarter 2	Wairarapa Public Health, Like Minds Like Mine – Te Whare Atawhai
		• Interagency monthly newsletter on activities etc – eg gardening clubs, cooking classes	Quarter 2	NGO led
Increased access to primary mental health and addiction services	Earlier intervention for young adults	• Primary care packages of care service available for secondary school students increased	Quarter 2	Planning and funding, PHO
		• All year 9 students in lower decile schools undergo a HEADSS assessment	Quarter 3	PHU, PHO
Increased access to secondary mental health and addiction services	Implement regionally agreed priorities for new Blueprint funded services	• Forensic step down beds • Eating disorder services • Workforce development • Respite family services	Ongoing	Planning and funding
	Increase mental health support to older people	• Establish closer linkages between provider arm services and residential care services for older people 0.5FTE established • Establish capacity among aged residential care providers to provide a secure environment for older people with mental health or addiction related issues	Quarter 2 Quarter 4	Mental Health Service Manager Planning and Funding
	Review client pathways to maximise recovery and minimise dependency	• Regular review of client care plans, all long term clients have current relapse prevention plans in place • Establish single point of entry to services	Quarter 2	NASC agency, MHS NASC, MHS, Planning and Funding
	Improve linkages and collaboration between services	• Service leaders group is established and meets monthly	Quarter 1	Planning and Funding All service managers
Implementing Te Puawaitanga	Goal 1 – providing services for Maori	New mix of Kaupapa Maori services will be operational from the start of the year	Quarter 1	Planning and Funding Te Hauora Runanga O Wairarapa
	Goal 2 – Active Maori participation in planning and delivery of services	Mental Health progress reported regularly to Iwi Kainga. Maori mental health and addiction plans are integrated into and part of generic Maori health planning processes DHB provider arm supports, plans and leads collaborative strategies with the Kaupapa Maori NGO sector to progress Maori responsiveness DHB provider arm responsiveness to Maori service goals are linked to and aligned with the work of: • The Cultural Competency Framework • Maori Pathways of Care Programme	Ongoing	Planning and Funding Director Maori Health Planning & Funding Service Managers Maori Directorate Iwi Kainga
	Goal 3 provide choice to access Kaupapa Maori mental health services to tangata whaiora Objective 3: Promote kaupapa Maori mental health provision within major mainstream services	Improve access of Kaupapa Maori Addiction Service clients to GP and psychiatric services DHB provider arm establishes and implements a cultural practice awareness training programme for mainstream staff who hold clinical leadership and management roles focussing on how cultural practice sits alongside clinical interventions DHB provider arm service strengthens Maori responsiveness through the development and implementation of a cultural assessment tool	Qtr 1 Qtr 1	Wairarapa Addiction Services Te Hauora Runanga O Wairarapa Planning and funding Service Manager Maori Directorate Service Manager Maori Directorate

	Goal 4 – increase the Maori mental health workforce	Continue to support development of Maori Addiction Service staff to achieve full AOD qualifications The DHB provider arm increases linkages with education sponsors such as: • Te Rau Matatini • Te Rau Puawai	Ongoing	Planning and Funding Service Manager
	Goal 5 – maximise opportunities for intersectoral co-operation	Joint interagency initiatives to increase services for Maori youth are prioritised: • group AOD programmes in schools • Multi agency funded and supported CAYAD service established in Community Based Youth Centre • AOD and mental health services based in community youth centre	Ongoing	Planning and funding Director Maori Health All providers
Outcome Measurements	*IDPs:* QUA 02 (b) results for People with enduring severe mental illness POP 06 improving the status of people with severe mental illness POP 07 alcohol and drug service waiting times		*DHB Indicators:* 250 people per annum supported by PHO "To Be Heard" project Number of HEADSS assessments completed	
Health Target	98% of long term clients have up to date relapse prevention plans			

For mental health workforce developments and plans see section 5.7 of this DAP.

5.17 Elective Services

Why are Elective Services so important to us?
The DHB wants to ensure that:

- the people of Wairarapa receive the same level of care that is available to people living in other districts
- that our population has the right to receive clarity about how long they will have to wait for treatment
- that, with limited resources, we ensure we are treating those with the greatest need first.
- that better integration with Primary Health Providers will improve the health care of our population.

Elective services are those services provided to patients that have a condition that does not require immediate hospital treatment and can be planned. The Wairarapa DHB provides a range of services that fall into this category including general surgery, general medicine, ophthalmology, orthopaedics, urology, gynaecology, ENT and paediatrics. These services are provided by a mix of Wairarapa DHB consultants and visiting specialists.

Access to elective services is based on an assessment of an individual's need and ability to benefit from treatment. Priority is given to people with the greatest need and ability to benefit. Since the adoption of the National Electives Programme Guidelines, the DHB has made significant changes to the way referrals are processed for First Specialist Assessment and decreasing waiting times for elective procedures. However continued efforts are required to ensure that the DHB can provide ongoing sustainable Elective Services to its population.

Past year achievements

Primary /Secondary Care Interface

- Progress made on the electronic referrals project to the stage of advanced product development. The project has been integrated with the Patient Journey Initiative.
- DHB GP liaison role has been enhanced regionally with active involvement in Regional Cancer and Plastics groups.
- GP liaison projects at the primary/secondary interface included;
  - Enhanced GP access to radiology services
  - Continued analysis of inter-district flows to enhance the provision of services locally
  - Continuation of the Bariatric surgery programme for morbidly obese patients with co-morbidities
  - Ongoing liaison between primary and secondary providers.

Volumes

- With continued ESPI compliance additional surgery has been achieved in a number of areas, namely Plastics, ENT, Lithotripsy, General Surgery, Ophthalmology and Orthopaedics.
- Employed third Orthopaedic Consultant

Plans for the year ahead

The focus for 2008/09 year is to maintain and improve the DHBs performance on Elective Service Patient Flow Indicators (ESPIs) and quality requirements so as to achieve a 10% increase in Elective procedures. This will be achieved by:

Continuous quality improvement

- Further involvement of the GP liaison at the primary/secondary interface, including audit of process and quality in areas of referral, patient and provider satisfaction, complaints, patient cancellation and DNA, prioritisation of treatment and clarity of procedure.
- Enhancing the role of Nurses in Outpatient areas including Ophthalmology, pre-assessment, Urology and Hep C to improve patient flow and increase access..
- Continue to monitor and review patient flow processes, productivity and efficiencies to ensure delivery of services, meeting volume and financial targets.
- Continue a schedule of audits to augment monitoring of ESPI compliance. These will include regular audits of DNA rates, trends and DHB responses,

theatre utilisation, cancellation trends, compliance with management and discharge guidelines.
- Further improvement of primary care access to diagnostics
- Improve patient communication further (new PMS)

Managing the prioritisation process and the link between priority and treatment

The Electronic referrals system will be piloted using standard referral proforma included in the Electronic Referral process. Implementation of processes for the use of Virtual FSA's will further contribute to greater access to Consultant advice and ensure those most in need are accepted as patients for specialist opinion and treatment.

Developing Innovative strategies or alternative delivery options aimed at increasing elective capacity (including initiatives across the primary/secondary interface)

Past year achievements continued…

New services

- Paediatric Surgery performed locally, reducing IDF's
- Hep C and Irritable Bowel clinics, enhanced service to patients
- Women's Physio impacting on demand on Urology services

CQI and ESPI Compliance

- Full compliance on all ESPIs through extra clinics and theatre sessions in Urology, ENT and Ophthalmology
- More timely FSAs and surgical procedures for Orthopaedics
- Implemented Ophthalmology *Addressing Disincentives* pilot increasing the ratio of FSA's to follow up appointments
- Enhanced Orthopaedic Clinical Nurse Specialist role to include post op follow up and inpatient nurses education.
- Random theatre audits conducted to improve theatre utilisation
- Nurse-led pre-assessment clinics evaluated and established
- Nationally recognised prioritisation tools established in General Surgery and Urology
- Scheduled Blitzes in ENT (school hols) and Urology
- Increased provision of laparoscopic surgery.
-

Orthopaedic and Cataract Initiatives (OI & CI)

- Exceeded targets for numbers of procedures completed.
- The Orthopaedic Clinical Nurse Specialist has further developed Nurse-led clinics, performing 2 year follow ups of joint replacement patients as well as performing active review and pre-assessment for surgery. There is greater involvement in staff education and inter-disciplinary patient management.
- Enhanced ophthalmology service with nurse assistance and nurse led clinics.

Pilot projects planned

- Virtual FSA's introduced
- Gynaecology proforma piloting the Electronic Referral project
- Gynaecology ultrasound in OPD

Future developments at Wairarapa Hospital to improve access to elective services

Wairarapa Hospital is committed to improving local access to hospital services. A number of initiatives will be undertaken in the 2008/09 year including:

- Developing a sustainable urology service by enhancing Visiting Consultant cover and their relationship with the resident urology nurse.
- Using the blitz approach to reduce waiting lists in ENT, Ophthalmology and Urology
- Offering service to other DHB's to assist in achieving their additional volumes

Additional Elective Services Funding

Extra funding for Elective services has been announced for 2008/09 and Wairarapa DHB has been allocated $2.07m. Part of this funding will be used to deliver extra surgical procedures in Ophthalmology, Orthopaedics, General Surgery, Gynaecology, ENT and Plastics. It will also enable more lithotripsy procedures to be performed. Funding from the new Ambulatory Initiative will be used to increase access to both medical and surgical specialist assessments and also increase the level of outpatient/primary care based procedures.

Key Objectives for Elective Services		
Project/plan area of focus	**Objectives**	**Measures - Improved management of elective surgery**
Continuous Quality Improvement • Improved efficiency and effectiveness of preoperative services	• Maintain FSA/follow up utilising Nurse and allied health practitioner led clinics • Continue a schedule of audit to augment monitoring of ESPI compliance. Included: regular audits of DNA rates, trends and DHB responses, clinic waiting times, theatre utilisation, cancellation trends, compliance with management and discharge guidelines. • Monitor the impact of the Electronic Referral Project	• Improve the efficiency and effectiveness of Perioperative services. • Improve and streamline elective service processes.
ESPI's Compliance with MoH Elective Services strategy	Maintain sustainable processes that ensure all clients receive assessment or treatment within 6 months of being referred and meeting access criteria for the same, all clients receive clarity relating to access, priority and expected wait time and all clients are treated in an equitable and consistent manner. • Monitor the impact of the electronic referral process • Monitor and review patient flow processes, productivity and efficiencies to ensure delivery of services and meeting volume and financial targets.	• Ensure the DHB is compliant with Ministry of Health Elective Services strategy. • Consistently meet all ESPI requirements. *Volumes* • Deliver OI and CI additional volumes ensuring wider access to older people for major joint and cataract procedures
Process Improvements	Identify new opportunities, enhance and streamline current processes that maximize service efficiencies. • Implement Virtual FSA processes • Implement planned improvements in Primary care access to diagnostics • Electronic discharge and post operative notes • Enhanced GP follow up • Nurse led clinics • Staff and GP up-skilling • Reduce impact of DNA's on clinic utilisation • Telephone reminders to the most likely clinics to DNA • Clear communication to the public of WDHB DNA policy • Optimum capacity booking of clinics most likely to have DNAs	IDP: SER07 – Continuous Quality Improvement – elective services Reduced waiting times for elective services. Enhanced elective services delivery OTHER: Average 90% clinic and 80% theatre utilisation. Consistently meet all eight ESPIs across all specialties Deliver agreed 2008/09 OI and CI volume targets.

5.18 Managing Acute Demand and Increasing Efficiency at Wairarapa Hospital

Wairarapa hospital has very high rates of emergency department attendances, and avoidable admissions in comparison with other parts of New Zealand. This indicates some deficiencies in access to primary care, and in discharge planning and post-hospital community support services and linkages.

Acute hospital treatments account for approximately half of the DHB provider's expenditure. Strong uncontrolled growth in acute presentations puts at risk the provider's ability to deliver on its contracts for elective services and manage within budget.

Patients who frequently attend hospital for emergency care account for a large proportion of hospital costs. Good community treatment pathways and hospital assessment processes can reduce the requirement for hospitalisation, reduce costs and improve a patient's quality of life.

However, much of this potential can only be released if all sectors of the local health community work together.

Past year achievements at Wairarapa hospital

- Ophthalmology outpatient service opened
- Paediatric surgery established
- New service established for TOPs and Mirena insertion
- New model of midwifery care established
- DNAs reduced, particularly for Maori
- New model for discharge planning introduced
- Increase in day case rates and DOSA
- Increase in theatre utilisation
- The Patient Journey project commenced
- Introduced home IV service
- Established working group to review and reduce ASH rates

Plans for the year ahead

- Review utilisation of acute assessment unit and develop strategies to reduce unnecessary admissions
- Improve acute assessment processes to move from an 'admit to decide' system to one that facilitates 'decide to admit'
- Complete and implement new model of RMO staffing
- Further develop and implement systems for virtual FSAs
- Change ED practice to ensure patients are not recalled to ED who could be followed up in primary care
- In partnership with primary care, develop programmes and action plans to reduce admissions of 'high intensity' service users.
- Develop and implement protocols for management of chest pain, cellulitis, and DVT in ED and primary care
- Work with PHO Long Term Conditions project to develop district wide care pathways for those affected by chronic illness, so as reduce need for hospital level services.
- Develop advanced care planning to enable Advance Directives to be put in place for those who wish to avoid unnecessary or unwanted acute interventions.

