Wairarapa District Health Board

ANNUAL PLAN

2012/2013

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

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

16 JUL 2012

Dear Mr Francis

Wairarapa District Health Board 2012/13 Annual Plan

This letter is to advise you I have approved and signed Wairarapa District Health Board's (DHB) 2012/13 Annual Plan for three years.

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

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2012, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to safeguarding and growing our public health services.

Health targets

Government Health Targets are selected to drive on-going improvements in specific priority areas in order to meet the public's growing expectations of accessing quality health care.

I appreciate your DHBs efforts to deliver on the Health Targets and your progress in achieving these. Your plan acknowledges the changes in focus with regard to the cancer, immunisation and tobacco targets and identifies actions to support their achievement. I am satisfied the activities you have identified in your Annual Plan will deliver on these new targets, while building on current achievements for emergency departments, electives as well as cardiovascular disease and diabetes.

Shorter waiting times

The Government has made commitments to New Zealanders to deliver even faster access in a number of key areas including elective surgery, diagnostic tests, chemotherapy treatment and youth drug and alcohol services. Thank you for your work to support these commitments. I look forward to seeing your planned results in these priority areas.

Integrated care

I expect all DHBs to increase their focus on service integration, particularly with respect to primary care, ensuring the scope of activity is broadened and the pace significantly stepped up. I look forward to seeing an integrated care approach driving delivery and improved performance, especially in relation to unplanned and urgent care, long term conditions and wrap around services for older people.

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I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan and movement towards more tangible actions to show how you will achieve real progress towards providing a better range of services in the community. I expect you to be active in advancing these improvements to the way primary and community services are delivered closer to home. The Ministry and National Health Board (NHB) will be working closely with DHBs to support the implementation of integration work programmes.

Living within our means

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

Approval of your Annual Plan is conditional upon your Board fully supporting the investment required in Health Benefits Limited's Finance, Procurement & Supply Chain detailed business case. This is expected to follow completion of the current business case approval process with DHBs and shareholding Ministers.

I am pleased to see that your DHB is planning to break even in 2013/14 2014/15. I note that the planned deficit of $3.1M for 2012/13 is a step back from the $2.4M signalled for that year in your 2011/12 Annual Plan. I am prepared to accept this in view of the accelerated return to break even signaled and will be watching with keen interest your progress against these planned results.

Savings from the community pharmaceutical budget

Earlier in the year, I directed DHBs to put the $30 million savings from the community pharmaceutical budget for 2012/13 towards the following initiatives:

- extending zero fees for primary care for children under six to afterhours;
- providing support for child and adolescent mental health services;
- implementing faster cancer treatment initiative;
- supporting smart investment home care for older people;
- providing an increase in aged care residential subsidy for bed day price, and for further improvements in dementia services.

I am interested to follow your progress in implementing these initiatives.

Health of older people

Our aging population poses many challenges to the health system and addressing these challenges is a government priority. DHBs are expected to develop wrap around services for older people and continue to invest in home and community support services, including post hospital discharge support to reduce acute admissions.

I am pleased to see detail in your Annual Plan on how you are planning to deliver health services for older people. I am particularly interested to follow your progress in relation to the provision of organised stroke services, services to reduce acute admissions, improvements in respite care and the development of dementia care pathways.

Regional Integration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities.

Included in these priorities are the achievements of regional workforce, IT and capital objectives that have been set, as well as your on-going support for the work of Health Benefits Limited, the National Health Committee and the Health Quality and Safety Commission. I look forward to seeing tangible benefits provided to patients as a result of these important regional initiatives being implemented.

It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan.

Whānau Ora

Whānau Ora is an inclusive interagency approach to providing health and social services in which DHBs play a key role. I expect your DHB planned actions to deliver on Whānau Ora to reflect the strategic change, confirmed support to selected Whānau Ora collectives; greater involvement of DHB leaders; and activities to improve performance and build mature providers.

Prime Ministers Youth Mental Health Project

The Prime Ministers Youth Mental Health Project cross-agency initiatives aim to prevent youth mental health problems developing and improve access to specialised treatment for those who need it. I would like to thank you for your demonstrated commitment to this government priority, including through your planned actions to build capacity and capability of specialist child and youth mental health and addition services, in order to improve service responsiveness.

Cardiac Services

The focus on improving access to cardiac surgery has resulted in very positive outcomes for patients over recent years. I am pleased to see your commitment to continuing progress in this area, through reducing waiting times and ensuring an appropriate level of access during 2012/13, not only for surgery, but across a wider suite of cardiac services.

The link between regional networks and cardiac providers is very important in this area, and I expect your local contribution to align with regional planning, and for regional collaboration to be strengthened to support delivery, waiting list management, and improved patient pathways.

Diabetes Care

This year each DHB has been asked to develop a Diabetes Care Improvement Package in consultation with primary care partners to better support prompt access to services and increasingly more effective management of people with diabetes.

These packages should enable innovation in service delivery, more focused activity to improve patient care where it is most needed and are to be built with strong evidence based best practice in mind. They should build on the good practice already provided through general practice to enhance and optimise outcomes for patients. I look forward to following the progress of these packages with your primary care partners.

Community Pharmacy Services Agreement

DHBs have undertaken to provide a well executed transition to the new Community Pharmacy Service Agreement. I know you will want to ensure your management confirms this happens locally.

Annual Plan Approval

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

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

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2012/13 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

My approval of your Annual Plan is contingent on your commitment to (along with your regional DHB partners) present an agreed joint plan, by 30 September 2012 which will ensure the sub-region has broken even financial result for the 2013/14 and out-years. I expect that this plan will contain specific actions that are achievable and fit within government policy requirements. I have instructed National Health Board officials to work with you to achieve this.

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

Yours sincerely

Tony Ryall

Hon Tony Ryall
Minister of Health

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MODULE 1: INTRODUCTION

1.1 EXECUTIVE SUMMARY

We are pleased to present our 2012/13 Annual Plan. The Annual Plan outlines how the Wairarapa District Health Board (DHB) will pursue its vision of a *Well Wairarapa* for the next three years and how it will deliver Better, Sooner, More Convenient integrated care to its population. We are committed to implementing the Governments priorities and health targets and recognise the importance of accelerating service integration across the continuum of health services.

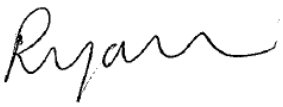
Wairarapa DHB will continue to implement its Clinical Services Action Plan which identifies actions the DHB must take to ensure services are clinically and financially sustainable. Key to our success is the Triple Aim Approach – improving the patient experience, improving the health of the population and reducing and controlling costs. We recognise that putting the patient at the centre of all of our endeavours will be key. The voice of the consumer is important to us and we have established a consumer forum to guide and advise us on the development of health services in this region.

The Wairarapa DHB has been working hard to control and contain its costs. Efficiency programmes over the past three years have delivered $6.5M in efficiencies -2009/10 planned $4.65M (achieved $4.0M), 2010/11 planned $2.35M (achieved $.871M), 2011/12 planned $1.67M (forecast $1.67M). Despite these achievements we are forecasting a deficit position of $3.1M for 2012/13 and breakeven results for the 2013/14 and 2014/15 financial years. The breakeven out-year projections are predicated on an agreement with our sub-regional partners, Capital & Coast DHB and Hutt Valley DHB whereby the aggregate of the three DHB results will be breakeven. The 3 DHBs are committed to developing this joint plan by 30 September 2012 to ensure the sub-region has a break even financial result for 2013/14 and out years.

We will not be able to resolve the challenges we are facing alone. This year we will be accelerating a programme of work with our partners in the sub region – Capital and Coast and Hutt Valley DHBs. Our vision is a *Shared Community* approach which recognises the need for the sub region to work together to advance improvements in the quality of patient care, manage risk, improve processes and sustain service delivery through a fit for purpose, flexible, professional workforce.

Regional and National programmes of work will have an increasing influence on how we carry out our business as we look to implement the Central Regional Information System Plan (CRISP) programme and new national purchasing and workforce arrangements through Health Benefits Limited (HBL) and Health Workforce New Zealand (HWNZ) which will control and contain costs and provide a framework for the ongoing development of our workforce. Improving the quality and safety of our health services is also a priority and we will continue to support the implementation of programmes of work through the Health Quality and Safety Commission (HQSC).

The Wairarapa DHB recognises that 2012/13 will be a challenging year as we strive to live within our means and achieve the targets and aspirations set by the Government. We are committed to meeting these challenges and achieving our financial targets and will continue to explore ways to reduce and control costs across the range of services that we provide while providing an enhanced patient experience to our population.



Board Chair **Chief Executive** **Minister of Health**

1.2 CONTEXT

1.2.1 BACKGROUND

DHBs are responsible for providing or funding the provision of health and disability services. DHBs' statutory objectives under the New Zealand Public Health and Disability Act 2000 (and amendment Act 2010) include:

- Improving, promoting and protecting the health of people and communities
- Promoting the integration of health services, especially primary and secondary health services
- Seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs
- Promoting effective care or support of those in need of personal health services or disability support.

Other statutory objectives include promoting the inclusion and participation in society, independence of people with disabilities, and reducing health disparities by improving health outcomes for Māori and other population groups.

DHBs are also expected to show a sense of social responsibility, to foster community participation in health improvement, and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations.

Health sector context

The Wairarapa DHB is one of twenty DHBs. As well as meeting statutory objectives, Wairarapa DHB also recognises and respects the Treaty of Waitangi, and the principles of partnership, participation and protection. At a local level, the DHB works in partnership with its Māori governance body, Te Oranga o te Iwi Kainga, to ensure Māori participation at all levels of service planning, and service delivery for the protection and improvement of the health status of Māori.

DHBs are strongly influenced by the Minister of Health's expectations and priorities including the Minister's six health targets and other Government priorities identified in the Minister's Letter of Expectations. DHBs are also guided by the Ministry of Health (the "Ministry") which is the Governments principle advisor on health and disability matters - improving, promoting and protecting the health of all New Zealanders. Its Statement of Intent provides guidance for DHBs on the strategic direction and priorities for the New Zealand health sector.

The DHB is committed to delivering *Better Sooner More Convenient* Care and will continue to focus on the integration of health services utilising its Alliance Leadership Team to drive whole of health system integration.

DHBs acknowledge the increasing role of national organisations such as HBL, HWNZ, National IT Board and the HQSC who are driving a number of national initiatives to assist DHBs with their operations and workforce planning.

DHBs are now required under New Zealand Public Health and Disability Amendment Act 2010 to develop a Regional Services Plan (RSP) which considers how they can ensure the clinical and financial sustainability of the region's health services. It focuses on those services that require strengthening if they are to be sustainable, including cardiac, cancer and radiology services. At a regional level, the Wairarapa DHB works closely with the other five DHBs in the Central region[1], with a particular focus on its sub-regional relationship with Hutt Valley and Capital & Coast DHBs where people of the

[1] The other five DHBs in the Central Region include Hawke's Bay, Whanganui, MidCentral, Hutt Valley and Capital & Coast DHBs.

Wairarapa access a range of more specialised services. The three DHBs have adopted a 'one community approach' recognising that each DHB is accountable to the populations they serve, irrespective of where they receive services.

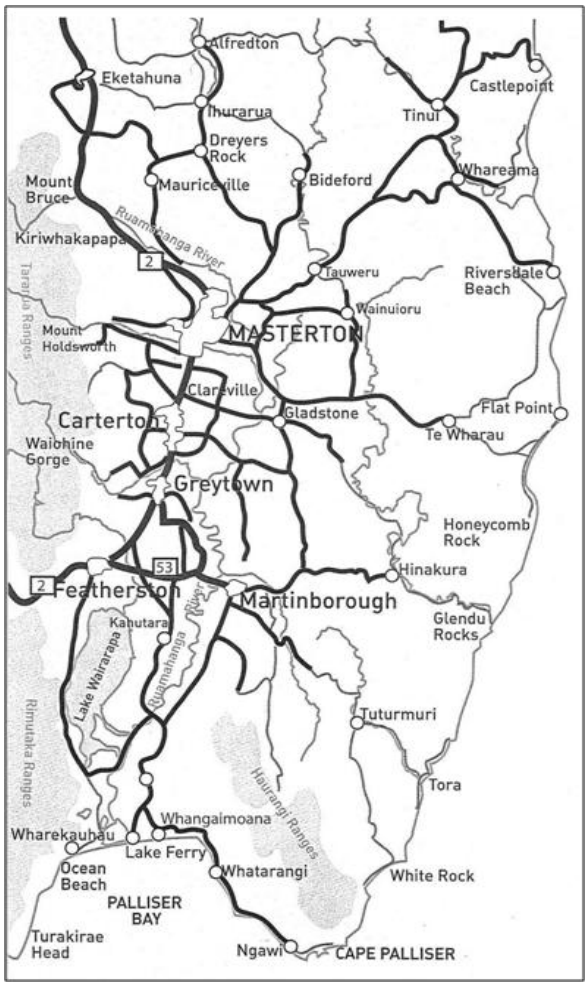
Planning for the needs of our local population is heavily influenced by our national, regional and sub regional planning activity, as this will shape the location and delivery of services in the Central region over the next five to ten years.

Population profile

This section describes the Wairarapa DHB's population.

Demographics

The Wairarapa DHB is home to 1.1% of the national population and is the second smallest of the twenty DHBs, with a population of nearly 40,000.



Our small population is spread over a large geographic area extending from the Rimutaka Hill and Ocean Beach in the south to Mount Bruce in the north. The Wairarapa district is located in the southeast of the North Island and includes three Territorial Local Authorities (TLA's) Masterton, Carterton and South Wairarapa. It extends from the Rimutaka Hill in the west to Ocean Beach in the south and Mount Bruce in the north, a total of 5,936 square kilometres.

The area forms part of the Greater Wellington Regional Council, participates in the Wellington Regional Strategy, but is separated geographically from the rest of the Wellington Region by the Rimutaka Ranges.

About half of the population lives in urban centres compared with the national average of 83% for all DHBs.

Masterton, the largest of these urban clusters, is located in the heart of the Wairarapa and has a population of 24,000. Masterton, separated geographically from the rest of the Wellington region by the Rimutaka Ranges, is about an hour and a half drive from both Wellington and Palmerston North.

Carterton, located south of Masterton, has a population of just over 7,000. South Wairarapa, with a total population of nearly 9,000, includes the towns of Featherston, Greytown and Martinborough.

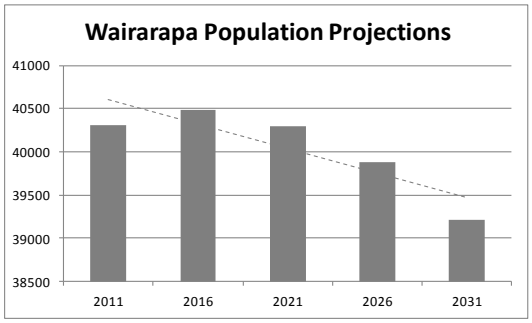
The national census scheduled for 2011 did not take place due to the Christchurch earthquakes. It has been rescheduled for March 2013 and in the meantime Department of Statistics population projections remain based on the 2006 census results.

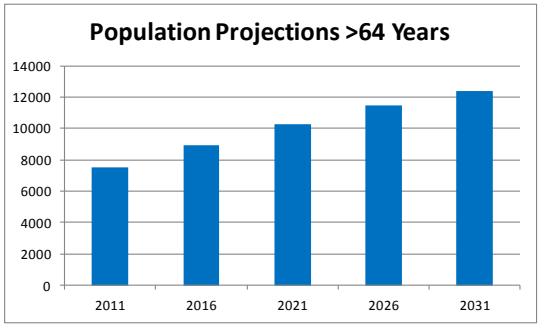
In all regions of New Zealand population growth is projected to slow and age between 2006 and 2031. The 'baby boomers' (those aged 45–64 years in 2011) will be aged 65–84 years in 2031.

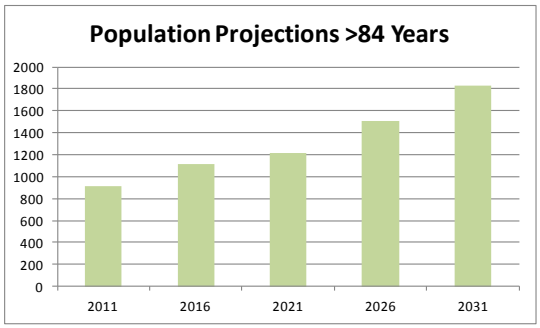
Two-fifths of New Zealand's territorial authority areas will have fewer residents in 2031 than in 2006 and all regions, cities, and districts will be home to more people aged 65 years and over in 2031.

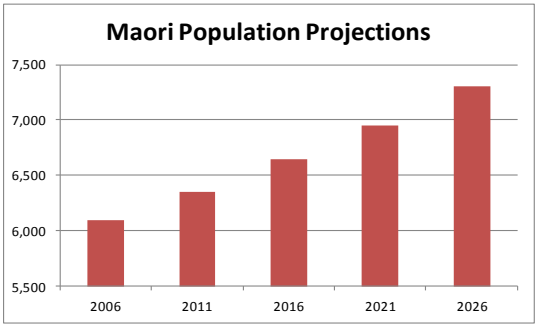
The make-up of Wairarapa's population will similarly change. As shown in the graphs, the total population is projected to decrease by 1,100 (from 40,310 in 2011 to 39,210 in 2031), but:

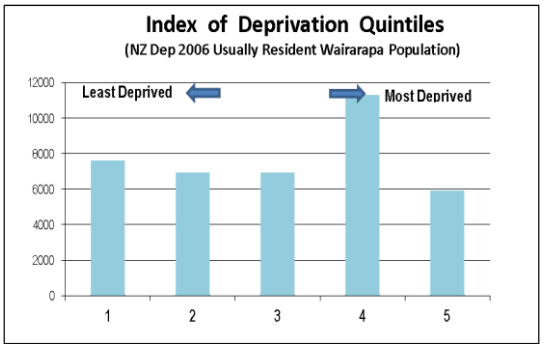
- the number of people in Wairarapa over 65 years is expected to increase from 19% of the population in 2011 to 32% by 2031
- the percentage of people 85+ years will increase from 2% of the population to 5%
- The Wairarapa Māori population is projected to increase by 20% between 2006 and 2026.
- Different areas of the Wairarapa have different deprivation patterns; the most deprived group (quinitile 5) account for 22% of Masterton population but only 3% for Carterton and 7% in South Wairarapa.
- A large number of Wairarapa people live in quintile 4.











As the identified groups are expected to be higher users of health and disability services, in 2012 the DHB is focusing on:

- *Aging population and older people:* The proportion of older people in the population (including Māori) is increasing, resulting in escalating pressure on services for the elderly and this is set to continue over the next twenty years.
- *Socio economic status:* Deprivation can occur due to lack of income, employment, communication, transport, support, qualifications, living space and owning your own home. The urban areas of Wairarapa have a greater proportion of people class ified as more deprived than the national average and it is well documented that Māori and people of low socio-economic status have consistently poorer health outcomes in comparison with the rest of the population. Across all groups, positive social change will drive improved health.
- *Long term chronic conditions*: The five most common causes of admissions to hospital for Wairarapa people are heart disease, respiratory disease, cancer, renal failure and kidney disease, and stroke. This is a slight change from previously as diabetes is no longer included since admissions have dropped from 97 in 2009 to 75 in 2010 and down to 37 in 2011. Strokes are now positioned in 5th place.
- *Lifestyle factors affecting health:* Lifestyle choices such as physical activity, healthy eating and not smoking can improve the health profile of individuals and the community as a whole. Māori have a lower prevalence of adequate fruit and vegetable intake, and Māori women have the highest percentage of smokers in Wairarapa (47.4% smoke). Wairarapa residents have higher levels of obesity and a higher prevalence of hazardous drinking than their New Zealand counterparts. Local initiatives to reduce the risk of developing chronic conditions and improve health status include a Wairarapa Community Healthy Lifestyle Programme and an Active Families programme.
- *Māori health:* It is well documented that Maori suffer poorer health than their counterparts in other ethnic groups. Maori have poor health outcomes across most indicators although differences are reducing for some areas such as immunisations and oral health. The leading causes of death for Maori adults between the age of 25-44 were due to external causes such as car accidents and intentional self harm (suicide) while the leading cause of death for Maori adults aged over 65 were due to circulatory disease or cancer with ischemic heart disease being the leading circulatory system disease. *Te Huarahi Oranga,* the Wairarapa DHB Maori Health Plan 2010-2015, is a five year strategic framework aiming to improve Māori health gains in the Wairarapa through effective strategies and actions that support positive health outcomes for whānau at a local level.
- *Children and Young People:* While generally improving, health statistics for children in Wairarapa are below national averages in some key areas. Wairarapa children are more likely than adults to live in areas of high deprivation, they have high rates of hospitalisation and there are high and increasing child abuse notifications in the Wairarapa. Typically, children living in Wairarapa's most deprived areas have the poorest health status.

1.2.2 OPERATING ENVIRONMENT & RESPONDING TO OUR FINANCIAL CHALLENGES

Balancing the changing health needs of our population with the realities of a constrained financial envelope is a difficult task for DHB governance, management and clinicians. However, the Wairarapa DHB will continue to provide services to the levels required by its service coverage schedule agreed with the Ministry. The Wairarapa DHB faces the same fiscal pressures as other DHBs: demographically and technologically driven demand, increasing expectations, increasing cost growth and wage and salary expectations. The DHB acknowledges however that it operates within a constrained financial environment.

The Wairarapa DHB has operated in a deficit position for the last five financial years and is projecting a deficit for the first year of this plan. The deficits are then projected to cease with work being undertaken with our sub-regional partners, Capital & Coast DHB and Hutt Valley DHB where the expectation of the Minister is that the sub-region, as an aggregate, will deliver breakeven results for the second and third years of this plan. There is no "quick fix" solution. To ensure the health system is financially sustainable, we are focussed on making the whole of system work properly and achieving the best possible outcomes for our investment. This is work that Wairarapa DHB has been focussing on, and investing in, over the last two years to meet the challenges faced across the health system.

Forecast financial performance

For the 2012/13 year we are forecasting a deficit position of $3.1M. We are planning to achieve $2.3M in further efficiencies in 2012/13 which is a continuation of the efficiency programme over the past three years which has delivered $6.5M in efficiencies – 2009/10 planned $4.65M (achieved $4.0M), 2010/11 planned $2.35M (achieved $.871M), 2011/12 planned $1.67M (forecast $1.67M).

The DHB projected a deficit of $2.4M for the 2012/13 year in the 2011/12 AP. However, we are unable to achieve that deficit position through the efficiency targets included in that Plan totalling $2M plus absorb a range of additional costs.

We have identified sub regional opportunities and costs savings which will allow the DHB to achieve a deficit position of $3.1M in 2012/13. The sub regional work plan and associated projected cost savings have been included in our financial position and financial assumptions. To achieve this non clinical support areas will be reviewed to identify potential opportunities to deliver more effective and efficient service delivery. Appropriate consultation and engagement processes will be initiated where there any potential staff impacts. Module 3, section 3.3 provides information on the agreed work programme for the sub region.

In addition, the out-year projections have been revised from the financial projections in the 2011/12 AP. The out-years are now projecting a breakeven result for both the 2013/14 and 2014/15 financial years. These results are predicated on an agreement with our sub-regional partners, Capital & Coast DHB and Hutt Valley DHB whereby the aggregate of the three DHB results will be breakeven. The 3 DHBs are committed to developing this joint plan by 30 September 2012 to ensure the sub-region has a break even financial result for 2013/14 and out years.

Constraining our cost growth

Constraining cost growth is also critical to our success. If an increasing share of our funding continues to be directed into meeting the growing cost of providing services, our ability to maintain current levels of service delivery will be at risk. We will also be severely restricted in terms of our ability to invest in new equipment, technology and new initiatives that allow us to meet future demand levels.

It is also critical that we continue to reorient and rebalance our health system. By being more effective and improving the quality of the care we provide, we reduce rework and duplication, avoid unnecessary costs and expenditure and do more with our current resources. We are also able to improve the management of the pressure of acute demand growth, maintain the resilience and viability of services and build on productivity gains already achieved through increasing the integration of services across the system.

Wairarapa DHB has already committed to a number of mechanisms and strategies to constrain cost growth and rebalance our health system. We will continue to focus on these initiatives, which have contributed to our considerable past success and given us a level of resilience that will be vital in the coming year:

- Reducing variation, duplication and waste from the system;
- Doing the basics well and understanding our core business;
- Investing in clinical leadership and clinical input into operational processes and decision-making;
- Developing workforce capacity and supporting less traditional and integrated workforce models;
- Realigning service expenditure to better manage the pressure of demand growth; and
- Supporting unified systems to shared resources and systems.

Within the forecast deficit in the 2011/12 year is a shortfall of $1.4M relating to the Wairarapa DHBs delivery of elective services over and above our equitable share of elective volumes. Wairarapa DHB is committed to achieving the electives health target and in 2011/12 will deliver 1,841 discharges, 253 discharges higher than our equitable share of the national electives health target.

Options for reducing the deficit
From a number of differing benchmark studies it is clear that our "Provider arm" is a very efficient provider (2010/11 average cost per WIES: Wairarapa $4,119 -lowest, national average $4,854). The price projected to be paid by the Funder arm to the Provider arm in 2012/13 is $3M below the pricing arising from the DHB national pricing programme. A negative price adjuster at this level, whilst the provider arm is running a deficit of $2M, demonstrates the level of efficiencies that have been achieved within the DHB provider arm over the last five to six years.

As noted the Wairarapa DHB is planning a $3.1M deficit for the 2012/13 financial year with breakeven results included for 2013/14 and 2014/15. To address this level of deficit, we have considered a number of options. These included withholding funding for HBL initiatives and withdrawal from CRISP. The aggregate of these two would save over $400,000 of operating expense allowed for in the financial projection for 2012/13. As they are contrary to collaborative regional and national partnerships, we have discounted them.

In late 2011, we participated in an exercise conducted by the Crown Health Financing Agency (CHFA) around the key drivers of the deficit. This report from the CHFA has been provided to the National Health Board (NHB). A number of initiatives were proposed that could have been considered to reduce and control the deficit. However many of these initiatives are not possible due to current national policy parameters or other limiting factors.

Acknowledging this, we will continue to focus on our planned efficiencies programme and will continue to actively reduce our costs and pursue saving opportunities from national, regional and sub regional initiatives while also providing assurance to the Board that the DHB will continue to be able to provide services to agreed service coverage levels.

Internal and External Factors Impacting the DHB
As well as meeting the changing health needs of our population within a constrained funding envelope, there are a range of other external and internal factors that impact on the Wairarapa DHB and influence the decisions we make, including how we plan, fund and deliver health services on behalf of our population. These include:

- *New Zealand economy* – the tight financial environment means that the health sector is required to reduce its expenditure by controlling and containing costs and reconfiguring services to improve financial (and clinical) sustainability.
- *Public expectations* – greater expectations from the community about receiving better, sooner more convenient healthcare.
- *More informed public* – people are able to access a greater range of information about their health needs and have higher expectations of health professionals.
- *Sub regional and regional partnership*s – Government expects DHBs to cooperate and collaborate on the provision of services across the region. Wairarapa with its DHB neighbours is working in partnership to plan and fund for health services.
- *Aging population* – the population is aging and the Wairarapa has an older population compared to the rest of the country. Older people are greater consumers of health services and often have more complex long term needs.
- *Continued inequalities* – there are disparities in the health outcomes of Maori. Wairarapa has a growing Maori population which serves to increase health disparities in our district.
- *Growth in demand for all health services* – there is increasing demand on health services especially at our hospitals for acute and elective care challenging DHBs to look at better ways to manage long term conditions and the frail elderly to reduce demand on health services.
- *Aging workforce* – our health workforce is aging and we will need to work with national agencies and our DHB partners to support the development of our work force and new models of care that can incorporate new practices and make the best use of technology
- *Technology Advancements* – technology continues to rapidly advance and health services need to look for opportunities for greater integration and sharing of information through enabling IT solutions.

1.2.3 NATURE AND SCOPE OF FUNCTIONS

The DHB receives funding from the Government to enable it to fund and provide health and disability services to the people that live in the Wairarapa.

How we fund and provide services is overseen by the DHB's governance structure. The Board consists of eleven members and has overall responsibility for the operation of the Wairarapa DHB. Seven of the members are elected as part of the three-yearly local body election process. The Board has established a Māori partnership committee, Te Oranga o te Iwi Kainga, three statutory advisory committees and an audit and risk committee to assist it discharge its various responsibilities. The DHB's Clinical Board and the Alliance Leadership Team[2] provide clinical leadership and direction for the DHB.

We work within our allocated funding to "improve, promote, and protect" the health of the population within the district and to promote the independence of people with disabilities (as set out in section 23 of the NZPHD Act).

This requires the Wairarapa DHB to consider all needs and services including:
- prevention services
- early detection and management services
- intensive assessment and treatment services
- rehabilitation and support services.

[2] The Alliance Leadership Team provides a mechanism for the DHB to further cement the working relationship established between primary and secondary care providers in the Wairarapa.

It is the role of the Wairarapa DHB to consider how these services can be funded and provided to best meet the needs of the population. It is these four service groupings that comprise the different output classes used in our Statement of Forecast Service Performance (Module five).

The scale and scope of services we fund across each of these four output classes is influenced by the outcomes and priorities that the Government and the DHB want to achieve, as well as the Government's service coverage requirements and our assessment of the health needs within our community. Planning for health services is also influenced by National, Regional and Sub regional strategies and work programmes. For example the National Health IT Board has developed a strategy that is influencing DHBs investment decisions into IT infrastructure.

Whilst many of the services we fund are provided locally, many of the more specialist services are delivered by health providers outside the Wairarapa by our DHB partners.

Approximately half the services we fund are provided by the DHB's Provider Arm. The other half of the services funded by the Wairarapa DHB are delivered by service providers other than Wairarapa Hospital and community services, including local pharmacists, general practice, rest homes, non-government owned (NGO) providers and hospitals located in other districts.

Our Provider Role

The Wairarapa DHB provides health and disability services via its Provider Arm, Wairarapa Hospital and community services.

The services delivered include emergency services; specialist medical and surgical services delivered in inpatient, outpatient and community settings; maternity services; paediatric services; mental health services; radiology services; pharmacy services; allied health services; community nursing; and rehabilitation services.

The Wairarapa DHB's ownership of assets is less extensive than many other DHBs who own and operate assets in a variety of locations throughout their districts. The DHB's ownership of assets is limited to Wairarapa Hospital campus.

Our Funder Role

In addition to the funding the DHB makes available to its Provider Arm, the DHB also funds a range of other health and disability service providers to deliver services to the people of Wairarapa.

The DHB has service agreements with a range of providers for the delivery of primary health services, well child services, oral health services, Māori health services, community pharmacy and laboratory services, aged residential care services, home based support services, palliative care and hospital services delivered by DHBs other than the Wairarapa DHB. For instance, Capital and Coast, Hutt Valley, MidCentral and Auckland DHBs receive funding from the Wairarapa DHB to provide specialist services to the people of Wairarapa.

In funding these different services, the DHB must manage its share of the national funding allocation in a financially responsible manner. The DHB's share of this funding is determined by the Government based on the number of people living in our district, taking into account different population factors such as age, sex, ethnicity and levels of social deprivation and unmet need, as well as the extent to which our district is rural as opposed to urban. This formula makes up our Population Based Funding Formula (PBFF).

Although our population is declining, the increasing number of elderly people and Māori within our population means we will receive an increase in our funding in 2012/13 for demographic changes of $1.9m. We will also receive a contribution towards the cost pressures within the health system of $1.7m.

Funder Arm Allocation

In total the Wairarapa DHB expects to receive $116 million in 2012/13 from the Government as its share of the Crown health funding envelope to spend on health and disability services. This represents an increase of 3.23% or $3.6 million (cost pressure adjustor of $1.7 million and demographic adjustor of $1.9 million). The Funder Arm is also forecasting to receive a total of $5.7 million in year revenue from other sources in 2012/13. This includes other funding from the Ministry or other agencies for use on specific services and activities.

How we allocate this funding amongst our different services providers each year is a critical decision for the DHB. In 2012/13, the DHB plans to allocate a total of $54.9 million to services provided by its Provider Arm and to its governance function. Of note for 2012/13 are new facility costs of $444k to move staff out of earthquake prone buildings and HBL costs of $250k associated with agreed change management programmes. Revenue to the provider arm has also reduced by $550k as the result of Kiwisaver changes. The DHB will allocate $70.9 million to services delivered by providers other than its Provider Arm. This includes payments of $22.2 million (inflows of $3.4m and outflows of $25.6m) that the DHB expects to make for inter district flows.

The DHB has committed resources in 2012/13 to the range of new initiatives and headline priorities announced by the Minister as part of the 2012/13 planning package. Initiatives that will be implemented in 2012/13 include;

- extending zero fees for Primary Care for children under 6 to after-hours care
- providing support for Child and Adolescent Mental Health Services as part of the new package announced by the Prime Minister
- implementing the faster cancer treatment initiative funding multidisciplinary meetings for all main tumour types
- Supporting smarter investment in home care for older people, including a stronger focus on home support services after hospital discharge
- Encouraging greater use of the wider primary care team such as nurse and pharmacy led care
- Providing an increase in the Aged Residential Care subsidy for bed day price and for further improvements in the treatment of dementia.

