Wairarapa District Health Board

District Annual Plan

2010/2011

Wairarapa DHB

Wairarapa District Health Board

Te Poari Hauora o-rohe o Wairarapa

Office of Hon Tony Ryall

Minister of Health
Minister of State Services

10 AUG 2010

Mr Bob Francis
Chair
Wairarapa District Health Board
PO Box 96
MASTERTON 5840

Dear Mr Francis

Wairarapa District Health Board: 2010/11 District Annual Plan

This letter advises you that I have signed Wairarapa District Health Board's (DHB) 2010/11 District Annual Plan (DAP) for one year.

Clinical and financial sustainability

I appreciate the efforts your Board and management have put in over the past year to manage your DHB in a sustainable manner. More work lies ahead to achieve long lasting sustainability, while ensuring that New Zealanders get an improved delivery of services. The challenge for us all is to achieve this.

All DHBs must budget within their allocations and improve financial performance. I note that your planned financial position for 2010/11 is a deficit of $2.2M. This has emerged from poor financial performance in 2009/10. The development of your recovery plan is a move in the right direction. I note your DAP is appropriately aligned to the recovery plan.

Additionally it is important that you achieve the performance improvement actions (PIA's) and efficiencies identified in your DAP for 2010/11. Finding further efficiencies and cost control measures for the out years are critical in the current fiscal environment. My approval of your DAP does not mean acceptance of your assumptions in the out years.

Health targets and priorities

I note that your Board is a consistently high performer in all health targets. The Ministry of Health (Ministry) informs me that your actions indicate you will continue with this regard. Your continued performance is commendable and a credit to your organisation.

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New Zealanders want better access to a wider range of services closer to home. The progress you are making with your local clinical services plan and the Tihei Wairarapa Better Sooner More Convenient is promising and more in the right direction. I expect your DHB to make substantial progress with integrating hospital services into community settings in 2010/11 as a result of the business case. The DHB will need to keep the Ministry well informed of its progress in this priority area.

Mental Health ring fence

While I am not viewing your mental health ring-fence spending as an impediment to the overall approval of your DAP, I expect the DHB to work with the Ministry during 2010/11 to ensure my expectations regarding the mental health ring-fence are met. This includes ensuring that the amount of funding not allocated in accordance with ring-fence expectations is tagged for allocation on mental health and addiction services in out years.

This should include the DHB working with the Ministry's Mental Health Group to determine the appropriate level of service delivery for the DHB's population; and in 2011/12 and out years allocating sufficient funding to support this. The NHB will ensure that this work is undertaken, as it forms part of my agreement to your 2010/11 DAP.

As part of this discussion, it will be important to work with the NHB to establish whether any proposed changes to mental health service models, including integrating primary and secondary mental health services, should be considered under the service change protocols outlined in the 2010/11 Operational Policy Framework (OPF).

Integrating services and working with other DHBs

I note that your Board plans to work closely with other Central DHBs in continuing to support implementation of the Regional Clinical Services Plan with its current focus on vulnerable services (radiology and women's health) together with cardiology and renal services. Additionally, the developing sub-regional arrangements with Hutt Valley and Capital Coast DHBs are moving in the right direction. I remain convinced that regional collaboration is the pathway forward to long term clinical and financial sustainability.

DAP approval

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

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

I wish you, your Board and management every success with the implementation of your 2010/11 DAP, and thank you for your contribution and efforts towards a unified health system.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

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 Oranga o 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

Statement from the Chair and Chief Executive

We are pleased to present our 2010/11 District Annual Plan. This plan demonstrates our continued commitment to delivering on the Government priorities for Better, Sooner, More Convenient Health Care. We must meet the Government's priorities and respond to our community's expectations within a tight fiscal environment.

Over the past year, clinicians in the hospital and in the community have worked closely with management to build a sustainable future for health service delivery in the Wairarapa. This close collaboration has resulted in the development of our Wairarapa Clinical Services Action Plan and the establishment of a Joint Clinical Forum to support its implementation.

Our Clinical Services Action Plan identifies actions the DHB must take to ensure services are clinically and financially sustainable. The actions recognise we are operating within a difficult financial environment where we must reduce and control our costs.

Balanced against the need to control our costs, we also want to improve the health of our population and improve the patient's experience.

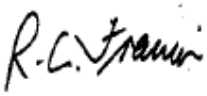
Wairarapa DHB has adopted a Triple Aim approach to guide its way forward. The Triple Aim puts the patient at the centre of all endeavours and says patient needs will be served best when we simultaneously provide the services which make the most difference to health overall, in ways which provide the best possible experience for the patient, and provide them at the lowest cost.

It is this Triple Aim, reflected in our Clinical Services Action Plan, and the set of actions that support this Triple Aim, that underpins our 2010/11 District Annual Plan. Our 2010/11 District Annual Plan also reflects key service and efficiency projects and cost management initiatives that we must pursue to manage within our budget.

In 2010/11, we need to make changes to the way we work. We will focus on the continued development of patient centred models of care and the redesign of patient pathways to better manage acute demand and the burden of long-term conditions. We will be looking at key aspects of our business to determine how we can be more cost effective.

This will involve discussions with other DHBs in the Central region as we work to implement the Regional Clinical Services Plan, involving the most efficient and effective way to fund and deliver services across the region. Our regional collaborative efforts include a focus on opportunities with neighbouring DHBs, in particular Hutt Valley and Capital and Coast. Together, the three DHBs will be exploring new opportunities for clinical and corporate service collaboration in 2010/11, resulting in greater clinical and corporate convergence.

There is also closer collaboration between primary and secondary health care services in the Wairarapa consistent with our successful proposal *Tihei Wairarapa* to develop an Integrated Family Health Model of Care in the district.



Board Chair

Chief Executive

Minister of Health

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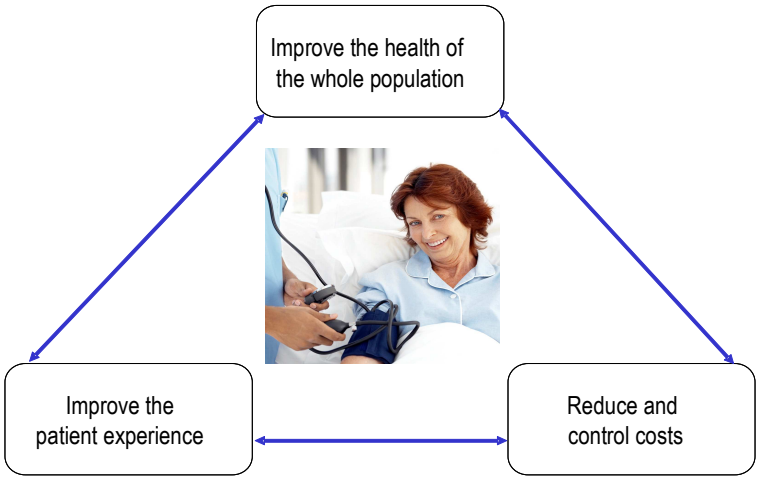
1. OVERVIEW

In 2009/10, it was apparent to the DHB that continuing to provide and fund service delivery as it had previously done was not financially sustainable. In response, our 2009/10 District Annual Plan (DAP) proposed savings of $3M in 2009/10. Due to IDFs and other cost pressures, a $4.6M efficiency programme was required to achieve the $1M deficit. Realising these savings has involved a line by line analysis of all of the DHB's Provider and Funder Services and various initiatives to control costs.

However without 'transformational organisational change' these results will not be sustained. The DHB has imbedded the need for "transformational organisational change" into the organisation's culture and the need for further direct costs reductions and revenue improvement strategies as part of its work with staff under the "Good to Great" programme.

The DHB needs to intensify its service review and cost control activity in 2010/11. This activity will be underpinned by our Wairarapa Clinical Services Action Plan (CSAP) which identifies how we must change the way we deliver services so that we can provide safe, sustainable, value for money healthcare services well into the future. Our need to control costs whilst at the same time, improving the patient experience and the health of the whole population is reflected in our Triple Aim:

Wairarapa Clinical Services Action Plan's Triple Aim



Achieving our Triple Aim also involves better integration of primary and secondary services consistent with our successful proposal to develop an Integrated Family Health Network in the Wairarapa.

It will also involve working more closely with other DHBs in the Central region as we determine the most efficient and effective way to fund and deliver services on behalf of our population. Our work with other DHBs will involve exploring opportunities for joint procurement and sharing support and administrative services.

Our efforts to control and reduce costs must happen in a way that protects and promotes the health of those people in our community with poorer health status. These efforts must give special consideration to the needs of Maori given that health

outcomes for Maori are typically poorer than other population groups within our district. We need to avoid increasing inequalities within our community. Instead, we must direct our spending more towards those with the greatest needs, including the frail elderly, those with long term conditions, and population groups with poorer health outcomes.

As well as a commitment to live within our means, we are committed to delivering on the Government's six health targets, delivering better, sooner, more convenient health care, and strengthening clinical leadership and clinical networks.

1.1 Year in Review

Key planning, service development and systems achievements in 2009/10 included:

- Active participant in the Central Region Clinical Services Plan implementation
- Developed Wairarapa CSAP through a collaborative process involving clinicians in the hospital and in the community together with management
- Established the Wairarapa Joint Clinical Forum involving clinicians from primary and secondary care to support implementation of the CSAP
- "Tihei Wairarapa", the Wairarapa business case for Better Sooner, More Convenient primary health care was approved for implementation
- Implemented stage one of an eReferrals solution between primary and secondary care
- Implemented Fingertips financial reporting and forecasting in Wairarapa Hospital, with the next stage involving workforce information soon to be completed
- DHB's Good to Great Programme has forecast savings of $3.8M as a result of various workforce and service efficiency projects (e.g. perioperative service review, outpatients review, nursing workforce project, community nursing review, clinical administration review, Maori health service benchmarking review, transport review, FOCUS review, hospital pharmacy review, improved supply and locum use, radiology review, improved diagnostic management, increased ACC and maternity revenue)
- Restructured the senior leadership team as part of the Good to Great Programme to align accountabilities with integrated care service development
- Introduced enabling strategies to help staff do their jobs well (e.g. revised performance development framework, capacity planning, releasing time to care project, training, IT prioritisation and implementation project, facility developments) as part of the Good to Great Programme
- Agreement reached between Hutt Valley, Capital and Coast and Wairarapa DHBs to seek further benefits through collaborative clinical and corporate arrangements

Key service delivery and population health achievements in 2009/10 included:

- Standardised access rates to both primary and secondary services are well above the NZ average
- Wairarapa residents access to elective services is above the national average
- Reduced the gap between Maori and others accessing annual diabetes checks and also those with satisfactory control of their diabetes
- Continued to support family carers by guaranteeing access to respite care
- Enrolled aged residential care providers in the DHB Professional Development Recognition Programme (PDRP) for their nursing staff
- Increased the number of older people supported to live in the community
- High performer against the Minister of Health's six Health Targets:

- 98% of people attending our emergency department were seen within six hours (2nd best performing DHB)
- Improved access to elective surgery (5th best performing DHB)
- 100% of people waited less than six weeks between their first specialist assessment and the start of cancer treatment (1st best performing DHB)
- 89% of two year olds fully immunised (4th best performing DHB)
- 86% of smokers who are hospitalised received advice to help them quit (1st best performing DHB)
- Provided better diabetes and cardiovascular services (2nd best performing DHB).

- Wairarapa Hospital is producing services cost effectively and efficiently based on various measures of cost, efficiency and productivity, being ranked:
  - 1st best performing DHB in terms of caseweight per FTE
  - 1st best performing DHB in terms of output per FTE
  - 1st best performing DHB in terms of total cost per standardised output
  - 2nd best performing DHB in terms of average length of stay (ALOS) for acute inpatients
  - 2nd best performing DHB in terms of surgery on day of admission for elective and arranged patients (DOSA rate)
  - 3rd best performing DHB in terms nurse/medical ratio
  - 4th best performing DHB in terms of day of stay admission
  - 6th equal performing DHB in terms of standardised day surgery rate
  - Wairarapa Hospital would have been in surplus by $5M if it had been paid national prices in 2009/10.

1.2 Minister's Expectations

Our 2010/11 DAP is informed by, and aligned with, the Minister of Health's expectations[1] for DHBs. In 2010/11, these expectations are that we:

- Improve service and reduce waiting times
  - Increase elective surgical volumes year on year
  - Improve emergency department waiting times
  - Improve cancer waiting times
- Take the next steps in the Primary Health Care Strategy and implement Tihei Wairarapa
- Enhance, encourage and involve Clinical leadership
- Develop and enhance regional co-operation
- Create a more unified health system
- Reduce and control costs.

As part of our 2010/11 DAP, our activity will also be influenced and guided by the Minister of Health's six Health Targets:

- Shorter stays in Emergency Departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- Better diabetes and cardiovascular services.

[11] These are further detailed in the Minister of Health's 2010/11 Letter of Expectations.

The targets that the DHB has agreed for 2010/11 are detailed Section 4.

1.3 Local Priorities

As well as delivering on the Minister of Health's expectations, the DHB's 2010/11 DAP is also informed by its local priorities.

The DHB's District Strategic Plan (DSP) for 2005-2015 sets out seven priority outcomes for improving health and reducing inequalities in Wairarapa. These priority outcomes were chosen by the Wairarapa DHB through an extensive health needs assessment and public consultation process.

Wairarapa DHB District Stratagic Plan

Every three to five years, DHBs are required to develop a Strategic Plan (DSP) which identifies how the DHB will meet local population priorities, improve health and reduce inequalities in Wairarapa.

The DHB will soon be reviewing its DSP which was developed in 2005. However, there is still strong alignment between the seven priorities set out in our current DSP and the work we have done more recently on our Clinical Services Action Plan. These seven DSP priorities include:

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 of mental illness and addictions
7. Reducing the incidence and impact of cancer

The revised DSP will be informed by our CSAP which was developed in 2009/10 through a major collaborative exercise involving clinicians in primary and secondary care, management, and other key stakeholders. The CSAP's vision of better integrated health services is consistent with our current DSP.

Our CSAP envisages a single integrated system of local services, encompassing all service provider organisations in the Wairarapa, with clear access pathways to more specialised services in other DHBs, supported by regional clinical networks. Better integration has the potential to improve patients' experience of care, improve health outcomes and lower costs. An integrated health system requires:

- systems integration where linkages between service providers and clinicians are clearly identified and understood by both staff and patients and their families;
- patient level integration where patients know their "medical home" and that this "home" will ensure their health care needs are well communicated and seamlessly met.

This commitment to achieve better integration underpins the changes we are seeking to make within primary care. This involves the development of one virtual integrated family health network for Wairarapa incorporating primary and secondary services.

The CSAP identifies the changes necessary to ensure Wairarapa DHB's financial sustainability; to address increasing workforce constraints; and to improve patient experiences and health outcomes. The CSAP has the Triple Aim of:

- Improving the patient experience
- Improving the health of the whole population
- Reducing and controlling costs.

Whilst both the DSP and CSAP give focus to addressing health inequalities in the Wairarapa, the DHB wants to ensure that as it makes changes in order to live within its means, these changes do not increase but instead, reduce inequalities in health

outcomes. This will be a focus of *Te Huarahi Oranga* the Maori Health Plan that the DHB is currently finalising.

1.4 Regional collaboration

Efforts to control costs and improve the patient experience and health of the population cannot rely solely on efforts by local clinicians working in partnership with management and our community. We are also working closely with other DHBs in the Central region to determine the most efficient and effective way to fund and deliver services that are both clinically and financially sustainable on behalf of our population. This may require changes to the way services are currently organised in the Central region.

These projects to increase productivity include implementing a Regional Elective Surgery Plan, progressing clinical pathway development for key procedures across the region and undertaking the Strengthening Hospital Services Projects in Radiology, Women's Services and Older Adults.

Our work with other DHBs will also involve exploring opportunities for joint procurement and sharing support and administrative services. It will also ensure standardised prioritisation tools and processes are used to inform access to regional services and review access to elective services to ensure equity with other DHBs. This may result in changes in some procedures that are performed regionally (and locally) given that Wairarapa is providing higher intervention levels for its population than the national average.

Sub-regional collaboration

In 2010/11, we will work particularly closely with neighbouring DHBs (Hutt Valley, and Capital & Coast) as we explore the optimal arrangements for securing specialised hospital capacity. We will also investigate opportunities to change how inter district flows are funded between the three DHBs as well as opportunities to converge the three DHBs support and corporate functions. Four clinical services projects have been identified by Clinical Leaders across the three DHBs and will be progressed sub-regionally in 2010/11. Services will include ENT, Health of Older People, Mental Health Service and Paediatrics.

1.5 Prioritising access to services according to need

A key principle underpinning the use of prioritisation tools is to ensure those people most in need have access to services. A needs based approach also underpins the DHB's commitment to focus spending on health services that target those with poorer health outcomes and to reduce health inequalities in the Wairarapa.

For instance, Maori are frequently over-represented among those with poorer health outcomes. Improving the health status of Maori so that the incidence and impact of disease is no greater than that of other population groups is one of the DHB's key strategic goals. This will require an emphasis on Maori leadership and a greater emphasis on the development of services that meet the needs of Maori, including whanau ora services. Improving the health status of Maori will be a feature of the *Te Huarahi Oranga* the Maori Health Plan.

This will influence the DHB's spending decisions in 2010/11 as well as potential changes we make to existing services – as our efforts to reduce and control costs must avoid increasing inequalities in health outcomes.

1.6 Living within our means

Wairarapa DHB continues its commitment to manage expenditure within the provided funding. To respond to the Government's request to all Crown Entities to '*Improve the Business of Government: Delivering Better, Smarter Public Service for Less* the Wairarapa DHB has developed 4 Performance Improvement Actions. These are outlined below:

1. **Address Inequalities** ensuring all of our spending decisions consider those with the poorest health status, where possible focus spending on those with the greatest need. Amongst those identified are Maori, the frail elderly and those with long term conditions.

2. **Achieve Financial Security** by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings.

3. **Improve productivity and quality** with a focus on hospital wards, theatre utilisation, increasing day surgery, and emergency departments.

4. **Enhance regional cooperation** through clinical regional service plans and through greater regionalisation of shared services and back-office functions.

These performance improvement actions (PIAs) will impact positively on our financial and service performance by up to $2.35M in 2010/11 and will enable the DHB to deliver on both Government and local priorities. These PIAs with specific actions are detailed further in Section 2.

As noted above the DHB is planning to achieve $ 2.35M of efficiencies from our PIAs in the 2010/11 year. To achieve our forecast deficit result of ($2.2M) in 2010/11 will require the DHB to deliver a total efficiencies package of $4.5M.

As we pursue strategies and actions to help us live within our means, we remain committed to our vision of a "Well Wairarapa" – in which the DHB works continuously to improve, promote and protect the health status of the people in the Wairarapa.

The DHB's vision and how this is supported by implementation of strategies and actions such as the CSAP and its Triple Aim, Tihei Wairarapa, our PIAs and funding health and disability services across four output classes is reflected in the table below.

Wairarapa DHB Outcomes Framework

In order for Wairarapa DHB to realise its vision of "Well Wairarapa – Better Health for All", it must purchase a range of outputs aggregated into four output classes (i.e. Public Health Services, Primary and Community Services, Hospital Services and Support Services).