5.19 The Future Workforce

Delivery of health and disability services relies on a dedicated and diverse workforce. The health and disability workforce is our core resource for sustainable service delivery now and in the future. Evidence suggest that simply increasing the numbers of health and disability workers will not be enough. We will have to work differently to ensure our services will be able to meet the health and disability needs of our communities.

Future Workforce is DHBs' joint strategic plan to progress a coherent sector wide approach to developing the health and disability workforce. It provides a clear direction for development and sets eight priorities and actions for development of the health and disability workforce. Future Workforce has an annual work programme. Implementation of ***Future Workforce*** is supported by the another combined DHB initiative – the Health Workforce Information Programme (HWIP)

Past year achievements

- Increased numbers of specialists at Wairarapa hospital, 26 including visiting specialists
- Continued to employ graduates from the UCoL bachelor of nursing programme
- Establishment of a mentoring programme for Maori nursing students at UCoL
- Robust systems in place to support the Health Practitioners Competence Assurance Act 2003
- Training and education of staff in meeting all core competencies required to work in models of care across Wairarapa hospital
- Developed and implemented improvements to orientation programme for new staff and specialised training for existing staff.
- Continued to provide series of Treaty of Waitangi workshops for all staff
- Provided staff training seminars on a number of general topics applicable to staff across all work groups. e.g. Bullying in the Workplace
- Supported a number of staff to attend the LAMP MAP programme
- Increase in numbers of Maori nurses employed by the DHB and other local providers
- Collective agreements that expired this year have been successfully renegotiated
- Provided training for wider NGO sector e.g. diversity training, infection control and other clinical topics
- Clinical Nurse Educators have assisted in the delivery and support of training with service and individual training plans in place
- Links with PHO and other DHBs have supported training programmes
- Pay and Employment Equity Review completed

Plans for the year ahead

Workforce Design – DHB provider arm

The opening of the new Wairarapa hospital in 2006, introduced new models of care that required an extensive workforce redesign. During 2007/2008 the new workforce design was reviewed and where appropriate some refinements were made. In addition, during 2007/08, community, public health, and mental health services have all been reorganised and their workforces restructured. A key focus for the organisation through 2008/09 is to ensure the bedding in and consolidation of these new arrangements, and that the workforce and work processes are functioning effectively and providing the outcomes expected.

Workforce development and training

Priorities for the DHB provider arm workforce development, at the local level, in 2008/09 are:

1. Increased training and support for managers
2. Provision of a programme to eliminate workplace bullying
3. Diversity awareness training (to increase responsiveness to needs of people with disabilities)
4. Training in family violence screening and prevention

We will actively follow a strategy of succession planning including, where feasible, training our own staff in critical areas.

Employee Relations

2007/08 has been a significant year with a number of collective agreements being renegotiated. A new MECA was agreed with NZNO in Nov 2007. Other local collective agreements that were successively renegotiated in 2007/08 were Homelinks (SFWU), Maintenance Services (NZ Amalgamated Engineering, Printing & Manufacturing Union), PSA Clerical, and the Ambulance Service (Amalgamated Workers Union). These national, regional and local agreements have posed some significant challenges for the DHB in terms of affordability. However, it also means that staff in several workgroups within Wairarapa DHB provider arm are now remunerated at an appropriate level. This has had a significant positive impact on recruitment and retention.

Negotiations are ongoing at national level for the Senior Medical Officers and the Residential Medical Officers. In 2008/09 there will be negotiations for PSA Nursing, Medical Radiation Technologists, and PSA Allied/Technical national collective employment agreements.

As a small DHB participation in regional and national initiatives is essential to maximize opportunities and use scarce resources wisely. There is an increasing trend for professional groups to move towards MECA arrangements, which require DHBs to work collaboratively.

At the local operational level the effective management of employee relations will have a positive impact on turnover rates and job satisfaction. This includes not only fair and equitable conditions of employment but also performance management.

In 2008/09 we will increase our focus on the role of the union delegate to ensure that our relationships with all unions and staff who are union members continues to be effective through a robust manager/union delegate relationship.

Another focus will be on full implementation of the national MECA documents and continuing to build on the constructive engagement processes we have for our bipartite relationships. There are a number of employment groups that have MECAs up for negotiation during 2008/09. This will place some significant pressures on the sector in relation to both union expectations and affordability.

Working towards an efficient and effective workforce

Having an efficient and effective workforce means constant evaluation and being flexible enough to accommodate new ways of providing a workplace that satisfies the demands of the available labour pool.

As we look ahead to achieving an efficient and effective workforce we are mindful of our end vision and desired outcomes as set out in the 2003 DHB/DHBNZ Workforce Action Plan:

- **A *flexible workforce***, responsive to consumer need and able to deliver integrated care across a continuum of care; key characteristics continue to include professionalism and technical competence.
- Professional agendas increasingly defined in terms of a ***consumer centred approach***, developing and delivering services with and for communities, families and individual consumers/patients.
- ***Supportive work environments*** providing a context for personal and professional work satisfaction and enhanced productivity.
- A ***resilient workforce*** with individual and team competencies and confidence to explore new ways of working and delivering services to support enhanced sector performance and outcomes.

Workforce Challenges in the Provider Arm

Managing a workforce for a 24 hour 7 day a week health service in a regional location is challenged by a number of factors. These include:

- Scarcity of qualified candidates across a range of skills.
- Staff preferring part time and flexible employment options.

- Higher level of maternity leave due to the predominately female workforce.
- Female workforce who wish to return to work but find it difficult to manage rotating shifts and on-call needs due family responsibilities.
- Coverage during extended sick leave and education/long service leave.
- Ageing workforce.

In 2008/09 Wairarapa Hospital will be focussing on a number of initiatives to improve the level of care being delivered. These include:

- Mentoring of Clinical Nurse Managers – this will involve both internal and external support
- Ensuring clinical skills and nursing care is of the highest standard.
- Coordination between the CNE, CNM, Duty Nurse Manager, and RNs activities which needs to continue outside of normal working hours.
- Retention and recruitment of skilled theatre nurses within the local population.
- Managing ESPI performance while managing workforce constraints i.e. locum staff
- Registered staff multi-skilling across all aspects of their specialist service within a desirable timeframe while meeting service expectations.
- Recruitment and retention of skilled personnel with generalist medical and surgical skills and of specialist skills in Social Work, speech therapy, clinical typing, physiotherapy
- Adequate House surgeon coverage
- One on one mentoring for new graduates.
- Investigating ways of meeting increasing Imaging referrals for ultrasound
- Reducing waiting times for non urgent patients.
- Evaluating the workforce implications of the AT&R review and developing appropriate strategies

Nursing Workforce 2008/09

The DHB sector wide Nursing Entry to Practice (NetP) Programme is now in its second year. The provision of this programme to nurses in primary health care, secondary care, NGOs and the aged and residential care sector is ensuring a degree of consistency in care delivery and competence of the registered nurse workforce as well as improving collaboration, connectedness and intra-professional relationships. Achieving accreditation of the sector wide programme through the Nursing Council of NZ (the Provider Arm one is accredited) is critical for ongoing success.

The availability of post graduate funding is enabling nurses to commence and continue academic preparation at an advanced level. This support will enable the advancement of qualifications and extension of skill base which is necessary to meet the growing complexity of health. Nurses in primary health care are being supported to achieve Nurse Practitioner in Family Health status through DHB/CTA funding for education and mentorship from the South Wairarapa Nurse Practitioner in post.

The development of a Nurse Practitioner in training role for Health of Older Persons is a new initiative which will improve and advance the care planning and management of older persons across the continuum. This DHB wide role will add advanced nursing skill and expertise to the HOP teams in the district and contribute to ensuring the competence of the HOP workforce.

Significant additions to the education calendar for the coming year are training in palliative care and orthopaedics. Whilst small amounts of training has been previously provided there has been a need identified for enhancement of that training. There is also a significant gap in education and training for many in the aged and residential care sector. The DHB is working with this sector to close the gap through provision of professional development support for programmes such as NetP and the clinical management of patients/residents through the NP in training HOP role.

The Maori Student Nurse Mentor role is commencing with the 2008 UCOL Bachelor of Nursing class. The nurse in this role will work closely with the UCOL tutors and WDHB and is a member of the DHB's Nursing Practice Development Unit.

A DHB Nurses' conference is planned for later in the year. This follows on from a very successful primary health care nurses' conference held in September 2007. In the interim time there are opportunities for nurses to network and learn through attendance at journal club sessions and professional forums as well as the multitude of study days now on offer.

All midwives are undertaking their Midwifery Standards Review over the coming months. This is a mandatory component of their recertification process. The DHB fully supports its midwifery workforce in all their requirements for ongoing maintenance of competence. Midwives generally need to attend more external education sessions than nurses due to the smaller numbers in our service. Independent midwives are invited to attend sessions provided by the DHB.

In Mental Health the most pressing need is the recruitment of suitably qualified clinical staff to meet the requirements of the Mental Health Standards and the legal requirements of the Mental Health Act. This will need a concerted and aggressive recruitment effort regionally, nationally and certainly internationally, as the available workforce in NZ is very limited. Alongside this sits the requirement to recruit Maori clinical staff.

Mental Health Service workforce developments

The main workforce issues for the Mental Health Service are:

- difficulty in attracting experienced and qualified clinical mental health professionals, including psychiatrists;
- need for greater career development through training support;
- need for upskilling of CSW's (post mental health certificate) to a level which will enable us to develop acute services in people's homes;
- lack of access to CNE for mental health nurses;
- significant salary differences in a multidisciplinary team in which all need to be able to have skills, experience and qualifications to provide a secondary community mental health service .

The following table outlines the issues and the associated strategies that are planned to address them in 2008/09:

MHS - Workforce Development Plan 08/09	
Recruitment Issues	Actions planned for 2008/09
Ongoing clinical vacancies put service/clinicians under considerable stress / limits quality of service delivery	Develop MHS Recruitment Plan Continue current strategies – and actively pursue experienced clinicians
	Promote Wairarapa and rural MH Services as a great place to work. Identify and promote positive features of working in Wairarapa. Website links/brochures Identify and market to targets e.g. students
National shortage of Maori MH clinicians	Support national initiatives to attract Maori MH clinicians to MHS
Retention Issues	Actions planned for 2008/09
Turnover and inability to retain younger graduates	Use feedback from staff and exit interviews to improve MHS – make it a great place to work
Ongoing changes in leadership - Adult MHS	Ensure high quality clinical leadership is well supported in new MHS structure
Ageing workforce – age of all disciplines is increasing nationally	Increase flexibility of work roles/hours
Clinical Skills Development	Actions planned for 2008/09
Ongoing vacancies means clinicians cannot	Support clinicians to develop their specialty areas - clinical interest

focus on areas of interest/clinical specialty	and expertise – support them to attend regional and national fora related to their specialty
All clinicians need to complete DAO training as soon as clinically eligible	Provide regular DAO training programmes
Ongoing need to assure non Maori work appropriately with Maori	Working with Maori – growing bicultural approach and skills, implement cultural competency framework
Currently no staff identified as seniors who are able to preceptor new staff including new grads.	Identify senior clinician roles and provide training in supervision and preceptoring to enable them to provide clinical supervision / competency assurance for new staff & new grads.
Lack of cultural supervision	Identify ways that clinicians could access cultural supervision e.g. Maori
Need to grow confidence & competence of all staff in managing MH crisis contacts	Develop assessment and risk management competency Develop senior staff to provide supervision and practice development reviews
Team Development	Actions planned for 2008/09
Adult MH Clinical team – requires clearer clinical purpose, practice definitions and team work model	Develop clinical team framework – purpose, and practice models
	Monitor team feedback and culture development

There is an ever increasing shift in mental health service delivery from inpatient/acute to community which will require a shift in service provision. For our MHS this will mean a much clearer focus on clinical and what that means in relation to recovery, and a greater reliance on community organizations (NGOs and Maori organisations). The inclusion therefore of these groups of organisations in workforce development will be crucial to ensuring service users have access to high quality, recovery focused and culturally safe services, while staff will be able to progress to professional qualifications (and possible careers) through developing an interest in clinically provided services

The increasing focus on community based service delivery also requires a community support workforce which is skilled and qualified in supporting people who experience acute episodes and/or ongoing mental illness to maintain connections within their communities of choice. Capacity building for this group of mental health non clinical workers should therefore also be considered within the wider context of mental health workforce development.

Other WDHB Workforce Development Strategies

In 2008/09 we will be reviewing the nature of the workforce as the new generations e.g 'generation X & Y', begin to be present in increasing numbers in the workforce. These generations will require a different style of leadership and management, if they are to be motivated and retained within the environment they find them selves in. The DHB will in 2008/09 focus on developing leadership skills for existing and aspiring managers and team leaders.

A range of national workforce projects will require significant input from the DHB. For each of these there are actions that will support these national initiatives and actions to enable the achievement of local initiatives.

Health Workforce Information Programme (HWIP)

During the past year the Wairarapa DHB has continued to improve the accuracy of the data supplied to support HWIP. We will continue to support HWIP through:

- Providing timely responses to data requests by ensuring there are trained staff undertaking the data collection, changing, and recording process
- Examine ways in which the HWIP data can assist with the Wairarapa DHB's workforce analysis, planning, and development
- Implementing the HWIP data standard

- Improving the quality of HWIP base data by resourcing any approved activity designed to achieve this
- Engaging with HWIP before undertaking workforce information development and analysis
- Referring request for workforce information to HWIP
- Look for ways to streamline the data collection and dissemination process

5.20 Progressing the Health Information Strategy of New Zealand

Information Systems Strategic Planning is a key tool for the DHB to ensure alignment of information systems developments with the needs of the DHB and the population it serves. The Information Systems Strategic Plan (ISSP) for Wairarapa DHB was completed in 2005 and describes seven core strategies for development of Information Systems at Wairarapa DHB over a four year period. The strategies are:

- Implement an electronic medical record containing the minimum information necessary for clinical decision making.
- Enhance the patient journey with integrated information flows across the healthcare continuum.
- Purchase integrated solutions in well-defined areas such as corporate support functions.
- Support the capacity to act with integrated information and knowledge management systems.
- Give priority to electronic capture of existing data that can inform public health planning.
- Learn from other organisations and converge on regionally proven solutions as much as possible.
- Support all information systems with secure, high-capacity, high-availability technology services.