Detail on each of these initiatives is included in the priority tables outlined in module 3 of the Annual Plan.

These allocations (and assumptions underpinning these allocations) are detailed in Table one below

Table 1: Funder Arm expenditure allocation

Expenditure category	2011/12 Budget	2011/12 Forecast	2012/13	Comments
	$million	$million	$million	
Provider and Governance	53.9	53.9	54.9	Demographic and cost pressure adjustor applied. Ambulance service now outsourced.
Pharmaceuticals	11.9	12.2	11.5	Share of reduced national community pharmaceuticals budget and impact of proposed new national pharmacy contract
Other demand driven primary care items	0.6	0.6	0.6	1.5% Cost Pressure Adjustment
Net Services purchased from other DHBs (Net IDFs)	21.7	21.7	22.2	Per Funding Envelope $25.6m outflows less $3.4m inflows; less $0.3m repatriated outflows, plus provision for service wash-ups
DSS –aged residential care	11.7	11.2	11.7	Made up of $0.4m increase of 3.23% Demographic and Cost Pressure Adjustment offset by increase in super contribution of $0.4m which reduces cost to DHB. $0.5m increase in Aged Residential Care beds.
DSS – aged care – non residential	3.0	2.9	3.0	1.5% Cost Pressure Adjustment
Medlab Central	3.5	3.5	3.6	1.5% Cost Pressure Adjustment
Wairarapa PHO	8.9	9.0	9.5	1.5% Cost Pressure Adjustment and 1.73% Demographic Adjustment on capitated payments
NGO Providers	5.2	5.4	5.4	1.5% Cost Pressure Adjustment
Total Allocated by Funder	**120.4**	**120.4**	**122.4**	

MODULE 2: STRATEGIC DIRECTION

The Government's overarching policy objectives in healthcare are that New Zealanders lead longer, healthier, and more independent lives.

The DHB contributes to this overarching objective through the services it plans, funds and delivers. However, the actions of individuals, families, other agencies, local and central government, and our social and physical environment also influence achievement of this overarching objective.

Wairarapa DHB is responsible for working within its allocated resources to 'improve, promote and protect' the health of the population within the district and to promote the independence of people with disabilities as set out in the New Zealand Public Health and Disability Act 2000. This requires Wairarapa DHB to consider all needs and services including health promotion and prevention, early detection and management, intensive assessment and rehabilitation and support services.

The New Zealand Public Health and Disability Amendment Act 2010 also requires DHBs to prepare a Regional Services Plan (RSP) to outline how they will cooperate for regional service planning, funding and provision in order to improve the quality of care as well as reduce service vulnerability and cost. This plan is submitted separately by the Technical Advisory Service (TAS) of the central region DHBs.

2.1 DHB VISION

Well Wairarapa – Better Health for All (Wairarapa ora – Hauora pai mo te katoa).

To achieve better health for all, it is our mission 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.

To achieve our vision we developed a Clinical Services Action Plan (CSAP) in 2009[3] 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. A key focus of the plan is identifying how the DHB can move to a more integrated health system. This strategy is underpinned by our Triple Aim approach which identifies *three key aims* for the DHB while ensuring we keep the patient at the centre of all of our endeavors. These aims are outlined in figure 1:

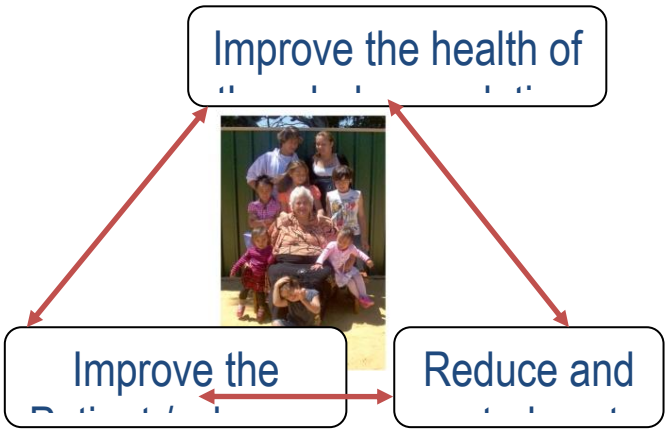


Figure 1: Triple Aim

[3] The Clinical Services Action Plan (CSAP) was a clinically led review of health services in the Wairarapa.

2.2 STRATEGIC OUTCOMES IN NATIONAL, REGIONAL & LOCAL CONTEXT

Our vision is informed and guided by Government priorities and expectations and the overarching objective that New Zealanders lead longer, healthier, and more independent lives.

New Zealanders lead longer, healthier and more independent lives

Building on this the Board has endorsed seven strategic outcomes which have been informed by the findings of our Health Needs Assessment, the CSAP and other national strategies and priorities. These are:

- Minimise the impact of chronic disease
- Children in the Wairarapa are safe and healthy
- Optimise quality of life for people with mental illness and addiction and their family or whānau
- Optimise quality of life for people with disabilities and their family or whānau
- Māori enjoy the same health gains as non-Māori
- People in the Wairarapa live longer, they are healthier and more able to live independently
- Health services are clinically and financially sustainable.

National strategies to achieve our vision

As well as a commitment to deliver on our CSAP and its Triple Aim, we are committed to meeting the *Minister of Health's Letter of Expectations*, which includes delivering better, sooner, more convenient health care, integrating primary care with other parts of the health system, shortening waiting times, delivering on the Government's six health targets, developing integrated services for older people, delivering on RSPs while demonstrating improvements in efficiency and cost containment through supporting and advancing the work of HBL, HWNZ and HQSC. These targets and priorities are summarised in Table 2 below and further discussed in module 3.

Table 2: 2012/13 Health Targets and Priorities

Health Target	Description
Shorter stays in emergency departments	95% of patients will be admitted, discharged or transferred from an Emergency Department within 6 hours
Improved access to elective services	The volume of elective surgery will be increased by at least 4000 discharges per year nationally. (Wairarapa's target will be the same as for 2011-12, which is 1841).
Shorter waits for cancer treatment	Everyone needing radiation or chemotherapy treatment will have this within four weeks.
Increased immunisation	85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90 percent by July 2014 and 95 percent by December 2014.
Better help for smokers to quit	95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. Within the target a specialised identified group will include: Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.
Better diabetes and cardiovascular services	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. DHBs are required to achieve at least 75 percent by 1 July 2013, and DHBs exceeding 75 percent are expected to be actively moving toward the 90 percent goal.
Government Priority	
Integrated care	• Service integration with primary care with a focus on integrated family health centres and enhanced multidisciplinary family health teams • Expanding zero fees in primary care for after hours GP visits for children under 6 • Greater use of the wider primary care team – expanding the role of nurses and pharmacy led care • Unplanned and urgent care • Long Term conditions • Better coordinated health and social services and the development of care pathways designed and supported by clinicians • Further integration of child and maternity services • Providing support for Child and Adolescent Mental Health Services (new expectations to be announced) and the Prime Minister's youth mental health project
Shorter waiting times	• Improved access to diagnostic tests • Shorter waits for cancer treatment health target • Expansion of the four week waiting time target for radiation treatment to include chemotherapy • Faster cancer treatment that takes a patient pathway approach with a focus on patients getting faster treatment from the time their cancer diagnosis is suspected • Implementing the faster cancer treatment initiative by funding multidisciplinary meetings (MDM) for all main cancer tumour types and increasing the number of cases discussed at MDMs • Shorter waits for child and youth drug and alcohol treatment
Health Targets	• Achieving the 6 health targets noting changes for implementation in 2012/13 • Joint planning with primary care networks for at least smoking, cardiovascular disease (CVD) and immunisation targets
Health of older people	• Develop integrated services for older people particularly after a hospital discharge • Improving stroke and dementia services • Supporting smarter investment home care for older people, including stronger focus on home support after hospital discharge • Wrap around services for older people and smarter investment in home care for older people, including a stronger focus on home support and hospital discharge • Provide an increase in aged residential care subsidy for bed day price, and for further improvements in dementia services, in particular, development of local pathways for diagnosis and treatment of dementia with primary and community care
Regional Integration	• Implement Regional Services Plans delivering on workforce, IT and capital objectives. • Support and advance the work of Health Benefits Limited, Health Workforce New Zealand and the Health and Safety Quality Commission
Living within our means	• Achieving financial targets • Significant productivity gains across services and organisations particularly hospitals
Cardiac Services	• Support the development of regional plans to ensure collective delivery of individual DHB cardiac surgery targets within agreed timeframes
Whanau Ora	• WDHB will contribute to the strategic change for whānau ora in the district through the promotion of Whānau ora ideology at internal and intersectoral forum

National Service Planning

A small group of services outlined in table 3 are also planned nationally, as their small size, retention of specialists, or critical mass make them vulnerable if they are not funded, planned and managed in a nationally co-ordinated way. These services will continue to be delivered by DHBs, but will be centrally led by the Ministry.

Table 3: National Services

National Services	
Clinical Genetics	Paediatric Oncology
Paediatric Pathology	Paediatric Gastroenterology
Paediatric Metabolic Services	Neurosurgery
Paediatric Cardiology	Major Trauma
Paediatric Cardiac Surgery	

National service planning will have a minimal impact on the DHB. This is because where these services are required for our population, they are already delivered by other providers. The DHB is not intending to provide any specific contribution to national services, other than by a proportionate financial contribution. National planning does not generate any specific strategic priorities for the Wairarapa DHB.

A work programme to develop National Services and National Service Improvement programmes was introduced by the National Health Board in 2010 aimed at improving equity of access, quality, consistency and sustainability for vulnerable services, particularly high cost low volume specialist services for example, paediatric and congenital cardiac services. Building on the DHB model, lead DHB providers were selected to be responsible for the provision and development of a national service, most of which were funded from "top slice". DHBs that were recipients of the service were expected to work collaboratively with the national service provider, supporting outreach clinic arrangements to improve access for their populations. National Service Improvement programmes require the commitment of clinicians and managers within DHBs across a designated service pathway to identify areas of opportunity and work together on interventions to improve equity of access, quality, consistency and sustainability nationwide.

Regional strategies to achieve our vision

Regional Services Plan

The Regional Services Plan (RSP) has been developed by the six Central Region's District Health Boards (DHBs) to provide an overarching framework for future planning, and sets the region's short and medium term priorities to 2016/17 and beyond. It builds on the Regional Clinical Services Plan (2008) and the 2011/12 Regional Service Plan (RSP).

Better integrated, more convenient and people centred services will provide a better experience for patients. These changes can also potentially decrease the demand for higher cost hospital based care, decrease the average cost per intervention and make better use of our specialist workforce and expensive technologies.

In alignment with our APs across the region and to provide options for achieving the Governments aims for the health and disability system in a sustainable way, we have identified the following seven strategic foci. These have been developed as follows:

1. **Service Models–** Designing services to meet individual needs which respond to demographic changes; particularly the ageing and increasing diversity of need and poorer health outcomes for Māori and pacific peoples will require new models of care which should drive investment in

workforce, capital and information. For example, investment in information systems such as shared electronic records, to enable improved coordination between primary care services.

2. **System/Service Integration –** Supporting health professionals, service providers and DHBs to better coordinate and integrate care, by placing patients and carers at the centre of service delivery, while reducing waste, harm and unjustified variation in the quality of care and service performance.

3. **Building a Workforce of the future -** We need to strengthen innovation, new ways of working and the development of sustainable workforces into the future. We will do this by ensuring workforce development enables sustainable service delivery. The regional focus includes health work force across the continuum of service delivery. The clinical workforce is the key agent in delivering better health care at the frontline and needs to be effectively engaged in designing and implementing change.

4. **Ensuring services are supported by appropriate infrastructure and enablers -**We operate in a challenging environment. The development of regional IT systems will enhance patient care by enabling clinicians from one DHB to have access to medical records from another DHB thus improving patient outcomes by quicker access to medical histories.

5. **Improving quality and safety across regional services -**We will improve the quality of services as a region. Central DHBs have adopted the Triple Aim which focuses on improving the design and coordination of care through population health management and by understanding how service cost and productivity can impact on the quality of a patient's experience.

6. **Promoting strong corporate and clinical governance -** Effective leadership ensures that the region is moving in the same direction and working collaboratively. For example the shift towards a regional planning approach and focus on establishment of a Regional Shared Service Organisation (RSSO).

7. **Increasing productivity whilst living within our means. -** Increasing our focus on proven preventative measures and earlier intervention. Incremental change to improve existing services is necessary, but is unlikely to be sufficient to meet the simultaneous challenges arising from the fiscal position and the changing needs of regions residents. New incentives, financial and non financial may be needed to deliver better performance.

Key Highlights for the 2012/13 Regional Services Plan

- Detailed action plans have been developed for the following service priority areas - cancer, cardiac, electives, health of older people (including stroke), radiology, and renal
- A continued focus remains on Mental Health and Addiction services, Māori Health, Renal Services, Population Health, sub regional work programmes and Quality and Safety
- Detailed action plans have been developed for four non clinical service priority areas or key enablers such as development of a regional shared service organisation (identifying its future focus), Central Region Information System, Workforce and Capital Asset Management
- Detailed action plans have been developed for the sub regional work programmes for the 3DHBs and CentralAlliance
- All action groups and networks continue to be clinically led
- Further alignment and integration of clinical services at both a regional and sub regional level builds on earlier work

- System integration opportunities with primary care partners at a local level and across the Central Region.

A 'whole of system' approach is being led by DHB clinicians and managers to integrate and transform the Central Region health system. The regional, sub-regional and local DHB work programmes for 2012/13 are being aligned with the strategic drivers and intentions set out above.

Table 4 summarises the action roadmap of Central Region DHBs over the next five years. The focus is to join up the region's clinicians, clinical systems and pathways to become a more regionally integrated health service. The roadmap has an implementation outcome focus.

Table 4: Central Region DHB Roadmap towards 2017 – our focus for 2012/13

	2012–13	2013-14
SERVICE MODELS AND INTEGRATION Designing new models of care which have a whole of system integrated approach	Integration • Whole of health continuum Integrated care strategy developed for four services • Common integrated clinical pathways including access to diagnostics developed for four services and implemented Electives • Collaborative action initiated to ensure the region meets the new ESPI compliance targets • Regional and sub-regional surgical acute /elective pathway flows are consulted upon and developed • Regional/ sub regional interim booking system in place for four services • Regional elective prioritisation criteria in place for four services • Common referral guidelines and access criteria developed four services • Reduce inequalities in access • DHBs meet health targets • Regional facility and capacity strategy developed Cardiac • Implement scoring tools for Acute Coronary Syndrome (ACS) Radiology • Regional Radiology referral guidelines and access criteria in place. Cancer • Implement national colonoscopy prioritisation tool • Discussion and planning for alignment of the regional cancer services commences • Regional plan developed for implementation of faster cancer treatment indicators 3DHB • Four sub regional services established Population Health • Move towards a regional approach to Public Health	Integration • Whole of system Integrated care strategy implementation commences for agreed next phase • One population and one system approach for service delivery and funding Electives • Regional elective waitlists in place • Regional electives services strategy implemented • Acute/ elective pathways are implemented • Regional electives prioritisation criteria in place for four more services • Commence implementation of 18 week elective pathway in four services Cancer • Regional cancer services fully aligned 3DHB • Further four sub regional services established
WORKFORCE Strengthen innovation, new ways of working and the development of sustainable workforces	• Within 3DHBs and centralAlliance all new Senior Medical Officers (SMO) are joint collaborative appointees • Regional work force strategy across whole of system developed • Integrated sub regional HR functions implemented • Continue to review roster arrangements for acute services sub regionally and regionally • A single regional Resident Medical Officer Unit consulted on and developed • Regional staff orientation and education programmes developed • Clinical skills passport developed to allow for a more mobile workforce • Commence discussion with workforce and unions re potential flexibility of work locations. • Programme Director for Regional training Hub in place • Increase in radiology registrar numbers	• Further review of roster arrangements for acute services • Regional elective management teams established • Regional training Hub facilitating professional workforce development • A single regional Resident Medical Officer Unit established • A single regional Senior Medical Officer Unit consulted on and developed • Standardised clinical policies and procedures are implemented
INFRASTRUCTURE & ENABLERS Supporting health professionals to better coordinate and integrate care	• 3DHB single planning and funding unit established • Integrated Regional Decision Support functions established • Strategy developed for a regional IT service • Business case prepared exploring regional laundry options • Investigate options for internal audit and sharing of food services CRISP • Local clinical work stations (CWS) implemented in Central Alliance • Local Patient Administration System (PAS) implemented in Central Alliance • Regional Picture Archiving & Communication System (PACS) developed and implemented • Regional Radiology Information System (RIS) developed • E referrals implemented across 3DHB region E Medicine • E medicine reconciliation commence rolled out • Plan for regional e prescribing • Sub regional executive team consultation commences.	CRISP • Regional clinical work stations (CWS) rolled out to all clinicians in the region • Regional Patient Administration System (PAS) archive rolled out • E referrals implemented across region • Regional Radiology Information System (RIS) implemented E medicine • Implement regional e prescribing • Plan e Medication Management Sub regional • Executive leadership team (including clinical leaders) for each sub regional grouping established
QUALITY & SAFETY Improving the quality of services as a region, reducing waste and harm	• Region works collaboratively on national initiatives e.g. falls, pressure areas, medicine reconciliation, hand hygiene • Regional adverse events framework developed • Adopt principle of zero tolerance for preventable patient harm regionally • Continue to standardise clinical policies and procedures • Regional SMO credentialing of further four services	• Regional framework for consumer involvement developed • Annual Consumer forum established • 3 year Regional Quality Plan developed • Implement regional adverse event management framework
GOVERNANCE Good leadership and governance ensures the sector is engaged and moving in the same direction.	• Regional Clinical Governance framework embedded • Māori participation in decision making at Regional governance level • Consumer participation in decision making at the Regional governance level • Commence discussion with Boards to review what sovereignty could be transferred to a regional governance entity centralAlliance • Increase number of reciprocal members on each DHBs clinical Board Regional Shared Services • Regional Shared Service Organisation established	• Greater alignment and integration of PHO and DHB Governance • Recommendations on sovereignty delegations re regional governance entity developed and implemented Regional Shared Services • Alignment of RSSO with Planning and Funding Services
FINANCE & PRODUCTIVITY	• Regional Asset ownership methodology agreed • Regional prioritized Capex Plan in place • Leveraging national buying power to reduce costs of goods and services. • Agreed regional payment schedule for services delivered by one DHB at another DHB's site in place	• Regional clinical service level costing commenced • Flexible funding models developed to support appropriate service delivery. • Consistent system approach for funding and monitoring of regional services in place • Regional IT service implemented • Regional Facilities Management programme developed
	← Equity of access	
	← Sustainability	
	← Consumer involvement	
	← Clinical Engagement	

2014-15	2015-16	2016-17
Integration • Continue to roll out whole of system integrated care strategy • Interdisciplinary teams provide networked health care to people with complex needs. Electives • Regional electives prioritisation criteria in place for all services • Implement 18 weeks pathway across all elective services	• Regional IT booking system in place	• Every consumer has a team based coordinated health care "home" • System integration has reduced waste, harm and unjustified variation in the quality of care • New models of care drive investment in workforce, capital and information Population Health • Reduced health inequalities
• Regional DHB multi-employer contract agreement(MECA) variations eliminated • A single regional Senior Medical Officer Unit established	• Regional HR directorate embedded	• Training initiatives and sub regional approach to workforce configuration result in sustainable services • Clinical workforce is the key agent in delivering better health care at the frontline.
• Health facilities are utilised in line with integrated services E Medicine • Roll out e Medication Management	E Medicine • E medication fully implemented across region CRISP • One patient portal available for all clinicians	• Sub regional centralised Patient administration established • Health Facilities rationalised across the region
• Regional framework for consumer involvement embedded • Regional standards for quality audits in place. • Culture of Zero tolerance for preventable patient harm and continuous quality improvement embedded	• Standardised regional open disclosure process fully embedded	• Improved quality and safety of services regionally
	• Streamline governance arrangements further to support regional service configuration • Regional Clinical and Corporate Governance integrated	• Effective leadership ensures the region is moving in the same direction
• Regional view of service costs • Reconfiguration/ rationalisation of health facilities to improve service efficiencies Electives • Standardised intervention rates across the region • Regional facilities management programme implemented.	• No regional debt and investment fund established • Investment strategic plan in place • Rationalisation of health facilities across the region completed Electives • Regional Budget hold for electives	• Region maintains s financial viability • Increased focus on preventative measures and earlier intervention

Sub Regional strategies to achieve our vision

A Shared Community

The Three District Health Board Health Services Development (3DHB HSD) programme is a collaborative programme between Hutt Valley, Wairarapa and Capital & Coast DHBs. The Sub-Regional Clinical Leadership Group (SRCLG) believe that by collaborating we can advance improvements in the quality of patient care, manage risk, improve processes, sustain our workforce and make the best use of our resources to a greater extent that working separately.

A whole of system approach that spans the health continuum will enable the greatest gain to the patient/whanau experience, population health and clinical / financial sustainability. This is consistent with the Triple Aim of improving the patient/ whanau experience and the health of the population whilst ensuring value for money and living within our means.

3D - Design and Development Principles

All future service development in the sub region will have the following themes:

1. The programme of work will be clinically led. Managerial support will enable the collaborative approach to be achieved.
2. The level of response for any particular action will be predetermined, e.g:
    a. National
    b. Regional
    c. Sub regional or
    d. Local responses.
3. Clinical pathways will be developed and implemented that take into account cultural, ethnic, gender and age specific needs.
4. Planning and implementation activity will actively consider how any action will impact on the 7 parameters of clinical quality (safe, responsive, efficient, effective, provided in continuity, equitable access, appropriate).
5. Services will be patient/whanau centred (not provider centred). Service users will be engaged in the development and design of services.
6. The inclusion of services that support peoples self management will be a desired outcome.
7. Clinicians supported by managers will lead the development, design and implementation of services, systems and processes.
8. A whole of health system approach will be taken that is cognisant of non-publicly funded health care provision, that has the community setting as the centre of health care provision and ensures that hospitals focus on what they are best placed to provide.
9. Delivery of services will be within available funding (including an allowance for future investment).
10. The design of services will enable a flexible and mobile workforce to provide care in keeping with the 7 parameters of quality, with the workforce moving to deliver services in the right place, in the right time.

The shared Vision and Principles mean that every decision is made within the context of the sub region. Table 5 refers.

Table 5: 3D Vision and Principles

Common functions: • Common models of care • Clear pathways across the health service continuum • Streamlined (reduced waiting and reduced duplication) • CRISP • Shared referral guidelines, and prioritisation, common access criteria	**Integrated Services**[4] • Single service that may be delivered from multiple sites • Services operate across the sub-region with service specific resources • Services have clear deliverables and quality expectations • Potential to review on-call arrangements	**Reconfigured Use of Facilities** As integrated services are developed distinct from facilities the configuration and utilisation of facilities would be considered by each service and as a whole
Integrated HR and workforce support • HR functions • Occupational health services • SMO / RMO units • Nurse resources • Allied health resources • Administration staff • Shared training • Single HRIS	**Integrated Funding** • Purpose designed funding mechanisms (not IDF default) • Has a common planning function with individual Board accountability for funding	**Integrated Quality and Risk frameworks** • One quality and risk management framework • Single credentialing system • Shared policies, procedures (clinical and corporate)

Integrated infrastructure (in addition to CRISP)
• One telecommunication function (e.g. 1 switch board)
• One shared knowledge management system
  ○ website,
  ○ intranet,
  ○ email
	Integrated planning processes and documents
	• One workforce plan
	• One Capital plan
	• One common Annual plan
	• One learning and development strategy
		Integrated NHB accountability frameworks
		• Shared health targets
		• Shared performance assessment targets

Progress to date

A range of joint initiatives, joint appointments and joint agreements have been implemented through the collaborative approach. The more substantive examples are outlined in table 6 below.

Table 6: Joint initiatives, agreements and appointments across the 3 DHBs

Joint initiatives	Joint Agreements	Joint Appointments
Payroll Services – HVDHB provides these to WDHB	HR review (3 DHBs)	Director of Allied Health, (HVDHB and WDHB)
Child Health and Gastroenterology Service Review	General surgery agreement (HVDHB and WDHB)	A joint Human Resources GM has been agreed between CCDHB and HVDHB, and the appointment process is underway
Obstetric and Gynaecologist and General Surgery clinics and surgery across HVDHB and WDHB	MOU agreed between the three DHBs for SMO appointments (subject to ASMS consultation). It includes agreement to implement joint SMO credentialing processes, and SMOs working sub regionally with opportunities to do elective lists or clinics within the 3 DHBs	An Allied Health Educator has been appointed between CCDHB and HVDHB, to support the Directors of Allied Health in both organisations
Sub-regional approach to Planning and Funding under consideration		
Joint sonographer service WDHB and HVDHB	Lab project (CCDHB and HVDHB)	Radiology registrar training position and start of shared after hours call (HVDHB and CCDHBs)

[4] Integrated services has been used generically in this table. This could mean single function across the 3 DHBs or other such combinations as best enables the vision and principles. This would be determined through employment consultation and clinical engagement.

Joint initiatives	Joint Agreements	Joint Appointments
ENT service review and implementation of initiatives such as: -Joint speech language therapy and ENT SMO clinics have started and are reducing waiting times and duplication of work -e Tree across all 3 DHBs enable staff to access patients details -Voice dictation in theatres is available in all theatres allowing surgical procedure to be available on Concerto and available on e Tree	Joint child health, ENT and gastroenterology steering group	Gastroenterologist employed by HVDHB and WDHB
	Hospital laboratory service project (CCDHB and HVDHB)	OH&S manager and clinical leader across HVDHB and CCDHB
	Common board chair and members (CCDHB and HVDHB)	Communications advisor across HVDHB and WDHB
Tilt table clinic (HVDHB and CCDHB)		
Palliative care opportunities are being explored		
Reduction of radiology wait list through utilisation of spare capacity (HVDHB for CCDHB)		

An ongoing programme of work will continue in 2012/13 including consideration of the optimal configuration of services across sites in our sub-region and how equitable access to services can be provided across the sub region. Sub regional priorities are outlined in module three.

Progressing whole of system integration – local strategies to achieve our vision

Clinical Services Action Plan - Better Sooner More Convenient Integrated Care

Local plans and strategies are also key to our success. The DHB has recognised since it developed its CSAP in 2009 and also its primary care business case Tihei Wairarapa in 2010 that progressing and advancing integration across the whole health system is key to achieving a more clinically and financially sustainable health system. As such Wairarapa DHB is well on the way to developing a more integrated approach.

The CSAP represents 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 reduce and control costs to put the Wairarapa DHB back onto a financially sustainable pathway whilst at the same time, improving the patient experience and the health of the whole population (our Triple Aim).

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

- Focus on individuals and whanau

Ensuring we have a consumer voice

Following a public call for expressions of interest, Wairarapa DHB has appointed nine consumer representatives to give their perspectives on health delivery in Wairarapa. They represent a cross section of the community and will provide a patient perspective on health services across the Wairarapa health system. They will be a resource for the DHB and the PHO providing the voice of the consumer to help us improve services, processes and health care development.

They represent a range of consumer perspectives from the older person to the young disabled and live in both rural and urban centers in the Wairarapa.

They will meet on an as-needed basis to discuss health care development and delivery and make suggestions about improving services for patients.

This is part of a quality initiative at Wairarapa DHB to improve, promote and protect the health status of Wairarapa people and the independent living of those with disabilities.

- Redesign and coordinate the patient journey
- Develop primary care services
- Reorganise and develop the workforce
- Implement public health intervention
- Control costs and maximise revenue.

We have recently assessed our progress against the CSAP and have identified that we have made good progress towards a more integrated approach, but that more work is needed to achieve the end point of an integrated health system with connected providers and patient centred care. Figure 2 refers.

Figure 2: Assessment of progress against the CSAP

(O = Provider)

2008 CSAP
Disconnected providers
Fragmented services
Provider focused

2012 Assessment
Fewer providers, increased connectivity across primary care; Electronic enablers assisting system integration; Increased sub-regional collaboration; Whanau focused yet to be achieved

The Future
Connected providers
Integrated services
Patient/whanau centred

The CSAP is inclusive of our current activity at a sub-regional and regional level. It highlights the need to work 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.

The Alliance Leadership Team (ALT), which includes clinical representation from across the Wairarapa health system, plays a pivotal role in helping the DHB make good progress against the six action areas in the CSAP and in progressing the outcomes identified in Tihei Wairarapa. In 2011-12, the DHB undertook a governance review of the Wairarapa Community PHO and the ALT and has identified an opportunity to strengthen our multi-partner approach to achieve whole of system clinical governance.

This development will include broadening the scope of the ALT to include whole of health system integration and reducing and streamlining the Governance arrangements between the DHB and its primary care partners. These changes are expected to strengthen the governance role of the ALT and drive progress in achieving Tihei Wairarapa.

Tihei Wairarapa

As part of implementing CSAP the DHB has worked in partnership with its primary care providers to implement Tihei Wairarapa which was the region's successful business case to provide better, sooner, more convenient integrated care. Tihei Wairarapa is strongly focussed on enhancing primary care services, better integrate primary and secondary services and give effect to the Government's expectation that primary health care in the Wairarapa is better, sooner and more convenient.

2012/13 will be year three of this programme of work and will be strongly focused on the implementation of new service models (guided model of care, integrated mental health model), patient pathways and key enablers such as the shared care record Manage My Health and the continued development of the Integrated Family Health Network (IFHN).

We anticipate that implementing Tihei Wairarapa will lead to:

- Reduced non-admitted self presentations to the hospital's emergency department,
- Reduced ambulatory sensitive (avoidable) hospital admissions
- Reduced medical and paediatric outpatient volumes
- Reduced spending on community pharmaceuticals
- Increased proportion of people over 85 living well in the community
- Improved performance in our Health Targets.

Te Huarahi Oranga-Māori Health Plan

The DHB is committed to reducing health inequalities and disparities and in 2010 developed in partnership with Te Oranga O Te Iwi Kainga, *Te Huarahi Oranga*, the DHBs Maori Health Plan. Te Huarahi Oranga -The pathway to wellness, is the name given to this plan and provides a context for understanding and implementing Māori health practice in the Wairarapa. It provides a strategic vision, proposes actions to improve Māori health gains and uses Māori strength based approaches within health service delivery. It includes actions for improving Māori health, many of which recognise that services need to be whānau-centred. Improving Māori health requires long term commitment and a concerted investment in the strengths of the whānau – hence the plan provides a pathway to wellness and a context for understanding and implementing Māori health practice in the Wairarapa.

Te Huarahi Oranga also highlights a need to focus on Māori who have the greatest need and the importance of leadership. Strong leadership, at a governance level and through Te Oranga O Te Iwi Kainga, is seen as another critical factor in ensuring that Māori health in the Wairarapa improves.

Te Huarahi Oranga recognises the importance of being able to measure whether we are achieving the very best outcomes for whānau. It includes a set of actions and performance measures grouped under three broad areas which together, will support our vision of vibrant, confident and strong whānau.

These three broad areas include:

- *Pouaro*: actions required to develop the workforce and culture of Wairarapa health organisations, and measures to assess how well providers integrate Māori world views, values and tikanga into their daily activities.
- *Poutokomanawa*: expectations for health providers as they deliver services across the four output classes – including measures to assess the effectiveness of promotion and screening services to keep Māori well and measures to assess the hands on work required to care for Māori when they have a long term condition and to heal them when they are unwell and are in need of support.
- *Poutuarongo*: activities required to support and enable health services to be more effective for individuals and whānau, including measures to assess the responsiveness and connectedness of health providers to the people they serve.

