ANNUAL PLAN

2013 - 2014 Wairarapa

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

HUTT VALLEY DHB

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

26 SEP 2013

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

Dear Mr Francis

Wairarapa District Health Board 2013/14 Annual Plan

This letter is to advise you that together with the Minister of Finance, I have approved and signed Wairarapa District Health Board's (DHB) 2013/14 Annual Plan for one year.

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

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

Better Public Services (BPS): Results for New Zealanders

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

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

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

National Health Targets

Your plan includes a good range of actions that will lead to improved or continued performance against the health targets. The target set has remained stable for 2013/14 allowing you to build on the results from the 2012/13 year.

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

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

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

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

I am pleased to see your DHB has developed your Annual Plan through your current Alliance and that there will be a focus on shifting your *Better, Sooner, More Convenient* Business Case onto a 'business as usual' footing. I look forward to seeing the results of your work to improve the breadth of service primary care has direct access to through the implementation of a 'primary options to acute care' programme and direct access to elective surgical procedure lists for skin lesions and colonoscopy. It is positive that you will maintain access to a full range of X-rays and ultrasounds and specialist advice.

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

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

Guidance on national entity priorities was provided to all DHBs in April, for inclusion in final 2013/14 Annual Plans, following the successful completion of the Health Sector Forum lead work between the Ministry, national entities and DHBs. Ministers expect that your DHB will deliver on these commitments, as included in your plan financials. I note that there are areas that you are not in full alignment with the national priority initiatives and expect your DHB will work with the national entities to achieve alignment. Attached is a summary of National Entity Priority Initiatives that shows your DHB's commitments for 2013/14. I look forward to observing progress on the delivery of these priorities.

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

I note that you are planning a deficit of $1.2M for 2013/14 and breakeven for the outyears of the plan. Approval of your annual report is subject to the combined planned deficit of Capital & Coast, Hutt Valley and Wairarapa DHBs not exceeding $7.2M and supported by acceptable recovery plans provided to the NHB by 18 October 2013.

Budget 2013
The expectation is that you will deliver on Budget 2013 initiatives. The Ministry of Health will discuss these more fully with you and develop monitoring arrangements during 2013/14.

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

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

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2013/14 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

KEY MESSAGES FROM THE CHAIRS

We are pleased to present the Wairarapa DHB Annual Plan for the 2013/2014 financial year. Following the format established over the last two years, this Annual Plan incorporates the Statement of Intent and serves several purposes:

(a) It details the priorities for the coming year and the actions we have planned to meet the goals of the DHB and the Minister's Health Targets;

(b) It outlines the DHB's commitment and approach to improving the DHB's financial sustainability;

(c) It sets out a clear accountability framework that allows Parliament to review our service delivery and provide assurances to the public that we are providing services that meet local needs in line with our legislative and statutory requirements.

This plan is significant not just for this DHB but for the three DHBs working in the Wairarapa, Hutt Valley and Capital and Coast Collaboration (3 DHBs). As Chairs of Wairarapa, Hutt Valley and Capital and Coast DHBs, we believe it is important that this joint letter is seen as a genuine commitment to true collaboration between our organisations, ensuring the strengths of each are harnessed to ensure the sustainability of health services across the Greater Wellington region, and a continual improvement in health outcomes for our population and our communities.

The three DHBs recognise that 2013/14 is going be another year of challenges as we continue our subregional programme of change to ensure we can live sustainably within our means. Further changes to some service configurations will be required as the DHBs consider the most efficient and client focussed ways of delivering services in local and subregional contexts.

Since last year, Wairarapa, Hutt Valley and Capital and Coast DHBs have accelerated the work in consolidating our planning and funding functions. This has resulted in the establishment of a joint Service Integration and Development Unit (SIDU) to advance a collective plan of action aimed at improving the sustainability, efficiency, effectiveness and equity of services for our individual communities and collective population. This plan is a tangible outcome of this consolidation.

While each of the DHBs are presenting a separate document in compliance with our legislative requirements, significant parts of the plan are written to reflect the 3DHB regional approach upon which we have collectively embarked. Specific areas such as our local activities, Statement of Forecast Service Performance and Financial Performance sections remain specifically focussed at a local DHB level. Over time, it is anticipated that the workstreams within and between each DHB will become ever more synergistic, and future versions of this document will reflect a truly integrated mix of services across the Greater Wellington region.

It is significant therefore that during the last financial year Graham Dyer was appointed to the role of joint CEO across Hutt Valley and Wairarapa DHBs. Additionally, a joint executive team has been appointed across the two organisations. This is intended not just to develop efficiencies between the Hutt Valley and Wairarapa operations, but also to further improve the collaborative environment that has been building across all three DHB, which Graham Dyer and CCDHB CEO Mary Bonner have led. More recently, Debbie Chin has commenced as interim CEO of Capital and Coast DHB. With her experience as Crown Monitor of Capital and Coast and Hutt Valley, she is well placed to continue the collaborative relationship across the three DHBs.

Collectively, the three DHBs will receive a total of one billion, five hundred and thirty six million, twelve thousand, seven hundred and eight dollars ($1,536,012,708) in 2013/2014, an increase over last year of $15 million. Despite the increases, cost pressures in the health system remain significant and we continue to need to find further efficiencies whilst maintaining a focus on service coverage, population health outcomes and health equity. We acknowledge that this will not be an easy task.

The three DHBs have committed to a $7.2 million deficit position across our collective catchment for 2013/2014, with an aim for a breakeven position in future years. Over the past year we have put significant effort into ensuring the right people and structures are in place to accelerate the change programme.

We anticipate that this effort will reap rewards across the following areas of collective focus for 2013/2014:

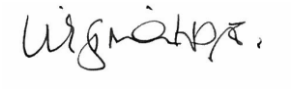
(a) The integration of services across the continuum to improve the financial and clinical sustainability of our organisations;

(b) Delivery against the Government's health targets;

(c) Continuing the journey to improved integration between primary and secondary care – advancing the Minister's goal of Better, Sooner, More Convenient Health Services; and

(d) Continuing to improve the health of communities, ensuring we continue to reduce disparities and improve health equity for vulnerable populations.

2013/2014 will undoubtedly be another challenging year for each of our Boards. It is however also an exciting one in terms of the positive programme of change in which we are investing. We look forward to reporting on our significant progress in our collaborative journey over the course of the year.



Bob Francis
Chair
Wairarapa District Health Board

Dr Virginia Hope
Chair
Hutt Valley District Health Board
Capital and Coast District Health Board

MODULE 1: INTRODUCTION

MODULE 2: STRATEGIC DIRECTION

MODULE 3: DELIVERING ON PRIORITIES & TARGETS

MODULE 4: STEWARDSHIP

MODULE 5: FORECAST SERVICE PERFORMANCE

MODULE 6: SERVICE CONFIGURATION

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MODULE 8: APPENDICIES

Annual Plan Approval

The Wairarapa District Health Board's Annual Plan for the financial year 2013/14 is approved.

Hon Tony Ryall
Minister of Health

Hon Bill English
Minister of Finance

Bob Francis
Chairperson
Wairarapa District Health Board

Graham Dyer
Chief Executive
Wairarapa and Hutt Valley DHBs

MODULE 1: INTRODUCTION

1.1 EXECUTIVE SUMMARY

This Annual Plan outlines to Parliament, the Minister of Health and the general public the performance intentions for the DHB for the next three years as it works to improve, promote, and protect the health status of our local people.

The Annual Plan reflects our continued commitment to deliver on the Government's priorities and health targets within a tight fiscal environment. The way forward will require a range of efficiency and effectiveness initiatives including the further integration of primary and secondary health care services across our district and the advancement of the 3DHB work programme – a collaborative approach between Wairarapa, Hutt Valley and Capital and Coast DHBs (the 3 DHBs) to improve the way we deliver hospital and specialist services across the district boundaries.

To that end, this plan has been prepared using a single process with significant parts of the document shared across the 3 DHBs, reflecting our collaborative approach to service planning and delivery. Where activity, targets and budgetary information are specific to each District, these are presented uniquely for each DHB.

The DHB recognises that 2013/14 is going be another year of challenges as it continues its programme of change to ensure it can live sustainably within its means. Further changes to some service configurations will be required as the DHB considers the most efficient and client focussed ways of delivering services in local and subregional contexts.

In late 2012, the 3 DHBs pooled their Planning and Funding functions into a single unit that is jointly directed by the DHB CEOs but is operationally managed by Capital and Coast DHB. It is now known as the Service Integration and Development Unit (SIDU) and its role is to provide a mix of strategic leadership and change management across the region. Funding pools remain specific to each DHB, but SIDU has the role of maximising opportunities for efficiencies whilst minimising service delivery and financial risk for the benefit of all three DHBs.

In early 2013 a joint CEO was appointed across Hutt Valley and Wairarapa DHBs and work began creating a single executive team across these two DHBs. This process is intended as a key enabler to bringing about operational efficiencies across the hospital services of both DHBs. It also provides a simpler mechanism in building collaborative approaches with the executive team of Capital and Coast DHB.

Across the districts, and in support of the Government's *Better, Sooner, More Convenient Health Services* approach, the DHBs have dedicated significant resource and focus to a partnership approach between each DHB's Hospital services and Primary Care delivery services to improve access to specialist services. Each DHB is operating a unique relationship and service development programme, but the goals are the same. Wairarapa DHB acknowledges the participation of local primary care partners, through the Alliance Leadership Team, in the development of, and agreement with this Annual Plan.

1.2 CONTEXT

1.2.1 BACKGROUND

District Health Boards are responsible for providing and funding the provision of health and disability services. The statutory objectives of DHBs under the New Zealand Public Health and Disability Act 2000 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; and
- 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 and independence of people with disabilities and reducing health disparities by improving health outcomes for Māori and other vulnerable 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 of public sector organisations.

Health Sector Context
Wairarapa, Hutt Valley and Capital and Coast DHBs are three of 20 DHBs across New Zealand.

In addition to being required to meet their statutory objectives, DHBs recognise and respect the Treaty of Waitangi, and the principles of partnership, participation and protection. At a local level, each DHB works in partnership with its Māori Partnership Board, 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.

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

Integral to our success is collaboration with other DHBs and the wider health sector:

- The Central Regional Services Plan that has been developed between Wairarapa, Hutt Valley, Capital and Coast, MidCentral, Hawke's Bay, and Whanganui DHBs, and has been extensively revised in this, its third year of being, to drive our region more quickly towards greater efficiency across services we provide to the population of the lower North Island.

- At a subregional level, Wairarapa, Hutt Valley and Capital and Coast DHBs are continuing with their joint integration and efficiency programmes whilst maintaining a clear focus on the needs and provision of services to their local populations. As noted previously, the 3DHB work

programme is the key deliverable to ensure all three DHBs are able to provide sustainable, equitable and appropriate services to local communities and the broader population.

- Within the wider health sector, the DHBs continue to work with organisations such as Health Benefits Limited to improve the value we secure out of areas of procurement, and the Health Safety and Quality Commission to ensure we can provide the highest quality services to our clients.

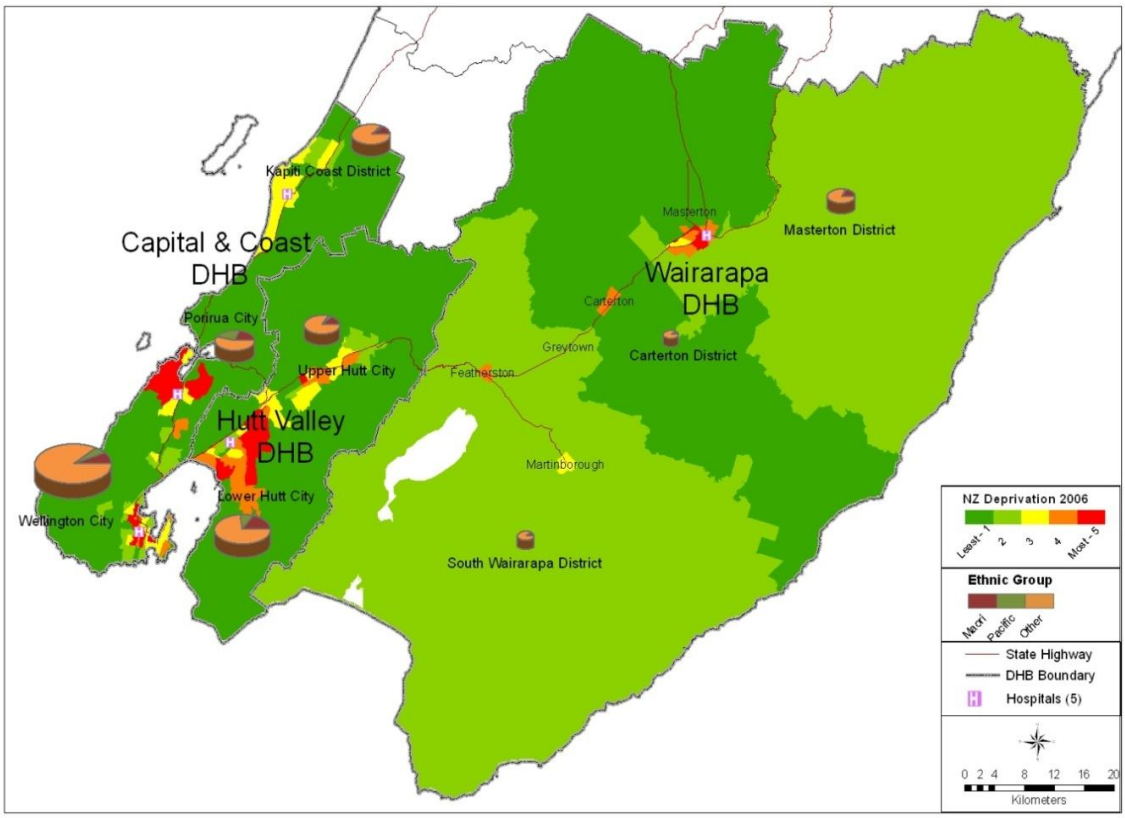
Across the region, the DHBs work individually and collectively with strategic partners to both improve health outcomes and efficiency in delivery. Of particular importance are the DHBs' active partnerships with our PHO partners in respect to the *Better, Sooner, More Convenient* (BSMC) change activity.

The DHBs are committed to working across national and regional work programmes to actively improve our collective regional performance, whilst also contributing to a better performing health sector. In particular, the DHBs are key players in the ongoing development and implementation of the Central Region's Regional Services Plan, and in respect to contributing to national sector priorities such as the National Vulnerable Service Employment programme.

Population and Health Profile

The 3DHB region is home to nearly 11 percent of the national population in 2013 (484,345 people). The Wairarapa population is small (40,715 people) however it is spread across a large, geographic area: South Wairarapa District, Carterton District and Masterton District. Around half of the Wairarapa district population lives in an urban centre. Capital and Coast is the seventh largest DHB in New Zealand (298,600 people) covering three Territorial Authorities (TAs): Wellington City, Porirua City and the Kapiti Coast District south of Te Horo. The Hutt Valley district, with a population half that of Capital and Coast (145,030 people), covers two TAs: Lower Hutt City and Upper Hutt City.

Figure 1 - Map of 3DHB Region Population

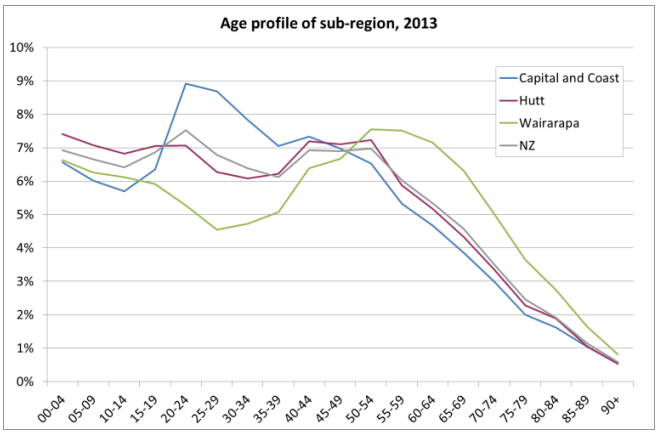


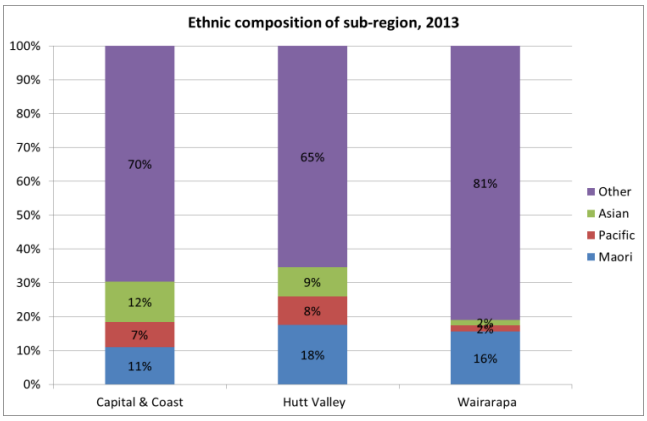
Overall, Capital and Coast has one of the least deprived populations in the country however the socio-economic profile of the three TAs is very different. Porirua is a city of contrasts with 30 percent living in quintile one areas (the least deprived) and 42 percent living in quintile five areas (the most deprived) mainly in Porirua East. There are also pockets of deprivation in the south and east Wellington suburbs (parts of Newtown, Berhampore, Kilbirnie, Strathmore and Miramar).

A quarter of the Hutt Valley population lives in a quintile one area, however a quarter of the Lower Hutt population live in quintile five areas (particularly Naenae, Taita, Moera and parts of Petone, Stokes Valley, Wainuiomata and Waiwhetu).

The Wairarapa population is more evenly spread across the deprivation quintiles; however there are areas of relatively high deprivation in Masterton and Featherston.

Figure 2 – 3DHB Age Profile





Age is the most significant factor determining the health need of a population, with higher consumption of health resources as people age and develop more complicated needs and co-morbidities. In comparison to the national average Capital and Coast and Wairarapa have a smaller proportion of children whereas Hutt Valley's child population is greater. Capital and Coast has a large proportion of young to middle aged adults whereas Wairarapa has a smaller proportion. Wairarapa has a significant 'baby boomer' and older adult population while Capital and Coast has fewer than average.

The age profile varies significantly across the three Capital and Coast TAs whereas it is more similar across the Hutt Valley and Wairarapa. There are a very large proportion of older people living on the Kapiti Coast, a large proportion of children living in Porirua City and a large proportion of young to middle aged adults in Wellington.

Ethnicity is also a strong indicator of the need for health services with Māori and Pacific affected at a younger age and experiencing a greater burden of long term conditions. The Māori populations of Hutt Valley and Wairarapa are higher than the national average (15%) whereas in Capital and Coast this is lower than average. There are significant Pacific populations living in both Capital and Coast and the Hutt Valley. Capital and Coast also has a large Asian population. The Māori and Pacific populations are young in comparison to other ethnic groups with a greater proportion of children and fewer older adults. Wellington's Asian population has a significant proportion of young adults.

Health Needs - Wairarapa DHB

The groups identified below are expected to be higher users of health and disability services, and in 2013/14 the DHB is continuing to focus on:

- *Ageing 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. 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 home ownership. The urban areas of Wairarapa have a greater proportion of people classified 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 2009 to 2011, and strokes are now positioned in fifth 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 Māori suffer poorer health than their counterparts in other ethnic groups. Māori 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 Māori adults between the ages of 25-44 were due to external causes such as car accidents and intentional self-harm (suicide). The leading causes of death for Māori adults aged over 65 were due to circulatory system disease or cancer, with ischemic heart disease being the leading circulatory system disease. *Te Huarahi Oranga,* the Wairarapa DHB Māori 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.

Population Change

The demographics of the subregion will change over the next fifteen to twenty years, with varying rates of population growth but significant ageing across all three DHBs (as well as nationally).

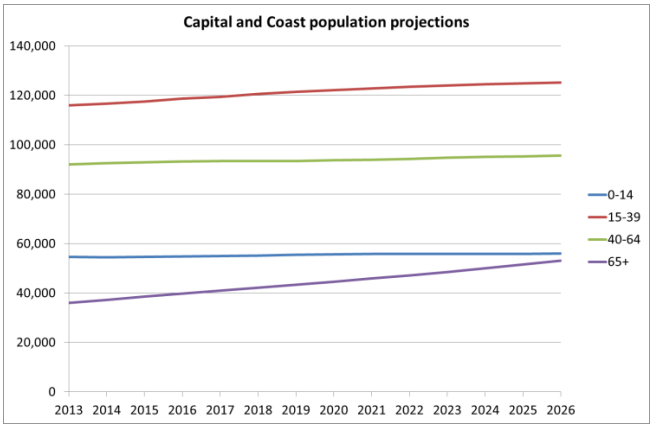
Table 1: Population Profile

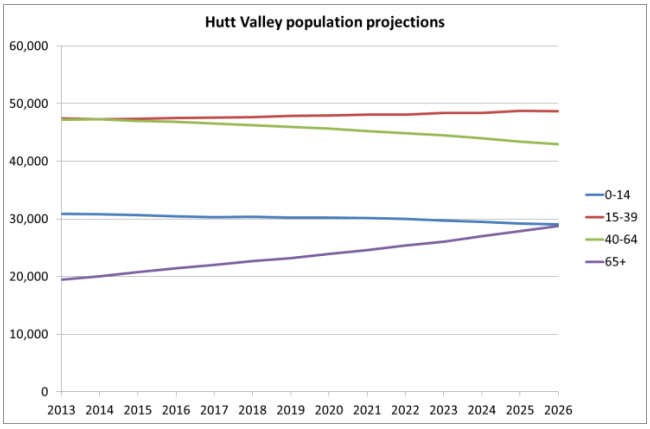
District	2013 population	2026 population	% change 2013-2026	% change average annual
Wairarapa	40,715	40,820	0.3	0.0
Capital & Coast	298,600	329,920	10.5	0.8
Hutt Valley	145,030	149,420	3.0	0.2
Subregion	**484,345**	**520,160**	**7.4**	**0.6**

The subregional population is projected to increase an average 0.6% per year to 2026; slightly lower than national growth (0.9%). The growth is mostly going to occur in the Capital and Coast district (with Kapiti and Wellington the fastest growing areas) while modest growth is predicted for Hutt Valley and very little for Wairarapa.

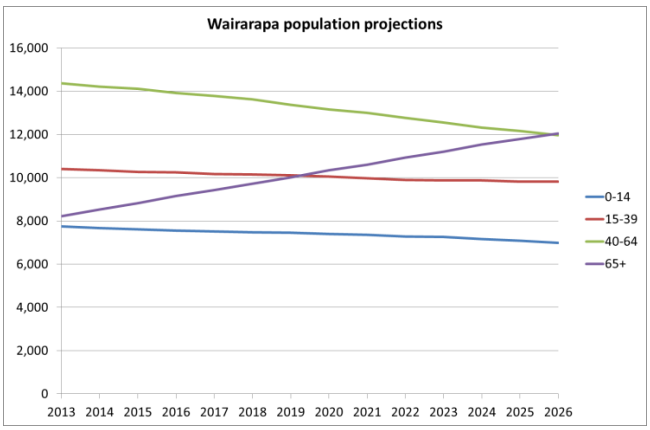
The Māori population of all three DHBs will increase and while significant Pacific growth is projected in Hutt Valley, very little is expected for Capital and Coast. The Asian populations across all three DHBs will increase and is projected to be larger than the Māori population in Capital and Coast by 2026.

Figure 3 – Population Projections





The number of older people will increase by around 50% in each DHB between 2013 and 2026. As the number of people aged over 65 increases the subregion will face challenges in terms of providing care and support to people in their own homes, capacity of residential care and demand for acute and complex healthcare services. Capital and Coast is the only DHB projected to have an increase in the number of children (although modest at 2.5% by 2026). In the Wairarapa, the population across all the life-cycle age groups under 65 will decline whereas the Hutt Valley can expect a slight increase in the youth and younger adult age groups.



1.2.2 OPERATING ENVIRONMENT

In 2013/2014 the 3 DHBs will operate in an environment where the costs of service provision continue to stretch our financial resources. Individually, and collectively through the 3DHB work programme, the three DHBs have set an ambitious target for a $7.2 million deficit across the subregion which will require an acceleration of the efficiency changes already underway.

To be able to meet our forecasted $7.2 million deficit position, the DHBs will continue improve service efficiency, reconfigure services to better meet the needs of clients, and in some circumstances, end service investment where the impact is minimal.

All three DHBs have made good progress over the past two years in either reducing deficits or eliminating the risk of significant budget blow-outs. Hutt Valley and Wairarapa have made significant progress in improving financial efficiency and sustainability limiting the financial risk to their organisations, while Capital and Coast has reduced its operating deficit of $60 million in 2008/09 to $10 million in 2011/12.

Sustainability and a focus on population health outcomes remain critical to all three DHBs. Robust impact assessments of the planned service changes are regularly undertaken and provided to the Boards to ensure the DHBs are able to continue to provide services to the levels required within their service coverage schedules as agreed with the Ministry. The DHBs (through SIDU) continue to balance the financial savings requirements with the need to continually improve the client experience and quality of our services. This is dramatically improving the value for money the DHBs are securing out of their local health service investments.

External Influencers

As well as the health needs of the population, there are a range of external factors that impact on the DHBs and influence the decisions they make. These are built into the process of planning, funding and delivering health services across the regional population and in respect to the needs of local communities.

New Zealand Economy

The Government has indicated that the rate of growth in health funding is unsustainable, particularly in view of the global financial situation.

Table 2: Economic Factors

Factor	**Implications**
The health sector recognises the need to reduce expenditure and reconfigure services to improve efficiency and financial sustainability of services	Prioritisation of funding to those most in need of health and disability services. Funding allocation to different services and different service providers based on the principle of addressing health inequalities and targeting at risk populations. The performance of the three DHBs' Hospital services relative to our peers. All three DHBs will continue to look for efficiencies in all that they do. Ongoing consolidation of provider contracts to increase economies of scale and reduce expenditure on administration will be required to ensure services are delivered to desired standards.

Social Factors

People are taking a more active interest in their health; they are better informed about their conditions and are more aware of options for treatment than in the past. At the same time public expectations are expanding, the health system is experiencing workforce shortages, and the recruitment and retention of health professionals can be difficult in an internationally competitive labour market.

Table 3: Social Factors

Factor	**Implications**
The public is becoming better informed about health	Patients have higher expectations of health professionals and health services. With the right information, people can take more responsibility for their own care (self-management).
People want services suited to their needs	Services become more patient centred and culturally responsive. Difficulty satisfying society's growing demands for health services means greater attention on what services are publicly funded and access criteria for those services.
Difficulty satisfying society's growing demands for health services	Greater attention on what services are publicly funded and access criteria to those services.
Continuing moderate levels of unemployment	Some people cannot afford to visit their GP, delaying early detection and treatment, increasing ED attendances and admissions to hospital that are potentially avoidable.

Clinical Engagement and Leadership

The DHBs continue to embrace the active involvement of clinicians in the planning and development of services to improve operational efficiencies across our organisations and improve health outcomes for the wider population and our local communities. Through our BSMC projects and clinical governance processes, clinicians are regularly engaged in service prioritisation and development locally, subregionally and regionally.

Table 4: Clinical Engagement and Leadership

Factor	**Implications**
Greater involvement by clinicians in decision making	Continued development of processes and systems that ensure clinical engagement and involvement in planning and delivery of health services.
Increased focus on quality and safety of services	An increased focus on quality and safety of services can lead to better health outcomes. Meeting quality and safety guidelines and compliance may impose additional costs on DHBs.

Factor	Implications
Greater focus on planning and delivering services nationally and regionally	Changes to the way services are delivered at a local, regional and national level. Service capacity across DHBs is reorganised to ensure best use of available resources. Areas of mutual priority - particularly in respect to vulnerable services - are addressed through the Central Region's Regional Services Plan
Higher level of Service Integration between Hospital and Primary Care Services	Clients access services in a setting closer to home Efficiencies in service provision are achieved across the system

1.2.3 NATURE AND SCOPE OF FUNCTIONS

The DHBs receive funding from the Government to fund and provide health and disability services to the people who live in each district.

The DHBs work within the 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 New Zealand Public Health and Disability Act 2000).

This requires the DHBs to consider all health needs and services including:

- prevention services
- early detection and management services
- intensive assessment and treatment services
- rehabilitation and support services

It is the role of the DHBs to determine how these services can be provided to best meet the needs of the population. It is these four service groupings that comprise the output classes used in our Statement of Forecast Service Performance (see Module 5).

The scale and scope of services the DHBs fund across each of these four output classes is influenced by the outcomes and priorities that the Government and each DHB want to achieve, as well as the Government's service coverage requirements and our assessment of the health needs across our communities. Whilst most of the services the DHBs fund are provided locally, there are a few specialist services that are delivered by health providers outside each DHB's catchment or indeed outside of the region.

Amongst the 3 DHBs, Capital and Coast is the largest regional provider hospital services, and has responsibility for providing a mix of specialist services to other DHBs in the Central Region. Hutt Valley provides a smaller number of regional services, with the specialist plastics and rheumatology services located at its Hutt facility.

Service capacity and capability needs are managed across the DHBs, and where services are provided by a DHB to a patient of a different domicile, that DHB is recompensed through the inter-district flow (IDF) mechanism for the service it has provided. This year SIDU will be developing an alternative approach to managing IDFs within the 3DHB service mix, ensuring services (in particular

electives) are provided in a cost effective and sustainable way to each DHB, whilst ensuring equity of access is maintained across the regional population.

With the new SIDU structure now in place, the DHBs will plan and purchase services through this unit, with each DHB maintaining oversight in respect to services for their own communities. Each Board consists of eleven members (including the Chair), with Capital and Coast and Hutt Valley DHBs also having a Crown Monitor position appointed by the Minister of Health.

Each Board has a mix of elected (as part of the three-yearly local body election process) and appointed members. Virginia Hope is Chair of both Capital and Coast and Hutt Valley DHB Boards, and Bob Francis is Chair of the Wairarapa Board and a member of the Capital and Coast Board.

A joint Community and Public Health Advisory Committee (CPHAC) and Disability Services Advisory Committee (DSAC) has been established across the 3 DHBs. In addition to the statutory roles, this committee is now the key mechanism whereby the work of SIDU and in particular the monitoring of progress across the 3DHB work programme takes place.

In addition to this joint committee, each Board operates a committee focussed on finance, risk and audit and there are two Hospital Advisory Committees (HAC) (one at Capital and Coast and one for Hutt Valley/Wairarapa) to assist Boards in discharging their responsibilities. Additionally, each DHB has its own Māori Advisory/Relationship group, and Capital and Coast and Hutt Valley also have an equivalent Pacific group. These forums are critical in assisting the DHBs to maintain a focus on improving access to services and outcomes for those populations.

Each DHB operates its own governance mechanism in respect to supporting the primary/secondary integration work within the *Better, Sooner, More Convenient* suites of activity. In the Wairarapa the Alliance Leadership Team (ALT) provides oversight of the work programme established as one of the early Ministry supported primary/secondary integration business cases. At Capital and Coast the integrative work streams are part of the Integrated Care Collaborative (ICC) with each ICC workstream having its own management mechanism. At Hutt Valley, integrative work is being developed and supported through the Primary Secondary Strategic Governance Group (PSSG).

The Provider Role

Across the 3 DHB region, there are four main hospital sites which provide a mix of services.

The DHBs provide a complex mix of secondary and tertiary services across the subregion. Services provided across our Hospital arms include: emergency services; specialist medical and surgical services delivered in inpatient, outpatient and community settings; maternity services; paediatric services; mental health services; diagnostic services such as laboratory and radiology services; pharmacy services; allied health services; district nursing; and rehabilitation services. (See Module 4 for further details of the three DHB Provider Arms).

The Funder Role

The SIDU is now the central planner and funder of services across the 3 DHBs. Its role is to maximise efficiency across the service continuum and across the district boundaries, whilst ensuring communities, families and individuals across the three catchments have equitable and appropriate access to services.

In addition to the funding SIDU makes available to the 3 DHBs' hospitals for the provision of services they provide, it also funds a range of other health and disability service providers to deliver services to the people of the three districts.

SIDU manages, on behalf of each DHB, a number of service agreements across a range of providers for the delivery of primary health services, Well Child services, public health services, oral health services, Māori and Pacific health services, community mental health services, community pharmacy and laboratory services, community diagnostic imaging services, aged residential care services, home based support services, and palliative care services. It also manages the cross-DHB payments for services provided for patients of other DHBs.

In funding these different services, the SIDU, on behalf of each of the three Boards, must manage the share of the national funding allocation in a financially responsible manner.

The funding received by each DHB is determined by the Government using the Population Based Funding Formula (PBFF), and is based on the number of people living in the district, taking into account different population factors, such as age, sex, ethnicity, level of socio-economic deprivation and unmet need.

The population of each of the three DHBs will change differently over time meaning service configuration will be provided generically in certain areas, but in others requires planned local responses.

The Wairarapa DHB population continues to rise, albeit at a much slower rate than the national average. The DHB has an increasing proportion of elderly, Māori and Pacific people within the population and fewer children. Wairarapa DHB will receive an increase in funding for 2013/14 reflective of these demographic changes relative to national, as well as a contribution towards the cost pressures experienced by various service providers.

In total, Wairarapa expects to receive $116.0 m in 2013/14 from the Government to spend on health and disability services for the people of the DHB's catchment area. This represents an increase in funding of 2.68 % over our 2012/13 funding allocation. Wairarapa will also receive $3.5 m to provide services to populations other than its own residents (funding envelope total $119.5 m). Additional revenue is also earned on top of the funding envelope allocation, taking Wairarapa's total budgeted revenue for 2013/14 to $135.1m.