The work programme in the IS strategic plan for Wairarapa DHB aligns to and is consistent with the HIS-NZ, in that it addresses a proportion of the action zones directly. The relationship between the WDHB ISSP and the HIS-NZ is described in Section 4.4 of the ISSP.

The ISSP is being refreshed for 2008.

Past year achievements

- Implemented an electronic solution for "Smoke Free" data collection
- Completed establishment of the Regional high-speed shared network
- Implemented major upgrade to the Clinical Information System (Concerto) including a version upgrade, improvements to discharge summary and Lab results integration carried over from work started previously
- Medlab integration with CDR
- CostPro clinical costing model implemented
- Participated in Regional project to implement a Regional solution for sharing of clinical images and sharing of long term image storage for DR. RFP. Project is ongoing
- Refreshed a large number of end of lease desktop devices
- Expression of interest for Corporate Performance Management solution developed and put to the market
- Developed plans for implementation of PRIMHD solution locally
- Begun programme of work to migrate SQL databases to new SQL platform running SQL. 2005.
- Scope done for phase 1 electronic referrals
- Sought formal agreement from Midcentral and Whanganiu DHB's for joint PAS replacement project
- Refreshed ISSP end of 2007/2008.

Plans for the year ahead

The DHB continues to progress the work programme identified within the ISSP. The key focus for the 2008/09 year will be on:

- Complete requirements, business case, RFP, and product selection of replacement patient management system with Midcentral and Whanganui DHB's. Begin implementation.
- Implement phase 1 electronic referral solution between primary care providers and Wairarapa Hospital
- Progressing the electronic medical record programme
- Complete planning and commence implementation for an information system for the school dental service
- Continuing the business intelligence programme
- Complete planning and commence implementation for a replacement financial information management system

Alignment with HIS-NZ

The Health Information Strategy for New Zealand (HIS-NZ) contains 12 "action zones" which are intended to serve as areas of focus for future developments. The following table is taken from the ISSP and provides a summary of how the WDHB information systems strategic plan aligns to these action zones. Note that the sections referred to in the table are sections within the WDHB ISSP.

Action Zone	What it means	How the WDHB plans aligns
National network strategy	Progressively implementing a secure network to enable the ability for organisations in the healthcare continuum to exchange information securely.	This action zone is aligned with the WDHB strategy to develop robust, secure IT infrastructure and particularly the network development plan described in Section 4.2.7. In addition WDHB has worked with its partner DHB's to establish the Central Region high-speed network for improved sharing of information.
NHI Promotion	Routine use of National Health Index numbers in the collection and analysis of healthcare data.	WDHB is accustomed to the use of NHI numbers in all of the hospital provider systems. The work programmes in the electronic medical record strategy will ensure that the routine use of NHI numbers will continue.
HPI implementation	Routine use of Health Practitioner Index identifiers to secure access to clinical systems.	WDHB will follow developments in this area and incorporate the HPI standards into new and existing systems as appropriate.
ePharmacy	Implementation of electronic prescribing throughout the continuum.	WDHB will address electronic prescribing as part of the Electronic Ordering project in the third major phase of the EMR work programme (Section 4.2.1).
eLabs	Implementation of electronic reporting and test ordering systems	WDHB will implement lab results reporting in Phase I of the EMR strategy, and address electronic test ordering as part of the Electronic Ordering project in the third major phase of the EMR strategy (Section 4.2.1).
Discharge summaries	Implementation of structured systems for sending discharge information electronically.	WDHB has already implemented a version of electronic discharge reporting to general practice. These facilities will be extended under the EMR work programme (Section 4.2.1).
Chronic Care and Disease Management	Electronic support for processes of integrated care across primary and secondary care organisations.	WDHB is progressing this via a contract with its PHO implementing Chronic Care software in all its GP practices.
Electronic referrals	Implementation of structured systems for sending referral information electronically.	Basic, unstructured forms of electronic referral will be introduced in the Phase I of the EMR work programme. More sophisticated, structured referrals will be adopted in later phases as the standards are developed (Section 4.2.1).
National Outpatient Collection	Implementation of a national statistical collection system for outpatient data.	Project to meet phase 1 of NNPAC is complete. WDHB will consider the implications of future NNPAC requirements as part of the requirements specification for a replacement for the Galen ADT system (Section 4.2.1).
National Primary Care Collection	Implementation of a national statistical collection system for primary care data.	WDHB will monitor progress of this work, and schedule specific arising activities in the annual refresh of the ISSP.
National System Access	Implementation of facilities for accessing national statistical collections in secure fashion.	WDHB will ensure that the IT infrastructure provides the building block to facilitate implementation of the identified access initiatives (Section 4.2.7).
Anchoring framework	Development of standard national "data dictionary" to provide a standard reference for how data should be stored and used.	WDHB will ensure that the requirements specifications for systems to be acquired take into consideration the emerging standards.

Improving National Collections Systems Data Quality

A data integrity position leads improvements in data quality around Hospital systems which feed many National collections including the NHI, NMDS and MWS. This position audits the quality of the data and provides ongoing guidance and training to staff involved in data entry and collection for those systems.

Other positions are responsible for reviewing and addressing data quality issues in specific areas, for example staff in the Mental Health service are responsible for addressing data quality and ensuring that extracts to MHIC are reconciled and errors corrected. The elective services manager audits all processes associated with the elective services contract.

Improved reporting systems are being developed at the DHB in order to provide improved feedback and information to managers. A benefit of this improved feedback is improving awareness of the importance of applying resourcing and education to staff to ensure appropriate data quality.

Collaboration

As the DHB progresses its Information Systems Strategy it will continue to collaborate in the Information Management area with other DHB's in a number of areas. This includes:

- active participation in the national Chief Information Officer forums
- active participation in the Central Region Chief Information Officer forums
- attendance at Primary Care Information Management Group
- collaborating with Midcentral and Whanganui DHB's in the procurement of replacement Patient Administration Systems and their implementation
- examining options for collaboration on the FMIS replacement project
- sharing IS human resources and knowledge with other DHB's
- leveraging the new Central Region high-speed network to improve access to information systems
- collaborating on specification development and testing for system changes related to National initiatives with other DHB's using common systems
- vendor management

5.21 Continuing to improve quality and safety of all services

Wairarapa District Health Board's quality framework describes our approach to quality assurance and improvement. We focus on a systems approach to quality improvement that is designed to:

- Ensure services provided are safe, and meet national and professional standards.
- Develop systems and organisational culture to achieve high quality outcomes
- View quality as the search for continuous improvement
- Ensure services provided are consistent with best practice and improve consumer's quality of life.

We achieve our quality and safety objectives through use of the following tools and processes:

- Accreditation and certification
- Legislative compliance
- Policies, procedures and patient information publications
- Clinical governance
- Credentialing
- Reportable events and complaints
- Consumer participation – surveys and focus groups
- Monitoring, audit and risk management

Wairarapa District Strategic Plan 2006 – Appendix 3

Past Year Achievements

- Completion of Wairarapa DHB Strategic Quality Plan for 2007-2010
- Audited against new draft EQIP standards in February 2008
- Certification surveillance audit completed.
- Established The Patient Journey project with dedicated project manager.
- Credentialling of General Practitioner Obstetricians (GPOs)
- ACC Endorsed Provider Accreditation for Physiotherapy
- ACC Workplace Safety Management tertiary status maintained.
- HDC closure of two complaints, which were managed successfully avoiding full investigation by the HDC.
- National Cervical Screening Unit audit undertaken and corrective actions implemented.
- Disability Access audit undertaken of new facilities. Corrective actions undertaken.
- Review of clinical audit systems undertaken.
- Development of mortality and morbidity process transfer review process
- Review of legislative compliance programme

Plans for the Year Ahead

In 2008/09 Wairarapa DHB will continue implementation of its Strategic Quality Plan and will strengthen its clinical governance systems and processes.

QIC programme

We will work at both the national collective level and at our individual DHB level to deliver the nationwide Quality Improvement Committee (QIC) programme over the next 3-4 years. Each project will be run by a lead DHB with help from other DHBs. The lead DHB and DHBNZ will provide resources to run the national programme and to help other DHBs implement the outcomes from the projects.

Wairarapa DHB is committed to actively working with the national collective to support the lead DHBs and to ensuring that we in Wairarapa are prepared in terms of planning and resourcing to implement the results of these projects as they become available.

We acknowledge that 2008/09 is the establishment phase for the national programme. The Lead DHBs will begin to deliver the first outputs by the end of 2008/09. At Wairarapa DHB we expect to be to be ready to start implementing outputs from the national programme by the end of 2008/09. We expect our commitment of resources to the national QIC programme to increase over the 2009 and 2010 calendar years as the programme enters its implementation phase.

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

Wairarapa DHB will undertake activity in 2008/09 to progress the five key QIC initial priorities at local level as follows:

QIC initial priority	Wairarapa DHB action for 2008/09	Performance measures and target dates
Safe Medication Management	Establish and recruit to a clinical pharmacist position for Wairarapa hospital Develop and begin implementation of medicines reconciliation project in Wairarapa Hospital Audit the hospital's management of medications for in-patients	Post established 1 July 2008 Recruitment completed 30 November 2008 Project plan agreed 1 July 2008 Project milestones achieved on time Audit completed by 30 Sept. 2008 Recommendations acted on fully by 31 March 2009
Management of Healthcare Incidents	National Policy on Open Disclosure implemented in Wairarapa DHB Training in adverse event management and open disclosure provided for frontline staff Regional Policy on Communication with the Coroner developed and implemented	Policy operational in WDHB by 30 September 2008 90% of staff trained by June 2009 Policy completed by 30 Sept. Implemented in Wairarapa by 1 Feb 2009
Optimising the Patient's Journey	Complete the Wairarapa DHB Maori cultural competency framework and establish in at least one hospital service Advanced care management project implemented to encourage care planning and the concept of Advanced Directives Complete establishment of single point of entry for access to all community nursing and support services. (includes triage)	Establish and recruit to new position to support roll-out of cultural competency framework – 30 September 2008 Terms of reference and project workplan, with milestones, completed by 30 September Fully implemented by 30 June 2009

	Implement electronic referral system and virtual first specialist assessments (FSAs) Implement new palliative care service framework	Virtual FSA implemented from 1 July, electronic referral system in place by 1 February 2009 New specialist palliative care service commences 1 July
Infection Prevention and Control	Continue Hand hygiene education programme Implement Wairarapa DHB Infection Control Plan (ICP)	80% of all DHB staff have attended hand hygiene education by 30 June 2009 Quarterly reports provided to Clinical Board on progress in implementing ICP
National Mortality Review Systems	Continue to develop local mortality review systems and processes	Reportable Event Group (REG) review of deaths reported to the Clinical Board each quarter.

Clinical Governance

Clinical Governance is the collaboration of those involved in the provision of clinical care (clinicians) and those involved in the structure for the provision of clinical services (managers) to oversee the quality of clinical care and services. In Wairarapa DHB the Clinical Board is responsible for clinical governance.

Clinical Board

The Clinical Board is responsible for providing clinical leadership; leading the development of clinical governance across all of the services provided by the DHB; overseeing the quality and safety of services delivered by the DHB's provider arm and the clinical quality programme; and providing advice and recommendations to the DHB Board, chief executive and management.

The Clinical Board receives reports from, and oversees the work of many sub committees including:

- Reportable Events Group
- Product Evaluation Group
- Clinical Records Group
- Health and Safety Committee
- Infection Control
- Medicines Advisory Committee
- Blood transfusion Committee
- Library Committee

And has the power to create other sub committees as may be required.

The Clinical Board works in liaison with the Wellington Ethics Committee.

In 2008/09 the Clinical Board will focus on:

- the concept of coordination and unification of the goals of care for the individual patient
- the evaluation of clinical quality
- the agreed goals for patient safety
    - Patient identification
    - Communication

        - Medication Safety
        - Medication Reconciliation
        - Health care associated infection
        - Patient Involvement
        - Patient Falls
        - Pressure Areas
    - the identification of goals of care, standards of care and improvement in the process of care through the successful implementation of "Optimising the Patient Journey"
    - recruiting a clinician working in a rest home to the clinical board

The Clinical Board is responsible for oversight of systems and processes to assure clinical safety and the management of clinical risk. Clinical Risk includes "risks" for both patients and the organisation resulting from both the provision and the non-provision of clinical care.

Clinical risks for the Wairarapa District Health Board include concerns relating to the 8 "goals for patient safety":

- Communication
- Patient identification
- Medicines Safety
- Medicines reconciliation
- Healthcare associated infections
- Patient involvement issues
- Patient falls
- Patient pressure areas

Many of these areas of risk and concern will be addressed in 2008/09 through the local QIC initiatives listed in the table above. In addition the Clinical Board will also work to reduce communication risks in the following areas:

- Clinical typing
- Clinical discharge summaries
- Clinical referrals
- Clinical staff experience at night in the Emergency Department
- Clinical information sharing between nurses and doctors on the Med/Surg ward
- Clinical investigation results being readily available.
- Clinical policies being concise, readily available and giving a concise message
- Clinical secretarial support
- Clinical "Handover" processes

Increased resources for clinical governance and quality improvement activity

During 2007/08 a full time management position was established to lead and manage the Patient Journey programme. Further positions to be established in 2008/09 are as follows:

Executive officer for Clinical Board – 1 FTE
Quality assurance and internal audit – 1 FTE
Implementation of cultural competency framework – 1 FTE Maori
Clinical pharmacist – 0.2 FTE

Many improvements in clinical safety and management of clinical risks are also highly dependent on information technology. Over the next three years Wairarapa DHB expects to implement significant improvements in its IT and IS.