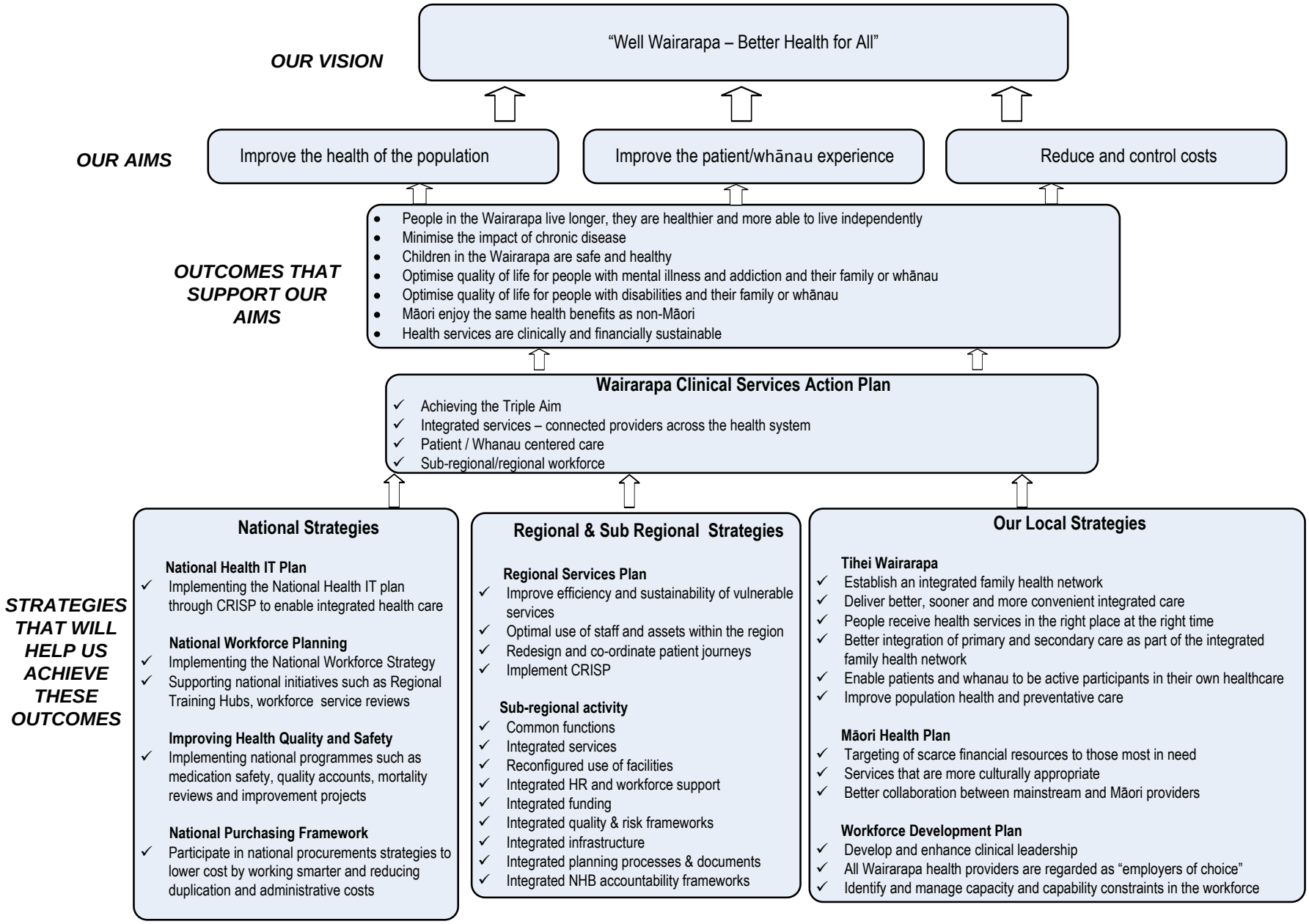
In 2011-12 the ALT conducted a review of current Whānau Ora services with the aim to ensure that integrated services are available to whānau using a Whānau Ora approach, and that barriers to

accessing essential primary care services are minimised. A range of opportunities were identified by the review to improve continuity of care and better targeting of services to those who would most benefit. Twenty two specific recommendations were presented in the report, grouped into two main categories; “Services to promote Whānau Ora” and “Increasing access to primary care for vulnerable groups”. The recommendations are specifically targeted towards whānau who require additional assistance to improve and maintain their health and wellbeing and to ensure all people are able to access coordinated primary care services delivered by the primary care team of their choice. It is expected that these recommendations will drive changes towards an approach which is;

- Whānau Centered
- Self empowering
- Coordinated
- Strengths based
- Integrated.

National, Regional and local Maori Health initiatives and actions have been collated and summarised into the Maori Health Plan for 2012/13. This plan is required by the Ministry of Health through the Operational Policy Framework and provides a framework for measuring a range of initiative aimed at reducing inequalities and improving Maori health gain. This plan draws on Te Huarahi Oranga.
How these different national, regional / sub regional and local plans contribute to the achievement of our overall vision, our Triple Aim and the seven high level strategic outcomes that we have also identified is reflected in Figure 3 below.

Figure 3: Strategy map



2.3 PLANNING, FUNDING AND DELIVERING SERVICES TO ACHIEVE OUR VISION

The way we plan, fund and deliver services is guided by our local, regional / sub regional plans and national strategies and the outcomes we are seeking to achieve. These strategies guide what we do and the services we fund. These strategies also influence how much funding the DHB decides to allocate across the four groups of health and disability services (known as output classes) that we purchase:

- health promotion and prevention services;
- early detection and management services which are usually delivered in a community setting;
- intensive assessment and treatment services which are usually delivered in a hospital setting;
- rehabilitation and support services which are provided in both community and hospital settings.

We place an emphasis on health promotion and prevention services and on primary health care as it is better placed/more appropriate to prevent problems at an early stage. If people do develop a long term chronic condition, it is more effective to manage these people in the community to avoid unnecessary hospital admissions.

To maintain people with long term chronic conditions in the community, general practice must have good access to diagnostic services (e.g. radiology and laboratory services) and responsive specialist advice. These services must also have the capacity and capability to manage people within the community if we are to avoid people coming to hospital for treatment.

The DHB intends to plan, fund and provide services that are relevant to our community, that are well co-ordinated and deliver best value for money, and which help us achieve our vision of *Well Wairarapa – Better Health for All*.

2.4 KEY IMPACTS AND MEASURES OF PERFORMANCE

Figure 4 provides a summary of how the DHB's seven high level strategic outcomes are aligned with the DHBs vision of a *Well Wairarapa – Better Health for All*. This table also outlines the anticipated impacts on the population and our service providers as a result of the DHB's interventions and actions and the high level performance measures and three year targets that the DHB will use to determine if it has been successful. In some cases, improvements in people's health and wellbeing are measured by macro indicators such as life expectancy and reduced mortality and morbidity from cancer and will only be able to be seen over time rather than within the space of the three years of this plan. The tables in module five provide further definition around these high level measures, and where appropriate, specify targets and output levels we will be seeking to achieve in the next year.

As part of its performance reporting, the Wairarapa DHB has developed a Balanced Score Card (BSC) for the organisation which provides a reporting framework against the DHBs key strategies such as Tihei Wairarapa, the Maori Health Plan and Government priorities such as health targets. The BSC is structured around the DHB's CSAP and four quadrants:

1. Patient/whānau experience and service outcomes
2. Organisational process and innovation
3. Learning and growth
4. Financials and productivity.

All of the BSC measures are monitored and reviewed by the Senior Leadership Team and BSC results are discussed and reviewed monthly with the Board and the various committees including Te Oranga O Te Iwi Kainga. The BSC is a key mechanism for the DHB to measure its performance and many of these measures are picked up in the Statement of Service Performance section in module five of this Annual Plan.

Figure 4: Wairarapa DHB Vision, aims, key impacts and high level measures of performance.

<table>
<tr><th>DHB Vision</th><th>DHB Aims</th><th>Strategic Outcomes</th><th>Impacts</th><th>High Level Measures of Performance</th><th>Targets (2012/13-2014/15)-</th></tr>
<tr><td rowspan="3">Well Wairarapa – Better Health for All

Wairarapa ora – Hauora pai mo te katoa</td><td rowspan="3">Improve the health of the whole population

Improve the patient/ whānau experience</td><td rowspan="3">People in the Wairarapa live longer, they are healthier and more able to live independently</td><td>People in the Wairarapa have confidence in their access to services to meet their health and disability needs</td><td>Life expectancy of people in the Wairarapa increases over time</td><td></td></tr>
<tr><td>People are smoking less
People are eating more healthily
People are more physically active
Minimise harm from alcohol and/or drug use
Fewer people develop a chronic disease</td><td>Increased numbers of patients get advice and help to quit smoking
  </td><td>Maintain 95% of hospitalised smokers provided with advice and support to quit
<table><tr><td>Baseline 2011</td><td>2011/12[5]</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr><tr><td>99.1%</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr></table>
Achieve 90% of patients seen in primary care who smoke provided with advice and support to quit
<table><tr><td>Baseline 2011</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr><tr><td>14.1%</td><td>90%</td><td>90%</td><td>90%</td><td>90%</td></tr></table></td></tr>
<tr><td>Primary health care is better, sooner and more convenient
People regard general practice as their “medical home”
Tihei Wairarapa achieves one virtual integrated family health model in the Wairarapa
Providers and consumers take steps to improve the use of pharmaceuticals</td><td>Reduce rates of:
• non-admitted self presentations to the hospital’s emergency department (ED)
• ambulatory sensitive (avoidable) hospital admissions (ASH)
• acute readmissions</td><td>Reduced number of non-admitted triage 4 and 5 ED self presentations:
<table><tr><td>Baseline 2011</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr><tr><td>8874</td><td>6,643</td><td>5,814</td><td>5,814</td><td>5814</td></tr></table>
Reduced Avoidable Hospital Admissions: Total
<table><tr><td>Age</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr><tr><td>0-4</td><td>98</td><td>117</td><td>111</td><td>106</td></tr><tr><td>45-64</td><td>110</td><td>95</td><td>95</td><td><95</td></tr><tr><td>0-74</td><td>111</td><td>110</td><td>106</td><td>104</td></tr></table>
NB Targets for the Maori population are recorded later in this table
Minimise acute readmission rate (readmitted within 28 days):
<table><tr><td>Baseline 2011</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr><tr><td>8.81</td><td>8.81</td><td>8.81</td><td>8.81</td><td>8.81</td></tr></table></td></tr>
<tr><td>People have access to high quality hospital services</td><td>Shorter wait times for elective services and cancer treatment
 
There is a reduction in reportable events and blood stream infections within Wairarapa Hospital
  </td><td>Reduce waiting times for radiation or chemotherapy treatment
<table><tr><td>Baseline 2011</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr><tr><td>< 4weeks</td><td><6weeks</td><td><4 weeks</td><td><4 weeks</td><td><4 weeks</td></tr></table>
Improving waiting times for diagnostic services:
• Coronary angiography
• CT and MRI
• Diagnostic colonoscopy
• Follow up colonoscopy
<table><tr><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr><tr><td>Establish baseline data</td><td colspan="2">Out year targets will set according to each procedure</td></tr></table></td></tr>
</table>

[5] Forecast performance for the 2011/12 year

	Reduce and control costs				Total number of elective surgical discharges provided Baseline 2011: 2060; 2011/12: 1841; 2012/13: 1841; 2013/14: 1841; 2014/15: 1841 Minimise acquired BSI (per quarter): Baseline 2011: 3.5; 2011/12: < 3.5; 2012/13: < 3.5; 2013/14: < 3.5; 2014/15: <3.2
		Minimise the impact of chronic disease	Reduce morbidity and mortality from cancer, diabetes and cardiovascular disease	People with high cardio-vascular risk are identified 	Increased percentage of people checked for cardio-vascular risk Baseline 2011: 63%; 2011/12: 60%; 2012/13: 75%; 2013/14: 80%; 2014/15: 90%
		Children in the Wairarapa are safe and healthy	Providers identify vulnerable children and intervene early to keep children healthy	Increase immunisation rates and reduce ASH rates among children  Improve breastfeeding rates in the district Audit scores for child and partner abuse	Immunisation: % two year olds fully vaccinated Baseline 2011: 93%; 2011/12: 95%; 2012/13: 95%; 2013/14: 95%; 2014/15: 95% Immunisation: % 8 months old babies fully vaccinated Baseline 2011: new; 2011/12: new; 2012/13: 85%; 2013/14: 95%; 2014/15: 95% Breastfeeding rates of babies at six weeks Baseline 2011: 67%; 2011/12: >74%; 2012/13: 74%; 2013/14: 75%; 2014/15: 76% Breastfeeding rates of babies at three months Baseline 2011: 55%; 2011/12: 57%; 2012/13: 57%; 2013/14: 58%; 2014/15: 59% Breastfeeding rates of babies at six months Baseline 2011: 25%; 2011/12: 26%; 2012/13: 27%; 2013/14: 28%; 2014/15: 29% Audit scores for child and partner abuse Baseline 2011: 166/200; 2011/12: 140/200; 2012/13: 170/200; 2013/14: 160/200; 2014/15: 170/200
		Optimise quality of life for people with mental illness and addiction and their family or whānau	Reduce the negative impact of severe mental illness for people who live with this condition	People have up-to-date crisis prevention plans and improved access to mental health services	% of long term service users who have up to date prevention plans Baseline 2011: 96%; 2011/12: 97%; 2012/13: 97%; 2013/14: 97%; 2014/15: 97% % of adults accessing mental health and addiction services Baseline 2011: 4.28%; 2011/12: 4.5%; 2012/13: 4.8%; 2013/14: 5.0%; 2014/15: 5.5% % of people under 19 years accessing mental health and addiction services Baseline 2011: 4.34%; 2011/12: 4.5%; 2012/13: 4.8%; 2013/14: 5.0%; 2014/15: 5.5%
		Māori enjoy the same health gains as non-Māori	Māori can easily access health and disability services More Māori access population health screening and early intervention programmes	Māori with high cardio-vascular risk are identified 	Increased percentage of Maori people checked for cardio-vascular risk Baseline 201: 63%; 2011/12: 60%; 2012/13: 75%; 2013/14: 80%; 2014/15: 90%

<table>
<tr><td rowspan="4"></td><td rowspan="4"></td><td rowspan="4"></td><td></td><td>Reduce Māori ASH rates

Increase the percentage of high needs women aged 20 – 69 screened for cervical cancer in the last 3 years</td><td>Reduced Avoidable Hospital Admissions: Māori:
Increased % of Maori women aged between 20 – 69 screened for cervical cancer in the past 3 years
<table>
<tr><td>Baseline 2011</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr>
<tr><td>74.06%</td><td>74%</td><td>≥75%</td><td>≥75%</td><td>≥75%</td></tr>
</table></td></tr>
<tr><td rowspan="3">Health services are clinically and financially sustainable</td><td>Improve integration of primary and secondary care
Hospital specialists work with primary care and community services to better manage patients with acute, complex or long term conditions</td><td>Percentage of population covered by shared care record across Wairarapa Health Services</td><td>
<table>
<tr><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr>
<tr><td>75%</td><td>85%</td><td>100%</td><td>100%</td></tr>
</table></td></tr>
<tr><td>Patients are satisfied with health services
Services have strong clinical leadership
Within the hospital, tasks are allocated to maximise use of skilled workforce
The hospital improves its capacity planning</td><td>Increase service d productivity while managing cost of service delivery. Measured by
• Length of stays in ED
• Average length of inpatient stay
• Theatre utilisation
 
</td><td>% of patients admitted, discharged or transferred from ED within 6 hours
<table>
<tr><td>Baseline 2011</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr>
<tr><td>98%</td><td>>95%</td><td>>95%</td><td>>95%</td><td>>95%</td></tr>
</table>
Optimise ALOS for acute inpatients (days)
<table>
<tr><td>Baseline 2011</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr>
<tr><td>3.81</td><td>3.81</td><td>3.81</td><td>3.81</td><td>3.81</td></tr>
</table>
Maximise theatre utilisation (resourced hours)
<table>
<tr><td>Baseline 2011</td><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr>
<tr><td>85%</td><td>85%</td><td>85%</td><td>85%</td><td>85%</td></tr>
</table></td></tr>
<tr><td>Wairarapa DHB works with other DHBs to ensure improved efficiency and sustainability of vulnerable services
Cross DHB boundary clinical networks and service delivery models make optimal use of staff and capital assets
Wairarapa DHB ensures referrals to other DHBs are appropriate</td><td>Single service approaches for:
• ENT
• Child Health
• Gastroenterology
Will be considered by the Sub Regional Clinical Leadership Group and recommendations forwarded to each Board</td><td></td></tr>
</table>

2.5 KEY RISKS AND OPPORTUNITIES

The nature and complexity of the DHB's activities and services mean that it is exposed to a wide variety of risks. The DHB faces two types of risks- those we can manage by our self – those internal to the DHB – and external risks that fall more broadly across the sector as a whole. We can only manage these external risks by working jointly with other DHBs and the Ministry. Some of these internal and external factors have already been referenced in section 1.2.2.

The most significant risks facing the Wairarapa DHB going into 2012/13 and the DHBs mitigation strategies are shown in Table 7.

Table 7: Risks and Mitigation

External Risks	Mitigation
Impact of the economic climate and the Christchurch earthquake	Continued implementation of the DHB's efficiency programme to ensure the DHB lives within its means. Implementation of national initiatives through HBL to reduce duplication and waste while increasing productivity.
Growth in demand for health services	Develop integrated models of care that promote primary care as the medical home and encourage preventative strategies and self management.
Growth in health services out of the region (Inter District Flows)	Implement the 3D work programme - common functions, integrated services (including human resources, workforce and funding) and combined quality and risk frameworks across the sub region with Capital & Coast and Hutt Valley DHB.
Ageing Population	Continued investment in services for older people that allow older people to stay well and live in their own environment e.g. support to live at home programme, investment into Home Based Support Services to maintain people in their own homes, improved management of long term conditions through the Guided Model of Care.
Unsustainable growth in community pharmacy dispensing fees	Work with national DHB agents to implement new service and funding models to control and contain costs.
High incidence of youth suicides	Continued implementation of suicide prevention work programme through the Suicide Prevention Coordinator with a focus on coordinated multi sectoral response, involvement of CASA and other support agencies and continued positive use of the media to support key community messages.
Internal Risks	
Achieving our financial targets	Implement planned efficiency programme for 2012/13 and national initiatives through HBL to control and contain costs. Progress sub regional work programme to review health services and opportunities for service integration and sharing of resources (work force and capital).
Patient harm	Continued focus on implementing HQSC initiatives to reduce patient harm and injury. Reporting of all reportable events, MDT incident management review process, identification of trends, education targeted at key areas for improvement, implementation of strategies for early identification of deteriorating patients.
Work force shortages	Develop critical mass for vulnerable services staffing through sub regional relationship development and department integration where viable. Implement retention strategies and succession planning.
Seismic risk to hospital and associated facilities	Contingency plan to relocate staff from affected buildings, decant staff into compliant buildings, building strengthening where appropriate, develop new facilities where appropriate e.g. facilities and stores.
Insufficient funding for devolved disability services	Work with FOCUS (needs assessment agency) to reassess patient needs and review packages of care.

Managing these risks

Wairarapa DHB actively manages a wide range of risks across the range of health services that it provides. The DHB actively manages risks through the Senior Leadership Team and the Audit and Risk Committee where risks are regularly reported and mitigation and management strategies discussed and managed.

A key risk for the DHB is that in 2012/13 the DHB will continue to operate in an environment where the costs of service provision are higher than the revenues we receive. Our Annual Plan includes a planned deficit of $3.1M in 2012/13, with breakeven results in 2013/14 and 2014/15. Achieving improved financial performance over the three year plan is reliant on actions at a national, regional, sub-regional and local level. However, various benchmarking exercises already indicate that the Wairarapa DHB is relatively efficient, reflecting the significant efficiency gains that have already been made internally across the organisation[6]. Therefore, we are looking to collaborative efforts at a sub-regional level with Hutt Valley and Capital & Coast DHBs as the major source of gains in out years and will also be looking for efficiencies and opportunities to reduce costs through initiatives flowing from national agencies such as HBL and HWNZ.

Work on a 'Three DHB Health Services Development Programme' and agreement on any changes is well advanced and specific projects and actions are outlined in Module 3. We have identified sub regional opportunities and costs savings which have been included in our financial position and assumptions, and have been agreed with our partners- Capital and Coast and Hutt Valley DHBs.
It is anticipated that Tihei Wairarapa will deliver a range of benefits for our population and providers. We expect Tihei Wairarapa will deliver improved patient/whānau experience and population health outcomes resulting from improvements to models of care and patient pathways. From a hospital perspective, Tihei Wairarapa will also deliver reduced emergency department (ED) presentations and reduced Ambulatory Sensitive Hospital (ASH) admissions. However, these gains principally enable additional costs to be avoided. Tihei Wairarapa will help the DHB manage future cost growth by reducing the need to deliver more services within the hospital setting in future years.

[6] Efficiency programmes over the past three years have delivered $6.5M in efficiencies -2009/10 planned $4.65M (achieved $4.0M), 2010/11 planned $2.35M (achieved $.871M), 2011/12 planned $1.67M (forecast $1.67M).

MODULE 3: DELIVERING ON PRIORITIES & TARGETS

3.1. IMPLEMENTING GOVERNMENT PRIORITIES

Our vision and strategic direction is informed and guided by the Minister of Health's expectations, priorities and targets and the overarching Government objective that New Zealanders lead longer, healthier, and more independent lives.

The Minister of Health's Letter of Expectations identifies a continued emphasis on better, sooner, more convenient health care and lifting health outcomes for patients within constrained funding increases. The Minister wants DHBs to focus strongly on service integration, particularly through broadening the scope and pace of primary care integration. Key areas of focus for greater integration include:

- integrated family health centers
- primary care direct referrals to diagnostics and
- clinical pathway development involving community and hospital clinicians.

The Minister expects annual plans to illustrate how integration between community and secondary hospital services will be used to drive delivery and improve performance in three areas:

- Unplanned and urgent care
- Long term conditions and
- Wrap around services for older people.

There is also continued focus on shorter waiting times, achieving the six health targets, developing integrated services for older people and progressing regional integration.

How we plan to deliver on each of the Minister of Health's key expectations and health targets is outlined in the following tables. The first five tables detail how we will make progress against the Minister's health priorities:

- Service integration – Primary care development and delivery
- Child and Youth Mental Health
- Cardiac Services
- Whanau Ora
- Living within our means
- Health of Older People.

The next seven tables detail how we will make progress against the Minister'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.

- Child and maternal health.

These tables include how we intend to measure our progress against the Minister's priorities and health targets. Our intention is to capture data to assess progress against the various performance measures for Māori as well as the total population.

In delivering against the Minister's key expectations and health targets, we will also be giving affect to our seven strategic outcomes. Where relevant, the tables below identify how delivering on the Minister's expectations and targets will also contribute to achievement of our strategic outcomes which are identified in Module Two.

Service Integration -Primary Care Development and Delivery

Better Sooner More Convenient Health Services for all New Zealander from a holistic primary care perspective means: A better patient (and whanau) experience – patient Improved access to more services delivered within local community/primary care settings			Clinical integration of services across the whole system Efficient, effective and sustainable health system Reduced waiting times for health services	
A primary care system that functions well is one that: Provides accessible and affordable first point of contact services for all New Zealanders Is integrated to deliver services that are provided in the right place by the right person			Is sustainable in the dimensions of workforce, capacity and infrastructure	
2012/13	**Key planning approaches**	**Actions to deliver improved performance**	**Measured by**	**High level systems outcomes**
Primary Care Development & Delivery: *Effective partnerships, joint implementation and whole of system view*	The planned activities reflect the DHBs priority to progress service integration across the sector where this is expected to deliver better, sooner, more convenient care and support the DHB's CSAP and triple aim. The planning approach is via the Tihei Wairarapa Programme overseen by the ALT. Utilise demographic and clinical data to identify those patients at most at risk or who are poorly managed or at risk of complications who would benefit from a targeted primary care response.	**PRIMARY CARE DEVELOPMENT** To deliver on the agreed Year 3 implementation plan, and accelerate the progression of integrated care across the sector, the DHB will: • put in place streamlined governance arrangements to oversee integrated service developments and delivery • ensure that streamlined clinical governance arrangements support quality care across the sector • provide management support and guidance for service integration, including the appointment of a programme director • accelerate and embed collaborative data analysis across providers to monitor progress, better understand patient flows and establish priorities for integrated service development • enhance connectivity of information across providers including further development of the shared electronic patient record • supporting and further developing service level alliances for the development, implementation and monitoring to integrated service provision • further develop joint MDT processes for patients with complex needs including aged care, long term conditions, mental health, child health and whanau ora • coordinate workforce development programmes across providers. • Support the continued development of the Integrated Family Health Network across Wairarapa • Practices recruit patients to the Guided Model of care who would most benefit targeted intervention – including diabetes care improvement package. • Fully implement the clinical pathways for diabetes, respiratory, frail elderly and cardiovascular disease.	**PRIMARY CARE DEVELOPMENT** As in previous years WDHB will identify progress against key milestones for each of the actions to be delivered in 2012/13 as agreed in the ALT Year 3 implementation plans. A sample of these include: -Streamlined governance arrangements in place (Q2) -Plan and process in place for the sharing of appropriate clinical information collated through Concerto to primary care (Q2) -Process for sustainable MDT forums for aged care identified and implemented and aligned with the frailty pathway (Q3) -Establish a whole of health system approach and plan to continuing professional development (Q4) Plan and implement a technology solution that supports an integrated comprehensive assessment tool for guided care (Q3) Clinical pathways for diabetes, respiratory, frail elderly and cardiovascular disease fully implemented (Q4)	A more unified and improved health and disability system. People receive better health and disability services.

<table>
<tr><th>2012/13 Areas of focus</th><th>Key planning approaches</th><th>Actions to deliver improved performance</th><th>Measured by</th><th>High level systems outcomes</th></tr>
<tr>
<td>Primary Care Development & Delivery: Effective partnerships, joint planning and whole of system view</td>
<td>Consolidate the third year of the Tihei Wairarapa work programme imbedding new service models, pathways and enablers such as the shared care record across the Wairarapa health system.

Work programmes include:

• Long Term Conditions
• Acute Care
• Frail Elderly
• Mental Health
• Pharmacy initiatives</td>
<td>PRIMARY CARE DELIVERY
The priority for 2012/13 will be the completion of the initial Tihei work programme, including:
• Full implementation of guided care across practices, hospital and community services for people with long term conditions
• Embed and monitor LTC pathways developed in year 2
• Implementation of the diabetes guided care programme
• Complete implementation of a pathway of care for frail elderly
• Embed new mental health services in primary care
• Continue to progress the IFHN across Wairarapa, enhancing the existing range of services co-located with general practices, increasing access to primary care records and continuing to progress options for DHB/ primary care service integration (including facility development where indicated).
• Establish whanau ora navigators and implement whanau ora pathways
• Continue the ED High User MDT with members across the health spectrum. This group will coordinate individual case management for patients..
• Establish care pathways for community access to radiology.
• Develop common protocols for the management of skin infections across the health system.
• Estsablish protocols for second and subsequent clexaine treatment in primary care.
•
During 2012/13 the DHB will support the ALT in identifying future priorities for service integration and CSAP implementation. The intended planning approach includes:
• Collaborative data analysis to identify opportunities for improving service integration
• Clinician led clinical pathway development
• Stream-lining existing advisory and working groups into functional service level alliances
• Enhancement of MDT processes to coordinate care
• Further develop the Shared Care Record to enhance patient care across providers.
Identification of system wide performance indicators which will be monitored by ALT. The DHB will work with the PHO and the Wairarapa After Hours Service to ensure that by 1 July 2012 100% of children under 6 will be able to access free after hours care. On-going access to free after hours care for children under six will be maintained through contracting arrangements including a commitment to monitor and fund any volume growth and, a collaborative communications strategy.</td>
<td>PRIMARY CARE DELIVERY
As in previous years WDHB will identify progress against key milestones for each of the actions to be delivered in 2012/13 as agreed in the ALT Year 3 implementation plans. A sample of these include:

- Up to 2000 patients (targeted cohort) are enrolled into the funded Guided Care programme (Q3).
- Implement the diabetes Guided Care programme including diabetes improvement packages (Q3)
- Implement a relevant model of care / access pathways for child and youth mental heath and addiction service s (Q3)
- Whanau ora navigators are employed and pathways implemented (Q2)
- Managment of skin infection protocols added to established clinical pathways (Q2)

Deliver Health Targets:
- 85% of 8 month olds are fully immunised.
- 90% of smokers seen in primary care are given advice.
- 75% of eligible people will have had a CVD check completed in the last 5 years.

Deliver against Tihei Aspirational Target:
- Reduce the number of ash admissions by 15% over 2009/10 levels (80 per month by 30 June 2013).
- Reduce Triage 4 and 5 non-admitted ED attendances over 2009/10 levels by 30% (5,814 2012/13)
- Reduce the community pharmacy spend by $750,000 (by 30 June 2013). Target for 2012-13 is $13.1M.
- Increase the percentage of the 85+ population who are living well in the community to 81% by June 2013.

Manage Acute Demand:
- Agreed plan to move avoidable attendance presentation in ED in place and communicated whole of sector (Q2)
Maintain or reduce acute hospital bed days at current levels - ≤20,000.
<table>
<tr><td>Baseline</td><td>2009/10</td><td>2010/11</td><td>2011/12 FC</td><td>2012/13</td></tr>
<tr><td>Acute bed days</td><td>18,674</td><td>19,856</td><td>19,379</td><td>≤20,000</td></tr>
</table>
Maintain or reduce acute admissions below 5,500.
<table>
<tr><td>Baseline</td><td>2009/10</td><td>2010/11</td><td>2011/12 FC</td><td>2012/13</td></tr>
<tr><td>Acute admissions</td><td>5503</td><td>5467</td><td>5477</td><td>5,500</td></tr>
</table>
- Agreed plan to move avoidable attendance presentation in ED in place and communicated whole of sector (Q2)
- Coverage for free after hours care for children under 6 years (Q1).</td>
<td></td>
</tr>
</table>

Child and Youth Mental Health and Addiction Services

Better, Sooner and more Convenient for child and youth mental health and addiction services means Early intervention recovery focused services.

A health system that functions well for child and youth mental health and addiction services is one that is responsive and addresses inequalities with a particular focus on Māori through:

- building resilience
- being recovery focused
- supporting self management
- early intervention
- integrated services

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Child and youth mental health and addiction services	The DHB will ensure that young people with mental health and addiction issues have easy access to assessment, treatment and support. The DHB will maintain a high level of focus on reducing the risks of self harm and suicide across its younger population Appropriate clinical governance structure that aligns with service alliance groups including NGO, PHO and DHB participation will be established to ensure integrated decision making and service establishment and delivery.	Undertake a review of child and youth mental health and addictions services to develop an integrated service model that places the needs of the young person at the centre of all endeavours. This will include investigating the best possible journey for young people that includes : • The principles of the Choice & Partnership Approach (CAPA) • Development of pathways that improve the integration of all services including school guidance services, school based health services, paediatric services, CAHMS and the NGO provided addiction services • Understands the drivers behind young people identified as 'frequent flyers' in the Hospital Emergency Department • Assessments associated with the diagnosis of Behavioural Disorders • The delivery of mental health services for young people identified through the Gateway Assessment process • A review of resources required to implement the service model including: o Application of new resources associated with the Child and Youth Services Gateway initiative and reallocated Community Pharmaceutical Budgets o The co-location of mental health /AOD youth health clinics and hours of operating o Continue to integrate Alcohol and Other Drug competencies into child and adolescent mental health workforce development programmes. CAMHS will be an active participant in the Wairarapa multi agency Postvention Suicide Group to ensure responsive and holistic service provision and follow up for young people identified at risk of suicide. The Child & Youth Mortality Review Group established in the last quarter of 2011/12 will review suicides of young people up to 24 years of age and identify systemic and service delivery issues that require action.	Continue to increase access rates to Child and Youth Mental Health and Addictions Services. PP6: Improve the health status of people with severe mental illness: Age 0-19: Māori 4.5%; Total 4.5% PP8: shorter waits for non-urgent mental health and addictions services: Age 0-19: 80% of referrals are seen within 3 weeks 95% of referrals are seen within 8 weeks	A more unified and improved health and disability system for high needs children and youth Children and youth receive a better and more convenient health and disability service. Good health and independence are protected and promoted.

Cardiac Services

Better Sooner More Convenient Health Services for New Zealanders in relation to cardiac services means improved and more timely access to cardiac services				
A health system that functions well for Cardiac Services is one that is: • increasing cardiac surgery discharges • improving access to cardiac diagnostics and specialist assessment • reducing waiting times for people requiring cardiac services • improving prioritisation and selection of patients selected for cardiac intervention				
2012/13 Areas of focus	**Key planning approaches**	**Actions to deliver improved performance**	**Measured by**	**High level systems outcomes**
Cardiac services will help New Zealanders to live longer, healthier and more independent lives.	We will support development of regional plans to ensure collective delivery of individual DHB cardiac surgery targets within agreed timeframes. Standard intervention rates will be used to support equity of access.	The National Cardiac Clinical Network will identify and agree cardiac surgery targets with DHBs which will improve equity of access. Referral processes will be established and appropriately refer patients for cardiac services. Improved access to cardiac diagnostics that facilitates appropriate treatment referrals. Regional plans will be developed (within allocated funding) and implemented for the provision of cardiac services including surgery, percutaneous revascularisation and coronary angioplasty. The number of people waiting for cardiac surgery will be managed so that waiting times are reduced, and no patients wait longer than agreed timeframes for first specialist assessment, diagnostics or treatment. Clinical leadership and involvement in the management of patient pathways in order to reduce waiting times and improve outcomes.	We aim to provide a minimum of 34 cardiac surgery discharges for Wairarapa people in 2012/13. 85 percent of Wairarapa people will receive elective coronary angiograms within 90 days, and no patient will wait longer than six months. Refer Appendix 8.1Measure SI4 Elective services standardised intervention rates. Regional Production plans will be developed for cardiac surgery. The regional plan will deliver 521 cardiac surgery procedures. Population access to the following conditions will not be statistically below the following agreed rates: • Cardiac Surgery: 6.5 per 10,000 of population • Percutaneous revascularisation: 11.9 per 10,000 of population • Coronary angioplasty> 32.3 per 10,000 of population • Patients will wait no more than 6 months for first specialist assessment in cardiothoracic and cardiology services from July 2012. The waiting time will reduce to no more than 5 months by the end of June 2013. • Patients will wait no more than six months for elective surgery from July 2012. The waiting time will reduce to no more than 5 months by the end of June 2013.	Patients with suspected ACS receive seamless co-ordinated care across the clinical pathway. More people receive better and timelier access to cardiac services which supports New Zealanders to live longer, healthier and more independent lives. People receive better health and disability services. The health and disability system and services are trusted and can be used with confidence.