Outcomes	Well Wairarapa – Better Health for All			
	Improve the health of the whole population, improve the patient experience and reduce and control costs (i.e. the Wairarapa Clinical Services Action Plan's Triple Aim) By focusing on our Triple Aim and creating a more integrated health system, we will contribute to our District Strategic Plan's seven priority outcomes 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; reducing the incidence and impact of mental illness and addictions; reducing the incidence and impact of cancer.			
Impacts	Achieve the Wairarapa Clinical Services Action Plan's Triple Aim by having an impact on six key components of the health system: individuals and whanau; the patient journey; primary care services; the healthcare workforce; public health interventions; and costs and revenues. This focus will help us create a more integrated health system, characterised by connected providers and integrated services that are patient centred. A more integrated health system will be supported by providers having clearer roles and responsibilities, establishment of district-wide patient pathways, primary care established as the "medical home", improved communications, joint clinical forums and governance and regional clinical leadership and decision making.			
	Government Priorities: Better, Sooner, More Convenient Care Minister's Expectations, Health Targets			
Output classes	Public Health Services ($2.095M)	Primary & Community Services ($39.442M)	Hospital Services ($65.128M)	Support Services ($18.216M)
Outputs	Health promotion and education services Statutory and regulatory services Population based screening Immunisation, well child and school health services	Primary health care services Oral health services Primary and community care programmes Community pharmaceuticals Community referred tests/diagnostic services	Mental health services Electives services Acute services Maternity services Assessment, treatment and rehabilitation services	Support services assessment and coordination Palliative care Rehabilitation and transition services Aged residential care services Home based support services Services to support family care givers
Key measures (quantity)	Number of people participating in smoking cessation programmes Number of breastfed infants Number of before school checks Number of people screened Number of children and elderly vaccinated	Proportion of population enrolled Number of oral health enrolments and examinations of pre-school and school children and adolescents Number of people enrolled in programmes (e.g. diabetes annual reviews, CVD risk assessments, Care Plus) Number of dispensed items Number of laboratory tests	Number of unique clients receiving mental health services Number of elective discharges Number of ED and triage attendances Number of acute bed days Number of maternity deliveries Number of ATR patients Number of blood stream infections	Number of patients supported for palliation % people >65yrs receiving funded support who are living at home % of clients under 65 years receiving long term services to support them to live at home who are Maori % of people over 65 years accessing support needs assessment who are Maori Number of people admitted to hospital from residential care who have a decubitus ulcer Waiting time for routine >65 support needs assessments % of patients in the palliative service who die in the place of their choosing
Key priorities/ activities	Implement Clinical Services Plan Keeping Well Strategy Implementation Healthy Lifestyles Go 4 Your Life Immunisation programme Before School Check Programme	Implement Clinical Services Plan Create one virtual Integrated Family Health model for the Wairarapa Implement Oral Health Business Case Pilot community pharmaceuticals initiatives (i.e. synchronisation and budget holding) Progress clinical pathway development Develop primary health pathway for frail older people	Implement Clinical Services Plan Implement the Regional Elective Surgery Plan Progress clinical pathway development for key procedures within the district and across the region Develop integrated service models across community and hospital services	Implement Clinical Services Plan Wairarapa Elder Local Links plan implementation Progress implementation of InterRAI Develop home based support framework

2. PERFORMANCE IMPROVEMENT ACTIONS

The DHB has identified four performance improvement actions (PIAs) which will assist the DHB to achieve its Triple Aim of improving the patient experience, improving the health of the whole population and reducing and controlling costs. These PIAs are all aligned and supported by specific actions contained within our CSAP.

2.1 Performance Improvement Actions

In 2010/11, the DHB will focus its efforts on progressing four key PIAs which span activity within the Provider and Funder Arms as well as our relationship with DHBs in the Central region. These PIAs are detailed in the table below.

Objectives	Savings Impact
1. **Address Inequalities** ensuring all of our spending decisions consider those with the poorest health status, where possible focus spending on those with the greatest need. Amongst those identified are Maori, the frail elderly and those with long term conditions.	$0.0m
2. **Achieve Financial Security** by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings.	$0.95m
3. **Improve productivity and quality** with a focus on hospital wards, theatre utilisation, increasing day surgery, and emergency departments.	$0.70m
4. **Enhance regional cooperation** through clinical regional service plans and through greater regionalisation of shared services and back-office functions.	$0.70m

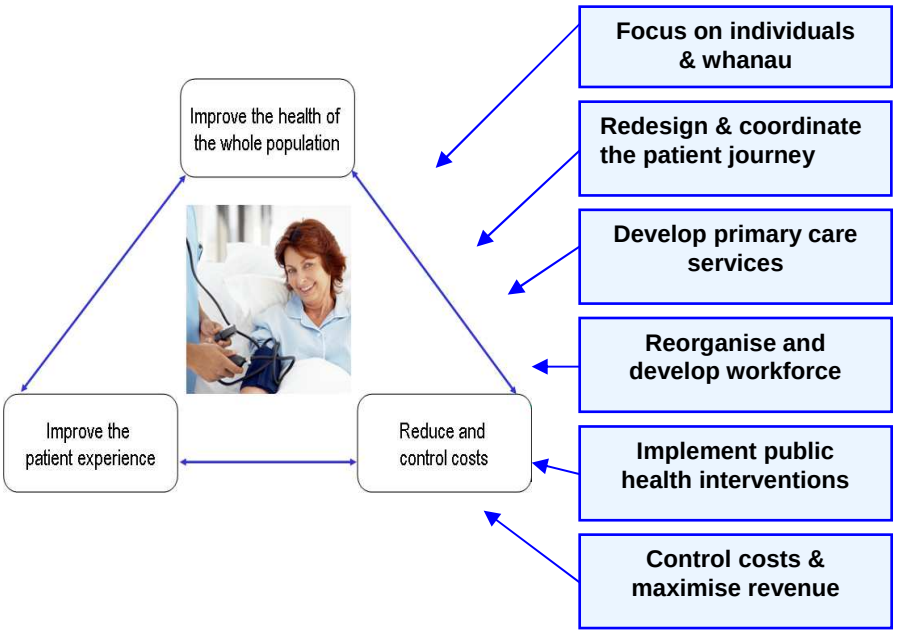
2.2 PIAs, the Clinical Services Action Plan and the Good to Great Programme

These key PIAs are all supported by more detailed and specific actions contained within the CSAP.

This linkage is critical as the CSAP is the culmination of a significant collaborative effort between many individuals from across a range of service providers in the Wairarapa. This work was predicated on a shared understanding that the DHB needs to move quickly to make decisions about how it will deliver services and what services it will deliver in the face of increasing financial and workforce constraints.

The CSAP identifies the changes necessary to put Wairarapa DHB back onto a financially sustainable pathway, manage increasing workforce constraints, and improve patient experiences and health outcomes as encapsulated in the Triple Aim.

The CSAP identifies six areas in which actions are required to achieve our Triple Aim:



Progressing the detailed actions within each of these six action areas will see the DHB make progress on the key PIAs in our 2010/11 DAP.

The Joint Clinical Forum will play a pivotal role in helping the DHB make good progress against the six action areas in the CSAP. The Joint Clinical Forum has been established with clinical representation from across the Wairarapa health system and mandated with the task of monitoring and facilitating progress against the CSAP.

The table on page 16 demonstrates how the detailed actions in our CSAP are aligned with and will support achievement of these PIAs.

How the Wairarapa CSAP and the Good to Great Programme contributes to the PIAs

Focus on individuals and whanau	Clinical Services Action Plan Actions	Timeframe for Delivery	Sponsor
Put the patient at the centre of all endeavours	<u>All services</u> • Promote WDHB values and the cultural competency framework, Te Arawhata Totika, across the organisation and to other health providers. Align the values with employee performance planning and development. Incorporate the values into contract negotiations. • Hold workshops for staff on what being patient centred means, including workshops on disability awareness. • Add session on patient focus to DHB staff induction programme. • Listening to our Patients o Enhancing our patient feedback process and using the information to continually improve services o Developing more Consumer participation in service and Policy development • Introduction of quality staff to clinical areas to promote quality improvement in patient care and ensure that incidents occurring with patients are addressed. <u>Child Health Services</u> • Promote integration of child health services through implementation of the Child Health Strategy, including: o Extend the PHO's existing community child health co-ordination role to focus on ensuring that every child in the Wairarapa is enrolled with and accessing primary care services, receives their full entitlement of well child checks, including the B4School checks and is fully immunised at the appropriate age. o Children with long term conditions and complex needs (i.e. autism spectrum disorders) are supported in primary care through the guided care model with ready access to specialist paediatric support and advice. <u>Oral Health Services</u> • Improve child oral health by implementing the new oral health service model, with a focus on reducing caries among children and increasing utilisation by adolescents. <u>Disability Support Services</u> • Change ways of contracting for home based support services to ensure they are client and family/whanau centred. <u>Long Term Conditions</u> • Engage WDHB services and staff in the Central Cancer Network Projects, particularly the Tumour Stream Patient Pathway workshops and implementation.	Ongoing 2010/11 2010/11	GM HR&OD DQS&R DQS&R DQS&R DQS&R WCPHO GM CS WCPHO GM SD&PH GM SD&PH GM SD&PH

Focus on individuals and whanau	Clinical Services Action Plan Actions	Timeframe for Delivery	Sponsor
Put the patient at the centre of all endeavours	Primary Health Services Roll out prescription synchronisation within community pharmacies to reduce the need for people with Long Term Conditions to make multiple visits to pharmacies and General Practice for their prescriptions.	2010/11	GM SDPH
Support patients as active participants in planning their own care	Long Term Conditions • Support the primary health and residential care sector to develop advanced care plans for residents in ARC facilities with long term conditions. • Implement the Guided Care model in primary care Public Health Services • Promote whānau ora to individuals and whānau, being smokefree, healthy eating practices and exercise to reduce risk or better manage chronic disease, with an emphasis on smokefree and cessation programmes that target young people.	2010/11 2010/11	WCPHO WCPHO GM SD&PH
Manage patient and community expectations of ever-increasing access to health services	All services • Increase public understanding of the DHB's resource limits and options by working with local media and key organisations in the community. Disability Support Services • Promote the concept of supported household management and review the arrangement with packages of care for new clients. Oral Health Services • Complete the review and implement a model for oral health services for low income adults in order to develop consistent application of access criteria and improve ability to manage demand.	Ongoing 2010/11 2010/11	CEO GM SI&CSS GM SD&PH

Redesign and coordinate the patient journey	Actions	Timeframe for Delivery	Sponsor
Streamline patient pathways encompassing all providers	Long Term Conditions • Develop district-wide care pathways and guidelines, and reduce service duplication for common conditions such as diabetes, CVD, palliative care, wound care, COPD and asthma. Mental Health Services • Implement Tihei Wairarapa Mental Health Services projects across all mental health services. Hospital Services • Improve pathways from hospital admission to discharge, including pre-operative assessment and follow-ups (including redesigning outpatient services to reduce face-to-face clinics and support virtual GP consults).	2010/11 2010/11 2010/11	CMO GM CS GM CS

Redesign and coordinate the patient journey	Actions	Timeframe for Delivery	Sponsor
Streamline patient pathways encompassing all providers	Service Integration • DHB facilitates system-wide integration across all providers. • Increase the range of patient focus groups and facilitate patient input into process redesign. Palliative Care • Implement the actions from the Palliative Care Review.	Ongoing 2010/11 2010/11	CEO DQS&R GM CS
Collaborate effectively with other DHBs, including shared staffing	Regional Networks • Be an active participant in regional clinical networks (i.e. renal, cardiac, cancer, plastic surgery and mental health networks) established as part of the implementation of the Regional Clinical Services Plan (RCSP). • Implement the Regional Elective Surgery Plan and Monitoring Group consistent with the RCSP. • Investigate and implement sharing of corporate support functions between Hutt Valley and Capital & Coast DHBs. • Participate in joint procurement opportunities at a regional and national level. • Explore and implement with neighbouring DHBs (Hutt Valley and Capital and Coast) optimal arrangements for securing specialised hospital capacity (e.g. general surgery, anaesthetics, paediatrics, mental health, radiology, emergency services, public health) including opportunities to develop shared staffing of clinicians across DHBs. • Increasing the data collected on clinical outcomes/indicators to benchmark locally, regionally and nationally.	Ongoing 2010/11 2010/11 2010/11 2010/11	GM CS GM CS CEO GM F&I GM CS DQS&R
Increase capacity and capability of aged residential care (ARC) services to manage their own patients	Workforce Development • All ARC facilities offered the opportunity to have their nurses participate in the DHB Professional Development Recognition Programme (PDRP).	2010/11	DNM&AH
Create effective integrated IT/IS systems	Disability Support Services • Implement the InterRAI assessment tool for older people. Hospital Services • Implement prioritised initiatives for the 2010/11 Wairarapa DHB's Information Systems Strategic Plan (ISSP).	2010/11 2010/11	GM SI&CSS GM F&I

Develop primary care services	Actions	Timeframe for Delivery	Sponsor
Create one virtual Integrated Family Health network for Wairarapa incorporating primary and secondary services	Implement Year One actions from the Better, Sooner, More Convenient business case (see Appendix one for details): <u>Organisational</u> • Develop an alliance contracting model with Wairarapa PHO to support the integrated family health model. • Conduct a feasibility study of options for the development of facilities required by primary care and community services in Masterton. • Investigate and develop IT systems ("Manage My Health") to support the integrated family health model.	2010/11	GM SD&PH GM SICSS WCPHO
Establish general practices as the "medical home" for each patient	<u>Pharmacy</u> • Support the integration of community pharmacy with primary care and hospital based information systems. • Implement Structured Pharmacist care. • Explore opportunities for all primary care practices to use optimed service model to optimise prescribing. <u>Older People / Frail Elderly</u> • Better support for the frail elderly and people with long term conditions through screening for frailty and improved multi-disciplinary coordination. • Develop improved patient pathways for the frail elderly. • Improve the interface between primary care and aged care in Masterton.	2010/11	GM F&I GM SD&PH WCPHO CMO
Re-orient services to support self care and independence from medical services	<u>Maori Health</u> • Imbed Maori models of care into planning and delivery of primary healthcare. • Focus on smoking cessation, family violence and lifestyle issues for Māori through contracts with NGOs including how these contracts are integrated with activity being undertaken by the PHO. <u>Mental Health</u> • Develop mental health pathways that provide integrated care for people at all levels of need. • Align community mental health teams with the IFHN	2010/11	WCPHO GM SD&PH WCPHO
Ensure acute first contact care occurs in the most appropriate setting for best use of health service resources	<u>Acute Care</u> • Investigate and potentially develop use of advanced paramedics as first response providers in the home. • Increase collaboration between primary care and the emergency department to reduce ED presentations and avoidable hospitalisations.. • Implement primary care management of cellulitis and DVT. <u>Long Term Conditions</u> • Better support for people with long term conditions through development of a guided care nurse role in primary care.	2010/11 2010/11 2010/11	GM CS GM CS WCPHO WCPHO

Reorganise and develop the healthcare workforce	Actions	Timeframe for Delivery	Sponsor
Ensure tasks are allocated to maximise the use of the skilled workforce	Hospital Services • Review the composition of the hospital clinical team, including the role of RMOs and investigate alternative workforce roles (hospitalists, advanced care pharmacists and physician assistants). • Implement recommendations from the Clinical Administration Review to support frontline clinicians. • Implement *The Productive Ward: Releasing Time to Care.* • Review use and placement of Community Nurses, Clinical Nurse Specialists (CNS) and Clinical Nurse Educators (CNE). • Participate in regional Womens Health Services, Radiology and Older persons reviews.	2010/11	CMO GM CS DNM&AH DNM&AH GM CS
Strengthen clinical leadership	Hospital Services • Strengthen clinical leadership through the activity of the Clinical Forum, the Clinical Board and involvement of clinicians in the development of collaborative service models (e.g. general surgery, anaesthetics, paediatrics, mental health, radiology, emergency services, public health) at a sub-regional and regional level. • Establish oral health clinical advisor role.	2010/11	CMO and DNM&AH GM SD&PH
Develop a culturally competent clinical workforce	Primary Health Services • Implement cultural competency framework, Te Arawhata Totika, with an initial focus on maternity, paediatrics, mental health and primary care.	Ongoing	DMH
Workforce Development	• Provide relevant and accessible training programmes that support the DHB to achieve better, sooner, more convenient health care.	Ongoing	GM HR&OD

Public Health interventions	Actions	Timeframe for Delivery	Sponsor
Improve quality of life and reduce morbidity and mortality through improved understanding of the determinants of health	Mental Health • Complete and implement suicide prevention plan. • Implement Men's Mental Health Project (within available funding) Public Health • Further develop tobacco control and smoking cessation programmes (e.g. include requirement for a smoke-free policy in all DHB contracts) through stronger regional collaboration. • Develop and implement nutrition and physical activity programmes to address child health and obesity. • Promote exclusive and full breastfeeding to 6 months • Address modifiable risk factors for developing chronic disease through health promotion and healthy lifestyle interventions. • Continue to advocate for clean waterways within the Wairarapa.	2010/11 Ongoing	GM SD&PH GM SD&PH

Public Health interventions	Actions	Timeframe for Delivery	Sponsor
Improve quality of life and reduce morbidity and mortality through improved understanding of the determinants of health	Reduce Inequalities • Advocate on health issues as a participant in the Masterton East project being led by Masterton District Council.	Ongoing	DMH
	System integration • Clarify and streamline health promotion actions between the PHO, Public Health Unit and NGOs (e.g. Better, Sooner, More Convenient business case considers the role of health promoters within primary care). • Facilitate development of cross sector capacity through Healthy Lifestyle Programme to address social determinants of health	2010/11	GM SD&PH GM SD&PH

Control costs and maximise revenue	Actions	Timeframe for Delivery	Sponsor
Maximise revenue generating opportunities	Hospital Services • Explore opportunities for expanding revenue from Selena Sutherland. • Explore opportunities for appropriate reimbursement for private diagnostic procedures. • Improve clinical coding and ACC claiming processes. • Capture all revenue for IDF inflows through improved address coding. • Actively encourage other DHBs to utilise Wairarapa's available capacity to increase IDF inflows.	2010/11	GM SI&CSS GM SI&CSS GM F&I GM F&I GM CS
Reduce expenditure outflows	Hospital Services • Introduce Wairarapa DHB IDF referral repository to ensure appropriateness of all IDF outflows. • Consider referral pathways to Hutt Hospital outpatient dental service, and explore options for improving Wairarapa delivered service.	2010/11	GM CS GM SD&PH
Use all resources more efficiently	Hospital Services • Benchmark use of diagnostics and take appropriate action where necessary to rationalise use (i.e. radiology project). Regional and National Networks • Secure financial benefits from joint procurement opportunities at a regional and national level.	2010/11 2010/11	GM SI&CSS GM F&I
Increase efficiency of hospital services	Hospital Services • Strengthen hospital capacity planning, systems and processes.	2010/11	GM CS
Improve funding allocation to maximise value for money	Hospital Services • Review access to elective services to ensure equity with other DHBs Community and Primary Care Services • Review optimal funding allocation to NGOs and the PHO	2010/11	GM CS GM SD&PH

Control costs and maximise revenue	Actions	Timeframe for Delivery	Sponsor
Ensure funding/contracting arrangements promote/support improved service performance	Disability Support Services • Following consultation with stakeholders, develop action plan for implementation of home based services framework. • Implement joint funders' (ACC, DSW, DHB) service for care and support in the community, provided this is fiscally neutral for the DHB. Primary Health Services • Run a pilot of Bulk Funding pharmacy services (dispensing fees and drug costs) in Carterton and Featherston and evaluate outcomes for both DHB and pharmacy providers	2010/11 2010/11	GM SD&PH GM SD&PH

Sponsor

CEO:	Chief Executive Officer
CMO:	Chief Medical Officer
GM CS:	General Manager, Clinical Services
GM SI&CSS:	General Manager, Service Improvement and Clinical Support Services
GM F&I:	General Manager, Finance and Information
GM SD&PH:	General Manager, Strategic Development and Population Health
GM HR&OD:	General Manager, Human Resources and Organisational Development
DNM&AH:	Director, Nursing Midwifery and Allied Health
DMH:	Director, Maori Health
DQS&R:	Director, Quality Safety and Risk
WCPHO:	Wairarapa Community PHO

Various enabling strategies which were a feature of the DHB's Good to Great Programme in 2009/10 need to continue into 2010/11 in order to make progress against our PIAs and the CSAP. These enabling strategies help DHB staff to do their jobs well and include training, our revised performance development framework, capacity planning, releasing time to care project and the information technology prioritisation and implementation project.

The information projects are particularly important given that high quality, easily accessible, timely clinical information will support and facilitate clinical decision making. Information projects planned for 2010/11 which will improve information flows between primary and secondary care and improve the quality and accessibility of information within the hospital setting (e.g. eReferrals, immediate access to diagnostic images across the region, development of a shared electronic medical record) are detailed in Section 7.

Collectively, our PIAs will underpin the DHB's efforts to reduce and better control its costs, enabling Wairarapa DHB to break even by 2012/13. However, in 2010/11, the DHB is forecasting a deficit of $2.2M. How the DHB plans to allocate its funding for 2010/11 together with the assumptions is detailed below.

2.3 DHB Funding for 2010/11

Wairarapa DHB will receive $107.819M in 2010/11 as its appropriation from the Government. As part of this $107.819M, the DHB has received an increase of $1.82M as a contribution to cost pressures as well as an increase in funding of $0.87M for demographic growth - a total funding increase of $2.69M.

Of this $2.69M increase, $0.63M is specifically targeted to cover price increases in contracts the DHB has with aged residential care providers, the Wairarapa PHO and for increased prices for IDFs. This leaves a balance of $2.06M in additional revenue that is available to be applied.

The DHB has allocated its total revenue of $107.819M across all of its services resulting in a deficit of $2.2M in 2010/11. The DHBs allocation of its funding for 2010/11 is illustrated in the table below.