5.22 Value for Money

"Value for money" includes a wide range of quantitative and qualitative considerations. Wairarapa DHB defines "value for money" as:

"Using resources effectively, economically and without waste in achieving health and disability outcomes desired by government and beneficial for people of the Wairarapa."

Ensuring value for money requires:

- Robust prioritisation and funding allocation processes
- Delivery on planning and funding decisions
- Monitoring and review of impacts and outcomes
- Self-evaluation by the DHB of decisions and processes – a culture of enquiry and change
- Application of learnings

Value for money is a combination of efficiency and effectiveness and may be determined from different perspectives such as those of the DHB as funder, the service provider, the clinician, and the service user.

Assessment of value for money needs to occur across planning, service delivery, service development, and evaluation.

Past year achievements

- Completed Wairarapa Hospital development and implementation of the new models of care.
- Achieved large increases in percentages of operations/procedures completed as day cases, and day of surgery admissions
- Increased rate of flu vaccination of people aged 65 years and above from 73% in 2006 to 89% in 2007
- Increased the proportion of people receiving aged care services in their own home (rather than residential care) from 59% to 68%
- Increased hospital productivity: service volumes/throughput increased by 5% above plan while expenditure increased only 2% above plan.
- Digital dictation implemented fully across all clinical services. This has resulted in improvements in the prioritisation of clinical typing and the response times from the central typing pool.
- Established IV in the home service
- Benchmarking of the diabetes programme shows the DHB is delivering a very good service through out the district.
- Benchmarked expenditure per client on aged care service provision, and assessed cost-effectiveness of different service provision options
- Reviewed ambulatory sensitive hospitalisation rates and trends and set up project to develop community/primary and hospital initiatives to reduce admissions for cellulitis, angina and gastroenteritis.
- The DHB linked strongly into the national VFM programme with the DHB's Chief Financial Officer a member of the Steering Group.
- Achieved full compliance with elective services performance indicators.

Plans for the year ahead

The DHB continues to progress a number of value for money initiatives within the coming year. The key items identified for the 2008/09 year are:

- The Patient Journey: continue to further streamline the operations of the Hospital and the flow of the patient from primary care through the hospital and back to primary/community care.
- Continue to use transparent prioritisation and funding allocation processes across all areas of DHB activity, and within specific services
- Increase use of outcome measures, particularly in mental health services
- Review and evaluate school clinics and flexible packages of care service for older people
- Streamline primary care practitioners' access to imaging diagnostics
- Regional collaborative procurement: The DHB will continue to participate within the LNI Buying Group for collaborative procurement across the central region DHBs. The DHB expects to achieve further savings on bulk buying in addition to gains from the national procurement project.
- CDEvolution: continue to work with the WCPHO to progress the CDEvolution product and review the results achieved.
- Palliative Care strategy: Implementation of new palliative care strategy with coordinated assessment of need and care planning, and improved matching of individual needs to service provision.
- Evaluate impacts and outcomes of new services and service changes as they are introduced – eg IV in the home, new model for palliative care
- Continue to monitor ambulatory sensitive admissions, analyse data, and identify and implement system changes to reduce these admissions.
- Continue to increase percentage of older people supported in their own homes

Performance measures	Targets for 2008/09
Percentage of people admitted for surgery whose surgery is performed on the day of admission (DOSA)	100%
Percentage of people receiving elective operations whose operation is performed as a daycase	70%

5.23 Emergency Planning

The World Health Organisation (WHO) have been monitoring the possibility of a new pandemic of human influenza since 1968 when the last of the previous century's three pandemics began. Concerns were raised in early 2004 following reports that a new highly pathogenic strain of avian influenza, H5N1, was spreading across Asia, infecting both birds and humans. Although the virus has not yet gained capacity for sustained human-to-human transmission, it continues to undergo genetic changes and h as the potential to develop this capacity. By the end of December 2007, the virus had infected 349 people in 14 Countries, and a total of 216 people had lost their lives.

The possibility of a pandemic involves an extra dimension to emergency planning and has been a key feature of Ministry of Health planning work since 2005. Wairarapa DHB has dedicated resources to ensure that robust Regional, District and Hospital plans are in place. Planning has involved working with all health providers and multi-agencies both within the district, regionally and nationally.

In the event of a pandemic event Wairarapa DHB is the lead agency for coordination across the Wairarapa. The plans developed have been endorsed by all Wairarapa stakeholders.

Wairarapa DHB also recognises that there is a need to be prepared for other major emergencies such as natural and technological hazards

Past Year Achievements

- Pandemic Action Plans have been successfully tested on the National Pandemic Influenza Exercise, Exercise Cruickshank.
- Considerable effort has been put into Coordinated Incident Management System Training for Senior Management, to that end capable Incident Management Teams have been established.
- Huge efforts have been made with assisting schools within the Wairarapa with their Emergency Planning.
- Successfully put in place Memorandums of Understanding with Rathkeale College and the YMCA to use their premises as either a Community Based Assessment Centre or Field Hospital in the event of a Public Emergency.
- Achieved excellent attendance at Maori and Pacific Island Pandemic Education Seminars and Train the Trainer Sessions. Staff and Community education is an ongoing effort.
- Highly successfully established an Emergency Operations Centre with Masterton Civil Defence Headquarters whereby all three Territorial Authorities Combined as one, Police, Welfare Agencies, Primary Health Organisation, Regional Public Health and the DHB operated alongside each other.
- Roles and responsibilities of key agencies have been identified and fully understood by those agencies; this was successfully tested during Exercise Cruickshank
- Completion of the Emergency Response Manual.
- Purchased an Inflatable Shelter for use as either a Mobile CBAC, Mobile Triage Centre for Mass Casualty events or a Temporary Ward in the event of a Technological or Natural disaster event.
- Fully and successfully tested both the Hospital and DHB Emergency Operations Centres'.
- Implemented robust Emergency Communications Channels within the DHB whereby the following systems are in place:
    - Internet
    - Landline

- Facsimile
- Cellular
- Radio/Telephone (Team Talk)
- Iridium Satellite Phones

Plans for the year ahead

This will largely be a continuation of the building blocks established during 2007/08; these include the following:

- Preparing for the potential of a pandemic event will be ongoing.
- Ensure that Emergency Response Plans are in place that meet the requirements of the National Civil Defence Emergency Plan, Order, 2005.
- Ensure that plans meet National, Regional and Local requirements to enable it to respond to all emergency situations.
- Continue to strengthen already firm alliances within the community as a whole by holding regular meetings and participating in National, Regional and local exercise and forums.
- Provide support to Health Care agencies to develop and evaluate their Emergency Plans.
- Work regarding Community Based Assessment Centres' is an ongoing project.
- Introduce and train staff on the use of WebEOC.
- Participate on National, Regional and Local exercises on an Annual basis at the very least.
- Educate staff on the Emergency Response Manual, by training and exercising.
- Exercise aspects of the Emergency Response Manual, be it 'Desk-Top' or 'Deployment'.
- Research emergency management and preparedness best practice methods and where applicable implement within Wairarapa DHB.

5.24 The NZ Disability Strategy

The needs of people with disabilities cut across all health and population groups. All of the DHB's strategies and actions must reflect the DHB's commitment to implementation of the New Zealand Disability Strategy and achievement of its vision of a fully inclusive society. This is being addressed by the DHB:

- Being an inclusive employer
- Working with the local disability community to ensure they have input to service planning and development and that people with disabilities have equal access to holistic health services, as well as to the disability support services they require to participate in the community
- Ensuring DHB staff receive disability awareness training and practice it
- Providing information in disability accessible formats
- Working with all services and sectors to promote social inclusion and understanding of the needs of disabled people

In addition Wairarapa DHB recognizes its specific responsibility for local implementation of the New Zealand Disability Strategy action 8.4 "Ensure disabled people are able to access appropriate health services within their community". The DHB's disability support advisory committee regularly reviews accessibility of services for people with physical and non-physical disabilities and ensures that barriers identified are addressed.

The Disability Strategy aims for an inclusive society which focuses on highly valuing lives and continually enhancing full participation of people with disabilities. Through its Disability Action Plan, published in 2007, The Wairarapa DHB has recognised its role as:

- A health and disability services provider and employer.
- A funder and planner of health and disability services.
- A communicator and provider of information.
- A community leader.

This plan will continue to guide DHB activity in 2008/09. With the occurrence of disability tending to increase with age, the Health of Older People Strategy has also contributed to addressing the needs of people with disabilities. Wairarapa DHB recognises sign language as an official language of New Zealand and provides sign language interpreter services when required.

Past year achievements

- DHB Submissions have contributed to improved transport options for people with disabilities including wheelchair access on the Wairarapa-Wellington train service.
- Progress in Implementation of recommendations of the Wairarapa Hospital Accessibility Audit
- Increase in the number of Maori accessing Disability Support services through the NASC (from 5% clients to 11% clients)
- Establishment of a single point of entry for all Community Health and Disability support services, to enable seamless transition between services
- Enabling essential high cost services through a national funding pool for people with a high level of need who are disabled by their condition
- Flexible packages of care responsive to individuals with high and complex needs introduced for older people
- Personal Communication Guide developed for people in hospital who have a disability and wish to notify others of their communication preferences
- Increased links with Workbridge to enable increasing DHB employment of people with disabilities.

Plans for the year ahead

- Continue to address any accessibility gaps identified in the hospital barrier-free audit carried out in 2006 – 07.
- Extend the use of the Personal Communication Guide for people with disabilities from AT&R to other inpatient and outpatient areas.
- Further progress the long term (2006 – 2009) development of a single point of entry for health and disability support services to enable better integration and smoother processes between health and disability support functions.
- Focus on improving equity and transparency for access to support services for people with disability and those with long term needs arising from their health condition.

- Continue to develop carer support in Wairarapa for primary carers of disabled people (all ages).
- Implement the recommendations of the 2007 AT&R Review and establish Stroke protocols according to the Stroke Guidelines
- Address HR related objectives in the DHB Disability Action Plan (e.g. Disability Awareness Training). Implement a strategy to increase employment of people with disabilities.

6. MANAGING FINANCIAL RESOURCES

6.1 Overview

Wairarapa DHB is continuing to forecast a zero operating surplus following the trend of previous years. This is despite significantly increased cost pressures, particularly wage and salary growth which continues to be in excess of FFT, combined with a Board commitment to increased investment in District Strategic Plan priorities, while maintaining the level of service delivery set in the previous two years.

The 2008/09 District Annual Plan continues to focus on strong financial management and fiscal control, assisted by the FFT adjustment and demographic growth adjuster. However, Wairarapa DHB has been left in a very challenging position than at the same time last year due to the impact of the recognition of the full costs of recent and proposed (as at the time of writing) MECA settlements as well as the impact of very significant IDF outflow and pricing adjustments.

To achieve the District Annual Plan operating position in 2008/09, we have "capped" the allowable and fundable growth within the Provider Arm. As noted elsewhere in this Plan, the Provider Arm growth has exceeded expectations over the last two years, however the financial results achieved have been at the projected level. This will present a challenge to contain the growth and related cost within these parameters.

6.2 Managing within the operating budget

Wairarapa DHB will receive a funding increase through the FFT and demographic growth adjusters of approximately $5.2 million for 2008/09. This brings the total revenue for the DHB to a projected $112 million. Wairarapa DHB remains committed to operate long-term sustainable health and disability services and manage its financial resources within the amount of funding provided.

The financial results are summarized as follows:

Summary Statement of Financial Performance

	2006/07 Actual $000	2007/08 Budget $000	2007/08 Forecast $000	2008/09 Budget $000	2009/10 Estimate $000	2010/11 Estimate $000
Revenue	98,711	103,711	106,821	112,071	116,632	121,273
Operating Costs	95,284	99,133	102,021	106,855	111,199	115,652
Net Operating Surplus	**3,427**	**4,578**	**4,800**	**5,216**	**5,433**	**5,621**
Depreciation	2,276	2,440	2,454	2,479	2,690	2,878
Interest	1,396	1,485	1,485	1,885	1,885	1,885
Capital Charge	853	650	850	850	850	850
Net Surplus/(Deficit)	**(1,098)**	**3**	**11**	**2**	**8**	**8**

In budgeting for the breakeven position, the DHB has assumed that the sector will be able to manage cost increases, especially wage and salary growth, within the baseline funding increase. In addition, efficiencies will be realized from the improved management of chronic conditions and long-term illness, improved management of acute demand and service innovations flowing from "The Patient Journey" programme.

The assumptions utilised in preparing the financial projections are set out in section 7.4.

6.3 Outlook for 2009/10 and 2010/11

The DHB has completed the two outer years of the DAP based on indicative funding levels advised by the Ministry of Health. The DHB has also assumed that the expenditure will increase at the same rate as the funding from the Ministry of Health. As a result, a breakeven financial result is forecast for the years 2009/10 and 2010/11.

All assumptions carry risks as identified within sections 2.2 and 2.3 of this Plan.