The Capital and Coast DHB population continues to rise at a rate only slightly lower than the national average. The DHB has an increasing proportion of elderly and Māori people within the population and slightly fewer children. Capital and Coast DHB will receive an increase in funding for 2013/14 reflective of these demographic changes relative to national, as well as a contribution towards the cost pressures experienced by various service providers.

In total, Capital and Coast expects to receive $660.7m in 2013/14 from the Government to spend on health and disability services for the people of the DHB's catchment area. This represents an increase in funding of 2.08% over our 2012/13 funding allocation. Capital and Coast will also receive $ 175.3 m to provide services to populations other than its own residents (funding envelope total $ 836.0 m). Additional revenue is also earned on top of the funding envelope allocation, taking Capital and Coast's total budgeted revenue for 2013/14 to $952.2m.

The Hutt Valley population continues to rise, albeit at a much slower rate than the national average. The DHB has an increasing proportion of elderly, Māori and Pacific people within the population and fewer children. Hutt Valley DHB will receive an increase in funding for 2013/14 reflective of these demographic changes relative to national, as well as a contribution towards the cost pressures experienced by various service providers.

In total, Hutt Valley expects to receive $411.2m in 2013/14 from the Government to spend on health and disability services for the people of the DHB's catchment area. This represents an increase in funding of 2.32% over our 2012/13 funding allocation. Hutt Valley will also receive $65.4m to provide service to populations other than its own residents (funding envelope total $411.2m). Additional revenue is also earned on top of the funding envelope allocation, taking Hutt Valley's total budgeted revenue to $447.4m, which includes an adjustment to remove funding received relating to the contract with Aotea Pathology Ltd.

Allocation of funding in 2013/14

How each DHB shares this funding amongst different services providers is a critical decision each year for the Board.

Wairarapa DHB

Of the $135.1m Wairarapa expects to receive in 2013/14, $64.2m will be spent on services provided by the DHB and the governance arm. The balance of $72.1m will be spent on services delivered by other primary care and community providers. This includes $26.2m in payments Wairarapa expects to make to other DHBs for services they provide to its own residents (inter district flows).

Funding Allocation WDHB (GST exclusive)

Expenditure Category	Actual 2011/12 $m	Forecast 2012/13 $m	Budget 2013/14 $m	Budget 2014/15 $m	Budget 2015/16 $m
DHB Provider Arm	61.6	60.6	61.6	61.6	63.0
Funder Arm	44.6	45.4	45.9	47.1	48.2
Services Purchased from Other DHBs (IDF Outflows)	26.7	26.1	26.2	26.8	27.5
Governance Arm	3.1	3.1	2.6	2.7	2.7
Total Allocated	**136.0**	**135.2**	**136.3**	**138.2**	**141.4**
Funding (excluding IDF inflows below)	125.8	128.5	131.6	134.6	137.7
Services provided for Other DHBs (IDF Inflows)	3.5	3.4	3.5	3.6	3.7
Total Funding	**129.3**	**131.9**	**135.1**	**138.2**	**141.4**
Surplus / (Deficit)	**(6.7)**	**(3.3)**	**(1.2)**	**0.0**	**0.0**

Capital and Coast DHB

Of the $952.2m Capital and Coast expects to receive in 2013/14, $637.4m will be spent on services provided by the DHB and the governance arm. The balance of $320.8m will be spent on services delivered by other primary care and community providers. This includes $67.6m in payments Capital and Coast expects to make to other DHBs for services they provide to its own residents (inter district flows).

Funding Allocation CCDHB (GST exclusive)

Expenditure Category	Actual 2011/12 $m	Forecast 2012/13 $m	Budget 2013/14 $m	Budget 2014/15 $m	Budget 2015/16 $m
DHB Provider Arm	612.4	624.0	626.6	634.6	643.7
Funder Arm	253.3	250.5	253.2	259.9	269.0
Services Purchased from Other DHBs (IDF Outflows)	65.3	65.6	67.6	69.0	70.4
Governance Arm	8.2	8.7	10.8	10.8	10.8
Total Allocated	**939.2**	**948.9**	**958.2**	**974.2**	**993.9**
Funding (excluding IDF inflows below)	743.8	756.5	776.9	789.1	804.4
Services provided for Other DHBs (IDF Inflows)	175.5	182.5	175.3	185.2	189.5
Total Funding	**919.3**	**938.9**	**952.2**	**974.2**	**993.9**
Surplus / (Deficit)	**(19.9)**	**(10.0)**	**(6.0)**	**0.0**	**0.0**

Hutt Valley DHB

Of the $447.4m Hutt Valley expects to receive in 2013/14, $230.0m will be spent on services provided by the DHB and the governance arm. The balance of $217.4m will be spent on services delivered by other primary care and community providers. This includes $77.2m in payments Hutt Valley expects to make to other DHBs for services they provide to its residents (inter district flows).

Funding Allocation HVDHB (GST exclusive)

Expenditure Category	2011/12 Audited $m	2012/13 Forecast $m	2013/14 Plan $m	2014/15 Plan $m	2015/16 Plan $m
DHB Provider Arm	218.7	223.1	226.7	229.8	232.9
Funder Arm	133.0	138.0	140.2	142.1	144.0
Services Purchased from Other DHBs (IDF Outflows)	79.3	80.8	77.2	78.0	78.7
Governance Arm	2.9	3.0	3.3	3.3	3.3
Total Allocated	**433.9**	**444.9**	**447.4**	**453.1**	**459.0**
Funding (excluding IDF inflows below)	387.0	394.0	395.8	401.3	406.8
Services provided for Other DHBs (IDF Inflows)	47.0	48.4	51.5	51.9	52.2
Total Funding	**434.0**	**442.4**	**447.4**	**453.1**	**459.0**
Surplus / (Deficit)	**0.1**	**(2.5)**	**0.0**	**0.0**	**0.0**

MODULE 2: STRATEGIC DIRECTION

Each of the three DHBs has been operating with its own Vision, Values and Priorities over the past decade. As we move into a new era of the 3 DHBs aligning service development and provision for the wider population, a new strategic framework will be developed in consultation with communities to underpin a new cohesive way forward. This piece of work will be undertaken in the 2013/2014 financial year for rollout in 2014/2015.

In the interim, the vision and priorities of each Board remain intact, but for the purposes of the annual planning process and the development of the Statement of Intent, the Boards have agreed to a single operating framework that consolidates the vision and priorities to allow a clear intervention logic to be created from our collective activities and joint priorities.

In essence, this has been relatively simple to achieve for the year as an interim step toward a single framework, since the visions and strategic priorities have been very similar across the organisations for some time.

2.1 VISION

The Government's policy objective in healthcare is for New Zealanders to lead longer, healthier, and more independent lives. This Annual Plan is underpinned by (s)38 2.d of the Public Health and Disability Act 2000 and reflects the overall direction set out in the Act, in addition to addressing those areas outlined in the Minister's Letter of Expectations for 2013/14. Additionally, the strategic direction of this Annual Plan is consistent with, and supports the DHB's Māori Health Plan.

Achieving this requires the actions of many stakeholders, including those operating outside of the three DHBs. The DHBs each play a key role in working across a wide range of stakeholders to influence their positive impacts on the social determinants of health in our communities. These stakeholders include individuals, families, community collectives, NGOs, local government and central government agencies. Only through genuine partnership will true health improvement across our population be achieved.

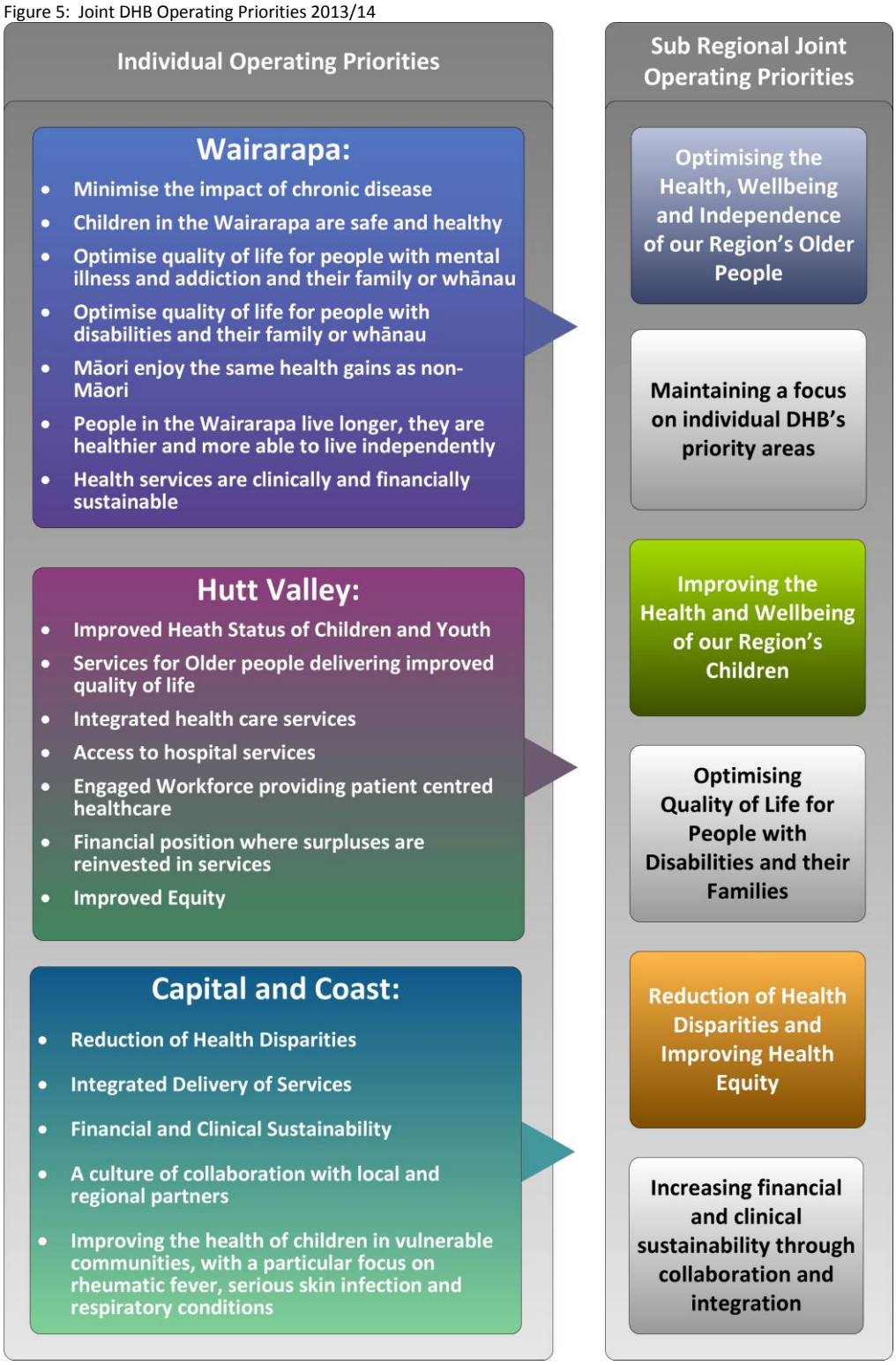
The Boards have agreed to consolidate their individual vision statements into a single operating vision for the purposes of joint planning in 2013/2014 as shown in Figure 4.

Figure 4: Vision Statement

2.2 STRATEGIC OUTCOMES AND NATIONAL, REGIONAL AND LOCAL CONTEXT

The DHBs manage a mix of demand driven services and long term investment approaches within a paradigm that aims to improve each organisation's individual and collective capacity to meet the Government's service objectives, and the overall health of the regional and local populations. The Boards have agreed to consolidate their individual sets of priorities into a single set of operating priorities for the purposes of joint planning in 2013/2014. Figure 5 refers.

Figure 5: Joint DHB Operating Priorities 2013/14



National strategies to achieve the vision

The Government's priorities are expressed as a set of national Health Targets which, as part of a larger balanced scorecard, provides a snapshot of how local DHBs are performing. These are described in Table 5.

Table 5: National Health Targets

Health Target	Description
Shorter stays in Emergency Departments 	95 percent of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.
Improved access to elective surgery 	More New Zealanders have access to elective surgical services with at least 4,000 additional discharges nationally every year.
Shorter waits for cancer treatment 	All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.
Increased immunisation 	90 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 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.

Health Sector Agencies

The need for national initiative prioritisation was identified in December 2012, along with an initial analysis of affordability impacts on DHBs. Further work has been undertaken between National Health IT Board (NHITB) and Health Benefits Limited, with the support of the Ministry of Health, to validate costs and benefit impacts and obtain NHITB and HBL feedback on possible national priorities for 2013/14.

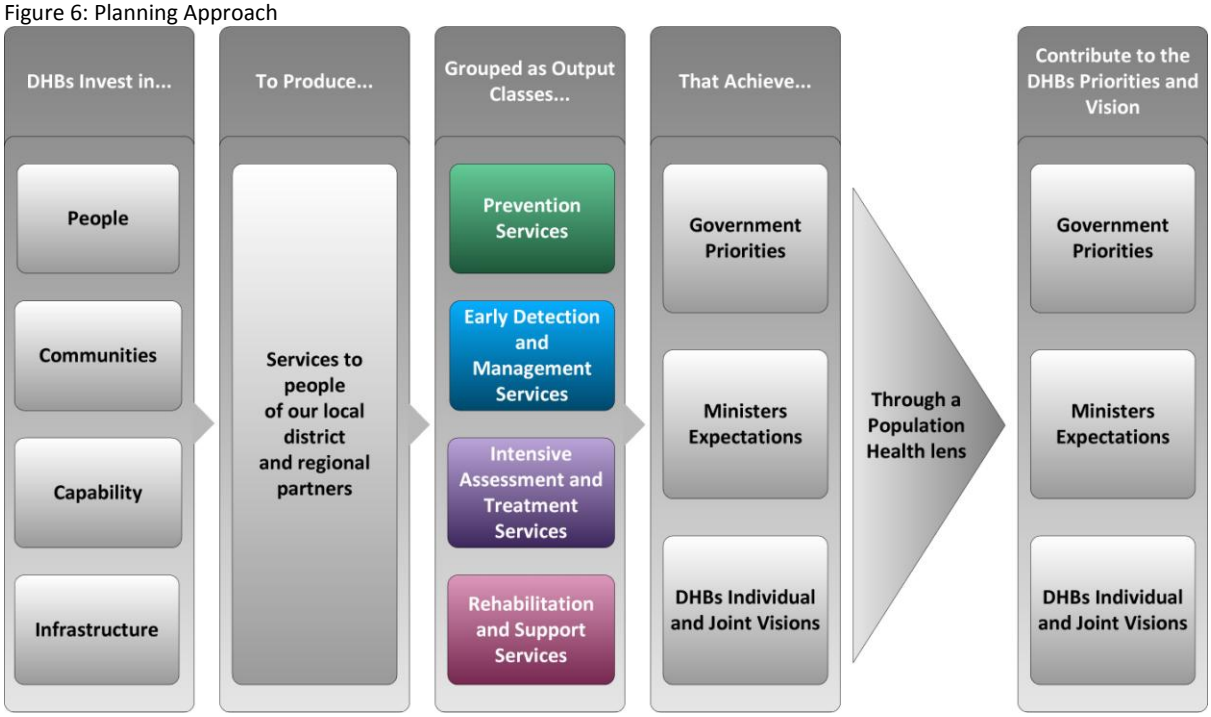
The National Entity Initiative Priorities expected to have financial impacts on Wairarapa DHB are included in the table below. Further details regarding the financial impacts, including costs and benefits to the DHB are included in Module 7 – Financial Performance.

Table 6: National Entities Initiative

Initiative
Common Operating Environment (Upgrade from Windows XP and Office 2003)
Health Identity Programme
NCAMP
Finance, Procurement and Supply Chain (HBL)

2.3 PLANNING APPROACH

Figure 6: Planning Approach



The planning of services across both the subregion and the districts to achieve outcomes at multiple levels is a complex exercise. SIDU therefore uses an intervention logic approach to provide assurance as to how raw funding is converted into tangible health outcomes. This approach provides assurance to the Executives and the Boards that the services we provide or purchase are well targeted and have a high probability of achieving the desired health outcomes or equity results over the medium or longer term. Figure 6 refers.

Supporting the logic model are a number of engagement mechanisms which ensure the decisions that the DHBs make involve the right mix of clinicians, planners and funders.

Integrative Approaches – Better, Sooner, More Convenient Healthcare

Each of the three DHBs across the subregion is engaged in locally developed primary/secondary integration work that contributes to the Minister's priority of better, sooner, and more convenient healthcare.

The Wairarapa Alliance Leadership Team (ALT) Approach

The Wairarapa DHB was an early adopter of the Better, Sooner, More Convenient health system goals, and to advance these developed the Alliance Leadership Team (ALT) made up of clinicians from across the continuum of care, to provide the governance and leadership for whole of sector health care in the Wairarapa. The ALT works under an Alliance Charter which sets out a commitment to act in good faith to reach consensus decisions on the basis of "best for patient, best for system". The ALT is guided by Alliance principles which include:

- supporting clinical leadership, and in particular clinically-led service development;
- conducting themselves with honesty and integrity, and develop a high degree of trust;
- promoting an environment of high quality, performance and accountability, and low bureaucracy;
- striving to resolve disagreements co-operatively, and wherever possible achieve consensus decisions; and
- adopting a patient-centred, whole-of-system approach and making decisions on a 'Best for System' basis.

Supporting the ALT is a management group whose role is to manage and drive the work programme and deal with some of the system barriers that make integration difficult. A joint Clinical Governance Group will be established in 2013 to provide the whole of system approach to clinical governance in the Wairarapa, while maintaining a focus on leading the development and improvement of the systems and delivery of clinical care.

The DHB has been implementing an ongoing programme of work for the past three years called Tihei Wairarapa. This is our Better, Sooner, More Convenient Business Case to deliver more integrated health services in the Wairarapa. 2013 will be the fourth year of this programme of work. In 2013/14 we will continue a work programme focussed on acute care, mental health, Whānau Ora, and care of the frail elderly and people with long term conditions (LTC). A new feature of the work programme in 2013 will be the incorporation of activity related to maternal, child and youth health services across a range of primary and community providers with a view to providing a more integrated approach in the Wairarapa. Key planned activities include:

- full implementation of guided model of care across practices, hospital and community services for people with LTC;
- embed and monitor LTC pathways developed in year 2 and 3;
- implementation of the diabetes guided care pathway;
- embed new mental health services in primary care and extend to child and youth;
- continue to progress the Integrated Family Health Network (IFHN) across Wairarapa, enhancing the existing range of services collocated with general practices; and
- delivery of health targets – immunisations, smokers seen in primary care and CVD risk assessment.

Through the ALT, Wairarapa DHB acknowledges the participation of local primary care partners in the development of, and agreement with, this Annual Plan. Module 3 provides further details of the work programme and action plans agreed with PSSG.

The CCDHB Integrated Care Collaborative Approach

The Integrated Care Collaborative (ICC) is Capital and Coast's pan-health sector approach to looking at how and where services are delivered, and developing more cost effective and client centred approaches to improved personal and population health outcomes. It is the DHB's key mechanism to driving service change and achieving the Government's vision of Better, Sooner, and More Convenient health services.

The ICC process is based upon the principles of *Triple Aim* change management. These are:

- to improve the quality, safety and experience of care
- to improve health and equity for all populations
- to gain the best value from the resources made available to the public health system

As a collaborative the ICC partners have begun a programme of action that will focus on a number of key areas for integrative change over the next 2-3 years. The activity is modelled on an improvement cycle used effectively by the National Health Service in the UK, which CCDHB has adapted to address the level of change and accountability required across the local system.

There are five areas of focus that have been initially identified as work streams to be developed within the ICC change process (refer to Table 7). In turn, each of these areas of focus are tasked with improving a number of key performance indicators across the continuum of care. The areas of focus impact upon each other, and have vertical and horizontal integrative effects on overall sector performance. Table 7 below demonstrates how, and where in the continuum the projects will have a positive and sustainable impact on the achievement of Better, Sooner, More Convenient health outcomes.

Table 7: ICC Work Programmes

ICC Project Integration	Number of Admissions	Length of Stay	Patient Outcome	Primary Care Activity	HHS Outpatient Community Activity
Acute Demand & After Hours	▼	►	▲	▲	►
Long Term Conditions	▼	►	▲	▲	▼
Communication between Primary and Secondary Care	►	▼	▲	►	▼
Health of Older People	▼	▼	▲	▲	►
Child Health Action Plan	►	►	▲	▲	►

The ICC Work Programmes are undertaken collaboratively with a wide number of partners across the health services continuum. These include:

Table 8: ICC Partners

CCDHB Hospital and Health Services	**Compass Health Clinical Quality Board**
SIDU Management Team	**Well Health Clinical Quality Board**
Compass Health Board	**Ora Toa PHO Clinical Quality Board**
Well Health PHO Board	**Cosine Primary Health Care Network Clinical Quality Board**
Ora Toa PHO Board	**Cosine Primary Health Care Network Board**
Nurse Maude – Care Coordination	**Wellington Free Ambulance**
Regional Public Health	

Through ICC, Capital and Coast DHB acknowledges the participation of local primary care partners, in the development of, and agreement with, this Annual Plan. Module 3 provides further details of the work programme and action plans agreed with ICC.

The Hutt Valley Primary Secondary Strategic Governance (PSSG) Approach

The PSSG is an integrated primary and secondary multidisciplinary clinical group created to provide and contribute to clinical leadership across the primary/secondary continuum in the Hutt Valley.

Its agreed vision is "Keeping people in the community healthy".

Its goals have been established as:

- ensuring seamless healthcare for people in the Hutt Valley;
- fostering high quality innovative integrated services – i.e. safe, patient centred, effective, timely, efficient, accessible, sustainable and equitable;
- identification and removal of barriers to communication and care; and
- better management of preventative services, acute episodes, and long term conditions.

The PSSG's agreed functions include:

(a) identifying and considering opportunities that exist across Primary/Secondary care to enhance the patient experience (including quality, access, and reliability);

(b) developing, leading, and sponsoring a work programme in partnership with Hutt Valley DHB, Te Awakairangi Health PHO (TeAHN), and Ropata Medical Centre (Ropata);

(c) providing advice regarding priorities across the primary/secondary care continuum;

(d) reviewing and assessing the clinical implications of proposed service changes and innovations across the continuum of care;

(e) assisting Hutt Valley DHB, TeAHN, and Ropata in determining and achieving strategic goals; and

(f) modelling integrated clinical leadership amongst clinical colleagues.

Through PSSG, local primary care partners have participated in the development of and agreement with the Hutt Valley DHB Annual Plan.

Clinical Governance

A number of clinical governance groups have been established across the 3DHB region. Their purpose is to look at how services can be provided more efficiently and effectively across the wider population – improving both delivery and equity of access.

The clinical governance groups play an important role both in the operational planning across services and in supporting the ongoing development of the Regional Services Plan (RSP). Bringing together regional experts in local population health services (e.g. Child Health and Health of Older Peoples) within these clinical forums will ensure planners of future regional service configurations will be best informed. This will allow the Central Region DHBs to move more quickly and robustly towards achieving medium- and long-term efficiency gains for both their organisations and the local populations.

Fitting it all together

Figure 7: 3 DHB Outcome Intervention Logic 2013/14

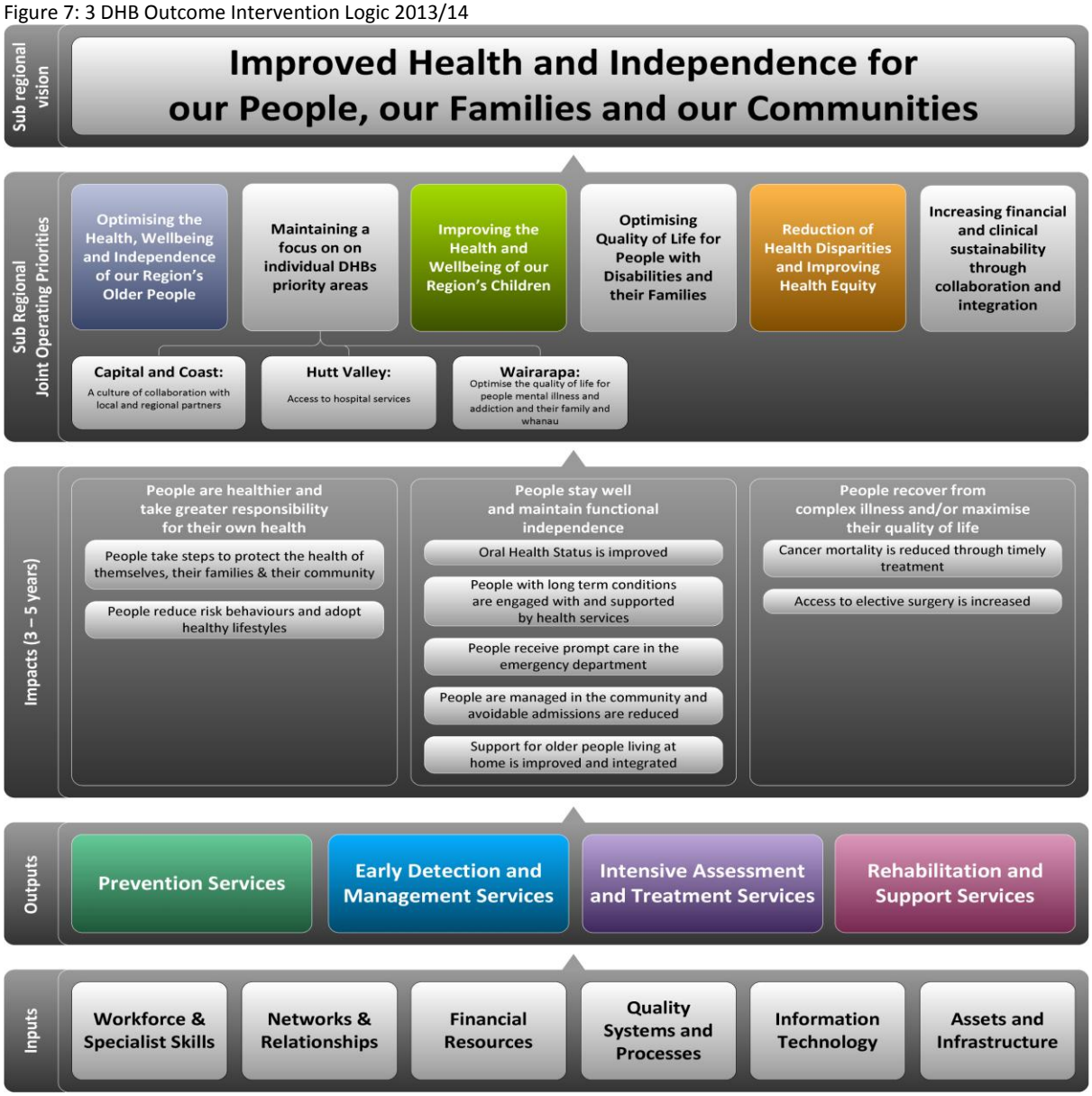


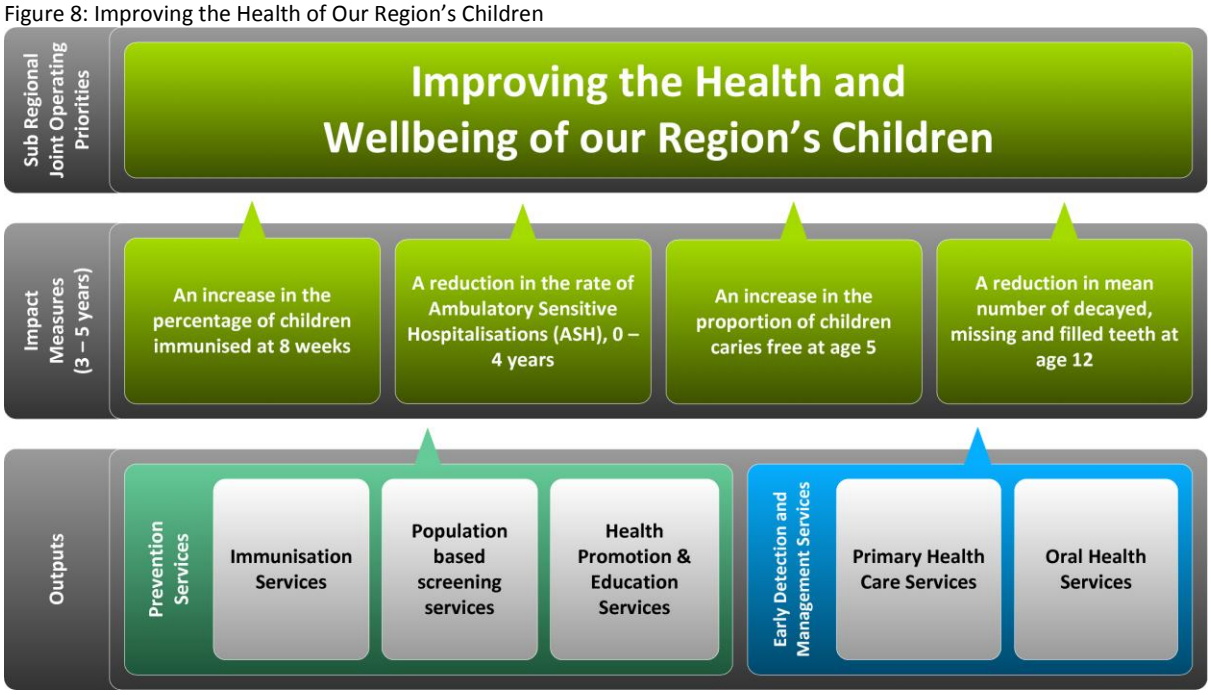
Figure 7 above shows the relationships between the inputs, outputs, impacts, and subregional joint operating priorities. Each layer of this diagram contributes to the next level up, however the relationships are complex and not necessarily one to one. DHBs can influence health outcomes, although the outcomes are also reflective of:

- socioeconomic determinants, such as income and housing;
- health literacy, or understanding of health problems and the health system; and
- the value individuals place on their health and health decisions.

The inputs are the items which are put into the local health system. The outputs, grouped by output classes as per the Statement of Forecast Service Performance (see Module 5), reflect the activities undertaken by the local health system as described in Module 3 and assessed by the performance measures in Module 5. Annual activities are decided in response to population needs, service development priorities, and the guidance from the Minister and Ministry of Health. The impacts are the changes the DHB would like to see in the short to medium term (<5 years) as a result of the annual outputs. The 2013/14 joint operating priorities, developed from the three DHBs' 2012/13

local priorities, act as interim outcomes (5-10 years) that the DHBs aspire to achieve. As closer collaboration continues between the three DHBs, a single framework is intended for the subregion.

Figure 8: Improving the Health of Our Region's Children

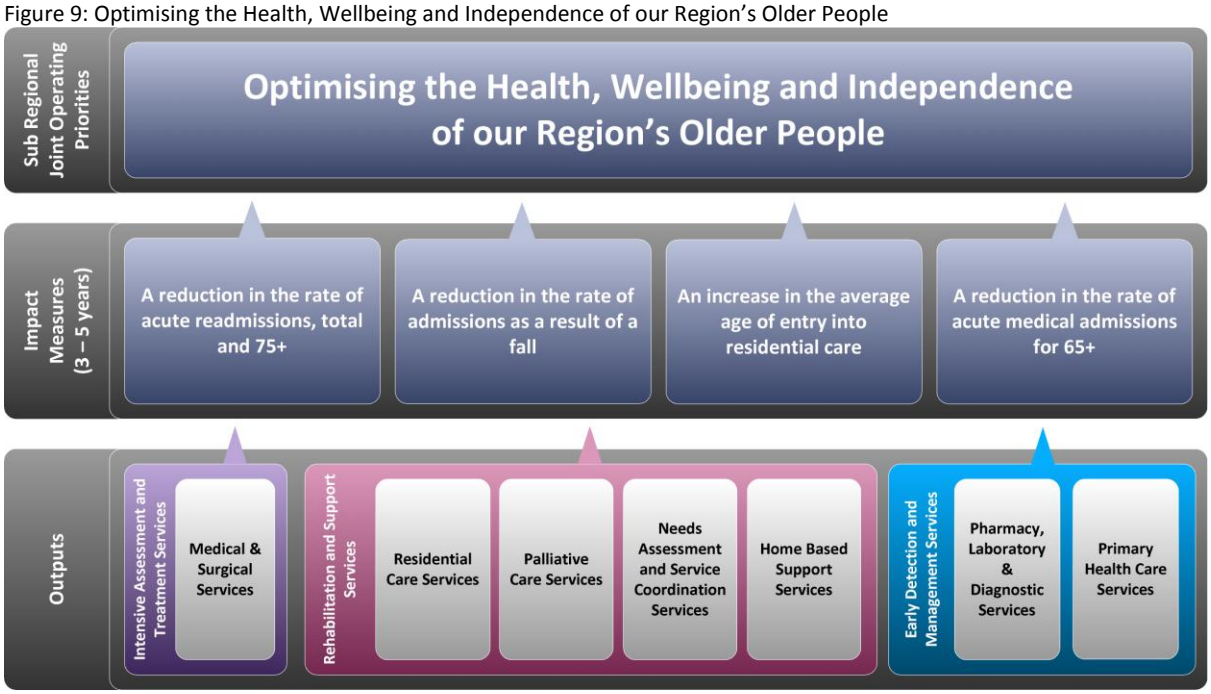


Across each sub-regional priority area, the DHB's performance will be the product of a spectrum of DHB services working together across a range of output classes. It is important to note that there is seldom a simple or linear relationship between a sub-regional priority and the work of DHB services. Figure 8 is provided to help show what the intended linkages are, and to enhance accountability by specifying which DHB service areas will be making some contribution towards Improving the Health of Our Region's Children. The DHB will regularly examine its progress relative to this subregional priority area by monitoring the four Impact Measures in Figure 8 through the Statement of Forecast Service Performance (Module 5) and the Ministry of Health's Non-financial Monitoring Framework (Appendix 8.1).