Crown Funding Envelope Allocation (GST exclusive)

Expenditure category	**2008/09 $**	**2009/10 $**	**2010/11 $**	**Comment**
DHB provider and governance total	44,514,677	47,033,563	48,730,599	Increased by $1.7m or 3.6% as costs rising at rates higher than increased funding and productivity levels.
Demand driven primary care items	11,115,088	11,949,847	12,127,389	0.5% increase in community pharmaceutical expenditure + our share of $10m increase in PHARMAC national budget ($110k).
Net Services purchased from other DHBs (Net IDFs)	15,774,106	17,503,421	20,063,472	$2.6m increase in expenditure based on 2008/09 actual volumes adjusted for 0.84% demographic increase and 2.2% increase in national CWD price.
DSS –residential aged care	9,577,606	10,146,528	10,929,574	Price increase to ARC contract of 1.73% plus provision for additional beds coming on-stream.
DSS – aged care – non residential	2,422,485	2,805,078	2,891,647	No price increase but 2.45 % increase in demand due to ageing population and 1.73% increase in Respite services
Medlab Central	3,257,000	3,371,380	3,456,220	Laboratory services as per contract (started 1/3/07).
Wairarapa PHO	6,492,386	6,919,402	7,095,059	1.73% increase less savings of $179k in Sched J +$234k demographic increase
Other personal health NGOs	1,507,848	1,437,700	1,121,824	Decrease of $316k made up of proposed $200k of NGO expenditure initiatives, $71k of funding to devolve services to Primary Care clawed back by MOH & 09/10 FFT provision not passed on.
Maori Health NGOs	575,472	593,404	574,914	09/10 FFT provision not passed on.
Mental Health NGOs (includes Maori providers)	3,825,209	3,899,892	3,716,371	Decrease of $184k being $38k increase offset by 09/10 FFT provision not passed on and expenditure initiatives of $100k.
Contingency for risks	527,354	300,000	0	No contingency allowed for in 2010/11
Funder Arm efficiencies to be allocated	0	0	(700,000)	Efficiencies yet to be allocated across funder contract lines
Total Allocated	**99,589,231**	**105,960,215**	**110,007,020**	
Total Funding	**99,589,231**	**105,002,669**	**107,818,546**	
Surplus/(Deficit)	**0**	**(957,546)**	**(2,188,524)**	

2.4 Reducing and controlling costs

Given the need to put Wairarapa DHB back onto a financially sustainable pathway, it is appropriate that our Triple Aim includes reducing and controlling costs and that all our PIAs will contribute towards this goal.

Whilst the DHB does not expect to achieve break-even until 2012/13, this masks the fact that the DHB has already given significant attention to achieving efficiencies and cost savings.

Recovery Plan
A recovery plan was developed by the DHB in 2009/10. As a result of recovery plan initiatives, $4.6M of efficiencies was built into the planned deficit of $0.957M for 2009/10. These efficiencies involved a range of initiatives spanning three key areas:

- Workforce and Service Efficiency Projects
- Enabling strategies
- Direct Cost reduction.

The DHB is projecting $3.9M in efficiencies will be achieved in 2009/10 across the range of services it funds. The DHB now needs to carry these savings through into 2010/11 and make further efficiency savings in order to achieve a deficit of $2.2M.

Given the DHB is already operating relatively efficiently and productively across a range of hospital benchmarks, it makes it more difficult to extract further efficiency savings.

However, further efficiencies and savings are required in 2010/11 to enable the DHB to breakeven by 2012/13 given projected cost growth in key areas such as:

- Hospital labour costs
- IDFs
- Community pharmaceuticals
- Age residential care services.

The need for further efficiencies to achieve financial sustainability is reflected in our PIAs which span both the Provider and Funder Arms. This will involve the need for savings and efficiencies across services provided and funded. This is likely to extend to service changes.

Supporting Private / Public Partnerships
Wairarapa DHB is committed to continuing to support Private Public Partnerships as reflected by the relationship the DHB has fostered with the Selina Sutherland Unit, a private hospital service located on the Wairarapa Hospital Campus. Selina Sutherland will be increasing its beds from 6 to 12 this year as part of an approved expansion plan. This partnership will provide further revenue opportunities for the Wairarapa DHB. As part of the Tihei Wairarapa Primary Care Business case the DHB will also be looking at options for supporting a private radiology service.

Volumes for Wairarapa Hospital for 2010/11 have been based on 2009/10 volumes with the exception of acute medical CWDs, ED presentations, targeted follow ups and nurse led clinics which have been adjusted to reflect the increasing activity that will be occurring in Primary Care as part of the *Tihei Wairarapa* Business Case for Better Sooner More Convenient Healthcare in the Wairarapa.

National Cost Saving Initiatives

As well as the initiatives noted above the Wairarapa DHB will also be supporting a number of national initiatives through DHBNZ to manage and control costs. These will include:

- High Cost Treatments – seeking to be consistent in our menu of high cost treatments, appropriately linked with advanced care plans. Options and a national service implementation plan by end of June 2011 in conjunction with the National Health Board Business Unit (NHBBU);

- National Services Location – Options and a national service implementation plan by end of June 2011 in conjunction with the NHBBU;

- Health Procurement – Deliver a set of savings projects in 2010/11 to a total of $30M, Health Procurement to provide detail of current plans, potential and range of potential savings being sought. Each DHB assessing its likely share of this total based on expenditure and timing of contract renewal;

- Shared Services –Working jointly with the Shared Services Establishment Board (SSEB) to deliver a shared services change programme that offers best value to DHBs over the next three years with appropriate risk management given the importance of shared services as an enabler for DHB delivery of health and disability services to their populations; and

- Low Evidence Activities & Treatments – Seeking a single agreed list of low-evidence activities and treatments, including better targeting of pharmaceuticals schedule. Options and a national service implementation plan by end of June 2011 in conjunction with the Ministry of Health/NHBBU.

2.5 Key Risks

The DHB's key risks are grouped into two categories: non clinical and clinical risks. However, they are often interrelated with a failure in one often resulting in a negative consequence in the other. Through our mitigation strategies, we seek to actively manage our non clinical and clinical risks.

Non Clinical Risks

- *Financial Performance:* The DHB needs to make efficiency savings to achieve its planned deficit. The DHB will progress its CSAP, its Good to Great programme, build financial management skills in all 2nd, 3rd and 4th tier managers and continually monitor and review spending by hospital departments and other Funder contracts to achieve its forecast result in 2010/11.

- *Financial Liquidity:* The DHB has a constrained cash position. This requires the DHB to monitor its cash flow on a daily basis and maintain regular communication with the Crown Health Funding Authority.

- *ACC Revenue:* Whilst there are opportunities to increase ACC revenue, ACC is tightening approval criteria. These factors may constrain the DHB's ability to earn extra ACC revenue, although the DHB's review of how it can maximise ACC revenue and organisational changes to support this approach will assist.

- *IDF:* The DHB's IDF position is very volatile with small changes in referral patterns of outlier cases having a significant financial impact. IDF financial risks

are also heightened by greater use of new services such as brachytherapy and PET scans. To offset these risks, the DHB is actively working with regional DHBs on alternative service delivery models and is supporting regional planning work on electives. The DHB is also developing and implementing IDF management controls so that elective IDF outflows are controlled as tightly as possible and risks identified and planned for. This will involve the implementation of a pre-approval process.

- *Pharmaceuticals and pharmacy services:* Growth in pharmaceutical spending is a major risk to the DHB. Changes in the pharmaceutical schedule widen access to medicines whilst screening programmes and the district's ageing population are increasing utilisation. Projects are in place locally to improve prescribing and medication management and a new contracting strategy is under discussion with local pharmacies to limit dispensing fees risk from July 2010.

- *Recruitment:* Labour pressures and vacancies exist across a range of areas - specialist and general medical and nursing staff, RMOs and SMOs, Maori Health staff and mental health clinicians and general practice clinicians. This impacts on rosters and service delivery, and necessitates bringing in high cost locums or senior staff having to fulfill more junior roles. To address workforce shortages the DHB is working with sub-regional DHBs (Hutt Valley and Capital & Coast) to develop a clinically led programme over the next 1-2 years to explore optimal arrangements for securing specialised hospital capacity. The DHB is also actively pursuing improved recruitment and retention strategies and investing in succession planning and performance development.

- *Political/Environmental:* Adverse reporting on the financial constraints of the DHB and reporting of serious/sentinel events may impact on the public confidence of healthcare consumers in the Wairarapa DHB.

Clinical Risks

- *Clinical safety and quality:* Health care delivery by its nature has everyday clinical risks (e.g. falls and medication errors). While the DHB seeks to minimise clinical risks through education, incident management and monitoring trends, risk avoidance and minimisation can impact on efficient service delivery and drive up costs (e.g. increased communication and documentation costs and impact on service volumes).

Finding a better way

Albert is 82 and lives in Masterton with his frail wife. He receives a letter advising him that he would be having long awaited hip replacement surgery in three weeks. The letter also advises him that he has two appointments at the outpatients department the following week. A couple of days later he receives another letter advising him of an appointment with the Surgeon, also next week. As he no longer drives, Albert's family and friends rearrange their schedules to transport him to and from the hospital.

At the pre-assessment clinic the nurse tells him that he needs to have an x-ray and blood test done before going home, that he needs an ECG on Thursday, half an hour before his anaesthetic clinic appointment, and that he needs to come in for another blood test 2 or 3 days before the day of his surgery. That afternoon he receives a telephone call from the physiotherapist advising him that on Thursday he will also need to see the physiotherapist and occupational therapist.

By the end of the week Albert has made 3 trips to the hospital and been to 7 different appointments or departments. It has taken him 7 hours. He is tired and bewildered by all the information he has been given, both verbally and in numerous sheets of paper and leaflets.

Our CSAP indentifies actions to streamline journeys like Albert's as a priority.

Extract from the Clinical Services Action Plan

- *Change management:* Change initiatives required to improve the patient journey need to match the DHBs capacity to manage change processes. As a result, the DHB will focus on patient pathways which will add the most value to the DHB and to patient care.

- *Ageing population:* The needs of the expanding elderly population, accompanied with the growth in co morbidities and long term conditions will result in increased service demands across primary and secondary care. The DHB is also supporting in the community increasing numbers of older people that are eligible for aged residential care.

- *Pandemic:* A pandemic would cause considerable disruption to service provision and the DHB's planned activities. Our DAP has been developed without taking into account the impact of a pandemic occurring or the additional costs that would be associated with this. The DHB has increased its planning and preparedness activity, including training, to enhance its ability to manage in a pandemic situation.

2.6 Clinical Safety and Quality

The DHB is using a 'Just Culture' philosophy to underpin all of its quality, safety and risk systems. This is demonstrated through:

- taking a fair and balanced approach to incident reporting
- learning from mistakes and protecting people's honest mistakes from being seen as culpable but at the same time holding people and the organisation accountable for patient safety.

To this end a shift in mindset around quality, safety, risk reporting and management is required throughout the DHB to raise the profile of quality and for staff to feel safe with the processes in place. Some of the actions supporting this are:

- Trial of the introduction of joint appointee quality leader roles into the clinical areas to lead by example, monitor and improve the quality of care provided. Dependent on the success of this project over the next 12 months in the secondary setting, consideration will be given to the quality leader roles

A dilemma
Tamati is a 78 year-old who lives alone since the death of his wife 6 months ago. He is independent and enjoys reasonable health. Recently Tamati has been thinking about what would happen if he was to become ill. He hates the thought of being "hooked up to a machine, having a long drawn-out death". He tried to talk to his family about his thoughts but it only upset them.

Tamati has now had a stroke. He is unconscious and requires assistance to breathe. His doctor calls the family together to talk about his condition and explains that even if Tamati regains consciousness, he will be unable to speak or manage the most basic personal tasks, such as feeding himself. She explains that it may be in Tamati's best interests if they remove the life support machines and provide comfort care, so that he may die peacefully. Tamati's family face a difficult decision. His daughter wants everything done but his son is sure that his father would not have wanted his life prolonged in this way.

How it could be
After the death of his wife, Tamati realised that he didn't want his children to be in the situation of having to decide whether or not he should have invasive procedures or be kept on life-support. He gathers his family together and tells them what he has been thinking about. They are upset that he is talking about death but he insists that he is only being practical and that he wants to ensure that there is no doubt about his wishes should he not be in a position to make them known himself.

Together they discuss a brochure on Advanced Care Planning which he picked up at the local Health Care Centre. It includes questions which guide Tamati and his family through the process of creating an Advance Care Plan. Tamati now has a clear record of his preferences about future medical care and his family is reassured that if they need to make decisions on his behalf, they will be based on a clear understanding of their father's wishes.

Extract from the Clinical Services Action Plan

supporting primary care and aged care facilities.

- Greater visibility and profile of the quality, safety and risk team.
- Embedding quality and risk management processes into everyday DHB practice.

Quality Improvements

To respond to the rapidly changing parameters of health care, the DHB needs to be able to change and foster innovation, quality improvements and clinical leadership. Through the DHB restructure, we are aiming to work smarter, not harder, and this is reliant on a willing and engaged workforce.

To support and encourage its workforce, the DHB has commenced the reintroduction of the quality and innovation awards at a local level, with the aim of dovetailing these into the National Quality Awards offering the staff public recognition for the achievements made across the DHB and resulting in an improvement to the patient's quality of health care.

The CSAP's Triple Aim and its six key areas for improvement form the basis of the DHB's quality and risk strategic plan. This involves improving the health of the whole population and the patient experience through:

- Improved inter-professional communication and collaboration
- Clarifying and improving coordination and integration across providers and services based on the patient, not the provider
  - Clarifying roles and responsibilities for the coordination of services for the individual patient
  - Develop clear accountabilities for patients under the care of multiple agencies and healthcare professionals.
- Improving systems and organisational support, particularly in regard to duty of care and medico-legal risk
- Continuing to develop the clinical governance of the DHB.

These strategic quality improvements support the six system components identified in the CSAP which are required to achieve the Triple Aim. They will be mirrored throughout the organisation in all levels of quality improvement.

The DHB is committed to the continuing support and participation in the identified National Quality Improvement Committee (QIC) projects[2] to manage the risk of maintaining patient safety and clinical quality. This will allow benchmarking with other DHBs and shared learning.

2.7 Workforce Development and Clinical Leadership

A skilled, supported and responsive workforce is essential for sustainable service delivery. The DHB needs the right mix of trained and qualified people in sufficient supply and working in partnership with each other. Trusting, valuing and fully engaging health professionals improves patient care and job satisfaction and will assist in recruitment and retention. Focusing on improving clinical workforce retention and fostering clinical leadership continues to be a key priority for the DHB in 2010/11.

[2] The current QIC projects include safe medication management, optimising the patient's journey, infection prevention and control, and national mortality review systems.

The DHB supports the *In Good Hands* task force report. This report identified qualities of the New Zealand healthcare system in regards to clinical governance based on the following six principles:

1. Quality and safety will be the goal of every clinical and administrative initiative
2. The most effective use of resources occurs when clinical leadership is embedded at every level of the system
3. Clinical decisions at the closest point of contact will be encouraged
4. Clinical review of administrative decisions will be enabled
5. Clinical governance will build on successful initiatives
6. Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.

Wairarapa DHB is committed to continuing to support and grow clinical leadership by supporting clinical governance of the patient journey across primary and secondary services. Our success in strengthening clinical leadership and clinician involvement in decision making will underpin our rate of progress in our PIAs.

Identifying more efficient and effective ways to deliver services at a regional, sub-regional and local level; controlling the growth of hospital labour costs; maintaining and where possible, improving hospital productivity: and achieving better integration of local primary and secondary services all require support, active involvement and leadership by clinicians.

The DHB will continue to ensure local clinicians take a lead role in the establishment of regional clinical networks, local and regional clinical pathways, and optimal clinical arrangements for securing specialised hospital capacity with neighbouring DHBs. This strengthened clinical leadership will be assisted through the activity of the Clinical Forum, the Clinical Board and involvement of clinicians in the development of collaborative service models (e.g. general surgery, women's health, anaesthetics, paediatrics, mental health, radiology, emergency services, public health) at a sub-regional and regional level. Both the Clinical Board and the Clinical Forum have a broad focus on health service delivery for the Wairarapa. Clinicians are also represented on the DHBs Strategic Information Group (SIG) and the Capital Committee playing an important role in determining the resource allocation of IT and capital initiatives across the DHB.

The Clinical Board[3] 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 DHB providers and the clinical quality programme; and providing advice and recommendations to the DHB Board, Chief Executive and management.

Meanwhile, the Clinical Forum[4] has clinical representation from across the Wairarapa health system and is currently supporting progress with Wairarapa's primary care business case. In the future, the Clinical Forum will focus on the wider strategy for the regionalisation of care and developing specific actions within the CSAP (e.g. pathway development between primary and secondary care).

[3] The Clinical Board is a multidisciplinary clinical forum chaired by Wairarapa DHB's Medical Officer and includes a total of 17 members, including senior nursing and medical staff from the hospital, a DHB psychiatrist, a representative from allied health as well as the CEO, a Board member, a representative from the DHB's Maori Health Unit and the DHB's GP Liaison and Quality and Risk Manager.

[4] The Clinical Forum is chaired by a local GP. Its multi-disciplinary membership is in the process of being confirmed, and currently includes provision for 16 clinicians and service managers from the hospital as well as 10 representatives from primary and community based services, including clinical and management staff from general practice, pharmacy, NGOs and Maori providers.

To support clinicians to take a leadership role, the DHB will include leadership and technical competence of the clinical workforce as a key part of the DHB's core organisational training initiatives in 2010/11. As well as developing leadership training for clinical staff, we will also offer a coaching and mentoring framework for current and potential clinical leaders.

The DHB will focus on the needs of each employee through individual performance planning and development. This will ensure all staff have performance objectives for 2010/11 that align to the DHB's strategy, goals and values. It is anticipated this individualised performance development framework will reduce staff turnover and improve staff retention.

3. PRIMARY HEALTH CARE

The Wairarapa CSAP and the PIAs both emphasise the importance of changes within primary health care to improve the patient experience, improve the health of the whole population and reduce and control costs.

By better integrating local primary and secondary care services, we expect that over time, we will be successful in reducing avoidable hospital admissions and readmissions. By developing new models of care that establish general practices as the "medical home" for each patient and re-orient services to support self care and independence from medical services, primary care will build its capacity to manage people with long term conditions.

The development of one virtual integrated family health network for Wairarapa incorporating primary and secondary services will support these changes.

3.1 Integrated Family Health

The DHB has worked closely with the Wairarapa Community Primary Health Organisation (WCPHO) and key Wairarapa stakeholders to develop a business case that sets out the work required to fulfil the Government's expectation of better, sooner, more convenient healthcare and the DHB's need for better integrated primary and secondary care services. *"Tihei Wairarapa"*, the business case for the transformation of primary care in Wairarapa outlines plans to develop an integrated family health network over the next three to five years.

This integrated family health network will involve:

- whanau ora being a standard component of all primary health care services
- full introduction of a guided care model to bring together management of chronic and acute care with care of the elderly and mental health
- clinicians will work through a schedule to design and implement clinical pathways spanning primary, secondary and tertiary care covering all of the higher volume activities over the next three years
- development of the network of primary care facilities with co-location of an increasing range of services
- development of an Integrated Family Health Centre, based in Masterton
- a significant redevelopment of mental health care to greatly enhance its community focus and add value to the significant spend on mental health services
- value for money initiatives particularly in pharmacy distribution and medicine management
- an electronic shared clinical record across the network of providers, with patient portal access and links to medication management systems.

As part of the integrated family health business case, funding and contracting arrangements will need to be modified to promote and support improved service performance. This will involve developing new ways of funding services to provide new models of care. For instance, as part of the business case, the DHB is wanting to combine WCPHO funding streams such as Diabetes Annual Reviews, Care Plus, B4 Schools and Services for Improving Access into a flexible targeted fund.

The approved implementation plan which includes milestones, specific actions and timeframes of Tihei Wairarapa in 2010/11 are detailed in Appendix one. Wairarapa DHB is currently completing a comprehensive evaluation of the draft implementation plan to determine what resource allocation will be required.

3.2 Primary Health and our PIAs

A successful integrated family health network is critical to achievement of our PIAs. Ultimately, the integrated family health network will contribute to our efforts to reduce and control costs by re-orienting services to support self care and independence and relieving pressure on the hospital.