Whanau Ora

Better Sooner More Convenient Health Services for New Zealanders in relation to Whānau Ora means supporting inter-connectedness				
A health system that functions well for Whānau Ora is one that: uses the opportunity to improve service delivery and build mature providers			• requires the health sector to work in a more seamless way with other parts of the social sector and expects improved outcomes and results for New Zealand families	
2012/13 Areas of focus	**Key planning approaches**	**Actions to deliver improved performance**	**Measured by**	**High level systems outcomes**
Delivery on Whānau Ora	**Te Huarahi Oranga** – The Wairarapa DHB Maori Health Plan is structured using three pou. Under Poutokomanawa there are specific actions for progressing Maori health governance, health service development and health system connectedness. The underlying principle is that the DHB will work with Maori communities to develop local infrastructure that supports the delivery of health initiatives in those communities. **The Wairarapa Whānau Ora Collective** – Wairarapa DHB is committed to supporting the ongoing development of the Wairarapa Whānau Ora Collective infrastructure (national Te Puni Kokiri led Whanua Ora initiative)and will provide structural support and assistance where possible through promoting Whānau ora idealogy, increasing intersectoral structures, progressing health system enablers for whānau centred service approach and integrated contracts. **Review of Whānau Ora Service Provision** – Wairarapa DHB completed a review of whānau ora services early 2012. The key principles used to determine whānau ora priorities are: Integrated and coordinated services, whānau centred / self empowering, strength based & outcome focused.	• Wairarapa DHB will contribute to the strategic change for whānau ora in the district through the promotion of Whānau ora ideology at internal and intersectoral forum. • Wairarapa DHB in communication with the Whanau Ora Collective will determine the intersectoral structures and processes required to best support their Whānau Ora service delivery model and identify and progress health system enablers to progress whānau ora service delivery e.g. funding mechanisms, workforce roles, IT support systems etc. • Wairarapa DHB will continue to utilise the Whanau Ora Leadership group to advise on whānau ora service development across the health service provision continuum. • Whānau Ora service assessment and care planning methods are further developed and agreed by the Tihei Wairarapa Whānau Ora Leadership Group and are consistent with both the Wairarapa Whānau Ora Collective model and Tihei Wairarapa Guided Care model. • Whānau Ora Services will assist whānau to be responsible for their own health by increasing people's knowledge and understanding of their health (Health Literacy). Health literacy and whānau ora ideology training sessions implemented. • Kia Rite Kia Ora'- whānau centred Innovation being delivered through Wairarapa Maori health provider Whaiora' is embedded and the learning from the evaluation utilized to further develop and enhance whānau ora service delivery.	The Whanau Ora Collective will be promoted across existing intersectoral forum and training on whanau ora practice delivered to 3 intersectoral forum, 4 Trainings provided in primary care /General practice/ secondary care settings. Improved integration and linkages across the health care continuum will be measured through the Tihei Wairarapa Whanau Ora Leadership Group's monitoring framework established to measure progress against the whanau ora recommendations following the review. A monitoring framework highlighting specific actions for progressing the 22 review recommendations is being developed and progress against these recommendations will be measured quarterly. A common Whanau Ora service Assessment tool will be developed and in use across the primary care continuum, referral process/ pathways clearly established and navigator roles in place. The Whanau Ora Collective Infrastructure will have established baselines for the numbers of whanau care plans developed and progressed and will have established meaningful outcomes based reporting framework.	Wairarapa whanau receive better, more integrated, easier to navigate health and disability services. Wairarapa individuals and whanau are self empowering and responsible for their own health through increased health literacy and access to whanau ora services. Wairarapa whanau are able to determine and access the support and care they need to be vibrant, strong, and confident whanau. Wairarapa will have a more unified and improved health and disability system.

Living Within Our Means

Better Sooner More Convenient Health Services for New Zealanders in relation to Living within our means (LWOM)—A health system that manages sustainable delivery of services and functions for its population within a slower funding path by:

- tight cost control: to limit the rate of cost growth pressure
- purchasing and productivity improvement: to deliver services more efficiently and effectively across both NGO and hospital providers
- service reconfiguration: to support improved national, regional and local service delivery models, including greater regional cooperation

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Tight cost control	Hold costs for health services within demographic and cost pressure adjustors.	Identify Shared Services actions aligned with HBL work programmes as agreed. Continued focus on reducing waste and duplication. Roll out of the productive ward and other productive tools as deemed of benefit.	Progress on delivery of actions aligned with HBL work programmes as agreed and reported on in monthly financial reports. Key actions to implement are carried out in line with HBL prescribed milestones. Patient pathway review and process changes.	Deliver DHB financial performance in accord with expected out-year financial targets.
Purchasing & productivity improvement	Support and implement national and regional procurement and service contract initiatives through HBL and DHB national services.	Implementation of HBL collective procurement programme initiatives. Proactive management of employment cost growth and improved use of workforce. Implementation of the National Community Pharmacy Services contract	Provider arm expenditure for clinical and non-clinical supplies in line with plan. FTE costs relative to outputs as reflected in financial templates and production plans. Community Pharmaceutical spend in line with plan.	Deliver DHB financial performance in accord with expected out-year financial targets.
Service reconfiguration	Support and Implement whole of health system integration.	Reconfigure and rationalise current service delivery models. Implement Manage My Health Phase 2. Review non clinical support areas to identify potential opportunities to deliver more effective and efficient service delivery across the sub region (subject to appropriate consultation and engagement processes where there any potential staff impacts)	Implementation of the sub-regional work programme performed in conjunction with Capital & Coast and Hutt Valley DHBs, in line with agreed milestones.	More efficient and effective service delivery models.

Health of Older People

Better Sooner More Convenient Health Services for New Zealanders in relation to health of older people means better quality services as shown in regular measurement, assessments and delivery of services as soon as possible, more conveniently in the older person home or community and provided in a cost effective way.

A health system that functions well for older people is one that:

- provides choice
- involvement in care decisions and clear information
- protects vulnerable older people
- is integrated around the older person (not just what fits the system) to improve their overall quality of life
- supports to stay at home when its safe and cost-effective
- provides care that doesn't increase an older person's dependence

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Quality home and community support services for older people	Planning for meeting the future needs of our aging population will be in conjunction with Hutt Valley and Capital and Coast DHBs. The needs of our aging population will be met through the adoption of the Central Region Integrated Framework of Care for Older People. It is expected that this framework will provide the underlying structure of the health system for older people that reduces health care fragmentation and duplication and leads to improved health outcomes, more efficient services and fewer wasted resources. Comprehensive clinical assessment, improved coordination across the whole of health system and monitoring of outcomes (such as older adults aging well and living in the community) will all contribute to implementation of the framework.	Implementation of InterRAI assessments occurred as planned in June 2011. All new assessments and reassessments for older people will use the relevant Comprehensive Clinical Assessment. There will therefore be a 'tail' of older people receiving long term support who will have been assessed using the previous assessment tool. Streamline systems for sharing InterRAI assessment and care plan information with Primary Care and Aged Residential Care providers. DHB quality measures for Health of Older People (HOP) will continue to be used until there are nationally agreed core quality measures identified through the HOP Steering Group. The DHB will continue to participate in Central Region HOP benchmarking and will participate in nation wide benchmarking for Older People on core quality measures as identified by the DHB HOP Steering Group. Participate in establishing regionally agreed Stroke rehabilitation protocols, processes and systems with primary care (e.g. TIA pathway) and implement them as part of the HOP Tihei Wairarapa workstream. Continue to work with regional and subregional DHBs to align service allocation for long term supports. Maintain or increase the proportion of older people who are assessed as having high/very high (complex) needs, who are assisted to remain at home.	67% percent of people receiving long term Home Based Support Services (HBSS) have a Comprehensive Clinical Assessment (using any of the interRAI assessment tools) Baseline July 2011 – Jan 2012: 33% Target 2012/13: 67% Target 2013/14: 100% Benchmarking indicators to be confirmed. Benchmarking results from Regional and National DHBs will be available for analysis. Benchmarking measures reported through the Australasian Rehabilitation Outcomes Centre (AROC) An increase in the proportion of older people over 85 years living well in the community as measured by a decrease of the inverse – the proportion of people over 85 who are assessed as having high/very high needs.	These actions will contribute to a more unified system because health professionals will be able to understand a common assessment language. Better services will be provided because benchmarking of support service quality will be possible. Independence will be promoted by quality home-based support services reducing the need for hospitalisation and residential care. Older people will have more confidence in a system when it uses a consistent, internationally recognised assessment and quality assurance tool.

<table>
<tr><th>2012/13 Areas of focus</th><th>Key planning approaches</th><th>Actions to deliver improved performance</th><th>Measured by</th><th>High level systems outcomes</th></tr>
<tr><td></td><td></td><td>Develop a whole of system Local pathway for frail older people, including a trial in primary care to screen for frailty and address any reversibility.

Using our PBFF share of smarter support services for older people ($33k), extend the Wairarapa Health Recovery Programme to enable a safe and sustainable pathway from hospital to home after an acute illness.

Through the Tihei Wairarapa HOP workstream, investigate options for rapid response for more acute situations

Continue to monitor readmission rates for people over 65 years. Through a range of activity in residential care (e.g. more active GP management of residents) and implementation of Tihei Wairarapa across the whole of system, continue our trend of reducing readmission rates for older people</td><td>% >85yrs ‘Living Well in the Community’<table><tr><td>Baseline 2011</td><td>Target 2012/13</td><td>Target 2013/14</td></tr><tr><td>65%</td><td>75%</td><td>81%</td></tr></table>% participants in the Health Recovery Programme returning home<table><tr><td>Baseline 2011</td><td>Target 2012/13</td><td>Target 2013/14</td></tr><tr><td>83%</td><td>85%</td><td>85%</td></tr></table>Readmission rate for people over 65 years<table><tr><td>Baseline 2011</td><td>Target 2012/13</td><td>Target 2013/14</td></tr><tr><td>12%</td><td>11%</td><td>10%</td></tr></table></td><td></td></tr>
<tr><td>Comprehensive Clinical Assessment in residential care</td><td>Comprehensive clinical assessment of older people is a feature of the Central Region Integrated HOP framework. It is expected to result in improved care for residents by identifying and monitoring the needs of individuals in a systematic way.</td><td>The DHB will support residential care facilities to implement Comprehensive Clinical Assessment in their facilities through contribution towards costs (determined on a national basis) and through support from the DHB InterRAI Lead Practitioner and Project Manager, in terms of sharing experience and expertise.</td><td>In the facilities that have implemented InterRAI, 20% of long term residents will have a care plan developed by utilising a Comprehensive Clinical Assessment.

All residential care facilities will have the option of view access of the comprehensive clinical assessment for new residents moving from home based services and those using respite care.</td><td>These actions will contribute to a more unified system because health professionals will be able to understand a common assessment language.

Older people will have more confidence in a system when it uses a consistent, internationally recognised assessment and quality assurance tool.</td></tr>
</table>

Dementia pathway	The DHB will reorientate investment and services to better meet the needs of our aging population through: • a focus on access to services and clarification of the pathway for people with dementia and their carers • Building workforce knowledge of dementia, delirium and depression across community, primary and specialist providers.	The DHB will work with GP Practices, AT&R and Alzheimer's Society to optimise the single point of entry for support services and enable ease of access to information and support across the whole health and disability continuum. Using its PBFF share of funding for dementia pathway development, ($27.5K), the DHB will formalise its dementia pathway in conjunction with Capital & Coast and Hutt Valley DHBs, based on a regional standard for a Dementia Pathway. The Wairarapa specific pathway will be developed in conjunction with primary care through the Tihei Wairarapa HOP workstream by February 2013 (refer to Funding Allocation, Page 13). Workforce knowledge of dementia for staff in primary care, residential care, com munity care and hospital will be increased through: • provision of a Dementia e-learning tool which will be available for staff of all providers of dementia care, informal and formal carers • Establishment of a specialist nurse role for assessment, information and advice across the whole of system.	Development of a dementia pathway across all settings by April 2013. Dementia e-learning tool available across the Region by June 2013. Psycho-geriatric nurse specialist role established by October 2012.	These actions will contribute to a more unified system because health professionals, patients and their families will more aware of available services that can help in their particular circumstance. Independence will be promoted by people receiving appropriate services sooner, enabling them to stay at home for longer.
Community specialist HOP teams	Improved patient care will be achieved through stronger clinical leadership.	The DHB will continue to provide proactive specialist gerontology support for all providers of services for older people. A specific HOP education programme for residential care providers and families of residents will be provided through the Tihei Wairarapa initiative. Following development in 2011/12 of more structured GP services in Aged Residential care facilities, investigate options for joint ward rounds in ARC with hospital SMOs, nurses and GPs	Establish baseline for 12/13: Monthly provision of HOP related education by clinical specialists for staff in primary care and residential care (at minimum 12 sessions PA).	These actions will contribute to people receiving better health and disability services through more skilled care by the existing workforce resulting in an improved experience for the patient and family.
Safety of Older People	The Tihei Wairarapa programme which focuses on better, sooner, more convenient system-wide health care is aligned with the DHB Clinical Services Action Plan, the 3D programme work streams and the Regional Plan (2012/12) which includes a focus on safety for older people by addressing poly pharmacy.	The DHB will continue to implement a system of medication review. A regional project will be to Implement poly pharmacy "tools" & multi disciplinary service to discontinue medications which are not clinically indicated.		Independence will be promoted by people receiving appropriate services sooner, enabling them to stay at home for longer.

Health Target – Shorter stays in Emergency Department

Better Sooner More Convenient Health Services for New Zealanders in relation to emergency departments, means all New Zealanders can easily access the right services, in a timely way, to improve acute health outcomes. This must be implemented within the context of service improvements that aim to reduce acute demand growth and better co-ordinate services that provide access to people who require unplanned care.

A health system that functions well for people with acute care needs is one that:

- delivers and coordinates acute care services in the hospital and community
- improves the public's confidence in being able to access services when they need to
- sees less time spent waiting and receiving treatment in the ED
- moves patients efficiently between phases of care

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Emergency Departments	Working with the Wairarapa Medical After Hours Service to make better use of this service and reduce inappropriate presentations at ED. NOTE: There is no current or recent impediment to access / flow from the ED to inpatient services. Key issues for the Wairarapa DHB regarding this target are the strategies and efforts to reduce innapporoipriate presentation to the emergency department. The DHB remains proud of its consistent delivery to the ED Health Target.	An MOU with Wairarapa After Hours Medical Service that reflects improved cross sector health provision for acute care. Refer primary care level patients back to primary care where primary care health is available. Increase out of hours ARC medical cover from GP's.	A whole of health system agreement to managing acute health care. Reduced T4&5 presentations in ED Decreased waiting times in ED (achieving our health target). Reduced admissions from ARC to ED out of hours.	People spend less time waiting for and receiving treatment meaning better outcomes and improved quality of health services. A coordinated, whole of system response resulting in a more unified and improved health and disability system.
	Maintain primary/secondary MDT to manage ED High Users.	MDT to meet fortnightly to prepare action plans for ED high users. MDT to include representatives from both primary & secondary care. Allocation of individual case managers to work across primary and secondary care	Reduction in ED high users presenting at ED. Improved primary care treatment plans for ED High Users. Improved communication between primary /secondary care health providers e.g. MDT attendance / case conferencing.	Improved hospital productivity by ensuring optimal patient flow and the efficient use of resources.
	Implement Guided Model Of Care.	Comprehensive health assessment training for practice nurses. Referral pathway implementation. Communication pathways established between primary care and District Nurses/Clinical Nurse Specialists.	Reduction in complex, multiple co-morbidity patients requiring acute intervention via ED.	A coordinated, whole of system response resulting in a more unified and improved response to chronically ill patients.
	Rationalise Key ED processes to reduce inappropriate presentations	Implement new process for Ascites drains (currently attend ED for this procedure) Implement new X-ray G.P referral process Implement new x-ray review process (currently provided by ED clinicians)	Reduction in ascites drains being performed in ED Reduction in non acute x-rays being referred through ED Reduction in referrals from X-ray	Reduce Ascites drains in Ed by 95% over next 12 months Reduce non acute x-rays transferred to ED by 80% over next 12 months 80% reduction on non inpatient x-ray reviews being completed by ED clinicians

	Continue Healthline /Wellington Free Ambulance initiative for South Wairarapa patients needing primary care after hours..	Wellington Free Ambulance Paramedics providing community based GP level care and /or transport out of hours.	Reduced inappropriate ED attendances.. Improved access to primary health care (South Wairarapa).	

Health Target- Improved Access to Elective Services

Better Sooner More Convenient Health Services for New Zealanders in relation to electives means improved and more timely access to elective services.				
A health system that functions well for Electives is one that is: • Increasing clinically appropriate elective surgery discharges • increasing surgical first specialist assessments • improving access to diagnostics and specialist assessment • reducing waiting times for people requiring elective services • improving prioritisation and selection of patients for specialist assessment and elective surgery • supporting innovation and service delivery				
2012/13 Areas of focus	**Key planning approaches**	**Actions to deliver improved performance**	**Measured by**	**High level systems outcomes**
Access to elective services	Elective activity is planned within the district and co-ordinated across the Central Region so as to provide improved and more timely access to elective services for the people of the Wairarapa.	Electives funding will be allocated to support appropriate levels of elective surgery, specialist assessment, diagnostics, and alternative models of care. Standardised intervention rates or other mechanisms will be used to assess areas of need for improved equity of access. Patient flow management will be improved to ensure reduced waiting times for electives, so that no patient waits longer than six months. Actions to give effect to this include: • internal policies and processes will be reviewed and revised to support improved patient flow management and reduced waiting times for electives, so that no patient waits longer than six months • relationships with primary care will be developed to improve referral management systems and guidance • Development of robust internal reporting systems to monitor and manage the waitlist down to 5 months by the end of June 2013 Patients will be prioritised for treatment on national tools, and treatment will be in accordance with assigned priority. Establish a system between sub regional DHBs to track inter DHB referrals electronically (initially with Capital and Coast).	The DHB will deliver a total of 1,841 elective surgical discharges in 2012/13, which is its share of the required electives 2012/13 national health target of 148,000 elective surgery discharges. Access to elective surgery for Wairarapa people will be measured by : • Elective service standardised intervention rates (see Appendix 8.1 Measure S14) • Elective Services Patient Flow Indicators or "ESPIs": All patients wait six months or less for first specialist assessment and treatment from July 2012. The waiting time will reduce to no more than 5 months by the end of June 2013. Increased uptake of latest national CPAC tools to improve consistency in prioritisation decisions. . Other existing measures used to monitor performance are: • theatre utilisation target of 85 % (see Appendix 8.1 Measure OS5) • rate of day of surgery target of 62 % (see Appendix 8.1 Measure OS6) • rate of day of surgery admission (DOSA) target of 95 % (see Appendix 8.1 Measure OS7).	More people receive access to clinically appropriate elective services which supports New Zealanders to live longer, healthier and more independent lives. People have shorter waiting times for elective services and can regain good health and independence sooner. The health and disability system and services are trusted and can be used with confidence. Hospital systems are more productive. Health services are clinically and financially sustainable.

Health Target – Shorter Waits for Cancer Services

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

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

- people get access to services in a timely way across the whole cancer pathway – screening, detection, diagnosis, treatment and management, palliative care where appropriate people have access to services that maintain health and independence
- people receive excellent services wherever they are
- services make the best use of available resources.

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Cancer Services.	Wairarapa DHB participates in the Central Region Cancer Network to provide better, sooner, more convenient services along the cancer patient pathway.	Wairarapa DHB will participate in the Central Region programme of work for Faster Cancer Treatment (FCT). Systems will be developed to identify patients referred urgently with a high suspicion of cancer. Wairarapa DHB will work with the two cancer centres who serve our population to sustain performance against the radiotherapy and chemotherapy wait time targets. On behalf of Wairarapa DHB, Capital & Coast and Mid Central DHB Cancer Centres will be developing data collection systems to support service improvements across the whole of system. Wairarapa DHB will continue to participate in the Central Region Cancer Network project to develop multi-disciplinary management (MDM) function through implementing an appropriate conferencing system to enable clinicians across the region to link into regional MDMs for all tumour types. Develop a regional funding model to ensure funding is channelled appropriately between MDM host and referring DHBs Development of systems to capture data for establishing a baseline for the national colonoscopy indicators	Everyone needing radiation or chemotherapy treatment will have this within four weeks. Faster cancer treatment (establishment of baseline). Including the following: • *62 day indicator* - proportion of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days • *14 day indicator* - proportion of patients referred urgently with a high suspicion of cancer who have their first specialist assessment within 14 days • *31 day indicator* - proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision-to-treat. Implement the national Guidance for Implementing Quality MDMs – implemented across existing MDMs by June 2013 <u>Diagnostic Colonoscopy</u> a. 50% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 days) and b. 50% people accepted for a diagnostic colonoscopy will receive their procedure within 6 weeks (42 days) <u>Surveillance/Follow-up colonoscopy</u> c. 50% people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	More people have improved access to clinically appropriate services that maintain good health and independence. More people have shorter waiting times for cancer treatment and colonoscopy services meaning people receive better health services.

Health system success is measured by five year survival rates, and cancer mortality data.

Health Target – Increased Immunisation

Better Sooner More Convenient Health Services for New Zealanders in relation to immunisation means more children are immunised according to best practice guidelines. This is implemented alongside improvements in Child and Youth health services that are focused on the child/tamariki and their family and whanau.

A health system that functions well for immunisation is one that:

- immunises children on time through streamlined systems for registering newborns on NIR and provides accessible immunisation services that suit different population groups
- intervenes early in the life course in order to reduce unnecessary suffering, provide better long term prognosis, and better cost efficiency
- supports parents to make immunisation decisions through a well-trained, confident and trusted workforce
- ensures vertical and horizontal integration across social sector services as well as primary and community care
- has a focus on quality improvement in particular reducing unavoidable variation in service and clinical outcomes (including evaluation and monitoring
- never misses an opportunity to immunise an infant who is overdue for an immunisation

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Immunisation	Planning for ensuring that all children are immunised in a timely fashion is consistent with the on-going implementation of the DHB's Child Health Strategy and is overseen by the interagency Child Health Executive Group.	Wairarapa DHB will continue to work with the PHO, in particular through the PHO based Community Child Health Coordinator and District Immunisation Facilitator to identify actions to achieve and maintain high immunisation rates for all milestone ages by: • utilise joint PHO. DHB resources, including practice registers and the NIR to develop systems for seamless handover of mother & child as they move from: antenatal care, maternity care, birth, Well Child, primary care/ DHBs monitor newborn enrolment rates • ensure that women's GP details are recorded on the birth event booking form • monitor and evaluate coverage at DHB, PHO and practice level and service delivery gaps are identified and managed • identifying immunisation status of children going to hospitals and referring for immunisation • maintain oversight of immunisation coverage (and other child health targets), and promote collaboration between child health providers and stakeholders, through on-going support of the Community Child Health Executive Group • As part of whanau ora service development, improve coordination of child health outreach services to ensure all children enrolled with Whanau Ora services are fully immunised for age.	**Health Target** **Increased immunisation** 85% of eight month olds will have their primary course of immunisation (six weeks, three month and five month immunisation events on time by July 2013, 90% by July 2014 and 95% by December 2014.	Good health and independence are protected and promoted. Health systems and services are trusted and can be used with confidence. Improving value for money.

Health Target – Better Help for Smokers to Quit

Better Sooner More Convenient Health Services for New Zealanders in relation to tobacco means more smokers make more quit attempts, leading to more successful quit attempts and a reduction in smoking prevalence.

A health system that functions well in terms of the provision of better help for smokers to quit is one that:

- supports people who smoke to abstain while in treatment or permanently quit with brief advice and cessation support or treatments
- treats smoking as a clinical 'vital sign'
- increases the chance of smokers making a successful quit attempt
- provides open and accessible services to all people who smoke, particularly pregnant women, Māori and Pacific People
- delivers smoking cessation support and services in a culturally appropriate manner.

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Tobacco	Collaboration between Primary and Secondary care to identify smokers and offer them advice and help to quit. Proposed funding allocation between primary and secondary care for 2012/13: Tobacco control contract total spend $169,750 Split: Primary Care: $39,750 Secondary Care: $130,000	WDHB will continue to work with primary care partners to ensure that brief advice and help to quit provided in primary care maintains /improves on 2011/12 performance. Planned actions include: • incorporating quitting support for smokers in all care management pathways / plans developed as part of Tihei Wairarapa and other integrated care pathways (including whanau ora plans) • ensuring funding is available to support on-going implementation of training, coordination, systems and procedures to support the primary care smoking target ($39,750 budget for primary care in 2012/13). • Continuing to support primary care with workforce and systems development required to provide, record and measure cessation advice in primary care, including evaluation of options for IT support of the tobacco and other health targets • Using practice level data, target advice cessation support to priority populations, including Maori, Pacific, pregnant women and people with long term conditions exacerbated by smoking. • Regular meetings with the PHO to monitor and promote progress towards the primary care target • Ensure systems and processes are in place to enable timely and accurate data collection and reporting to meet health target reporting requirements • Continued Senior Management commitment to promote and support ABC in the hospital setting to ensure the hospital target is improved and maintained. • Promote and support collaboration between primary care, cessation services and hospital services to match smoking data, coordinate cessation support and ensure continuity of care and advice across services, including group cessation support in a primary care setting	**Health Target** **Better help for smokers to quit** 95% of patients who smoke and are seen by a health practitioner in public hospitals and 90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking. Within the target a specialised identified group will include: • Progress towards 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity carer are offered advice and support to quit.	Good health is protected and promoted. People receive better health and disability services. New Zealanders leading longer, healthier and more independent lives. Reducing and controlling future costs.

		• Collaborate with partners in the Wairarapa Smokefree Network to increase community awareness of ABC activities across the health sector aimed at assisting smokers to quit • Ensure that cessation advice and support is routinely provided to families through antenatal, maternity, Wellchild, acute health services • Ensure that training and resources are available for LMCs to provide brief advice and an offer of cessation support to their patients • Include brief advice and cessation support in the DHB's Maternity Action Plan • Ensure that LMCs are aware of and utilise referral pathways to cessation services for those aptients that want to quit.		

Health Target - CVD / Diabetes

Better Sooner More Convenient Health Services for New Zealanders in relation to cardiovascular disease (CVD) and diabetes means: all people with, or at risk of CVD / diabetes are identified, assessed and managed and supported to manage their own condition in order reduce the impact on their health.

A health system that functions well for CVD / Diabetes is one that:

- promptly identifies all people at risk of or with CVD diabetes
- provides timely effective assessment and management of risk factors and/or conditions in primary care
- supports effective self management by people of their risk factors and/or conditions
- refers promptly between primary, secondary and tertiary care for assessment and management where appropriate

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
CVD / Diabetes	Wairarapa CVD/Diabetes developments are embedded within Tihei Wairarapa with the aim of providing better, sooner, more convenient health services for people with, or at risk of CVD and diabetes. The implementation of these service developments will be monitored (across the continuum) by the Alliance Leadership Team (ALT).	Wairarapa DHB will continue to work proactively with the Wairarapa Community PHO and General Practices to develop practice plans which focus on: • Setting practice targets for CVD risk assessment • identifying eligible populations • contacting people for CVD risk assessment/recalling • Use data from improved IT connectivity across the health sector to reduce duplication of assessment • meeting clinical guidelines • Adopt a whanau ora approach to increase risk assessment for Maori and effective management of their long term conditions. Current "Get Checked' funding will be transferred to GP practices according to their diabetes population – for the use of diabetes care improvement. The funding structure will align with the guided care model of Tihei Wairarapa, whereby those people whose diabetes or CVD clinical indicators are satisfactory will be managed through the standard pathway (including education for self management). Those with more complex needs and unsatisfactory clinical indicators will be managed through the Tihei Wairarapa Guided Care model Through the Tihei Wairarapa Chronic Health Condition project which spans the whole of system, Wairarapa DHB will work proactively with the Wairarapa Community PHO and General Practices to implement a 'Diabetes Care Improvement Package' within the local diabetes pathway, which includes the following actions:	Health Target – 75% of all eligible people will have had their CVD risk assessed within the past 5 years. Replacement of Get Checked with a Diabetes Care Improvement Package. Selected KPIs which are agreed with Primary Care will be monitored and will include HbA1c checks and diabetes management Submission of Quarterly reports providing the following description of the Diabetes Care Improvement Package: • planned annual patient volumes in identified improvement areas • delivery against planned outputs • 4th quarter confirmation of delivery against planned outputs and volumes. Annual report from the Local Diabetes Team or equivalent.	Lower rates of complications of CVD diabetes in local populations and fewer admissions to hospital for these means New Zealanders live longer, healthier and more independent lives. A more unified and improved health and disability system – Good coordination of primary and secondary diabetes services for patients. People receive better health and disability services – All patients have access to diabetes services in primary care, Staff have skills and capability to detect and manage diabetes well in primary care. Good health and independence are protected and promoted – Diabetes patients are enabled to self manage their own condition well. Reducing and controlling costs.

		• Use of recall systems to ensure at least a review annually. Apply nurse time or navigators to pursue those not being actively managed. • Ensure clinical data gained from outreach services and opportunistic testing is captured in the patient's primary care record. • Provide a validated self management course for people with diabetes • Monitor the effectiveness of diabetes management according to clinical guidelines and the Tihei Wairarapa Diabetes pathway across the whole of system • Focus on people with poorly managed diabetes through the guided care model (targeted cohort) • Nurse lead clinics (under GP direction) - agree a management plan with all people with an HbA1c over 64 mmols/mol which focuses on clinical outcomes • Provide specialist nurse support for up-skilling and advising nurses working within the Wairarapa health continuum (e.g. insulin starts)		
Use funding currently allocated for "Get Checked" annual reviews to support primary care to more effectively manage people with diabetes.		This is a community/primary-care based programme, building on core diabetes services already being provided, to improve specific clinical outcomes for people with diabetes eg: • glycaemic control - HBA1C< 55mmol/mol • cardiovascular protection - BP < 130/80 • renal protection - With microalbuminuria, an ACE inhibitor or ARB therapy • retinal screening - Within 2 years • foot care - Review of feet and access to podiatry on referral.	Submission of Quarterly reports through the PHO Performance Programme. This may include: • proportion of people with diabetes with HbA1c less than 64 mmols/mol • in out years, other measures such as renal function. The proportion of people with poorly managed diabetes who have a management plan (targeted cohort). The number of people with diabetes who attend the PHO self management programme.	

New Ministerial Priority -Maternal and Child Health

Better Sooner More Convenient Health Services for New Zealanders in relation to maternal and child health will result in improvements in Child and Youth health services that are focused on the child/tamariki and their family and whanau.

A health system that functions well for mothers and children is one that:

- intervenes early in the life course in order to reduce unnecessary suffering, provide better long term prognosis, and better cost efficiency
- is well coordinated so that parents are supported to keep their children healthy across the continuum of care from pre-birth to adulthood
- ensures vertical and horizontal integration across social sector services as well as primary and community care
- has a focus on quality improvement in particular reducing unavoidable variation in service and clinical outcomes (including evaluation and monitoring

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Maternity	Planning for improved antenatal, maternity and child health services is consistent with the on-going implementation of the DHB's Child Health Strategy and is overseen by the interagency Child Health Executive Group.	Wairarapa DHB will implement the Maternity Quality and safety Programme; including • Establish the programme and put systems and processes in place so the programme becomes business as usual by June 2014 • Resource and recruit into the budgeted shared role between sub regional partners • Develop Clinical Governance forums that are well attended by core midwives, obstetricians, LMCs, GPOs, and other health professionals and consumers as appropriate • Develop robust, measurable and meaningful reports for monitoring and improving plans against clinical indicator KPIs Wairarapa DHB will develop a Maternity Action Plan, including; • Define the model of care as a result of decreasing LMCs and GPOs in the district • Work with antenatal providers to ensure that women are offered and receive antenatal education tailored to describe the maternity service provided in Wairarapa • Work with antenatal education providers, public health, iwi, LMCs, Well Child providers and consumers to ensure breastfeeding rates following discharge are improved • Implement a tool for handover from LMC to secondary, and return to LMC	**Improving breastfeeding rates:** Target 2012/13 *6 weeks* Maori 74% Total 74% *3 months* Maori 57% Total 57% *6 months* Maori 27% Total 27%	Good health and independence are protected and promoted. Health systems and services are trusted and can be used with confidence. New Zealanders leading longer, healthier and more independent lives. Improving value for money.