Maintaining a focus on individual DHB's priority areas

While the DHBs' 2012/13 local priorities were well aligned and able to be brought into a set of subregional operating priorities, there were some that are specific to the local populations. These are reflective of system integration and functionality, and therefore have been included with the subregional operating priorities in Figure 7.

Figure 9: Optimising the Health, Wellbeing and Independence of our Region's Older People

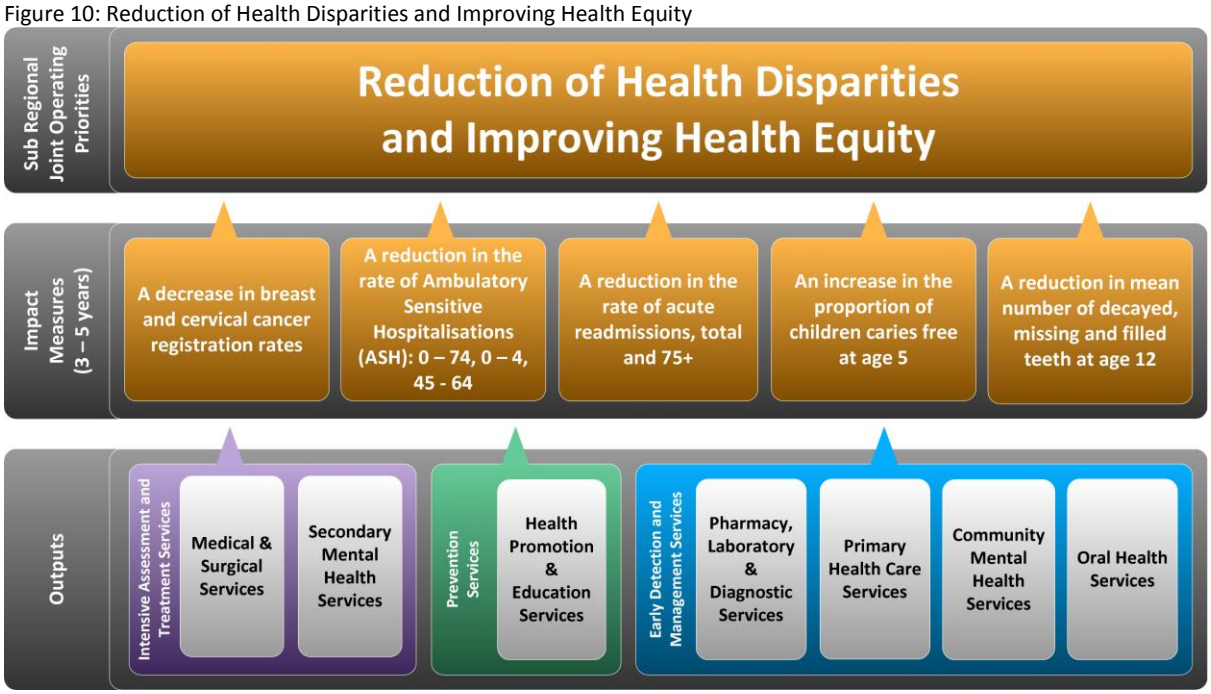


Across each sub-regional priority area, the DHB's performance will be the product of a spectrum of DHB services working together across a range of output classes. It is important to note that there is seldom a simple or linear relationship between a subregional priority and the work of DHB services. Figure 9 is provided to help show what the intended linkages are, and to enhance accountability by specifying which DHB service areas will be making some contribution towards Optimising the Health, Wellbeing and Independence of our Region's Older People. The DHB will regularly examine its progress relative to this subregional priority area by monitoring the four Impact Measures in Figure 8 through the Statement of Forecast Service Performance (Module 5) and the Ministry of Health's Non-financial Monitoring Framework (Appendix 8.1).

Optimising quality of life for people with disabilities and their families

This subregional joint operating priority reflects the joint Hutt Valley and Capital & Coast disability strategy 2012-2017, and the Wairarapa local initiatives. Because success in this outcome is dependent on whole of system responsiveness and functionality, it is difficult to identify specific impact measures which confirm progress against the outcome. Progress is measured at an output level by the measures of annual activities (Module 3) and projects undertaken in the joint Hutt Valley and Capital & Coast disability strategy.

Figure 10: Reduction of Health Disparities and Improving Health Equity



Across each subregional priority area, the DHB's performance will be the product of a spectrum of DHB services working together across a range of output classes. It is important to note that there is seldom a simple or linear relationship between a subregional priority and the work of DHB services. Figure 10 is provided to help show what the intended linkages are, and to enhance accountability by specifying which DHB service areas will be making some contribution towards the Reduction of Health Disparities and Improving Health Equity. The DHB will regularly examine its progress relative to this subregional priority area by monitoring the four Impact Measures in Figure 8 through the Statement of Forecast Service Performance (Module 5) and the Ministry of Health's Non-financial Monitoring Framework (Appendix 8.1).

Increasing financial and clinical sustainability through collaboration and integration
This outcome is reflective of system integration and functionality, and therefore has been included at the top Figure 7. Success in this outcome is dependent on closer collaboration and integration programmes, such as the 3DHB HSD and local programmes like Tihei Wairarapa, Hutt Valley's Primary-Secondary Strategy Group, and Capital and Coast's Integrated Care Collaborative. Detailed information on activities is provided in Module 3.

2.4 MĀORI HEALTH PLAN

Inequalities in access to and decisions over resources are the primary cause of health inequalities. These structural inequalities may explain more of ethnic inequalities in health than is often recognised.

Māori and Pacific peoples die on average ten to fifteen years earlier than non-Māori non-Pacific, and experience significantly higher acute admission and avoidable mortality rates. Although access to some health care services has improved, outcomes often remain worse for Māori and Pacific. For example, although Māori and Pacific are no more likely to be diagnosed with cancer (any type) than non-Māori non-Pacific, they are more likely to die from their cancer.

The DHB has developed a Māori Health Plan (MHP), which sets out our intentions toward improving the health of Māori and their whānau, and reducing health inequalities for Māori. The plan has been submitted in line with Ministry of Health requirements. This plan has been drawn from the Wairarapa DHB's Māori Health Plan, Te Huarahi Oranga, which was developed in 2010.

The MHP records a set of national priorities, Central Region priorities (see Tu Ora, the Regional Māori Health Plan), subregional and district priorities.

Our district priorities have been identified in conjunction with the DHB's Māori Partnership Board. They are: Maternal, Infant and Child Health, Oral Health, Long Term Conditions, Mental Health and Addictions and Workforce. Each of these priority areas has a set of identified action points.

Disability Plan

One of the objectives that all DHBs share is to promote the inclusion and participation in society and independence of people with disabilities.

The Minister of the Crown responsible for disability issues determines a strategy for disability support services to provide the framework for the Government's overall direction for the disability sector. The resulting New Zealand Disability Strategy, along with the UN Convention on the Rights of Persons with Disabilities, provides the big picture of what New Zealand aims to achieve with disabled people. Our disability plan seeks to give shape to the intent of the strategy, noting however that funding for Disability Services is administered by the Ministry of Health.

Wairarapa, Hutt Valley and Capital and Coast District Health Boards now share the advice of a joint Community Public Health Advisory Committee (CPHAC)/Disability Support Advisory Committee (DSAC). This change recognises the increase in shared initiatives between the DHBs, and the need for neighbouring communities to work together. A shared CPHAC/DSAC improves integration between the three DHBs, and provides opportunities for equity through alignment of initiatives.

Following the HVDHB and CCDHB joint pilot of the Health and Disability Commission Health Passport in 2011, we intend to launch the Health Passport in Wairarapa DHB and encourage members of the community who choose to complete a passport. We will make information on the passport initiative available to DHB staff, so it is a recognised part of interactions with patients. This process provides an opportunity for people with particular care needs to articulate them when they are well, in a form that staff recognise.

More detailed information regarding plans for reducing disparities can be found in Module 3, whilst population health measures for Wairarapa DHB is included in Module 5.2.5

2.5 KEY IMPACTS AND MEASURES OF PERFORMANCE

Shorter Stays in EDs	Improved Access to Elective Surgery	Shorter Waits for Cancer Treatment
Government Expectation **95% of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.**	**Government Expectation** **More New Zealanders have access to elective surgical services[1] with at least 4,000 additional discharges nationally every year.**	**Government Expectation** **All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.** [2]
Why is this target area important: This target is reflective of a whole of system approach to managing acute demand, strong clinical leadership and a commitment to improving the quality of care for patients across the whole continuum. ED length of stay is also seen by the Government as an important measure of the quality of acute care in public hospitals. Long stays in ED are reflective of overcrowding, which can lead to compromised standards of privacy and dignity for patients and are linked to negative clinical outcomes for patients, such as increased mortality and longer inpatients lengths of stay. The target is also reflective of the flow of patients through the hospital and how well different departments interact.	**Why is this target area important:** The Government wants the public health system to deliver better, sooner, more convenient health care for all New Zealanders. In order to achieve this, the growth in elective surgical discharges must keep up with population growth. This in turn will increase access and achieve genuine reductions in waiting times for patients. All patients have the right to: clarity about whether they will receive publically funded treatment, timeliness in terms of those who are given a commitment to treatment receiving that treatment in a timely manner (a maximum of five months) and fairness in ensuring that prioritisation status is based on a patient's level of health need compared to other patients.	**Why is this target area important:** Cancer is the leading cause of death and a major cause of hospitalisation in New Zealand. Timely cancer treatment is important to improve outcomes and provide a better quality of life. The target measures one part of a patient's journey with cancer and provides an indicator of how well the system is working. Māori and Pacific populations have proportionately higher cancer incidence compared to other populations. Providing support to improve access to treatment and ensure sufficient treatment capacity are both important factors in ensuring Māori and Pacific people have equitable outcomes.
Wairarapa DHB contribution: 95% of people presenting at Wairarapa DHB ED will be admitted, discharged or transferred within six hours.	**Wairarapa DHB contribution:** Wairarapa DHB will maintain compliance with all eight Elective Services Patient flow Indicators (ESPIs). 1,841 elective surgery discharges will be provided by Wairarapa DHB in 2013/14.	**Wairarapa DHB contribution:** All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.

[1] The national health target definition of elective surgery excludes dental and cardiology services.
[2] The national health target definition excludes Category D patients, whose treatment is scheduled to ensure effective sequence of radiation treatment with chemotherapy of other anti-cancer drugs.

		
Increased Immunisation Rates	**Better Help for Smokers to Quit**	**More Heart and Diabetes Checks**
Government Expectation **85% of eight month 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% by December 2014.**	**Government Expectation** **95% 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% 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.**	**Government Expectation** **90% of the eligible population will have had their cardiovascular risk assessed in the last five years.**
Why is this target area important: Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals but for the whole population by reducing the incidence of disease and preventing them from spreading to vulnerable people or population groups. Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and not sufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). Coverage for two year olds demonstrates whether children have received the full series of infant immunisations, when they are most vulnerable.	**Why is this target area important:** Smoking kills an estimated 5,000 people in New Zealand every year, and smoking-related diseases are a significant cost to the health sector. Smoking is also a major contributor to inequalities in health and to a number of long-term conditions, including heart disease, cancers and respiratory disease. Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care. This target is designed to prompt health professionals to routinely ask about smoking status and provide smokers with brief advice and support to prompt quit attempts and quit success.	**Why is this target area important:** Long-term conditions comprise the major health burden for New Zealand now and in the foreseeable future. These conditions are the leading cause of morbidity and disproportionately affect Māori and Pacific people. As the population ages and lifestyles change, these conditions are likely to increase significantly. Improving outcomes for people with diabetes and CVD will take a whole of system approach that encourages healthier lifestyles, supports early diagnosis, management plans and access to treatment. The targets measure one part of the journey and can provide an indication of how well long-term conditions are being identified and managed in primary care.

Wairarapa DHB contribution: 90% of Wairarapa DHB eight month olds fully vaccinated by July 2014. 90% of Wairarapa DHB Māori eight month olds fully vaccinated by July 2014.	**Wairarapa DHB contribution:** 95% of hospitalised smokers will be provided with advice and help to quit smoking by July 2014. 90% of smokers attending primary care will be provided with advice and help to quit smoking by July 2014. Progress towards 90% of pregnant smokers at the time of confirmation of pregnancy in general practice or booking with LMC are offered advice & support to quit.	**Wairarapa DHB contribution:** 90% of the eligible adult population in Wairarapa DHB will have had their CVD risk assessed in the last five years by 30 June 2014.

2.6 SECTOR COLLABORATION

Working Nationally

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

Table 9: National services

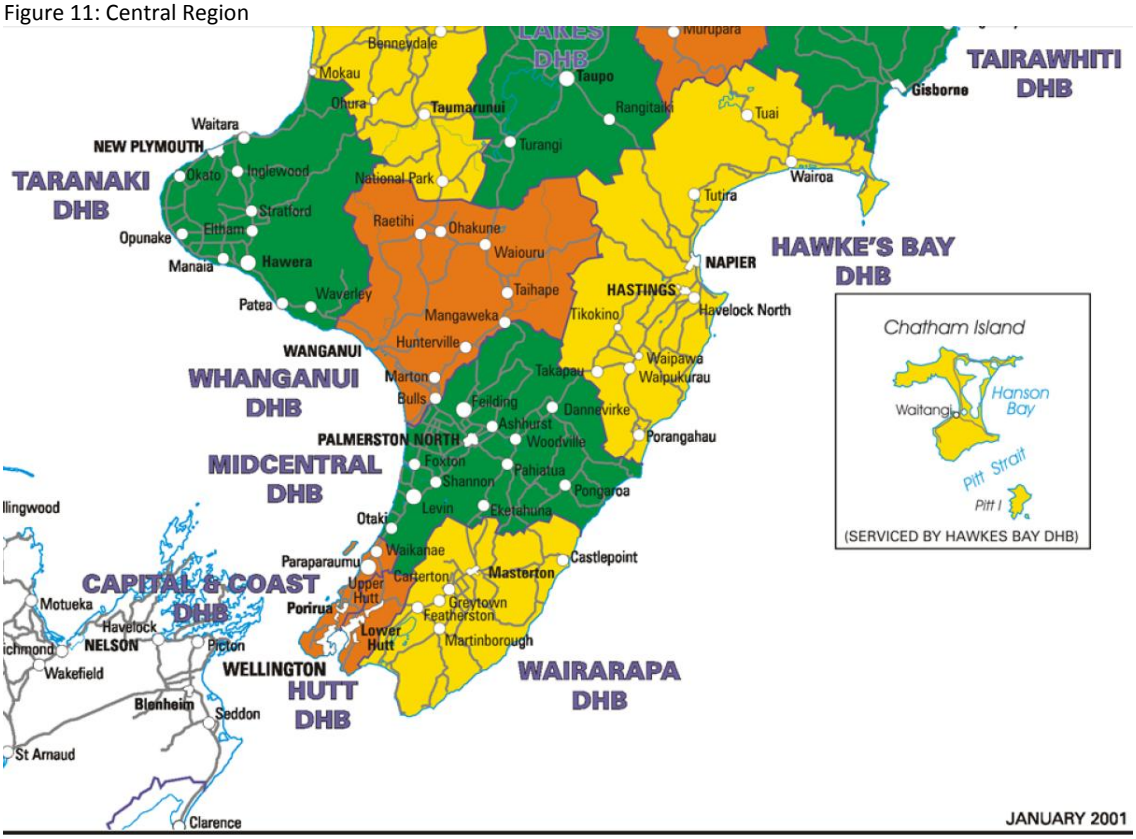
Intestinal Failure
Renal Transplantation
Hyperbaric Medical Service

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

Working across the Broader Central Region DHB Grouping

The 3 DHBs are part of a wider group of DHBs known as the Central Region. The Central Region covers the Lower North Island and comprises Wairarapa DHB, Hutt Valley DHB, Capital and Coast DHB, MidCentral DHB, Whanganui DHB, and Hawke's Bay DHB. A map of the Central Region is set out below. This region serves a population of over 870,000.

Figure 11: Central Region



Services provided by Capital and Coast DHB through its Hospital Services arm to the region are:

Table 10: Regional Services Based at Capital & Coast DHB

Clinical Genetics	Oncology	Haematology
Cardiothoracic Surgery	Neurology	Tertiary Paediatrics
Tertiary Cardiology	Neurosurgery	Tertiary Neonatal
Chronic Pain Service	Renal	Immunology
Vascular Surgery	Urology	Ophthalmology
Forensic Mental Health	Methadone programme	Infectious diseases
Regional Mental Health speciality services		

Services provided by Hutt Valley DHB through its Hospital Services arm to the region are:

Table 11: Regional Services based at Hutt Valley DHB

Plastic Surgery	Maxillofacial and Burns services	Reconstructive Surgery
Rheumatology Services (subregional)	Eating Disorder Service	Regional Screening
Regional Public Health		

The Central Region Services Plan

The Regional Services Plan (RSP) has been developed by the six Central Region 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. It builds on the Regional Clinical Services Plan (2008) and the 2011/12 RSP.

The RSP is the overarching strategy for all Central Region DHB Annual Plans for 2013/14 onwards. This includes agreed common Annual Plan assumptions, clarity about planned inter-district activity flows, changes to service models (including workforce appointments) and capital investment.

The active involvement of representatives from all six DHBs has helped create a positive environment for the next steps in regional collaboration. The leadership and engagement of health professionals in these processes ensures that work plans and planning principles are owned by those directly involved in the delivery of health services in the Central Region.

The priorities for inclusion in the RSP in 2013/14 include:

Table 12: RSP Priorities 2013/14

National and regional priority area	**Objectives**
1. Better public services for reduction of rheumatic fever	Implement effective rheumatic fever prevention and reduction programmes, especially in areas of high incidence

2. Elective services	To improve access to elective services by increasing the level of first specialist assessments and surgery and reducing waiting times; and to improve equity through improved prioritisation of patients
3. Long term conditions – Cancer services	People get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care) and have access to services that maintain good health and independence
4. Long term conditions - Cardiovascular services (Acute Coronary Syndrome)	• Improving access to cardiac diagnostics, specialist assessment and intervention where appropriate • Reducing waiting times for cardiac services – elective and non- elective services • Improving access to evidence based services and outcomes for people with suspected ACS • Improving access to and waiting times for PCI, angiography and cardiac surgery
5. Long term conditions – Stroke services	Better, Sooner, More Convenient Health Services for New Zealanders in relation to Stroke Services means improved and more timely access to organised stroke services meaning more patients survive stroke events, and the likelihood of subsequent stroke events is reduced.
6. Mental Health and Addictions	Improving access and effectiveness of services particularly for priority groups across the region: for people with eating disorders, adult and youth forensic services, perinatal and maternal services, and addiction services.
Regional priority plan:	
7. Regional Radiology	Deliver Better, Sooner, More Convenient Health Services for New Zealanders in relation to radiology with the objective that all New Zealanders are provided with a patient focussed and regionalised radiology service that is high quality, timely, affordable and therefore sustainable

Non- clinical priorities/ regional enablers	
8. CRISP	Support the delivery of integrated health services by developing core regional applications supporting Common Clinical Information available from 2013 and a foundation to support Community Information, Hospital Information and Shared Care Plan in the future is established
9. Regional Training Hub	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
10. Workforce	Develop a comprehensive plan that will support new models of delivery, the change processes and the prioritise workforce pressure areas for strategy development and

	action across the region
11. Regional funding models and mechanisms	Review regional funding mechanisms to develop a planned and managed approach to demand for high cost services and to reduce volatility
12. Capital planning	Describe key service planning issues that will impact on capital investment and will outline a work programme to address the issues and align the asset management plans with the local and regional service plans

In addition, the six DHBs in the region will also continue to contribute to the following regional networks and priorities:

- *Health of Older People Network:* Health of Older people is a national, regional and local priority. As the population ages, there will be an even greater demand for health services.
- *Renal Network:* The network exists to ensure the population of the region have improved equitable and timely access to renal services. It will also be investigating the possibility of greater alignment of renal services across the region.
- *Māori Health:* A reduction in health inequalities must remain a core focus of our regional work, ensuring that our DHBs pool their resources and understanding of how to reduce health inequalities, and implement a monitoring plan to ensure health inequalities are addressed at all organisational levels.
- *Population Health:* The region believes a 'whole of system' approach to the delivery of integrated services must include community based preventative services. Investment in preventative measures will, over time, help maintain and potentially improve people's health standards, reduce pressure on the health care services and avoid hospital admissions.
- *Quality and Safety:* The region is committed to working towards a zero preventable harm culture and with the establishment of the Clinical Board is already making positive steps towards enhancing patient outcomes across the region.

Regional Governance and Leadership

A revised governance and leadership framework is detailed in the RSP. There will be three key governance groups that oversee all clinical and business service activities:

1. The Regional Governance Group (RGG), supported by the Regional Māori Relationship Board Forum
2. The Central Region CEOs
3. Regional Executive Committee (REC)

Collaboration with other regional DHBs to improve service delivery efficiencies – 3DHB Health Service Development Programme

The 3DHB Health Service Development Programme (3D HSD) is a collaborative programme between Wairarapa, Hutt Valley and Capital and Coast DHBs that has been running for over two years, focussed on the joint planning of health services. The service development programme is clinically led with managerial support enabling a collaborative partnership approach to be achieved while delivering on the Triple Aim vision (Figure 12 refers).

Figure 12: HQNZ Triple Aim

The three DHBs collectively and individually face challenges in relation to service sustainability. The key factor in relation to these challenges is the population catchment size required to ensure clinical service and financial viability.

The Subregional Clinical Leadership Group (SRCLG) supports collaboration between the DHBs to advance improvements in the quality of patient care, manage risk and improve processes, sustain our workforce, and make the best use of our resources to a greater extent than working separately. The SRCLG has gone on to support an ongoing programme of clinically led work which considers the optimal configuration of services across the three districts to provide equitable access to the subregional population.

Following the submission of the 2012/13 Annual Plans by the three DHBs, the Minister of Health issued a letter requesting that the three DHBs submit a collective breakeven plan. The *3DHB Subregional Savings Plan* developed by Health Partners Limited in collaboration with the three DHBs has subsequently been accepted by the Minister and the three DHB Boards, and proposes a range of projects and activities that will deliver improved financial performance across the three DHBs.

The focus of the 3D HSD Programme is to take a whole of system approach spanning the health continuum to enable the greatest gain to the patient/whānau experience, population health and clinical and financial sustainability consistent with the Triple Aim Approach. This comprehensive programme of work is supported by a 3D Programme Office, resourced from existing SIDU capacity and reporting to SRCLG, and combined CPHAC. Good progress has already been made. The following tables reflect the agreed work programme for 2013/14, made up of a range of enablers and clinical workstreams.

This is a combination of work identified by the SRCLG and the actions identified in the *3DHB Subregional Savings Plan*. Specific workstream actions and milestones are being developed to inform the 2013/14 work programme. Table 13 reflects the range of enablers and clinical workstreams that make up the 3D HSD Programme, and Table 14 provides further details of the 3D HSD work programme.

Table 13: 3D HSD Work programme 2013-2014 - Summary

3D HSD Work programme 2013-2014 - Summary		
Outcome areas	**Status**	**Oversight Body**
Enablers		
Capacity Modelling / Optimal facilities	ACTIVE	SRCLG
Sub Regional policy alignment for: • HR • IT • Health	ACTIVE	SRCLG
Sub regional SMO teams	ACTIVE	SRCLG
Sub regional management RMOs	ACTIVE	SRCLG
Single Communication Team	TO BE INITIATED	Boards
Single HR Team	TO BE INITIATED	Boards
Executive team amalgamation HV / WDHB	ACTIVE	HV & W Boards
Funder arm value for money review	ACTIVE	CPHAC
IT Service alignment CC and HVDHB	ACTIVE	FRAC
Provider team amalgamation HV / WDHB	ACTIVE	HAC HV and W
CAPEX spend review	TO BE INITIATED	A/R and FRAC
Clinical Work Streams	**Status**	**Oversight Body**
ENT	ACTIVE	SRCLG
Gastroenterology	ACTIVE	SRCLG
Child Health	ACTIVE	SRCLG
Ophthalmology	TO BE INITIATED	SRCLG
Orthopaedics	ACTIVE	SRCLG
Non melanoma skin cancer	Pre project discussion	SRCLG
Palliative care initiative (MOH funding)	ACTIVE	SRCLG
Amalgamation HV and CCDHB Laboratories	ACTIVE	SRCLG
Sub-regional radiology service	ACTIVE	SRCLG
Reducing outsourced electives	TO BE INITIATED	HAC
Critical Care Management	Pre project	SRCLG

	discussion	
Clinical Work streams for further discussion 2013-2014		
Anaesthesia	Pre project discussion	SRCLG
Mental Health	Pre project discussion	SRCLG
Health of Older People	Pre project discussion	SRCLG
Dermatology	Pre project discussion	SRCLG
Sub-regional Clinical Governance	Pre project discussion	SRCLG

Table 14: 3D HSD Work Programme 2013-2014 - Detail

The DHBs will undertake the following:	Actions to improve performance	Health system success is measured by:	In support of systems outcomes
Scope and agree a subregional clinical service model of care for the following clinical work streams • ENT • Gastroenterology • Child Health • Orthopaedic	Implement subregional referral pathways for common ENT conditions Develop and implement a subregional approach to community ear health services Investigate a business case to provide a sustainable sub-regional head and neck surgery sub-speciality Develop and implement a subregional approach to colonoscopy referral and wait list Develop and agree a subregional model of care for child health Participate in the development of and implementation of regional approach to paediatric surgery Scope and agree a subregional approach to orthopaedic services	A single population approach for specific services is embedded across the 3 DHBs Clinical leadership drives projects and service changes are facilitated by comprehensive project management Sub-regional Clinical Leadership Group provides oversight and endorsement of all project milestones Equity of access for services across the sub region	Improved patient/whānau quality, safety and experience of care A whole of health system approach is applied Improved health outcomes Best value for 3 DHB health system resources Enabling workforce to support 3 DHB service development
Scope and develop a Lower North Island Palliative Care Clinical Network with support from Health Workforce New Zealand	Secure project management support from Health Workforce New Zealand Scope project and agree implementation plan	Lower North Island Palliative Care Clinical Network established by June 2014	Improved patient/whānau quality, safety and experience of care A whole of health system approach is applied
Undertake pre-project scoping and identify a project mandate to support a subregional approach to: • Ophthalmology • Non –melanoma skin cancer • Critical Care Management	Data and business analysis is undertaken for each of the projects as part of scoping Clinical leadership identified for each project and potential steering group membership Project mandate agreed for each project	A single population and subregional approach to clinical service delivery Equity of access to services across the sub-region Clinical leadership drives project mandate	Improved patient/whānau quality, safety and experience of care A whole of health system approach is applied

		and service changes, facilitated by comprehensive project management	Improved health outcomes Best value for 3 DHB health system resources
Develop and progress implementation of a laboratory strategy to inform future direction and configuration of laboratory services across the subregion.	Scope and implement a project based on the strategy document to advance the integration of laboratory services in 2013/14.	Streamlined and integrated service delivery for laboratory services for sub-region Ongoing arrangements are in place at the end of current agreements in October 2014 Equity of access to services across the sub-region	Best value for 3 DHB health system resources Best use of resources (Clinical and financial sustainability)
A sub-regional approach to radiology services is scoped and preferred option agreed	Data and business analysis is undertaken to support project mandate and proposed options Preferred option identified and implementation plan agreed Progress implementation plan	Equity of access to services across the sub-region Clinical leadership drives project mandate and service changes, facilitated by comprehensive project management	Best value for 3 DHB health system resources Best use of resources (Clinical and financial sustainability) Enabling workforce to support 3 DHB service development
Scope and undertake detailed modelling for optimal use of facilities	Data, business analysis and bench marking is undertaken to support project mandate. Proposed options are investigated with clinical leadership	System capacity information is well understood and utilised by clinical work streams in considering sub regional service development	Improved patient/whānau experience Improved quality of care Efficient use of infrastructure investment
Undertake a funder arm review across 3 DHBs	Implement agreed "value for money" processes and review for all contracts expiring in 2013/14 Identify ongoing opportunities for efficiencies		Efficient use of investment Best use of resources (Clinical and financial sustainability)
Align CC/HVDHB IT Service Alignment	Refer to Module 2 RSP		

Corporate policies and procedures in Human Resources, Occupational Health and Information Technology will be reviewed with the objective of developing common processes Scope and implement a single Human Resources team across the three DHBs	Refer to Module 4 Stewardship section for further details of subregional workforce development plans		Enabling workforce to support 3 DHB service development Best value for 3 DHB health system resources
Develop and implement a Sub regional approach to the recruitment and deployment of SMO teams across the DHBs in line with the implementation of integrated clinical services			Best value for 3 DHB health system resources Best use of resources (Clinical and financial sustainability) Enabling workforce to support 3 DHB service development
Implementation of a single HV/WDHB Executive Team Structure			
Amalgamate HV/WDHB provider team			
Scope and implement a single communications team across the three DHBs	Refer to Module 4 Stewardship section for further details of subregional Communications development		

MODULE 3: DELIVERING ON PRIORITIES & TARGETS

This section sets out our key activities, actions, and outputs for 2013/14 to deliver on each of the priorities outlined in the Minister's Letter of Expectations, Health Targets, and other priorities identified in Module 2. These are presented in the tables in this Module 3. They have been developed with our primary care partners, through our Alliance Leadership Team process, with our subregional DHB colleagues, and our Māori Partnership Board.

3.1 PRIORITIES AND TARGETS

The Ministry of Health and DHBs are charged with giving effect to the overarching goal for the health sector of *Better, Sooner, More Convenient* health services for all New Zealanders (BSMC).

Key principles that are foundational to planning in order to achieve BSMC services are:

- using a partnership approach to service planning in which (primary/secondary) clinicians and (primary/secondary) managers jointly agree service priorities along with appropriate funding levels;
- using a whole of system view to determine the most efficient model of service delivery and ensuring service planning is not done in silos;
- providing a model of care that incorporates a range of 'hospital' services to be delivered within community/primary care settings;
- active engagement of 'front-line' clinical leaders/champions in health services delivery planning across the sector at both local and regional levels;
- integrating/coordinating clinical services to provide greater accessibility and seamless delivery;
- strengthen clinical and financial sustainability; and
- make better use of available resource

Three important policy drivers have been identified through which the health sector may best utilise resources to achieve BSMC services – regional collaboration, integrated care (clinical and systems focused), and continuing to seek better value for money. For consistency in application, these terms are defined below:

- *Regional collaboration* means DHBs working together more effectively, whether regionally or subregionally.

- *Integrated care* includes both clinical and service integration to bring organisations and clinical professionals together, in order to improve outcomes for patients and service users through the integrated delivery of care. Integration is a key component of placing patients at the centre of the system; increasing the focus on prevention and avoidance of unplanned acute care; and redesigning services to be closer to home.

- *Value for Money* is the assessment of benefits (better health outcomes) relative to cost, in determining whether specific current or future investments/expenditures are the best use of available resource.

Government Priorities

Specific areas of focus within the policy settings described above are presented in the Minister's Letter of Expectations. The priorities for 2013/14 are:

- reducing rheumatic fever
- clinical integration *(including acute and unplanned care, primary care development, health of older people, long term conditions (including diabetes care improvement), stroke, child and maternity)*
- delivery of the mental health service development plan
- delivery of the Prime Minister's Youth Mental Health Project
- actioning the Children's Action Plan
- improved access to diagnostics
- faster cancer treatment
- living within our means
- Whānau Ora

Health Targets

For 2013/14, the Government has also required DHBs to work to continue to deliver a set of six Health Targets. These are confirmed as:

- Shorter Stays in Emergency Departments
- Improved Access to Elective Surgery
- Shorter Waits for Cancer Treatment
- Increased Immunisation
- Better Help for Smokers to Quit
- More Heart and Diabetes Checks

For further information on the Health Targets, see Section 2.5 for definitions and rationales, or further in this section for activities planned for 2013/14.

Regional, subregional and local actions sponsored/led by the DHB to deliver on RSP

See Section 2.6 regarding the specific activities the DHB will undertake at a local level to deliver on their RSP implementation plan commitments and the 3D HSD programme in the 2013/14 year.

DHB local priorities

Module 3 also includes local priorities the DHB will undertake to achieve its identified local strategic outcomes and priorities not already included through Government priority areas and targets, specifically Māori Health.

3.2 IMPLEMENTING GOVERNMENT PRIORITIES

Integration

Demands on health services are increasing within a tight financial environment. An ageing population, long term conditions and the needs of vulnerable populations are placing greater pressures on the health system. These pressures mean we need to explore new and different models of care and increase our focus on early intervention and acute services. Integrating health services to ensure a more coordinated and closer to home service provides an opportunity to develop a more efficient and sustainable health system.

This involves:

- developing of new models of care
- improving quality through efficiency and effectiveness
- ensuring sufficient change management capability to undertake this development and its implementation
- effective clinical leadership.

As outlined in section 2.3, Tihei Wairarapa is Wairarapa DHB's *Better, Sooner, More Convenient* Business Case. This is the DHB's key mechanism to achieve the Government's vision of Better, Sooner, More Convenient health services and to drive service change to deliver more integrated services in the Wairarapa.

Prime Minister's Youth Mental Health Project

Context

A significant number of young people in New Zealand will experience mental health problems during adolescence. Problems such as depression, anxiety and substance abuse can have life-long consequences. The current system for addressing youth health issues has many strengths, but it also has significant gaps and there are many barriers to access for young people.