Tihei Wairarapa includes a number of aspirational goals to assist in our efforts to reduce and control costs. These cost savings have been built into our PIA savings (PIA 2). These aspirational goals include:

1.	Reducing, triage 4 and 5 Emergency Department non-admitted self-presentations over 2009/10 by 30% levels over the next three years
2.	Reducing the number ASH admissions by 15 % over 2009/10 levels over three years by targeting the most common Wairarapa ASH conditions which are cellulitis, asthma, gastroenteritis, angina and chest pain and pneumonia
3.	Reducing medical and paediatric outpatient volumes to 2006 levels over three years
4.	Reducing the community pharmacy spend by $750,000 in total over three years, through implementation of a structured pharmacy programme
5.	Increasing the percentage of the over-85 population who are living well in the community from 74% to 81%

3.3 Shifting Services to Primary Care

The business case will involve the implementation of a number of new service models which will provide more streamlined and integrated services for patients as close to home as possible.

Specific initiatives that are included in the business case that will support shifting services to primary care are limited at this stage while service models are being agreed by the joint Clinical Forum.

However included in the business case is a specific imitative to shift the delivery of IV antibiotics for conditions such as cellulitis from the hospital to primary care. This service will commence 1 July 2010 with an expected 500 patients treated in primary care in 2010/11 at a cost of $69,000.

The DHB will also be implementing treatment for DVT in primary care during 2010/11. This work has already commenced in collaboration with Primary Care.

Other opportunities are currently being considered as part of the feasibility study on potential building options for an Integrated Family Health Center (IFHC) in Masterton. For example the DHB services that are being considered for location in the IFHC include Community Mental Health, District Nursing, Oral Health and Public Health Nurses.

4. PERFORMANCE MEASURES

The Government wants the public health system to deliver better, sooner more convenient healthcare for all New Zealanders. This section details how Wairarapa DHB will measure its performance in 2010/11 against the Minister of Health's priority areas and health targets ("Policy Priorities") and against various measures of "System Integration" and "Ownership", collectively known as the indicators of DHB performance (IDPs).

Achievement of these performance measures will also contribute to achievement of the DHB's PIAs and its overall efforts to improve the patient experience, improve the health of the whole population and reduce and control costs.

The DHB is already performing well against a range of these measures, and wants to continue this strong performance, to the extent it is clinically and financially appropriate.

This section includes quantitative targets the DHB will seek to achieve in 2010/11 for each of the six health targets, including key actions the DHB will take to at least maintain, and in most cases, improve performance against the health targets. Appendix two includes detail of the other IDPs that involve setting a quantitative target for 2010/11.

The DHB is in the process of developing a balanced scorecard to measure and monitor its performance, and assist it assess how successfully the DHB is contributing to its vision of "Well Wairarapa". The balanced scorecard measures will include many of the IDPs which are currently used to report performance to the Ministry of Health. The DHB's balanced scorecard approach will include four dimensions (or key results areas): patient experience and service outcomes; internal business process and innovation; learning and growth; and financial and productivity.

4.1 Productivity and Performance

Nationally, Wairarapa DHB is seen as a leader in developing creative strategies for the provision of health services, performing well across a range of performance indicators:

- significant gains in hospital productivity
- high levels of patient satisfaction
- increased community services activity
- greater proportion of older people being supported at home compared to residential care.

Appendix three provides a summary of Wairarapa DHB's productivity across a range of measures. However, as noted in Section 2, the DHB needs to further enhance its productivity and efficiency if it is to become financially sustainable.

Improving Ward Productivity

Wairarapa DHB has rolled out *Releasing Time To Care* in two of the wards (combined medical / surgical department and acute services which includes ED, HDU and the acute assessment unit). This was launched in March 2010. The first module being rolled out is called *Put It Back Jack* which is related to reducing the time it takes clinicians to find clinical documentation related to patient care.

For 2010/11 Wairarapa DHB has committed to the following actions:

- Creating a dashboard which indicates progress towards increasing the amount of time that clinicians spend in direct patient care.
- This dash board will include four key patient and staff indicators - improved patient safety, improved patient experience, improved efficiency of care delivery and improved staff well being.
- Each of these four indicators will be aligned with specific modules in the programme in order to improve productivity. Key activities will include a reduction in patient falls, reducing medication errors, reducing hospital acquired pressure areas, ensuring discharges occur before 1100 hours and keeping ward cost consumables within budget.
- Targets will be set against each of the four indicators which will lead to an overall improvement in ward productivity.

4.2 Policy Priorities

Health Targets

In 2010/11, Wairarapa DHB will continue to progress the six health targets that were identified as national targets for 2009/10 as demonstrated in the table below. Given the DHB's commitment to reducing inequalities, the DHB is particularly mindful of the need to set targets that are challenging but still realistic and which will contribute to an improvement in Maori health status (e.g. Maori immunisation rates, Maori cardiovascular risk, percentage of diabetes annual reviews for Maori, breastfeeding rates for Maori, rates of ambulatory sensitive admissions for Maori).

Whilst not part of the formal IDPs against which the DHB must report to the Ministry on a quarterly basis, as part of its 2010/11 Statement of Intent, the DHB has set targets for the number of cervical smears and mammograms provided to women in an effort to reduce the incidence of cancer. These measures include increasing screening rates for Maori, given the higher incidence of cancer amongst our Maori population.

Indicator	Current Achievement (Quarter Three, 2009/10)	Targets 2010/11
Shorter stays in ED	Achieved. 98%of patients were seen within 6 hours	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Improved access to elective surgery	102% of YTD plan	A total of 1841 elective surgical discharges
Shorter waits for cancer treatment	100%	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010
Increased immunisation	DHB is achieving coverage rates just above target.	90% of all two year olds and 91% of Maori two year olds are fully immunised by July 2011; and 95% by July 2012
Better help for smokers to quit	87% New Target for 10/11. No baseline.	90% of hospitalised smokers will be provided with advice and help to quit by July 2011 and 95% by July 2012 80% of patients attending primary care will be provided with advice and help to quit by July 2011, 90% by July 2012 and 95% by July 2013.

Indicator	Current Achievement (Quarter Three, 2009/10)	Targets 2010/11
Better diabetes and cardiovascular services: • Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	Achieved and exceeded target rates for Total, Maori and Other.	75% Percent of the eligible adult population (Maori) have had their CVD risk assessed in the last five years 82% Percent of the eligible adult population (Other ethnicity) have had their CVD risk assessed in the last five years 80% Percent of the eligible adult population (All ethnicities) have had their CVD risk assessed in the last five years
• Increased percent of people with diabetes attend free annual checks	Achieved and exceeded target rates for Total, Maori and Other.	73% Percent of people with diabetes (Maori) attend free annual checks 77% Increased percent of people with diabetes (Other Ethnicity) attend free annual checks 77% Percent of people with diabetes (All Ethnicities) attend free annual checks
• Increased percent of people with diabetes have satisfactory or better diabetes management.	Achieved and exceeded target rates for Total, Maori and Other.	72% Percent of people with diabetes (Maori) have satisfactory or better diabetes management 80% Percent of people with diabetes (Other ethnicity) have satisfactory or better diabetes management 78% Percent of people with diabetes (All ethnicities) have satisfactory or better diabetes management.

The DHB plans to maintain its good performance against these six health targets by continuing to profile the importance of the targets with hospital and community based service providers and orienting their activity to achievement of the targets through its service funding and contracting processes. The DHB will also seek where possible to enhance its good performance through the following Health Target initiatives:

Shorter stays in ED

Increase collaboration between primary care and the emergency department to reduce acute demand through the following initiatives:

- Monitor and review "frequent fliers": using patient management systems, identify those people who are regularly presenting at ED (i.e. 12 or more presentations in a year) and where appropriate, identify a health service provider or hospital department that should take a lead role in co-ordinating the patient's care
- Support better integration of the multi-disciplinary team approach, including case management of patients with long term conditions
- Investigate and potentially develop use of advanced paramedics as first response providers in the home
- Develop primary care's capacity to manage people with cellulitus and DVT
- Make the Concerto electronic medical record used in the hospital accessible to primary care and community based providers and integrate the hospital patient record with MedTech so that primary care information from all patients in the district can be viewed within Concerto - a "shared care record" which will be developed over time.

The DHBs Delivery Plan for Shorter Stays in ED provides an outline of how the DHB plans to continue to maintain its performance in this area.

Improved access to elective surgery

- Maintain and where possible, enhance hospital productivity (i.e. optimise theatre use and scheduling)
- Review access to elective services to ensure equity with other DHBs
- Implement a Regional Elective Services Plan and Monitoring Group consistent with the RCSP.

Wairarapa DHB is committed to improving electives productivity and outputs. The following table reflects specific actions that the DHB will be taking in 2010/11 to support the delivery of the Elective Services health target and reduce waiting times:

Action	Outcome	Measurement	Timeframe
1. Establish a centralised referral systems for all domiciled patients	Remove unnecessary wait and duplication for referral of patients to access specialised services both locally and out of the region.	Identify the overall patient waiting times from start to finish of their whole elective journey setting new targets based on baseline metrics. In addition to current ESPI - 6 month maximum for specialty Referral to FSA and FSA to treatment, new measures will be defined to capture wait times from; • Referral acknowledgement to Acceptance/Declination FSA. • FSA event to decision to treat. This will provide a baseline total wait time for the elective journey. 10% improvement to overall wait time for the elective journey.	January 2011
2. Upgrade eReferrals forms and support new referral management pathways within the hospital and community.	Improve the timeliness of referral process and patient journey. Acknowledge and act on referrals in a more timely way. Improve quality and minimise risk of lost referrals and miscommunication.	Development of a robust event level reportable/ query enabled system to process capture. • Referral receipt to acknowledgement • Referral acknowledged to acceptance / declination.	October 2010

Action	Outcome	Measurement	Timeframe
3. Improve theatre utilisation	Increased use of current theatre capacity through better theatre management so as to improve both capacity for and access to elective surgery. Projects to include: - Theatre scheduling improvement: reviewing scheduling options with the objective of maximising use of existing theatre capacity. - Reducing late starts: work with clinicians and support staff to minimise occurrence of late starts by isolating causes and removing these barriers. - Maximise theatre use: actively encourage other DHBs to utilise Wairarapa DHBs available capacity.	Target of 85% theatre utilisation monitored on a monthly basis.	Ongoing 2010/11

Shorter waits for cancer treatment

- Encourage Wairarapa PHO to increase the number of women being screened for breast and cervical cancer, and ensure early detection and prevention activity by primary care focuses on those population groups with poorer outcomes (i.e. Maori)
- Monitor Wairarapa PHO's screening performance through the PHO Performance Management Programme
- Progress implementation of the Central region cancer network and its associated projects (e.g. the tumour stream patient pathway), arising from the RCSP.

Wairarapa DHB is committed to meeting the Shorter Waits for Cancer Treatment – Radiotherapy. The following table contains specific actions that the DHB will under take to show how the providers of radiotherapy treatment will be supported by the DHB to meet the Health Target:

Action	Outcome
Monitor waiting times for radiotherapy in both Mid-Central and Capital & Coast Treatment Centres through current quarterly reporting processes. Escalate any issues to Wairarapa DHB Clinical Board for action.	Early identification of delays in treatment and local attention to issues
Wairarapa DHB will work with CCDHB and MCDHB to reduce waiting times to 4 weeks and will action any local responses required to facilitate that plan.	4 week waiting time target met
Implement E referrals from primary to secondary care services to facilitate more streamlined process for diagnosis and treatment.	Less delays and improved access to secondary care services
Wairarapa Hospital will action recommendations and plans from CCN projects particularly Lung and Bowel Tumour Stream project.	Better outcomes for patients with Lung or Bowel tumours

Increased immunisation

- Extend the PHO's community child health co-ordination role to ensure that every child in the Wairarapa is fully immunised at the appropriate age
- Monitor Wairarapa PHO's immunisation performance through the PHO Performance Management Programme.

Better help for smokers to quit

- Identify opportunities for Central region collaboration in smoking cessation and tobacco control (e.g. controlled purchase operations)
- Re-orient public health/health promotion activity to ensure greater focus on smoke free (e.g. smoke free schools programme) and smoking cessation
- Smoke free and cessation programmes to target Maori and young people
- Achieve closer alignment between smoke free and cessation activity in primary care, NGOs and public health
- Include requirement for a smoke-free policy in all DHB contracts
- Close monitoring and regular internal audits to ensure continued improvement in ABC and coding
- Focus on consistent referrals to community based Cessation supports including Quit Line to ensure quit attempts initiated through hospital admissions are maintained post discharge
- Campaign to raise awareness of current levels of A, in the ABC programme in each Medical Centre and ongoing reporting of monthly progress towards achieving the target of 90%
- Regular training of primary care staff in the ABC will be offered throughout the year with follow up support to each practice
- Clinical Champions among Primary Care clinicians will be identified and supported to encourage their colleagues to commit to the ABC programme.
- Regular feedback will be provided to both primary and secondary care services and identification of any low performers to address any systemic barriers to coding and ABC provision.

Better diabetes and cardiovascular services:

- Develop district-wide care pathways and guidelines, and reduce service duplication for common conditions such as diabetes and cardiovascular disease

- As part of the implementation of Year One actions from the Tihei Wairarapa business case, better support people with long term conditions through development of a guided care role and case management of patients with long term conditions.

As well as meeting the health targets, achieving Government's policy priorities requires the DHB to make progress against the following measures, most of which involve six monthly or annual qualitative reporting to the Ministry:

- Clinical leadership self assessment
- Implementation of Better, Sooner, More Convenient primary health care
- Local Iwi/Maori engagement and participation in DHB decision-making, development of strategies and plans for Maori health gain
- Improving mainstream effectiveness DHB provider arms pathways of care for Māori
- Waiting times for chemotherapy treatment
- Improving the health status of people with severe mental illness
- Improving mental health services using crisis intervention planning
- DHBs report alcohol and drug service waiting times and waiting lists
- Delivery of Te Kokiri: the mental health and addiction action plan
- Oral health DMFT score at year 8
- Children caries free at 5 years of age
- Utilisation of DHB funded dental services by adolescents
- Improving the number of children enrolled in DHB funded dental services
- Family violence prevention.

4.3 Systems Integration

'System Integration' performance measures assess how well the DHB is meeting service coverage requirements and supporting sector inter-connectedness. They also measure how well the DHB is influencing health outcomes and managing and co-ordinating relationships within its community. This includes creating positive partnerships with the local community (including NGOs such as PHOs) and local Maori.

Systems integration measures also focus on how well the DHB is coordinating activity between primary and secondary care and across the continuum of care.

System integration measures include:

- Ambulatory sensitive (avoidable) hospital admissions
- Regional Service planning
- Service Coverage
- Elective Services Standardised Intervention Rates.
- Agreed Funding for Māori Health and disability initiatives
- Risk reporting
- Improving breast-feeding rates.

4.4 Ownership

Ownership performance measures assess whether the DHB is providing quality services efficiently:

- Staff Turnover
- Capital Expenditure to Plan
- Elective and Arranged Inpatient Length of Stay
- Acute Inpatient Average Length of Stay
- Theatre Productivity
- Elective and Arranged Day Surgery
- Elective and Arranged Day of Surgery Admission
- Acute Readmissions to Hospital
- Mortality
- National Patient Satisfaction Survey
- Improving the Quality of Data Submitted to National Collections
- Output Delivery Against Plan.

This measure will provide a useful guide as to how well the DHB is progressing its PIA actions specifically: improving business practices, increasing the efficiency of the hospital, strengthening clinical involvement in change management, and improving systems and processes. As Appendix three illustrates, the DHB is already performing well against many of the ownership measures such as day surgery, acute inpatient average length of stay and output delivery.

The DHB will seek to maintain its strong performance, and where possible improve its performance, recognising it must operate within available funds.

5 SERVICE COVERAGE AND SERVICE CHANGE

5.1 Service coverage

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 2010/11.

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

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

Not all services are available locally within Wairarapa and travel to publicly funded services in other districts is required for a range of services. For services that cannot be provided within Wairarapa, the DHB has funding arrangements in place with other DHBs.

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.

5.2 Service change

The PIAs in Section 2 signal the need to review the services the DHB funds and provides to determine their clinical and financial sustainability and whether they can be provided in more cost effective ways.

The DHB Funder will be required to achieve $700k of efficiencies in 2010/11 as indicated on page 22 of the DAP. This will require the Funder to review its full range of contracted providers and other purchased services to identify where sensible cost savings and efficiencies can be achieved. If as a result of these decisions there is a proposed service change, the DHB will work closely with the Ministry of Health to ensure that it meets all of its obligations under the Operational Policy Framework and Service Coverage Schedule.

The outcome of these reviews may include service reductions and or service reconfigurations. Wairarapa DHB will work closely with the Ministry of Health as it works through this planning process and will consult with the Ministry and other key stakeholders on any proposed service changes or reconfigurations resulting from this work.

5.3 Impact of Regional Clinical Service Plan

Efforts to control costs and improve the patient experience and health of the population cannot rely solely on efforts by local clinicians working in partnership with management and our community. We are also working closely with other DHBs in

the Central region to determine the most efficient and effective way to fund and deliver services on behalf of our population.

Wairarapa DHB has worked closely with the Central region DHBs[5] on the Regional Clinical Services Plan (RCSP) and its associated implementation plan. The RCSP sets out a vision and framework for the region's health services to the year 2020. This vision involves a regionally co-ordinated system of health service planning and delivery which enhances the sustainability, quality and accessibility of clinical services.

The RCSP proposes a new service model which envisages more health care being provided at home and in the community, including care for long term conditions and rehabilitation following discharge from hospital. It envisages community health centres being developed to meet a wide range of health needs without resorting to hospital care. Underpinning this vision are two aims:

- improved clinical outcomes
- patients and their families / whānau have an enhanced experience of the Central region health service.

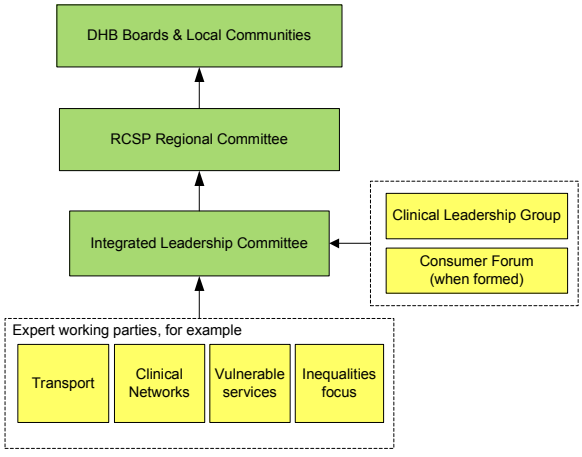
These aims are balanced with the need for an affordable health service that is able to demonstrate value for money and to live within available resources.

Regional Governance and Decision Making

Being able to implement the RCSP requires a framework that supports regional decision making whilst still recognising the autonomy of the local DHB Boards. The following decision making committee framework has been put in place.

A regional governance group (called RCSP Regional Committee) comprising board chairs and CEO's has been established to lead regional decision making for the region. An independent chair has been appointed in the first quarter of 2010 to facilitate a consensus approach to decision making by DHB Boards. Decisions will be based on expert recommendations from the RCSP Leadership Committee (RLC), a group representative of different disciplines from across the region and DHBs. The RLC is a clinical and managerial partnership that will provide direction to the programme and ensure regional proposals are of the highest quality and have undergone rigorous review.

Figure 1: Regional Decision-making Framework



Supporting the RLC is a regional Clinical Leadership Group (CLG). CEOs directed in February 2009 that a clinical group be formed to ensure a broad base of clinical participation and leadership, with Chief Medical Officers (CMO) and Directors of Nursing (DON) as the nucleus group. The CLG convened in June

[5] Central Region DHBs include Capital and Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa, and Whanganui DHBs.

2009, has a membership of primary and secondary clinicians from across the region and has worked in partnership with the interim RCSP Steering Group (and future RLC when formed in March 2010) to shape the direction of the work programme.

Clinical Networks and Patient Pathways

Part of the implementation of the RCSP involves establishing regional clinical networks for cancer, cardiac, mental health, plastic surgery, and renal. These clinical networks emphasise common predefined disease pathways to support consistent management of patients across the region. There will be an increasing need for DHBs to share the clinical workforce to ensure clinical viability across all hospitals and specialist services.

The regional clinical networks will enable hospitals in the Central region to achieve greater co-ordination and standardisation of care.

Regional Elective Surgery Plan and Strengthening Hospital Services

Central region DHBs are also committed to a range of projects that will increase productivity such as implementing a Regional Elective Surgery Plan, progressing clinical pathway development for key procedures across the region and undertaking the Strengthening Hospital Projects in Radiology, Women's Services and Older Adults.