2012/13 Areas of focus	Key planning approaches	Actions to deliver improved performance	Measured by	High level systems outcomes
Child Health	Planning for improved antenatal, maternity and child health services is consistent with the on-going implementation of the DHB's Child Health Strategy and is overseen by the interagency Child Health Executive Group.	Wairarapa DHB will continue to implement its Child Health Strategy and through the PHO based Child Health Coordinator, monitor progress against key goals and priorities including: • Immunisation at all milestone ages (as detailed elsewhere in this plan) • Early enrolment of infants with primary care • Primary care access rates for priority groups • Timely handover of all children to Well Child providers • Completion of all Well Child Checks, including the B4 School Check • Reduced rates of infectious disease • Improved oral health • Access to specialist services for children with complex health, behavioural, and developmental needs Priority projects for 2012/13 include: • Implement ion of Gateway Assessments • Evaluate options for improved access to child development services • Implement systems for coordinating the NIR and B4S databases with Well Child and practice enrolment databases to ensure timely enrolment of new born and all 0-5s are accessing Well Child and primary care services • PHO will be assisting the Ministry of Health to develop and test national system for newborn enrolment • Continue to implement the sub-regional skin infection project, as an exemplar for improved approaches to the prevention and treatment of infectious disease (to reduce ASH rates) • Development of improved child health outreach services, incorporating immunisation, B4S checks and vision and hearing screening • Completion of the oral health hub	Increased percentage of 4 year olds have B4 School Checks before they turn 5 Target 2012/13 90% Increased percentage of high needs 4 year olds have B4 School Checks before they turn 5 Target 2012/13 90% % of children caries free at age 5 Target 2012/13 65% Reduced ASH rates Target 0-4 Total 117%	Good health and independence are protected and promoted. Health systems and services are trusted and can be used with confidence. New Zealanders leading longer, healthier and more independent lives. Improving value for money.

3.2 BETTER, SOONER MORE CONVENIENT SYSTEM WIDE VIEW

The DHB recognises the importance of moving towards more integrated service models across the whole health system in the Wairarapa and also the sub region. As such it has started on this journey through the development of the CSAP and the subsequent development of Tihei Wairarapa. The DHB acknowledges that integration takes time and we will continue to work with the ALT towards more integrated services across the continuum of care. Key activities that will be progressed by the ALT through Tihei Wairarapa that will contribute to system wide integration include:

- Full implementation of guided care across practices, hospital and community services for people with long term conditions
- Implementation of the diabetes guided care programme
- Complete implementation of pathway of care for frail elderly
- Embed shared IT systems across providers
- Progress the regional analysis collaborative and increase the use of patient level data to identify opportunities for streamlining care across providers
- Embed the new mental health services in primary care
- Continue to progress the Integrated Family Health Network (IFHN) across Wairarapa
- Coordinate workforce development opportunities across providers
- Establish a single clinical governance structure across providers and
- Establish whanau ora navigators and implement whanau ora pathways

The DHB and primary care have through Tihei Wairarapa and the ALT continued to engage with primary care on developing and strengthening the IFHN as referenced above. This includes expanding the access to the shared care record to a wider range of health professionals across the health system, planning for the integration of community nursing, clinical nurse specialists, community services and visiting specialist services into the IFHN and supporting future development for the collocation of health services in Masterton and the South Wairarapa as opportunities arise.

In parallel the DHB will put in place the structures and processes needed to progress service integration in the longer term, across the health sector, where this is expected to deliver better, sooner, more convenient care and support the DHB's triple aim and CSAP. Specific considerations that the DHB, in collaboration with its partners, will be addressing are:

- Putting in place streamlined governance arrangements to oversee integrated service developments and delivery
- Ensuring that streamlined clinical governance arrangements support quality care across the sector
- Providing management support and guidance for service integration, including the appointment of a Programme Director
- Accelerate and embed collaborative data analysis across processes to monitor progress and, better understand patient flows and establish priorities for service development
- Identifying further priorities for integrated service development in year 3 and out years. These are likely to include cancer and dementia services, child health, and health promotion.
- Enhance connectivity of information across providers including further development of the shared electronic patient record

- Supporting and further developing service level alliances for the development, implementation and monitoring of integrated service provision
- Further develop MDT processes for patients with complex needs, including aged care, long term conditions, mental health, child health and whanau ora.

3.3 DHB REGIONAL, SUB REGIONAL AND LOCAL ACTIONS TO DELIVER ON THE REGIONAL SERVICES PLAN

DHB Regional Actions

Module 2 of the Annual Plan outlined the Central Regions DHB Roadmap towards 2017 and outlines a range on outcome focussed actions that the six DHBs will be working towards over the next five years. The Central Region's RSP also identifies Service Performance Priorities that require regional action to improve quality and strengthen clinical services. The service priority areas for 2012/13 that are being led through a strong clinical governance framework are;

National Priority Services

- Cardiac services
- Cancer services
- Stroke services

Regional Activity

- Elective services
- Maori health
- Population Health
- Quality and Safety
- Radiology

Clinical Networks

- Cancer Network
- Cardiac Network
- Health of Older People Network
- Mental Health and Addictions Network
- Renal Network

Sub Regional Activity

- The 3 DHB Health Services Development
- Central Alliance

The RSP provides a comprehensive description of outcomes, impacts, outputs and measurements for all of the Service Performance Priorities identified above. To review the RSP and detailed actions please refer to the RSP which can be accessed online at the following web address: *www.centraltas.co.nz*

Sub-regional actions / priorities

The 3DHB HSD is a collaboration programme between Hutt Valley, Wairarapa and Capital and Coast DHBs. The focus of the programme is to take a whole of system approach that spans the health continuum that will enable the greatest gain to the patient / whanau experience, population health and clinical and financial sustainability consistent with the Triple Aim Approach. As already outlined in module two good progress has already been made. The following table outlines the eight key actions that have been agreed by the SRCLG that will be progressed by the Wairarapa, Hutt Valley and Capital and Coast DHBs as part of our collaborative work programme for 2012/13. These sub regional actions are also reflected in the RSP.

	Government Priority: Sub-Regional Collaboration – working with our neighbours			
The actions we'll take this year	Time frame for delivery	How they will help	Measured by	In support of system outcomes
Implement agreed recommendations from the completed service reviews: - ENT - Child Health - Gastroenterology	Quarter 1 Quarter 4 Quarter 3	A single service approach will assist with workforce sustainability challenges, improve equity of access and improve the quality of care (against the 7 quality parameters)	Recommendations are implemented within agreed timeframes and fiscal parameters	Mobile and flexible health workforce Improved quality of care Improved patient / whanau experience
Consult on the development of a 'single service' approach for General Surgery , Orthopaedics , Breast Surgery and Anaesthetics across the 3 DHB's	Quarter 3		'Single service' approaches for the named specialties will be considered by the SRCLG and recommendations forwarded to each Board	
Utilise sub-regional radiology capacity – equipment and staff – to reduce radiology wait lists and improve equity of access to diagnostic services	Quarter 2	Wait times for diagnostic services will reduce and imaging equipment will be utilised to its full potential	Wait times for diagnostic radiology referrals	Improved quality of care Efficient use of infrastructure investment Improved patient / whanau experience
Implement the outcomes of the consultation process on a sub-regional approach to planning and funding functions	Quarter 2	Planning and funding functions support a collaborative sub-regional / whole of system approach to service delivery	Recommendations are implemented within agreed timeframes and fiscal parameters	

	Government Priority: Sub-Regional Collaboration – working with our neighbours			
The actions we'll take this year	Time frame for delivery	How they will help	Measured by	In support of system outcomes
Human resource and occupational health and safety policies and practices across the 3 DHB's will be aligned	Quarter 4	This will enable joint appointments / shared staffing arrangements to be more easily implemented		
Complete capacity analysis work for the 4 facilities / 3 DHBs that considers physical, workforce and equipment capacity	Quarter 1	Capacity information, collected in a consistent manner, will aid clinicians in considering 'single service' approaches to improve the utilisation of scarce workforce and capacity resource	Capacity information is utilised by services in considering 'single service' approaches	Improved patient / whanau experience Improved utilisation of scarce resources
Collaborate on the implementation of a Finance Management Information System (FMIS) solution that is consistent with the national FMSS approach	Quarter 4	A consistent FMIS will improve data collection, procurement knowledge and enable shared service delivery as per direction by HBL	Agreement to implement FMIS solution at HVDHB and WDHB	Value for money
An alternative funding approach to IDFs will be developed and piloted as part of a 'single service 'implementation	Quarter 2	Funding arrangements should incentivise providers to deliver services consistent with design principles, the IDF mechanism has been highlighted as a deterrent to a 'single service ' approach	Implementation and evaluation of an alternate funding mechanism	Improved patient / whanau experience Improved quality of care

3.4 DHB LOCAL PRIORITIES

The DHB's key strategies, Tihei Wairarapa and our CSAP, will help us deliver against the Minister of Health's key priorities such as better, sooner, more convenient health care for all New Zealanders, continued achievement against the six health targets and improved patient care through stronger clinical leadership. Actions from Tihei Wairarapa and our CSAP that will help us achieve the Minister of Health's key priorities and targets are identified in the tables above.

Implementation of these two key plans will also help us to ensure health services are clinically and financially sustainable and potentially help us to reduce and control costs.

As noted in Module Two, another key plan for the DHB is Te Huarahi Oranga, the Wairarapa DHB's third Māori Health Plan. This plan provides a five year framework for improving Māori health in the Wairarapa. Actions and measures from Te Huarahi Oranga are woven throughout this Annual Plan and included in this section under the Whanau Ora template earlier in this module.

MODULE 4: STEWARDSHIP

4.1 MANAGING OUR BUSINESS

This section details how the organisation manages its business effectively and efficiently to deliver on the priorities described in this Plan. It shows how the DHB's high level strategic planning translates into action in an organisational sense within the DHB and details the supportive infrastructure requirements to achieve this. As both funder and deliverer of health services, the DHB must operate in a fiscally responsible manner and be accountable for the assets it owns and manages.

Governance and Organisational Structure

The Wairarapa DHB has a governance and organisational structure as required by the New Zealand Public Health & Disability Act 2000 (NZPHDA).

The Board of the Wairarapa DHB assumes the governance role and is responsible to the Minister of Health for the overall performance and management of the DHB. The responsibilities of the Board include:

- Setting strategic direction and policies which are in line with Government objectives and priorities;
- Appointing the Chief Executive;
- Monitoring the performance of the organisation and the Chief Executive;
- Ensuring compliance with the law (including the Treaty of Waitangi), accountability requirements and relevant Crown expectations;
- Maintaining appropriate relationships with the Minister of Health, Parliament, Ministry and the public.

The Board comprises seven members elected by the community and four appointed by the Minister of Health. The Board has established the three advisory committees required by the NZPHDA (Community & Public Health Advisory Committee, Hospital Advisory Committee and the Disability Support Advisory Committee) and a non-statutory committee (Audit & Risk Committee) to help the Board meet its responsibilities. Membership of these committees is a mix of Board members and community representatives. The DHB also works in partnership with its Maori partnership Board, Te Oranga o te iwi Kianga, to ensure Maori participation at all levels of service planning, and service delivery for the protection and improvement of the health status of Maori.

Whilst the Board is responsible for the DHB's overall performance, operational and management matters are assigned to the Chief Executive who is supported by the Senior Leadership Team.

The Wairarapa DHB is committed to the philosophy and practice of clinical leadership where clinicians are accountable for outcomes they have the ability to affect. To facilitate this, we have implemented an organisational structure that ensures active, robust decision making and partnership between clinicians and management.

Performance Reporting

Two years ago the DHB implemented a comprehensive balanced scorecard reporting framework as the core of our performance management framework. This is reviewed on an annual basis to ensure the key measures reported against in the BSC are aligned to the delivery of the AP. The various measures included in the BSC are allocated across the Board and its established Committees and

each receive a regular report against the allocated measures. In addition the BSC report is reviewed monthly by the Senior Leadership Team.

Funder Interests

The concept of value for money is evident is all phases of the procurement life cycle. Our funding processes follow closely the Office of the Auditor General's procurement guidelines which includes contestable provider selection. This allows the DHB to compare proposals from a number of providers, including pricing, in order to find the most effective provider for the services sought. There are some circumstances where a contestable provider selection process may not be appropriate. Management of funding agreements includes formal performance monitoring and auditing by external organisations as well as continuing an informal relationship to ensure accountability for service value.

We apply industry and public sector standard practices that ensure best practice financial management at both the macro and micro level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable to the Chief Executive and Board. A clear, documented management and financial delegation framework ensures the highest level of financial accountability. At a micro level funding providers requires a commercial approach coupled with the need to ensure our NGO providers remain viable. A continuing tight fiscal environment continues to put pressure on greater reliance on financial management and our providers to deliver sustainable value for money health services.

The management of risk in funding arrangements is one of measured mitigation, balancing the application of appropriate mitigation strategy/cost to the degree and size of risk. The Wairarapa DHB risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various DHB risks. A key to the robust management of risk is the approach employed where the same principles of high level contractual rigour for high value complex funding agreements are applied to simple letters of agreement for low cost "one off" arrangements. The continued approach of using a combination of informal relationship monitoring with external resourced audit and monitoring ensure risks are managed prudently.

Provider Interests

The concept of value for money is evident in all phases of the review of service performance. We work closely with the Health Round Table to ensure we are aware of both best practice, best performers in Australasia for public hospitals, and we follow up on what is required for Wairarapa DHB to be on the leading edge of best practice. The Wairarapa DHB places a very high emphasis on quality to help drive good outcomes at an affordable price, with quality and safety being a key component of the delivery of our Triple Aim strategy. There is continuous work on reviewing and implementing improvements to clinical pathways, which are focused on delivering patient centred results.

There is also the CSAP and Asset Management Plan (AMP) which are prepared to assist in determining the ongoing capital requirements to meet the DHB's service objectives. These plans are prepared to best practice standards in New Zealand and incorporated into the RSP and Regional AMP. These various plans are critically reviewed for their value for money prospects for health care delivery, with an eye for being prepared for emerging health needs. Funding for clinical services requires a commercial approach which is based on nationally based Price / Volume (P/V) schedules.

Provider Arm risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various DHB risks. High organisation risks are reviewed monthly by the Senior Leadership Team and every two months by the Board's Audit & Risk Committee, to ensure that appropriate attention is given to these risks.

To help ensure that services are delivered to an acceptable standard, Wairarapa DHB Provider Arm clinical results are reported on a regular basis within the DHB including to the Clinical Board.

Audit and review

The Wairarapa DHB Funder Arm coordinates a Routine Audit Programme to assess the extent to which NGO providers are complying with terms of their contract with the DHB. Additional issues based audits can be commissioned if there are particular concerns about a provider's performance. The Central Region Technical Advisory Service Ltd coordinates this Routine Audit Programme. In addition to the Routine Audit Programmes, Audit & Compliance (Sector Services) and MedSafe provide additional audit and investigation services on behalf of the DHB.

The Procurement Guidelines for Funder Arm Services require that service agreements are reviewed at least on an annual basis. This is an opportunity for us to assess how well a provider has performed over the term of an agreement, review the services that we have purchased, and review and improve our contract documentation.

The Wairarapa Provider Arm services are actively involved in regular programmed internal audits as well as the annual statutory audit to ensure the accuracy and integrity of the DHB's financial results. Additionally, there are certification and assurance audits carried out to verify service provision to acceptable standards.

Wherever possible, we endeavour to coordinate audit activity with other DHBs.

4.2 BUILDING CAPABILITIES

When considering the development of capability, whether that is capabilities in workforce, innovation, infrastructure or Information Technology; in order to develop a sustainable health system the Wairarapa DHB needs to consider all health services providers – within the Wairarapa and those providing services outside of the Wairarapa for Wairarapa domiciled patients.

Workforce

It is recognised at a national, regional, sub-regional and local level that sustainable services rely on a sustainable, fit for purpose, clinical and non-clinical workforce. The Wairarapa DHB is committed to support the initiatives of HWNZ and partnering with our regional, sub-regional neighbours and local partners in developing a workforce that is fit-for-purpose for the next 15 years. This will require both a planned approach (focus on vulnerable services at a regional level and service initiatives via the 3D programme and Tihei Wairarapa work at a local level) as well as opportunistic intervention e.g. when vacancies arise, service reviews occur.

The Wairarapa DHB has a goal to be an employer of choice, and as a good employer and a responsible health care provider, is obligated to ensure that the right clinician is providing the right care at the right time in the right place. This will necessitate a systemic review of roles and scopes of practice and consideration of who is best placed to provide the care, which may be different from who has been providing the care in a more traditional service delivery model.

The Tihei programme has an extensive workforce development component, as does the 3D programme. Examples include the education and training for all primary care practitioners and nursing staff on the roll out of the Guided Model of Care and the development of a joint Continuing Professional Development Programme (CPD) across the Wairarapa health system. For those initiatives being targeted in 2012/13, a tailored workforce plan will be developed for each initiative to enable the delivery of services in a more sustainable manner. This will consider new roles, alternative rostering arrangements, training and non-clinical support requirements.

Throughout all of these initiatives a key area of focus will be the development of the Maori clinical workforce. Our future workforce will be supported by encouraging – through interaction with schools and workforce agencies – the enrolment of Maori children in technical and science related subjects and mentoring their developments through college and professional training institutions. This began last year with the positive local response to a series of workforce hui targeted at secondary school teachers and principals.

Information Technology

CRISP is the key enabler for the development of a sustainable, fit-for-purpose information technology infrastructure in the Central Region. The Wairarapa DHB has, and will continue to be (through the CE as CRISP Sponsor) a prime advocate for the implementation of this initiative.

In tandem to this regional development, a shared care record for Wairarapa (primary, community and secondary care providers) will continue to be rolled out utilising the Manage My Health Medtech software. The Tihei Wairarapa programme is overseeing this phased implementation. This will support / dove tail with the implementation of Phase 2 CRISP in four years time.

Infrastructure

As part of Tihei Wairarapa the Wairarapa DHB considered a range of options for the development of an IFHN on the Wairarapa Hospital site. For a variety of reasons (timing, capital investment, service model development) this has not progressed.

The Wairarapa DHB continues to have conversations with the largest GP practice, Masterton Medical Ltd and other general practices, regarding integration opportunities albeit the development of shared infrastructure is not under consideration in the foreseeable future.

One of the potential limiting factors to more services being delivered in the community is the lack of available physical space at GP practices. This is being addressed on a case by case basis.

Wairarapa DHB is rapidly progressing the development of an Oral Health Hub, funded by the Ministry of Health as part of the Wairarapa DHBs Oral Health Business Case (which has already resulted in the commissioning of two mobile clinics). The Oral Health Hub will be located at Masterton Intermediate School and will consist of a two chair clinic with the ability in the future to commission a third chair, and will be the base for the regions Dental Therapists and Dental Assistants.

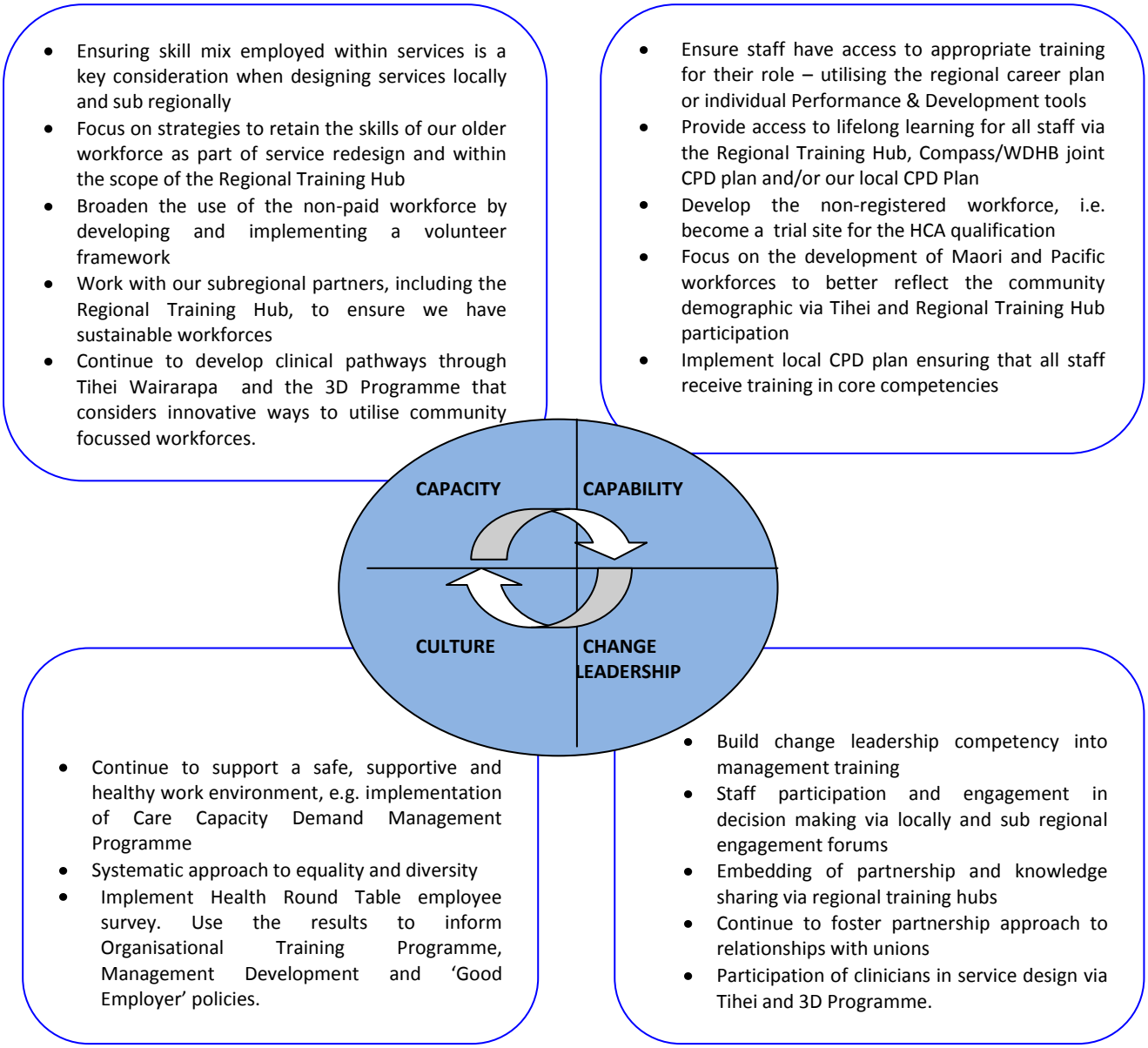
With the relocation of 120 staff in 2011/12 due to the poor seismic strength of some of the buildings on the Wairarapa Hospital campus, the physical infrastructure requirements for all staff have been reviewed. By 1 July 2012 it is intended that all staff will be in buildings that are 65% compliant with current building codes. This will require the development of a fit-for-purpose facility / stores / maintenance building on the Wairarapa Hospital campus and the rehousing of 1.2 Kms of clinical records.

4.3 STRENGTHENING OUR WORKFORCE

Ensuring that we have a fit for purpose and capable workforce is a key strategy for the DHB. The vision of the Wairarapa DHB Workforce Plan is “To work collaboratively with health providers to ensure as a district we recruit, develop and maintain a collaborative skilled workforce focused on the health needs of the population of the Wairarapa”. This plan sits within the wider context of CSAP and Tihei Wairarapa, and subregional, and regional directions for developing and maintaining a sustainable health workforce within the changing health environment across the whole of system. The RSP reflects the expectation of HWNZ and focuses on Regional Training Hubs, the regional implementation of the National Services Reviews, Clinical Leadership and career planning .

Within the context of HWNZ strategy, the Wairarapa Workforce plan focuses on capacity, capability, culture and change leadership as depicted in Figure 5 below;

Figure 5: Wairarapa Workforce Plan



The intent of the Wairarapa DHB Workforce Development Plan is to:

- identify the main workforce demands, and the potential challenges, that the Wairarapa DHB will be faced with over the next 5 years and
- articulate the workforce outcomes, strategies and policies that will support and enable the Wairarapa DHB, and the broader subregion, to address these challenges.

After analysis of the current and predicted external environment and context, and the needs of the organisation as defined in policy, legislation, national and regional service planning, the four main health related issues impacting on the Wairarapa DHB workforce were determined to be:

- The ageing workforce
- The increasing health gap between Maori and others
- Increased generalization and evolution of clinical roles resulting from the integration of primary and secondary health care provision
- Growing emphasis on regional models of care.

The Workforce Development Plan predominately focuses on the impact that local and regional strategies will have on the workforce of the Wairarapa DHB and the sub region and is considered a first step towards Wairarapa DHB having a comprehensive and integrated workforce strategy that will encompass the primary and NGO sectors. This plan focuses on the priority areas and supports sustainable outcomes that strengthen the workforce of the Wairarapa DHB as an independent DHB and a DHB within a sub regional and regional context.

Wairarapa DHB acknowledges the aim of HWNZ to implement a range of initiatives designed to recruit, retain and develop the workforce in all specialties and in all areas, ensuring NZ has the right mix and numbers of people to provide world class health care. This leadership direction provided by HWNZ forms the basis of planned subregional and regional workforce development as outlined below.

HWNZ tasked DHBs with creating Regional Training Hubs to support post graduate training and education. Working collaboratively will allow each DHB to contribute to the success of the region's workforce development without sacrificing its own autonomy. It will allow the experience, strengths, lessons learnt and best practice identified in one DHB to be shared throughout the entire region.

The Central Region Training Hub will ensure that post graduate training and education within the region is coordinated to provide the best use of available resource whilst maximising the quality of the product delivered.

In November 2011, the Central Region Training Hub Working Group was established. The programme of work is led within the region by lead CEO, Graham Dyer and Clinical Lead Dr Grant Pidgeon. From July 2012 a Regional Programme Director of Training will be employed to drive the programme of work in collaboration with the working group.

The focus for the Central Region Training Hub services plan for 2012/13 is:

- To improve clinical workforce development across the Central Region by including medical, nursing, midwifery and allied health training, as well as promoting inter-disciplinary training and education where appropriate and integrated primary and secondary health.
- To strengthen recruitment, retention and skills development of the clinical workforce by creating a Central Region framework to facilitate DHBs to coordinate and promote training and education across the region.
- To improve operational efficiencies and effectiveness through collaboration and technology.

Regional Training Hubs	
Why this is a priority? The hubs will help contribute to a more cohesive national approach to health professional education and training across the New Zealand health sector. They are created to better support health professionals in their education and training journey.	
Activity in 2012/2013	**What we will achieve by 2015**
• Wairarapa DHB will contribute to the design and function of the Central Region Training Hub via clinical attendance on the Hub Governance Group and attendance on the Hub Working Group. • Minutes and actions of Training Hub will be circulated regionally and General Managers Human Resources will contribute to discussion via elected Training Hub Working Group members	• Ensure training has a clear purpose and provides benefit to the trainee and wider health sector and is manageable. • Improve clinical workforce development across the Central Region.

• 100% of all trainees in receipt of HWNZ funding have a career plan and in place and access to career guidance and resources by 31st July 2012. • Implementation of a minimum of 3 regional innovative clinical placements/new roles of practice by 30th June 2013. • A Central Region portal for innovation information sharing by 30th November 2012. • A report of recommendations for a Central Region learning management system by 31st May 2013. • A minimum of three PGY1/2 programmes regionally are standardised and training procedures implemented 30 June 2013. • A memorandum of understanding is implemented in the region for regional skills and simulation training by 31st March 2013	• Improve operational efficiencies and effectiveness through regional collaboration and technology. • Programmes are standardised and made available to other professional groups and hubs

Regional Implementation of National Service Reviews	
Why this is a priority? With rapidly rising demand for services and constraints on finances and availability of professional skills, the National Service reviews are tasked with thinking innovatively about how high quality services can be delivered for all New Zealand communities.	
Activity in 2012/2013	**What we will achieve by 2015**
The Wairarapa DHB is aware of the HWNZ service reviews and will participate with our sub regional colleagues to implement the recommendations as appropriate.	The service review recommendations will be considered in relevant service design as part of our sub regional strategy.

Clinical Leadership and Career Planning	
Why this is a priority? Regional and subregional projects such as the 3HSD Programme offer management and clinicians various leadership development opportunities as well as opportunities to develop more clinically sustainable service models across DHBs.	
What we are doing in 2012/2013	**What we will achieve by 2015**
• Engagement of our clinical workforce in regional service planning and development. Effort is focused on releasing senior clinicians so they can participate in sub regional discussions. • Participation in the pilot for GP registrar training across the sub region of Wairarapa, Hutt and Capital and Coast will continue with placements focused on South Wairarapa. As part of this trial we will provide support to the medical practices and the GP Registrars participating on the programme. • Continued involvement in the roll out of a national pilot for the recruitment of new graduate nurses (using the ACE process). • Implementation of a regional approach for the	• Service Models will be designed and endorsed by clinicians. The view of the workplace will be broader and the services will focus on a regional population. • The central Region will have optimum levels of NETP placements within the region. Students will have a streamlined application and appointment process. • There will be a regional picture of skill set and career pathways of out nurses. The region will be in a better place to encourage career pathways into priority areas. • The sub region will be working toward one workforce plan with an aim to have generic workforces who are more mobile and flexible.

allocation of placements and funding for the HWNZ Nursing programmes, i.e. Nursing Entry to Practice and Post Graduate Education. • Development of a nursing workforce plan for the sub region of Wairarapa, Hutt and Capital and Coast • Support the implementation of local, sub regional and regional workforce innovations that arise out of Tihei and the 3D programme, e.g regional ENT Specialists.	

Working Sub regionally to Sustain our Collective Workforce	
Why is this a priority? To support the vision of "three DHBs, shared community, three populations" the Clinical Leadership Group has been formed with the objective of advancing improvements in the quality of patient care, managing risk, improving processes, sustaining our collective workforce and making best use of our financial resource. As individual DHBs we have areas of vulnerability and clinicians working in isolation. Working as a sub region we can increase the likelihood of our workforce being supported, sustainable, and enabled.	
What we are doing in 2012/2013	**What we will achieve by 2015**
• Participating in the '3D' Enablers group to support work streams to develop sustainable service models with workforces which are flexible and mobile. • Work with sub regional DHBs and the PHO to obtain commitment to work collaboratively when developing and implementing new Models of Care. This will include the need to consider current practices and processes operating within other DHBs/primary practices and where appropriate how DHBs will implement the model of care consistently, e.g. communications, change management, professional development and education. • Participate in regional information sharing e.g. Solo Practitioners data base. • When a role becomes vacant consideration will be given to whether the role can be filled as a sub regional role. Sharing of information and entering new projects with the consideration and engagement of the other two DHBs.	• The implementation of clinical pathways that take into account cultural, ethnic, gender and age specific needs. • Clinicians, supported by managers, leading the development, design and implementation of services, systems and processes. • Strategies that promote a flexible and mobile workforce, with the workforce moving to where the people need to best receive the services and where it is best to deliver services.

4.4 QUALITY AND SAFETY

Wairarapa DHB is committed to ensuring that the patient is at the centre of everything that we do and that the DHB strives to achieve the best outcomes for our patients consistent with our Triple Aim approach.

Listening to our community and consumers voice is a priority and the DHB has recently established a Consumers Forum consisting of nine consumer representatives with a wide and diverse range of healthcare needs and experiences. Over the next year we are going to be using their experience to assist in service development and ensuring our patients receive safe, high quality patient centred

healthcare. This will include the development our new patient experience survey questions to ensure we target the correct information and feedback.

The DHB is also committed to implementing the range of initiatives being rolled out by the HQSC. These include:

- Improving medication safety
- Mortality review
- Reportable events
- Falls management
- Clinical effectiveness
- Global trigger tools.

The following provides an update on key HQSC initiatives that are being implemented by the DHB and key activities that will be implemented in 2012/13.

<table>
<tr><th colspan="2">Improving Medication Safety</th></tr>
<tr><td colspan="2">Why is this a priority?
Medication errors originating from prescribing and administration errors account for a significant proportion of reportable events generated; the potential for harm is great and this is reflected in the priority the Health Safety and Quality Commission have given to reduce the harm caused to patients through medication errors.</td></tr>
<tr><td>Where are we now?</td><td>What are our plans for 2012/2013</td></tr>
<tr><td>• Wairarapa DHB has introduced the National Medication chart following education and training prior to the roll out.
• Wairarapa DHB has Medicine reconciliation (MR) programme for patients admitted to the medical surgical ward. The aim is for 25% of patients admitted to have medicine reconciliation.
• All medication errors are reported through the reportable events process and scored using the national severity assessment code (SAC).
• Audits are in place to monitor the effect of the initiatives from both a prescribing and administration perspective.
• A total of 46 errors were reported in 2010/11 none of these were SAC1 or 2.</td><td>• Reduce the overall medication error rate to less than 4 per month per 1000 bed days.
• Focus on reducing the incidence of controlled drug errors and near misses by 20%.</td></tr>
</table>

Mortality Review	
Why is this a priority? Mortality and morbidity reviews offer an opportunity to review practices and systems to determine improveme opportunity and areas for change.	
Where are we now? • Last year we completed a mortality review on 50% of all adult deaths occurring within the Wairarapa, each of these mortality reviews was reviewed for trends and improvement opportunities fed back to clinical staff through a variety of ways. • A child youth mortality review coordinator was appointed in November and the first Child Youth Mortality (CYMG) review took place in February 2012.	**What are our plans for 2012/2013?** • Increase the number of deaths with a mortality review completed to 80%. • Continue to communicate any clinical or system improvements to all health care professionals within the DHB.