In his report *Improving the Transition,* the Prime Minister's Chief Science Advisor highlighted the risks facing young people in New Zealand as they transition from childhood to adulthood. In response to this report, the Department of the Prime Minister and Cabinet (DPMC) developed a cross agency project looking at improving services for young people with, or at risk of, mild to moderate mental health disorders. The project is designed to build on existing successful interventions and to trial new initiatives for young people aged 12-19 years (inclusive) in settings in which young people live their lives: schools, the health system, their families and community, and online.

The 22 initiatives identified within the project will invest in evidence-based programmes that improve young people's resilience; identify mental health problems as early as possible; and provide effective, youth-friendly and timely treatment to those that need it. The package is designed to reflect that young people access support within these settings in an ad hoc way.

The Ministry of Health is leading the following seven initiatives:

1. Maintaining and expanding School Based Health Services
2. Expanding the use of HEEADSSS Wellness Checks in schools and primary care settings
3. Expanding primary mental health services to all youth in the 12-19 year age group and their families
4. Review and implement an internet based e-therapy for young people
5. Improve the responsiveness of primary care to youth
6. Review and improve the follow-up care for those discharged from CAMHS and Youth AOD services
7. Improve access to CAMHS and Youth AOD services through wait time targets and integrated case management.

Objectives

Ultimately we want to see: ***Better mental health and wellbeing for young people – including sub-groups of the population at comparatively higher risk of mental health issues, such as Māori and Pacific***. The expected outcomes after four years are:

- Improved knowledge about what works to improve youth mental health
- Increased resilience among youth, to support mental health
- More supportive schools, communities and health services
- Better access to appropriate information for youth and their families/whānau
- Early identification of mild to moderate mental health issues in youth
- Better access to timely and appropriate treatment and follow-up for youth with mild to moderate mental health issues

Linkages

Mental health section, especially references to CAMHS and AOD:

- review and improve follow-up care for those discharged from CAMHS and youth AOD services
- improve access to CAMHS and youth AOD services through DHB wait time targets and integrated case management services

Youth Mental Health (Primary Care)

Context To ensure that the Health sector contributes successfully to the Youth Mental Health Project goal of *Better mental health and wellbeing for young people – including sub-groups of the population at comparatively higher risk of mental health issues*, and the four year expected outcomes (outlined above), DHBs are required to develop a service which will improve primary care responsiveness to youth with mild to moderate mental health issues. Funding will incrementally increase over the period to 2015/16.

Objectives

To achieve improved health outcomes for young people aged 12-19, including:

- reduced suicide and self-harm rates
- reduced incidence of risky sexual behaviour
- reduced risky use of alcohol and drugs,

through better integration of primary health care services with the wider health, NGO and government sector

Linkages

Mental health services for children and youth

Subregional initiatives

Social Sector Trial

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Maintaining and expanding School Based Health Services The DHB will ensure School Based Health Services (SBHS) effectively improve students' access to primary health care. This will include ensuring the core components of SBHS, including primary health care clinics, youth development and wellness checks (such as the HEEADSSS assessments), proactive services (including promotional health campaigns) and referrals, are provided in all decile 1, 2 and 3 secondary schools. Specific actions for 2013/14 include: • ensuring service delivery is extended to alternative education and teen parent units • ensuring SBHS are delivered as per the service expectations previously advised under the SBHS Crown Funding Agreement variation.	• Increased number of decile 1, 2 and 3 secondary schools, teen parent units and alternative education facilities with School Based Health Services Target 2013/14 – maintain current services at Makoura (including TPU), Kuranui (decile 5) and alternative education facilities	• Quarterly reporting on School Based Health Services as outlined in the CFA, including identification of schools with School Based Health Services

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Expanding the use of HEEADSSS Wellness Checks in schools and primary care settings The DHB, through its primary care provider, will continue to offer HEEADSSS assessments to all year 9 students in colleges with SBHS In 2013/14 HEEADSSS assessments will also be offered to students enrolled in alternative education and teen parent units. The DHB and PHO will also work with Te Whare Kura to ensure health services and HEEADSSS assessments are offered to enrolled students. Through the Mental Health and Addictions Leadership Group, opportunities will be identified for promoting the use of HEEADSSS, or similar brief assessments, in primary care to ensure the early identification of mild to moderate mental health issues in young people up to 24 years.	• Increased numbers of Year 9 students receiving HEEADSSS assessment from nurses in decile 1-3 schools Baseline: 82% Target 2013/14: 85% • Increased numbers of students receiving HEEADSSS assessment from nurses in alternative education, teen parent units and whare kura: Baseline: 0% 2013/14 Target: 80% • Increased HEEADSSS assessment training for primary care clinicians	• Reporting as part of Quarterly reporting on School Based Health Services
Expanding primary mental health services to all youth in the 12-19 year age group and their families Through the Mental Health and Addictions Leadership Group and Alliance Leadership Team, the DHB will extend the integrated mental health and addictions service to youth aged 12-19, including: • an enhanced primary mental health service based on a stepped care model for service provision – a system of delivering and monitoring treatments so the treatment that is most effective, yet least resource intensive, is delivered first • addressing workforce development issues to build the capacity and capability of appropriately trained primary mental health providers as funding for the primary mental health service increase • adoption of responsive services to meet the unique needs for the youth population 12-19 years in the DHB, including determining the settings for a primary mental health service, such as cultural appropriateness, accessibility, gender, age and developmental stage.	• Increased primary mental health interventions	• Six monthly reporting against CMS contracts

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
• Ensuring services are culturally competent and provided to meet the health needs of Māori and Pacific populations. • Maintain DHB suicide prevention and postvention activities. • Identification of points of access in the community and development of referral systems into the primary mental health service, to ensure comprehensive coverage for all youth within the DHB region including: - A clear two-way system between SBHS and the primary mental health service - Extending primary mental health service access to youth presenting through services outside of PHOs.		
Improve the responsiveness of primary care to youth From 2013/14 the development of services for children and young people will be overseen by the DHB's Alliance Leadership Team and sit within the BSMC work programme. Planned actions for 2013/14 include: • Undertake a stocktake of the DHB funded (or DHB provided but not funded) primary and community services (including sexual health services), for the youth population aged 12-19 (at a minimum), by December 2013. • Identify gaps in access, service provision, clinical and financial sustainability, and potential actions to address identified gaps by December 2013 • Work with subregional and other central region DHBs partners to identify opportunities for improving services for youth through subregional and regional collaborations • Develop linkages to Whānau Ora services (There are multiple regional and subregional contracts that require forward planning and negotiations with the other DHBs; this is managed through two regional mechanisms – the Regional MH Portfolio Managers and the Mental Health and Addiction Network (MHAN), which comprise of the six Central Region DHBs' Clinical Directors, MH Service Managers & MH PMs). • Identify concrete and targeted actions to improve the responsiveness of primary care to youth and implement from 2013/14.	• Completion of stocktake • Identification of actions	**Quarter one:** • Narrative report on progress in developing stocktake and gaps analysis. **Quarter two:** • Written stocktake, gaps analysis and actions being considered, to be provided as part of 2013/14 quarter two reports

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Review and improve the follow-up care for those discharged from CAMHS and Youth AOD services • Through the Mental Health and Addictions Leadership Group and Alliance Leadership Team, the DHB will identify actions to improve follow-up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction services through providing follow-up care plans to primary care providers. • Secondary and NGO providers to review current practice locally and subregionally during 2013/14. • This will include the expectation that the follow-up care plans are activated by the primary care provider within three weeks of discharge from secondary services. ensuring services are culturally competent and provided to meet the health needs of Māori and Pacific populations • Refine data collection systems and collect baseline data of the percentage of youth discharged from CAMHS and Youth AOD services into primary care being provided with follow-up care plans, by 30 June 2014	• Progress on specified initiatives and actions • Current practice reviewed by Q3 Mechanism in place for refinement of data collection from primary care	• Progress report against specified actions
Improve access to CAMHS and Youth AOD services through wait time targets and integrated case management. • The DHB will maintain its current 'no wait time' policy.	• Delivery to agreed targets	• Progress in delivery to agreed targets
Social Sector Trial • The DHB will collaborate with intersectoral partners on a Wairarapa wide Social Sector Trial to improve outcomes for young people aged 12-19 years.	• Identification and implementation of agreed initiatives	

Maternal and Child Health

Context

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

- Effective services through a single, joined up network, including social services
- Reduced avoidable admissions and emergency presentations, especially in the first year of life
- Easy access to developmental checks, screening and preventative services including immunisation
- Easy access to referred services in a timely manner
- Appropriate services and cross-agency linkages for vulnerable children and families.

Objectives

- More people have improved access to services that maintain good health and independence.
- More people have shorter waiting times for referred services meaning people receive health services sooner.
- Vulnerable children and families are identified and offered the services they need to enjoy good mental and physical health and wellbeing.

Better Public Services: Supporting Vulnerable Children

Context

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

Objectives

- All children have timely access to health care services, including immunisation
- Reduced rates of infectious disease amongst Wairarapa children
- Better integrated health care services result in reduced ambulatory sensitive hospitalisations

Linkages

- Whānau Ora
- Better, Sooner, More Convenient primary care

- **Increase infant immunisation rates**

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Wairarapa DHB will continue to work with the PHO, in particular through the PHO based Community Child Health Coordinator, District Immunisation Facilitator and NIR Coordinator to identify actions to achieve and maintain high immunisation rates for all milestone ages. For 2013/14 this approach will be strengthened through undertaking service planning and development under the oversight of the Alliance Leadership Team. The DHB's interagency Community Child Health Executive Group will continue to monitor progress against child and youth health targets, but will report to ALT. Specific actions for 2013/14 include: • Maintain an immunisation working group that includes all the relevant stakeholders for the DHB's immunisation services including the Public Health Unit, and that participates in regional and national forums. • Work with primary care partners to implement newborn enrolment policy and monitor newborn enrolment rates. • Continue to use NIR, PHO and practice level data to track immunisation status of all children at a practice, PHO and DHB level on a weekly basis. Provide reports to all practices and monitor referrals to outreach. • Continue to facilitate PHO access to hospital Concerto system so that the immunisation status of children presenting at hospital can be monitored and flagged to relevant staff • Promote ED and paediatric services use of electronic shared care record to identify immunisation status of all children • In collaboration with primary care stakeholders develop systems for seamless handover of mother and child as they move from maternity care services to general practice and WCTO services, including establishing multiple enrolment process by 30 June 2014 • Collaborate with NGOs and government agencies, particularly Work and Income, the Child Outreach Service provider and CYF, to ensure high needs families are linked to health services including primary care. • Match data between the PHO and Public Health Unit to establish a baseline for the completion of BCG and year 7 immunisation programmes, with the aim of increasing immunisation coverage under these programmes	**Increase infant immunisation rates** 90 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 2014 and 95 percent by December 2014 • 95% of newborns enrolled on the NIR at birth (measure NIR) • 100% of newborns enrolled with general practice (measured at 6 weeks, measure B code uptake) • Narrative report on DHB and interagency activities to promote immunisation week • 85% of 6 week immunisations are completed (measured through the completed events report at 8 weeks) Establish baseline for BCG and year 7 immunisation completion	• Progress against Health Target • Progress on specific actions

- **Reduce the incidence of Infectious disease, including Rheumatic Fever,**

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Wairarapa DHB will aim to maintain its current rate of zero hospitalisations per 100,000 for rheumatic fever through participating in the development and implementation of a subregional rheumatic fever prevention plan by October 2013. This includes a plan to: • Appoint a rheumatic fever champion at senior executive level. • Develop systems to identify families with children at high risk of rheumatic fever living in crowded housing and appropriately refer to local housing and/or social services for follow up and intervention. • Ensure that primary care providers and other health professionals likely to see high risk children follow the National Heart Foundation Sore Throat Management Guidelines • Ensure people with Group A streptococcal infections are treated appropriately within 7 days of developing symptoms • Ensure that all cases of acute rheumatic fever are notified to the Medical Officer of Health within 7 days of hospital admission • Review all cases of rheumatic fever to identify any identifiable risk factors and system failure points • Ensure patients with a past history of rheumatic fever receive monthly antibiotics not more than 5 days after due date • Conduct an annual audit of secondary prophylaxis coverage	Hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 10% lower than the average over the last 3 years (measured by National Minimum Data Set). The 2013/14 target for Wairarapa DHB is to maintain a rate of 0 per 100,000.	• Six-monthly reporting against DHB's rheumatic fever prevention plan. A template will be supplied by the Ministry. • The Ministry will analyse DHB performance against target on a six monthly basis. Those DHBs that are not on track or do not meet the target will be required to provide an exception report

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Through the Community Child Health Executive Group (CHEG) and the Alliance Leadership Team, the DHB will work with its partners to plan and implement actions which will reduce the rate of ambulatory sensitive hospitalisations due to infectious disease among Wairarapa children. This approach will build on the existing implementation of the subregional skin infection project. Specific actions for 2013/14 include: • Complete implementation of skin infection protocols, including professional development and coding guidelines • Collaborative data analysis to clarify the main conditions and drivers for the most common ASH conditions • Development of implementation plans for ASH reduction of targeted conditions • Combined PHO/Public Health approaches to population health planning and delivery • Increased integration (including the development of MOU and referral guidelines) between primary care and public health nursing • A focus on better integrated services for high needs families, including linking with Whānau Ora services • Align with subregional work programmes, including the Regional Public Health Housing project.	Reduced ASH rates for 0-4 Baseline: 128 Target: 115 Condition and age specific baselines and targets to be developed	

- **Reduce the number of assaults on children / Implement the Children's Action Plan**

The White Paper for Vulnerable Children and associated Children's Action Plan (CAP) was released on 11 October 2012. The proposals in the CAP are the result of research, discussion and policy development, and set out how the Government will improve outcomes for our most vulnerable children.

The CAP includes a range of important initiatives for the health sector that will enable us to do even more to support vulnerable children alongside other key social service agencies and providers.

DHBs, through delivering on the CAP, and through other initiatives that support the prevention and early identification of child maltreatment, are expected to:
• help improve outcomes for vulnerable children
• contribute to a reduction in the number of child assaults

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Reduce the number of assaults on children / Implement the Children's Action Plan (CAP) **Implementing CAP Initiatives** As a component of the 3 DHB Subregional Child Health Project, Capital & Coast, Hutt and Wairarapa DHBs will establish governance arrangements across the subregion to oversee engagement and implementation of the Children's Action Plan. The governance arrangements will be in place by November 2013. Planning for the CAP engagement process will begin from July 2013. Planning for a stocktake of services for vulnerable pregnant women, children and parents will begin from July 2013 upon receipt of further guidance from the Ministry of Health on CAP initiatives. Mental Health and Addictions and Infant Mental Health Service projects will be aligned to CAP initiatives from July 2013.	Violence Intervention audit score Baseline: (2011 audit score) Partner abuse 89% Child abuse 90% Target: Partner abuse 90% Child abuse 94%	
Wairarapa DHB will undertake service and development planning to ensure that a continuum of services across primary and referred health services are well positioned to meet the needs of vulnerable pregnant women, children and families. Actions will include: • Establishing the Community Child Executive Group (CHEG) as a Service Level Alliance reporting to the Wairarapa Alliance Leadership Team from 1 July 2013 • Work will be undertaken to review DHB policies and procedures to ensure compliance with Violence Intervention Programme and the Family Violence Intervention Guidelines by December 2013 • On-going leadership, support, training and monitoring of the WDHB Violence Intervention Programme, including ongoing development of DHB programmes and policies to incorporate Family Violence Intervention Guidelines • Implementation of the National Shaken Baby training package and prevention programme by March 2014. • Complete implementation of the DHB National Child Protection Alert System • On-going collaboration with CYF, including support for the CYF funded liaison social worker and gateway Assessments • Review the implementation of the primary care violence intervention programme and provide on-going support for	(CHEG) established as a Service Level Alliance reporting to the Wairarapa Alliance Leadership Team from Q1 DHB policies and procedures reviewed to ensure compliance with Violence Intervention Programme and the Family Violence Intervention Guidelines by end of Q2 On-going leadership, support, training and monitoring of the WDHB Violence Intervention Programme, including ongoing development of DHB programmes and policies to incorporate Family Violence Intervention Guidelines throughout 2013/14 National Shaken Baby training package and prevention programme implemented by end of Q3 Implementation of the DHB National Child Protection Alert System completed by Q4 Development of scoping of the paediatric MDT for at risk children by Q2 Plans for implementation of the paediatric MDT for at risk children developed by Q3 Implementation of paediatric MDT for at risk children by July 2014	Quarterly progress report on specific actions

general practice • Improve coordination of primary maternal, infant and child health services to identify and coordinate care for children at risk • Participation in the subregional development of perinatal and infant mental health services • Further development of the paediatric MDT for at risk children		

- **Contribute to increased participation in quality early childhood education**

Context

It is expected that DHBs will support and contribute to actions in the Better Public Services Action Plan, including supporting an increase in the participation in quality early childhood education

Objectives

The Ministry of Education will lead, and be accountable for this action area, with the support of the Ministries of Social Development and Health. It is expected that DHBs will work locally and regionally to help deliver on key actions in the BPS Action Plan (that locate, engage and retain vulnerable children in ECE), including by actions below:

Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Participation in early childhood education is a goal of the DHB Child Health Strategy. The DHB will support this action in the BPS Action Plan by prioritising this goal for implementation in 2013/14. The DHB, through the PHO based Community Child Health Coordinator and interagency Community Child Health Executive Group, will build on existing collaborative initiatives to plan for implementing the following actions: • Working with primary and community based health services to raise awareness of the importance of early childhood education in improving health and wellbeing and education outcomes • Strengthening connections between frontline health services working with families with young children and early childhood education • Contributing to initiatives that help to locate, engage and retain vulnerable children in quality early childhood education, including for example integration projects and initiatives stemming from the Children's Action Plan • Establish baseline of early childhood participation through audit of B4SC data to identify gaps and priority groups • Work with Well Child /Tamariki Ora providers to develop referral process to ECE	The Ministry will work with the Ministry of Education in 2013/14 to further consider how we could monitor referrals to ECE using a mix of education and health sector data, such as Well Child and B4SC data. Until the monitoring mechanism is clarified we expect DHBs to report, using the quarterly reporting process, on the actions that DHBs have taken to encourage PHOs and DHB employed/contracted frontline workers (such as public health nurses) to routinely provide information about ECE, ask and know how to connect parents to local ECE providers in their communities. This will require DHBs and the Ministry of Education (e.g. through regional offices) to actively work together on the dissemination of agreed information and developing local pathways from health services to ECE services.	Quarterly updates on actions to support improved participation rates

Maternal and Child Health

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

Wairarapa DHB has already instituted a number of actions to better integrate services for mothers, babies and children. These include:

- the shifting of immunisation coordination and NIR services to the PHO,
- a collaborative PHO led model for B4 School delivery which sees this check delivered in the child's primary care practice in collaboration with both Well Child providers and the Public Health Unit
- the establishment of a PHO based Community Child Health Coordinator (CCHC) to drive the implementation of the DHB's Child Health Strategy; and
- the establishment of an interagency Community Child Health Executive Group (CHEG) to oversee these initiatives.

For 2013/14 the DHB intends to build on these initiatives by bringing the CHEG and its work programme under the oversight and governance of the Alliance Leadership Team. The 2013/14 work programme has been aligned to Government priorities and includes a focus on increased integration of primary maternity services.

a) Higher coverage and more equitable access to universal services and primary care.

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Increase number of women who register with an LMC by week 12 of their pregnancy	Women are supported to maximise their health and the health of their baby during pregnancy. At least 90% of all eligible children receive a B4 School Check, including at least 90% of children in most deprived regions. Decrease in ASH rates for 0 – 4 year olds. (Refer SI: 1).	Report quarterly on progress towards 90% of eligible children and 90% of eligible children in most deprived areas receiving a B4SC; on referral activity and follow up with respective services Report quarterly on WCTO services Report six-monthly on ASH rates
Work with primary care partners to ensure every pregnant woman is enrolled with a PHO and registered with a GP.		
Through the CHEG and Community Child Health Coordinator, institute systems to further integrate maternal and child health services, including using national and PHO databases to track babies and children. Specific actions will include: • Establish and monitor formal referral processes between GPs and LMCs (and vice versa) to ensure timely (12 week) registration with an LMC and PHO/GP enrolment for pregnant women • Establish formal referral processes between LMCs and WCTO providers to ensure timely transfer care for all babies and antenatal referral for high needs families • Track enrolment into and completion of core contacts of the Well Child services so as to ensure universal access to the core WCTO services and equitable access to additional WCTO contacts		
As part of the integration of primary maternity services, establish formal referral processes between LMCs and WCTO providers to ensure timely transfer of care for all babies and antenatal referral for high needs families.		

B4 School Check coverage maintained or improved.		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Work with the PHO to ensure continued 100% access of under-sixes to free after hours primary care		Report quarterly on progress towards achieving as close as possible to 100% coverage of under-six access to free after hours primary care and where the DHB is not achieving this, report quarterly on proposed actions to improve coverage.
Ensure the Wairarapa Smokefree plan includes actions to implement all components of the Tobacco Health Target, including working with LMCs and within maternity services to enable clinicians to support pregnant women who smoke to quit.	Pregnant women, who smoke receive advice and support to quit, measured as per the health target – refer to the **Tobacco Health Target**.	
Through the DHB collaborative Maternity Strategy Group, ensure pregnancy and parenting education meets the needs first time mothers with a focus on the needs of vulnerable groups such as teen parents and families where English is a second language.	Pregnant woman can access DHB funded parenting and pregnancy education. Vulnerable families are prioritised.	Progress on actions to ensure families can access DHB funded parenting and pregnancy education. Progress on actions to ensure pregnancy and parenting education services meet the needs of vulnerable families.
Implement primary maternity model that is sustainable and integrated with primary and community health services for mothers and infants		
b) More timely access to specialist and referred services		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Contribute to the subregional perinatal mental health project which aims to result in improved access to maternal/perinatal mental health services for pregnant and postpartum women.	No waiting times when LMCs and DHBs refer women for maternal/perinatal mental health services. Further measures will be agreed once detailed actions are identified	Performance against measures (tbc)
Through the CCHC, CHEG and ALT, monitor timeliness of access to referred services following WCTO referral and B4SC assessment and implements actions required to expedite service delivery	All infants and children identified as requiring referral for specialist advice or care receive timely access to appropriate services. Children referred following a B4 School Check are seen before their fifth birthday.	Performance against local wait times measures (as developed in 2012/13). Progress on specific actions to address access to services with significant wait times.
Through the subregional child health project, improve access of Wairarapa children to specialty services including child development services	Reduced waiting times for child development services	

c) Quality improvement across all services		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Consolidate the Maternity Quality and Safety programme, and identify actions for 2013/14 to embed MQSP as business as usual by June 2015. Complete review of clinical care in areas where the DHB is an outlier in the New Zealand Maternity Clinical Indicators and implement recommendations.	Improved quality and safety of maternity services including improved access, outcomes and consumer satisfaction. DHBs who are outliers in the New Zealand Maternity Clinical Indicators put programmes in place to review clinical care in these areas and reduce unnecessary variation in clinical practice.	Maternity Quality and Safety Programme Strategic Plan in place as soon as possible in 2013/14. Second annual Maternity Quality and Safety Programme report by 30 June 2014
CCHC and CHEG monitor B4SC quality improvement letters and ensure on-going quality improvement for the delivery of the B4 School Check programme including high quality data collection and reporting.	Every DHB incorporates findings of B4SC quality improvement letters. Quality of B4SC service delivery improves.	n/a
DHB joint Clinical Board agrees WCTO quality improvement plan. Incorporate Quality Improvement Framework (in development 2012/13) across all WCTO services including B4SC.	Every DHB implements their WCTO Quality Improvement Plan, building on national and local reviews. Unnecessary variation in the delivery of WCTO is reduced. Access to WCTO and associated services is improved.	Progress on specific actions to locally implement the Quality Improvement Framework

Service Development		
As the population grows and changes the health needs of New Zealanders change. This requires service development in emerging priority areas.		
Cancer Services – HEALTH TARGET Better, Sooner, More Convenient health services for New Zealanders in relation to Cancer means all New Zealanders can easily access the best services, in a timely way to improve overall cancer outcomes. A health system that functions well for Cancer is one that ensures all: • people get timely services across the whole cancer pathway (screening, detection, diagnosis, treatment and management, palliative care); • people have access to services that maintain good health and independence; • people receive excellent services wherever they are; and • services make the best use of available resources.		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***

In conjunction with the MidCentral and Capital and Coast DHBs' cancer treatment centres and other regional DHBs, Wairarapa DHB will implement the regional initiatives identified in the National Cancer Programme Work Plan including:
• sustain performance against the radiotherapy and chemotherapy wait time targets by more efficient use of existing resources; and investing in workforce and capacity as required
• identify and implement actions to improve faster cancer treatment data collection systems to support service improvements along cancer patient pathway
• improve the functionality and coverage of multidisciplinary meetings (MDMs) across the region:
  • Wairarapa DHB runs MDMs in accordance with protocols for both Capital & Coast and MidCentral DHBs, who primarily deliver cancer services for our DHB.
  • The Wairarapa has developed its own system to meet the needs of the tumour stream requirement by asking the specialists at the MDMs to present for local generalists, in consultation with them.
• implement the priority areas identified in National Medical Oncology Models of Care Implementation Plan 2012/13
• begin implementing the national tumour standards of service provision
• enable and support cancer nurse coordinators attendance at national and regional training and mentoring forums
• implement priorities identified in the Prostate Cancer Quality Improvement Plan
• begin implementing regional clinical data repositories for cancer
• Improve waiting times for diagnostic services: Colonoscopy (see Diagnostic services)
• Continue to support the implementation of the Endoscopy Quality
	Health target – All patients, ready-for-treatment, wait less than four weeks for radiation or chemotherapy.
	Faster cancer treatment (establishment of baseline). Including the following:
	• 62 day indicator - proportion of patients referred urgently with a high suspicion of cancer who receives 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 receives their first cancer treatment (or other management) within 31 days of decision-to-treat.
	
	Progress on delivery of the actions and milestones agreed in 2012/13 APs to support implementation of the faster cancer treatment initiative by funding multi-disciplinary meetings (MDMs) for all main cancer tumour types and increasing the number of cases discussed at MDMs.
		Monthly and quarterly reporting against indicators and targets
		
		Quarterly RSP reporting

Improvement (EQI) Programme, including through participating in pilot programme. • Identify and implement actions that contribute to primary secondary integration identified in the implementation of the Cancer Nurse Coordinator role		

Diagnostic Services		
Context Achieve identified waiting time targets by more efficient use of existing resources; making improvements to referral management and patient pathways; and investing in workforce and capacity as required.		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Work with regional and national clinical groups to contribute to development of improvement programmes. Support and participate implementation as required. Ensure internal data collection systems are in place to facilitate accurate reporting. Patients access diagnostic services in accordance with priority. Utilisation of national referral criteria for direct access outpatient colonoscopy to be considered and developed as part of 3D programme – Gastroenterology.	Improving waiting times for diagnostic services: – Coronary angiography – 85% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days). – CT – 85% of accepted referrals for CT scans will receive their scan within six weeks (42 days) – MRI – 75% of accepted referrals for MRI scans will receive their scan within six weeks (42 days) – Diagnostic colonoscopy – 50% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); and 50% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days) – Surveillance/Follow-up colonoscopy – 50% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	Monthly reporting against targets and indicators

Elective Services – HEALTH TARGET		
More people receive access to services which support New Zealanders to live longer, healthier and more independent lives. • People have shorter waiting times for elective services meaning they receive better health services, and can regain good health and independence sooner. 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 elective surgery discharges • Increasing first specialist assessments • Reducing waiting times for people requiring elective services • Improving prioritisation and selection of patients • Supporting innovation and service delivery		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Electives funding will be allocated to support increased levels of elective surgery, specialist assessment, diagnostics, and alternative models of care.	Delivery against agreed volume schedule, including a minimum of 1,841 elective surgical discharges in 2013/14 towards the Electives Health Target.	
WDHB will work with its subregional partners to plan for delivery across the 3D subregion. Standardised intervention rates or other mechanisms will be used to assess areas of need for improved equity of access. **Refer to Section 2 for more details re 3D Programme**	Refer to SI4: Elective services standardised intervention rates.	
Patient flow management will be improved to ensure reduced waiting times for electives, so that no patient waits longer than five months during 2013/14, and progress is made toward managing patients within four months.	Elective Services Patient Flow Indicators expectations are met, and all patients wait five months or less for first specialist assessment and treatment from June 2013.	
Patients will be prioritised for treatment using national, or nationally recognised, tools, and treatment will be in accordance with assigned priority and time waiting.	Increased uptake of latest national CPAC tools to improve consistency in prioritisation decisions.	
The new 2D Directorate Leadership Team will work to ensure increased efficiencies and improved access through review of theatre processes, staffing and supports. Potential efficiencies through 2D opportunities to be explored.	Quarterly Progress report regarding 2D development	
Through the DHB Joint Clinical Board, opportunities for improved access to elective procedures through improved primary secondary integration will be explored and developed. • The ALT has agreed to investigate GP referral without an FSA for colonoscopy and skin lesions, to be live by Q3		

Cardiac Services

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

A health system that functions well for Cardiac – Secondary 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 cardiac surgery patients

Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
A target intervention rate for cardiac surgery will be set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access.	(Refer SI4) Standardised Intervention Rates: WDHB Cardiac surgery rate has been agreed as 6.5 per 10,000 of population.	Quarterly Reporting against agreed targets
In conjunction with CCDHB, manage waiting times for cardiac services, so that no patient waits longer than five months for first specialist assessment or treatment.	Elective Services Patient Flow Indicators: all patients wait five months or less for first specialist assessment and treatment from June 2013. Reduce waiting times to a maximum of four months by the end of December 2014.	
Regional planning, including standard intervention rates, will ensure population access to cardiac services is not significantly below the agreed rates. This includes cardiac surgery, percutaneous revascularisation and coronary angiography.	Percutaneous revascularisation: 11.9 per 10,000 of population Coronary angiography: 33.9 per 10,000 of population.	

Acute Coronary Syndrome		
DHBs will develop regional and local implementation plans that ensure patient flows and models of care enable access to optimal interventions.		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Linkage to regional ACS programme (see RSP) In conjunction with subregional DHBs Wairarapa will implement the Cardiac ANZACS QI and Cardiac Surgical registers when available. *Note: ANZACS QI delayed until October 2013 – to be adopted nationally by Q4. This will impact on ACS measures, as system to gather information will not be available* *In Q1 and Q2, Central Region DHBs will assess the requirements for the systems once implemented, and develop a plan to operationalise systems once the 'go live' date is confirmed.*	• >70% of high-risk ACS patients accepted for coronary angiography will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') • >95% of patients presenting with ACS who undergo coronary angiography have ANZACS QI ACS and Cath/PCI registry data collection completed, once system is available. Expected Q3.	Performance against the measures. Progress on specific actions.

Primary Care
Better, Sooner, More Convenient Health Services for all New Zealanders from a holistic primary care perspective means: ▪ A better patient (and family) experience (patient centred) ▪ Improved access to more services delivered within local communities / primary care settings ▪ Clinical integration of services across the whole health system ▪ The operation of an efficient, effective and sustainable health system, and ▪ Reduced waiting time for health services Tihei Wairarapa is WDHB's key mechanism in driving service change to achieve the Government's vision of Better, Sooner, More Convenient health services. It is leveraging our already existing strengths in local relationships and collaborative initiatives between primary care and health and hospital services. The DHB has already devolved significant services to Primary Care, and will build on this progress as the integration work programme enters its fourth year. During 2012/13 the DHB has reorganised the governance and clinical governance arrangements for the on-going integration work. The new Alliance Leadership Team (ALT) will oversee the development of the work programme to reflect both local priorities and increased integration with our subregional partners. For 2013/14 there will continue to be a focus on the current priority areas including: ▪ Enablers (ICT, communications, infrastructure, workforce) ▪ Long term conditions (including co-morbidity and reduction in disparity for Māori, Pacific and high need populations) ▪ Health of Older People ▪ Acute Demand and After Hours Services ▪ Mental Health Services (Te Kahui) ▪ Whānau Ora

Reflecting both emerging local priorities and those of the Government, there will also be a focus on integration of maternal, child and youth health services and population health.

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Through the Alliance Leadership Team and its mental health and child health sub-groups, the DHB will take a whole of system approach to the development of youth health services that meet the specific needs of Wairarapa young people and are integrated with other primary and community health and social services. Development of services must include a youth focus working with all community youth providers including Youth One Stop Shops.	Specific measures will be determined once policy work is complete.	Further detail will be provided upon completion of policy work and engagement with the sector.
Wairarapa DHB will build on the integration of child health services achieved through the location of immunisation and child health coordination roles in the PHO by developing options for further integration of maternal and child health services, including: • primary maternity /LMC services • public health nursing • vision and hearing testing		

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Wairarapa DHB will continue to support and drive its integration work programme through the newly reconstituted Alliance Leadership Team and Joint Clinical Governance Group. In 2013/14 the work programme will incorporate measures to integrate maternal, child and youth health services across a range of primary and community providers. There will also be an increased focus on a district wide approach to population health and self-management programmes. The existing programme of work focussed on acute care, mental health, Whānau Ora and care for the frail elderly and people with long term conditions will also be progressed. For 2013/14 this will include: • 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 and 3 • 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 and extend to child and	As in previous years WDHB will identify progress against key milestones for each of the actions to be delivered in 2013/14 as agreed in the ALT Year 4 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 health and addiction service s (Q3) - Whānau Ora navigators are employed and pathways implemented (Q2) - Management of skin infection protocols added to established clinical pathways (Q2) *Deliver Health Targets:* - 90% of 8 month olds are fully immunised.	