6.4 Financial Assumptions

The prospective financial information in this District Annual Plan has been prepared in accordance with the New Zealand Equivalents to International Financial Reporting Standards (NZIFRS). The move to NZIFRS saw a liability for outstanding sick leave entitlements recognised in the 2006/07 financial year which resulted in a restatement of the reported (within the DHB's 2006/07 Annual Report for the 2006/07 year) net surplus of $55,000 to a net deficit of $1,098,000 as shown in section 7.2.

The following is a summarised list of assumptions used in the preparation of the financial information:

a) All pressures for additional expenditures must be managed within the DHB's allocated funding envelope for 2008/09 of $99M.

b) Net costs to the DHB of increases in staff remuneration negotiated through MECAs and other agreements will be no greater than 2.3%. This means any claims for pay increases above 2.3% can only be agreed if offset by new agreements for matching increases in productivity.

c) The funding envelope provides for general price increases of 2.3%, with further amounts provided for specific purposes as follows:
   - 0.5% for expenditures on new/additional technologies, including higher IDF prices
   - 0.25% for expenditure on quality improvement initiatives to support the national QIC programme
   - 0.25% to meet the costs of procurement initiatives.

d) The price increase to be agreed by DHBs collectively for national contracts will be no greater than 2.3%. This includes all prices in DHBs' service agreements with providers of:
   - Primary health care services
   - Aged residential care services
   - Oral health services
   - Pharmacy services

e) The national price increase for Blood and Blood products will be no greater than 2.8%.

f) Volume growth in key demand driven areas of service provision will be no greater than:
   - 7% in number of prescriptions dispensed
   - 5% in aged residential care
   - 0-2% in acute presentations to Wairarapa Hospital

g) IDF volumes will be at levels advised by the Ministry of health.

h) Costs of new initiatives required by Government in 2008/09 will be fully funded by specific additional funding allocations to the DHB. This includes the roll-out of Before School Checks; and possible introduction in 2008/09 of hearing screening for newborn babies; HPV vaccination against cervical cancer; and reduction in

patient co-payments for dispensing of scripts written by hospital doctors.

i) Interest and foreign exchange rates will remain within the parameters of the Treasury forecasts announced in January 2008.

j) The capital charge rate will remain at 8%.

k) Wairarapa DHB will retain early payment status.

l) The impact on the DHBs' cash flow of moving to payment in advance for IDFs will be able to be managed within the DHBs' overdraft limits and will not impact adversely on the DHBs' facility development and capex programmes.

m) Government will fully fund the costs to the DHB of implementing Kiwisaver.

n) The national cost of pharmaceutical cancer treatments in 2008/09 will be no more than $20M greater than the amount forecast by PHARMAC, and Wairarapa DHB's share of this cost will be no greater than 1%. For 2008/09 pharmaceutical cancer treatment (PCT) costs have been unbundled from other cancer treatment costs and accounted and billed for separately. There are serious doubts about the robustness of the calculations and a risk that the amount estimated is around $10M less than the actual expenditure in 2007/08. In addition there are huge growth pressures on PCTs.

o) No allowance has been made for any increased asset valuation in line with the requirements of NZIFRS.

The following table shows the financial impact of a 1% change in some of the critical assumptions listed above on the projected 2008/09 financial results:

	$000
Change of 1% on salary & wages	306
Change of 1 % on consumable & other costs	154
Change of 1 % on IDFs provided by other DHBs	190
Change of 1 % on demand driven primary care costs	114
Change of 1 % on aged care volumes/costs	120

6.5 Efficiencies

Wairarapa DHB has made significant efforts to ensure its health and disability services are provided in the most effective and efficient manner within the funding available.

The DHB over the last four years has undertaken a number of efficiency projects that were identified within the business case for the Wairarapa Hospital development. These projects delivered the total efficiency target identified in the business case. Without those gains the DHB would be faced with an estimated $5-5.5 million deficit for the 2008/09 financial year.

In budgeting for breakeven results, Wairarapa DHB is expecting to achieve a number of efficiency gains to offset higher than expected cost increases. Examples of the initiatives to be undertaken include:

- Improve chronic conditions and acute demand management and reduce avoidable admissions;
- Improve Provider Arm employee cost control processes, leave management and roster activity;

- Continue to implement the initiatives within "The Patient Journey" programme;
- Achieve procurement savings on clinical and non-clinical consumables through the national and regional procurement initiatives; and
- Implement the new model of care for the rehabilitation service within the hospital.

6.6 Asset Planning and Investment

6.6.1 Asset Management Planning

Wairarapa DHB is committed to asset management planning with a view to a more strategic approach to asset maintenance, replacement and investment.

A revised Asset Management Plan (AMP) has been developed. The revision of the AMP includes a detailed review of the asset management practices and will provide a robust platform on which to base capital investment decisions in the future. The AMP reflects the joint approach taken by all DHBs and current best practice.

6.6.2 Capital Expenditure

The projected capital expenditure for 2008/09 is $3.7 million. Of this total $2.2 million is primarily for normal asset replacement and priority new equipment. This level of expenditure is approximately equivalent to the level of depreciation.

The remaining $1.5 million reflects the approved funding provided by the Ministry of Health. This funding is for the implementation of the Oral Health project following the business case submitted in late 2006 and approved in September 2007.

6.6.3 Business Cases

Business cases relating to information technology and other significant capital projects will include Regional Capital Committee (RCC), National Capital Committee (NCC) and Ministry of Health (MOH) review and endorsement, where appropriate.

The DHB has lead the development of an options analysis for the replacement of the outdated legacy patient administration system (PAS) and has provided this analysis to Mid Central DHB and Whanganui DHB who also need to replace their legacy PAS. The three DHBs have agreed to work collaboratively on the replacement with the detailed planning work currently underway. It is expected that the value of the PAS replacement will require notification to the RCC and likely to the NCC and MOH. It is also likely that capital will be required from the Health Capital Envelope following completion of the detailed planning work.

At the time of writing no business cases requiring notice to RCC, NCC or MOH are planned other than the replacement of the PAS.

6.6.4 Alternate Funding

As capital investment proposals are finalized managers will review the most appropriate financing option currently available for a particular item. This may result in items being acquired via donation or leasing options and therefore not being purchased via the capital expenditure programme.

6.6.5 Asset Valuation

Wairarapa DHB revaluated its property and building assets at 30 June 2007 in line with generally accepted accounting practice requirements and NZIFRS.

There is increasing likelihood that there will be a need for an asset revaluation to be carried out on the building and property assets during the future financial years (2008/09, 2009/10, 2010/11) due to increased land and building costs. At the current point in time no allowance has been made for any increased asset valuation. However, this will depend on whether the valuation has a material impact on the financial statements. If a revaluation does occur then there will be additional depreciation and capital charge costs which are unlikely to be reimbursed on a yearly basis.

6.6.6 Asset Disposal

Wairarapa DHB actively reviews assets to ensure that it has no surplus assets. No significant assets are scheduled for disposal during the plan period as a result of being declared surplus.

The approval of the Minister of Health is required prior to the DHB disposing of land. The disposal process is a protective mechanism governed by various legislative and policy requirements.

6.7 Debt and Equity

The DHB's total term debt is expected to be $26 million as at June 2008 and for the three years covered by this Plan.

The DHB has a long-term debt facility that is fully drawn down, of $25.75 million with the Crown Health Financing Agency (CHFA). The CHFA waived the covenant ratios that had previously covered this facility. Until that point the DHB had fully complied with the covenants.

The DHB has a range of finance leases covering the replacement of the Ambulance fleet and partial funding for the implementation of the RIS/PACS system. These leases are at very competitive interest rates (ranging from 1% to 4% per annum) and are provided by the Wairarapa Community Health Trust. This reflects a long standing arrangement where the Trust has provided the funding for the regular replacement of all the ambulance fleet. A further lease, to a value of $120,000, will be entered into early in the 2008/09 year.

The DHB maintains a working capital facility of $4 million with the ANZ Bank. The ANZ Bank also provide the transactional banking facilities for the DHB.

6.8 Projected Financial Statements

The projected financial statements have been prepared in accordance with the accounting policies adopted by the Board and included within the Statement of Intent. The accounting policies reflect the move to NZIFRS. These statements, including the underlying assumptions, were approved by the Board of Wairarapa DHB in February 2008.

The consolidated financial statements contained herein include the consolidation, in accordance with the accounting policies adopted by the DHB, of Biomedical Services (New Zealand) Limited which is a 100%-owned subsidiary of the Wairarapa DHB.

The actual results achieved for the period covered by the financial projections are likely to vary from the information presented, and the variations may be material. The financial projections comply with section 142(1) of the Crown Entities Act 2004 and the information may not be appropriate for any other purpose.

Wairarapa District Health Board
Forecast Statement of Financial Performance
For the year ended 30 June

	2006/07		2007/08		2008/09		2009/10		2010/11	
	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's
Revenue										
Revenue	99,864	98,771	107,792	106,821	113,058	112,071	117,639	116,632	122,280	121,273
Total Revenue	**99,864**	**98,771**	**107,792**	**106,821**	**113,058**	**112,071**	**117,639**	**116,632**	**122,280**	**121,273**
Expenditure										
Provider Expenditure	(52,018)	(52,018)	(56,523)	(56,523)	(58,675)	(58,675)	(61,159)	(61,159)	(63,687)	(63,687)
Operating Expenditure	(44,244)	(43,267)	(46,313)	(45,498)	(48,998)	(48,180)	(50,864)	(50,040)	(52,789)	(51,965)
Depreciation	(2,355)	(2,275)	(2,539)	(2,454)	(2,569)	(2,479)	(2,787)	(2,690)	(2,975)	(2,878)
Interest	(1,396)	(1,396)	(1,485)	(1,485)	(1,885)	(1,885)	(1,885)	(1,885)	(1,885)	(1,885)
Capital Charge	(853)	(853)	(850)	(850)	(850)	(850)	(850)	(850)	(850)	(850)
Total Expenditure	**(100,866)**	**(99,809)**	**(107,710)**	**(106,810)**	**(112,977)**	**(112,069)**	**(117,545)**	**(116,624)**	**(122,186)**	**(121,265)**
Net Surplus/(Deficit)	**(1,002)**	**(1,038)**	**82**	**11**	**81**	**2**	**94**	**8**	**94**	**8**
Gain/(Loss) on Sale of Assets	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-
Income Tax	(28)	-	(23)	-	(26)	-	(28)	-	(28)	-
Net Surplus/(Deficit)	**(1,030)**	**(1,038)**	**59**	**11**	**55**	**2**	**66**	**8**	**66**	**8**

Wairarapa District Health Board
Forecast Statement of Movements in Equity
For the year ended 30 June

	2006/07		2007/08		2008/09		2009/10		2010/11	
	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's
Opening Equity	10,227	9,789	9,871	9,631	9,927	9,639	9,204	8,863	9,267	8,868
Equity Injection/(Repayment)	173	173	(3)	(3)	(778)	(778)	(3)	(3)	(3)	(3)
Change in Revaluation Reserve	707	707	-	-	-	-	-	-	-	-
Net Surplus/(Deficit) for the Period	(1,030)	(1,038)	59	11	55	2	66	8	66	8
Net Surplus/(Deficit)	**10,077**	**9,631**	**9,927**	**9,639**	**9,204**	**8,863**	**9,267**	**8,868**	**9,330**	**8,873**

Wairarapa District Health Board
Forecast Statement of Financial Position
As at 30 June

	2006/07		2007/08		2008/09		2009/10		2010/11	
	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's
Public Equity										
Equity	18,268	18,268	18,265	18,265	17,487	17,487	17,484	17,484	17,481	17,481
Revaluation Reserve	1,479	1,479	1,479	1,479	1,479	1,479	1,479	1,479	1,479	1,479
Retained Earnings	(9,876)	(10,116)	(9,817)	(10,105)	(9,762)	(10,103)	(9,696)	(10,095)	(9,630)	(10,087)
Total Equity	**9,871**	**9,631**	**9,927**	**9,639**	**9,204**	**8,863**	**9,267**	**8,868**	**9,330**	**8,873**
Represented by:										
Current Assets										
Bank in Funds	-	-	4,500	4,500	4,500	4,500	4,500	4,500	4,500	4,500
Receivables	2,785	2,678	3,353	3,250	3,164	3,027	3,351	3,155	3,468	3,273
Other Current Assets	3,160	3,160	3,150	3,150	850	850	850	850	850	850
Total Current Assets	**5,945**	**5,838**	**11,003**	**10,900**	**8,514**	**8,377**	**8,701**	**8,505**	**8,818**	**8,623**
Current Liabilities										
Bank Overdraft	(2,928)	(3,121)	(2,759)	(3,018)	(2,542)	(2,872)	(2,137)	(2,554)	(1,631)	(2,048)
Payables & Provisions	(15,707)	(15,592)	(18,584)	(18,458)	(18,633)	(18,463)	(19,018)	(18,774)	(19,318)	(19,075)
Short Term Borrowings	(72)	(72)	-	-	-	-	-	-	-	-
Total Current Liabilities	**(18,707)**	**(18,785)**	**(21,343)**	**(21,476)**	**(21,175)**	**(21,335)**	**(21,155)**	**(21,328)**	**(20,949)**	**(21,123)**
Net Working Capital	**(12,762)**	**(12,947)**	**(10,340)**	**(10,576)**	**(12,661)**	**(12,958)**	**(12,454)**	**(12,823)**	**(12,131)**	**(12,500)**
Non Current Assets										
Property, Plant & Equipment	43,031	42,871	46,607	46,450	47,895	47,746	47,441	47,306	46,871	46,678
Other Investments	-	103	-	103	-	103	-	103	-	103
Trust Funds	43	43	45	45	45	45	45	45	45	45
Total Non Current Assets	**43,074**	**43,017**	**46,652**	**46,598**	**47,940**	**47,894**	**47,486**	**47,454**	**46,916**	**46,826**
Non Current Liabilities										
Borrowings	(20,023)	(20,023)	(25,988)	(25,988)	(25,678)	(25,678)	(25,368)	(25,368)	(25,058)	(25,058)
Provisions	(375)	(373)	(352)	(350)	(352)	(350)	(352)	(350)	(352)	(350)
Trust Funds	(43)	(43)	(45)	(45)	(45)	(45)	(45)	(45)	(45)	(45)
Total Non Current Liabilities	**(20,441)**	**(20,439)**	**(26,385)**	**(26,383)**	**(26,075)**	**(26,073)**	**(25,765)**	**(25,763)**	**(25,455)**	**(25,453)**
Net Assets	**9,871**	**9,631**	**9,927**	**9,639**	**9,204**	**8,863**	**9,267**	**8,868**	**9,330**	**8,873**