Reportable Events	
Why is this a priority? The national reportable event policy ensures that we can compare and benchmark with other DHBs, and share experiences.	
Where are we now? • Wairarapa have been working to the national reportable event policy and actively using the national repository at the HQSC for the notification and management of all SAC 1 and 2 events. • Submitting events for the annual serious and sentinel event release. • This year we have worked with our neighbouring tertiary hospital on joint reviews of complex patient transfers and other clinical case reviews to align practices and collaborate on improvements.	**What are our plans for 2012/2013?** • To continue to utilise the next edition of the national reportable event policy. • Commence supporting age residential care through education towards adopting the national reportable events policy.

Falls Management	
Why is this a priority? Even when there is no injury associated with a fall, we recognise that a fall is an unpleasant experience for patients and we need to do all we can to prevent them taking place whilst preserving patients' independence. Wairarapa DHB aimed to initially reduce the harm sustained as a result of falls during the 2011/2012 period.	
Where are we now? • All falls are reviewed and investigated. • A total of 139 falls were reported for the 2010/2011 period, only 2 of these resulted in SAC2 events. • Patients presenting at ED following a community fall are reviewed by an Occupational therapist and followed up. • Wairarapa DHB has an active Falls Management Group.	**What are our plans for 2012/2013?** • To reduce our falls rate to <10 per month per 1000 days. • Continue to try to reduce serious harm from falls. • Form closer alliances with the aged residential. care facilities to align processes and systems. • Adopt national indicator for falls measurement.

Infection control and management	
Why is this a priority? Healthcare-acquired infection is one of the most frequent adverse events in healthcare worldwide. Up to 10 percent of patients admitted to modern hospitals in the developed world acquire one or more infections. Infections not only impact on the patient experience but also add to the cost of treatment.	
Where are we now? • Hand Hygiene project continues within the DHB with auditing and education. • Compliance to hand hygiene following audit shows low compliance at 34%. • Surveillance activity reported and monitored Hospital acquired blood stream infections (BSI) for the period of 2010/2011 was 0.3712 per 100 bed days. • Surgical site infection monitoring of all clean orthopaedic surgery wound rate for 2010/2011 was 3.8%.	**What are our plans for 2012/2013?** • To improve hand hygiene to 64% compliance. • To continue to maintain our low BSI rates. • Reduce the SSI for clean orthopaedic surgery to below 3%. • Commencing Caesarian section SSI surveillance.

Improved Pressure Ulcer prevention	
Why is this a priority? Healthy people do not get pressure ulcers because they are continuously and subconsciously adjusting their posture and position so that no part of their body is subjected to excessive pressure. However, people with health conditions that make it difficult for them to move their body often develop pressure ulcers. In addition, conditions that can affect the flow of blood through the body, such as type 2 diabetes, can make a person more vulnerable to pressure ulcers. We recognise that we must improve our care to patients who are at risk of developing pressure sores whilst in hospital and will achieve this reduction in 2012/13.	
Where are we now? For the period 2010/2011 we had an incidence of 0,038 hospital acquired pressure sores per 1000 bed days. Whilst this is still relatively low we would like to see zero tolerance to pressure sores. A small group of nursing staff are working on improving the management of at risk patients on admission to hospital.	**What are our plans for 2012/2013?** To reduce the incidence of hospital acquired pressure sores and work towards being a pressure area free hospital.

Other improvement projects

Wairarapa DHB is continuing to work with the HQSC on other initiatives and is actively participating in both the development of Quality Accounts, and the development of National Clinical Indicators. Wairarapa DHB is also undertaking the IHI Global Trigger Tool training to monitor patient safety and harm. Key clinical staff are undertaking the training this year and will be using the results to form part of our quality accounts next year.

The DHB is introducing an Early Warning Score (EWS) and the ISBAR communication tool at Wairarapa Hospital. The EWS is designed to identify early signs of clinical deterioration and provides a structured escalation process to ensure appropriate intervention occurs in a timely manner. This is a national patient safety initiative aimed at the early recognition and appropriate management of the deteriorating patient.

4.5 ORGANISATIONAL HEALTH

The Wairarapa DHB is committed to developing and maintaining a clinically and financially sustainable organisation. This is reliant on having a high performing Governance Board and committee structure, a high performing DHB Senior Leadership Team and a high performing clinical workforce and supporting infrastructure within our Provider Arm.

We will ensure our Board and Leadership Team have the necessary skills and capacity to ensure the success of our organisation, making training opportunities available where this is appropriate.

We will continue to develop our Provider Arm's workforce and support the development of the wider health workforce and promote and foster a professional and supportive working environment. We will also seek to ensure we have sufficient health workers with the right skills in the right place at the right time delivering the services our population needs.

Having the right workforce to deliver high quality, effective services is critical if we are to realise our high level outcomes: provision of health services that are clinically and financially sustainable and people in the Wairarapa live longer, they are healthier and more able to live independently.

To support achievement of these outcomes, the Wairarapa DHB aims to be a health system of choice, offering employees flexibility, opportunities for innovation, skill development and leadership. The DHB also aims to develop a reputation as a preferred employer among health workers.

As a 'good employer', the Wairarapa DHB will continue to grow a positive organisational culture, ensuring the fair and proper treatment of employees in all aspects of their employment. This will be achieved by ensuring all human resource policies and procedures are equitable and fair, and by providing a work environment where employees are able to develop new skills and have opportunities to work in professionally challenging and rewarding roles.

The Wairarapa DHB believes that it will benefit from a diverse workforce and is committed to recognising and valuing different skills, talents, experiences and perspectives of employees.

4.6 REPORTING AND CONSULTATION

Wairarapa DHB provides regular reporting to the Minister of Health as outlined in the table below. In accordance with s 141 (1) (g) Crown Entities Act 2004 we will consult with the Minister via the Minister of Health on any significant developments not covered in this plan. Table 8 refers.

Table 8: Reporting and Consultation

Reporting	**Frequency**
Information Requests	Ad Hoc
Financial Reporting	Monthly
National Data Collections	Monthly
Risk Reporting	Quarterly
Health Target reporting	Quarterly
Crown Funding Agreement non-financial reporting	Quarterly
Indicators of DHB Performance	Quarterly
Annual Report & audited statements	Annually

4.7 SHARES INTERESTS OR SUBSIDIES

The Wairarapa DHB, with other central region DHBs, has joint ownership of the Central Regional Technical Advisory Service (CRTAS). CRTAS provides analytical and planning support services to the central region DHBs. CRTAS is funded by the DHBs on an annual budget basis to provide services. The Wairarapa DHB also has a wholly owned subsidiary company – Biomedical Services New Zealand Limited (Biomed) which has its own board of directors and reports on a regular basis to the Wairarapa DHB as their owner. Biomed provides testing and servicing of patient related equipment to a number of DHBs NGOs and private hospitals throughout New Zealand.

MODULE 5: FORECAST SERVICE PERFORMANCE

5.1 STATEMENT OF FORECAST SERVICE PERFORMANCE

The Statement of Forecast Service Performance (SFSP) describes the classes of outputs the DHB plans to fund and provide, the total revenue the DHB is making available to each output class and how delivering these outputs will contribute to our key strategic outcomes.

Our SFSP includes four output classes:

- Prevention Services
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support

Wairarapa DHB believes the outputs and measures presented in this section provide a reasonable representation of the range of services provided by the DHB.

5.2 OUTPUT CLASSES AND MEASURES OF DHB PERFORMANCE

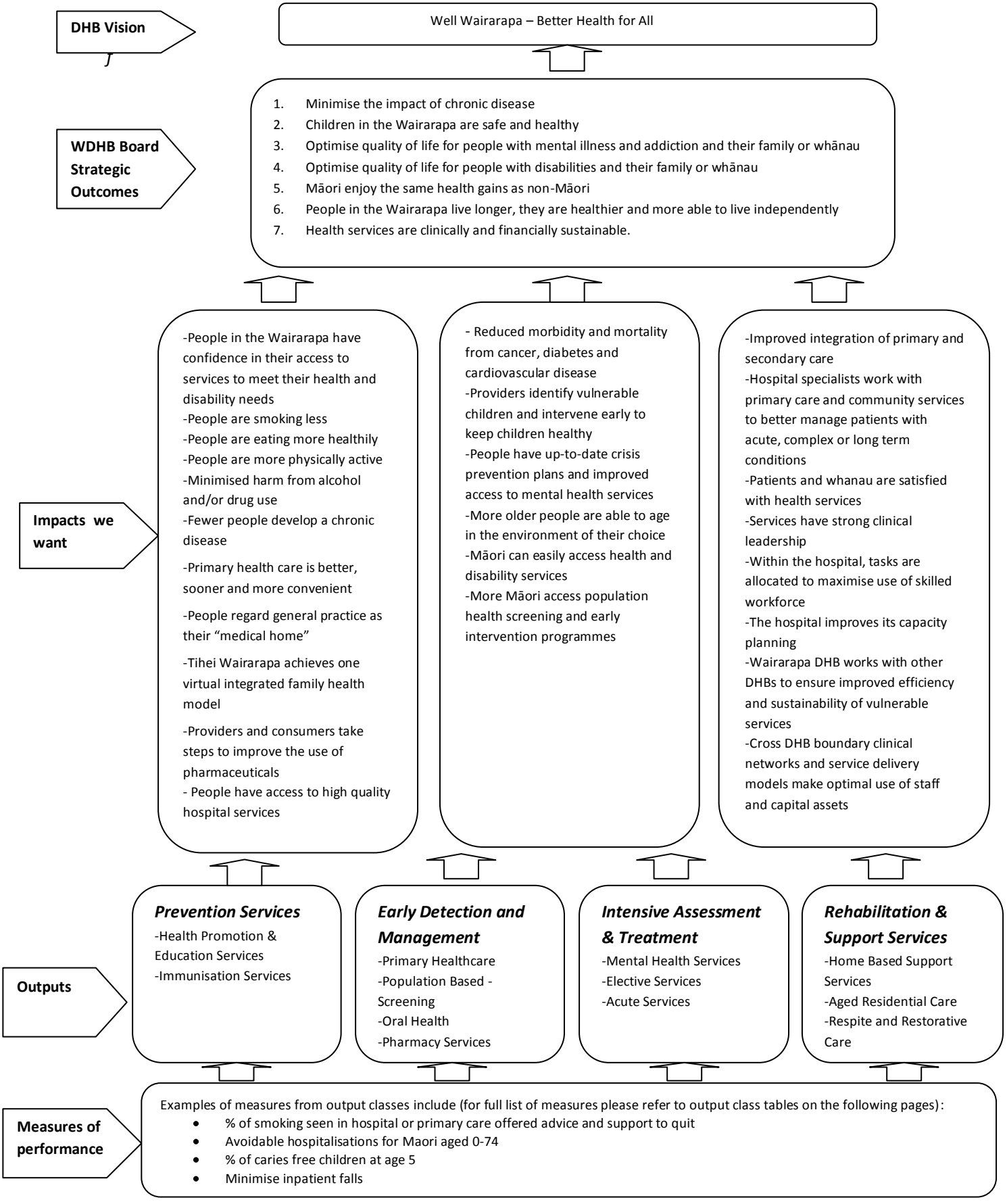
The following section describes these four output classes in more detail. These tables do not cover all the services that we fund and deliver under each output class. Given the wide range and diversity of services within each output class, we have focused on those services which are particularly important if we are to deliver on local, regional and national expectations, priorities and targets identified in Modules 3.

These tables include measures which we will use to evaluate our performance in delivering these outputs over 2012/13. Our intention is to capture data to assess progress against the various performance measures for Māori as well as our total population which is a key commitment from our Maori Health Plan. This progress will be reflected in our 2013/14 Annual Report.

A large number of the measures outlined in this section are also captured in the DHBs BSC and are part of the DHB's regular performance monitoring through its Senior Leadership Team and Governance Committees.

Figure 6 reflects the Wairarapa DHBs intervention logic against the four output classes. Detailed measures, trend information and expenditure are also provided for each output class in the following section.

Figure 6: Output class intervention logic



PREVENTION SERVICES

Output Class Description

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations. They comprise services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Preventative services include;

- health promotion to ensure that illness is prevented and unequal outcomes are reduced
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases and
- population health protection services such as immunisation and screening services

On a continuum of care, these services are public wide preventative services. In 2012/13, the Wairarapa DHB is planning to spend $3.7M on Prevention Services.

Why is this Out Class significant for the DHB?

Prevention services are important to us as these services support people to make healthy choices and reduce risk factors that lead to long term conditions. Prevention services are cost effective in that they can deliver consistent messages to a large number of people. Prevention services provide the opportunity to target improvements in the health of high needs populations who are more likely to engage in risky behaviours.

Prevention services in the Wairarapa are delivered through a range of providers within the Wairarapa district including Regional Public Health and the Wairarapa DHB Population Health Unit. Other providers include Primary Health providers such as General Practice, our Maori health service providers and other private and non-governmental organisations e.g. Sports Trusts and local and regional government.

Outputs -short term performance measures (2012/13)

Over the next three years we will fund and provide outputs (services) which will make a positive impact on the health and wellbeing of the Wairarapa population. The Quantity (V), Timeliness (T), Coverage (C) and Service Quality (Q) of those outputs will be measured using the following output performance measures:

Health Promotion and Education Services	**Key**	**Actual 2010/11**	**Target 2011/12**	**Target 2012/13**
These services inform people or their caregivers about risks and support them to be healthy through increased awareness and engagement. This involves programmes that support people to maintain wellness or assist them to make healthier choices. This is measured by rates of positive or negative behaviours.				
Increased percentage of smokers seen in hospital are offered advice and support to quit (health target) –*see historical trend information*	C[7]	99%	95%	95%
Increased percentage of smokers seen in primary care are offered advice and support to quit (health target)	C	new	90%	90%
Increased percentage of infants (Maori) are exclusively and fully breastfed at 6 weeks of age -–*see historical trend information*	V[8]	70%	74%	74%

[7] Evidence shows that advice and support to stop smoking increases the chance of smokers making a quit attempt thereby increasing the chance that smokers will be able to become smoke-free.

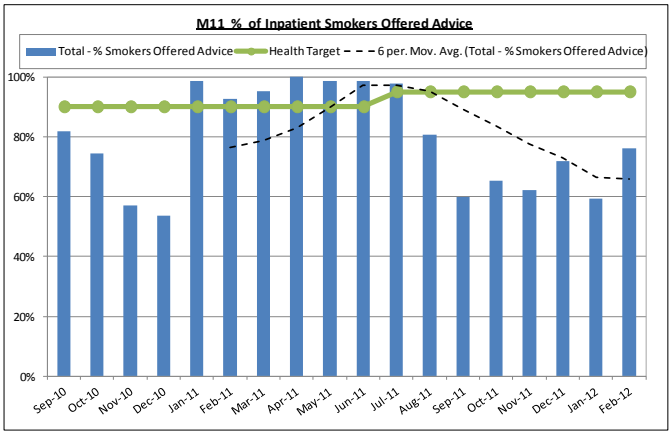
[8] The proportion of mothers breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period.

Increased percentage of infants (all ethnicities) are exclusively and fully breastfed at 3 months of age - *see historical trend information*	V	55%	57%	57%
Improve the score for family violence intervention auditing	Q	166/200	140/200	170/200

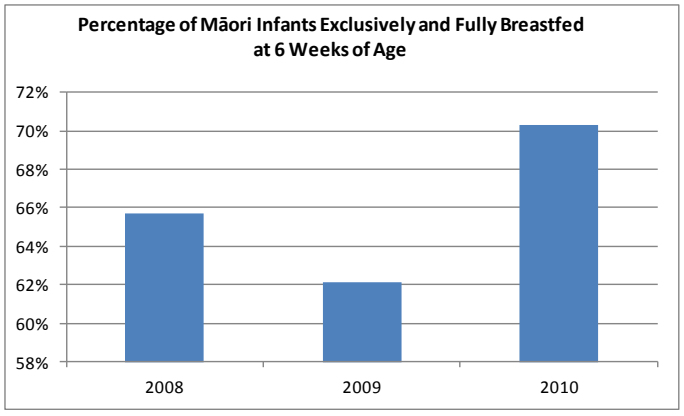
Immunisation Services	**Key**	**Actual 2010/11**	**Target 2011/12**	**Target 2012/13**
These services reduce the transmission and impact of vaccine preventable diseases. The DHB works with primary care and other health providers to improve the provision of immunisations across all age groups both routinely and in response to specific risk. High coverage rates are indicative of a well coordinated and successful service.				
Children are fully immunised at eight months of age (health target)	C[9]	new	new	85%
Maori children are fully immunised at eight months of age	C	new	new	85%
Children are fully immunised at two years of age –*see historical trend information*	C	93%	90%	95%
Increased percentage of over 65 year olds are vaccinated against seasonal influenza	C	68%	67%	69%

HISTORICAL DATA/TREND INFORMATION

Inpatient smokers offered advice:

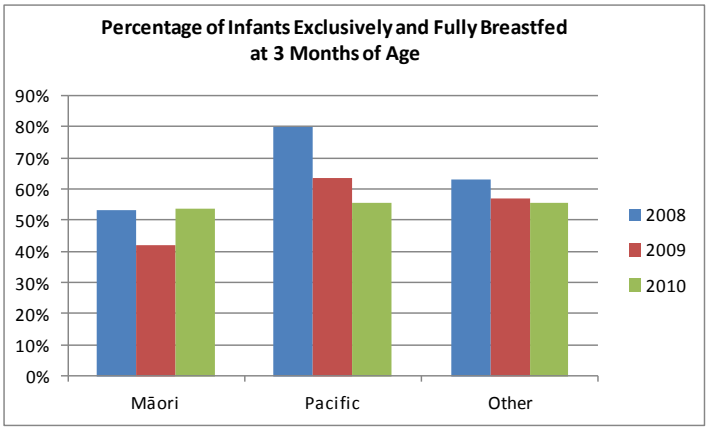


Maori infants exclusively fully breastfed at six weeks:

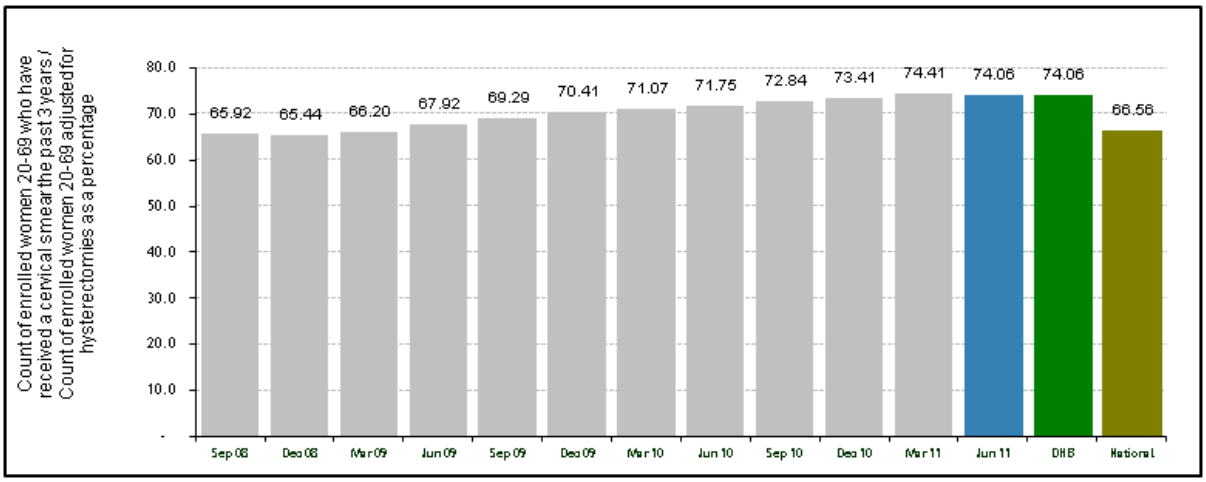


[9] Vaccination reduces the incidence of vaccine preventable diseases among children and influenza and respiratory complications among older people.

Percentage of infants exclusively and fully breastfed at 3 months:



Age appropriate Vaccinations – 2 Year Olds:



EXPENDITURE ON PREVENTION SERVICES

The following table provides a summary of the DHBs expenditure on prevention services.

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Expenditure					
Workforce costs	1,096	941	990	1,024	1,056
Treatment related costs	53	55	79	81	84
Non-treatment related & other costs	362	273	236	244	252
External providers	784	776	978	1,012	1,043
Inter district flows	0	0	0	0	0
Depreciation & amortisation	98	98	98	102	105
Total expenditure	**2,393**	**2,143**	**2,381**	**2,463**	**2,540**
Allocation of corporate costs	1,095	1,174	1,293	1,338	1,379
Total cost of services	**3,488**	**3,317**	**3,674**	**3,801**	**3,919**
Income	2,944	2,607	2,910	3,012	3,104
Net result of service	**(544)**	**(710)**	**(764)**	**(789)**	**(815)**

EARLY DETECTION AND MANAGEMENT

Output Class Description

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings including general practice, community and Māori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature generalist, usually accessible from multiple health providers and from a number of different locations within the DHB area. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

In 2012/13, the Wairarapa DHB is planning to spend $41.6M on Early Detection and Management Services.

Why is this Output Class significant for the DHB?

Wairarapa, as with the rest of the country, is experiencing an increase in the prevalence of long term conditions and has an ageing population profile which has an impact of the prevalence of long term conditions. This will create future demand on health services both in the community and hospital settings.

We believe that enhancing primary and community services, and encouraging the community to engage early with health services and maintain good health through earlier diagnosis and treatment, this will reduce the impact on the health system while also achieving better long term outcomes. We will achieve this by continuing to integrate health services through our better, sooner more convenient business case; working in partnership with our clinicians across the health system to reduce inefficiencies and provide a wider range of services closer to home.

Outputs -short term performance measures (2012/13)

Over the next three years we will fund and provide outputs (services) which will make a positive impact on the health and wellbeing of the Wairarapa population. The Quantity (V), Timeliness (T), Coverage (C) and Service Quality (Q) of those outputs will be measured using the following output performance measures:

Primary Health Care (GP) Services	**Key**	**Actual 2010/11**	**Target 2011/12**	**Target 2012/13**
These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary care professionals aimed at improving, maintaining or restoring people's health. High levels of enrollment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.				
Consultation rates per enrolled population	C[10]	4.77	4.6	4.8
Reduced avoidable hospital admissions Maori aged 0-74	V[11]	112	111	110
Reduced avoidable hospital admissions Total aged 0-74	V	125	111	110
Reduced number of non-admitted triage 4 and 5 ED self presentations	V[12]	8874	6643	5814
Increased percentage of people with satisfactorily	V[13]	72%	78%	78%

[10] Consultation rates reflect the accessibility of primary care. The aim is to increase the accessibility of primary care services so the population receives the health services they require to maintain their health.

[11] A number of admissions to hospital are seen as preventable through appropriate early intervention and these admissions provide an indication of the access and effectiveness of primary care and an improved interface between primary and secondary services. The expected rate is the national average and a result greater than 100 indicates worse than average performance.

[12] Many triage 4 and 5 ED presentations could be more effectively and efficiently treated in primary care, freeing up acute hospital services for management of more complex patients. Through effective integration of services the DHB has an aim to reduce these presentations by 30% over a three year period.

controlled diabetes - *see historical trend information*				
Increased percentage of Maori with satisfactorily controlled diabetes	V	61%	72%	78%
Increased percentage of people checked for cardiovascular risk -*see historical trend information*	C[14]	63%	Measure changed in 11/12	75%

Population Based Screening Programmes	**Key**	**Actual 2010/11**	**Target 2011/12**	**Target 2012/13**
These services are mostly funded and provided through the National Screening Unit and help identify people at risk of illness and pick up health conditions early. They include breast and cervical screening. Cervical screening is accessed through our GPs and Maori health providers while breast screening is provided by regular visits to the region by a mobile service. The DHB is also funded to provide early detection of health problems through the B4 School checks programme. A high percent of children being screened by this programme increases the opportunity for early identification and treatment of health concerns.				
Increased percentage of high needs women aged 20-69 screened for cervical cancer in last 3 years - *see historical trend information*	C[15]	74%	74%	>/ 75%
Increased percentage of four year olds have B4 School checks before they turn 5	C[16]	87%	90%	90%
Increased percentage of high needs four year olds have B4 School checks before they turn 5	C	87%	90%	90%

Oral Health Services	**Key**	**Actual 2010/11**	**Target 2011/12**	**Target 2012/13**
These services are provided by registered health professionals to assist people in maintaining healthy teeth and gums. Wairarapa has a child oral health service operating from two mobile clinics and a soon to be completed oral health hub. The DHB also funds adolescent dental services and the emergency relief of pain service through local dentists. High enrollments are indicative of engagement while an increase in carries free at the age of 5 indicates improving oral health in children.				
% of caries free children at age 5	C	67%	65%	65%
Mean Decayed, missing of filled (DMFT) permanent teeth at year 8 – *see historical trend information*	C	1.23	1.07	1.10
Children under 5 enrolled in a DHB funded dental service: -Maori -Pacific -Total	 V / C V / C	 671 61 2213	 646 44 1,830	 683 63 2257
Children examined at age 5: -Maori -Pacific -Total	 V / C V / C	 129 17 431	 130 15 495	 135 20 505
Children examined at Year 8: -Maori -Pacific -Total	 V / C V / C	 113 15 411	 80 10 480	 115 18 523
Utilisation of DHB funded dental services by adolescents	V / C	82%)	85%	85%

[13] As indicated by blood glucose levels. Uncontrolled diabetes leads to other health complications.

[14] This indicator is measured through the PHO Performance Programme in 2012/13 and is a different measure to previous years. The National Health Target is 75% for 2012/13.

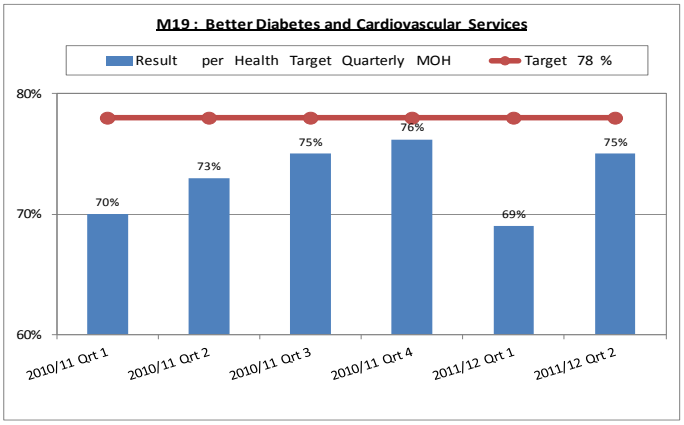
[15] Cervical screening rates are measured through the PHO Performance Programme. The programme goal is that at least 75% of women will have been screened for cervical cancer in the last three years.

[16] The B4 School Check is the final Well Child/Tamariki Ora check, which children receive at age 4. The free check includes vision, hearing, oral health, height and weight. The check allows for health concerns to be identified and addressed early in a child's development, giving him/her the best possible start for school and later life.

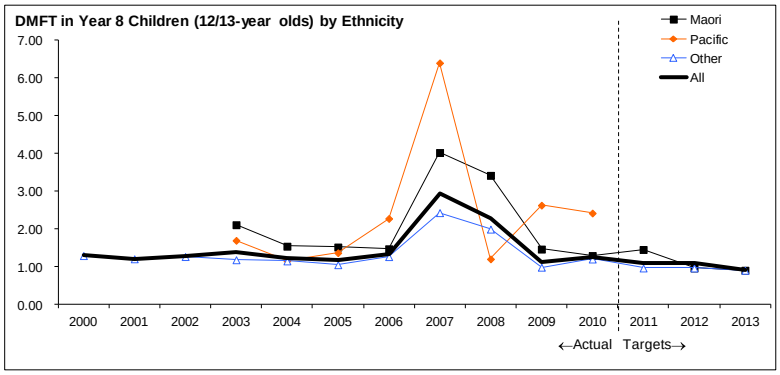
Pharmacy Services	Key	Actual 2010/11	Target 2011/12	Target 2012/13
These services include provision and dispensing of medicines and are largely demand driven. As our population is ageing and long term conditions become more prevalent, we are likely to see an increased number of dispensings of pharmaceutical items. To improve service quality we have introduced the OPTIMED service; a community based program that seeks to optimise drug treatment for people with complex medicines regimens.				
Number of people having OPTIMED reviews	Q	55	160	160

HISTORICAL DATA/TREND INFORMATION

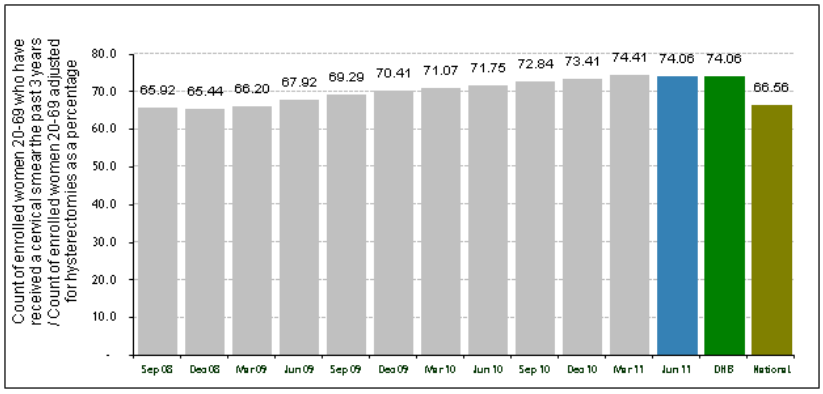
Better Diabetes and Cardiovascular Services:



Mean Decayed, missing of filled (DMFT) permanent teeth at year 8:



Cervical Cancer Screening – High Need:



EXPENDITURE ON EARLY DETECTION AND MANAGEMENT SERVICES

The following table provides a summary of the DHBs expenditure on early detection and management services.

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Expenditure					
Workforce costs	6,574	6,318	6,193	6,409	6,606
Treatment related costs	1,521	1,554	1,509	1,562	1,610
Non-treatment related & other costs	695	626	549	568	586
External providers	28,302	28,984	28,839	29,133	29,630
Inter district flows	1,941	1,930	1,858	1,923	1,982
Depreciation & amortisation	165	114	17	18	18
Total expenditure	**39,198**	**39,526**	**38,965**	**39,613**	**40,432**
Allocation of corporate costs	4,077	3,017	2,614	2,464	2,446
Total cost of services	**43,275**	**42,543**	**41,579**	**42,077**	**42,878**
Income	42,921	42,723	42,128	43,602	44,940
Net result of service	**(354)**	**180**	**549**	**1,525**	**2,062**

INTENSIVE ASSESSMENT AND TREATMENT

Output Class Description

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a 'hospital'. These services are generally complex and provided by health care professionals that work closely together.

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

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

In 2012/13, the Wairarapa DHB is planning to spend $69.2M on Intensive Assessment and Treatment Services.

Why is this Output Class significant for the DHB?

Timely access to intensive assessment and treatment services is essential for the Wairarapa population many of whom live rurally and have in some cases significant travel time to access acute services. Timely access to intensive assessment and treatment can significantly improve a person's quality of life through early intervention or corrective actions. Timely and equitable acute services also give people confidence that complex interventions are available when needed.

Wairarapa DHB has a responsibility to ensure that safe, high quality services are provided and that no further harm to patients occurs. Quality improvements in service delivery, systems and processes will improve patient safety, reduce the number of events causing harm or injury and provide improved outcomes for patients accessing these services.

The Government has set clear expectations regarding the delivery of increased elective services, reduced waiting times in the emergency department and an increasing emphasis on improving the quality and safety of services in a hospital environment such as reducing falls and surgical site infections.