• 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). 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	- 90% of smokers seen in primary care are given advice and support to quit. - 90% of eligible people will have had a CVD check completed in the last 5 years. *Deliver against Tihei Aspirational Targets. The following are indicative of measures **to be confirmed** and targets updated for 2013/14, to be agreed by the ALT in Q1:* - 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.	
Work collaboratively with Primary Care to develop plans to implement primary care access to 2 procedure lists detailing quarterly measures to achieve implementation within 2013/14	In Quarter 1 2013/14 there will be agreed primary care access to two elective procedure lists. The Alliance Leadership Team have identified direct access to booking lists for colonoscopy (in line with national guidelines) and skin lesions will be progressed in 2013/14. By 31 December 2013 pathways will be developed to implement the primary care access to two elective procedure lists In Quarter 3 implementation of agreed primary care access to two elective procedure lists will have commenced	Pathways developed to implement the primary care access to two elective procedure lists by end of Q2 Agreed primary care access to two elective procedure lists implemented by end of Q3
Work collaboratively with Primary Care to develop plans to	In the Wairarapa primary care already has direct access to at least two specialist services. Primary care have direct access to diagnostics including xray and ultrasound. Primary care also has direct access to specialist advice - the advice only option of e-referrals is well used, as is phone advice. Other examples include Specialist nurses and physicians are working in the community (both in practice and home visits) and there is an	Maintain access to specialist services as outlined and where appropriate extent to other specialist service areas.

implement 'primary care options to acute care' service detailing quarterly measures to achieve implementation within 2013/14. For the Wairarapa this will include acute pathways for frail elderly being developed to mitigate inappropriate admissions and the continued implementation of IV antibiotics and clexane in primary care. This will be part of the Tihei Wairarapa work programme for 2013/14.	integrated primary care/specialist team working collaboratively with the ARC sector for older people. Acute demand workstreams are part of Tihei Wairarapa's work plan for 2013/14. Specific initiatives to improve primary care access to services to reduce hospital admissions to be scoped, agreed, developed and implemented in 2013/14 but will focus on acute pathways for frail elderly and the implementation of IV antibiotics and clexane in primary care.	Implementation plans developed by end of Q2 Initiatives trialled during Q3
Implementation of the Community Pharmacy Service Agreement (CPSA)		
WDHB is committed to and plans to fully support the effective implementation of the three-year CPSA (1 July 2012 to 30 June 2015) in accordance with the direction of the lead DHB CEO and Programme Director. This includes the necessary support to effectively implement contract variations, related national priority measures and subsequent transition steps that are yet to be made within the CPSA. WDHB will proactively support communication with community pharmacies, the related communications with PHOs, General Practitioners and secondary care specialists for the effective management of the new community pharmacy services and funding model. WDHB financial forecasts will reflect best estimates of forecast pharmacy services expenditure and related supporting resource requirements, and support the DHB's commitment to taking all reasonable steps to avoid triggering an annual funding envelope review. WDHB will demonstrate a higher level of engagement between hospital prescribers and pharmacy to support people with long-term conditions and high need programme patients.	• Community pharmacies have relevant information available to them • dispensing costs are contained.	

Mental Health and Addiction Service Development Plan

Rising to the Challenge:

The Mental Health and Addiction Service Development Plan (SDP) clearly articulates prioritised service developments for the next 5 years. The Plan aims to ensure that across the spectrum of health promotion, primary, specialist treatment and support services access and responsiveness will be enhanced; integration will be strengthened while improving value for money and delivering improved outcomes for people using services.

The objectives of the plan are to:

- Actively using our resources more effectively
- Building infrastructure for integration between primary and specialist services
- Cementing and building on gains in resilience and recovery
- Undertake a gap analysis between the actions identified in the SDP and current service provision model. For quarter one, provide a report on what SDP actions have already been met describing the current service model, what changes are required to the service model, how resources will be reprioritised and what will be the sequencing of meeting the actions of the SDP over 3 years.

Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Wairarapa DHB will progress implementation of each of the four key areas from the SDP through the following actions	***Expectation of targets and 6 monthly milestones for 2013/14.***	**Health system success is measured by:**
1. Make better use of resources/value for money • Increase local mental health & addiction services PRIMHD sustainability & capability • Explore incentive payment contract model arrangements that improves the Service Users journey & utilises resources more efficiently & effectively	Access rates to mental health services	• quarter one report on SDP actions met • quarter two and quarter four report against identified actions and milestones • Performance against agreed measures. • Progress on specific actions.
2. Improve primary secondary integration • Continue to provide mental health & addiction leadership in the Tihei Wairarapa implementation • Explore workforce development opportunities such as joint training and shared care arrangements	Percentage of long term clients with up to date relapse prevention/treatment plans	
3. Cement and build on gains in resilience and recovery (this includes developing services for Children of Parents with Mental illness and Addictions). • Establish local or subregional mental health and/or addictions Peer Advocacy positions or service • Explore the development of a local or subregional mental health		

Age 0-19	Total	4.71%
	Māori	4.71%
Age 20-64	Total	4.57%
	Māori	4.57%

Adult (20)	Total	95%
	Māori	95%
Child and youth	Total	95%
	Māori	95%

Family / Whānau Advocacy positions or service		

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
4. Deliver increased access for all age groups: • Support Te Hauora Runanga o Wairarapa Whānau ora alignment / Integration • Increase non Māori staff and providers local tikanga and kaupapa Māori knowledge, skills & experience		
5. Develop actions with targets and 6 monthly milestones for 2013/14 to increase access or improve outcomes for each of the following Government work programmes: • Drivers of Crime • Implementation of the Suicide Action Plan - mechanism agreed 2012/13 implemented and in place with ED, through suicide prevention coordinator, local community agencies and communities • Welfare reforms	Mechanism in place with ED by Q2	Progress report on specified initiatives/actions
Implement the recommendations of CC, HV & WDHB Addictions Action Plan 2013-18	Achievement of agreed targets for access and waiting times with DHB Provider Arm Mental Health services and NGO for AOD (PP6 and PP8)	Reports against agreed targets

Whānau Ora		
Supporting Whānau Ora provider collectives to transform to a whānau-centred integrated approach to deliver whānau improved whānau health and other social outcomes A health system that delivers on Whānau Ora is one that: • maximises the opportunity to support and build capacity and capability of provider collectives to support the growth towards mature providers • works in a seamless and integrated way with other parts of the social sector and delivers improved outcomes and results for whānau		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
WDHB will support the implementation of the national Te Puni Kōkiri led Whānau Ora initiative that is supported by the Ministry of Health. The DHB will support the transformation of Whānau Ora provider collectives towards becoming mature providers through:	• The outcome of the Whānau Ora approach in health will be improved health outcomes for whānau through quality services that are integrated (across social sectors and within health), responsive and patient/whānau centred • Refer S15: Delivery of Whānau Ora	
Building capacity and capability – build on the investment TPK are making to strengthen both the capacity and capability of the provider collectives across the governance, management and service delivery levels		
Being Outcomes focused – begin the implementation of integrated contracting processes, focused on outcomes – Continue to support the development of an outcomes-focussed, DHB-funded Whānau Ora service, including providing dedicated resource to establish processes for linking Whānau Ora services with primary care and community providers.		
Implementing programmes of action – support the provider collectives in the planned activities for implementation in 2013/14		
Supporting Strategic Change – continue to participate in Regional Leadership Group(s). – strategic planning with the DHB includes participation of the Whānau Ora collectives – building and maintaining relationships with agencies implementing Whānau Ora – support Whānau ora across all levels of the DHB, including at Board and SIDU level		

Acute and Unplanned Care
Demands on health systems are increasing in a tight fiscal situation. An ageing population, long term conditions, and the needs of vulnerable populations are placing greater pressures on the health system. Effectively managing these pressures is expected to assist in bending hospital's acute demand curves.

Cardiovascular Disease – (Including More Heart and Diabetes Health Target, DCIP, and Stroke)

- **More Heart and Diabetes Checks**

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*

In conjunction with the PHO, agree an implementation plan for improving performance on 'More heart and diabetes checks' provided in primary care including actions in the following areas:
• identifying eligible populations (including any demographic changes).
• proactively contact/invite people due for CVD risk assessment, starting from Q4 2012/13 including:
  ○ provision of practice specific information on numbers of patients needing CVRA to meet target
  ○ identification at a practice level of patients coded as having a cardiac event but no CVRA recorded
  ○ provision of support materials for practices
  ○ Funding nursing hours required to provide free CVRA for patients
  ○ Updating CVRA missing lists weekly
  ○ PHO in-practice assistance for small practices which do not have nursing hours available
• building systems to ensure people attend CVD risk assessments (eg, efficient recall systems) and fully report performance.
• ensuring the expertise, training and tools they need to successfully complete the CVD risk assessment to meet clinical guidelines.
• Development of effective services tailored to the needs of targeted patients.
• Including practice specific targets in practice plans and monitoring performance
	Health Target – More heart and diabetes checks. 90 per cent of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years. DHBs are required to achieve at least 75 per cent by 30 June 2013 and 90 per cent by 30 June 2014, and 95 per cent by 31 December 2014.
	
	As at 31 March 2013, Wairarapa DHB achieved 69% of the eligible adult population having a cardiovascular risk assessment in the last five years. Quarterly targets for 2013/14 to measure the success of the initiatives to the left are:
	Q1: 75%
	Q2:80%
	Q3: 85%
	Q4: 90%
		Performance against the Health Target
		
		Progress on specific actions

• Complete implementation of patient dashboard system		
Through the joint Clinical Board and ALT, develop and agree an implementation plan for reducing the impact and incidence of cardio-vascular disease in Wairarapa, including: • Develop and implement self-management programmes for at risk populations • Undertake joint data analysis of admissions for heart disease /angina to establish priorities • Review and complete implementation of cardiac pathway across primary, secondary and tertiary care • Ensure smoking cessation advice and support is offered to smokers • Funding for Wairarapa through PPP for CVD Risk Assessments is estimated to be approximately $5,000 based on 2012/13 actuals.	Pathway implemented and use monitored	

- **Diabetes Care Improvement Packages**

Actions to deliver improved performance	*Actions to deliver improved performance*	*Reporting Requirements*
Wairarapa DHB, through the joint Clinical Board and ALT will identify actions to improve performance of the Diabetes Care Improvement Package (DCIPs) implemented in 2012/13. This will include: • Final sign-off of adapted CCDHB plan by Wairarapa Clinical Board, by 1 July 2013 • Reviewing and implementing the pathway across primary and secondary care • Ensuring congruence with the Guided Care Model, including full implementation of bulk funding by 1 July 2013 and the Comprehensive Health Assessment Tool (CHAT) by 31 August 2013 • Establishing Wairarapa representation, and processes for clinical governance, within the CCDHB diabetes clinical network by 30 September 2013 • Providing professional development to support the agreed pathway (eg insulin initiation) and to ensure that care provided for people with diabetes is consistent with the guidance contained in the New Zealand Primary Care Handbook 2012. • Capturing patient level clinical information and actively using audit tools to ensure that the care provided to people with diabetes is consistent with that contained in the New Zealand Primary Care Handbook • Establishment of systems for practice profiling and risk-stratification to identify the population with diabetes and pre-diabetes • Development and implementation of a self-management programme (in conjunction with planning for other LTCs) • Ensuring practice specific diabetes targets are aligned to PHO, DHB and National targets • Ensure detailed performance feedback is provided to practices on progress against targets • Establishing processes for specialist support of practice teams • Establishing monitoring and reporting mechanisms to Clinical Board to measure progress.	Measurement of improved diabetes outcomes using a set of nationally consistent clinical indicators, phased in over time. **Refer Section 8.1PP20 Focus Areas 3a and 3b - Diabetes Management** Diabetes clinical indicators to be collected in 2013/14 are: • *Microalbuminuria* • *HbA1c* Baselines to be developed and information collected in discussions with primary care and MOH	6 monthly reporting against indicators Baselines to be developed and information collected in discussions with primary care and MOH Progress on specific actions

- **Acute Coronary Syndrome**

Actions to deliver improved performance	*Actions to deliver improved performance*	*Reporting Requirements performance*
Please refer to Cardiac Services in the Service Development Template	Please refer to Cardiac Services in the Service Development Template	

Better Help for Smokers to Quit – HEALTH TARGET

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

Objectives

- Patients who smoke and are seen by a health practitioner in either the public hospitals or in primary care will be offered brief advice and support to quit smoking; and
- Pregnant women who smoke will be offered advice and support to quit.

The longer term aspirational goal is for a Smokefree New Zealand by 2025.

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
- Treats smoking as a clinical 'vital sign'
- Increases the chances of smokers making successful quit attempts
- Provides open and accessible services to all people who smoke, particularly pregnant women, Māori and Pacific people, and
- Delivers smoking cessation support and services in a culturally appropriate manner

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
WDHB will work with the PHO and other providers to ensure that systems are in place within primary, secondary and maternity settings to support ABC smoking cessation practice as a routine component of clinical care. This will include: • Continuing to support hospital clinicians and processes so as to maintain achievement of the secondary care Health Target • Continuing to fund and support dedicated resource to assist practices to reach the primary care target. Compass Health Wairarapa has been contracted by WDHB since July 2012 to provide this support. This has enabled the employment of a part-time health promoter who is solely focussed on tobacco control	• 95 percent of **hospitalised** smokers will be provided with brief advice and support to quit by July 2014 • 90 percent of **enrolled patients** who smoke and are seen in **General Practice** are offered brief advice and support to quit smoking. • 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.	Performance against the Health Target. Progress on specific actions Progress on the 2012-14 Smokefree Plan

and assisting primary care in their actions towards achieving the primary care target

- Compass Health Wairarapa will evaluate the two different methods used to increase the primary health care target during 2012/13. This evaluation will inform action required for Q1 and Q2 2013/14.
- Installation of the patient dashboard system in Wairarapa practices to support ABC as a routine part of primary care clinical contact
- The Dashboard has been installed in 4 of the 7 Wairarapa practices. It will be trialled and practices will be assisted to resolve issues. Once working effectively these practices will be promoted as role models to encourage other practices to install The Dashboard
- Progress towards achieving the primary care target will be monitored with each of the seven Wairarapa practices. Compass Health will provide practices with weekly statistics on their progress and they will be encouraged to continually increase towards the target. Practices will be offered assistance and successful strategies will be shared.
- Continued development and support of rolling "Quit Groups" which meet weekly.
- Increase referral rates from primary and secondary care to Quit Groups and Aukati Kai Paipa
- Clarify with all practice staff how Champix is prescribed. Provide prescribing flow charts, and patient information sheets on Champix to assist with a standardised practice approach for the prescribing and follow up consultations for patients
- On-going development and implementation of collaborative cessation and tobacco control activities including; group cessation, Communications, World Smokefree Day, Smokefree Environments and Smokefree Signage
- Continue to offer appropriate training and refresher courses across the whole health sector, including WDHB staff, primary care community and mental health
- Training offered will include, Cultural Competence, Cessation Practitioner Training by the Heart Foundation, Tobacco and Co-Morbidity, Motivational Interviewing, Group Facilitation, Primary Care Target update training
- Maternity will be offered Cultural Competency training during 2013.

Reporting

- Monitoring of performance for services delivered by WDHB and Compass Health will be through quarterly and six monthly reporting. This will include reporting on achievement against the 2012-14 Smokefree Plan. Qualitative, Quantitative and Milestone measures will be reported.

The following measures will indicate improved performance

Primary Care Target

- An increase in baseline for Smoking Brief Advice and Cessation support. In quarter 3 2012/13 Wairarapa Primary Care achieved 63%; we aim to achieve 73% in Q4 2012/13. In 2013/14, we aim for 83% in Q2, with an aim to achieve the 90% target by 30 June 2014.
- An increase in the number of practices installing the Dashboard
- Practices who have installed the Dashboard are using it effectively
- Increased referral of patients from primary and secondary care to the Quit Groups and Aukati Kai Paipa
- Practices implement a standardised prescribing and consult approach for Champix
- Number of training sessions held and number of people attending training

• Integration, networking and collaboration with other services, eg maternity, mental health and Māori Health Providers • Continue with the implementation of the WDHB 2012-14 Smokefree Plan which is a collaborative plan for primary and secondary care. • WDHB and Compass Health Wairarapa will review progress to date with the WDHB 2012-14 Smokefree plan and update and add actions to occur during 2013-14 • The review of the 2012-14 Smokefree Plan will include the addition of actions for the maternity target. Key maternity personnel will be consulted to advise on this • Actions for Maternity will include but not be limited to; strategies to achieve the target, training, antenatal networking • Advocate for electronic processes at Wairarapa Hospital that record smoking status as mandatory fields • Increase the amount of NRT being used in the Hospital by promoting NRT standing orders and NRT training • Offer cessation support to all patients who smoke and staff •	**WDHB Target** • WDHB will maintain ≥95% percent of **hospitalised** smokers being provided with brief advice and support to quit by July 2014 **Maternity** • A Champion LMC is identified • Strategies are discussed to enable work to progress towards achieving the Maternity health target • Maternity staff attend training offered	
The DHB Smokefree Coordinator will continue to support the Wairarapa Smokefree Network.		

Shorter Stays in Emergency Departments - HEALTH TARGET

- More people have improved access to services that maintain good health and independence.
- More people have shorter waiting times for emergency department services meaning people receive better health services**.**

Objectives

Better, Sooner, More Convenient Health Services for New Zealanders in relation to emergency departments means all New Zealanders can easily access the best services, in a timely way to improve overall health outcomes. 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 phase of care
- Makes the best use of available resources.

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
In 2013/14 the DHB will build on the high performance already achieved against this target through analysis of internal workflows, by further alignment with the whole of system approach taken to reducing ED triage 4 and 5 attendances. The DHB will establish an ED High User Group led by a senior clinician to address triage 4 and 5 patients. This will include continuing the current MDT approach utilised, and ongoing process improvement planning with ED and primary care, to connect frequent attendees and/or target conditions with more appropriate primary and on-going care arrangements (eg. GP plaster removal pilot) The DHB will look at the development of an Operations Centre (as per HVDHB's) to oversee patient flow into and out of the DHB to ensure, among other things, that the ED target is monitored and managed. This is a new innovation for WDHB and allows the technology used and developed for Hutt to flow into Wairarapa. The Operations Centre will monitor the patient flow, timing and resources across the inpatient area to facilitate and manage flow. Technology including Trendcare and Patient Management System will provide data to allow staff to track the flow, anticipate blockages and problems, and intervene early to alleviate them. The DHB will establish the Tihei Wairarapa project for management of GP referred presentations to ED. **Refer to Primary Care section.** This will also align to work to improve access to diagnostics and elective procedures	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours. Target for reduction of triage 4 and 5 presentations to be agreed by Q2. Quarterly Progress reports regarding developments	• Performance against the Health Target • Progress on specific actions

Long Term Conditions

a) Long Term Conditions

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Wairarapa DHB will continue implementation of the Guided care Model across primary and specialist services. This will include: • Full implementation of the Comprehensive Health Assessment Tool (CHAT) • Redesign of self-management programmes with core and disease specific modules • Use of risk stratification / predictive modelling to target Guided Care funding and services • Review and implementation of the respiratory pathway • Full implementation of practice plans and targets • Monitoring of system level KPIs	Performance against the acute demand targets **Readmissions for people over 75 years** **2011**: 9.2% **2012**: 7.1% **Target 2013-14**: ≤7.1%	• Quarterly performance against the acute demand targets • Progress on specific actions

b) Stroke Services

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*

Through the Central Region Clinical Stroke Steering Group (CRCSSG) the DHB will:
• Monitor key performance indicators and ensure quality assurance to achieve and maintain a high standard of care for all patients.
• Use Australian Rehabilitation Outcomes Centre indicators (AROC) for benchmarking with other DHBs
• Wairarapa DHB will provide an organised acute stroke service for their population (as recommended in the NZ Clinical Guidelines for Stroke Management):
  • dedicated areas for management of people with stroke, thrombolysis services, acute transient ischaemic attack services, rehabilitation – supported by clinical advice from the CCDHB stroke physician on-call
  • develop specific stroke pathway and protocols in collaboration with Hutt Valley DHB
  • use AROC data to review ALOS
	• 6 percent of potentially eligible stroke patients thrombolysed
	  • Baseline annualised TL rate for ischaemic stroke is 3.5%. We will work towards the regional target of 6% during the year.
	• 80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.
	  • Baseline: Stroke patients admitted to a general medical ward where clinicians are supported by clinical advice from CCDHB stroke physician
	• KPI performance
	• Benchmarking against AROC	

c) Health of Older People

i. Community support services for older people (PP23)

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Actively manage the risk of variable service quality and service failure in Home and Community Support Services, through active contract management (including complaints management) and monitoring of referral declines due to travel time or distance.	Evidence of proactive risk management in relation to the provisions of Home and Community Support services.	Quarterly reports on progress against measures
On-going implementation of the *Home and Community Support Sector Standard NZS 8158:2012* to maintain current full certification of contracted providers. The DHB acknowledges the intention of the HOP Steering group to develop a nationally agreed framework for a shared understanding of service delivery costs, and a national structure and consistency about the cost components that are factored into H&CSS purchasing, and will participate in and be informed by this process.	All contracted Home and Community Support Service providers hold a certificate of conformance with the *Home and Community Support Sector Standard NZS 8158:2012*.	Quarterly reports on progress against measures
Use the core quality measures for Home and Community Support Services identified by the subregional HOP Steering Group for each level of management.	Evidence that the DHB is utilising core quality measures at each level of management. Wairarapa DHB has worked with central region DHBs to identify core quality measures	Quarterly reports on progress against measures
Formally establish baselines for the core quality measures (once produced by the Ministry of Health and HIQ) and benchmark with other DHBs	Annual benchmarking across Central region DHBs will include quality measures.	Quarterly reports on progress against measures, providing evidence of benchmarking with other DHBs by 30 June 2014.

ii. Wrap Around Services for Older People (PP23)

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Monitor investment in smarter services for older people living at home to reduce acute admission and readmissions, including rapid response and discharge management teams and processes. For 2013/14 priorities for the DHB include: • Implementation of the Acute Pathway for older people (Tihei Wairarapa) • Implementation of primary care referral pathway to transitional	DHB review of rapid response and discharge management services/teams by the end of June 2014. **% of Participants on the Health Recovery Programme returning home** **2011-12:** 83.0% **2012-13 (July – Dec):** 85.0% **Target 2013-14:** 85.0%	• Quarterly reports on progress against measures, including provision of review documentation.

health recover programme • Extension of Health recovery Programme into home based settings to enable more flexible response • Monitor outcomes from the Health Recovery Programme • Collaborative data analysis (matching acute admission and primary care data) to inform targeted initiatives ***(refer OS08)***		

iii. Comprehensive Clinical Assessment in residential care (PP23)		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
The DHB will support aged residential care facilities to implement Comprehensive Clinical Assessments in their facilities, through working with the National InterRAI training facilitator to encourage & enable uptake in training by ARC facilities and provide support for such training (e.g. venue, expertise of DHB InterRAI Lead Clinician) Reallocate DHB share of annual ARC project funding	All aged residential facilities in DHB area using, or training their nurses to use, the InterRAI LTCF assessment tool. The DHB has engaged with Central TAS to bring forward funding to support implementation of the InterRAI LTCF from 2014/15 to 2013/14	Quarterly reports on progress against measures.

iv. Dementia pathway (PP23)		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Applying best practice in dementia care locally, into a pathway that provides clarity of access to services across the continuum as set out in the National Dementia Care Pathway Framework (2013).	A dementia pathway will be implemented by the end of June 2014. • Multidisciplinary steering and project group which includes GP, primary care nursing, nurse specialist and tertiary clinician, community and NGO representation (e.g. Alzheimers Wairarapa) • Action Plan to be developed and confirmed by this group by end of Q1.	Quarterly reports on progress against measures including evidence that a dementia pathway has been implemented (e.g. a documented pathway, an implementation plan, working group minutes, new services)

v. Community specialist HOP teams (PP23)		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Proactive use of DHB specialist Health of Older People Services (geriatricians, gerontology nurse specialists) to advise and train health professionals in primary care and aged residential care. Use 2012/13 baseline to monitor increase in all specialty input for Aged Residential Care. Baseline data is developed for HOP specialist input for primary care.	The DHB has increased the number of hours specialist HOP services consult with health professionals in primary care and aged residential care (will 'maintain' rather than increase). Specialist inputs for ARC and primary care through: • Assessment, education and advice with regard to specific clients • Shared case review • Multidisciplinary forums (e.g. weekly MDT meeting for shared clients, dementia MDT meeting for people with complex dementia) • Education forums Specialist input for ARC target = 500 hours 2013/14	Quarterly reports on progress against measures

	Specialist input for primary care target = 160 hours 2013/14	
The DHB has established a baseline for 'inappropriate' admissions to hospital (i.e., where an older person is simply observed, rather than given an intervention) from the community and residential care. The DHB will establish a methodology whereby older people being admitted to hospital for social rather than clinical reasons are identified and follow an appropriate discharge pathway	The DHB has established a baseline for social admissions and established a pathway for planned care on discharge.	Quarterly reports on progress against measures
vi. Elder Abuse Guidelines		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
WDHB has implemented the Elder Abuse Guidelines developed by the Ministry of health in 2007	The DHB Family Violence Intervention Programme (VIP) Co-ordinators have ensured that the Elder Abuse guidelines have been implemented.	Quarterly reports on progress against measures.
vii. Fracture Liaison Service		
Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Deliver high quality secondary preventative care for fragility sufferers (through identification, investigation and intervention) to prevent future fractures. This will be supported by the Minimum Data Set (MDS) for hip fractures developed by the Australia New Zealand Hip Fracture Registry (ANZHFR) Working Group. (An electronic copy of the Fracture Liaison Services Resource Pack is available from the Osteoporosis New Zealand website www.bones.org.nz.)	The DHB has established a Fracture Liaison Service (FLS) by June 2014. MDT stakeholders across the health continuum develop an action plan by 30 September 2013. This plan to include: • Identify baseline and current services provided for fracture liaison • Identify service gaps • Explore options of building on these systems for patients with fragility fractures which are consistent with a fracture liaison service (including identification, investigation and intervention) • Identify key quality indicator(s) for primary care aiming to prevent secondary fractures	Quarterly reports on progress against measures.

Living Within Our Means (LWOM)

Context - Describe: Why are we doing this? Performance story – what are the expected impacts/objectives?

Better, Sooner, More Convenient Health Services for New Zealanders in relation to Living within our means (LWOM)

Health is a significant component of government expenditure. Current and projected constraints on government funds mean the health and disability system must focus strongly on maximising value from a limited set of resources.

Objectives

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

Linkages

- Link with Outcomes Framework (Module 1 & 2)
- Links with National, Regional, Local, NGO e.g. HBL collective actions

Living Within Our Means - subregional

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Increase theatre utilisation. **Refer 3DHB and Regional Service Plan**	• Ownership OS3: Inpatient Length of Stay • Ownership OS8: Reducing Acute Readmissions to Hospital • Output 1: Output Delivery Against Plan	Quarterly reports to the Ministry, with exception reporting if target is not met.
Proactive management of employment cost growth and improved use of workforce. **Refer Module 4 – Stewardship for subregional workforce plans**		
Reconfigure and rationalise current service delivery models. **Refer 3DHB Programme and ALT plans**		
Increase in service outputs delivered within a primary care and/or community setting, relative to hospital delivery, and reduction in demand for acute hospital services **Refer Acute Demand and Primary Care-integration sections**		
Alignment of national entities – NHIT Board and HBL Continue the implementation of Shared Services actions aligned with Health Benefits Limited (HBL) work programmes as agreed. Updated costs and benefits		

of each national priority initiative included in 2013/14 annual plans **Refer Section 7 Financial Performance for details**		

Disability Responsiveness
The DHB has developed the following plan with a subregional focus, for advancing the objectives of the New Zealand Disability Strategy (NZDS) that addresses the health needs of people with disabilities of all ages. In 2013/14, the three DHBs expect there will be advantages of having a shared 3DHB CPHAC/DSAC, in terms of improved integration and opportunities for equity through the alignment of initiatives across the three DHBs

Disability Responsiveness – subregional

Actions to deliver improved performance	***Health system success is measured by***	***Reporting Requirements***
Improved data collection within all provider arms with respect to patient disability needs by collation of needs assessment information and improvement in systems that allow baselines to be established. Disability icon within webPAS will be key enabler within HVDHB and CCDHB provider arms	Establishment of baselines for attendance, complaints and admissions will enable targeted actions around the patients with the highest health needs leading to improved service for disabled patients Health passport launched in Wairarapa in line with HVDHB and CCDHB 1000 health passports uptake in Wairarapa DHB Improved quality and safety within health care for people experiencing disability accessing secondary services	Quarterly reports on progress against measures.
We will implement a joint disability strategy for Hutt Valley, Capital and Coast and Wairarapa in 2013/14, utilising a joint CPHAC/DSAC meeting across 3 DHBs to improve disability services across three districts. This will align all three DHBs to a common vision.	Positive learnings from each DHB consolidated into an improved subregional response to disability responsiveness and services Identification of opportunities to collaborate and improve efficiencies in the improvement of services to those with disabilities One annual subregional disability forum One local forum for planning in each of the three DHBs Improved equity of service provision within main stream hospital and community services	Quarterly reports on progress against measures.

Local priorities: Māori Health

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Support the Wairarapa Whānau Ora Collective to develop and implement Whānau Ora services. Develop clear linkages between Whānau Ora services and primary health care. Develop and implement processes for co-ordination of maternal, infant and child health service. Develop referral pathways between public health and Whānau Ora services.	More integrated health services and improved patient pathways will enable earlier access to preventative and primary care % Māori children caries free at five years of age The numbers of whānau care plans developed and progressed	Annual reporting to the Ministry, local monitoring
Implement Tihei Wairarapa Mental Health and Addictions Leadership Group integrated service and workforce development initiatives. Work with generalist health providers to implement a treaty of Waitangi and cultural competence training package	Better integration of local and regional services reduces duplication and fragmentation and people are able to access services easily. % Māori (aged 0-19 years) seen by mental health services % Māori (aged 20-64) seen by mental health services	Six monthly reporting
Develop and implement agreed Tihei Wairarapa acute care, long term conditions and Whānau Ora initiatives Promote collaboration between providers, including Māori health providers. Develop an Integrated Family Health Network to enable integrated health services for Māori to increase access to all health services Develop integrated clinical pathways to assist providers and whānau to navigate the available services easily, effectively and appropriately Support the Whānau Ora Collective in the development of Whānau Ora referral pathways.	More integrated health services and improved patient pathways will enable earlier access to preventative and primary care Services become more culturally appropriate, effective and responsive to the needs of Māori Ratio of primary care consultations by high needs people to primary care consultations for all people % Māori Did not Attends (DNA) at outpatient clinics	Quarterly through PPP Regular internal monitoring

Actions to deliver improved performance	*Health system success is measured by*	*Reporting Requirements*
Review ethnicity data collection protocols Work with the DHB NASC services in relation to increasing Māori health gain and the reduction of inequalities	Better monitoring of Māori health outcomes and coordination of services will enable targeting of services to those who will benefit most. % of people over 65 years accessing support needs assessment who are Māori	Regular internal monitoring
Monitor the performance of DHB NASC services in relation to increasing Māori health gain and the reduction of inequalities Establish formalised training options to advance knowledge of the Treaty of Waitangi, Training; foundation course, online tool and the roll out of the Treaty Responsiveness framework with Wairarapa healthcare providers	Better monitoring of Māori health outcomes and coordination of services will enable targeting of services to those who will benefit most.	

MODULE 4: STEWARDSHIP

4.1 MANAGING OUR BUSINESS

This section details how the organisations manage their business effectively and efficiently to deliver on the priorities described in their Plans. It shows how the DHBs' high level strategic planning translates into action in an organisational sense within the DHBs and details the supportive infrastructure requirements to achieve this. As both funders and deliverers of health services, the DHBs must operate in a fiscally responsible manner and be accountable for the assets they own and manage.

Governance and Organisational Structure

The 3 DHBs have governance and organisational structures as required by the New Zealand Public Health & Disability Act 2000 (NZPHDA).

The Boards of Wairarapa, Hutt Valley and Capital and Coast DHBs assume the governance role and are responsible to the Minister of Health for the overall performance and management of the DHBs. The responsibilities of the Boards 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 Boards comprise members elected by the community and appointed by the Minister of Health.

The Boards have recently changed the structure of the advisory committees required by the NZPHDA: Community & Public Health Advisory Committee (CPHAC); Hospital Advisory Committee (HAC); and the Disability Support Advisory Committee (DSAC). From the beginning of 2013, the 3 DHBs have moved to a subregional CPAC and DSAC, comprised of members from the Wairarapa, Hutt Valley and Capital and Coast Boards. This is to allow greater subregional planning and funding of services across the collective population. The Wairarapa DHB Hospital Advisory Committee has also been combined with the Hutt Valley DHB Hospital Advisory Committee as a result of the executive teams coming together and to facilitate the greater alignment of the two Provider Arms.

Both the Wairarapa and Capital and Coast DHBs have maintained a non-statutory committee (WDHB Audit & Risk Committee and CCDHB Finance, Risk and Audit Committee) to help the Boards meet local responsibilities. Membership of these committees is a mix of Board members and community representatives. Each of the three DHBs also works in partnership with its Māori Partnership Board, Te Oranga o te iwi Kianga, to ensure Māori participation at all levels of service planning and service delivery for the protection and improvement of the health status of Māori.