Wairarapa District Health Board
Forecast Statement of Cash Flows
For the year ended 30 June

	2006/07		2007/08		2008/09		2009/10		2010/11	
	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's	Consolidated $000's	Parent $000's
Operating Cash Flows										
Cash Receipts	100,258	99,256	107,798	106,821	113,061	112,071	117,651	116,632	122,292	121,273
Payments to Providers	(50,264)	(50,264)	(58,028)	(58,028)	(58,675)	(58,675)	(61,160)	(61,160)	(63,687)	(63,687)
Payments to Employees & Suppliers	(46,465)	(45,563)	(46,327)	(45,498)	(49,014)	(48,177)	(50,886)	(50,036)	(52,852)	(51,962)
Interest Paid	(1,395)	(1,395)	(1,385)	(1,385)	(1,840)	(1,840)	(1,885)	(1,885)	(1,885)	(1,885)
Capital Charge Paid	(622)	(622)	(850)	(850)	(850)	(850)	(850)	(850)	(850)	(850)
Net Operating Cash Flows	**1,512**	**1,412**	**1,208**	**1,060**	**2,682**	**2,529**	**2,870**	**2,701**	**3,018**	**2,889**
Investing Cash Flows										
Cash Received from Sale of Fixed Assets	16	11	-	-	2,300	2,300	-	-	-	-
Cash paid for purchase of deposit investment	-	-	(4,500)	(4,500)	-	-	-	-	-	-
Cash Paid for Purchase of Fixed Assets	(3,022)	(2,964)	(2,591)	(2,509)	(3,857)	(3,775)	(2,332)	(2,250)	(2,379)	(2,250)
Net Investing Cash Flows	**(3,006)**	**(2,953)**	**(7,091)**	**(7,009)**	**(1,557)**	**(1,475)**	**(2,332)**	**(2,250)**	**(2,379)**	**(2,250)**
Financing Cash Flows										
Additional Loans Drawn	120	120	6,120	6,120	120	120	120	120	120	120
Equity Drawn	173	173	-	-	1,525	1,525	-	-	-	-
Equity Repaid	-	-	(3)	(3)	(2,303)	(2,303)	(3)	(3)	(3)	(3)
Loans Repaid	(136)	(136)	(65)	(65)	(250)	(250)	(250)	(250)	(250)	(250)
Net Financing Cash Flows	**157**	**157**	**6,052**	**6,052**	**(908)**	**(908)**	**(133)**	**(133)**	**(133)**	**(133)**
Net Cash Flows	**(1,337)**	**(1,384)**	**169**	**103**	**217**	**146**	**405**	**318**	**506**	**506**
Opening Cash Balance	(1,591)	(1,737)	(2,928)	(3,121)	(2,759)	(3,018)	(2,542)	(2,872)	(2,137)	(2,554)
Closing Cash Balance	**(2,928)**	**(3,121)**	**(2,759)**	**(3,018)**	**(2,542)**	**(2,872)**	**(2,137)**	**(2,554)**	**(1,631)**	**(2,048)**
Represented by:										
Short term deposits										
Bank Overdraft	(2,928)	(3,121)	(2,759)	(3,018)	(2,542)	(2,872)	(2,137)	(2,554)	(1,631)	(2,048)
Total Cash on Hand	**(2,928)**	**(3,121)**	**(2,759)**	**(3,018)**	**(2,542)**	**(2,872)**	**(2,137)**	**(2,554)**	**(1,631)**	**(2,048)**

Wairarapa District Health Board (Parent) - Output Class
Forecast Statement of Financial Performance
For the year ended 30 June

	2006/07 Actual $000's	2007/08 Forecast $000's	2008/09 Projection $000's	2009/10 Projection $000's	2010/11 Projection $000's
Revenue					
Funder	91,870	101,538	106,123	110,580	115,114
Governance	1,638	1,737	1,999	2,063	2,127
Provider	46,426	47,057	51,397	53,430	55,500
Elimination	(41,140)	(43,511)	(47,448)	(49,441)	(51,468)
Total Revenue	**98,794**	**106,821**	**112,071**	**116,632**	**121,273**
Expenditure					
Funder	(90,844)	(100,034)	(106,123)	(110,581)	(115,114)
Governance	(1,669)	(1,740)	(1,999)	(2,063)	(2,127)
Provider	(48,459)	(48,547)	(51,395)	(53,421)	(55,492)
Elimination	41,140	43,511	47,448	49,441	51,468
Total Expenditure	**(99,832)**	**(106,810)**	**(112,069)**	**(116,624)**	**(121,265)**
Net Surplus/(Deficit)	**(1,038)**	**11**	**2**	**8**	**8**

7. APPENDICES

I. Crown Funding Agreement Indicators of DHB Performance 2008/09

Measure	Definition	Frequency	Targets, Expectations and Deliverables 2008/09
HKO - 01	Local Iwi / Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain	Six monthly (Q2, Q4)	**Ongoing partnership model with local Iwi and Māori and the implementation of the Māori Health Plan.** **Associated Deliverables** DHBs to report providing the following information: 1. Percentage of PHOs with Māori health plans (MHP) that have been agreed to by the DHB. 2. Percentage of DHB members that have undertaken Treaty of Waitangi training. 3. Provide a copy of the Memorandum of Understanding (MoU) between the DHB and its local Iwi/Māori health relationship/ partner, report achievements against key objectives in the MoU, and describe other initiatives achieved that are an outcome of engagement between the parties. The performance report for measure 3 has been endorsed by the local Iwi/ Māori health relationships. (If possible) Develop a reporting template based on the key points above. 4. Report on how (mechanisms and frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs). 5. Report on how an MHP is being implemented by the PHO and monitored by the DHB. 6. Report on when Treaty of Waitangi training (including any facilitated by the Ministry) has, or will take place for Board members. 7. Identify at least two key milestones from your Māori Health Plan to be achieved in 2008/09. For reporting in Quarter 2, provide a progress report on the milestones, and for reporting in Quarter 4, provide a report against achievement of those milestones.
HKO - 02	Development of Māori Health Workforce and Māori Health Providers	Six monthly (Q2, Q4)	**Implementation of the Māori Strategic Health Plan, including workforce and provider development.** **Associated deliverables** 1. Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Māori out of the total numbers of (i) management (ii) clinical (iii) administrative and (iv) other FTEs in the DHB respectively 2. Provide a copy of the DHB Māori Health Workforce Plan (or agreed regional Māori Workforce Plan) or the timeframe to complete the Plan 3. Report on achievements based on key deliverables in the DHB (or Regional) Māori Workforce Plan, or if the plan is being developed, describe <u>at least</u> two key DHB Māori health workforce initiatives that the DHB has achieved
HKO - 03	Improving mainstream effectiveness	Six monthly (Q2, Q4)	**To assist the ongoing monitoring and development of the capacity of mainstream and other providers to address Māori health priorities** **Associated deliverables** 1. Report on the reviews of pathways of care that have been undertaken in the last 12 months that focussed on improving health outcomes and reducing health inequalities for Māori 2. Report on example(s) of actions taken to address issues identified in the reviews

<table>
<tr><th>Measure</th><th>Definition</th><th>Frequency</th><th>Targets, Expectations and Deliverables 2008/09</th></tr>
<tr><td>HKO - 04</td><td>DHBs will set targets to increase funding for Māori Health and disability initiatives</td><td>Annual (Q4)</td><td>To increase funding for Māori health and disability initiatives

Associated deliverables
1. Actual expenditure on Māori Health Providers by General Ledger (GL) code
2. Actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit
3. Total expenditure for Iwi / Māori- led PHOs
4. DHBs to report a comparison between expenditure for above measures for 2007/08 (in addition to mandatory reporting against 2008/09 expenditure).
5.
Expenditure on Maori Health

<table>
<tr><th></th><th></th><th>2008/09 Budget</th><th>2009/10 Target</th><th>2010/11 Target</th></tr>
<tr><td>1</td><td>Mainstream PHO services for Maori</td><td>190,500</td><td></td><td></td></tr>
<tr><td>2</td><td>Maori providers (incl Mental Health Services)</td><td>1,356,000</td><td></td><td></td></tr>
<tr><td>3</td><td>Maori specific in mainstream</td><td>668,200</td><td></td><td></td></tr>
<tr><td>4</td><td>Maori workforce development</td><td>65,000</td><td></td><td></td></tr>
<tr><td>5</td><td>Iwi PHO</td><td>-</td><td>-</td><td></td></tr>
<tr><td>6</td><td>Funding increase</td><td></td><td>60,000</td><td>60,000</td></tr>
<tr><td></td><td>TOTAL EXPENDITURE</td><td>2,279,700</td><td>2,324,700</td><td>2,384,700</td></tr>
</table>
</td></tr>
<tr><td>PAC - 01</td><td>Pacific peoples are engaged and participate in DHB decision making and the development of strategies and plans for Pacific health gain</td><td>Six monthly (Q2, Q4)</td><td>Strategies and plans for Pacific health gain

Associated deliverables

Provide a report responding to the following key points:

1. The percentage of DHB strategies and plans on which Pacific communities or representatives were consulted
2. The percentage of DHB working groups and steering groups that included representation from Pacific communities
3. Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Pacific peoples out of the total numbers of (i) management (ii) clinical (iii) administrative and (iv) other FTEs respectively in the DHB.</td></tr>
<tr><td>POP - 01

POP - 02

POP - 03</td><td>Smoking

Cardio-vascular Disease

Stroke</td><td>Annual (Q3)</td><td>
<table>
<tr><td colspan="3">Outcome 1: Reduced development of contributory risk factors</td></tr>
<tr><td>Indicator</td><td>Risk reduction - smoking</td><td>The number of PHO enrolled people over 14 who smoke</td></tr>
<tr><td colspan="3">Baseline to be established</td></tr>
<tr><td colspan="3">Outcome 2: Increased co-ordination across providers, processes and community resources</td></tr>
<tr><td>Indicator</td><td>Cardiac rehabilitation programme</td><td>The number of people who have suffered Acute Coronary Syndrome who attend a cardiac rehabilitation outpatient programme.
Target - 55% (Breakdown by ethnicity not available)</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Measure</th><th>Definition</th><th>Frequency</th><th>Targets, Expectations and Deliverables 2008/09</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Indicator</td><td>Organised Stroke Services</td><td>The number of people who have suffered a stroke event, who have been admitted to organised stroke services and remained there for their entire hospital stay

Target - 75% (The small numbers of patients involved distorts target setting by ethnicity).</td></tr>
<tr><td colspan="3">Baselines to be established</td></tr>
</table>
</td></tr>
<tr><td>POP - 04</td><td>Oral Health - Mean DMFT score at Year 8 (Form 2)</td><td>Annual (Q3)</td><td>To reduce the average Decayed / Missing / Filled Teeth score for children at year 8

The total number of permanent teeth of year 8 children, decayed, missing (due to caries), or filled at the commencement of dental care, at the last dental examination These targets are still under discussion.
Targets
DMF score at Yr 8 – fluoridated
<table>
<tr><th>Overall</th><th>Māori</th><th>Pacific</th><th>Other</th></tr>
<tr><td></td><td>1.62</td><td>N/A</td><td>1.28</td></tr>
</table>
DMF score at Yr 8 – non fluoridated
<table>
<tr><th>Overall</th><th>Māori</th><th>Pacific</th><th>Other</th></tr>
<tr><td></td><td>1.60</td><td>N/A</td><td>1.30</td></tr>
</table>
</td></tr>
<tr><td>POP-05</td><td>Oral Health - Percentage of children caries free at age five years</td><td>Annual (Q3)</td><td>To increase the percentage of children caries free at age 5.
These targets are still under discussion
Targets
% 5 yr olds caries free – fluoridated
<table>
<tr><th>Overall</th><th>Māori</th><th>Pacific</th><th>Other</th></tr>
<tr><td></td><td>43</td><td>N/A</td><td>50</td></tr>
</table>
% 5 yr olds caries free – non- fluoridated
<table>
<tr><th>Overall</th><th>Māori</th><th>Pacific</th><th>Other</th></tr>
<tr><td></td><td>30</td><td>N/A</td><td>50</td></tr>
</table>
</td></tr>
<tr><td>POP - 06</td><td>Improving the health status of people with severe mental illness (Total)</td><td>Quarterly</td><td>To increase access to treatment and support services for people with severe mental illness.