Outputs-short term performance measures (2012/13)

Over the next three years we will fund and provide outputs (services) which will make a positive impact on the health and wellbeing of the Wairarapa population. The Quantity (V), Timeliness (T),Coverage (C) and Service Quality (Q) of those outputs will be measured using the following output performance measures:

Mental Health Services	Key	Actual 2010/11	Target 2011/12	Target 2012/13
These are services for people who are most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment and rehabilitation as well as crisis response and respite as required. Inpatient services for our population are provided by neighbouring DHBs. Waiting times and utilization across our integrated mental health service are measured to demonstrate the responsiveness of the service.				
Waiting times across drug and alcohol services will be monitored to ensure services are responsive to needs. a. Specialist prescribing b. Structured counselling c. Residential rehabilitation	T/Q[17]	a.b. No wait time c.4-6 wks	a.b. No wait time c. 4-6 wks max	a.b. No wait time c. 4 wks max
Increased access rates across all mental health and addiction services:-*see historical trend information* a. 0-19 b. 20-64 c. 65+	 C C C	 4.34 4.28 .81	 4.5 4.5 1.8	 4.8 4.8 2.0
Percentage of people with serious mental illness who have a relapse prevention plan in place	Q	91%	95%	95%

Elective Services	Key	Actual 2010/11	Target 2011/12	Target 2012/13
These are services for people who do not need immediate hospital treatment and have "booked" or "arranged" services. This includes elective surgery, non surgical interventions and specialist assessments (either first assessments, follow-ups or preadmission assessments)				
Total number of elective surgical discharges provided (health target)	V[18]	2,060	1,841	1,841
Elective and arranged surgery is undertaken on a Day Case basis	Q[19]	58%	60%	62%
People receive their elective and arranged surgery on the day of admission	Q	97%	95%	95%
Average elective and arranged inpatient length of stay (in days) is maintained	Q	3.8	3.7	3.7
Outpatient "Did Not Attend" (DNA) rates are reduced	Q	5.9%	6.5%	6.2%
Number of people requiring a First Specialist Assessment who wait longer than six months	T[20]	0.4%	<1.5%	0%
Number of people given a commitment to elective surgery who wait longer than six months	T	2.9%	<4.0%	0%

[17] More people are able to access the right level of care and support that they need, when they need it. Fewer people present in crisis as they are cared for earlier. A seamlessly operational stepped care model ensures that people in need of mental health and addiction services receive the right level of care, at the right time.

[18] These elective service volumes exclude cardiology and dental and are discharges based on the national health target definition.

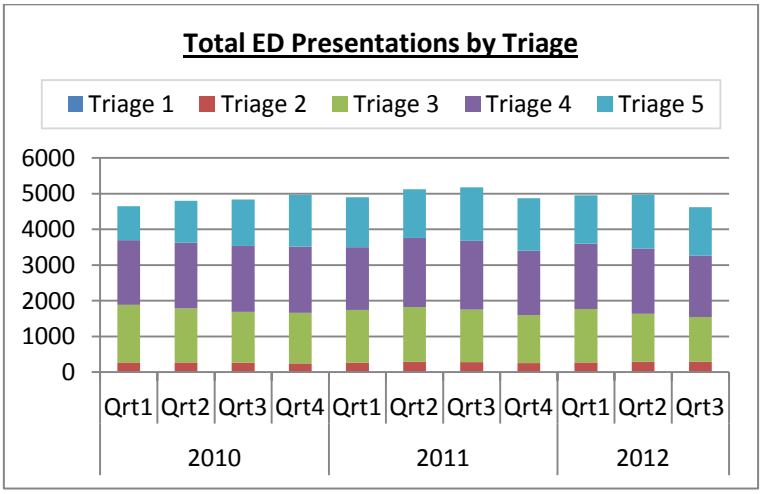
[19] These measures are based on OS3, OS5, OS6 and OS7 measures from the national indicators of performance set for DHBs –see Appendix 8.1. When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients who can spend the night before in their own homes and this frees up hospital beds. Day case, day of surgery rates and average length of stay are balanced against readmission rates to ensure service and quality are appropriate.

[20] This percentage measure is the number of people waiting over six months divided by the total number of people on the waiting list at a given point in time. Actual 2010/11 results are taken as at 30 June 2011.

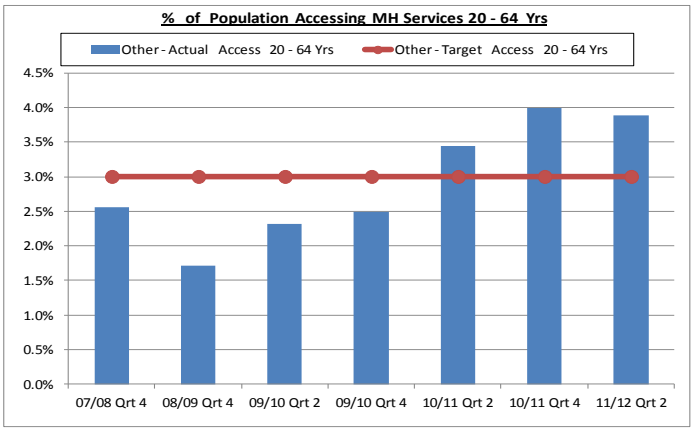
Acute Services	Key	Actual 2010/11	Target 2011/12	Target 2012/13
These are services for illnesses (or accidents) that have a sudden onset, are often short in duration for which the need for care is urgent. These presentations are usually to a hospital setting and may or may not involve admission for ongoing care. Hospital based acute services include the emergency department and acute inpatient beds. Acute services including intensive care and other complex or tertiary level acute care is provided to our population principally (not exclusively) by Capital and Coast and Hutt Valley DHBs. The DHB is working with its primary care partners to support initiatives to reduce the acute demand on the hospital.				
Number of ED–attendances - *see historical trend information*	V	20,199	18,500	18,000
Number of acute hospital admissions	V	5,467	5,477	5,500
% of patients discharged or transferred from ED within 6 hours (by ethnicity) – health target	T	95%	95%	95%
Rate of acute readmissions (readmitted within 28 days)	V/ Q	8.81	8.81	8.81
Maximize theatre utilization	C	85%	85%	85%
Optimize ALOS for acute inpatients	C	3.81	3.81	3.81
Minimise Blood Stream Infections (per quarter)	Q	8	<3.5	<3.5
Minimise inpatient falls (per annum) –*see historical trend information*	Q	139	<115	<100
Minimise surgical site infections (per annum)	Q	3.8%	3.2%	3.0%
Patients wait no longer than 4 weeks for radiation or chemotherapy treatment (health target)	C	<6weeks	<6 weeks	<4 weeks

HISTORICAL DATA/TREND INFORMATION

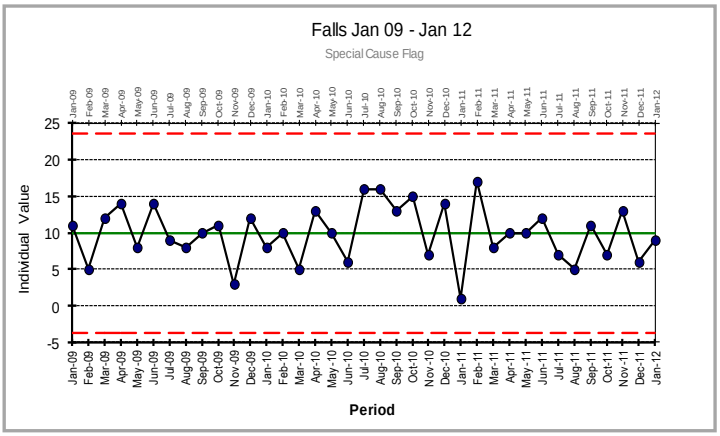
Total ED presentations by triage:



Population Accessing Mental Health Services 20-64 years:



Recorded Falls – Wairarapa Hospital:



EXPENDITURE ON INTENSIVE ASSESSMENT AND TREATMENT SERVICES

The following table provides a summary of the DHBs expenditure on early detection and management services.

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Expenditure					
Workforce costs	24,009	25,035	24,968	25,841	26,635
Treatment related costs	9,221	9,321	9,253	9,577	9,871
Non-treatment related & other costs	747	753	780	807	832
External providers	874	679	1,000	1,035	1,066
Inter district flows	21,464	21,960	22,182	22,958	23,663
Depreciation & amortisation	554	549	544	563	580
Total expenditure	**56,869**	**58,297**	**58,727**	**60,781**	**62,647**
Allocation of corporate costs	9,127	10,186	10,518	8,635	9,389
Total cost of services	**65,996**	**68,483**	**69,245**	**69,416**	**72,036**
Income	62,589	64,017	65,444	67,732	69,812
Net result of service	**(3,407)**	**(4,466)**	**(3,801)**	**(1,684)**	**(2,224)**

REHABILITATION AND SUPPORT SERVICES

Output Class Description

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination of services by Needs Assessment and Service Coordination (NASC) Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services provide support for individuals.

In 2012/13, the Wairarapa DHB is planning to spend $19.0M on Rehabilitation and Support Services.

Why is this Output Class significant for the DHB?

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life as a result of staying active and positively connected to their communities. This is evidenced by less dependence on hospital and aged residential care services and a reduction in acute illness or deterioration.

Wairarapa DHB faces specific challenges with the number of people over the age of 65 expected to increase by 32% by 2031. Rehabilitation and support services play a key role in preventing acute illness and deterioration and reducing acute demand on our hospital, ED and our General Practices.

Wairarapa DHB has focussed on providing early support to patients, though a single point of entry for all support service needs, to minimise the impact of functional loss and disability. The DHB has actively supported services that maintain people in their own homes including provision of complex packages of care. Over 30% of people who would otherwise be in residential care are supported in their homes through home based support services. With an aging population it is important that we understand the effectiveness of services in this area, and the DHB will use the INTERAI tool to ensure people receive the support services that best meet their needs.

Outputs-short term performance measures (2012/13)

Over the next three years we will fund and provide outputs (services) which will make a positive impact on the health and wellbeing of the Wairarapa population. The Quantity (V), Timeliness (T), Coverage (C) and Service Quality (Q) of those outputs will be measured using the following output performance measures:

Home-Based Support Services	**Key**	**Actual 2010/11**	**Target 2011/12**	**Target 2012/13**
These are services designed to support people to continue to live in their own homes and to restore functional independence. They may be short or long term in nature. Increased home based support service utilization increases the capacity in the system and reduces the early entry and volume demands into aged residential care.				
Total number of home based support service hours - *see historical trend information*	V[21]	92,468	94, 645	97,572
Timely needs assessment and service coordination from the time of routine (non urgent) referral to the time of service being authorised. –*see historical trend information*	T[22]	75% within 6 weeks (Ave 4 weeks)	100% within 6 weeks	100% within 6 weeks

[21] The number of home based support service hours reflects an emphasis on supporting older people to live in the place of their choice. This figure is based on forecast demographic growth of 3%. It is therefore not an aspirational target that the DHB is seeking to achieve.

[22] The length of time people wait for a (non-urgent) needs assessment is seen as a service measure of quality for timeliness. 42 days is the service specification requirement. Average to date for 2011-12 is 30 days.

Proportion of people 85 and over who are assessed as having high/very high support needs:	Q[23]	36%	19%	19%
All home based support providers comply with the Home and Community Support Standard	Q[24]	-	100%	100%

Aged Residential Care Services	**Key**	**Actual 2010/11**	**Target 2011/12**	**Target 2012/13**
These services are provided to meet the needs of a person who has been assessed as requiring long term residential care in a hospital setting or rest home indefinitely. Wairarapa is increasing its aged residential care capacity to cater for the future demands of an aging demographic, will also maximizing use of home base support services to keep people as long as practicable in their homes.				
The percent of aged residential care facilities with 3 year certification (excluding new providers and new facilities)	Q[25]	77%	95%	100%
Total number of subsidised aged residential care bed days	V[26]	118,721	119,725 (est. annual volume)	123,428

Respite and Restorative Care	**Key**	**Actual 2010/11**	**Target 2011/12**	**Target 2012/13**
These services provide people with a break from a routine so that crisis can be averted or so that a specific health need can be addressed. Services are provided in the Wairarapa by aged residential care facilities for a short term or temporary nature. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time as more people are supported to remain in their homes.				
The percent of people who access the transitional Health Recovery Programme who return home - *see historical trend information*	Q[27]	78%	83%	85%
The number of days people have used respite care	V[28]	1620	1670	1722

[23] The proportion of people over 85 years who are assessed as being frail (have high or very high support needs) is expected to reduce as reversible aspects of frailty are addressed through primary health care initiatives (e.g. medication reviews).

[24] This standard (NZS 8158:2003) is specifically related to aspects of quality for home based support and is currently being revised.

[25] This measure is intended to result in confidence in quality of service provision and quality improvement systems in aged residential care. The 3 year period of certification is an indication that the aged care facility substantially complies with the Health and Disability Sector Standards. This measure is also used as a quality benchmarking indicator across the 6 central region DHBs. It excludes new providers and facilities, which cannot be certified for more than one year. Three year's certification is the maximum awarded to any ARC providers.

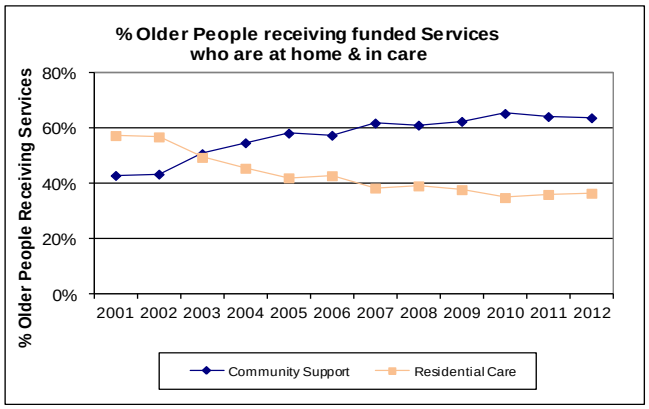
[26] This measure is based on forecast demographic growth of 3%. It is therefore not an aspirational target that the DHB is seeking to achieve. The number of (subsidized) aged residential care bed days is likely to be influenced by a number of factors such as older people's preference for living at home, socio-demographic factors and frailty.

[27] The Wairarapa Health Recovery Programme has provided a transitional process to enable a safe and sustainable return home after an acute illness. The programme spans both residential and community settings and links with general practices, acute medical/surgical and other hospital services, home and community care providers, and voluntary groups.

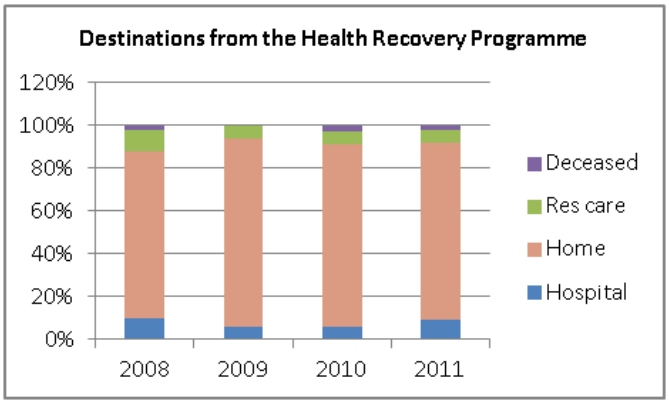
[28] The use of respite care relieves family carers to have a break. This break may be a day or longer and may either be a planned, routine break or available for the carer in a crisis situation. The number of respite care days used is therefore an indicator of support for carers. This measure is based on forecast demographic growth of 3%.

HISTORICAL DATA/TREND INFORMATION

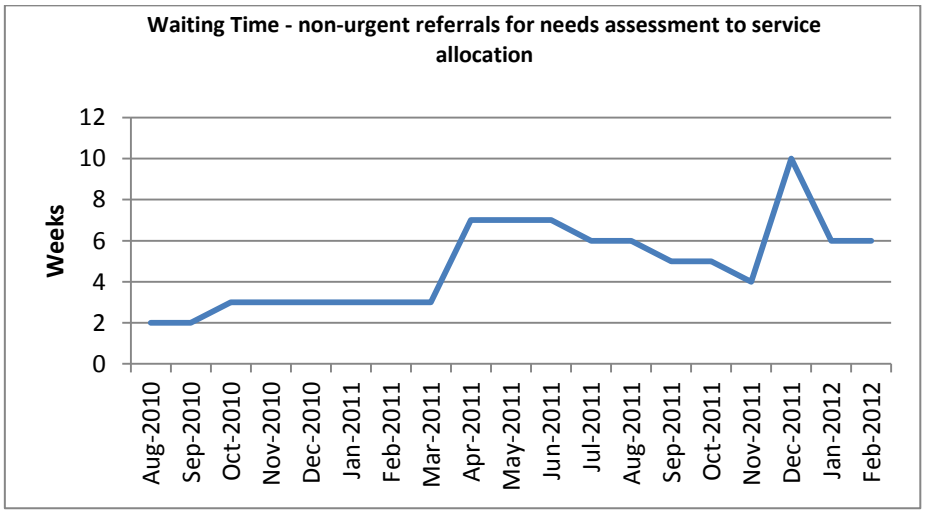
Percentage of older people who are supported to live at home or who are in care:



Destinations of all people who have accessed the Health Recovery (transitional) Programme:



The waiting time for non-urgent referrals for needs assessment and service allocation:



EXPENDITURE ON REHABILITATION & SUPPORT SERVICES

The following table provides a summary of the DHBs expenditure on rehabilitation and support services.

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Expenditure					
Workforce costs	802	794	817	846	872
Treatment related costs	479	466	495	513	528
Non-treatment related & other costs	53	54	55	57	59
External providers	13,712	14,635	15,155	15,685	16,167
Inter district flows	1,252	1,688	1,564	1,618	1,668
Depreciation & amortisation	0	0	0	0	0
Total expenditure	**16,298**	**17,637**	**18,086**	**18,719**	**19,294**
Allocation of corporate costs	953	927	936	969	998
Total cost of services	**17,251**	**18,564**	**19,022**	**19,688**	**20,292**
Income	17,937	19,210	19,938	20,636	21,269
Net result of service	**686**	**646**	**916**	**948**	**977**

MODULE 6: SERVICE CONFIGURATION

6.1 SERVICE COVERAGE

The Ministry's Service Coverage Schedule specifies the minimum access, scope and eligibility to publicly funded services that the population can expect. The 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 2012/13.

The Wairarapa DHB recognises the need for national consistency across services. Wherever possible, it 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.

6.2 SERVICE CHANGE

The Wairarapa DHB successfully reconfigured services in 2011/12 including the transition of the Wairarapa DHB's Ambulance service to Wellington Free Ambulance and the significant reconfiguration of Mental Health and Addition Providers into an integrated provider arrangement supporting a new model of care. These changes were made adhering to the Ministry's revised service change process and were generally well supported by patients/consumers/whanau/ saff and the wider community.

National

DHBs are currently in the process of consulting with the Pharmacy sector on a new service model and funding arrangement for community pharmacy which will result in a new contractual arrangement for the 2012/13 year. DHB agents are working with central agencies to seek the appropriate approval for this service change and with DHBs to understand and agree how the new service and funding model will impact in their regions. It is anticipated at this stage that the contract will take effect in the 2012/13 year.

Wairarapa DHB is participating in HBL initiatives to help the health sector to save money by reducing administrative, support and procurement costs for DHBs. Wairarapa DHB is supporting an Indicative Case for Change for the Finance, Procurement, & Supply Chain (FPSC). This is a national case for change that is being assessed on a DHB-by-DHB basis before any actions can be recommended and/or taken by DHBs. This case for change along with other initiatives from HBL may result in changes to the way in which Wairarapa DHB operates its business through a more collective approach to finance, procurement and supply chain; facilities management and support services; information services; and human resources and workforce management.

Regional / sub regional

The Wairarapa DHB is working with other DHBs in the Central Region and with our partners in the sub region on a programme of work to support a regionally coordinated system of health service delivery and planning that ensures improvements in sustainability and access to health services. In the sub region DHBs are also considering how we can work together taking a shared community approach. Both the regional and sub regional work programme will involve an ongoing number of service reviews and enabling projects such as the CRISP programme which may result in DHBs seeking to provide and support services in a different way. In the sub region we will also be working to better understand the capacity and capability of service in the sub region to inform the future planning of health services. Non clinical support areas will also be reviewed in the sub region to identify potential opportunities to deliver more effective and efficient service delivery. Appropriate consultation and engagement processes will be initiated where there any potential staff impacts. The DHB will work closely with the Ministry as it works through this regional and sub regional review process.

Local

In 2011 the Wairarapa DHB and the Wairarapa Community PHO (WCPHO) jointly commissioned a review of the roles of the above entities with respect to the Alliance framework that was established to improve health outcomes in the Wairarapa. This review has now been completed and the outcomes of the review are being discussed with respective Boards for feedback. The outcome of the review is a series of recommendations including that the Alliance Leadership Team be strengthened and its mandate expanded to drive whole of health system integration. Clinical Governance would also be strengthened. Recommendations are still to be confirmed with the WCPHO and the ALT and once finalised formal discussion with the various Boards and the National Health Board will commence. This will include notification, if appropriate, of any service change formally through the Ministry of Health for approval.

The DHB will also be working with its local Pharmacy providers to implement the new national contract and deal with any implementation issues that result from the new service and funding model currently being developed and finalised.

MODULE 7: FINANCIAL PERFORMANCE 2012-2015

7.1 FISCAL SUSTAINABILITY

Over the past ten years an increasing share of national expenditure has been allocated into the health budget. Whilst health continues to receive a significant share of the national funding, the Government has given clear signals that the health sector needs to rethink how it will meet the needs of the constituent populations with a more moderate growth platform now and into the future. In setting the expectations for 2012/13, the Minister expects DHBs to operate within existing resources and approved financial budgets and to work collaboratively to meet fiscal challenges and ensure services and service delivery models are clinically and financially sustainable.

The following section provides a summary of the Wairarapa DHB's financial assumptions and projections over the next three years, in order to achieve the objectives and goals outlined in this Annual Plan.

7.2 MEETING OUR FINANCIAL CHALLENGES

The Wairarapa DHB faces the same fiscal pressures as other DHBs: demographically and technologically driven demand, increasing expectations, increasing cost growth and wage and salary expectations. The DHB acknowledges however that it must ensure that it operates within a constrained financial environment.

The Wairarapa DHB has operated in a deficit position for five years and is projecting deficits for the three years covered within this AP. There is no "quick fix" solution. To ensure the health system is financially sustainable, we are focussed on making the whole of system work properly and achieving the best possible outcomes for our investment. This is work that Wairarapa DHB has been focussing on, and investing in, over the last two years to meet the challenges faced across the health system.

Forecast financial performance

For the 2012/13 year we are forecasting a deficit position of $3.1M. We are planning to achieve $2.3M in further efficiencies in 2012/13 which is a continuation of the efficiency programme over the past three years which has delivered $6.5M in efficiencies – 2009/10 planned $4.65M (achieved $4.0M), 2010/11 planned $2.35M (achieved $.871M), 2011/12 planned $1.67M (forecast $1.67M).

The DHB projected a deficit of $2.4M for the 2012/13 year in the 2011/12 AP. However, we are unable to achieve that deficit position through the efficiency targets included in that Plan totalling $2M plus absorb a range of additional costs.

We have identified sub regional opportunities and costs savings which will allow the DHB to achieve a deficit position of $3.1M in 2012/13. The sub regional work plan and associated projected cost savings have been included in our financial position and financial assumptions. To achieve this non clinical support areas will be reviewed to identify potential opportunities to deliver more effective and efficient service delivery. Appropriate consultation and engagement processes will be initiated where there any potential staff impacts. Module 3, section 3.3 provides information on the agreed work programme for the sub region.

In addition, the out-year projections have been revised from the financial projections in the 2011/12 AP. The out-years are now projecting a breakeven result for both the 2013/14 and 2014/15 financial years. These results are predicated on an agreement with our sub-regional partners, Capital & Coast

DHB and Hutt Valley DHB whereby the aggregate of the three DHB results will be breakeven. The 3 DHBs are committed to developing this joint plan by 30 September 2012 to ensure the sub-region has a break even financial result for 2013/14 and out years.

Constraining our cost growth
Constraining cost growth is also critical to our success. If an increasing share of our funding continues to be directed into meeting the growing cost of providing services, our ability to maintain current levels of service delivery will be at risk. We will also be severely restricted in terms of our ability to invest in new equipment, technology and new initiatives that allow us to meet future demand levels.

It is also critical that we continue to reorient and rebalance our health system. By being more effective and improving the quality of the care we provide, we reduce rework and duplication, avoid unnecessary costs and expenditure and do more with our current resources. We are also able to improve the management of the pressure of acute demand growth, maintain the resilience and viability of services and build on productivity gains already achieved through increasing the integration of services across the system.

Wairarapa DHB has already committed to a number of mechanisms and strategies to constrain cost growth and rebalance our health system. We will continue to focus on these initiatives, which have contributed to our considerable past success and given us a level of resilience that will be vital in the coming year:

- Reducing variation, duplication and waste from the system;
- Doing the basics well and understanding our core business;
- Investing in clinical leadership and clinical input into operational processes and decision-making;
- Developing workforce capacity and supporting less traditional and integrated workforce models;
- Realigning service expenditure to better manage the pressure of demand growth; and
- Supporting unified systems to shared resources and systems.

Within the forecast deficit in the 2011/12 year is a shortfall of $1.4M relating to the Wairarapa DHBs delivery of elective services over and above our equitable share of elective volumes. Wairarapa DHB is committed to achieving the electives health target and in 2011/12 will deliver 1,841 discharges, 253 discharges higher than our equitable share of the national electives health target.

Options for reducing the deficit
From a number of differing benchmark studies it is clear that our “Provider arm” is a very efficient provider (2010/11 average cost per WIES: Wairarapa $4,119 -lowest, national average $4,854). The price projected to be paid by the Funder arm to the Provider arm in 2012/13 is $3M below the pricing arising from the DHB national pricing programme. A negative price adjuster at this level, whilst the provider arm is running a deficit of $2M, demonstrates the level of efficiencies that have been achieved within the DHB provider arm over the last five to six years.

As noted the Wairarapa DHB is planning a $3.1M deficit for the 2012/13 financial year with breakeven results included for 2013/14 and 2014/15. To address this level of deficit, we have considered a number of options. These included withholding funding for HBL initiatives and withdrawal from CRISP. The aggregate of these two would save over $400,000 of operating expense allowed for in the financial projection for 2012/13. As they are contrary to collaborative regional and national partnerships, we have discounted them.

In late 2011, we participated in an exercise conducted by the Crown Health Financing Agency (CHFA) around the key drivers of the deficit. This report from the CHFA has been provided to the National Health Board (NHB). A number of initiatives were proposed that could have been considered to reduce and control the deficit. However many of these initiatives are not possible due to current national policy parameters or other limiting factors.

Acknowledging this, we will continue to focus on our planned efficiencies programme and will continue to actively reduce our costs and pursue saving opportunities from national, regional and sub regional initiatives while also providing assurance to the Board that the DHB will continue to be able to provide services to agreed service coverage levels.

7.3 ASSUMPTIONS

In preparing our forecasts the following key assumptions have been made:

- The DHB's funding allocations will increase as per funding advice from the Ministry of Health.
- Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives.
- Early payment arrangements will be retained by the DHB.
- No additional compliance costs have been budgeted, as it is assumed these will be cost neutral or fully funded. It is also assumed that the impact of any legislative changes, sector reorganisation or service devolvement (during the term of this Plan) will be cost neutral or fully funded.
- Any revaluation of land and buildings will not materially impact the carrying value or the associated depreciation costs.
- IDF volumes are held at 2010/11 levels plus cost growth (due to the national price increase).
- 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.
- External provider increases will be made within available funding levels, after allowance for committed and demand-driven funding.
- Price increases agreed collaboratively by DHBs for national contracts and any regional collaborative initiatives will be within available funding levels and will be 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.
- Deficit support funding will be made available by the Government to cover the cash shortfall arising from projected deficits.

- Allowance for changes to revenue or expenditure has been made relating to the three DHB programme underway with Capital and Coast DHB and Hutt Valley DHB.
- Out year financial forecasts include reduced costs associated with the impact of the new community pharmacy agreement and the impact of the new model of care on close control rates in the Wairarapa.
- Additional sub-regional efficiencies, the detail of which is still to be determined at the time of writing this Plan, have been incorporated for the 2013/14 and 2014/15 financial years.
- Agreement will be reached between the three sub-regional DHB partners, Capital & Coast DHB, Hutt Valley DHB and ourselves, on the efficiency programme for each DHB, individually and collectively, to ensure that as a sub-region an agrgregate breakeven position for the sub-regional is achieved for 2013/14 and 2014/15.
- There will be no impact on interest costs with the transfer of the CHFA to the Ministry of Health.
- CRISP will be completed in line with the business case adopted by the regional DHBs and costs will occur in line with the business case projections.
- Costs associated with HBL led work streams will be neutral to the DHB and no additional capital funding will be required.

7.4 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 due for completion in June 2012. This 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 Wairarapa DHB has significant capital expenditure committed in the next three financial years. This flows from the commitment to the CRISP and continues the increased capital expenditure budgets allocated in previous years.

Based on the DHB's fiscal position, we estimate that we will fund a total of $2.6M of capital expenditure in 2012/13 which includes the investment into CRISP. With this level of capital investment, the remaining capital expenditure funding available will be very tight. To manage this level of capital expenditure will require discipline and focus on the DHB's key priorities.

With the necessary investment for CRISP, the Wairarapa DHB has a very tightly constrained capital budget and any HBL initiatives may require additional capital funding to be provided by the Crown to enable us to meet any obligations. At the time of writing this Plan the capital requirements for HBL initiatives are not known with sufficient certainty to be included.

Business cases
Wairarapa DHB is aware of two business case initiatives in varying stages of development at the time of writing.

(i) CRISP: The six central region DHBs have committed to the completion of the implementation planning study for the development of CRISP. Assuming that this provides

the appropriate level of assurances to all DHBs it has been assumed that the programme will continue in line with the approved business case.

(ii) HBL initiatives: as noted earlier in this Plan HBL is completing a range of business cases or indicative cases for change for the following work streams: finance, procurement & supply chain; facilities management & support services; information services, human resources. The business cases are not available at the time of writing this Plan and the financial expectations arising from these business cases is not known.

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

Asset valuation
Wairarapa DHB completed a full revaluation of its property and building assets at 30 June 2011 in line with generally accepted accounting practice requirements. No further revaluation is expected to be completed during the term of this Annual Plan.

7.5 DEBT AND 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) will be $25.75M as at June 2012. Given the DHB's projected financial performance no repayments of this debt have been assumed to occur over the three years covered by this Plan.

The CHFA term liabilities are secured by a negative pledge. Without the CHFA's prior written consent the DHB cannot perform the following actions:

- Create any security over its assets, except in certain circumstances;
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- Make a substantial change in the nature or scope of its business as presently conducted, or undertake any business or activity unrelated to health; or
- Dispose of any of its assets except disposals at full value in the ordinary course of business.

The CHFA ceases to exist on 30 June 2012 with the functions largely transferred to the Ministry. No change in treatment or valuation of the debt portfolio is expected to result from this transference.

It is noted that $10M of core debt is due for refinancing within 2012/13. It is assumed that this will be refinanced to longer term arrangements. This amount is reflected in current liabilities as at 30 June 2012 in the projected statement of financial position (refer section 7.9) in accordance with generally accepted accounting practice.

Other debt facilities
The Wairarapa DHB has a finance lease facility with the Wairarapa Community Health Trust. This facility was established to cover the replacement of the Ambulance fleet but has also been applied to enable the acquisition of other assets from time to time. Any leasing arrangement is at very competitive interest rates (ranging from 1% to 4% per annum).

The Wairarapa DHB has received private financing 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.

At the time of writing the Wairarapa DHB has commenced a project to move to a national collective for banking and treasury services that has been arranged by HBL. This arrangement pools the collective bank balances of all participating DHBs and will provide savings in interest costs, transaction fees and line of credit charges.

7.6 ADDITIONAL INFORMATION AND EXPLANATIONS

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 2011/12 year. The Board have approved that these funds will be utilised to address the funding requirements of the CRISP programme.

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.

The investment in the CRISP includes the acquisition of preference shares in the Central Region Technical Advisory Services Ltd (TAS). TAS is owned in equal shares between the six DHBs within the central region. The preference shares are subject to a separate agreement between the six DHBs and it assumed that the requisite approvals from the Minister have been obtained.

Accounting policies
The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies refer to Appendix 8.2.

7.7 PROSPECTIVE FINANCIAL STATEMENTS

The projected financial statements are shown in sections 7.9 to 7.13 on the following pages.

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.

7.8 GROUP STATEMENT OF COMPREHENSIVE INCOME

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Income	**127,441**	**128,557**	**130,420**	**134,982**	**139,125**
Operating Expenditure					
Workforce costs	38,870	39,339	39,060	40,913	42,362
Treatment related costs	11,623	12,057	11,942	12,435	13,626
Non-treatment related & other costs	7,811	7,043	7,792	5,149	5,823
External providers	43,997	44,832	45,320	45,975	45,799
Inter district flows	24,657	25,579	25,604	26,453	27,326
Interest expense	1,713	1,642	1,525	1,705	1,761
Depreciation & amortisation	1,968	1,815	1,677	1,731	1,788
Capital charge	406	600	600	621	640
Total expenditure	**131,045**	**132,907**	**133,520**	**134,982**	**139,125**
Net surplus / (deficit)	**(3,604)**	**(4,350)**	**(3,100)**	**0**	**0**
Other comprehensive income					
Gain / (loss) on property revaluation	676	0	0	0	0
Total other comprehensive income	**676**	**0**	**0**	**0**	**0**
Total comprehensive income	**(2,928)**	**(4,350)**	**(3,100)**	**0**	**0**
Total comprehensive income attributed to:					
Wairarapa District Health Board	(2,928)	(4,350)	(3,100)	0	0
Non-controlling interest	0	0	0	0	0

Note on the financial projections:

The out-year projections are for a breakeven result for both the 2013/14 and 2014/15 financial years. These results are predicated on an agreement with our sub-regional partners, Capital & Coast DHB and Hutt Valley DHB whereby the aggregate of the three DHB results will be breakeven.