In describing the need for change, the RCSP identified a number of services that require strengthening, initially assessed on the basis of medical workforce shortages and then across a broader criteria. The result was a summary action plan, "Strengthening Hospital Services: Regional Action Plan" and which, when added to existing regional projects has agreed the following priority areas by way of a regional work programme for 2010/11:

- Clinical services – Cancer, Cardiac, Mental Health, Older Adults (AT&R and Specialist Rehabilitation for under 65 years), Plastics, Radiology, Renal, and Women's Services (Maternity, Gynaecology, Gynae Oncology Surgery and Maternal Foetal Medicine)
- Information Communication and Technology (ICT)
- Long Term Conditions (chronic conditions management)
- Regional Electives Surgery Collaboration
- Regional Credentialing of Medical Clinicians.

As part of the regional electives planning, Wairarapa will work with other DHBs in the region to adopt standardised prioritisation tools and processes as well as common thresholds, which will inform access to elective services. Our electives work will also consider who in the region is best placed to provide certain elective procedures.

Shared Services

Our work with other DHBs will also involve exploring opportunities for joint procurement and sharing support and administrative services.

5.4 Specific Sub Regional Arrangements

There are many signals from the Minister and the National Health Board Business Unit (NHBBU) that DHBs must move towards working together collaboratively in 2010/11. The Minister and the NHBBU have indicated that a number of enablers will be introduced to ensure that this occurs. For example the Minister has introduced legislative changes to ensure that that greater priority is given to regional collaboration amongst DHBs. The 2010/11 Operational Policy Framework now requires DHBs to develop a RCSP. Furthermore the newly established Shared

Services Establishment Board (SSEB) will be considering a wide range of potential initiatives including procurement, internal audit and facility management services that will go across all DHBs to achieve efficiencies and reduce duplication across the 21 DHBs.

Securing Specialist Hospital Capacity

Acknowledging these developments the Wairarapa DHB will work particularly closely with neighbouring DHBs (Hutt Valley and Capital & Coast) as we explore the optimal arrangements for securing specialised hospital capacity. Good progress has already been made. For example Hutt Valley DHB has for many years assisted the Wairarapa DHB in providing specific services for their population, for example, ear, nose and throat (ENT) and plastic surgery services.

The three DHBs have recently signed a statement of commitment which commits the organisations to developing a clinically led programme of work over the next 1-2 years. The statement of commitment is attached in Appendix four. At a joint planning day with Hutt Valley DHB, it was agreed that the first areas of focus are:-

- General Surgery / Anaesthetics - looking at opportunities for joint clinical work with the Hutt Valley DHB and a shared workforce
- Paediatrics-exploring opportunities for joint clinical work and a shared workforce
- Mental Health-participating in work already underway with Capital & Coast and Hutt Valley DHBs with a particular emphasis on regional acute Psychiatry cover
- Radiology-as part of the strengthening hospital's project, working with Hutt Valley DHB and other Central Region DHBs on initiatives to generally improve clinical sustainability
- Emergency Department-exploring how a sub regional arrangement might work with Capital & Coast and Hutt Valley DHBs
- Public Health Services-participating in work being under taken by the Ministry of Health and Regional Public Health on the future funding of Public Health Services.
- ENT and Health of Older People.

Corporate Service / Back Office Functions

As well as a focus on sustainable hospital services, Wairarapa DHB will be working with Hutt and Capital and Coast DHBs on opportunities for corporate convergence initiatives in a number of areas including:-

- Payroll
- Human Resources
- Planning and Funding and
- Financial transaction services.

It is anticipated that this work will lead to a greater level of corporate convergence between these DHBs and that there will be significant developments around shared support services both regionally and nationally in the next 12-24 months.

This convergence work also includes the opportunity to have a joint DAP/DSP (District Strategic Plan) process across Wairarapa, Hutt Valley and Capital and Coast DHBs in 2011/12.

6 FINANCIAL PLANNING – LIVING WITHIN OUR MEANS

This section outlines the DHB's projected financial position for financial year 2010/11 and the two out-years beyond this: 2011/12 and 2012/13. It also summarises the key financial challenges and the action plans for dealing with these challenges and provides projected financial statements for the Wairarapa DHB.

6.1 Financial Outlook

Wairarapa DHB continues its commitment to manage expenditure within the provided funding. However, we are projecting deficits for 2010/11, 2011/12 and break even in 2012/13. These deficits recognise the continuing increases in the costs of providing services provided by other DHBs for the Wairarapa population (i.e. the inter-district flows) as well as additional cost pressures across the Wairarapa DHB at greater rates than provided for in the Funding Envelope.

The financial results for the parent DHB are summarised as follows:

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Operating Revenue	**117,973**	**121,599**	**123,258**	**126,062**	**128,860**
Operating Expenditure					
Workforce costs	36,466	36,672	36,999	37,519	38,005
Treatment related costs	19,543	18,044	17,679	17,928	18,163
External providers	40,843	43,386	42,352	42,948	43,502
Inter district flows	20,674	23,132	24,056	24,395	24,711
Total Operating Expenditure	**117,526**	**121,234**	**121,086**	**122,790**	**124,381**
Result before Interest, Depreciation & Capital Charge	**447**	**365**	**2,172**	**3,272**	**4,479**
Interest, Depreciation & Capital Charge					
Interest expense	1,958	1,880	1,800	1,825	1,849
Depreciation & amortisation	1,912	2,123	2,081	2,110	2,137
Capital charge	685	562	480	487	493
Total Interest, Depreciation & Capital Charge	**4,555**	**4,565**	**4,361**	**4,422**	**4,479**
Net Operating Results	**(4,108)**	**(4,200)**	**(2,189)**	**(1,150)**	**0**

Key financial challenges

The Wairarapa DHB is facing significant financial challenges and the financial projections assumes that these challenges will be managed by the DHB with a reduced deficit in 2010/11 to that forecast for 2009/10. The key financial challenges affecting the DHB include:

- The downturn in the New Zealand and world-wide economy will continue to have a significant effect on the DHB. The immediate impact has been on the Crown's ability to continue the level of funding increases received in the last few years. there is also reliable evidence that an economic downtown creates an increase in demand across all areas of a public health service.
- The DHB competes in the national and international market for clinical staff and workforce shortage is currently being experienced in some specialised clinical areas. Wairarapa DHB is a small player on both the national and international markets and our ability to recruit and retain qualified clinical staff is hampered by our size. Hence the sustainability of a viable clinical workforce is a critical factor in the regional and sub-regional discussions as highlighted elsewhere in this Plan.

- The population of the Wairarapa is ageing at an increasing rate. Studies have shown that a significant percentage of the health dollar spent on an individual is incurred in the last two years of that individual's life. As the population ages there is an increasing demand placed on not just the hospital to provide services but also there is increasing demand on the aged residential care and supported at home areas of the sector.
- The continued rising costs of healthcare have contributed to increases in the pricing regime for services paid for by Wairarapa DHB, but provided by our neighbouring DHBs (i.e. IDFs). This higher price, in conjunction with additional capacity in these neighbouring DHBs, has resulted in an increased percentage of the new funding provided to Wairarapa DHB being applied to the total IDF spend.

Action plan for dealing with financial challenges

The DHB will progress the following four PIAs in an effort to reduce and control costs in 2010/11:

1. **Address Inequalities** ensuring all of our spending decisions consider those with the poorest health status, where possible focus spending on those with the greatest need. Amongst those identified are Maori, the frail elderly and those with long term conditions.
2. **Achieve Financial Security** by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings.
3. **Improve productivity and quality** with a focus on hospital wards, theatre utilisation, increasing day surgery, and emergency departments.
4. **Enhance regional cooperation** through clinical regional service plans and through greater regionalisation of shared services and back-office functions.

We expect these PIAs to impact positively on our financial and service performance in 2010/11 and enable the DHB to deliver on both Government and local priorities. Further detail on each of these initiatives is provided in section 2 of this Plan.

Out-years scenario

The DHB expects funding increases for out-years to be around 2.4% (planning advice from the Ministry of Health suggested funding increases should be at the same nominal value as the DHB received for 2010/11). The DHB has also assumed that it will contain expenditure increases to be, on average, below the rate of funding increase received.

We will continue implementing the strategies and actions developed to meet our financial challenges and achieve financial sustainability. We assume that our strategy and action plans will enable the DHB to further reduce its deficit in 2011/12 and reach break-even in 2012/13.

Financial assumptions and risks

Included in the financial forecast are the following key assumptions:

- The DHB's funding allocations will increase as per funding advice from the Ministry of Health and early payment is retained;
- The rate for capital charge will remain at 8%;
- No revaluation of land and buildings required in 2010/11 or the two out-years;
- No industrial action will occur over the coming year;
- Employee cost increases are based on terms agreed in current wage agreements. Expired wage agreements are assumed to be settled on

affordable and sustainable terms. Efficiencies will be generated under the partnership programmes and tripartite agreements;

- Staff vacancies (existing and as they occur in future) will be reassessed to ensure the positions are still required, affordable and alternatives explored before vacancies are filled. Improved employee management can be achieved with emphasis in areas such as sick leave, discretionary leave, staff training and staff recruitment/turnover;
- The cost of any new initiatives or programmes and the financial impact associated with any new legislative, regulatory or compliance policies, required by Government, will be fully funded through specific additional funding allocations to the DHB. Any financial impact associated with changes to DSS boundaries between age related and non-age related services and any contracts or services devolved will be cost neutral;
- External providers will operate within the available funding received after allowance made for committed and uncontrollable funding commitments;
- Price increases agreed collaboratively by DHBs for national contracts and any regional collaborative initiatives will be affordable and sustainable;
- Any increase in treatment related expenditure and supplies is maintained at affordable and sustainable levels and the introduction of new drugs or technology will be funded by efficiencies within the service;
- We are able to align our service and access criteria with that of other DHBs;
- The DHB can establish joint primary/secondary pathways to reduce hospital and specialist service demand and overall service costs;
- All other expense increases including volume growth will be managed within uncommitted funds available or deferred;
- The DHB will be an active participant in the development of an Integrated Family Health Network; and
- At the time of writing, it is assumed that the hospital site sale will be completed during FY2010/11.

The overriding risk to achieving the financial performance relates to the key assumptions above not holding true and the risks around wage increase expectations for the health sector, both internal staff and external providers, following the national employment collective settlements. Other risks include the inability to implement identified service reconfiguration or service reduction, according to planned timeframes and the inability to achieve efficiencies and address cost overruns internally.

6.2 Asset Planning and Sustainable Investment

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) is to be developed in the first half of the 2010/11 financial year. 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.

Capital expenditure

The DHB has significant capital expenditure committed in the 2010/11 financial year that flows on from increased capital expenditure budgets in previous years.

Based on the DHB's fiscal position, we estimate that we will be able to fund a total of $1.0 million of capital expenditure in 2010/11 which is a significant reduction in the planned amount of capital expenditure from the 2009/10 financial year. This decrease is necessary to ensure an improved liquidity position is achieved and to support the projected deficit. As capital expenditure funding will be tight, we plan to be disciplined and focus on the DHB's key priorities in determining our capital expenditure spending. Where possible, we will seek to collaborate with other DHBs to avoid duplication. This collaboration could arise through national or regional decisions made by the Shared Services Establishment Board.

Business cases

Wairarapa DHB has submitted a business case for the development of the Community Health facility. This facility will accommodate the oral health, community nursing, public health and Focus services as well as provide flexible clinic space. At the time of writing this business care was on hold pending discussions around the development of an Integrated Family Health Network, as per the Tihei Wairarapa Business Case. The capital cost and associated financing has not been incorporated within the financial statements presented herein.

As noted elsewhere within this Plan, Wairarapa DHB is in discussions with Capital & Coast DHB and Hutt Valley DHB regarding a range of clinical and non-clinical cooperation opportunities. It is likely that one or more business cases will be required to progress any initiatives, particularly information system initiatives. At the time of writing it is not known what the value of any investment is nor whether any additional capital funding will be required. In the financial statements presented, it has been assumed that any funding will be meet from baseline capital budgets.

Other than as identified above no other business cases are expected to be submitted.

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. At the current point in time no allowance has been made for any change in the 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.

Disposal of land and other assets

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.

It is noted that the Wairarapa DHB is progressing the sale of the old Masterton Hospital campus and this is expected to be complete and funds realised during the 2010/11 year.

6.3 Debt & Equity

Core debt

The DHB has a long-term debt facility of $25.75 million with the Crown Health Financing Agency (CHFA). The DHB's total term debt held with the Crown Health Financing Agency (CHFA) is expected to be $25.25 million as at June 2010 and reduces by $0.25 million in each of the three financial years covered by this Plan. There are no covenant ratios applicable to this debt facility.

Other debt facilities

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.

The DHB has received approval from the Ministers of Health and Finance for the extension of the Selina Sutherland private hospital wing. The cost of this extension is $0.7 million and is financed through a ten-year loan facility with Selina Sutherland Hospital Ltd. The repayment terms provide for the repayment of principal and interest over the term of the facility.

The DHB maintains a working capital facility of $6.0 million with the ANZ Bank. The ANZ Bank also provides the transactional banking facilities for the DHB. All banking covenants with the ANZ Bank are complied with.

6.4 Miscellaneous Financial Provisions

Activities for which compensation is sought

No compensation is sought for activities sought by the Crown in accordance with Section 41(D) of the Public Finance Act.

Acquisition of Shares

Before the Wairarapa DHB or any associate or subsidiary subscribes for, purchases, or otherwise acquires shares in any company or other organisation, the Board will consult the responsible Minister/s and obtain their approval.

6.5 Prospective Financial Statements

Accounting Policies

The accounting policies adopted are consistent with those in the prior year for a full statement of accounting policies refer to Appendix five.

Financial statements

The projected financial statements are shown in Appendix six. The projected financial statements include a cost of service financial statement for each of the four output classes of 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.

7 INFORMATION AND COMMUNICATIONS TECHNOLOGY

Although one of the smallest DHBs in terms of budget and staff numbers, the Wairarapa DHB has a relatively complex information environment to support the needs of the organisation. Development of information technology is within the context of the Wairarapa DHB's Information Systems Strategic Plan (ISSP) which may be found on the Wairarapa DHB's website: www.wairarapa.dhb.org.nz. The DHB has a Strategic Information Group (SIG) which prioritises major IS projects and provides Governance.

The Wairarapa DHB operates and maintains local and area wide networks across seven sites in the district, which service about 400 devices (Personal Computers, Thin Client terminals and printers). The network infrastructure also includes routers and firewalls that interconnect, route and secure authorised network traffic between the Wairarapa DHB's networks and others. During the past year there has been considerable progress as evidenced in implementation of new IS-IT services including:

- Implementation of a SAN in the production data centre as the first stage of consolidating or hardware and storage capacity.
- Additions of a range of new enhancements to the Concerto EMR including the addition of Operation notes and clinic letters, new patient views for clinicians and various interface improvements.
- Participation in the Health Management System Collaborative and programme enact.
- Implementation of the Fingertips reporting and forecasting system.
- Implementation of an eReferrals solution between primary and secondary care.
- Analysis and planning for an Oral Health information solution.
- Starting a programme to implement ITIL process and tools.

Major projects that are planned for 2010/11 include:

- The DHB will implement the Titanium Oral Health system into its school dental service. Planning for this started last year. This system is already running separately at several DHBs in the region and it is likely we will leverage one of those systems rather than install our own. This will save on implementation cost and speed implementation.
- The Concerto electronic medical record used in the hospital will be made accessible to primary care and community based providers. It will be integrated with MedTech so that primary care information from all patients in the district can be viewed within Concerto. This will effectively create the first iteration of a "shared care record" in the Wairarapa. The quality and capacity of the networks between primary care and the DHB ICT networks may need to be upgraded to efficiently support this.
- The eReferrals solution which was introduced into the district in 2009/10 will be upgraded providing new referral forms based on the developing national standards coming out of the Auckland Region project as well as supporting new referral management pathways within the Hospital and community.
- The management and care of patients through hospital acute services will be improved through enhancements to the systems which will see an improved flow of information electronically from the community and primary care, into the emergency department and back again.
- An initiative to provide clinicians and pharmacists with a patients medication list will be undertaken. This initiative will aim to provide a patient centric view within Concerto of medications that have been prescribed or dispensed for that patient.

This will integrate information from the hospital and GP systems as well as local pharmacies. This initiative will be an invaluable tool for aiding more efficient and safer medications management. This project will be supported through Tihei Wairarapa.

- Continuing IS infrastructure improvements.

At this stage, there are no plans to progress initiatives around the financial system replacement, or the human resource system until such time as the plans neighbouring DHBs are finalised and national initiatives are confirmed.

The Central region has identified the following information projects as a shared priority for 2010/11:

- Shared PACS image repository - that will enable immediate access to all diagnostic images in the region by any clinician and support radiologists from any DHB (or private provider) to report any other DHBs studies.

- Video conferencing interconnection – will make video conferencing technology more accessible to improve both corporate and clinical communications between DHBs, reducing travel and meeting costs.

- Single sign-on.

A copy of the Wairarapa DHBs ISSP is provided in Appendix seven.

8 APPENDICIES

Appendix 1: Approved Implementation Plan for Tihei Wairarapa

Activity	Intervention	Key Result Area	Milestone	Timeline
Integrated Family Health Network	Develop the Wairarapa IFHN Team and Model of Care	Optimal patient journey and enhanced patient experience with greater choice	Set up Very Low Cost Access provider	Completed
			Wairarapa IFHN Leadership group established with agreed Terms of Reference	Year 1 Q1
			Implementation of transitional practice plans and targets and new PHO contract	Year 1 Q1
			Develop four care pathways	Year 1 Q3
			Full roll out of practice plans and targets with associated contracts	Year 1 Q4
	Feasibility Study	Work up Business Case	Completion of feasibility study	Complete
			Work up implementation plans from feasibility study	Year 1 Q1
			Implement plan	Year 1 Q2
	Implement Systems integration	The patient journey will be optimized and enhanced	Shared patient records across IFHN providers – Purchase Manage my Health license for all General Practices	Year 1 Q2
	Better serve vulnerable populations	Improved access for vulnerable populations	MOU with Social Service provider organizations in plac	Year 1 Q4
Acute Demand	Improved practice triage	Patients access care sooner and more conveniently – Efficient care	Stocktake of existing processes (plan/do study/ act)	Year 1 Q1
			formulate a plan for dealing with acute patients in the practice	Year 1 Q2
			implement the plan	Year 1 Q3
			evaluate how well the plan is working and repeat the cycle	Year 1 Q4
			Assess how to improve integration with Ambulance services	Year 1 Q3

Activity	Intervention	Key Result Area	Milestone	Timeline
	Primary Care and ED staff work collaboratively		Campaign for community awareness of after hours service launched	Year 1 Q2
			Plan formulated for moving avoidable attendances to Primary health care	Year2 Q1
	Improved Acute and Urgent care arrangements		Include single district wide overnight call arrangements	Year 1 Q2
			GP 24/7 cover of all Wairarapa Aged Residential care facilities arranged	Year 1 Q2
			Implement approved arrangements for health line	Year 1 Q2
			Implement agreed Ambulance service changes	Year 2Q1
	Improved diagnostics		Options for radiology service investigated	Year 1 Q3
	Primary Options for Acute Care		Implement IV Therapy in practices	Year 1 Q1
			Refine arrangements with FOCUS for rapid disposition of inappropriately hospitalised patients	Year 1 Q3
	Advanced Directives		Complete investigation and formulate plan for Advanced directives	Year 1 Q4
Long Term Conditions	Guided Care	Integrated care approach supporting people to manage themselves	Guided Care Model developed	Year 1 Q3
			Guided Care Model implemented	Year 1 Q4
	Multi Disciplinary Teams	Coordinated Care for patients with complex support needs	MDT meetings programme schedule in place	Year 1 Q2
			rapid multi disciplinary response implemented	Year 1 Q4
	Clinical pathways for common conditions	Seamless patient journey	Four clinical pathways developed	Year 1 Q3

Activity	Intervention	Key Result Area	Milestone	Timeline
	Specialist and community based support for GP teams	Specialists focus on up skilling an supporting primary care providers	Role descriptions reviewed to reflect support requirements for primary care	Year 2 Q1
Older Persons	GP Health Based Assessment, health promotion and supported health care	Early identification of clinical and support health need for the elderly	Clinical pathway for care of the older person established and approved clinical forum	Year 1 Q4
			Screening tool for frailty introduced in all practices (align with InterRAI implementation)	Year 2 Q1
	Alignment of Care management to General Practice	Coordinated care and support services for the elderly including those in residential care facilities	MDT meetings programme schedule in place	Year 1 Q2
	Alignment of MDT to General Practice		GP cover for ARC facilities in place	Year 1 Q2
	Improved alignment and support for aged residential care facilities		Strengthening self-management of ARC providers in place in two facilities	Year 1 Q4
Pharmacy	Structured Pharmacist Care	Available through all pharmacy practices	Draft service spec agreed with community pharmacists	Year 1 Q1
			Contract representative meeting with PHO/GPs to review service spec	Year 1 Q1
			PHO and DHB to meet with Pharmacist representatives to confirm project funding and finalise service spec	Year 1 Q1
			contract finalized and commenced	Year 1 Q1
			Pharmacy facilitator engaged	Year 1 Q1
			Manual developed	Year 1 Q1
			phased service implementation	Year 1 Q1
	Optimed	Service supported by all pharmacy practices	Contract arrangements finalised	Year 1 Q2