The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by 3 months*):

Targets
<table>
<tr><td></td><td>2006/07 Actual annual access Oct06 – Sep07</td><td>2008/09 % Target annual access</td><td></td><td></td></tr>
<tr><td></td><td></td><td>Total</td><td>Maori</td><td>Other</td></tr>
<tr><td>Child & Youth</td><td>2.69%</td><td>2.8</td><td>2.8</td><td>2.8</td></tr>
<tr><td>Adult</td><td>2.69%</td><td>3</td><td>3</td><td>3</td></tr>
<tr><td>Older People</td><td>0.46%</td><td></td><td></td><td></td></tr>
<tr><td>Total</td><td>2.31%</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>POP - 07</td><td>Alcohol and other drug service waiting times</td><td>Quarterly</td><td>To improve the availability and access to addiction services

Reduced waiting times, clients staying engaged with services for longer, resulting in improved treatment results.</td></tr>
<tr><td>POP - 08</td><td>Progress towards 95% of two year olds fully immunised</td><td>Quarterly</td><td>Timely childhood vaccinations and increased childhood immunisation coverage.

Associated Deliverables
Percentage of eligible children fully immunised by 6 months of age</td></tr>
</table>

<table>
<tr><th>Measure</th><th>Definition</th><th>Frequency</th><th>Targets, Expectations and Deliverables 2008/09</th></tr>
<tr><td></td><td></td><td></td><td>Percentage of eligible children fully immunised by 12 months of age
Percentage of eligible children fully immunised by 18 months of age

Targets
<table><tr><th></th><th>DHB Total</th><th>Maori</th><th>Pacific</th></tr><tr><td>6 months of age</td><td>71</td><td>60</td><td>N/A</td></tr><tr><td>12 months of age</td><td>89</td><td>88</td><td>N/A</td></tr><tr><td>18 months of age</td><td>81</td><td>79</td><td>N/A</td></tr></table></td></tr>
<tr><td>POP - 10</td><td>Radiation oncology and chemotherapy treatment waiting times</td><td>Monthly & Annual (Q4)</td><td>Reducing cancer waiting times
Targets
1. All Patients (100%) will receive radiation oncology treatment within 6 weeks of their first specialist assessment (excluding category D)

2. All patients (100%) to receive chemotherapy treatment within 6 weeks of their first specialist assessment (excluding category D)

3. Complete data is supplied monthly for both chemotherapy and radiation oncology, and nationally agreed treatment standards for patients in priority categories A and B are met.</td></tr>
<tr><td>POP - 11</td><td>Family Violence Prevention</td><td>Q2 & Q4</td><td>Progress in taking a systemic approach towards the identification and intervention of child and partner abuse.
Targets
An overall score of 59/100 in the audits for child abuse and 49/100 for partner abuse responsiveness.</td></tr>
<tr><td>QUA - 01</td><td>Quality Systems</td><td>Annual (Q3)</td><td>To improve outcomes for consumers by maximising the quality of services provided by DHB provider arms through planned initiatives, effective monitoring and audit, and the promotion of an organisational culture.

Associated deliverables
The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting a high level summary of key quality improvement and clinical audit initiatives and results, focusing on those that are effective an/or ineffective against the goals in Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector</td></tr>
<tr><td>QUA - 02</td><td>Results for People with enduring severe mental illness</td><td>Annual (Q2)</td><td>Improving the health status of people with serious mental illness (who have been in treatment with any mental health service for 2 years or more)
Targets
<table><tr><td>No. and % of long term clients in full time work</td><td>No. and % of long term clients with no work</td><td>No. and % of clients in some form of education</td><td>No. & % of long term clients appropriately discharged</td></tr><tr><td>Number: 12
Percentage: 14</td><td>Number: 69
Percentage: 79</td><td>Number: 6
Percentage: 7</td><td rowspan="2">Nil</td></tr></table></td></tr>
<tr><td>QUA - 03</td><td>Improving the quality of data provided to the National Collections Systems</td><td>Quarterly</td><td>Provide high quality data to the National Collections Systems.

Associated deliverables
1. The percentage of NHI duplicate records that require merging by NZHIS
Target – 1%
2. The percentage of NHI records created with ethnicity status of “not stated” or “other”
Target – 3%
3. The number of versions of text descriptor per code
Target – Ratio > = 3
4. The number of discharge events with an error DRG
Target – Ratio < = 4%
5. The number of MHINC records able to be successfully loaded into the MHINC
Target – > 98%</td></tr>
</table>

Measure	Definition	Frequency	Targets, Expectations and Deliverables 2008/09
QUA - 04	Mental Health provider audit	Annually (Q3)	**Provide a summary of mental health audit activity of the provider arm and contracted providers** **Associated deliverables** Provide a summary of mental health routine and issues based audit activity
RIS - 01	Service Coverage	Quarterly	**Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay, and a high performing system in which people have confidence.** **Associated deliverables** Report progress achieved during the quarter towards resolution of gaps in service coverage identified in the District Annual Plan and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: 1. Analysis of explanatory indicators 2. Media reporting 3. Risk reporting 4. Formal audit outcomes 5. Complaints mechanisms 6. Sector intelligence
SER - 01	Accessible and appropriate services in Primary Health Organisations	Quarterly	**Progress is made towards improving access to appropriate primary health care services.** **Associated deliverable** Ratio of age-standardised rate of GP consultations per enrolled high need person compared to enrolled non-high need person. **Target Ratio – 1:1.15**
SER - 02	Care plus enrolled population	Quarterly	**To improve care for individuals with known high health needs.** **Associated deliverables:** Number of PHOs Care Plus enrolled population compared to the expected Care Plus enrolled population. **Target -95%**
SER - 03	The proportion of laboratory test and pharmaceutical transactions with a valid NHI	Quarterly	**To improve tracking of expenditure and usage of pharmaceutical and laboratory test transactions by DHB resident population and PHO enrolled population** **Associated deliverable** 1. The percentage of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district that have a valid NHI number submitted **Target – 95%** 2. The percentage of tests carried out by community laboratories in the DHB district with a valid NHI submitted **Target – 95%**
SER - 04	Continuous Quality improvement – Elective services	Six monthly (based on Q2 and Q4 results)	**To improve patient flow management and prioritisation** **Associated deliverables** Quantitative indicator – standardised discharge ratios for 11 elective procedures as published on the Ministry website each quarter (excluding hip and knee replacements, and cataracts covered by separate initiatives) **Qualitative indicator** Report demonstrating 1. For any SDR that is more that 5% below the national average, what analysis the DHB has done to review the appropriateness of its rate 2. The reason that the DHB considers the rate to be appropriate for its population, or an action plan as to how it will address its relative under delivery of that procedure

Measure	Definition	Frequency	Targets, Expectations and Deliverables 2008/09
SER - 07	Low or reduced cost access to first level primary care services	Quarterly	**To improve access to primary care services for low income people** **Associated Deliverable** Number of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients Compliance with the government policy for access and interim PHOs across all groups, where the subsidies apply, and where this is approved by the DHB and the Ministry. **Target - 100%**

II. Wairarapa Te Kokiri Implementation Plan 2008/09

Te Kokiri - The Mental Health and Addiction Action Plan 2006-2015 Wairarapa District Health Board Implementation Plan[5]		
Te Kokiri specific actions	**DHB Led milestones**	**Wairarapa District Health Board response**
Promotion and prevention		
1.2 Ministry of Health and DHBs will work with PHOs to include mental health and wellbeing in their work	Mental health is included in PHO health promotion plans	A WDHB Health Promotion strategy was developed in 200708, that includes mental health and addiction priorities. 2008/09 requires a DHB wide approach with a key focus on teenagers and their use of alcohol and other drugs
1.3 Implement other public health strategies that promote the impact of general health and wellbeing on mental health and wellbeing (eg HEHA	Implementation of other public health strategies that impact on mental health	MH&A providers embraced the importance of HEHA in client recovery plans and are working both individually and collectively on many initiatives. Opportunities to expand this continue to be developed with the biggest being in ensuring clients are aware of the range of services that is available – a coordinated approach to achieving this will be undertaken
1.7 Roll out the NZ Suicide Prevention Strategy and develop and implement an action plan for the first five years	Action plan is developed and implemented	NZSPS implementation plan will be developed and actioned intersectorally, commencing in 2008/09.
Building mental health services		
2.3 Strengthen the linkages between specialist mental health and addiction services and primary health care to ensure continuity and quality of care and appropriate integration	Locally agreed pathways and protocols exist between specialist mental health and addiction services and primary health care, which include information sharing DHBs support specialist services to improve the linkages with primary health care and specialist mental health services	The newly established NASC process will provide a platform from which client care plans are reviewed regularly, and resources to facilitate these reviews will ensure that it happens. This will include a greater emphasis on the client / key clinician / and support service relationship, and enhance the clients voice in the development of care plans. This is likely to require a review of the adult and CAMHS client pathway to ensure that processes are clear, and all parties involved are aware of their roles and responsibilities.
2.4 Develop transition arrangements between all mental health services and addiction services, and between mental health and addiction and other health services, with special emphasis on transfers involving:	All DHBs have transition protocols in place that are used	

[5] Te Kokiri identifies the Lead stakeholder in each of the identified specific actions. Those actions included in this document are those that are DHB led, and fall within the next three year timeframe.

• Child and youth services to adult services • Early intervention psychosis services to adult services • Adult services to older people's services		
2.5 Expand the range of effective and integrated services to include: • Psychological therapies • Service user-led services within mainstream services • Independent peer-led services for service users and families / whanau, which include support, recovery education and advocacy • Home-based support services • Family / whanau support services • Community and home –based acute services • Respite services	DHBs can demonstrate expansion in the range of services through routine reporting mechanisms	A review of the continuum of acute care for all age groups, within the Wairarapa was intended to be completed during 2007/08. A review of the adult MH service took priority and was required before any further service development could be undertaken. 2008/09 will see this work give consideration to the need for a broader range of home based acute services and opportunities to make greater use of skills within the NGO and community mental health team at the time eg fully utilise occupational therapists skills. A continued focus on the continuum of care in place for children and young adults will incorporate both local and regional initiatives: • Locally, the youth support team established in 2007/08 will work to establish clarity around its role in crisis and planned respite care either in residential facilities or in family homes • Regionally, the DHB is committed to the family respite service development initiative and will ensure that any developments in the Wairarapa complement regional initiatives
2.6 Ensure continuity of care between mental health services, between mental health and addiction services, between mental health and addiction and other health services, and between health and wider government social services	All providers can demonstrate mechanisms are in place for communication and coordination between multiple services involved in a service user's care	Acute service providers will continue to attend each others weekly multi disciplinary team meetings Client care plan individual review meetings will include support service staff, and step down services such as primary care where appropriate
2.7 Continue to develop and contribute to intersectoral activities that support recovery	DHBs can demonstrate in DAPs and regional plans their involvement in intersectoral initiatives that support recovery	Close linkages between employment support services and mental health providers ensure that all service users have access to this opportunity. MoU between Wairarapa Justice and Addiction Service providers was agreed during 2007/08 and ensures better referral and continuity of care for people presenting to the courts with alcohol and drug issues.
2.8 All providers will ensure that service users, tangata whaiora receive seamless service delivery and are supported to make informed choices	All providers can demonstrate: • The availability of information on services in a way that is easily	The NASC service will provide excellent information to tangata whaiora and their whanau about the choices available to them. This is expected to have a positive effect on referrals

	accessible by service users and families /whanau • Service users are informed of their choices and options for care	to the Kaupapa Maori service.
2.11 Increase access to specialist mental health and addiction services for children and youth	Agreed access targets are implemented	Greater utilisation of new and improved regional services will be a focus for 2008/09. In particular, residential AOD programme, MST programme for AOD and eating disorders.
2.12 Continue to contribute to intersectoral projects	DHBs can demonstrate their contribution through DAPS; the MoH can demonstrate its contribution through reporting	DHB active partner in the intersectoral Youth Centre project led by Rangitaane, Likely to result in a full health service provided for youth in the community. Police will be actively involved in youth AOD initiatives including MST and school based projects.
2.13 Implement initiatives to develop child/youth/whanau participation in service development and evaluation	Initiatives are implemented	Wairarapa Youth Council: • Ran a media campaign to reduce exam stress in senior students in Oct 2007. Similar campaign will run in 2008. • Will run a HEHA project during term 2 of 2008 in secondary schools • Will provide internal decorating advice for renovations for the crisis respite service facility and other youth based centres • Is providing representation for Youth Centre project noted in 2.12
2.16 Increase access to specialist mental health and addiction services for older people	Agreed access targets are implemented	The continuum of care for older people will be reviewed in a joint aged care / mental health project. Residential care for higher needs mental health service users will be established (2 – 3 beds)
2.18 Expand the range, quality and capacity of services available for people with high and complex needs, including recovery focused rehabilitation services, according to need, in the least restrictive setting	Each DHB can demonstrate the provision of a broader range of services for people with high and complex needs	Mental Health Services will undertake a project to improve specific interventions and effective responses for people with high and complex needs. The focus will be on long term clients who have been in the service for over 5 years.
2.19 increase access to specialist mental health and addiction services for adults	Agreed access targets are implemented	Adult CMH clinicians take up specialist areas of interest to strengthen local knowledge and access to specialist MH services
2.20 improve access to acute emergency response services	DHBs will report through DAPs on how they will improve access and measure improvements	3.5% of the Wairarapa population use the MHL – a media campaign to increase awareness of the service will be run in 2008/09
2.21 the physical health needs of people most severely affected by mental illness are appropriately addressed, including regular screening for medication and other	Each DHB can demonstrate that it is working with providers to ensure that the physical health needs of people with mental illness are	Provide ongoing funding for psychiatric and doctor services for alcohol and drug and methadone service clients through new Blueprint funding