There is also a joint Capital and Coast/Hutt Valley DHBs Subregional Pacific Health Strategy Group to ensure Pacific participation in service planning and service delivery for the protection and improvement of the health status of Pacific people.

Whilst the Boards are responsible for the DHBs' overall performance, operational and management matters are assigned to the respective Chief Executives who are supported by the Senior Leadership/Executive Management Teams.

The 3 DHBs are committed to the philosophy and practice of clinical leadership where clinicians are accountable for outcomes they have the ability to affect. To facilitate this, an organisational structure has been implemented that ensures active, robust decision making and partnership between clinicians and management across the Wairarapa and Hutt Valley DHBs, and is also in place at Capital & Coast DHB.

Performance Reporting

Three years ago the Wairarapa DHB implemented a comprehensive balanced scorecard (BSC) reporting framework as the core of its 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 who receive a regular report against the allocated measures. In addition the BSC report is reviewed monthly by the Senior Leadership Team.

In Capital & Coast DHB, performance against Government targets, annual planning obligations and financial performance is monitored by the Chief Executive, the Chief Operating Officer, the Executive Management team, SIDU and the Board (including the Board Committees).

In Hutt Valley DHB, performance against Government targets, annual planning obligations and financial performance is monitored by the Chief Operating Officer, the Funder Arm (now SIDU), Executive Management Team and the Board (including through the Board's Hospital Advisory Committee).

As part of the closer working relationships with the Hutt Valley and Capital & Coast DHBs, consideration is being given to what a subregional performance framework might look like. This work is being progressed by SIDU as part of the 3D subregional work programme.

Funder Interests

Funder interests are now part of the responsibility of the SIDU which replaced the three Planning and Funding departments across the Wairarapa, Hutt Valley and Capital and Coast DHBs. SIDU is responsible for ensuring:

- streamlined planning, funding, information and reporting processes across the subregion
- development of a clear shared strategic direction for the subregion
- working in partnership with clinicians to create more effective integrated models of care
- increasing value for money through effective purchasing
- a disciplined system for contracting, financial analysis reporting and audit across the subregion

Our funding processes through SIDU closely follow the Office of the Auditor General's procurement guidelines which includes contestable provider selection. This allows the DHBs 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. The funder arm funds a range of providers in the wider health sector. 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.

Summaries regarding Funding and Provider funding details for each DHB for 2013/14 can be found in section 1.2.3.

SIDU applies 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 Executives and Boards. 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. An ongoing tight fiscal environment continues to put pressure on greater reliance on financial management and our providers to deliver sustainable value for money health services.

SIDU ensures value for money in its purchasing of appropriate and targeted services through the following mechanisms:

- The Price Volume Schedule (PVS) development, monitoring and management for services provided by the Provider Arm
- Regular population needs assessment and strategic planning around service delivery targeted to local populations, ensuring the DHB is matching service delivery to demand
- The development of local services that are strongly supported by intervention logic modelling and defined by robust service specifications
- Robust and effective contract management and performance monitoring; and
- Effective demand management and service pricing strategies – ensuring the DHB is able to meet minimum service requirements across population groups within a constrained financial envelope, whilst managing increased demand and complexity of patient care (e.g – health of older peoples).

SIDU continues to develop its service delivery strategy across a range of primary and community care services. As funding becomes tighter, more emphasis is placed on maximising efficiencies within the models of care whilst ensuring client's needs in the community are delivered in as fair and robust a way possible.

Pursuant to s25 of the New Zealand Health and Disability Act 2000 (the Act) DHBs are permitted and empowered to negotiate and enter into any service agreement (and amendments to service agreements) which they consider necessary or desirable in fulfilling their objectives and/or performing their functions pursuant to the Act.

Across the 3 DHBs, 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 year ahead sees further refinement of the service delivery models in primary care and mental health. The 3 DHBs, through SIDU, continue to review services and programmes for cost effectiveness and value for money, along with ensuring the intervention logics around the areas in which we invest are robust to ensure targeting to areas of priority for the DHBs.

SIDU Service Integration teams are working across the three DHBs to develop constructive and inclusive approaches with providers to ensure the resulting service configurations are sustainable and outcome focussed.

The Wairarapa DHB employs a rigorous risk management process. 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 for the 3 DHBs.

Wairarapa DHB works closely with the Health Round Table to ensure it is aware of both best practice, and best performers, in Australasia for public hospitals, and follows 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 their Triple Aim strategy. There is continuous work on reviewing and implementing improvements to clinical pathways, which are focused on delivering patient centred results. This work is also a feature of the broader subregional work programme.

Wairarapa DHB Provider Arm risk management is managed centrally via a formalised process using specific risk management technology to assist and record the various risks to the DHB. 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.

The Wairarapa DHB's Provider Arm will be moving towards greater alignment and integration with the Hutt Valley Provider in the 2013/14 year.

The Hutt Valley DHB's Provider Arm, which provides secondary and tertiary care services and some regional and national services, is based at Hutt Hospital. The services it provides are described in Section 1.2.3.

The resources required to deliver these services include:

- $178.3m of land buildings, clinical and other equipment mostly located on the Hospital campus
- $222.3m of revenue mainly provided by the Crown
- 1745 full time equivalent staff members

The performance of the Hutt Valley Provider Arm against Government Targets, Annual Planning obligations, and financial performance is monitored by the Chief Operating Officer, the Funder Arm, the Executive Management Team, SIDU, and Board (including through the Board's Hospital Advisory Committee).

Base funding for the Hutt Valley Provider Arm is agreed through the Memorandum of Agreement (MoA). In 2013/14 the funding is $187.8m**,** with a national pricing programme determining the price of each purchase unit. A further $34.5m largely comes from direct contracts for service with the Ministry of Health, ACC and other DHBs.

There are planned efficiencies of $12.8m assumed in these budgets, which specifically relate to a range of efficiency programmes within the Hutt Valley Provider Arm. We are estimating a deficit for the Provider Arm of $4.3m for 2013/14 (to be offset in other activities of the DHB) to ensure an overall 2013/14 breakeven position.

Capital and Coast DHB

Capital and Coast DHB's Provider Arm provides a mix of secondary and tertiary services to local, regional and national populations. Most of the services are provided out of the main Wellington Regional Hospital campus in Newtown, with a mix of out-patient, orthopaedic and rehabilitation services delivered out of the Kenepuru campus in Porirua.

The resources required to deliver these services include:

- $500 million of land, buildings, clinical and other equipment mostly located on the hospital campus
- $620 million of revenue mainly provided by the Crown
- 4332 full time equivalent staff members

Base funding for the Provider Arm is agreed between the funder and provider at the beginning of each financial year, with a national pricing programme determining the price of each purchase unit. A further $83 million comes directly from contracts with the Ministry of Health, ACC, other DHBs and other external sources.

The services provided by the Provider Arm are reflected in a formal Price-Volume Schedule (PVS) with the Funder actively monitoring the Provider's performance against this and a range of service specifications relevant to the various services operated within the Provider Arm.

In 2012/2013 the Capital and Coast Provider Arm made further progress towards achieving its priorities, which are consistent with the Minister's Health Targets (see Modules 2 and 3). Clinical engagement (encompassing clinical leadership) and engagement with the wider primary care and community services sectors are critical to further gains being achieved.

A comprehensive recovery plan is in place to address issues along the health continuum and establish sustainable clinical and financial outcomes. The recovery plan is substantially based on productivity and efficiency as opposed to service reduction, and continues to be a revenue/cost reduction led recovery rather than a service reduction recovery. The principle continues to be that implementation occurs by Directorate and through Clinical leadership, reinforcing the development of an accountable culture. This has required and continues to require:

- developing a comprehensive understanding of the cost and revenue drivers
- understanding the impact of actions and benefits of strategy along the health continuum
- transparency and accuracy in reporting
- addressing deeply held organisational cultural issues
- establishing and enabling accountable leadership at all levels with a focus on clinical leadership, and
- building organisational capability – leadership, staff, systems, processes, skills, business acumen

Our key areas of priority for 2013/14 include:

- Revenue maximisation
- Personnel management and costs
- Supplies management

The Annual Plan provides for a further $4 million reduction in deficit from $10 million in 2012/13 to$6 million in 2013/14. This will result in a cumulative deficit reduction of $91.6 million since inception of the Recovery Plan in 2008. The 2013/14 plan shows $21.3 million of required savings to achieved this target which includes some 2012/13 initiatives not fully achieved. A performance

management framework remains in place within the Capital and Coast Provider Arm to monitor performance against these initiatives and to mitigate risks as they arise.

Audit and review

SIDU coordinates a Routine Audit Programme to assess the extent to which NGO providers are complying with terms of their contract(s) with the 3 DHBs. Additional issues based audits can be commissioned if there are particular concerns about a provider's performance. The Central Region Technical Advisory Service Ltd (CRTAS) 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 DHBs.

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 three 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 DHBs' financial results. Additionally, there are certification and assurance audits carried out to verify service provision to acceptable standards.

Wherever possible, all 3 DHBs endeavour to coordinate audit activity with other DHBs, in particular the subregional DHBs.

4.2 BUILDING CAPABILITY

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 3 DHBs need to consider all health services providers – those within the local region, and those providing services outside of the DHB district for each of the 3 DHBs' DHB- domiciled patients.

Workforce

It is recognised at a national, regional, subregional and local level that sustainable services rely on a stable, fit-for-purpose, clinical and non-clinical workforce. The 3 DHBs are committed to support the initiatives of HWNZ and partnering with our regional, subregional 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 and 2D programmes and DHBs' work at a local level) as well as opportunistic intervention e.g. when vacancies arise, service reviews occur.

The Wairarapa, Hutt Valley and Capital & Coast DHBs all have goals to be an employer of choice in their areas, and as good employers and responsible health care providers, are obligated to ensure that the right clinician is providing the right care at the right time in the right place. This necessitates 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 three DHBs also actively involve staff in the development and renewal of policies and procedures on a regular basis to support consistent practice across the three DHBs.

The three DHBs are committed to providing a focus on equal opportunities (EEO) and encourage applicants from varied and diverse backgrounds to apply for roles.

The 2D and 3D programmes both have a workforce development and training component. As services transition to a subregional focus tailored workforce plans will need to be developed to support and enable the transition. 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 Māori clinical workforce. The future workforce will be supported by encouraging – through interaction with schools and workforce agencies – the enrolment of Māori children in technical and science related subjects and mentoring their developments through college and professional training institutions.

Information Technology

The demand for reliable and improved information services continues to increase. Information systems enable better service integration, more efficient and effective services, support for high quality and safe delivery of patient care, earlier intervention, and support for improved access to services. Staff and service providers are increasingly reliant on systems and electronic information for their day-to-day operations, including resource allocation, performance monitoring and future service planning. There is a demand for both new information system capability and improved reliability of services leading to a continued requirement to invest in core IT infrastructure and staff skills.

Collaboration between the DHBs in the Central Region will continue towards the delivery of the Central Region Information Services Plan (CRISP). CRISP is the key enabler for the development of a sustainable, fit-for-purpose information technology infrastructure in the Central Region. CRISP will eventually deliver a shared system to all clinicians in the Central Region that will provide access to a single set of clinical records, and a single system. CRISP is also aligned with, and will support, the other regional initiatives and National Health IT Board programmes (subject to ordinary business case processes).

The Wairarapa/Hutt DHB CEO, Graham Dyer, is the CRISP Sponsor and is, and will continue to be, a prime advocate for the implementation of this initiative.

Work is underway across the subregion to implement a 3 DHB ICT function to deliver on the CRISP programme over the next three years. This will require prioritisation and pooling of the limited resources and expertise across the subregion while also ensuring that ICT infrastructure, systems and services swiftly enable the subregional and regional outcomes.

In tandem to this regional and subregional development, shared care records for Wairarapa, Capital and Coast and MidCentral DHBs (across primary, community and secondary care providers) will continue to be rolled out utilising the Manage My Health Medtech software. This will support/dove tail with the implementation of Phase 2 CRISP in four years' time.

Infrastructure

The 3 DHBs have Asset Management Plans (AMP) which are prepared to assist in determining the ongoing capital requirements to meet the DHBs' service objectives (refer to Module 7 for details of Financial Performance). 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.

Wairarapa DHB

As part of Tihei Wairarapa the Wairarapa DHB considered a range of options for the development of an IFHN on the Wairarapa Hospital site and also for the South Wairarapa region. These conversations with Primary Care and General Practice have recently been reinvigorated and will continue to be progressed through the 2013/14 Tihei Wairarapa work programme.

The Wairarapa DHB continues to have conversations with the largest GP practice, Masterton Medical Ltd, and other general practices, regarding other integration opportunities and the shifting of services closer to the patient in line with the expectations of Government.

The old hospital site has now been sold and during 2012/13 the DHB has largely completed a process of transferring existing staff out of old hospital facilities (with the exception of those services noted below).

Wairarapa DHB completed the development of the Oral Health Hub, funded by the Ministry of Health as part of the Wairarapa DHBs Oral Health Business Case. The Oral Health Hub is located at Masterton Intermediate School and consists of a two chair clinic with the ability in the future to commission a third chair, and is the base for the district's Dental Therapists and Dental Assistants.

A number of other infrastructure projects will be progressed in 2013/14. These include:

- The relocation of stores, clinical records and FOCUS offsite to the Corporate Office in Russell Street
- Completing a new build on the Hospital site for the maintenance team and for therapy equipment stores
- Co-location of some community based mental health services into the new build currently underway for the Pathways/CareNZ service.

Options are currently being explored for a suitable community based site for the Population Health Team who continue to lease space on the old hospital grounds. Site options are being explored to accommodate the changes that result from the 2D work programme including the accommodation of a new executive team and the development of hot desks space to allow clinical and administrative staff to move between hospital sites.

Hutt Valley DHB

Hutt Valley DHB's asset management program enables the DHB to continuously update its asset planning. As our ED theatre redevelopment has been completed, our focus now shifts to planning for replacement or rebuilding of two earthquake prone buildings on our campus (in accordance with our *Integrated Campus Plan)*. The other major piece of work underway at present is the implementation of the oral health business case. A three year view of capital is set out below:

Capex

Hutt Valley District Health Board
Capital Expenditure
For the Year Ended 30 June

$000s	2011/12 Audited	2012/13 Forecast	2013/14 Plan	2014/15 Plan	2015/16 Plan
Approved / Baseline Expenditure					
Property and Plant	1,199	2,042	3,000	3,000	3,000
Clinical Equipment	951	1,065	2,000	2,000	2,000
Computer Equipment	1,275	2,812	1,850	1,850	1,850
Other Equipment	88	42	100	100	100
Motor Vehicles	-	-	-	-	-
Total Baseline	3,513	5,961	6,950	6,950	6,950
Strategic (Approved)					
Central Region Information Systems Plan (PMS, EMR, PACS, RIS, ED, eReferrals, WhiteBoard) Programme	223	1,487	2,168	1,037	-
Finance Procurement Supply Chain	-	810	736	381	-
Citrix Farm	-	-	1,000	-	-
e-Pharmacy	-	-	500	-	-
MRI Scanner	-	-	2,300	-	-
Laboratory Information Systems	-	943	747	-	-
Total Approved	223	3,240	7,451	1,418	-
All Other Approved Projects	21,759	11,237	1	-	-
Total Capital Expenditure	25,495	20,438	14,402	8,368	6,950
Financed By					
Internally Sourced Funding	104	-	-	-	-
Equity Injections for Deficit Support	-	-	-	-	-
Depreciation	11,031	12,068	13,795	14,600	15,314
Sale of Fixed Assets	615	299	-	(5)	(5)
Equity Injections for Capital Expenditure	4,323	1,532	-	-	-
Private Debt	3,191	-	-	-	-
CHFA Debt	22,100	-	-	-	-
Other (Includes Cash Reserves)	4,122	19,991	13,452	12,845	19,072
Total Finance	45,486	33,890	27,247	27,440	34,381

We have not identified any significant assets that are surplus to long-term health service delivery needs, including land. When disposing of land, Hutt Valley DHB will abide by the appropriate statutes and be guided by appropriate business principles. Hutt Valley DHB will not dispose of any land without first consulting with the Minister of Health. We will also comply with the relevant protection mechanism that addresses the Crown's obligations under the Treaty of Waitangi and any process relating to the Crown's good governance obligations in relation to Māori sites of significance.

Our planned capital expenditure for 2013/14 is $14.4m.

Capital and Coast DHB

Infrastructure and support is seen as a key enabler for clinical staff to deliver services to our patients, and continues to be a key priority. The Hospital will participate in the national shared services work programme to ensure the objectives of this work are achieved. It has also identified a number of other areas of focus where our infrastructure requires development and improvement.

The areas of focus for 2013/14 include:

- Continued IT/IM developments following the implementation of EHR2 (Electronic Health Record) in 2010/11 and the development of the Central Region Information Services Plan (CRISP) over the next three years
- Corporate system development and enhancement including Payroll system improvements

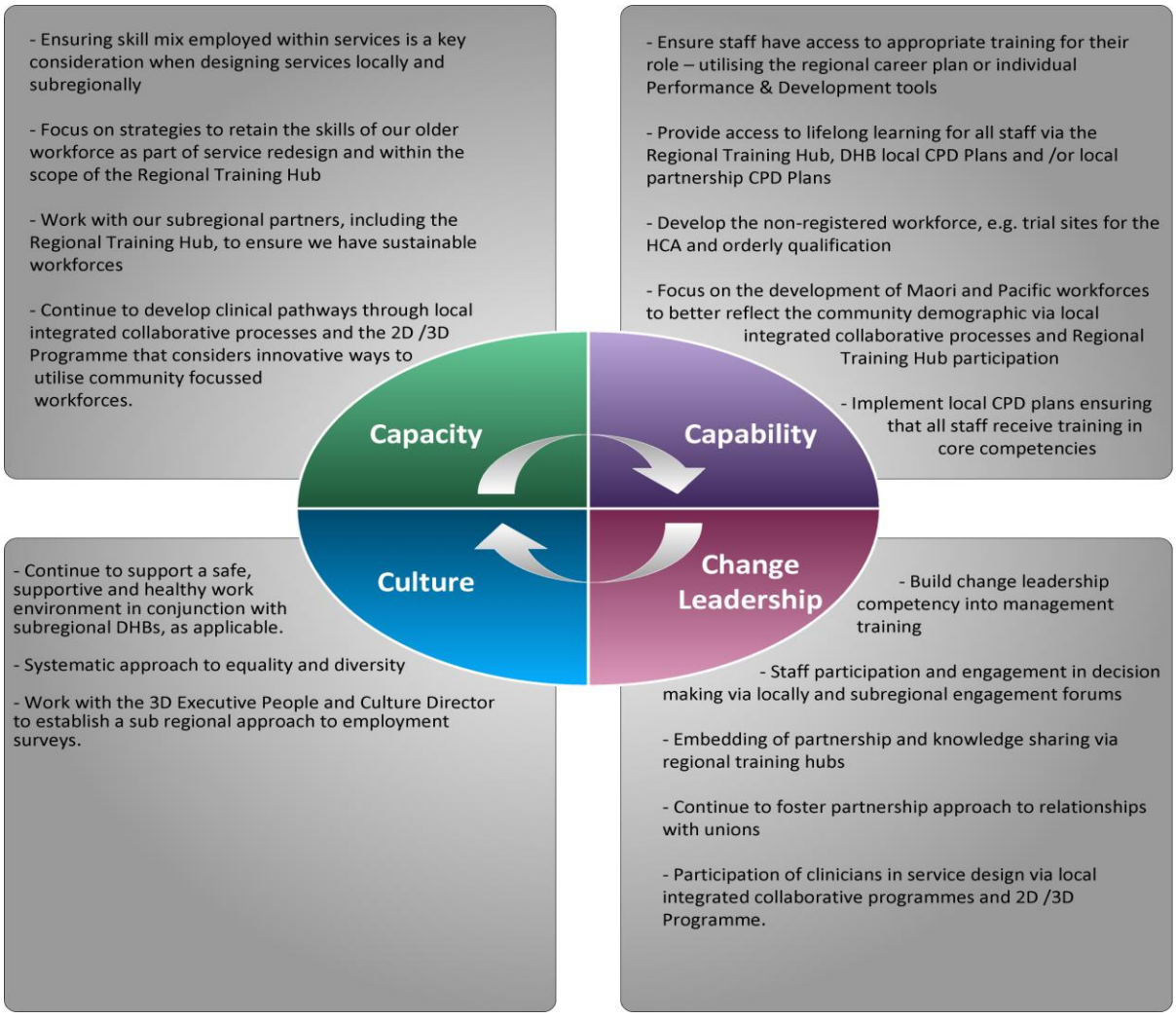
- Disaster Recovery and Business Continuity
- Rollout of the Manage My Health Medtech software across primary and community services
- Non Clinical Support service initiatives including procurement and supplies management, further roll out of the electronic rostering system
- Linkage with the national regional and subregional initiatives

4.3 STRENGTHENING OUR WORKFORCE

Ensuring that we have a fit for purpose and capable workforce is a key strategy for all three DHBs. The vision of the 3DHBs' Workforce Plans are to work collaboratively with health providers to ensure as a subregion, the DHBs recruit, develop and maintain a collaborative skilled workforce focused on the health needs of the population. Individual DHB plans sits within the wider context of 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, radiology recruitment, the regional implementation of the National Services Reviews, Clinical Leadership and career planning.

Within the context of HWNZ strategy, the subregional Workforce Plan focuses on capacity, capability, culture and change leadership as depicted in Figure 13 below:

Figure 13: Subregional Workforce Plan



The intent of the subregional Workforce Development Plan is to:

- identify the main workforce demands, and the potential challenges, that the 3 DHBs will be faced with over the next five years and
- articulate the workforce outcomes, strategies and policies that will support and enable 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 subregional DHBs' workforce were determined to be:

- The ageing workforce
- The increasing health gap between Māori and others
- Increased generalisation and evolution of clinical roles resulting from the integration of primary and secondary health care provision; and
- 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 subregion and is considered a first step towards the 3 DHBs 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 3 DHBs, both as independent DHBs, and DHBs within a subregional and regional context.

Continued collaboration in the area of human resources and workforce development across the subregion is demonstrated by the appointment of a 3DHB Executive Director of People and Culture (ED P&C) across the 3 DHBs. The intent of this role is to ensure that our workforce plans and organisational requirements are aligned. The new ED P&C will take responsibility for the completion of a Workforce Development Plan, which will factor in the requirements of HWNZ, the 3DHB subregional plans and the workforce sections of the Regional Services Plan (RSP).

The three DHBs are aware of the new HWNZ model for allocating postgraduate education funds. They will ensure that the required information is provided to the HWNZ on the mix and numbers of trainees, including their location. The requirements of the 70/20/10 model of funding will be implemented. A process will be developed to ensure that the changed reporting requirements can be met.

The suggested prioritisation to vulnerable or critical specialities will require further engagement with HWNZ to develop a model that suits small to medium-sized DHBs, in order to access the 10% funding allocated to this area. Further opportunities to develop an enhanced subregional approach to training will be explored.

The Regional GMs Human Resources have met with the Regional Director for the Training Hub to engage on the regional workforce plan and to align workforce activity.

The workforce plans for DHBs will be increasingly linked to subregional work around integrated services, for example, in the Laboratory and Radiology service reviews. As new models of care develop, consideration will be given to current and future workforce needs, and opportunities, such as professions working at the top of their scope, will support the workforce development.

All workforce strategies will be underpinned by the Triple Aim approach, which puts the patient at the centre of all endeavours, and says patient needs will be served best when we simultaneously

provide the services which make the most difference to health overall, in ways which provide the best possible experience for the patient, and provide them at the lowest cost.

Health Workforce New Zealand

The 3 DHBs acknowledge 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 while maximising the quality of the product delivered.

The focus for the Central Region Training Hub services plan for 2013/14 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.

Subregional workforce plans

Table 15: Clinical Leadership and Career Planning

Clinical Leadership and Career Planning	
Why this is a priority? Regional and subregional projects such as the 3D 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 2013/2014	**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 subregional discussions. • Participation in the pilot for GP registrar training across the subregion 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 support of a national pilot for the recruitment of new graduate nurses (using 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 our nurses. The region will be in a better place to encourage career pathways into priority areas. • The subregion will be working toward one

ACE process). • Implementation of a regional approach for the 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 subregion of Wairarapa, Hutt and Capital and Coast • Support the continued implementation of local, subregional and regional workforce innovations that arise out of local collaborative programmes and the 3D programme, e.g. regional ENT Specialists.	workforce plan with an aim to have generic workforces who are more mobile and flexible.

Table 16: Working Subregionally to Sustain our Collective Workforce

Working Subregionally 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 subregion we can increase the likelihood of our workforce being supported, sustainable, and enabled.	
What we are doing in 2013/2014	**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 subregional DHBs and the PHOs 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. regional leadership initiatives. • When a role becomes vacant consideration will be given to whether the role can be filled as a subregional 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

The three DHBs are committed to ensuring that the patient is at the centre of everything that we do and that the DHBs strive to achieve the best outcomes for our patients consistent with our Triple Aim approach.

Listening to our communities' and consumers' voices is a priority and the DHBs have established different ways of accessing consumer feedback.

Wairarapa DHB has a consumers' resource consisting of ten 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 (e.g. developing patient literature, providing advice on policies and procedures in the hospital) and ensuring our patients receive safe, high quality patient centred healthcare.

All three DHBs are 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 tables 17-22 provide an update on key HQSC initiatives that are being implemented by the Wairarapa DHB and key activities that will be implemented in 2013/14.

Table 17: Improving Medication Safety

Improving Medication Safety	
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.	
Where are we now? • 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). • The red square initiative has reduced controlled drug errors, only 2 of the	**What are our plans for 2013/2014?** • 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%. Targeting specific quality improvements in medicati management e.g. improving thrombo-prophylaxis VTE.

61 errors were CD • Audits are in place to monitor the effect of the initiatives from both a prescribing and administration perspective. • A total of 61 errors were reported in 2011/12 the majority being near misses	

Table 18: Mortality Review

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 70% 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 and three reviews meeting occurred covering six child deaths.	**What are our plans for 2013/2014?** • Increase the number of mortality reviews. completed to 80%. • Continue to communicate any clinical or system improvements to all health care professionals within the DHB. • Report quarterly to the HQSC.

Table 19: Reportable Events

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 and other clinical case reviews to align practices and collaborate on improvements.	**What are our plans for 2013/2014?** • The WDHB has adopted the national reportable events policy which is well imbedded in the reportable event process. • Continue supporting age residential care through education towards adopting the national reportable events policy building on the successful training provided to date.

Table 20: Falls Management

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 aims to initially reduce the harm sustained as a result of falls.

Where are we now?	What are our plans for 2013/2014?
• All falls are reviewed and investigated. • A total of 93 falls were reported for the 2011/2012 period, none of these resulted in SAC 1 or 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.	• 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. • Adopt new falls management tool kit released by the HQSC.

Table 21: Infection Control and Management

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?	What are our plans for 2013/2014?
• Hand Hygiene project continues within the DHB with auditing and education. • Compliance to hand hygiene following audit showed low compliance however has increased to 74% at the last audit making us the third most compliant DHB in the country. • Surveillance activity reported and monitored Hospital acquired blood stream infections (BSI) for the period of 2011/2012 was per 0.58 per 1000 bed days. • Continue the surgical site infection monitoring of all clean orthopaedic surgery • Commenced Caesarean section SSI surveillance.	• To continue to exceed the national hand hygiene target of 64% compliance. • To continue to maintain our low BSI rates. • Reduce the SSI for clean orthopaedic surgery to below 3%. • Commencing Caesarean section SSI surveillance. • Participating in the HQSC quality markers around hospital acquired infections

Table 22: Improved Pressure Ulcer Prevention

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 2013/14.

Where are we now?	What are our plans for 2013/2014?
For the period 2010/2011 we had an incidence of 0.08 hospital acquired pressure sores per 1000 bed days, and 0.16 per 1000 present on admission. 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. Improved identification of existing pressure ulcers on admission to hospital.	To reduce the incidence of hospital acquired pressure sores and work towards being a pressure area free hospital.

Other improvement projects

Wairarapa DHB

The 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.

Wairarapa DHB is providing data to the HQSC on key quality markers. To date we have provided baseline data for falls management and perioperative safety.

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.

Hutt Valley DHB – Clinical Engagement

The Hutt Valley Primary Secondary Strategic Governance (PSSG) approach is an integrated primary and secondary multidisciplinary clinical group created to provide and contribute to clinical leadership across the primary-secondary continuum in the Hutt Valley, with an agreed vision of "Keeping people in the community healthy". Its goals have been established as:

- ensuring seamless healthcare for people in the Hutt Valley
- fostering high quality, innovative integrated services – i.e. safe, patient-centred, effective, timely, efficient, accessible, sustainable and equitable
- identification and removal of barriers to communication and care
- better management of preventative services, acute episodes, and long term conditions.

The implementation of the 2D programme with Wairarapa DHB provides further stimulus for progressing clinical engagement at all levels within both organisations. Increasing clinical leadership within decision making and planning frameworks within the 2D framework will continue to be a high priority for 2013/14.

Capital and Coast DHB - Clinical Engagement

Capital and Coast DHB continues to have a strong commitment to making clinical engagement real at all levels within the organisation. Clinical leadership within decision making and planning frameworks are central to our structure and philosophy of service management. The continued development of semi-autonomous directorates within the Provider Arm and improvement of information systems to support decision making by clinicians continues to be a key focus, along with our 3D HSD programme.

The key areas of priority for 2013/14 include:

- continued development of clinical leadership capability
- development of the regional training hub in conjunction with the DHBs within the region
- integration of clinical thought in Clinical Governance and service development through the ICC programme of work and the operation of the ICC Leadership Group
- continued devolution of responsibility and accountability within directorates to Clinicians
- continuing to build on our clinical governance, leadership and engagement processes, which will in turn strengthen our safety and quality culture and improve the quality of our services
- strengthened integration of clinical and non-clinical governance.

Primary Secondary Clinical Governance

Capital and Coast DHB's focus this year is on maximising efficiency and service quality gains by leveraging off of the interface between hospital services and primary care through the ICC work programme. Particular areas of focus continue to include:

- Implement the work streams committed to under the ICC programme
- Improve communication between the primary secondary interface – continually exploring opportunities to deliver Better, Sooner, More Convenient healthcare
- Improve equity of access and care to services through robust and sustainable clinical pathways and
- Improve ethnicity and disability data collection

4.5 ORGANISATIONAL HEALTH

The three DHBs are committed to developing and maintaining clinically and financially sustainable organisations. This is reliant on having high performing Governance Boards and committee structures, high performing DHB Senior Leadership Teams and high performing clinical workforces and supporting infrastructures within the Provider Arms.

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

The three DHBs will follow 'good employer' practices and EEO principles.

Wairarapa DHB

The Wairarapa DHB will continue to develop our Provider Arm's workforce in conjunction with the Hutt Valley DHB 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. This will increasingly take a subregional focus in the coming year.

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 an employer 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.

Hutt Valley DHB
The DHB is committed to developing a workforce profile, and understanding the needs and expectations of its workforce. We are committed to promoting leadership opportunities and a positive culture for our organisation.

Workforce development and clinical engagement are fundamental to ensure that we continue to provide high quality and effective services. Through supporting flexibility and fostering innovation, and providing leadership and skill development opportunities, Hutt Valley DHB endeavours to promote equity, fairness and a safe and healthy work environment.

Capital & Coast DHB
Capital and Coast DHB has made significant progress towards achieving its priorities through the adaptation of its internal culture and systems. There has been an improvement in financial performance achieved by a focussed approach to the management of costs and the maximisation of revenue opportunities.

An essential element in continuing to achieve and improve our performance is the support through clinical engagement (encompassing clinical leadership) and the wider community through establishing and sustaining such programmes as Primary and Secondary Clinical Governance, and Subregional and Regional collaboration and co-operation.

The DHB continues to see it as essential that clinical staff and managers work closely to provide continued high quality, cost effective, services for our population.

Workforce and the ability to ensure sustainability of service delivery continue to be a key area of focus. Good progress has been made with the establishment of the shared services model to strengthen the delivery of Paediatric Oncology services to the region.

Areas where the DHB is currently experiencing difficulty with recruitment and maintaining service delivery are in some of sub specialty areas and include: Medical Oncology, Medical Physicists, Gynaecology Oncology, Maternal Fetal Medicine and some areas with the Allied Health disciplines.

In 2013/14 Capital and Coast DHB will continue to:

- Further develop its recruitment strategy and processes to ensure compliance with the DHB's Equal Employment Policy, that the impact on service delivery is minimised, regional solutions are maximised and key vacancies are filled
- Develop workforce plans in line with the framework developed by Health Workforce NZ and to minimise the impact on service delivery where there are critical vacancies
- Strengthen our clinical quality and patient safety culture as we move toward the development of a service excellence framework

- Work with the subregional partner DHBs to develop new models for delivering services which will strengthen those services which currently have areas of vulnerability improving their sustainability and maximise the use of available resources
- Work in collaboration with the region to maximise the use of regional resources, strengthen the workforce across the region and to strengthen the services that the DHB provides to the region
- Concentrate on financial sustainability to ensure that Capital and Coast DHB lives within its means and that the budget targets are achieved
- Improve relations across the primary secondary interface through the development of joint initiatives which maximise the utilisation of resources and improve services and health outcomes for patients.

4.6 REPORTING AND CONSULTATION

The 3 DHBs provide regular reporting to the Minister of Health as outlined in the table below. In accordance with s 141 (1) (g) Crown Entities Act 2004 each of the 3 DHBs will consult with the Minister via the Ministry of Health on any significant developments not covered in this plan.