Activity	Intervention	Key Result Area	Milestone	Timeline
	Medicines Reconciliation	Coordinated medicine information across primary and secondary care	Project parameters completed	Year 1 Q2
	Pharmacy input into MDT	Facilitates clinical information sharing and use of care plans	MDT meetings programme schedule in place	Year 1 Q2
Mental Health	Establishment of Demonstration project	Coordinated care and seamless patient journey for people suffering from mental illness	The components of the business case that will be treated as a demonstration site agreed	Year 1 Q2
	Amalgamate and strengthen existing groups including Inter-sectoral Mental Health Leadership Group		Terms of Reference agreed and signed off by Steering Group	Year 1 Q2
	Establishment of a single service		Integrated mental health service in place – CAMHS, WDHB, 2B Heard	Year 1 Q4
	Workforce development programme		Sector wide implementation plan for Let's Get Real operational and aligned with the Business Case	Year 1 Q2
	Integrated Family Health Networks and Community Mental Health teams aligned		Mental health clinical pathway, and associated relationships and protocols established 3 month evaluation of trial pathways to inform implementation completed Full implementation of integrated mental health and addiction pathways	Year 1 Q1
	Development of tools to facilitate service delivery		integrated information system in place to support clinical pathways Effectiveness of information system performance incorporated into the three month evaluation process	Year 1 Q2 Year 1 Q3

Activity	Intervention	Key Result Area	Milestone	Timeline
	Enduring Needs patients		Enduring needs pilot group identified and needs assessments completed Development of a programme that meets assessed needs and adopts a shared care approach with GP holding clinical responsibility supported by psychiatrist. GP support arrangements for pilot group agreed with practices and reflected in practice plans.	Year 1 Q2 Year 1 Q3 Year 1 Q4
Information Management		Access to a shared patient record within the Wairarapa	All patients enrolled in WCPHO have access to their own health record	Year 1 Q2
			All clinicians have the ability to access up to date health records	Year 1 Q4
		Implement E Referral (electronic transfer of care) process across the Wairarapa	Phase One implementation of e referral complete	Year 1 Q1
			Phase Two implementation of e referral complete	Year 1 Q2
		Create Web Hub as an online community for health providers and patients	Phase One implementation of e referral complete	Year 1 Q1
			Phase Two implementation of e referral complete	Year 1 Q2
		Enhanced digital workforce through use of video presence technologies throughout primary care	Phase One implementation of video conferencing complete	Year 1 Q1
			Phase Two implementation of video conferencing complete	Year 1 Q4
		Regional Analysis Collaborative to foster working relationships between health information analysts in primary and secondary care settings	Identify appropriate collective partners and pieces of work to work jointly	Year 1 Q4
Whanau Ora	Family Violence	For all practices to	Stocktake with GP Practices as to what gaps they perceive need to be filled	Year 1 Q1

Activity	Intervention	Key Result Area	Milestone	Timeline
	Screening	implement screening for family violence	with training or refresher courses additional to the training already undertaken	
			Define training plan based on identified gaps and known additional training requirements	Year 1 Q1
			Agree arrangements for VIP coordinator support with DHB	Year 1 Q1
			Deliver training to Practices	Year 1 Q2
			Implement screening across all GPs in the Wairarapa	Year 1 Q2
			Define IM requirements attendant to screening, referrals and reporting	Year 1 Q2
			Implement IM requirements re recording, referral and reporting and train/set up appropriate staff	Year 1 Q3
			Monitoring and evaluation of screening	Year 1 Q4
Clinical and Business Support Service		Provide the management and admin systems and services required to achieve the vision: To provide the best patient experience whilst building a clinically and financially sustainable system	Organisational restructure completed and BCSS established.	Year 1 Q1
			Change team identified and available to support	Year 1 Q1
			BCSS Structure supports clinically lead organisation IFHC development	Year 1 Q3

Appendix 2: Indicators of DHB Performance

This table details those IDPs where a quantitative target needs to be met in 2010/11.

<table>
<tr><th colspan="4">Policy Priorities</th></tr>
<tr><th>Code</th><th>Indicator</th><th>Frequency</th><th>Targets for 2010/11</th></tr>
<tr><td>PP-03</td><td>Local Iwi/Maori engagement and participation in DHB decision making, development of strategies and plans for Maori health gain</td><td>Six monthly Q2, Q4</td><td>Measure 1: 100% of PHOs have Maori Health Plans that have been agreed to by the DHB

Measure 2: 100% of DHB members have undertaken Treaty of Waitangi training

Measure 7:
(i) Te Arawhata Totika – The Wairarapa DHB Cultural Competency Framework is implemented in Mental Health Services and Physiotherapy Department
(ii) Te Reo & Tikanga Core Training Programme commenced for all DHB staff</td></tr>
<tr><td>PP-04</td><td>Improving mainstream effectiveness</td><td>Six monthly Q2, Q4</td><td>Measure 1: Report describing reviews of pathways of care
Measure 2: Report of examples of actions taken to address issues</td></tr>
<tr><td>PP-05</td><td>Waiting times for chemotherapy treatment</td><td>Quartertly (Q1,2,3,4)</td><td>People needing chemotherapy will not wait longer than 6 weeks for it to be supplied.
A resolution plan will be provided if this target is not met.</td></tr>
<tr><td>PP-06</td><td>Improving the health status of people with severe mental illness through improved access</td><td>Six monthly (Q2, Q4)</td><td>DHB to report confirming access targets are met. The average number of people domiciled in the WDHB region, seen per year rolling every 3 months being reported (the period is lagged by 3 months):

Targets:
<table>
<tr><td></td><td>Maori</td><td>Other</td><td>Total</td></tr>
<tr><td>Child & Youth (0-19)</td><td>2.8</td><td>2.8</td><td>2.8</td></tr>
<tr><td>Adults (20-64)</td><td>4.2</td><td>3</td><td>3</td></tr>
<tr><td>Older People (65+)</td><td>0.59</td><td>0.59</td><td>0.59</td></tr>
</table>
A resolution plan will be provided if agreed targets have not been met.</td></tr>
<tr><td>PP-07</td><td>Improving mental health services using crisis prevention planning</td><td>Six monthly</td><td>DHB to supply reports on crisis prevention planning. To include:
1. The number of adults and older people (20 years plus) with enduring mental illness who have been in treatment for 2 years or more since the 1st contact with any mental health service
2. The number of child and youth who have been in secondary care treatment for one or more years
3. The number and percentage of long term clients with up to date crisis prevention / resiliency plans, and describe how this is assured
A resolution plan will be provided if agreed targets/ expectations have not been met.

Targets:
<table>
<tr><td colspan="3">% of people with up to date crisis prevention/ resiliency plans within Recovery Plan</td></tr>
<tr><td></td><td>Maori</td><td>Other</td></tr>
<tr><td>20+ years (excluding those with addictions only)</td><td>95%</td><td>95%</td></tr>
<tr><td>AOD</td><td>100%</td><td>100%</td></tr>
<tr><td>Child & Youth</td><td>95%</td><td>95%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th colspan="4">Policy Priorities</th></tr>
<tr><th>Code</th><th>Indicator</th><th>Frequency</th><th>Targets for 2010/11</th></tr>
<tr><td>PP-10</td><td>Oral Health – Mean DMFT score at Year 8</td><td>Annually (Q3)</td><td>To reduce the average decayed/missing/filled teeth score for children at Year 8. Report to advise the total number of permanent teeth of Year 8 children, decayed, missing (due to caries), or filled, and the total number of caries free children at the commencement of dental care, at the last dental examination, before the child leaves the WDHB Community Oral Health Service.

Targets
DMF Score at Year 8 – fluoridated
<table>
<tr><th>Overall</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>1.43</td><td>1.70</td><td>1.50</td><td>1.35</td></tr>
</table>
DMF score at Year 8 – non fluoridated
<table>
<tr><th>Overall</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>1.43</td><td>1.70</td><td>1.50</td><td>1.35</td></tr>
</table>
A resolution plan will be provided if agreed targets/ expectations have not been met.</td></tr>
<tr><td>PP-11</td><td>Children caries free at 5 years of age</td><td>Annually (Q3)</td><td>To increase the percentage of children caries free at age 5 years. Report to advise the total number of caries free children and the number of primary teeth decayed, missing (due to caries), or filled at the first examination after the child has turned 5 years, but before their 6th birthday

Targets
% 5 yr olds caries free - fluoridated
<table>
<tr><th>Overall</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>63%</td><td>45%</td><td>45%</td><td>70%</td></tr>
</table>
% 5 yr olds caries free – non-fluoridated*
<table>
<tr><th>Overall</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>67%</td><td>45%</td><td>45%</td><td>70%</td></tr>
</table>
A resolution plan will be provided if agreed targets/ expectations have not been met.
*Higher target in non fluoridated population reflects higher decile.</td></tr>
<tr><td>PP-12</td><td>Utilisation of WDHB funded dental services by adolescent from Year 9 up to and including age 17 years</td><td>Annually (Q4)</td><td>Identify overall coverage and target the groups at greatest disadvantage in the district where children’s oral health is poorest. Report the total number of completions and non-completions under the Combined Dental Agreement for adolescent patients plus additional adolescent examinations with other DHB funded dental services.

Targets
Half of the cohort aged 13 years
<table>
<tr><th>Overall</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>79</td><td>79</td><td>79</td><td>79</td></tr>
</table>
All of the cohorts aged 14-17 years inclusive
<table>
<tr><th>Overall</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>79</td><td>79</td><td>79</td><td>79</td></tr>
</table>
A resolution plan will be provided if agreed targets/ expectations have not been met.</td></tr>
</table>

Policy Priorities

<table>
<tr><th>Code</th><th>Indicator</th><th>Frequency</th><th>Targets for 2010/11</th></tr>
<tr><td>PP-13</td><td>Improving the Number of children enrolled in WDHB funded dental services</td><td>Annually (Q3)</td><td>Report oral health enrolment data. Report to advise the total number of preschool and primary school children enrolled with DHB funded dental services (COHS and other contracted providers) under age five years

Targets
Enrolled children under age 5 years
<table>
<tr><th>Current Population</th><th>57% enrolment Overall</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>2740</td><td>1,554</td><td>494</td><td>54</td><td>1006</td></tr>
</table>
No. of preschool and primary school aged children enrolled in DHB funded dental services who did not receive an examination according to the planned recall period
<table>
<tr><th>Enrolled Population</th><th>10% in arrears Overall</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>6545</td><td>650</td><td>207</td><td>23</td><td>421</td></tr>
</table>
A resolution plan will be provided if agreed targets/ expectations have not been met.</td></tr>
<tr><td>PP-14</td><td>Family violence prevention</td><td>Annually (Q4)</td><td>Combined audit score of 140/200</td></tr>
</table>

Systems Integration

<table>
<tr><th>Code</th><th>Indicator</th><th>Frequency</th><th>Targets and Deliverables</th></tr>
<tr><td>SI-01</td><td>Ambulatory sensitive (avoidable) hospital admissions.</td><td>Six monthly (Q2, Q4)</td><td>To achieve a reduction in the variation between DHBs and between different population groups in the rate of admissions to hospital that are avoidable or preventable by primary health care for 0-4 years old, those aged 5-65 and those aged 0-74.

Targets
<table>
<tr><th>Ambulatory Sensitive Hospital Discharges</th><th>Maori</th><th>Other</th></tr>
<tr><td>0-74 years</td><td>125</td><td>134</td></tr>
<tr><td>0-4 years</td><td>120</td><td>120</td></tr>
<tr><td>45-64 years</td><td>113</td><td>120</td></tr>
</table>
A resolution plan will be provided if agreed targets/ expectations have not been met.</td></tr>
<tr><td>SI-04</td><td>Elective services standardised intervention rates</td><td>Six monthly (Q1. Q3)</td><td>Targets
<table>
<tr><td>Intervention rate</td><td>292 per 10,000</td></tr>
<tr><td>Major joint procedures intervention rate for Hip and Knee</td><td>21 per 10,000</td></tr>
<tr><td>Cataract procedures intervention rate</td><td>27 per 10,000</td></tr>
<tr><td>Cardiac procedures intervention rate</td><td>6.23 per 10,000</td></tr>
</table></td></tr>
</table>

<table>
<tr><th colspan="4">Systems Integration</th></tr>
<tr><th>Code</th><th>Indicator</th><th>Frequency</th><th>Targets and Deliverables</th></tr>
<tr><td>SI-07</td><td>Improving Breast-feeding rates</td><td>Annually
(Q4)</td><td>Maintain appropriate planning and implementation activity to improve the rates of breastfeeding and report progress against these.

Deliverable:
Increase the proportion of infants exclusively and fully breastfed at six weeks to 74% or greater; at 3 months to 57% or greater; and at 6 months to 27% or greater.

Target:
<table>
<tr><th></th><th>6 weeks</th><th>3 months</th><th>6 months</th></tr>
<tr><td>Maori</td><td>74%</td><td>57%</td><td>27%</td></tr>
<tr><td>Pacfic</td><td>74%</td><td>57%</td><td>27%</td></tr>
<tr><td>Other</td><td>74%</td><td>57%</td><td>27%</td></tr>
<tr><td>All (Total)</td><td>74%</td><td>57%</td><td>27%</td></tr>
</table>
A resolution plan will be provided if agreed targets/ expectations have not been met.</td></tr>
</table>

<table>
<tr><th colspan="4">Ownership</th></tr>
<tr><th>Code</th><th>Indicator</th><th>Frequency</th><th>Targets and Deliverables</th></tr>
<tr><td>OS-03</td><td>Elective and Arranged Inpatient Length of Stay</td><td>Quarterly</td><td>DHB is expected to reduce average length of stay (ALOS) for elective and arranged inpatients.

Target: 3.92</td></tr>
<tr><td>OS-04</td><td>Acute Inpatient Length of Stay</td><td>Quarterly</td><td>DHB is expected to reduce average length of stay (ALOS) for acute inpatients.

Target: 3.55</td></tr>
<tr><td>OS-05</td><td>Theatre Utilisation</td><td>Quarterly</td><td>Theatre Utilisation of 85%

Target: 85%

Note this is a temporary target subject to national productivity measures being agreed.</td></tr>
<tr><td>OS-06</td><td>Elective and Arranged Day Surgery</td><td>Quarterly</td><td>DHB is expected to increase the proportion of elective and arranged surgery undertaken on a day case basis.

Target: 62%</td></tr>
<tr><td>OS-07</td><td>Elective and Arranged Day of Surgery Admission</td><td>Quarterly</td><td>DHB is expected to provide 90% of its elective and arranged surgery on a day of surgery admission (DOSA) basis.

Target: 98%</td></tr>
<tr><td>OS-08</td><td>Acute Readmissions to Hospital</td><td>Quarterly</td><td>DHB is expected to maintain 28 day unplanned acute readmission rates at the current rate or lower. Will be calculated from information held in NMDS.

Target: </= 10.3%</td></tr>
<tr><td>OS-09</td><td>Mortality</td><td>Annually
Q4</td><td>DHB is expected to maintain its 30 day mortality rate at the same level, or reduce it, over the year. Will be calculated from information held in NMDS.

Target: 1.65 (maintain status quo).</td></tr>
<tr><td>OS-10</td><td>Improving the quality of data provided to national collection systems</td><td>Quarterly</td><td>Timeliness of NMDS data
Target: <=5%
NHI Duplications
Target: <=3%
Ethnicity not stated in NHI
Target: <=4%
Standard versus specific descriptors in NMDS
Target: >35%</td></tr>
</table>

Appendix 3: Measures of DHB Productivity

Hospital Productivity
Wairarapa Hospital's productivity has increased significantly over the past five years. This is illustrated in graph one below which reflects the inpatient (CWD) activity at Wairarapa Hospital compared to Provider Arm revenue, FFT and FTE numbers over the past five years.

There was an upward trend in total inpatient activity through to 2008/09 (from a low of 4,701 CWDs in 2005/06 to a high of 6,286 CWDs in 2008/09). A large part of this growth in CWDs is attributable to additional elective CWDs, which had grown to 1,733 CWDs by 2008/09, up from 1,047 CWDs in 2004/05. Acute CWDs remained largely static up to 2006/07, after which there has been growth of over 10 percent per annum.

Total inpatient activity is projected to decline from the high of 6,286 CWDs in 2008/09 to 5,403 CWDs in 2009/10. This is attributable to a reduction in additional funding from the Ministry of Health for additional elective surgery. (Elective CWDs are projected to decrease to 1,311 CWDs in 2009/10, from a high of 1,733 CWDs in 2008/09.)

Over the same period, the Provider Arm FTEs have remained very flat, growing from 429 FTE in 2004/05 to an estimated 432 FTE in 2009/10. The significant increase in output during a period of static FTE growth is evidence of Wairarapa Hospital's significant increase in productivity.

The significant fall in forecast Provider Arm Revenue in 2009/10 is due to the reduction in electives funding. In recent years, electives output in excess of our PBF share has been funded by the Ministry of Health. However, this source of revenue is not expected to be available in 2009/10.

Graph One: Wairarapa DHB productivity –getting more for less

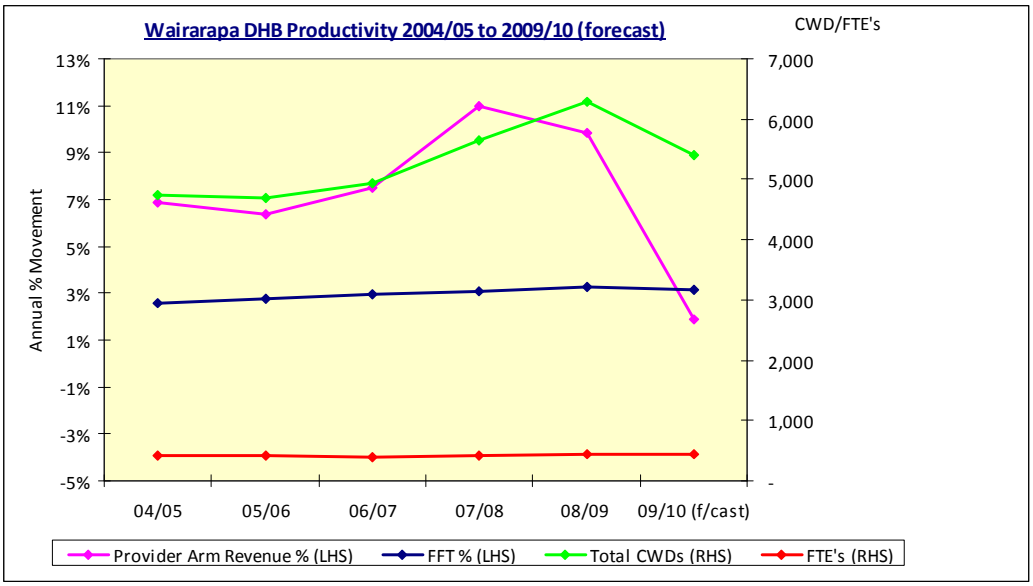
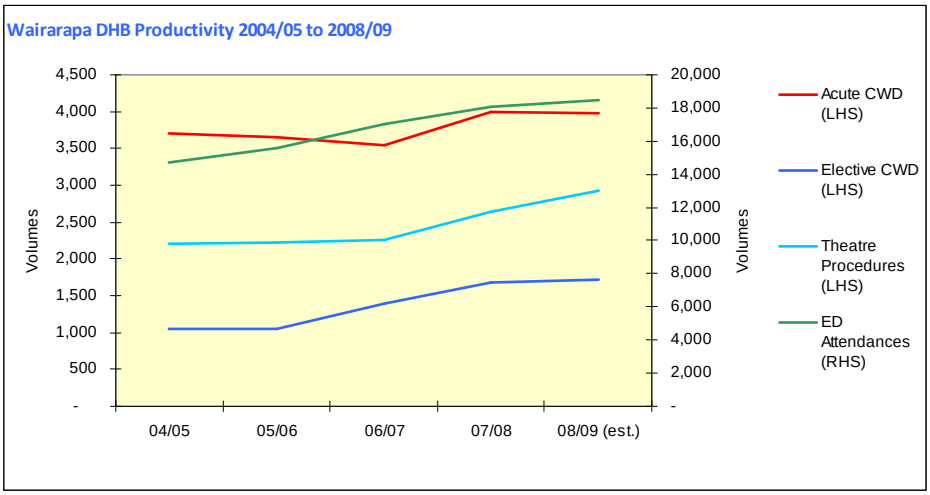


Table One: Wairarapa DHB CWD and FTE

	04/05	05/06	06/07	07/08	08/09	09/10 (est.)
Acute CWD	3,700	3,653	3,538	3,986	4,553	4,092
Elective CWD	1,047	1,048	1,390	1,673	1,733	1,311
Total CWDs	4,748	4,701	4,928	5,659	6,286	5,403
Total FTEs	429.17	417.18	400.7	416.34	432.19	432.19

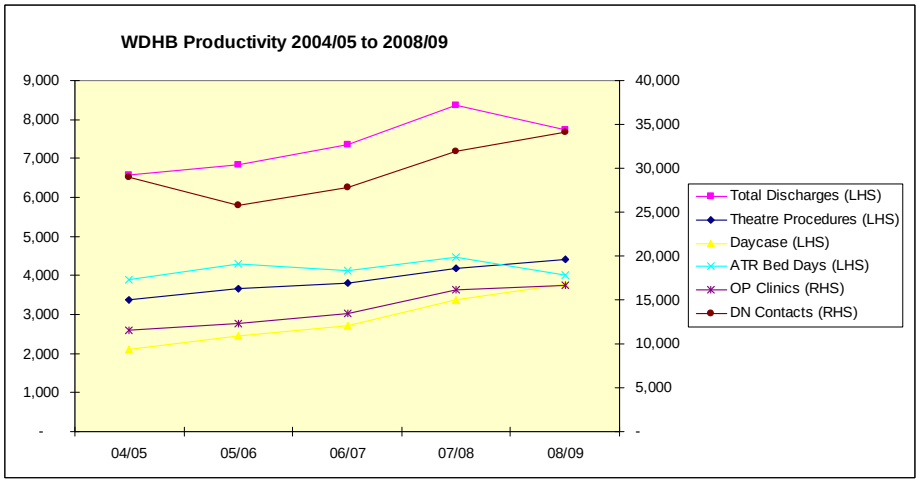
Graph two illustrates that this growth in productivity has not been confined to electives and acute CWDs. There has also been a marked growth in theatre procedures and emergency department (ED) attendances over the period: theatre procedures increasing from 2,205 procedures in 2004/05 to 2,936 procedures in 2008/09; and ED attendances increasing from 14,704 attendances in 2004/05 to 18,458 in 2008/09.