7.9 GROUP STATEMENT OF FINANCIAL POSITION

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Non-current assets					
Property, plant & equipment	41,773	41,568	41,251	39,603	38,500
Intangible assets	1,330	1,114	1,440	2,260	3,075
Investments	0	119	2,759	3,800	3,800
Trust fund assets	243	200	200	200	200
Total non-current assets	**43,346**	**43,001**	**45,650**	**45,863**	**45,575**
Current assets					
Cash & cash equivalents	(1,720)	2,006	2,006	2,006	2,006
Inventories	726	725	725	725	725
Trade & other receivables	5,022	5,610	5,110	5,110	5,110
Assets classified as held for sale	2,300	0	0	0	0
Total current assets	**6,328**	**8,341**	**7,841**	**7,841**	**7,841**
Total assets	**49,674**	**51,342**	**53,491**	**53,704**	**53,416**
Equity					
Crown equity	29,429	34,204	37,301	37,298	37,295
Revaluation reserve	2,155	2,155	2,155	2,155	2,155
Retained earnings	(23,235)	(27,571)	(30,671)	(30,671)	(30,671)
Total equity	**8,349**	**8,788**	**8,785**	**8,782**	**8,779**
Non-current liabilities					
Interest-bearing loans & borrowings	25,239	15,975	26,350	21,725	21,100
Employee benefits	628	620	620	620	620
Trust funds	243	210	210	210	210
Total non-current liabilities	**26,110**	**16,805**	**27,180**	**22,555**	**21,930**
Current liabilities					
Interest-bearing loans & borrowings	573	10,737	237	4,737	5,237
Payables & accruals	9,027	8,941	11,218	11,559	11,399
Employee benefits	5,615	6,071	6,071	6,071	6,071
Total current liabilities	**15,215**	**25,749**	**17,526**	**22,367**	**22,707**
Total liabilities	**41,325**	**42,554**	**44,706**	**44,922**	**44,637**
Total equity & liabilities	**49,674**	**51,342**	**53,491**	**53,704**	**53,416**

7.10 GROUP STATEMENT OF MOVEMENTS IN EQUITY

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Balance at 1 July	**7,332**	**8,349**	**8,788**	**8,785**	**8,782**
Net surplus / (deficit) for the year	(3,604)	(4,350)	(3,100)	0	0
Other comprehensive income	676	0	0	0	0
Total comprehensive income	**(2,928)**	**(4,350)**	**(3,100)**	**0**	**0**
Equity injection from the Crown	3,948	4,792	3,100	0	0
Repayment of equity to the Crown	(3)	(3)	(3)	(3)	(3)
Movements in equity for the year	**3,945**	**4,789**	**3,097**	**(3)**	**(3)**
Balance at 30 June	**8,349**	**8,788**	**8,785**	**8,782**	**8,779**
Total comprehensive income attributed to:					
Wairarapa District Health Board	(2,928)	(4,350)	(3,100)	0	0
Non-controlling interest	0	0	0	0	0
Total comprehensive income	**(2,928)**	**(4,350)**	**(3,100)**	**0**	**0**

7.11 GROUP STATEMENT OF CASHFLOW

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Cash flows from operating activities					
Operating receipts:					
Government & crown agency sourced	114,873	122,295	125,386	129,270	133,224
Other	10,892	6,198	5,033	5,712	5,901
Interest & dividends received	136	207	72	229	237
Payments to suppliers & employees	(128,589)	(129,523)	(127,658)	(130,217)	(135,333)
Capital charge paid	(305)	(600)	(600)	(620)	(640)
Interest paid	(1,713)	(1,651)	(1,525)	(1,705)	(1,761)
Goods & Services Tax (net)	(175)	0	0	0	0
Net cash flows from operating activities	**(4,881)**	**(3,074)**	**708**	**2,669**	**1,628**
Cash flows from investing activities					
Proceeds from sale of property, plant & equipment	0	2,750	0	0	0
Acquisition of property, plant & equipment	(1,263)	(1,571)	(540)	(500)	(500)
Acquisition of intangible assets	(238)	0	(500)	(1,000)	(1,000)
Acquisition of investments	0	(119)	(2,640)	(1,041)	0
Net cash flows from investing activities	**(1,501)**	**1,060**	**(3,680)**	**(2,541)**	**(1,500)**
Cash flows from financing activities					
Loans drawn down	700	1,400	0	0	0
Equity injected	3,948	4,792	3,100	0	0
Repayment of loans	(390)	(449)	(125)	(125)	(125)
Repayment of equity	(3)	(3)	(3)	(3)	(3)
Restricted fund movement	1	0	0	0	0
Net cash flows from financing activities	**4,256**	**5,740**	**2,972**	**(128)**	**(128)**
Net increase / (decrease) in cash held	**(2,126)**	**3,726**	**0**	**0**	**0**
Cash & cash equivalents at beginning of year	406	(1,720)	2,006	2,006	2,006
Cash & cash equivalents at end of year	**(1,720)**	**2,006**	**2,006**	**2,006**	**2,006**

7.12 SUMMARY OF REVENUE AND EXPENSES BY DIMENSION

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Expenditure					
Funder	120,321	124,115	125,790	129,767	133,303
Governance	3,339	3,163	3,111	3,266	3,374
Provider	58,064	59,423	59,486	59,289	61,696
Eliminations	(51,713)	(53,794)	(54,868)	(57,341)	(59,249)
Total expenditure	**130,011**	**132,907**	**133,519**	**134,981**	**139,124**
Income					
Funder	118,833	121,500	124,722	128,603	132,537
Governance	3,403	3,162	3,161	3,266	3,374
Provider	55,869	57,689	57,404	60,453	62,462
Eliminations	(51,713)	(53,794)	(54,868)	(57,341)	(59,249)
Total income	**126,392**	**128,557**	**130,419**	**134,981**	**139,124**
Net operating results					
Funder	(1,488)	(2,615)	(1,068)	(1,164)	(766)
Governance	64	(1)	50	0	0
Provider	(2,195)	(1,734)	(2,082)	1,164	766
Net surplus / (deficit)	**(3,619)**	**(4,350)**	**(3,100)**	**0**	**0**

7.13 SUMMARY RESULTS BY OUTPUT CLASS

	2010/11 Actual $000	2011/12 Forecast $000	2012/13 Projection $000	2013/14 Projection $000	2014/15 Projection $000
Expenditure					
Prevention services	3,488	3,317	3,674	3,801	3,919
Early detection & management services	43,275	42,543	41,579	42,077	42,878
Intensive assessment & treatment services	65,996	68,483	69,245	69,416	72,036
Rehabilitation & support services	17,251	18,564	19,022	19,688	20,292
Total expenditure	**130,010**	**132,907**	**133,520**	**134,982**	**139,125**
Income					
Prevention services	2,944	2,607	2,910	3,012	3,104
Early detection & management services	42,921	42,723	42,128	43,602	44,940
Intensive assessment & treatment services	62,589	64,017	65,444	67,732	69,812
Rehabilitation & support services	17,937	19,210	19,938	20,636	21,269
Total income	**126,391**	**128,557**	**130,420**	**134,982**	**139,125**
Net surplus / (deficit)	**(3,619)**	**(4,350)**	**(3,100)**	**0**	**0**

MODULE 8: APPENDICES

APPENDIX 8.1 MONITORING FRAMEWORK PERFORMANCE MEASURES

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

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

of their activity, including in relation to legislative requirements, but with the balance of measures focused on government priorities. Each target and performance measure has a nomenclature to assist with classification as follows:

Policy Priorities Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
PP1 Clinical leadership self assessment			
The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region. This will include a summary of the following – how the DHB is: • Contributing to regional clinical leadership through networks • Investing in the development of clinical leaders • Involving the wider health sector (Including primary and community care) in clinical inputs • Demonstrating clinical influence in service planning • Investing in professional development • Influencing clinical input at board level and all levels throughout the DHB – including across disciplines. What are the mechanisms for providing input?	No quantitative target qualitative deliverable required.	NA	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care			
The DHB provides a qualitative report as follows: 1. Those DHBs with BSMC Alliance are required to submit jointly agreed • Year Two Implementation Plans by 31 December 2011 or earlier. • Quarterly reports outlining progress against the key deliverables in the jointly agreed Year Two Implementation Plans including resolution plans for any areas of slippage against deliverables • Quarterly reports on the operation and expenditure of the Flexible Funding Pool, including how pool funding has been jointly prioritised to deliver services. 2. All DHBs are required to report progress against the deliverables in their jointly agreed approach to meeting the following expected measures: • Description of how all necessary clinicians and managers (primary/community and secondary) will be involved ongoing in the process of development, delivery and review • Activities to integrate community pharmacy • Activities to expand and integrate nursing services • Evidence of health needs analysis of population by localities • Identification of targeted areas/patient groups for improved outcomes as a result of enhanced primary and community service delivery (with a focus on managing long term conditions i.e. CVD/Diabetes) including: o Identification of and achievement against targets for the number of people that are expected to be appropriately managed in a primary/community setting instead of secondary care o Identification of and achievement against targets for growth reduction in ED attendance, acute inpatient admissions and bed days o Identification of and achievement against a target for the prevention of readmissions for the 75+ population (and any other target populations) o Identification of, and achievement against new service activity in quantified patient terms • Identification of and activities (with timeline) to ensure infrastructure and revenue streams appropriate to support the identified change in activities and service delivery model • Progress against the above infrastructure and revenue stream milestones • Identification of and progress against the activities to ensure free after-hours services to children under six years of age. Additional reporting deliverable required for Quarter 4: Each DHB must provide a report with the following information: • each PHO's working capital requirements	qualitative deliverable required Up to 2000 patients are enrolled into the funded Guided care Programme Reduce ASH admissions to 80 per month by 30 June 2013 Reduce triage 4 and 5 non-admitted ED attendances to 5,814 per annum by 30 June 2013 Acute hospital bed days are ≤20,000 Acute readmission rates for older people: Over 65 ≤11%	NA	Quarterly

• each PHO's total cash balance and total income in advance at the end of the financial year • the PHOs that the DHB has required to provide forecast expenditure plans for both cash balances and income in advance, including quarterly targets for reductions in cash balances to the agreed level, and • a copy of the relevant PHO's forecast expenditure plans.			Over 75 ≤11% qualitative deliverable required		
PP6 Improving the health status of people with severe mental illness					
The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: • child and youth aged 0-19, specified for each of the three categories Māori, Pacific , and in total • adults aged 20-64, specified for each of the three categories Māori, Other, and in total • older people aged 65+, specified for each of the three categories Māori, Other, and in total.	**Age 0-19**	Total	4.5%	N/A	Six- Monthly
		Maori	4.5%		
	Age 20-64	Total	4.5%		
		Maori	4.5%		
	Age 65+	Total	3.0%		
PP7 Improving mental health services using relapse prevention planning					
Provide a report on: 1. The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. The number of Child and Youth who have been in secondary care treatment* for one or more years (* in treatment = at least one provider arm contact every three months for one year or more) who have a treatment plan. 3. The number and percentage of long-term clients with up to date relapse prevention/treatment plans (NMHSS criteria 16.4 or HDSS [2008]1.3.5.4 and 1.3.5.1 [in the case of Child and Youth]). 4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.	**Adult (20+)**	Total	95%	**95%**	Six-Monthly
		Māori	95%	**95%**	
	Child & Youth	Total	95%	**95%**	
		Māori	95%	**95%**	

PP8 Shorter waits for non-urgent mental health and addiction services

80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks. *DHBs will be required to meet this target within three years. DHBs will need to set and agree with the Ministry individualised targets (based on data provided by the Ministry) stepped over the three years to ensure the target is met.*

Rolling annual waiting time data will be provided by the Ministry sourced from PRIMHD

A narrative is required to:
1. identify what processes have been put in place to reduce waiting times
2. explain variances of more than 10% waiting times target

Note: The Midland region DHBs will include, as requested, their Child and Youth NGO Mental Health services as part of this performance measure.

%

Mental Health Provider Arm

	<= 3 weeks	**<=8 weeks**
Age	**Proposed target (%)**	**Proposed target (%)**
0-19	80	95
20-64	80	95
65+	80	95
Total	80	95

Addictions (Provider Arm and NGO)

	<= 3 weeks	**<=8 weeks**
Age	**Proposed target (%)**	**Proposed target (%)**
0-19	80	95
20-64	80	95
65+	80	95
Total	80	95

Six-Monthly

PP10 Oral Health DMFT Score at year 8 Transitional measure (not included in performance dashboard reports)				
Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year olds) that are – • Decayed (D), • Missing (due to caries, M), and • Filled (F); and (ii) children who are caries-free (decay-free).	Total population	ratio year 1 1.10 year 2 1.10	NA	Annual
	Maori	ratio year 1 1.10 year 2 1.10	NA	Annual
	Pacific	N/A	NA	Annual
PP11 Children caries free at 5 years of age Transitional measure (not included in performance dashboard reports)				
At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are – • Decayed (d), • Missing (due to caries, m), and • Filled (f).	Total population	ratio year 1 65% year 2 70%	NA	Annual
	Maori	ratio year 1 65% year 2 70%	NA	Annual
	Pacific	N/A	NA	Annual
PP12 Utilisation of DHB funded dental services by adolescents **Transitional measure (not included in performance dashboard reports)**				
In the year to which the reporting relates, the total number of adolescents accessing DHB-funded adolescent oral health services, defined as: (i) the unique count of adolescent patients' completions and non-completions under the Combined Dental Agreement; and (ii) the unique count of additional adolescent examinations with other DHB-funded dental services (e.g. DHB Community Oral Health Services, Māori Oral Health providers and other contracted oral health providers). To reduce duplication of effort, at the end of each quarter in the year to which the reporting relates, the Ministry will organise a data extract from Sector Services for all DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs' use in determining part (i) of the Numerator.	Total Population	year 1 85% year 2 87%	**85%**	Annual
PP13 Improving the number of children enrolled in DHB funded dental services				
Measure 1 - In the year to which the reporting relates, the total number of children under five years of age, i.e. aged 0 to 4 years of age inclusive, who are enrolled with DHB-funded oral health services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers).	Children Enrolled **0-4 years**	year 1 79% year 2 84%	NA	Annual
Measure 2 - In the year to which the reporting relates:(i) the total number of pre-school children and primary school children in total and for each school decile who have not been examined according to their planned recall period in DHB-funded dental services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers); and(ii) the greatest length of time children has been waiting for their scheduled examination, and the number of children that have been waiting for that period.	Children not examined **0-12 years**	year 1 5% year 2 5%		

PP16 Workforce - Career Planning			
The DHB provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff a measure will be given for Numbers receiving HWNZ funding/ number with career plan for required categories: ● Medical staff ● Nursing ● Allied technical ● Maori Health ● Pacific ● Pharmacy ● Clinical rehabilitation ● Other	Supply of quantitative data required.	NA	Annual
PP18 Improving community support to maintain the independence of older people			
Numerator: The number of people aged 65 and older who have received long-term home-support services in the last three months who have had a Comprehensive Clinical Assessment and a completed care plan. Denominator: The number of people aged 65 and older who have received long-term home-support services in the last three months.	67%	95%+	Quarterly
PP 20 improved management for long term conditions (CVD, diabetes and Stroke)			
Part 1, Focus area 1: Cardiovascular disease DHBs supply a quarterly narrative report that comments on data supplied by the Ministry, and DHB performance in relation to the number of people diagnosed with ischemic heart disease and on lipid lowering medications, with a view to establishing a formal performance baseline for application in 2013/14.	No quantitative target Progress to be demonstrated via qualitative deliverable .	NA	Quarterly
Part 1, Focus area 2: Stroke services DHBs are to provide a quarterly narrative report on stroke services delivered including plans and actions to improve services.			
Part 1, Focus area 3: Maintain or Improve access to Diabetes Annual Reviews Numerator - Count of enrolled people in the PHO with a record of a Diabetes Annual Review during the reporting period Denominator - The number of enrolled people in the PHO who would be expected to have diagnosed diabetes, using the Diabetes Prevalence Estimate Data Source: PHO Performance Programme Indicators Definitions 1 July 2011 version5.3 Sept11	77%		
Part 2, Focus area 1. Progress in delivery of Diabetes care improvements Provide a quarterly progress report on delivery of actions and volumes agreed for each Improvement area identified in the Annual Plan.	Qualitative deliverable.		
Part 2, Focus area 2 Local Diabetes Team Service (or an equivalent service).. Provide the annual report from the local diabetes team to the Ministry as outlined in the Service Specification for Specialist Medical and Surgical Services – Diabetes Service – Local Diabetes Team Service (or an equivalent service).			Annual
Part 2, Focus area 3. Diabetes Management Numerator: (Data source: DHB to provide). The number of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64% at their free annual check during the reporting period. Denominator: (Data source: DHB to provide. Note that this is the numerator from the Diabetes Free Annual Check indicator). The number of unique individuals with type I or type II diabetes on a diabetes register whose date of their free annual check is during the reporting period.	Total	78%	Quarterly
	Maori	78%	
	Pacific	N/A	
PP 21 Ensure Immunisation coverage for two year olds			
Each quarter, DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan. The Ministry will provide summary data for the quarter on the nationwide service framework library web site NSFL homepage: http://www.nsfl.health.govt.nz/.	95%	95%	Quarterly

System Integration Dimension

Performance Measure and description			2012/13 Target	National Target	Frequency
SI1 Ambulatory sensitive (avoidable) hospital admissions					
Each DHB is expected to provide a commentary on their latest 12 month ASH data that's available via the nationwide service library. This commentary may include additional district level data that's not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Each DHB should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds.	**Age 0-74**	Total	110	NA	Six-Monthly
		Māori	110		
		Pacific	N/A		
	Age 0-4	Total	117		
		Māori	117		
		Pacific	N/A		
	Age 45-64	Total	95		
		Māori	95		
		Pacific	N/A		
SI2 Regional service planning					
A single progress report on behalf of the region agreed by all DHBs within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan. For each action the progress report will identify: • the nominated lead DHB/person/position responsible for ensuring the action is delivered • whether actions and milestones are on track to be met or have been met • performance against agreed performance measures and targets • financial performance against budget associated with the action. If actions/milestones/performance measures/financial performance are not tracking to plan, a resolution plan must be provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan.			No quantitative target Progress to be demonstrated via qualitative deliverable.	NA	Quarterly
SI3 Ensuing delivery of Service coverage					
Exception report - Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through:• analysis of explanatory indicators• media reporting • risk reporting• formal audit outcomes• complaints mechanisms• sector intelligence.			No quantitative target exception based qualitative deliverable required.	NA	Six-Monthly
SI4 Elective services standardised intervention rates					
Data sourced from National Minimum Dataset. Exception report - For any procedure where the standardised intervention rate in the 2011/12 financial year is significantly below the target level a report demonstrating: 1.what analysis the DHB has done to review the appropriateness of its rate AND 2.whether the DHB considers the rate to be appropriate for its population OR 3.a description of the reasons for its relative under-delivery of that procedure; and 4.the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved	**Major joint replacement procedures**		21.0 per 10,000	21.0 per 10,000	Annual quarter1
	Cataract Procedures		27.0 per 10,000	27.0 per 10,000	
Cardiac Procedures Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter is significantly below the target level a report demonstrating 1.what analysis the DHB has done to review the appropriateness of its rate AND 2.whether the DHB considers the rate to be appropriate for its population OR 3.a description of the reasons for its relative under-delivery of that procedure; and			6.5 per 10,000	For cardiac surgery a target intervention rate of between 6.2 and 6.5 per 10,000	Quarterly
			11.9 per 10,000	For percutaneous revascularization a target rate of at least 11.9 per 10,000	

4.the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved.			32.3 per 10,000	For coronary angiography services a target rate of at least 32.3 per 10,000	
SI5 Delivery of Whānau Ora					
The DHB provides a qualitative report identifying progress within the year that shows the DHB's active engagement with existing and emerging Whānau Ora Provider Collectives,steps towards improving service delivery within these providers, and supporting the building of mature providers. This will include a summary of the following – how the DHB is: • Contributing to the strategic change for Whānau Ora in the district • Contributing information about Whānau Ora within the district at appropriate forums, including nationally. • Investing in Whānau Ora Provider Collectives through deliberate activities • Involving the DHB's governors and management in the Whānau Ora activity in the district • Demonstrating meaningful activity moving towards improved service delivery and building mature providers.			No quantitative target qualitative deliverable required.	NA	Annual
SI7 Improving breast-feeding rates					
DHBs are expected to set DHB-specific breastfeeding targets with a focus on Māori, Pacific and the total population respectively (see Reducing Inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. DHBs will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Māori and Pacific communities. The Ministry will provide breastfeeding data sourced from Plunket, and DHBs must provide data from non-Plunket Well Child providers. DHBs are to report providing the local data from non-Plunket Well Child providers.	**6 weeks**	Total	74%	**74%**	Annual
		Māori	74%		
		Pacific	N/A		
	3 Months	Total	57%	**57%**	
		Māori	57%		
		Pacific	N/A		
	6 Months	Total	27%	**27%**	
		Māori	27%		
		Pacific	N/A		

Ownership Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
OS3 inpatient length of stay			
Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter is significantly below the target level a report demonstrating: 1.what analysis the DHB has done to review the appropriateness of its rate AND 2.whether the DHB considers the rate to be appropriate for its population OR 3.a description of the reasons for its relative under-delivery of that procedure; and 4.the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved.	WDHB is already below national ave of 4.02 days. The DHB confirms a target of 3.81 days and assumes 25 percent improvement towards target can be made each quarter	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly

OS5 Theatre Utilisation			
Each quarter, the DHB is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility. • Actual theatre utilisation, • resourced theatre minutes, • actual minutes used as a percentage of resourced utilisation The expectation is that DHBs will supply information on the template quarterly. Baseline performance should be identified as part of the establishment of the target. The goal for 2011/12 will be one of the following: a. For DHBs whose overall utilisation is less than 85%, a target that is a substantial incremental step towards achieving the 85% target is recommended b. For DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended	85%	85%	Quarterly
OS6 Elective and arranged day surgery			
Data sourced from National Minimum Dataset. Exception report - The standardised day surgery rate is the ratio of the 'actual' to 'expected' day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The DHBs 'actual' day surgery rate, and the nationwide day surgery rate, are both defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients), divided by the total number of surgical discharges in the 12 months to the end of the quarter (for elective and arranged surgical patients). The 'expected' day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG represents for the DHB, and summing the result across all DRGs.	62%	59.2% Standardised	Quarterly
OS7 Elective and arranged day of surgery admissions			
The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a percentage. Data sourced from National Minimum Dataset. Exception report - Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.	95%	DHBs will be supplied with comparative data on performance relative to other DHBs. For DHBs with a final 2010/11 result that is below 95 percent, their suggested target is 95 percent. For DHBs with a final 2010/11 result that is above 95 percent, their suggested target will be to maintain current levels.	Quarterly
OS8 Acute readmissions to hospital			
The standardised acute readmission rate is the ratio of the 'actual' to 'expected' acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage. The DHB's 'actual' acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The 'expected' acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the DHB. Readmissions are aggregated by DHB of service. Where an acute readmission occurs within a different DHB to that of the previous inpatient discharge (ie, the first admission), and the previous discharge DHB of Service is consistent with the previous discharge Agency Code, the readmission will be allocated against the DHB of the initial inpatient discharge. Data sourced from National Minimum Dataset. Exception report - Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.	TBC by 31 July 2012 with the Ministry of Health	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly

OS10 Improving the quality of data provided to national collection systems			
Measure 1: National Health Index (NHI) duplications Numerator: Number of NHI duplicates that require merging by Data Management per DHB per quarter. The Numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter. Denominator: Total number of NHI records created per DHB per quarter (excluding pre-allocated NHIs and newborns)	<6%	Greater than 3.00% and less than or equal to 6.00%	Quarterly
Measure 2: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI Numerator: Total number of NHI records created with ethnicity of 'Not Stated' or 'Response Unidentifiable' per DHB per quarter Denominator: Total number of NHI records created per DHB per quarter	<2%	Greater than 0.50% and less than or equal to 2%	
Measure 3: Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS) Numerator: Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB	>55%	Greater than or equal to 55.00% and less than 65.00%	
Measure 4: Timeliness of NMDS data Numerator: Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge. Denominator: Total number of publicly funded NMDS events in the NMDS per DHB per quarter.	<5%	Greater than 2.00% and less than or equal to 5.00% late	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event Numerator: Total number of NNPAC Emergency Department admitted events that have a matching NMDS event Denominator: Total number of NNPAC Emergency Department admitted events	>97%	Greater than or equal to 97.00% and less than 99.50%	
Measure 6: PRIMHD File Success Rate Numerator: Number of PRIMHD records successfully submitted by the DHB in the quarterDenominator: Total number of PRIMHD records submitted by the DHB in the quarter	>98%	Greater than or equal to 98.0% and less than 99.5%	

Output Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
OP1 Output Delivery Against Plan			
Part A: Hospital production. Each DHB is required to submit completed Production Plans as part of the Annual Plan round. From these Production Plans, the Ministry will calculate planned outputs for the following groups of personal health services. 1. Casemix included medical services 2. Casemix included surgical services 3. Casemix included maternity services 4. Non-casemix medical services 5. Non-casemix surgical services 6. ED non-admitted events	Output delivery within three percent of plan	Output delivery within three percent of plan	Quarterly
Part B: Monitoring the delivery of personal health services and mental health services For Mental Health Services provided by the DHB's provider arm, the DHB must complete the Mental Health Volumes Reporting template. This will be provided by the Ministry, and included with the main quarterly reporting template.	5%	Volume delivery is within five percent of plan	

Developmental – Establishment of baseline (no target/performance expectation is set)

Performance Measure and description		Frequency
DV1: Faster cancer treatment		
Detailed information will be provided in the Ministry of Health's data definitions for the Faster cancer treatment indicators. Please refer to this document for information on the definitions, data collection and exceptions. This information will be available on the NSFL by March 2012.	data is provided to establish baseline	Quarterly

Performance Measure and description		Frequency
DV2: Improving waiting times for diagnostic services		
• Elective coronary angiogram to be reported to the National Booking Reporting System (NBRS) in accordance with NBRS data dictionary reporting requirements. • CT, MRI and colonoscopy reporting templates to be submitted to the National Health Board within 20 days of the end of the previous month. The reporting template will be located on the NSFL website with other Performance Measure documents.	data is provided to establish baseline	Monthly

APPENDIX 8.2 STATEMENT OF ACCOUNTING POLICIES

Reporting entity

Wairarapa District Health Board ("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 2011 comprise Wairarapa DHB and its subsidiary Biomedical Services New Zealand Limited (together referred to as "WDHB") and joint venture the Central Region Technical Advisory Service Limited (TAS) which is one sixth owned.

Wairarapa DHB's primary objective is to deliver health, disability, and mental health services to the community within its district.

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

Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the DHB and its subsidiaries and associate is New Zealand dollars.

Measurement base

The financial statements have been prepared on the historical cost basis except where modified by the revaluation of land, buildings, and forward exchange contracts at fair value. 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.

Going Concern

Reliance is placed on the fact that WDHB is a going concern and will continue to receive revenue from the Ministry of Health and other sources sufficient to maintain its services beyond the year ended 30 June 2012. The Minister of Health and Minister of Finance have provided a letter of comfort in October 2011 thereby providing support to the Board to enable continuing supply of services. The Board places reliance on this support.

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

Early adopted amendments to standards

The following amendments to standards have been early adopted:

- NZ IFRS 7 Financial Instruments: Disclosures – The effect of early adopting these amendments is the following information is no longer disclosed:
    - the carrying amount of financial assets that would otherwise be past due or impaired whose terms have been renegotiated; and
    - the maximum exposure to credit risk by class of financial instrument if the maximum credit risk exposure is best represented by their carrying amount in the statement of financial position.
- NZ IAS 24 Related Party Disclosures (Revised 2009) – The effect of early adopting the revised NZ IAS 24 is:
    - more information is required to be disclosed about transactions between the WDHB and entities controlled, jointly controlled, or significantly influenced by the Crown;
    - commitments with related parties require disclosure; and
    - information is required to be disclosed about any related party transactions with Ministers of the Crown.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the Wairarapa DHB and group, are:

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is required to be adopted for the year ended 30 June 2014. The Wairarapa DHB has not yet assessed the effect of the new standard and expects it will not be early adopted.
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – These were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the

accounting standards in each jurisdiction. The amendments must first be adopted for the year ended 20 June 2012. The DHB has not yet assessed the effects of FRS-44 and the Harmonisation Amendments.

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by WDHB. Control exists when WDHB 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 WDHB has joint control, established by contractual agreement. The consolidated financial statements include WDHB'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

Intra-group balances and any unrealised gains and losses or income and expenses arising from intra-group 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 WDHB'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 DHB in its Annual Plan and included in the Statement of Intent tabled in Parliament except as noted on page 22 regarding the cost of service statements.

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 WDHB 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

Revenue is measured at the fair value of consideration received or receivable.

Crown funding

The vast majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue received is restricted in its use for the purpose of the DHB meeting its objectives. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

ACC contracted revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Revenue for other DHBs

Inter district patient inflow revenue occurs when a patient treated within the WDHB region is domiciled outside of Wairarapa. The MoH credits WDHB with a monthly amount based on estimated patient treatment for non-Wairarapa residents within Wairarapa. An annual wash up occurs at year end to reflect the actual non-Wairarapa patients treated at Wairarapa DHB.

Interest Income

Interest income is recognised using the effective interest method.

Revenue relating to service contracts

WDHB 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 WDHB, 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 WDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and WDHB 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 WDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by WDHB.

Rental income

Rental income from investment property is recognised in the statement of comprehensive income 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

Capital Charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Interest expense

The DHB has elected to defer the adoption of the revised NZ IAS 23 Borrowing Costs (Revised 2007) in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities. Therefore, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

Operating lease payments

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset.

Payments made under operating leases are recognised in the statement of comprehensive income in the periods in which they are incurred. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Finance lease payments

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of the asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

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 comprehensive income.

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

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

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. 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 comprehensive income, even when the asset was previously revalued. The same applies to gains and losses on subsequent re-measurement.

Non-current assets held for sale (including those that are part of the disposal group) are not depreciated or amortised while they are classified as held for sale.

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

Income tax

WDHB is a crown entity under the New Zealand Public Health and Disability Act 2000, section 169 of the Crown Entities Act 2004 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

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 comprehensive income. 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:

- land
- buildings
- clinical 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 comprehensive income. 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 comprehensive income.

Revaluation movements are accounted for on a class-of-asset basis.

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. 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 WDHB on 1 January 2001. Accordingly, assets were transferred to WDHB 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 comprehensive income is calculated as the difference between the net sales price and the carrying amount of the asset. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Properties Intended for Sale

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

Leased assets

Leases where WDHB assumes substantially all the risks and rewards of ownership, whether or not title is eventually transferred 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 WDHB. All other costs are recognised in the statement of comprehensive income as an expense as incurred.

Depreciation

Depreciation is provided on a straight line basis on all property, plant and equipment other than land at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Class of Asset	**Estimated Life**
• Buildings (including components)	2 to 50 years
• Clinical 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 recognised at cost, less impairment, and 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 WDHB 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 provided 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 10 years

Impairment

The carrying amounts of WDHB'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 surplus or deficit.

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 comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of comprehensive income 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 comprehensive income.

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 surplus or deficit.

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 surplus or deficit.

Debtors 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.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the period of the write-down.

Cash and cash equivalents

Cash and cash equivalents includes cash balances, deposits held at call with banks, other highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are repayable on demand and form an integral part of WDHB's cash management and are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

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 surplus or deficit over the period of the borrowings on an effective interest basis.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Employee benefits

Defined contribution schemes

Obligations for contributions to defined contribution schemes are recognised as an expense in the statement of comprehensive income as incurred.

Defined benefit schemes

WDHB's net obligation in respect of defined benefit pension schemes is calculated separately for each scheme 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 WDHB's obligations. The calculation is performed by a qualified actuary using the projected unit credit method.

When the benefits of a scheme are improved, the portion of the increased benefit relating to past service by employees is recognised as an expense in the statement of comprehensive income 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 surplus or deficit.

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 WDHB's obligation in respect of a scheme are recognised in the surplus or deficit.

Long service leave, sabbatical leave and retirement gratuities

WDHB'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 approach used in 2011 to determine the discount rate has been refined. The 2010 valuation was based on the yield on 10 year government bonds. The discount rates used for the 2011 valuation are based on the weighted average of bond yields such that the estimated term of the bonds is consistent with the estimated term of the liabilities. This approach is consistent with the requirements of NZ IAS19.

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 WDHB expects to pay. WDHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Provisions

A provision is recognised when WDHB 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 WDHB 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.

Creditors & 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 service performance, report the net cost of services for the outputs of WDHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost Allocation

WDHB 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.