Table 23: 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

Wairarapa, Hutt Valley and Capital and Coast DHBs, with other Central Region DHBs, have joint ownership of the Central Regional Technical Advisory Service (CRTAS). CRTAS provides support to the Central Region DHBs so they are able to meet the New Zealand Health Strategy and the New Zealand Public Health and Disability Act 2000 objectives. 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.

Hutt Valley DHB has no plans to acquire shares or interests in any company, trusts and/or partnerships except a potential acquisition of redeemable preference shares in CRTAS. Any proposal to do so would need to be approved by the Board and the Minister of Health.

MODULE 5: FORECAST SERVICE PERFORMANCE

5.1 STATEMENT OF FORECAST SERVICE PERFORMANCE

Measuring our performance

As the major funder and provider of health and disability services in our district, we aim to make positive changes in the health status of our population. The decisions we make about which services will be funded and delivered will have a significant impact on the health of our population and will improve the effectiveness of the whole Wairarapa health system.

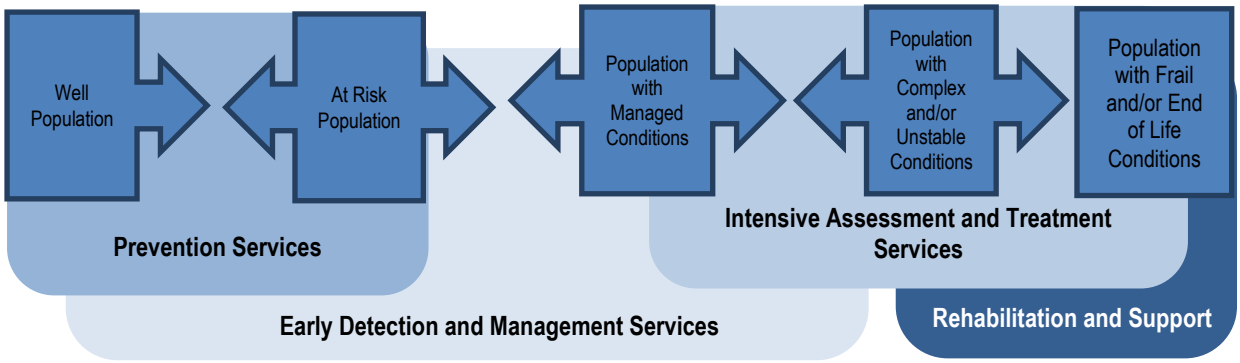


FIGURE 14: Scope of DHB Operations – Output Classes Against the Continuum of Care

In the Statement of Forecast Service Performance, the DHB links outputs to the desired medium-term impacts, which in turn influence achievement of long-term outcomes (outlined in Module 2). It is important to note that linkages will not always be directly quantifiable or separately identifiable. Many factors influence the impacts to which the DHB seeks to contribute. In addition, many of the impacts will not be seen within a single year, and trend data will be necessary to develop a view as to whether the impacts sought are eventuating.

In the more immediate term, we evaluate our performance by providing a forecast of planned performance (what services or 'outputs' we will deliver in the coming year). We then report actual performance against this forecast in our end-of-year Annual Report. The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes we are seeking over the longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the current year. They therefore reflect a reasonable picture of activity across the whole of the Wairarapa health system.

In order to present a representative picture of performance, the outputs have been grouped into four 'output classes' that are a logical fit with the stages of the continuum of care and are applicable to all DHBs:

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

Identifying a set of appropriate measures for each output class is difficult. We cannot simply measure '*volumes*'. The number of services delivered or the number of people who receive a service is often less important than whether '*the right person*' or '*enough*' of the right people received the service, and

whether the service was delivered '*at the right time*.'

In order to best demonstrate this, we have chosen to present our forecast service performance using a mix of output measures. Outputs are categorised by type of measure, reflective of whether the output is targeting coverage (C), quality (Q), quantity (volume (V)), or timeliness (T). These help us to evaluate different aspects of our performance and we have set targets against these to demonstrate the standard expected.

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T

Target Setting

Wherever possible, we have included the past year's baseline data to support evaluation of performance at year end. In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption the funding growth will be limited. Targets tend to reflect the objective of maintain performance levels against increasing demand growth but reducing waiting times and delays in treatment to demonstrate increased productivity and capacity. Baseline data for measures is for the 2011/12 year except where otherwise specified. National data, where available, is provided in line with the measure's baseline period.

It is also important to note a significant proportion of the services funded/provided by the DHB are demand driven, such as laboratory tests, emergency care, maternity services, mental health services, aged residential care and palliative care. Estimated service volumes have been provided to give the reader context in terms of the use of resource and capacity; however these are not seen as targets and are provided for information to give context to the picture of performance.

Our targets also reflect our commitment to reducing inequalities between population groups, and hence some measures appropriately reflect a specific focus on high need groups. Wherever possible measures will be monitored with a focus on reducing inequalities, and targets aim for equitable outcomes for all of the DHB population.

Where does the money go?

The table below presents a summary of the 2013/14 budgeted financial expectations by output class.

Revenue	Total ($000)
Prevention	$2,507
Early Detection & Management	$42,069
Intensive Assessment & Treatment	$70,391
Rehabilitation & Support	$20,095
Total	**$135,062**

Expenditure	Total ($000)
Prevention	$3,145
Early Detection & Management	$41,195
Intensive Assessment & Treatment	$73,024
Rehabilitation & Support	$18,898
Total	**$136,262**

5.2 OUTPUT CLASSES AND MEASURES OF DHB PERFORMANCE

PREVENTION SERVICES
Output Class Description

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

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

- 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.

Local Environment
Prevention services are delivered through a range of providers within the Wairarapa district. Regional Public Health and the Wairarapa DHB Population Health Unit are the main providers of public health services for the greater Wellington region. Other providers include General Practice and private and non-governmental organisations e.g. Māori providers, Well Child providers, Sports Trust and local and regional government.

Regional Public Health (RPH) is a regional service within Hutt Valley DHB, serving the populations of Wairarapa, Hutt Valley and Capital & Coast DHBs, and working under the shared strategy for population health "Keeping Well". Regional Public Health delivers:

- Health Promotion Services and Education Services; working with the district's communities, local government and government agencies to ensure that the settings in which people live, work, play and learn can support healthy choices.

- Statutory and Regulatory Services; address such issues as sanitation, water quality, promoting water fluoridation, food safety and control of the spread of infectious diseases.

- Preventing disease and improving health for families/whānau, children and young people through individual service delivery such as School Health Services, ear van service and vision and hearing tests in school and preschool settings.

The Ministry of Health contracts the Hutt Valley DHB to provide the regional breast cancer screening service (BreastScreen Central) and national cervical screening coordination services (National Cervical Screening Programme).

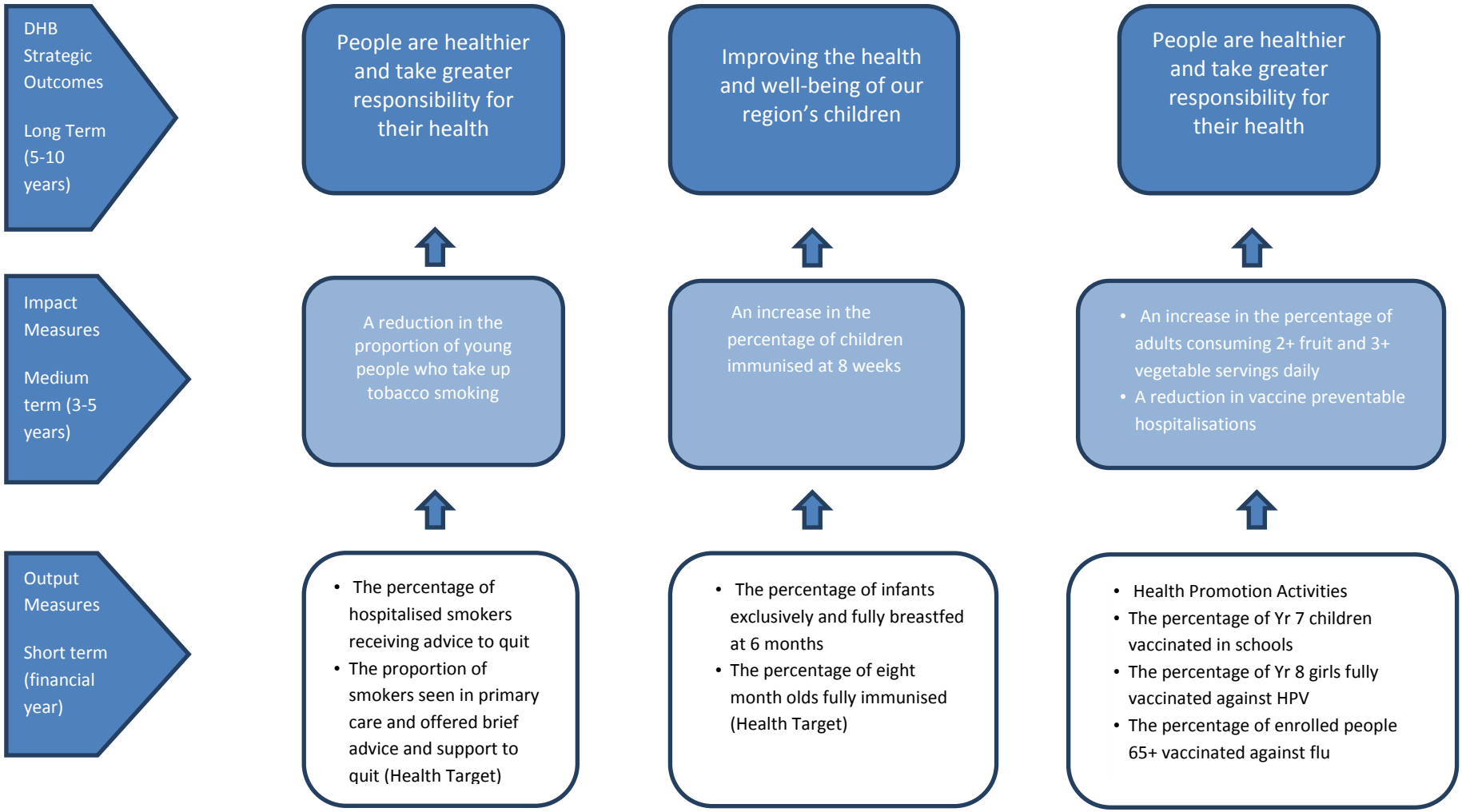
- BreastScreen Central provides breast cancer screening for women aged 45 to 69 years from fixed and mobile sites throughout the Wairarapa, Hutt Valley, and Capital & Coast DHB regions.

- Hutt Valley DHB provides one of the 12 regional National Cervical Screening Programme coordination services throughout New Zealand. Screening is delivered by primary and

community care providers.

In 2013/14 Wairarapa DHB will continue its work with primary health care providers to reduce the risk of chronic diseases and cancer, reduce the burden of preventable hospitalisations and increase immunisation and cancer screening rates. Wairarapa DHB will continue to work with the district's communities and local government to ensure healthier environments (e.g. clean air, safe water, healthy housing).

Intervention Logic: Prevention Services Output Class



Impacts

Impacts are medium-term results from activities that give an indication of progress towards desired outcomes. As these are medium-term measures they are not all available on an annual basis, and therefore are not part of the annual targets of performance. The impacts the DHB intends to make from outputs in this class are:

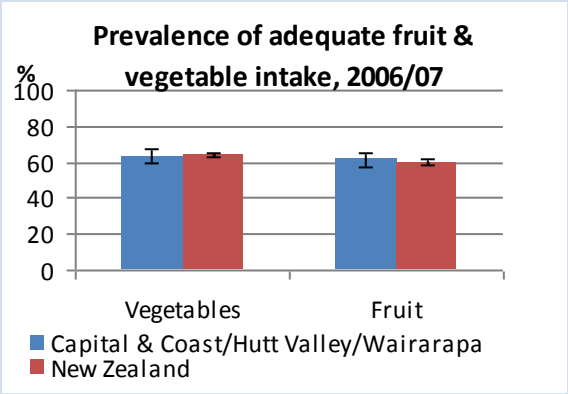
An increase in the proportion of young people who report never smoking

- Reducing smoking prevalence is dependent on smoking cessation and on preventing young people from taking up smoking. Over 95% of smokers have started smoking by 18 years of age.
- Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.

Data Source: ASH Yr 10 survey

An increase in the percentage of adults consuming 2+ fruit and 3+ vegetable servings daily

- Good nutrition is fundamental to health and the prevention of disease and disability. Appropriate fruit and vegetable consumption helps to protect people against obesity, CVD, diabetes and some common cancers and contributes to maintaining and healthy body weight.
- Nutrition-related risk factors (such as high cholesterol, high blood pressure, obesity and inadequate fruit and vegetable intake) jointly contribute to two out of every five deaths each year.



The percentage of eight week olds fully vaccinated

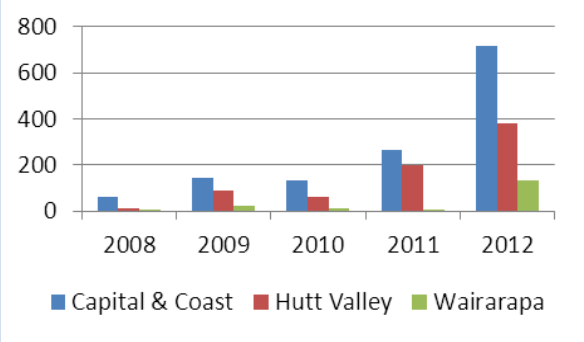
- Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also population-wide protection by reducing the incidence of infectious diseases and preventing spread to vulnerable people.
- In order to have timely immunisation by eight weeks there are a number of health services which need to be aligned, such as the lead maternity carer, PHO enrolment, Well Child enrolment and NIR registration. It also requires timely completion of the Well Child and GP six week checks.

Data not yet available.
New age group for
Ministry of Health monitoring.

A decrease in the number of vaccine preventable disease notifications

- Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also population-wide protection by reducing the incidence of infectious diseases and preventing spread to vulnerable people.

- Recent years have had an increase due to Pertussis outbreaks in the region. In the longer term, with increased immunisation, it is expected the number of vaccine preventable disease notifications will decrease. Regional Public Health reports figures for Pertussis have started to decline in early 2013.

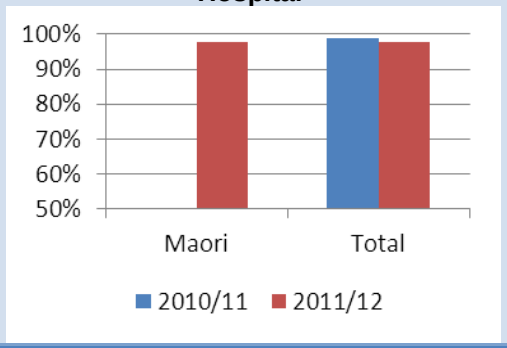


HISTORICAL PERFORMANCE

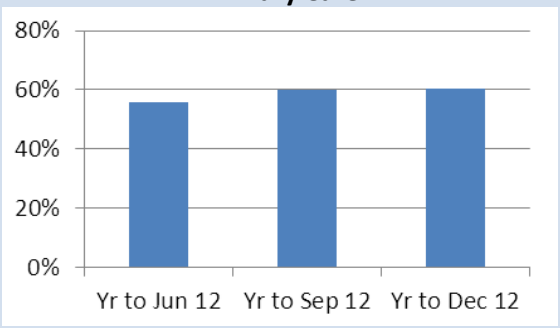
The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.

Smoking Cessation

Hospital

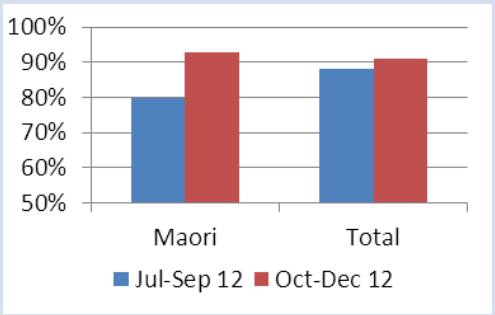


Primary Care

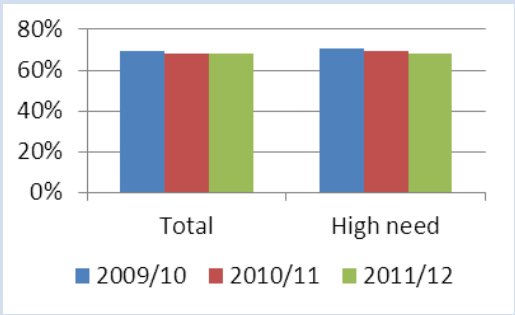


Immunisation

8 months



65+ Flu Immunisation



PERFORMANCE MEASURES

The DHB will monitor performance for 2013/14 with the following outputs:

Measure	Type of Measure	Baseline	Target 2013/14	National
Health Promotion Services				
The number of schools and early childhood services receiving health promotion visits	V	32	**45**	
The number of new client referrals by school health nurses	V	549	**550**	
The percentage of infants exclusively and fully breastfed at 6 months	C	31%[3]	**27%**[4]	
Immunisation Services				
Health Target: The percentage of eight month olds fully vaccinated[5]	C	91%	**90%**	89%
The percentage of Yr 7 children vaccinated in schools	C	84%	**85%**	
The percentage of Yr 8 girls vaccinated against HPV	C	66%	**68%**	
The percentage of enrolled people over 65 years vaccinated against flu[6]	C	68%	**69%**	
High Needs		68%	**69%**	
Smoking Cessation Services				
Health Target: The percentage of hospitalised smokers receiving advice and help to quit	C	98%	**95%**	95%
Health Target: The percentage of enrolled patients who smoke and are seen in General Practice who are offered brief advice and support to quit smoking	C	60%	**90%**	43%

[3] Based on Plunket data
[4] National target
[5] October-December 2012 baselines for Health Targets in this output class
[6] As at December 2012

EARLY DETECTION AND MANAGMENT

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. Include 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 more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

- On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

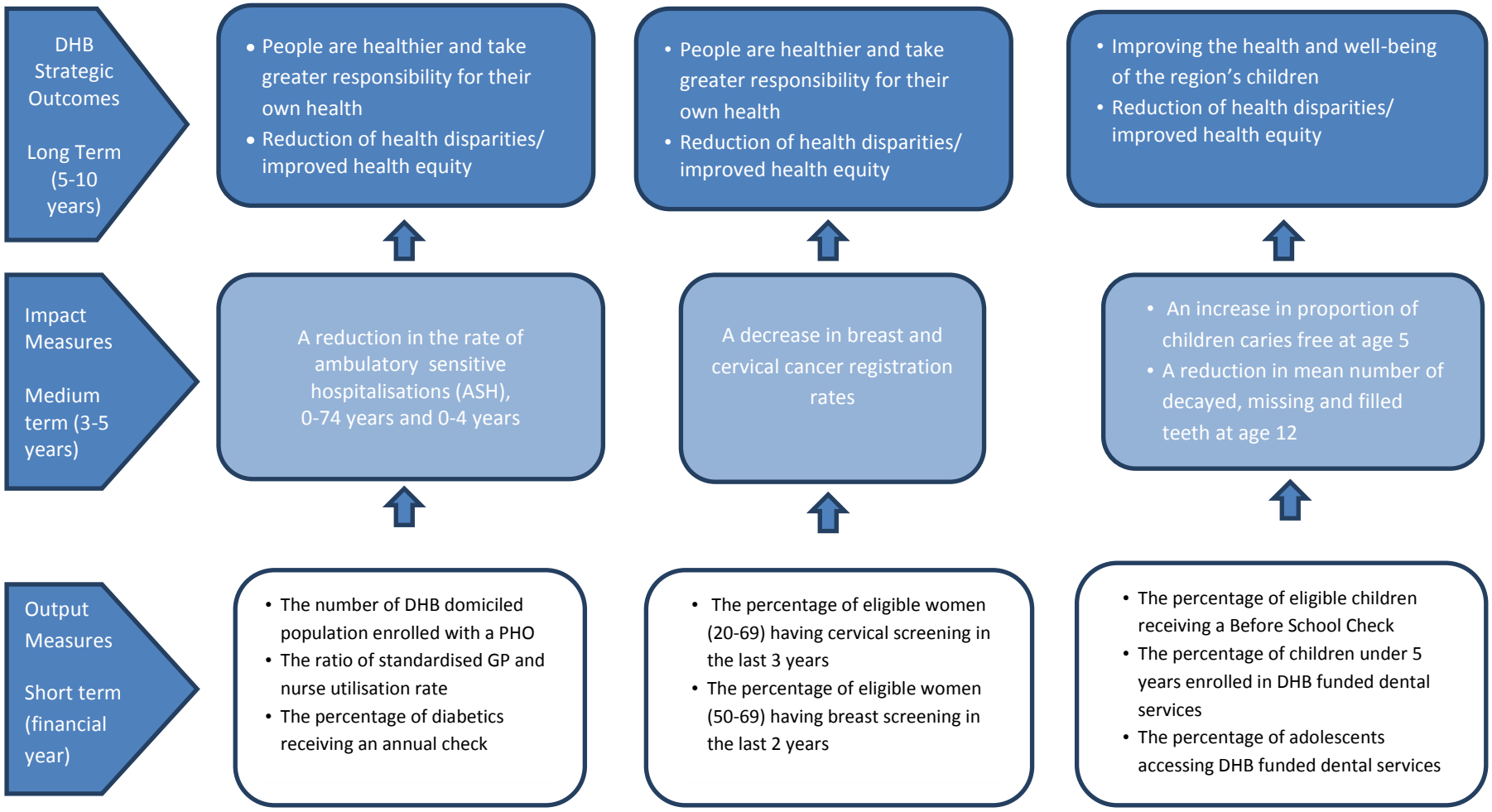
Local Environment

There is one Primary Healthcare Organisation (PHO) in the Wairarapa; Compass Health has 7 practices in the district. In addition, a range of NGOs and private businesses provide primary care services often targeted at specific population groups, or providing particular services in addition to those provided by GPs or Practice Nurses. In addition to national programmes, Wairarapa DHB supports a number of local primary health care programmes including:

The Community Dental Service encompasses the Wairarapa Hospital Dental Unit and the School Dental Service. Adolescent oral health services are delivered by private dentists contracted by the DHB.

The Community Pharmacist Service is provided for the Wairarapa population by 7 pharmacies in the district. Some prescriptions are filled by pharmacies outside of the district. The Community Referred Laboratory Service is provided under contract by Medlab Central.

Intervention Logic: Early Detection and Management Output Class

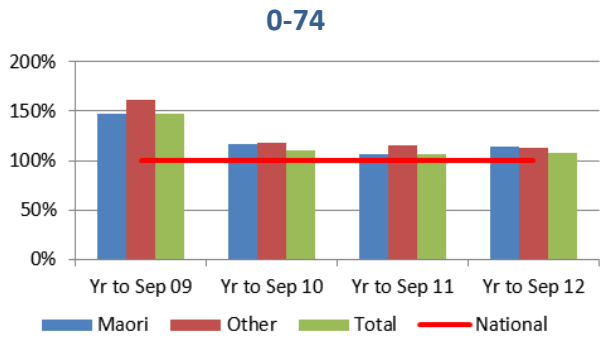


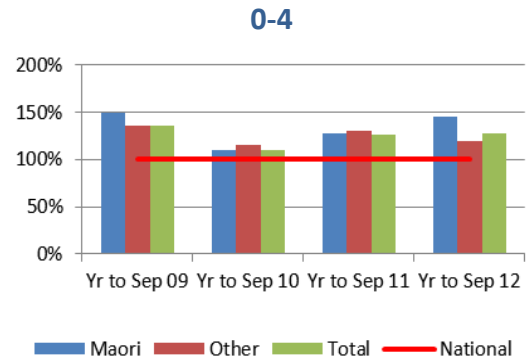
Impacts

Impacts are medium-term results from activities that give an indication of progress towards desired outcomes. As these are medium-term measures they are not all available on an annual basis, and therefore are not part of the annual targets of performance. The impacts the DHB intends to make from outputs in this class are:

A reduction in ambulatory sensitive hospitalisation (ASH) rates, 0-74 and 0-4

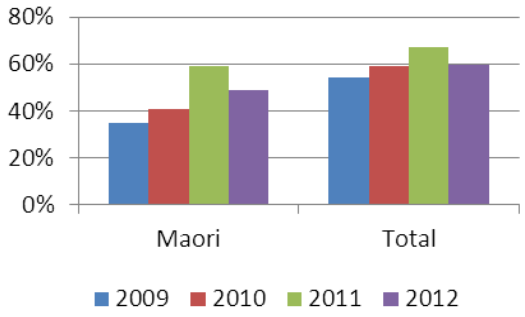
- There are a number of admissions to hospital which are seen as preventable through appropriate early intervention and a reduction of risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention, and the continuum of care across the system.
- The rate of preventable hospitalisations represents a substantial and avoidable burden on the health system and highlights opportunities to better support people to seek intervention early and manage their long-term conditions. A reduction in these admissions will reflect better management and treatment across the whole system.





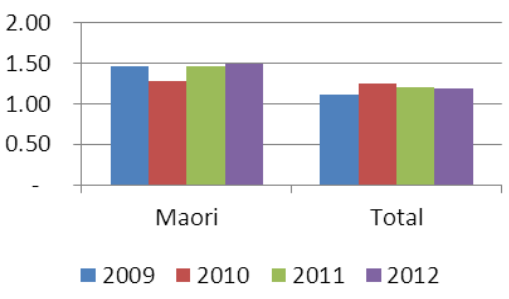
An increase in the proportion of children caries free at 5 years

- Regular dental care has life-long benefits for improved health. While water fluoridation can significantly reduce tooth decay across all population groups, prevention and education initiatives are essential to good oral health.
- Oral health outcomes are a good proxy measure of early contact with effective health promotion and prevention services. It also serves as an indicator of risk factors, such as poor diet, and therefore can provide other benefits in terms of improved nutrition and healthier body weights.



A decrease in the mean number of decayed, missing and filled teeth at 12 years

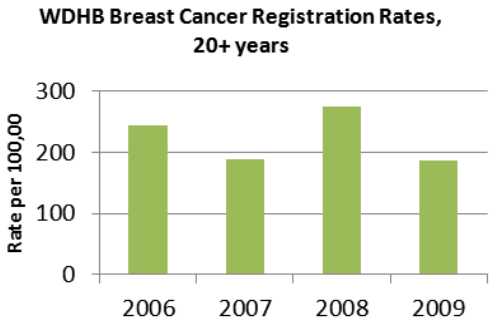
- Māori and Pacific children are more likely to have decayed, missing or filled teeth, and improved oral health is a good proxy measure of equity of access to services and the effectiveness of mainstream services in targeting those most in need.

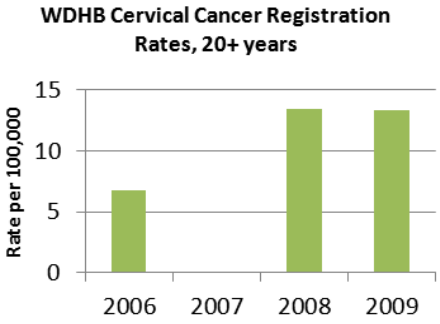


A decrease in the breast and cervical cancer registration rates

- Breast screening reduces the chances of dying from breast cancer by about 30% if aged between 50-65 and by about 45% if aged between 65-69. Cervical screening reduces the chance of developing cervical cancer by about 90%.

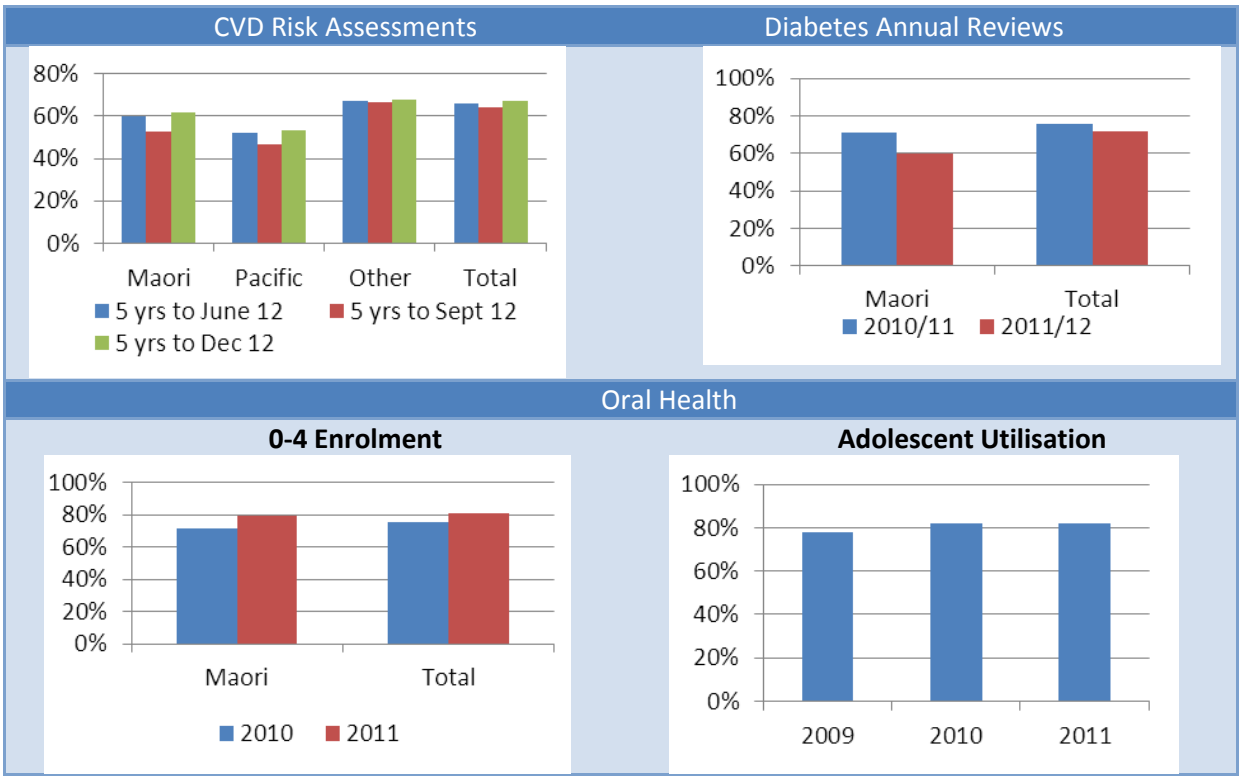
- To assess the impact of screening programmes over the medium term, Wairarapa DHB monitors cancer registration rates (incidence). WDHB has not set targets for this indicator due to the time lag in cancer registration data becoming available.





HISTORICAL PERFORMANCE

The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.



PERFORMANCE MEASURES

The DHB will monitor performance for 2013/14 with the following outputs:

Measure	Type of Measure	Baseline[7]	Target 2013/14	National
Primary Care Services				
The number of DHB domiciled population enrolled in a PHO	V	41,823	**41,823**	
Māori		6,511	**6,511**	
The ratio (high need: non high need) of standardised GP and nurse utilisation rate	V	1.16	**>1.16**	
Health Target: The percentage of the eligible population assessed for CVD risk in the last five years	C	67%	**90%**	55%
The percentage of diabetics receiving an annual check	C	72%	**90%**	
The percentage of practices with a diabetes care improvement plan	Q	-	**100%**	
Screening Services				
The percentage of eligible children receiving a Before School Check	C	99%	**≥90%**	
High Need		94%	**≥90%**	
The percentage of eligible women (20-69) having cervical screening in the last 3 years[8]	C	82%	**≥80%**	
Māori		78%	**80%**	
The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	76%	**≥70%**	
Māori		77%	**≥70%**	

Oral Health Services					
Measure	Type of Measure	Baseline 2012	**Target**		National
As oral health measures are reported on a calendar year the Ministry of Health requests targets be specified for each year.			**2013**	**2014**	
The percentage of children under 5 years enrolled in DHB funded dental services	C	77%	**85%**	**85%**	63%
The percentage of adolescents accessing DHB funded dental services	C	82%[9]	**85%**	**85%**	72%

[7] Baselines year to December 2012

[8] Data from National Screening Unit for breast and cervical screening. Targets aligned to national targets. Baseline for Cervical screening for 3 yrs to 31 December 2012.

[9] 2011 year. Finalised data for 2012 not yet available.