Graph Two: Wairarapa DHB Caseweights, Theatre Procedures and ED attendances 2004/05-2008/09



Graph three illustrates that there has also been growth in day case surgery, outpatient clinics, district nursing contacts and assessment, treatment and rehabilitation (ATR) bed days over the same period. Day case procedures increased from 2,100 to 3,776; outpatient clinic attendances from 11,555 to 16,699; district nursing contacts from 28,962 to 34,046; and ATR bed days from 3,884 to 3,996 between 2004/05 to 2008/09.

Graph Three: Wairarapa DHB productivity 2004/05-2008/09

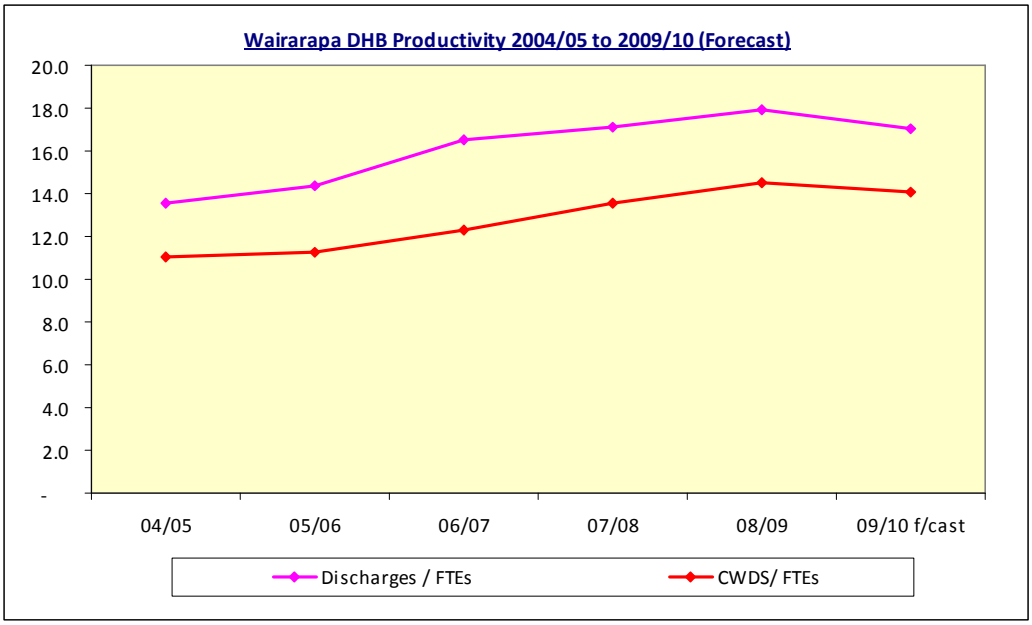


	04/05	05/06	06/07	07/08	08/09
Total Discharges	6,590	6,845	7,356	8,367	7,718
Theatre Procedures	3,365	3,651	3,794	4,195	4,415
Daycase	2,100	2,448	2,702	3,381	3,776
ATR Bed Days	3,884	4,302	4,126	4,466	3,996
OP Clinics	11,555	12,309	13,402	16,213	16,699
DN Contacts	28,962	25,788	27,878	31,884	34,046

Not only are we productive, but we are also efficient and cost effective. Wairarapa Hospital is making annual savings of approximately $5M per annum compared to national Provider Arm prices for hospital services (as advised by the Ministry of Health).

Graph four illustrates productivity per FTE over the past five years by showing the increasing number of CWDs and discharges per FTE. (The forecast drop in 2009/10 reflects the reduction in additional elective procedures that Wairarapa DHB was being funded to deliver.)

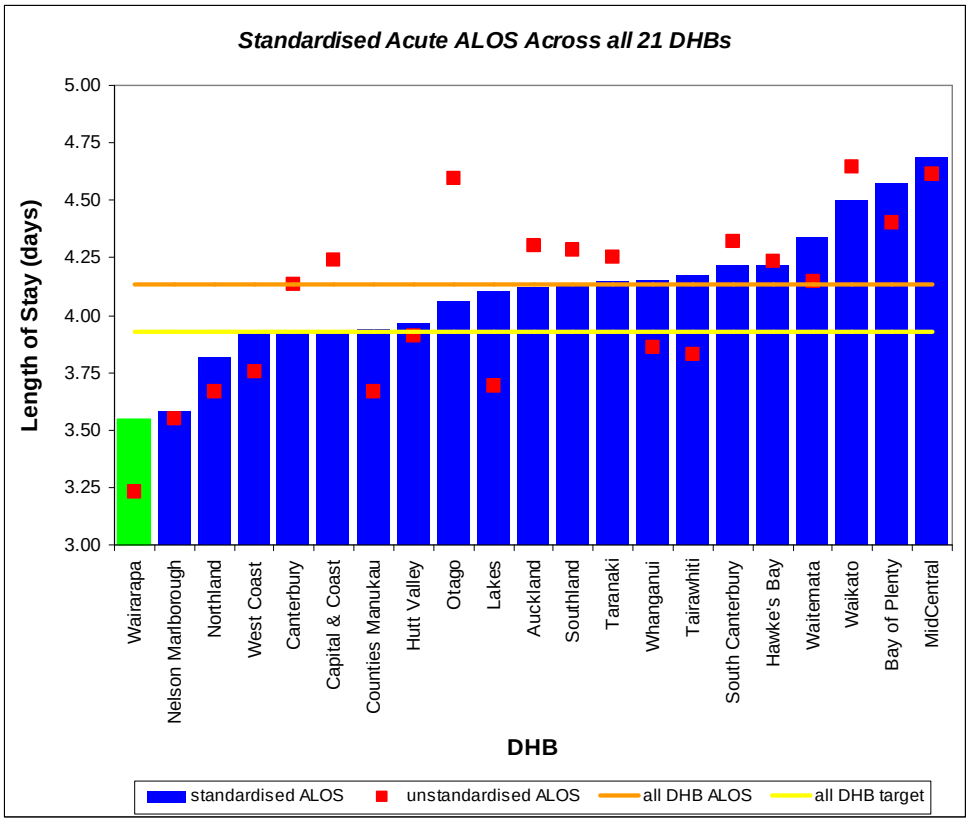
Graph Four: Discharges and CWDs per FTE



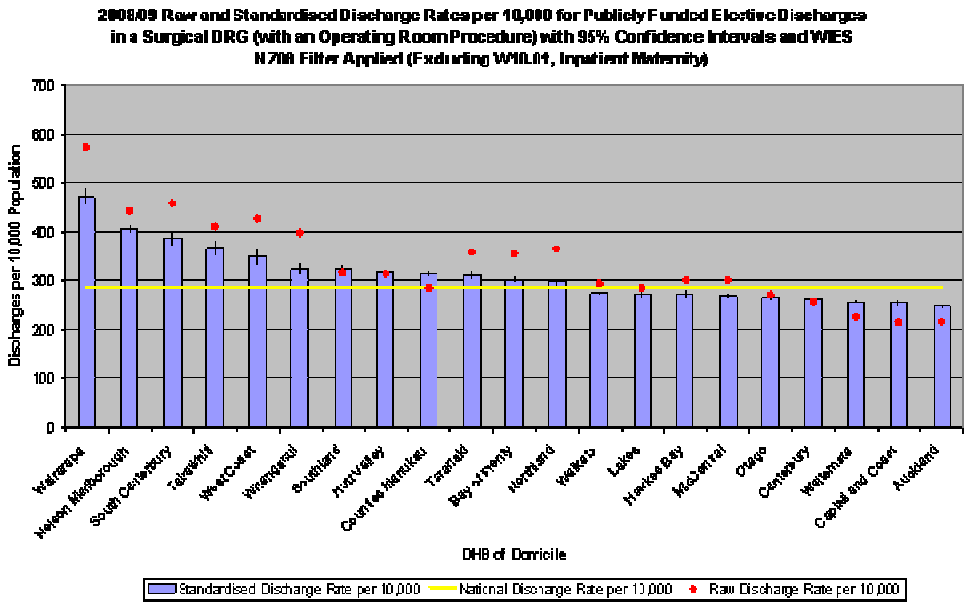
Whilst the hospital has been achieving growth across a range of hospital outputs, it has also been achieving desired changes in terms of how this care is provided, and the time within which care is made available.

For instance, the Quarter Two 2009/10 Health targets results show that 98% of people attending Wairarapa hospital's emergency department were seen within six hours, which is the second best performance nationally. We were also the best performing DHB in terms of timely access to cancer services, with 100% of people waiting less than six weeks between their first specialist assessment and the start of cancer treatment.

In 2009/10, our hospital achieved the lowest standardised average length of stay (ALOS) in New Zealand for acute cases as demonstrated in the graph below.

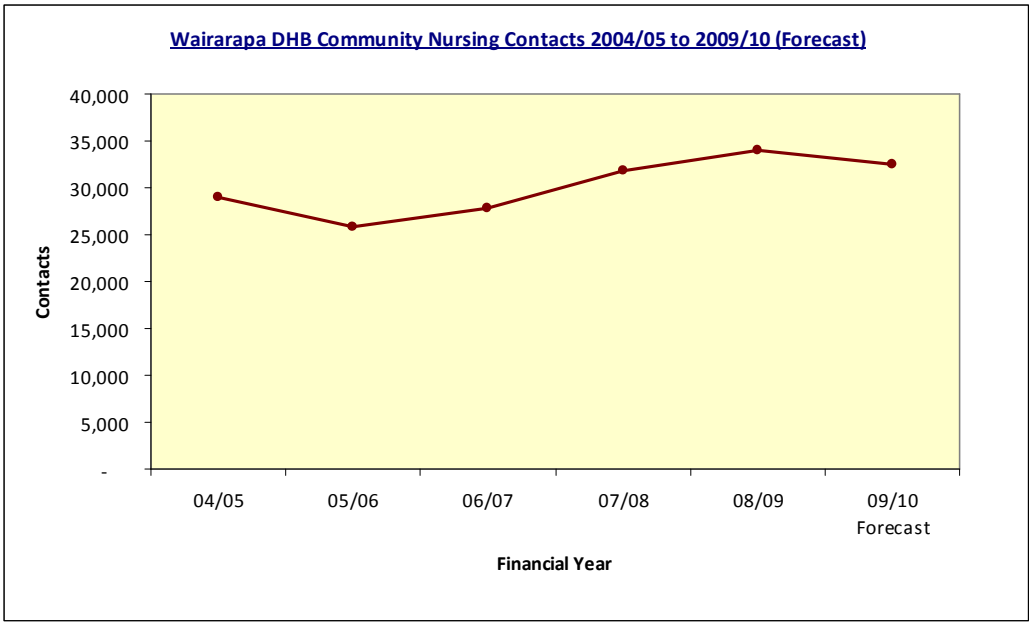


We were also the second best performing DHB in terms of providing day surgery on the day of admission. In 2008/09, Wairarapa DHB had the highest intervention rate in the country for providing elective surgical procedures as demonstrated in the following graph.



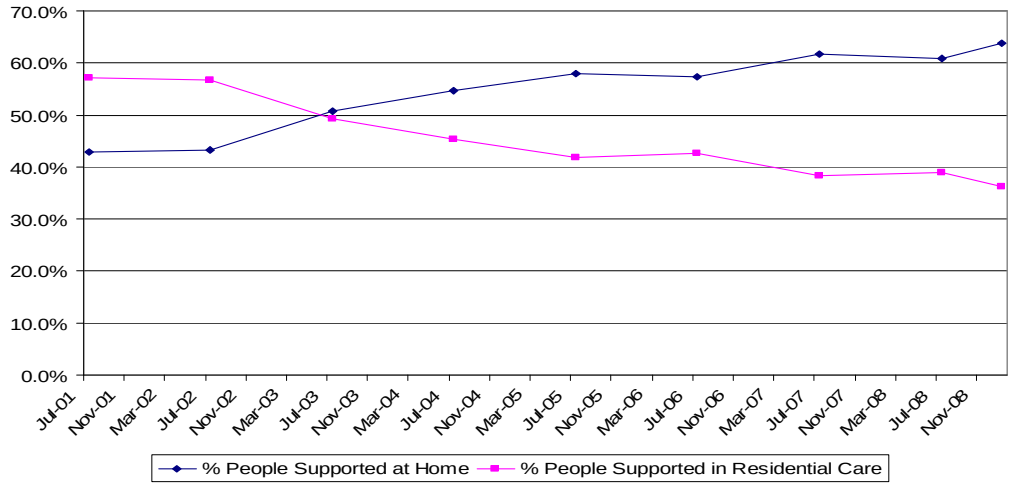
Community Services

Community services activity has increased, as illustrated by the increase in Community Nursing contacts in the following graph. These contacts are for services such as wound care, IV therapy in the home, palliative and oncology services.



Caring for Older People

In the Wairarapa, as reflected by the graph below, an increased proportion of older people assessed as needing support services are being supported at home compared to being supported in residential care.



Appendix 4: Statement of Commitment

Hutt Valley District Health Board | Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa | Capital & Coast District Health Board Epoko ki te Uru Hauora

Statement of Commitment to progress sub-regional initiatives between Wairarapa, Hutt Valley and Capital and Coast District Health Boards – January 2010

In 2008, Central Region DHBs collaborated to produce a Regional Clinical Services Plan (RCSP) intended to guide efforts over the coming years.

'The vision of the RCSP is to create a regionally coordinated system of health service planning and delivery, thus creating lasting improvements in the sustainability, quality and accessibility of clinical services'

The Wairarapa, Hutt Valley and Capital and Coast District Health Boards (the Three DHB's), recognise that there are potentially significant benefits to each of their respective communities through more collaborative clinical and corporate arrangements.

A clinically led programme of work will occur over the next 1 -2 years focused on implementing initiatives where these support improvements in the sustainability, quality and accessibility of clinical services.

This work programme will be outlined in the 10/11 District Annual Plans of each of the Three DHB's

Chair Wairarapa DHB

Chair Hutt Valley DHB

Chair Capital and Coast DHB

Appendix 5: Statement of Accounting Policies

Reporting entity

Wairarapa DHB is a Health Board established by the New Zealand Public Health and Disability Act 2000. Wairarapa DHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Wairarapa DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

Wairarapa DHB is a public benefit entity, as defined under NZIAS 1. The consolidated financial statements of Wairarapa DHB for the year ended 30 June comprise Wairarapa DHB and its subsidiary Biomedical Services New Zealand Limited and joint venture the Central Region Technical Advisory Service Limited (TAS) which is one sixth owned.

Wairarapa DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

The financial statements were authorised for issue by the Board on 30 October 2008.

Statement of compliance

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Basis of preparation

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, land and buildings and investment property.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value less costs to sell.

The preparation of financial statements in conformity with NZIFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Basis for Consolidation

Subsidiaries

Subsidiaries are entities controlled by Wairarapa DHB. Control exists when Wairarapa DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Joint ventures

Joint ventures are those entities over whose activities Wairarapa DHB has joint control, established by contractual agreement. The consolidated financial statements include Wairarapa DHB's interest in joint ventures, using the equity method, from the date that joint control commences until the date that joint control ceases.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates and jointly controlled entities are eliminated to the extent of Wairarapa DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Budget figures

The budget figures are those approved by the Wairarapa DHB in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZGAAP. They comply with NZIFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Wairarapa DHB for the preparation of these financial statements.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Revenue relating to service contracts

Wairarapa DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Wairarapa DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Goods sold and services rendered

Revenue from goods sold is recognised when Wairarapa DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Wairarapa DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Wairarapa DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Wairarapa DHB.

Rental income

Rental income from investment property is recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Expenses

Operating lease payments

Payments made under operating leases are recognised in the statement of financial performance in the periods in which they are incurred.

Finance lease payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Net financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, interest received and receivable on funds invested calculated using the effective interest rate method, dividend income and gains and losses on hedging instruments that are recognised in the statement of financial performance.

The interest expense component of finance lease payments is recognised in the statement of financial performance using the effective interest rate method.

Dividend income is recognised in the statement of financial performance when the shareholder's right to receive payment is established.

Non-current assets held for sale

Immediately before the classification of assets as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable NZIFRSs. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

Impairment losses on initial classification as held for sale are included in the statement of financial performance, even when the asset was previously revalued. The same applies to gains and losses on subsequent remeasurement.

Business combinations involving entities under common control

A business combination involving entities or businesses under common control is a business combination in which all of the combining entities or businesses are ultimately controlled by the same party or parties both before and after the business combination, and that control is not transitory.

Wairarapa DHB applies the book value measurement method to all common control transactions.

Income tax

Wairarapa DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Foreign Currency

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of financial performance. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Property, Plant and Equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings
- medical equipment
- information technology
- motor vehicles
- other plant and equipment
- work in progress.

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance.
Additions to property, plant and equipment between valuations are recorded at cost.
Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, Plant and Equipment Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Wairarapa Health Limited (a hospital and health service company) vested in Wairarapa DHB on 1 January 2001. Accordingly, assets were transferred to Wairarapa DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost (or in the case of land and buildings – the valuation) and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sales price and the carrying amount of the asset.

Properties Intended for Sale

Properties intended for sale are valued at the lower of cost or net realisable value.

Leased assets

Leases where Wairarapa DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

The property held under finance leases and leased out under operating lease is classified as investment property and stated at fair value. Property held under operating leases that would otherwise meet the definition of investment property may be classified as investment property on a property-by-property basis.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Wairarapa DHB. All other costs are recognised in the statement of financial performance as an expense as incurred.

Depreciation

Depreciation is charged to the statement of financial performance using the straight line method. Land is not depreciated.
Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of Asset	Estimated Life
Freehold buildings	2 to 50 years
Medical equipment	2.5 to 15 years
Information technology	2.5 to 15 years
Motor vehicles	5 to 12.5 years
Other plant and equipment	2.5 to 15 years

The residual value of assets is reassessed annually.
Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Intangible assets comprise computer software products acquired by Wairarapa DHB and are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life
Software	2 to 5 years

Impairment

The carrying amounts of Wairarapa DHB's assets, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance sheet date and was estimated at the date of transition.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted. Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely

independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Investments

Investments, including those in subsidiary and associated companies, are stated at the lower of cost and net realisable value. Any decreases are recognised in the Statement of Financial Performance.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Inventories

Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cost is based on weighted average cost.

Inventories held for distribution

Inventories held for distribution are stated at the lower of cost and current replacement cost.