health-related complications	being appropriately met	
Responsiveness		
3.1 All services are able to respond to the unique needs of specific population groups through planning for the provision of services based on: • A sound evidence base • Knowledge of specific cultural and clinical needs • Cultural and clinically relevant recovery models of practice • Service user expectations • A recovery-focused workforce for mental health service users • An assessment and treatment focused workforce for addiction services users • Links with specific population plans	DHBs can demonstrate a match between the mental health and addiction needs of their communities and the services provided Guidelines to inform service provision and practice are developed and implemented Memoranda of understanding and access referral protocols exist between specific population group services and mental health and addiction services	DHB funded services will work with the Wairarapa community to identify, prioritise and address specific needs. Groups identified as high risk of self harm and suicide based on statistical evidence are teenagers, and adults aged between 20 – 45 (European), and will be targeted for education, health promotion and prevention initiatives. Increase funding for primary care packages of care for youth through the 'To Be Heard' project.
3.2 Recovery plans will be developed in a collaborative process with service users/ tangata whaiora and their family, whanau and support networks, addressing their broader physical, spiritual, social and psychological needs and aspirations	DHB audits of all providers show the presence and use of integrated recovery plans	Refer to 2.3 Process to ensure all long term clients relapse prevention plans (recovery plans) are reviewed and up to date will be in place
3.4 DHBs will address the specific needs of women in the planning, development and delivery of mental health and addiction services	DHBs will proactively involve women in service planning and development	
3.5 Develop effective partnerships with Pacific communities to support active participation across all levels	DHBs can demonstrate through DAPS and regional plans engagement with and participation by Pacific peoples	Wairarapa represented on Central Region Pacific Advisory Group (led by TAS) with the aim of creating improved networks and development opportunities with the Pacific Community in the Central Region Will continue to work with the Wairarapa Pacific Steering Group to develop linkages and services to support Pacific Island peoples
3.16 Build the knowledge and skills of the workforce to respond to people with mental illness and disability, including those with sensory disabilities such as deafness and those with brain injury impairments	Training and development are provided	CCS disability action group, and IDEA services representation on the Local Advisory Group will assist in improving relationships and service for people with dual diagnoses Eg.(ID/MH) (Physical/MH)
3.17 Implement the NZDS	DHBs can demonstrate implementation through existing reporting requirements All employees will have access to diversity awareness training	Diversity training provided for workforce including NGOs

3.19 Implement initiatives that recognise the importance of family and whanau, and that act to increase family and whanau participation in: Recovery, whanau ora • Assessment and treatment • Service planning, delivery and evaluation • Workforce and leadership roles	Development and support of family advisory positions is continued DHBs can demonstrate initiatives to increase family and whanau participation across all levels, including assessment and treatment Training is provided for mental health workers on effective work with family and whanau	
3.20 Implement initiatives that recognise and respond to the specific needs of family and whanau, such as: • Assessment and referral for family and whanau to appropriate supports and services • The provision of education for family and whanau on recovery and the recovery process • Family whanau views about the responsiveness of services	• DHBs can demonstrate that family and whanau needs have been considered and provided for through auditing of case notes • Family and whanau express satisfaction with services received	
3.21 Develop effective partnerships with tangata whenua / Maori community to support active participation across all levels	DHBs can demonstrate engagement with and participation by Maori through DAPs and regional plans	Cultural assessments will be available to consumers at time of service entry Maori Health Committee representation on the LAG
3.22 Provide services that are based on Maori frameworks /models of health that promote clinical and cultural competency	DHBs can demonstrate services provided are based on Maori models of health	Quarterly reports on the whole mental health and addiction sector provided to Iwi Kainga Regular engagement with Maori via the Maori Health Committee and Iwi Kainga w
Workforce and culture for recovery		
4.7 Continue to build leadership capacity within all mental health and addiction services	Increased mental health sector involvement in management and leadership development programmes through either general health workforce or mental health workforce initiatives The NGO and tangata whaiora leadership programme for NGO and service users will continue to be implemented and will be supported by DHBs Workforce involvement in the DHBNZ leadership and management programme is encouraged by DHBs	Sponsorship of 2 NGO staff members to participate in the Executive Leadership and Management Programme each year (first recipients in 2008) Participation in Central Region program to support NGO development through Te Pou and the regional workforce development coordinator. Funding via regional Blueprint funding source MHS staff participate in LAMP Participation in **Let's get real** initiatives

4.8 Roll out training for mental health workers as noted in mental health workforce development programme and the responsiveness leading challenge	Training is developed and implemented for DHBs and NGOs to work more effectively with families, whanau Feedback from families and whanau reflects their satisfaction with services	
Maori mental health		
5.1 continue implementation of Te Puawaitanga; review and update	DHBs can demonstrate implementation through DAPS and regional plans	All Maori positions filled Robust cultural advice and leadership available to all services – DHB and NGO
5.2 Continue implementation of He Korowai Oranga and related action plans	DHBs can demonstrate implementation through existing reporting requirements	
5.3 Increase the number of high quality Maori mental health and addiction services across the continuum of care	Implement the Improving Quality Strategy and associated action plan All services will demonstrate compliance with the MHSS, particularly those that apply to Maori	
5.4 All providers will ensure that service users and tangata whaiora receive seamless service delivery and are supported to make informed choices	All providers can demonstrate: • The availability of information on services in a way that is easily accessible to service users and families, whanau • Service users, tangata whaiora are informed of their choices and options for care • Evidence of practice based on whanau ora and Maori models of care	
5.5 Plan and deliver effective and culturally relevant, Maori focused treatment practices across the continuum of care in both mainstream and Maori services that promote: • Whanau ora • Traditional Maori treatment processes • Cultural and clinical competency • Whanau-inclusive practices	DHBs will deliver training in cultural and clinical competencies for services providers DHBs will be able to demonstrate the use of Maori-relevant: • Assessment tools • Best practice guidelines /quality indicators	

	• Traditional Maori treatment processes • Evaluation methods • Outcomes measures	
5.7 DHBs will have in place early intervention strategies for Maori, including tamariki and rangatahi	Early intervention strategies will be in place and demonstrated through DAPs	HEADSS assessments provided for high risk students in low decile schools. Follow up support available through the *To be heard* project.
5.8 DHBs will work with all providers to ensure that education and information are available to Maori communities on mental illness and where services can be accessed	DHBs will provide evidence as part of regular quarterly reporting processes against the Primary Health Care Strategy	
5.9 Implement the NMHIS as it relates to Maori	Reliable ethnicity data will be used to inform DHB funding and planning	
5.10 Ensure continuity of care between mainstream and kaupapa Maori services, between mental health and addiction services, between mental health and addiction and other health services and between health and wider government social services	Locally agreed pathways and protocols exist for all mainstream and kaupapa Maori mental health and addiction services, across the range of providers	Pathways of care for Maori reviewed by Maori Health committee. Recommendations actioned
Develop effective partnerships with tangata whanau/ Maori community to support active participation across all levels	DHBs can demonstrate engagement with and participation by Maori in DAPs and regional plans	
Primary health care		
6.1Provide advice to the Government on the future direction of primary mental health care, including funding and possible models, using information from: • PHO demonstrations • Review of international models • The Mental Health Epidemiology study • Primary Health Care Strategy evaluation • Targeted primary health care services to improve access (SIA) • The review of Care Plus • Integration of mental illness with the care co-ordination programme development work	PHO/primary care mental health network meetings continue to develop PHOs will demonstrate the use of the PHOs service development Toolkit for Mental Health in primary health care	Wairarapa Community PHO works collaboratively with all NGO and DHB providers to ensure opportunities to improve the continuum of care, and holistic approaches to health services are maximised. In particular: • PHO and DHB continue to participate in national network meetings • PHO project steering committee will continue to meet bimonthly to provide input into 'To Be Heard' service • PHO will expand the 'mental health champions' approach amongst GPs and primary health care service staff • Increased medical input into Addiction Services provides regular health checkups for people affected by the physical consequences of alcohol and drug use. • The co-location of mainstream and Kaupapa Maori services ensures increased
6.3 DHBs and primary health care providers will address the physical health needs of people most severely affected by mental illness and those suffering the service ongoing physical consequences of alcohol and/or drug	DHB audits of PHO plans will demonstrate linkages with specialist services	

use, in the context of an holistic health approach		clinical services are easily accessible to Maori
6.4 Engage mental health and addiction service user participation in the planning and development of primary mental health and addiction services	PHOs demonstrate service user engagement in the planning and development of primary mental health and addiction services	• Service users participate in 'To Be Heard' Steering committee
6.5 Strengthen the linkages between primary health care and specialist mental health and addiction services other community agencies to ensure continuity and quality of care and appropriate integration	Locally agreed pathways and protocols exist between primary health care and specialist mental health and addiction services and other community agencies, which will include information sharing DHBs support specialist services to improve the linkages with primary health care and specialist mental health and addiction services and other community agencies	
PHOs will make mental health and wellbeing and mental illness and addiction an integral part of PHO/ primary health promotion	PHOs demonstrate in their planning documents a focus on mental health promotion and addiction prevention	
Addiction		
7.1 Improve access to addiction services	Gaps at local and regional levels in service provision are identified and plans developed to address the gaps	• Increase in outreach clinics provided in Wairarapa secondary schools • Investigate more efficient and effective models of intervention for groups of students from years 7 – 13 • Maintain zero waiting list for opioid replacement services • Regional specialty services training opportunities will be maximised • Participate in regional initiatives to increase residential and other services available • Provide a contracting environment that supports collaborative approaches between mainstream and Kaupapa Maori Services
7.2 Develop a plan to address respite and acute services	A plan is developed and implemented	
7.3 Develop a plan to address and strengthen residential treatment services	A plan is implemented and developed	
7.4 Clarify agency responsibilities and develop a common approach to the care of intoxicated people	MOH & DHBs demonstrate the initiatives they have undertaken through annual reporting on the implementation of this plan	
7.5 Implement agreed access targets to opioid treatment	Agreed access targets are implemented	
7.8 All providers will ensure that service users and tangata whaiora receive seamless service delivery and are supported to make informed choices	All providers can demonstrate: The availability of information on services in a way that is easily accessible by service users Service users are informed of their choices and options for care Evidence of a holistic treatment/intervention approach	

Transparency and Trust		
9.3 Review findings of the NZ Survey of Mental Health and Wellbeing epidemiology study, with a view to creating a between match between mental health service delivery and population need	DHBs demonstrate changes in the funding and planning of services based on the review findings	• The MHS will implement its Quality plan and any audit or certification recommendations that may result during the year. • Consumer satisfaction survey information from all services will be used to enhance services as appropriate • Areas where historically the DHB has not complied with the MHSS will be addressed in particular with respect to family whanau and consumer involvement in service development and planning (Maori and Pacific for PA MHS) PRIMHD implementation completed to national levels HONOS and HONOSCA outcome processes in place
9.5 DHBs will continue to provide an environment and ensure mechanisms exist for continuous learning and ongoing quality improvement in the planning and delivery of mental health and addiction services	Funders and providers will make use of service utilisation and outcome data to facilitate quality improvement, and for planning and service review purposes All services will demonstrate compliance with the MHSS	
9.6 Complete the review of sector standards: • Review and update audit workbook • Update the audit processes guidelines	New standards produced, audit workbooks developed and requirements implemented by all providers	
9.8 All providers will actively foster a research and evaluation-based approach to recovery practice	Providers will implement formative and summative evaluation processes where appropriate	
9.10 All service providers will implement collaborative note-taking and recovery planning for mental health service users and tangata whaiora and treatment / intervention planning for addiction service users	Recovery plans will be in place and evidenced through case notes and audit processes	Quarterly random review of case notes will be undertaken by all services
9.11 Service users, family, whanau and other agencies know and understand what they can expect from mental health and addiction services	All DHBs, at service locations and on their websites, will have information on the range of contracted mental health services, referral criteria and processes, complaints procedures, access to consumer and family advisors, and mechanisms in place for feedback	Service brochures maintained accurately and available across the Wairarapa
9.12 Roll out the national service user satisfaction survey tool using the hospital benchmarking process	Information gained is used by DHBs to contribute to improved quality of services	Service user satisfaction tool is in place, feedback monitored by LAG and used to improve services
9.13 Complete NGO information systems project (to allow input into MH-SMART)	Project to develop systems to meet NGO information needs is implemented	DHB will work with MoH to develop NGO information systems.

Working together		
10.1 Clarify the role, expectations and accountabilities of Regional Mental Health Networks	A joint DHB / Ministry of Health project to clarify the role of regional networks is established, and recommendations are implemented	Regional projects and initiatives reported locally to the DHB CPHAC and LAG, with working groups pooled when DHB feedback on regional issues is requested
10.2 Strengthen the partnership relationships between DHB mental health and addiction services through, for example: • Sharing best practice • Peer review and supervision • Information sharing	DHBs can demonstrate that mechanisms are in place and being used to improve their partnership relationships	Local Advisory Group Terms of Reference and work plan ensures: Wide range of community input is achieved AOD sector well represented in membership, and backed by robust service user groups Collaborative approaches to service development, workforce development is achieved AOD service users and staff encouraged to participate in central region addiction sector network hui
10.3 Continue to provide local and regional fora for service providers, workers, service users and tangata whaiora to provide input into mental health and addiction service development	DHBs can demonstrate that systems are in place and implemented for meaningful input into sector development The participation of the addiction sector in the regional networks and local advisory groups is increased	
10.4 Develop contracts that include the requirement for explicit linkages across health and wider government sector agencies	This action is included in the NSF review and reviews of contracting processes Changes to contracts are implemented as required	