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than twelve months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of Wairarapa DHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

Employee Benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of financial performance as incurred.

Defined benefit plan

Wairarapa DHB's net obligation in respect of defined benefit pension plans is calculated separately for each plan by estimating the amount of future benefit that employees have earned in return for their service in the current and prior periods; that benefit is discounted to determine its present value, and the fair value of any plan assets is deducted. The discount rate is the yield at the balance sheet date on New Zealand government bonds that have maturity dates approximating to the terms of Wairarapa DHB's obligations. The calculation is performed by a qualified actuary using the projected unit credit method.

When the benefits of a plan are improved, the portion of the increased benefit relating to past service by employees is recognised as an expense in the statement of financial performance on a straight-line basis over the average period until the benefits become vested. To the extent that the benefits vest immediately, the expense is recognised immediately in the statement of financial performance.

All actuarial gains and losses as at 1 July 2006, the date of transition to NZIFRSs, were recognised. Likewise, all actuarial gains and losses that arise subsequent to the transition date in calculating Wairarapa DHB's obligation in respect of a plan are recognised in the statement of financial performance.

Long service leave, sabbatical leave and retirement gratuities

Wairarapa DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

Annual leave, conference leave, sick leave and medical education leave

Annual leave, sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount Wairarapa DHB expects to pay. Wairarapa DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Provisions

A provision is recognised when Wairarapa DHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring

A provision for restructuring is recognised when Wairarapa DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Trade & other payables

Trade and other payables are stated at amortised cost using the effective interest rate.

Cost of Service Statements

The cost of service statements, as reported in the statement of objectives and service performance, report the net cost of services for the outputs of Wairarapa DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost Allocation

Wairarapa DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to major board activities. Indirect costs are charged to major board activities based on cost drivers and related activity/usage information.

Criteria for Direct and Indirect Costs

Direct costs are those costs directly attributable to a specific Wairarapa DHB activity.

Indirect costs are those costs which cannot be identified in an economically feasible manner with a specific Wairarapa DHB activity.

Cost Drivers for Allocation of Indirect Costs

The cost of internal services not directly charged to board activities is allocated as overheads using appropriate cost drivers such as direct cost ratios, actual usage, staff numbers and floor area.

Appendix 6: Projected Financial Statements

A. Projected Statement of Comprehensive Income

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Operating Revenue	**117,973**	**121,599**	**123,258**	**126,062**	**128,860**
Operating Expenditure					
Workforce costs	36,466	36,672	36,999	37,519	38,005
Treatment related costs	19,543	18,044	17,679	17,928	18,163
External providers	40,843	43,386	42,352	42,948	43,502
Inter district flows	20,674	23,132	24,056	24,395	24,711
Total Operating Expenditure	**117,526**	**121,234**	**121,086**	**122,790**	**124,381**
Result before Interest, Depreciation & Capital Charge	**447**	**365**	**2,172**	**3,272**	**4,479**
Interest, Depreciation & Capital Charge					
Interest expense	1,958	1,880	1,800	1,825	1,849
Depreciation & amortisation	1,912	2,123	2,081	2,110	2,137
Capital charge	685	562	480	487	493
Total Interest, Depreciation & Capital Charge	**4,555**	**4,565**	**4,361**	**4,422**	**4,479**
Net Operating Results	**(4,108)**	**(4,200)**	**(2,189)**	**(1,150)**	**0**
Other comprehensive income					
Gain / (loss) on property revaluations	0	0	0	0	0
Total other comprehensive income	**0**	**0**	**0**	**0**	**0**
Total comprehensive income	**(4,108)**	**(4,200)**	**(2,189)**	**(1,150)**	**0**
Total comprehensive income attributable to:					
Wairarapa District Health Board	(4,108)	(4,200)	(2,189)	(1,150)	0
Non-controlling interest	0	0	0	0	0

B. Projected Statement of Financial Position

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Assets					
Property, Plant & Equipment	42,269	42,662	40,194	38,975	37,732
Intangible Assets	516	784	1,296	2,055	2,811
Investments	103	103	103	103	103
Trust Fund Investments	61	52	52	52	52
Total Non-Current Assets	**42,949**	**43,601**	**41,645**	**41,185**	**40,698**
Cash & Cash Equivalents	(1,260)	(1,698)	77	1,577	2,114
Inventories	698	697	700	700	700
Trade & Other Receivables	3,998	4,064	3,962	3,963	3,964
Assets Classifed as Held for Sale	2,300	2,300	0	0	0
Total Current Assets	**5,736**	**5,363**	**4,739**	**6,240**	**6,778**
Total Assets	**48,685**	**48,964**	**46,384**	**47,425**	**47,476**
Equity					
Crown Equity	18,854	23,283	25,480	26,627	26,624
Revaluation Reserve	1,479	1,479	1,479	1,479	1,479
Retained Earnings	(15,247)	(19,447)	(21,636)	(22,786)	(22,786)
Total Equity	**5,086**	**5,315**	**5,323**	**5,320**	**5,317**
Liabilities					
Interest-Bearing Loans & Liabilities	20,208	20,600	20,925	20,850	21,275
Employee Benefits	520	486	486	486	486
Trust Funds	61	150	60	60	60
Total Non-Current Liabilities	**20,789**	**21,236**	**21,471**	**21,396**	**21,821**
Interest-Bearing Loans & Liabilities	5,557	5,307	5,057	4,807	4,057
Payables & Accruals	10,671	11,144	8,461	9,820	10,189
Employee Benefits	6,582	5,962	6,072	6,082	6,092
Total Current Liabilities	**22,810**	**22,413**	**19,590**	**20,709**	**20,338**
Total Liabilities	**43,599**	**43,649**	**41,061**	**42,105**	**42,159**
Total Equity & Liabilities	**48,685**	**48,964**	**46,384**	**47,425**	**47,476**

C. Projected Statement of Movements in Equity

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Balance at 1 July	**8,606**	**5,086**	**5,315**	**5,323**	**5,320**
Total comprehensive income previously reported	(4,108)	(4,200)	(2,189)	(1,150)	0
Effect on retained earnings of restatement	0	0	0	0	0
Total comprehensive income as restated	**(4,108)**	**(4,200)**	**(2,189)**	**(1,150)**	**0**
Equity injection from the Crown	591	4,432	2,200	1,150	0
Repayment of equity to the Crown	(3)	(3)	(3)	(3)	(3)
Movements in equity for the year	**588**	**4,429**	**2,197**	**1,147**	**(3)**
Balance at 30 June	**5,086**	**5,315**	**5,323**	**5,320**	**5,317**
Total comprehensive income attributable to:					
Wairarapa District Health Board	(4,108)	(4,200)	(2,189)	(1,150)	0
Non-controlling interest	0	0	0	0	0
Total comprehensive income	**(4,108)**	**(4,200)**	**(2,189)**	**(1,150)**	**0**

D. Projected Statement of Cash Flows

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Cash Flows From Operating Activities					
Operating Receipts	117,202	121,599	123,258	126,062	128,860
Interest Received	360	100	111	180	180
Payments to Supplies & Employees	(116,254)	(121,239)	(122,625)	(122,327)	(124,932)
Capital Charge Paid	(811)	(562)	(480)	(487)	(493)
Interest Paid	(1,958)	(1,850)	(1,440)	(1,200)	(1,200)
Taxes paid (net)	66	0	0	0	0
Total Cash Flows From Operating Activities	**(1,395)**	**(1,952)**	**(1,176)**	**2,228**	**2,415**
Cash Flows From Investing Activities					
Proceeds From Sale of Property, Plant & Equipment	0	0	2,300	0	0
Dividends received	17	50	25	25	25
Acquisition of Property, Plant & Equipment	(1,834)	(2,874)	(600)	(650)	(650)
Acquisition of Intangible Assets	(378)	(93)	(750)	(1,000)	(1,000)
Total Cash Flows From Investing Activities	**(2,195)**	**(2,917)**	**975**	**(1,625)**	**(1,625)**
Cash Flows From Financing Activities					
Loans Drawn Down	120	350	152	120	120
Equity Injected	590	4,435	2,200	1,150	0
Repayment of Loans	(358)	(351)	(373)	(370)	(370)
Repayment of Equity	(3)	(3)	(3)	(3)	(3)
Decrease in Investments & Restricted Funds Movement	7	0	0	0	0
Total Cash Flows From Financing Activities	**356**	**4,431**	**1,976**	**897**	**(253)**
Net Increase in Cash Held	**(3,234)**	**(438)**	**1,775**	**1,500**	**537**
Cash & Cash Equivalents at Beginning of the Year	1,974	(1,260)	(1,698)	77	1,577
Cash & Cash Equivalents at End of the Year	**(1,260)**	**(1,698)**	**77**	**1,577**	**2,114**

E. Projected Cost of Service Statements

Output Class Summary

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Operating Expenditure					
Hospital Services	65,416	67,609	65,694	66,853	67,948
Primary & Community Health Services	37,636	38,442	39,442	39,787	40,097
Public Health Services	2,710	2,622	2,095	2,125	2,153
Support Services	16,319	17,126	18,216	18,447	18,662
Total Operating Expenditure	**122,081**	**125,799**	**125,447**	**127,212**	**128,860**
Revenue					
Hospital Services	61,308	63,409	63,505	65,703	67,948
Primary & Community Health Services	37,636	38,442	39,442	39,787	40,097
Public Health Services	2,710	2,622	2,095	2,125	2,153
Support Services	16,319	17,126	18,216	18,447	18,662
Total Revenue	**117,973**	**121,599**	**123,258**	**126,062**	**128,860**
Net Operating Results	**(4,108)**	**(4,200)**	**(2,189)**	**(1,150)**	**0**

The following four tables show the costs of service for the four output classes.

I. Public Health Services

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Operating Expenditure					
Workforce costs	1,188	1,228	1,135	1,151	1,166
Treatment related costs	255	198	127	129	131
External providers	1,063	991	679	689	698
Inter district flows	0	0	0	0	0
Depreciation & amortisation	1	1	1	1	1
Total Operating Expenditure	**2,507**	**2,418**	**1,942**	**1,970**	**1,996**
Allocation of corporate costs	203	204	153	155	157
Total Cost of Service	**2,710**	**2,622**	**2,095**	**2,125**	**2,153**
Revenue	2,710	2,622	2,095	2,125	2,153
Net Result of Service	**0**	**0**	**0**	**0**	**0**

II. Primary & Community Health Services

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Operating Expenditure					
Workforce costs	4,924	4,122	4,134	4,042	3,944
Treatment related costs	1,064	1,116	968	985	998
External providers	27,039	28,149	27,456	27,957	28,433
Inter district flows	1,688	1,920	1,934	1,982	2,034
Depreciation & amortisation	105	144	153	155	157
Total Operating Expenditure	**34,820**	**35,451**	**34,645**	**35,121**	**35,566**
Allocation of corporate costs	2,816	2,991	4,797	4,793	4,782
Total Cost of Service	**37,636**	**38,442**	**39,442**	**39,914**	**40,348**
Revenue	37,636	38,442	39,442	39,914	40,348
Net Result of Service	**0**	**0**	**0**	**0**	**0**

III. Hospital Services

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Operating Expenditure					
Workforce costs	25,880	27,175	27,350	28,134	27,998
Treatment related costs	14,523	13,322	12,681	13,560	13,338
External providers	451	763	767	775	777
Inter district flows	17,943	19,577	18,869	21,129	21,360
Depreciation & amortisation	1,716	1,490	1,631	1,654	1,675
Total Operating Expenditure	**60,513**	**62,327**	**61,298**	**65,252**	**65,148**
Allocation of corporate costs	4,903	5,282	4,396	1,601	2,800
Total Cost of Service	**65,416**	**67,609**	**65,694**	**66,853**	**67,948**
Revenue	61,308	63,409	63,505	65,703	67,948
Net Result of Service	**(4,108)**	**(4,200)**	**(2,189)**	**(1,150)**	**0**

IV. Support Services

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Operating Expenditure					
Workforce costs	815	980	996	1,010	1,023
Treatment related costs	574	540	580	588	596
External providers	12,665	13,084	14,044	14,242	14,426
Inter district flows	1,043	1,188	1,252	1,284	1,317
Depreciation & amortisation	1	1	1	1	1
Total Operating Expenditure	**15,098**	**15,793**	**16,873**	**17,125**	**17,363**
Allocation of corporate costs	1,221	1,333	1,343	1,322	1,299
Total Cost of Service	**16,319**	**17,126**	**18,216**	**18,447**	**18,662**
Revenue	16,319	17,126	18,216	18,447	18,662
Net Result of Service	**0**	**0**	**0**	**0**	**0**

E. Funding Arm Financial Summary

The following table shows the summary financial performance for the three funding arms of the Wairarapa DHB as disclosed in previous DAPs.

	2008/09 Actual $000	2009/10 Forecast $000	2010/11 Projection $000	2011/12 Projection $000	2012/13 Projection $000
Revenue					
Funds	111,314	114,446	115,789	118,487	121,185
Governance & Funding Administration	2,067	3,207	3,438	3,486	3,534
Provider	54,976	55,010	55,600	56,385	57,112
Internal Eliminations	(50,384)	(51,064)	(51,569)	(52,296)	(52,971)
Total Revenue	**117,973**	**121,599**	**123,258**	**126,062**	**128,860**
Operating Expenditure					
Funds	112,066	117,946	117,978	119,638	121,185
Governance & Funding Administration	2,195	3,206	3,438	3,486	3,534
Provider	58,204	55,711	55,600	56,384	57,112
Internal Eliminations	(50,384)	(51,064)	(51,569)	(52,296)	(52,971)
Total Operating Expenditure	**122,081**	**125,799**	**125,447**	**127,212**	**128,860**
Net Operating Results					
Funds	(752)	(3,500)	(2,189)	(1,151)	0
Governance & Funding Administration	(128)	1	0	0	0
Provider	(3,228)	(701)	0	1	0
Internal Eliminations	0	0	0	0	0
Total Net Operating Results	**(4,108)**	**(4,200)**	**(2,189)**	**(1,150)**	**0**

Appendix 7: DHB ISSP Information

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/priority**	**DHB Project Reference #**	**Planned Start (Month/Yr)**	**Expected Completion (Month/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP. State how project aligns to specific DHB Objectives**	**Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**

Column 2: Project Ranking	**Column 6: HISAC Action Zone**	**Column 7: Project type**	**Column 8: Project significance**	**Column 10: Project Funding Source**
1: Must Do in 2010/2011	1: National Network Strategy	N: New	N: National	I: Internal (in approved DAP)
2: Should Do in 2010/2011 - Probable Do in 2011/2012	2: NHI Promotion	U: Upgrade	R: Regional	M: MoH New Funding
3: Nice to Do in 2010/2011 - Should Do in 2011/2012	3: HPI Implementation	R: Replacement	L: Local	P: Third Party
4: Non-urgent-Requested by Clinicians	4: ePharmacy			N: Not yet determined
5: Non-urgent-Requested by Board/Staff	5: eLabs			
6: Non-urgent-Requested by Ministry	6: Discharge Summaries			
7: Early Warning-upcoming work-probable future Rank 1	7: Clinical Care and Disease Management'			
8: Early Warning-upcoming work-probable future Rank 2	8: Electronic Referrals			
9: Early Warning-upcoming work-probable future Rank 3	9: National Outpatient Collection			
	10: National Primary Care Collection			
	11: National Systems Access			
	12: Anchoring Framework			

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/priority**	**Project Reference #**	**Planned Start (Month/Yr)**	**Expected Completion (Month/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP. State how project aligns to specific DHB Objectives**	**Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**
Production Server virtualisation project	1		Sep10	Mar 11	12	U	R L	120 (incl 5 yrs maintenance)	I	DAP Ref p46 Project contributes towards improving the infrastructure necessary to support the ICT environment and other projects	Reduction of 40 physical servers down to 3-4 , connect to SAN and virtualise. 1) DHB systems resilience enhanced 2) Downtime reduced and ability to recover key systems when required improved 3) Savings in maintenance for old servers e.g. If we were paying 5 years maintenance/support on existing old physical servers it would be in excess of $400K. 4) Will reduce ongoing power and cooling costs for the hospital, $$$ unknown but likely significant.
eReferrals phase 2	1		Sep 10	Jan 11	8	U	R L	100	I	DAP Ref p46 Project provides increased ability for DHB to meet HISNZ targets, and supports the National Health IT Plan and *Tihei Wairarapa* Business Case for Better Sooner More Convenient	Install new version eReferrals application and introduce new processes. 1) Allows referring to other areas of the business with improved workflow 2) less manual resource applied to referrals management 3) referrals status

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/priority**	**Project Reference #**	**Planned Start (Month/Yr)**	**Expected Completion (Month/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP. State how project aligns to specific DHB Objectives**	**Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**
										Healthcare in the Wairarapa	information electronically communicated to referrers
Implement Oral Health Application	1		Aug 10	Dec 10	7	N	R L	100	I	DAP Ref p35 and 46 Project supports ability to meet dental health targets	Review and install Titanium system hosted by another DHB or enhance existing Clinical system to support recording of Oral health clinical information. 1) Faster turnaround of processing for Children – less backlog 2) DHB meets national targets and can share information with other clinicians
Regional PACS repository or additional storage	2		Tbc	Tbc	7	N	R	140	N	DAP Ref p10, 47 Radiology is a regional vulnerable service in the region due to workforce issues. Project supports regional collaboration in the delivery of Radiology reporting services.	Current local PACS has local storage limitations and there is a risk of losing data. Sharing of studies for reporting or clinical utility is through push only. This initiative will: 1) Provide long-term protected storage for the region's diagnostic images. 2) Allow clinicians to access diagnostic images for a patient on demand regardless of which Hospital in the region performed the procedure. 3) allow flexibility around diagnostic reporting of studies by Radiologists sited at any of the participant DHBs and private providers.
ED Discharge Summaries	1		Jul 2010	Nov 2010	6, 7	N	L	30	I	DAP Ref p18, 46 Project supports	Current the way in which information is recorded

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/priority**	**Project Reference #**	**Planned Start (Month/Yr)**	**Expected Completion (Month/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP. State how project aligns to specific DHB Objectives**	**Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**
										improving the flow of information between ED and primary care.	and provided to primary care during and post an ED presentation is paper based. This initiative will see: 1) more information captured electronically as part of the Hospital EMR. 2) The ED information sent electronically back to ptimary care.
Primary access to Concerto	1		Oct 10	Deb 10	7,12	N	L	40	I	DAP Ref p34, 46. Project supports improving integrated care and *Tihei Wairarapa* Business Case for Better Sooner More Convenient Healthcare in the Wairarapa	Currently GPs and other primary care providers don't have access to the Hospital EMR. This initiative will: 1) allow GPs and other community based providers have controlled and secure access to the Hospital Concerto electronic record. 2) Provide comprehensive auditing capability for seeing who has accessed what information for a patient. 3) 'Loose' integration between

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/priority**	**Project Reference #**	**Planned Start (Month/Yr)**	**Expected Completion (Month/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP. State how project aligns to specific DHB Objectives**	**Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**
											MedTech and Concerto.
Integrating MedTech and Concerto	3		Dec 10	Apr 11		4, 7	L	50	N	DAP Ref p 47	Provides tighter integration between MedTech and Concerto so: 1) Medications and long term conditions data can be transferred from MedTech into the Concerto EMR.
Dispensed Medications views in Concerto	3		Dec 10	Apr 11		4	L	20	I	DAP Ref p 47	Provides better information to clinicians and pharmacists on a patients medication profile by: 1) showing within Concerto what medications have been prescribed by hospital and GPs 2) showing what medications have been dispensed.
Medications Reconcilliation module	3		Jun 11	Aug 11		4, 7	L	40	I	DAP Ref p47	Implements Orion's medicaton reconciliation module into the Concerto EMR. This provides pharmacists and clinicians with: 1) A n electronic medication history form 2) Electronic Medication reconciliation 3) Improved

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank/priority**	**Project Reference #**	**Planned Start (Month/Yr)**	**Expected Completion (Month/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance: National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP. State how project aligns to specific DHB Objectives**	**Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**
											medication table in discharge summaries 4) NZULM Medications terminology. 5) Electronic yellow cards for patients.
Replace FMIS	7		Tbc	Tbc		N	N or R	Unknown	N		Support for existing FMIS is unofficial and a high risk. A replacement has been on the wish list for many years. A descision is pending from the SSEB on direction for DHB FMIS Nationally.
Replace Legacy PAS	7		Tbc	Tbc		N	R	Unknown	N	While not specifically mentioned in the DAP, the termination of the HMSC means we are left with legacy operational systems that need replacing in the next few years.	Replacement of the Galen, PAS, ED, Theatre and Pharmacy systems as well as Mental Health systems.