INTENSIVE ASSESSMENT AND TREATMENT SERVICES
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:

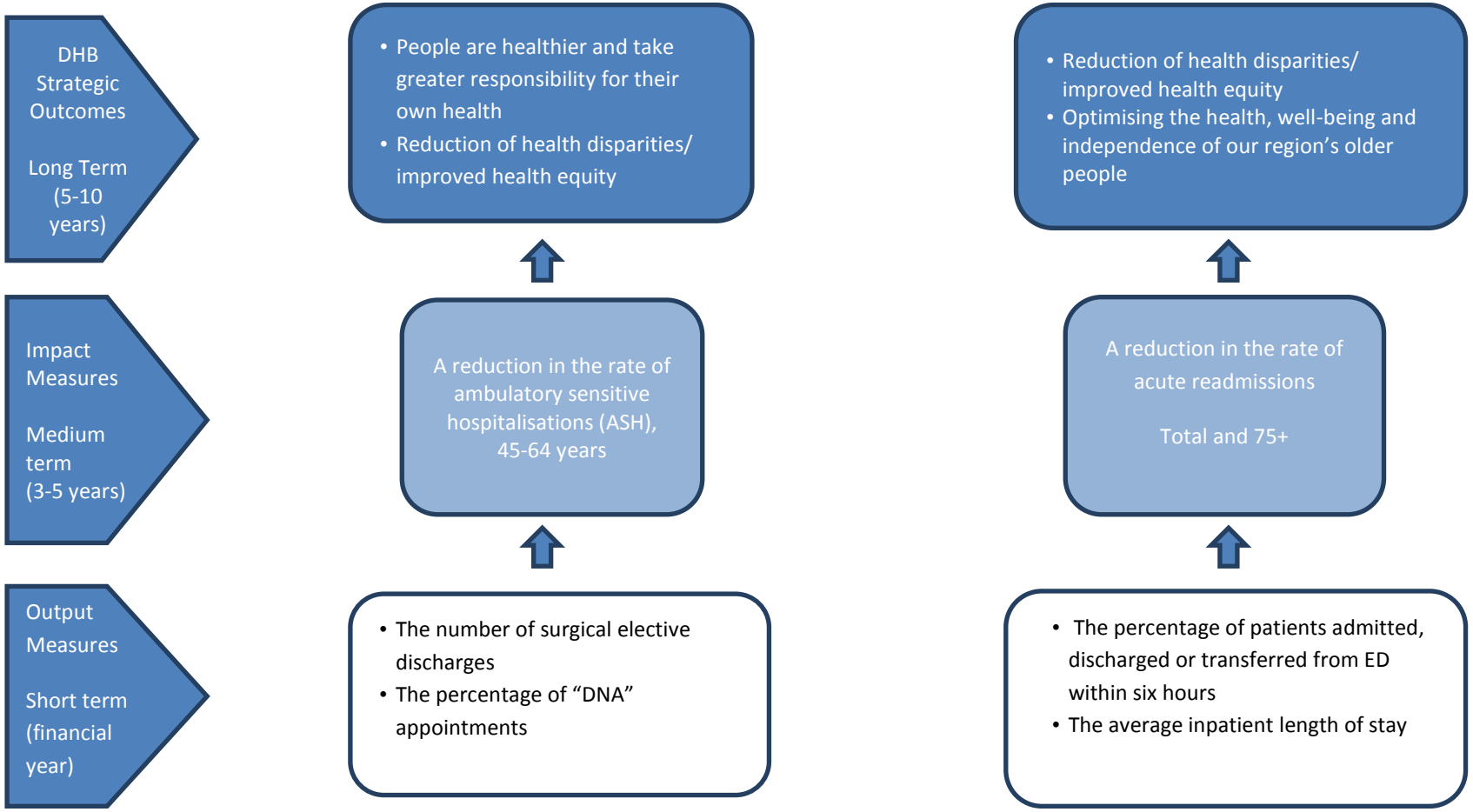
  - Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
  - Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
  - Emergency Department services including triage, diagnostic, therapeutic and disposition services
- On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

Local Environment
Medical services include emergency department and the medical services that manage patients with chronic illnesses and those that present to the hospital with an acute illness. The services involve both inpatient and outpatient streams.

Wairarapa DHB does not deliver cancer services and patients are referred to Capital & Coast DHB or MidCentral DHB for cancer treatment services.

The Ministry of Health estimates that those in highest need of mental health services represent around 3% of the population. Wairarapa DHB currently funds Mental Health and Addiction Services provided by Wairarapa Hospital and NGO providers, including a range of regional specialty services primarily delivered by Capital & Coast DHB. These services include Alcohol and Drug Rehabilitation services, Day services, Māori Health services, and the Hutt Valley DHB based Central Regional Eating Disorder Services.

Intervention Logic: Intensive Assessment and Treatment Services

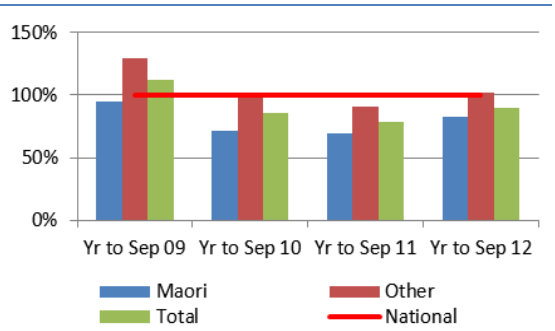


Impacts

Impacts are medium-term results from activities that give an indication of progress towards desired outcomes. As these are medium-term measures they are not all available on an annual basis, and therefore are not part of the annual targets of performance. The impacts the DHB intends to make from outputs in this class are:

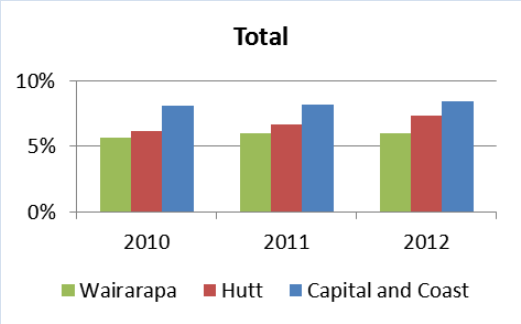
A reduction in ambulatory sensitive hospitalisation (ASH) rates, 45-64

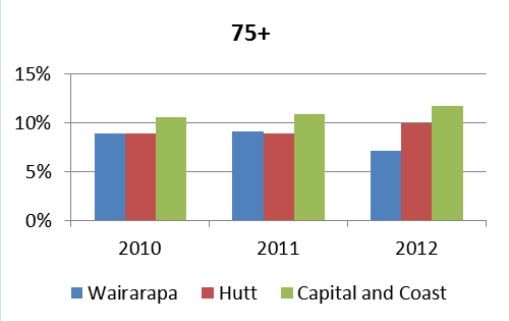
- There are a number of admissions to hospital which are seen as preventable through appropriate early intervention and a reduction of risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention, and the continuum of care across the system.
- The rate of preventable hospitalisations represents a substantial and avoidable burden on the health system and highlights opportunities to better support people to seek intervention early and manage their long-term conditions. A reduction in these admissions will reflect better management and treatment across the whole system.



A reduction in acute readmissions, Total & 75+

- Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services. Through the intermediate outcome that people receive better health and disability services, the measure contributes to the high level outcome of WDHB residents living longer, healthier and more independent lives.
- The following actions and activities are examples of initiatives that have a proven impact on this measure:
  - Focus on effective management of long term conditions
  - Process mapping and redesign of patient pathways
  - Initiatives to improve hospital discharge processes
  - Appropriate referral from secondary to primary and community based services[10]

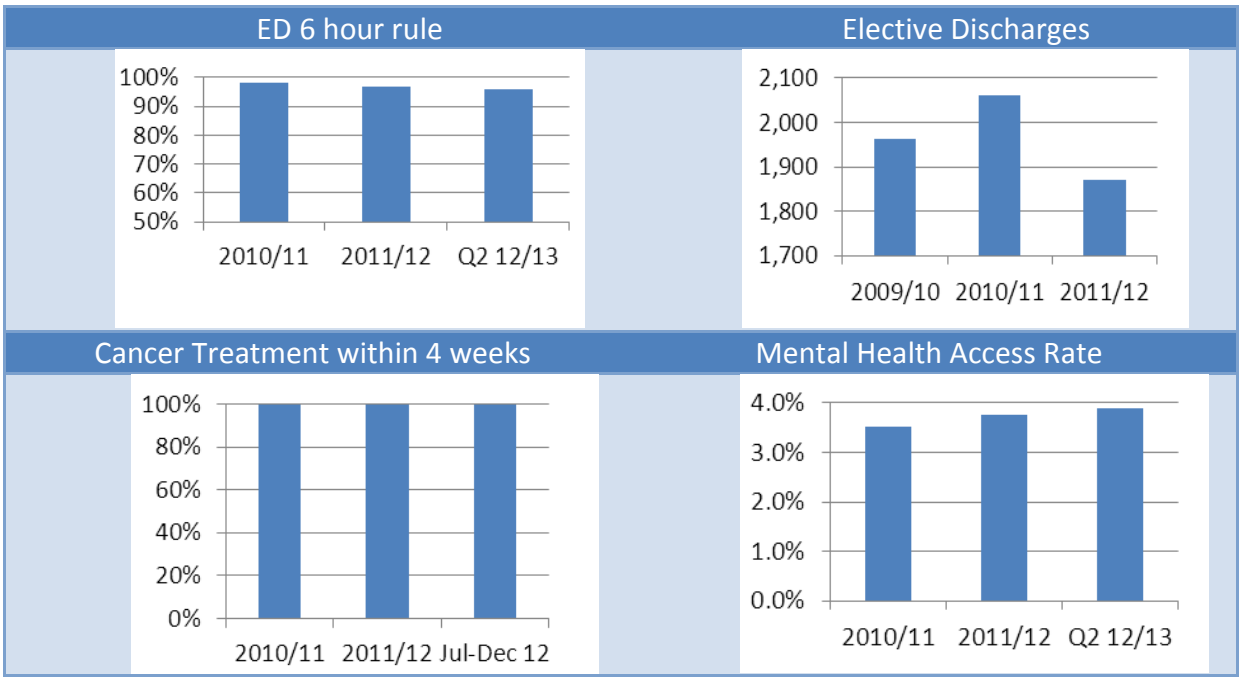




[10] Ministry of Health Non-Financial Reporting Template, 2012/13

HISTORICAL PERFORMANCE

The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.



PERFORMANCE MEASURES

The DHB will monitor performance for 2013/14 with the following outputs:

Measure	Type of Measure	Baseline	Target 2013/14	National
Medical and Surgical Services				
Health Target: The percentage of patients admitted, discharged or transferred from ED within six hours	T	97%	**95%**	93%
Health Target: The number of surgical elective discharges	V	1,841	**1,841**	
The average length of stay for inpatients (days) - Acute	T	4.22	**4.22**	4.52
Elective		3.48	**3.48**	3.43
Quality Measures				
The percentage of "DNA" (did not attend) appointments for outpatients	Q	9%	**7%**	
Māori		19%	**17%**	
The ratio of first specialists assessments (medical & surgical) to follow up appointments	Q	1: 1.7	**<1: 1.7**	
The rate of falls per 1000 bed days	Q	4.5%	**<4.5%**	
The rate of medication errors per 1000 bed days	Q	2.9%	**<2.9**	
Cancer Services				
Health Target: The percentage of patients, ready for treatment, who wait less than four weeks for radiotherapy or chemotherapy	T	100%	**100%**	

Measure	Type of Measure	Baseline	Target 2013/14	National
Mental Health and Addictions Services				
The percentage of people accessing secondary mental health services	C	3.89%	**3.89%**	
The percentage of people accessing secondary mental health services, 0-19		4.43%	**4.71%**	
Māori		4.8%	**4.71%**	
The percentage of people accessing secondary mental health services, 20-64		4.43%	**4.57%**	
Māori		8.6%	**4.57%**	
The percentage of long term clients who have up-to-date relapse prevention plans	Q	93%	**95%**	
The percentage of patients referred to non-urgent mental health services who are seen within eight weeks	T	95%	**95%**	
The percentage of patients referred to non-urgent addictions services who are seen within eight weeks	T	82%	**95%**	

REHABILITATION AND SUPPORT

Output Class Description

- Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by 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.

Local Environment

The population of older people (65 years and over) in the district is 8,373[11] or 21% of the Wairarapa total population compared with 14% for New Zealand. The Hutt Valley 65 plus population is projected to increase by 54% between 2012 and 2026. Contracted providers include 15 aged residential care facilities; which provide a mix of rest home, hospital, dementia, psycho-geriatric, day support and respite care services. Two home based support providers cover the Wairarapa. Wairarapa hospital provides a specialist multidisciplinary rehabilitation service for people over the age of 65.

Palliative care is care provided to terminally ill people to assist them to make the most of their life that remains and to ensure that patients die comfortably. Wairarapa DHB provides care for patients at home by community nurses; specialist palliative care nursing advice and assistance; and education and training for general health professionals. Te Omanga provides a specialist medical service including a weekly clinic in Wairarapa and 24/7 telephone advice for local doctors. General Practice Teams refer patients to the service and provide general ongoing care for patients in the community, including at home.

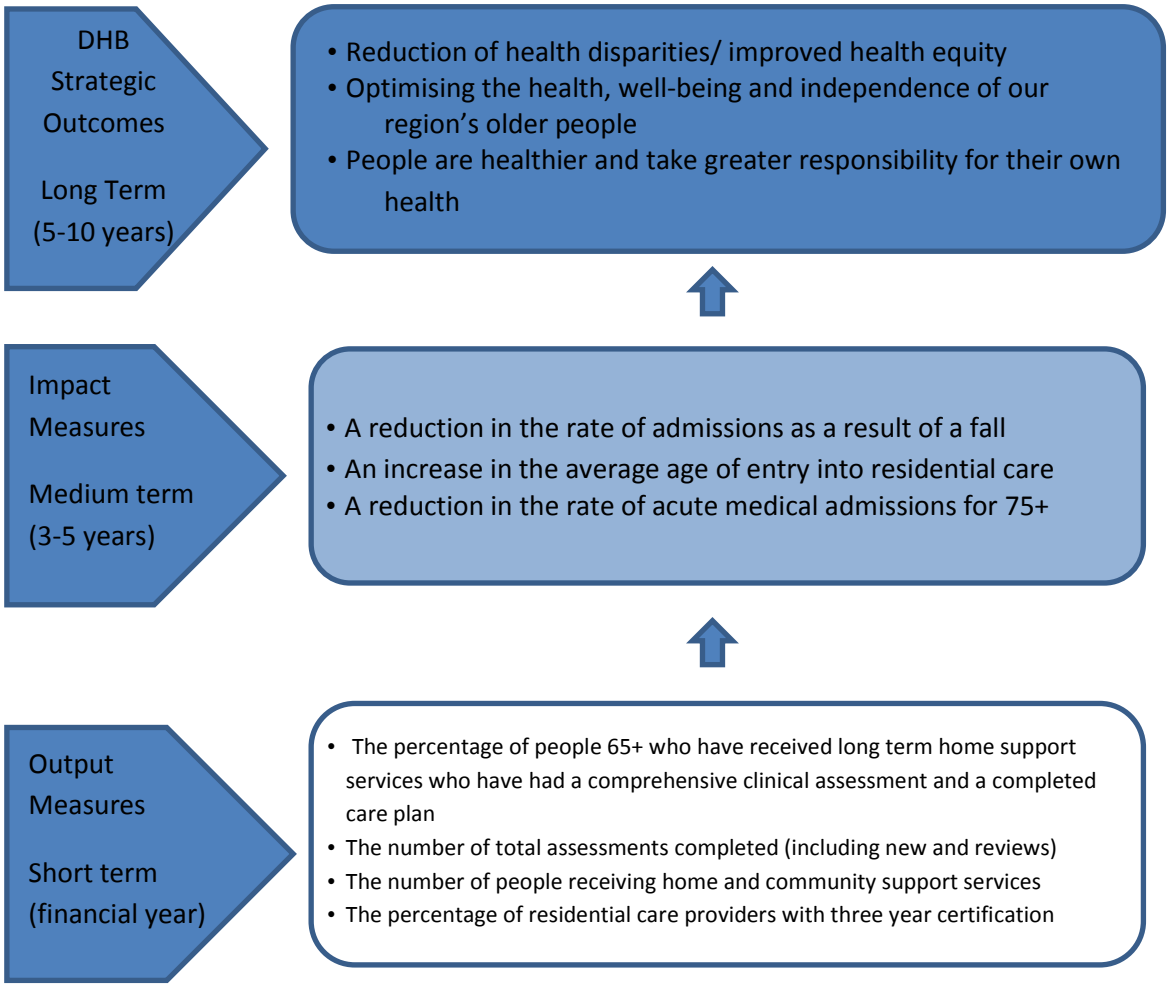
The DHB seeks to improve accessibility and responsiveness of services to people with disabilities. Disability relates to the interaction between the person with the impairment and the environment. The focus for the WDHB is twofold, 1) to work cross-sectorally to ensure that disability needs are

[11] Based on Statistics New Zealand projections for 2013/14

met as part of WDHB health (business as usual) services and 2) where business as usual cannot meet a need, examine and implement activity to ensure that there is ease of access to services for disabled people.

Wairarapa DHB provides a range of services to support older people maintain their health and to recover from illness or injury. These include physiotherapy, occupational health, dietetic, community nursing, and social work services.

Intervention Logic: Rehabilitation and Support Output Class

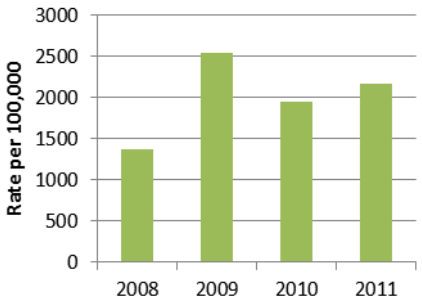


Impacts

Impacts are medium-term results from activities that give an indication of progress towards desired outcomes. As these are medium-term measures they are not all available on an annual basis, and therefore are not part of the annual targets of performance. The impacts the DHB intends to make from outputs in this class are:

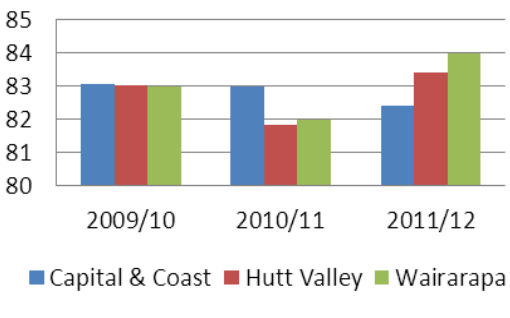
A reduction in the rate of admissions as a result of a fall, 65+

- Falls are a commonly used indicator in the health older persons sector, both nationally and internationally. High rates of falls can be associated with: osteoporosis, lack of physical activity, medications, impaired vision, and environmental hazards.[12] People who suffer a fall tend to have poorer health outcomes after the fall incident, and therefore reducing falls will improve the health of our older people.
- Improved performance to this measure will promote and protect good health and independence, as older people will be able to do more things for themselves and potentially remain in their own homes for longer. It will also reduce the impact on other services which provide treatment or interventions for falls.



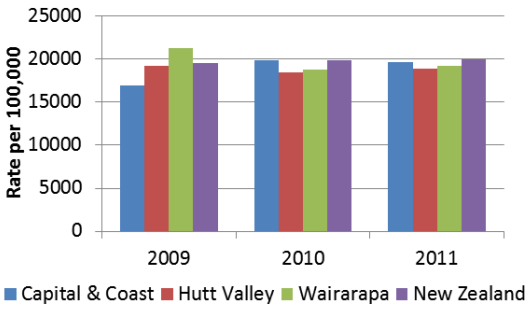
An increase in the average age of entry into Aged Residential Care

- With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. Increasing the average age of entry into Aged Residential Care is a marker of service configuration suitable to the population's needs.
- A 2008 study found that "…home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy."[13] This shows the importance of efforts to help older people maintain their independence.



A reduction in the rate of acute medical admissions for 65+

- Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of acute care, in the hospital and/or the community, ensuring that people receive better health and disability services. Through the intermediate outcome that people receive better health and disability services, the measure contributes to the high level outcome of WDHB residents living longer, healthier and more independent lives.
- The following actions and activities are examples of initiatives that have a proven impact on this measure:
  - Focus on effective management of long term conditions



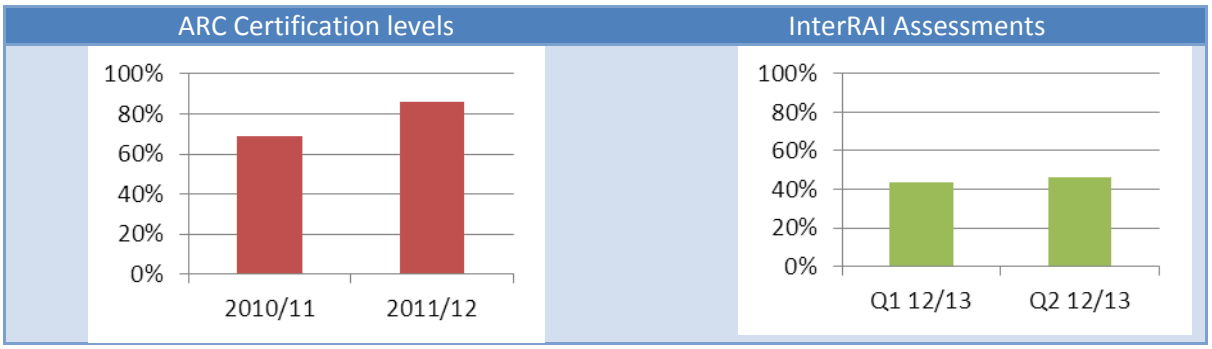
[12] Ministry of Health Non-Financial Reporting Template, 2011/12

[13] Hambleton, Penny, Sally Keeling, & Margaret McKenzie (2008). "Quality of Life is…:The Views of Older Recipients of Low-Level Home Support." *Social Policy Journal of New Zealand (33).*

- Process mapping and redesign of patient pathways
- Initiatives to improve hospital discharge processes
- Appropriate referral from secondary to primary and community based services[14]

HISTORICAL PERFORMANCE

The DHB has attained the following results for priority measures, which provides background on why targets have been set at current levels.



PERFORMANCE MEASURES

The DHB will monitor performance for 2013/14 with the following outputs:

Measure	Type of Measure	Baseline	Target 2013/14
The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan[15]	Q	46.5%	**>95%**
The number of total assessments (including new and review) [16]	V	557	**758**
The number of people receiving home and community support services	V	733	**740**
The number of home based support hours	V	92,910	**91,122**
The number of respite days	V	1,628	**1,258**
The number of subsidised aged residential care bed days	V	122,354	**123,000**
The percentage of residential care providers meeting three year certification standards[17]	Q	93%	**100%**
The number of Disability Forum meetings (subregional and local)	V		**2**

[14] Ministry of Health Non-Financial Reporting Template, 2012/13
[15] Data for Oct-Dec 2012 quarter. This is a new measure in 2012/13.
[16] Rather than a true target the DHB would like to achieve, it is expected that actual volumes will fall within a range around this level of expected volumes for this and the following five measures.
[17] Excluding new providers and facilities as these are required to have a one year certification.

MODULE 6: SERVICE CONFIGURATION

6.1 SERVICE COVERAGE

The three DHBs will meet all their obligations against the Ministry's Service Coverage Schedule for 2013/14. Nothing in the service change section below will impede Wairarapa, Hutt Valley, or Capital & Coast DHB's capacity to deliver against any of the service coverage levels agreed for 2013/14.

6.2 FUTURE PLANNED SERVICE CHANGE

The following areas of focus indicate possible areas that the 3 DHBs are currently aware of where there may be changes in 2013/14.

National

Pharmacy contracts

The ongoing implementation of new national agreements for Community Pharmacy will continue through 2013/14. However, this is not expected to have major service change impact.

Subregional

3DHB Work Programme

As described in Section 2.6, the 3DHB Programme is a subregional programme across Wairarapa, Hutt Valley and Capital & Coast DHBs, covering workstream areas such as clinical areas of focus, change enablers and financial sustainability projects. It should be noted that as this programme moves forward, any service changes that result will be managed in line with OPF Service Change requirements and communicated with MOH accordingly.

Value-for-money (VFM) Reviews

Consistent with the recommendations in the *3DHB Health Partners* report on achieving an improved financial position across the subregion in 2013/14, SIDU has undertaken to identify $7M of potential savings across the 3 DHBs (funders) from reviewing the value-for-money of current services.

The proposed savings have been 'allocated' to each DHB (broadly on the basis of population size) and included in 2013/14 budget assumptions for the DHBs (funders) as follows:

CCDHB - $4.2M

HVDHB - $2.1M

WDHB - $0.7M

The framework for this work is the 'triple aim' of improved health for all, an improved patient journey and best value-for-money from publicly-funded health care.

A review of a range of services will occur during the 2013/14 year as part of an ongoing programme of review. The impact of these reviews may impact on providers during the 2013/14 year. Reconfigurations may affect areas where a review has identified service areas to better align with subregional or local priorities, or identified as efficiency gains. The aims of the reviews will be to:

- Improve the quality, safety and experience of care delivery
- Ensure improvements in the health of populations by the provision of equitable access to services for the subregional population
- Ensure the provision of optimum service by maximising use of resources, in order to gain 'best value' from the public health system.

To date, contracts from all three DHBs due to expire in June 2013 have been reviewed using a single 'VFM' template. These have been considered by the SIDU internal 'Business Board', which

includes Māori, Pacific, clinical and disability representation. No specific contracts have been exited at this point as the approach is to consider the service model and appropriate delivery across the care continuum i.e. both community and hospital-based services, rather than focus on specific providers or contracts.

All providers whose contracts are expiring have been notified that they will be issued a new contract and that SIDU will be conducting an ongoing programme of service reviews as part of continuing work on service integration. The outcomes of the reviews may have implications for their services, which may require the contract to be modified or stopped (with three months' notice). There is a commitment that the reviews will be done in conjunction with providers.

Community Radiology
WDHB will implement the clinical access criteria for community radiology following finalisation of the regional community radiology access criteria by the Central Region Community Referred Radiology Access Criteria Working Group. The objective this work is to reduce the use of unnecessary investigations, with a view to expanding access and ensuring better quality care.

Community Referred Laboratory Services
The three DHBs are developing a laboratory strategy to inform boards of future directions and configuration of laboratory services across the subregion. An active procurement project based on the strategy document is planned to advance the integration of laboratory services in 2013/14. This project will ensure ongoing contractual arrangements are in place at the end of current contracts in October 2014 and is unlikely to impact on services in 2013/14.

Local

Primary Care
All 3 DHBs continue to develop and implement their integrated work programmes with the relevant local primary care and community partners. There may be possible future impacts on primary care services from these programmes, however at this stage it is not possible to identify the exact nature of these.

MODULE 7: FINANCIAL PERFORMANCE 2013 - 2016

7.1 FISCAL SUSTAINABILITY

Over the past ten years an increasing share of national expenditure has been allocated into the health budget. While 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 2013/14, 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. 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 2013/14 year Wairarapa DHB is forecasting a deficit of $1.2m, returning to breakeven for 2014/15 and 2015/16. The achievement of this financial result is dependent on the savings and efficiencies identified within the 3 DHB subregional financial plan being achieved. Further details on the 3 DHB subregional plan are included in section 2.4 and as noted below.

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.

7.3 3DHB Subregional Savings Plan

Following the submission of the 2012/13 Annual Plans by the three DHBs, the Minister of Health issued a letter requesting that the three DHBs submit a collective breakeven plan. The *3DHB Subregional Savings Plan* developed by Health Partners in collaboration with the three DHBs has subsequently been accepted by the Minister and the three DHB Boards, and proposes a range of projects and activities that will deliver improved financial performance across the three DHBs. Potential savings from initiatives in that report, which are part of the 3D HSD work programme, have been included in the budget assumptions for each DHB. These are allocated across the three DHBs total funding as follows:

Capital and Coast DHB $7.5m

Hutt Valley DHB $6.0m

Wairarapa DHB $1.9m

7.4 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 2011/12 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 appropriation is available to fund financial deficits that result in cash shortfalls.
- 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 subregional efficiencies as identified within the 3DHB subregional financial plan will be achieved.
- 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.

7.5 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.

An Asset Management Plan (AMP) across the 3-DHBs in the subregional collaboration will be required. This AMP will include a detailed review of the delivery of clinical services and the assets required to deliver on those clinical services to ensure the asset management practices 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 $1.5M of capital expenditure in 2013/14 which includes the investments into CRISP and the HBL lead FPSC programme. 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 and FPSC, the Wairarapa DHB has a very tightly constrained capital budget. Any sector initiatives through the NITB or HBL may require additional capital funding to be provided by the Crown to enable us to meet those obligations.

Business cases
Wairarapa DHB has two approved business case initiatives 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 lead FPSC programme: Wairarapa DHB is committed to the FPSC programme and has allocated the capital necessary to deliver on its obligations for this programme.

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

Asset valuation
Wairarapa DHB is planning to complete a full revaluation of its property and building assets at 30 June 2013 in line with generally accepted accounting practice requirements. No further revaluation is expected to be completed during the term of this Annual Plan.

7.6 DEBT AND EQUITY

Core debt
The DHB has a long-term debt facility of $25.75 million with the Debt Management Office (previously the Crown Health Financing Agency). The DHB's total term debt held with the Debt Management Office will be $25.75M as at June 2013. 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 Debt Management Office term liabilities are secured by a negative pledge. Without the Debt Management Office'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.

It is noted that $4.5M of core debt is due for refinancing within 2013/14. It is assumed that this will be refinanced to longer term arrangements. This amount is reflected in current liabilities as at 30 June 2013 in the projected statement of financial position 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.

Wairarapa DHB is part of the 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.

Equity drawing

Equity is drawn in the plan as follows ($m):

Equity Type	2013/14	2014/15	2015/16	Total
Equity for Capital Expenditure	0.0	0.0	0.0	0.0
Equity Deficit Support	1.2	0.0	0.0	1.2
Total	1.2	0.0	0.0	1.2

Note: excludes unapproved Business Cases

Equity is drawn for Capital Expenditure items which are over and above base depreciation and for deficit support.

Deficit support is planned as an equity injection to fund the cash flow shortfall in 2013/14.

7.7 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.

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 investments in both the CRISP and FPSC programmes include the acquisition of preference shares in Central Region Technical Advisory Services Ltd (CRTAS) and HBL respectively. 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.

7.8 PROSPECTIVE FINANCIAL STATEMENTS

The projected financial statements are shown in sections 7.9 to 7.17 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.

7.9 GROUP STATEMENT OF COMPREHENSIVE INCOME

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Income	**129,284**	**131,890**	**135,062**	**138,179**	**141,368**
Operating Expenditure					
Workforce costs	38,286	39,849	39,812	40,212	40,652
Other operating expenses	20,384	20,264	20,984	20,573	21,585
External providers	44,627	45,388	45,843	47,127	48,215
Inter district flows	26,696	26,050	26,226	26,831	27,450
Interest expense	1,619	1,390	1,174	1,186	1,198
Depreciation & amortisation	1,762	1,695	1,741	1,750	1,768
Capital charge	669	590	482	500	500
Total expenditure	**134,043**	**135,226**	**136,262**	**138,179**	**141,368**
Net surplus / (deficit) from continuing activities	**(4,759)**	**(3,336)**	**(1,200)**	**0**	**0**
Discontinuing Activities					
Ambulance services	(672)	0	0	0	0
Impairment on property valuation	(1,313)	0	0	0	0
Net surplus / (deficit) from discontinuing activities	**(1,985)**	**0**	**0**	**0**	**0**
Net surplus / (deficit)	**(6,744)**	**(3,336)**	**(1,200)**	**0**	**0**
Other comprehensive income					
Gain / (loss) on property revaluation	0	0	0	0	0
Total other comprehensive income	**0**	**0**	**0**	**0**	**0**
Total comprehensive income	**(6,744)**	**(3,336)**	**(1,200)**	**0**	**0**
Total comprehensive income attributed to:					
Wairarapa District Health Board	(6,744)	(3,336)	(1,200)	0	0
Non-controlling interest	0	0	0	0	0

7.10 GROUP STATEMENT OF FINANCIAL POSITION

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Non-current assets					
Property, plant & equipment	40,452	39,953	39,213	37,826	37,698
Intangible assets	1,382	839	1,073	1,357	1,390
Investments	294	2,623	3,204	3,918	3,969
Trust fund assets	255	312	250	250	250
Total non-current assets	**42,383**	**43,727**	**43,740**	**43,351**	**43,307**
Current assets					
Cash & cash equivalents	(1,120)	(1,817)	(2,000)	(1,609)	(1,451)
Inventories	767	830	830	800	800
Trade & other receivables	4,646	5,120	5,080	5,080	5,080
Assets classified as held for sale	1,125	0	0	0	0
Total current assets	**5,418**	**4,133**	**3,910**	**4,271**	**4,429**
Total assets	**47,801**	**47,860**	**47,650**	**47,622**	**47,736**
Equity					
Crown equity	34,247	37,330	38,527	38,524	38,521
Revaluation reserve	2,155	2,155	2,155	2,155	2,155
Retained earnings	(29,979)	(33,301)	(34,501)	(34,501)	(34,501)
Total equity	**6,423**	**6,184**	**6,181**	**6,178**	**6,175**
Non-current liabilities					
Interest-bearing loans & borrowings	20,362	21,765	22,081	21,497	20,663
Employee benefits	697	697	697	697	697
Trust funds	247	310	310	310	310
Total non-current liabilities	**21,306**	**22,772**	**23,088**	**22,504**	**21,670**
Current liabilities					
Interest-bearing loans & borrowings	6,127	4,575	4,575	5,075	5,825
Payables & accruals	8,190	8,592	8,169	8,103	8,304
Employee benefits	5,755	5,737	5,637	5,762	5,762
Total current liabilities	**20,072**	**18,904**	**18,381**	**18,940**	**19,891**
Total liabilities	**41,378**	**41,676**	**41,469**	**41,444**	**41,561**
Total equity & liabilities	**47,801**	**47,860**	**47,650**	**47,622**	**47,736**

7.11 GROUP STATEMENT OF MOVEMENTS IN EQUITY

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Balance at 1 July	**8,349**	**6,423**	**6,184**	**6,181**	**6,178**
Net surplus / (deficit) for the year	(6,744)	(3,336)	(1,200)	0	0
Other comprehensive income	0	0	0	0	0
Total comprehensive income	**(6,744)**	**(3,336)**	**(1,200)**	**0**	**0**
Equity injection from the Crown	4,821	3,100	1,200	0	0
Repayment of equity to the Crown	(3)	(3)	(3)	(3)	(3)
Movements in equity for the year	**4,818**	**3,097**	**1,197**	**(3)**	**(3)**
Balance at 30 June	**6,423**	**6,184**	**6,181**	**6,178**	**6,175**
Total comprehensive income attributed to:					
Wairarapa District Health Board	(6,744)	(3,336)	(1,200)	0	0
Non-controlling interest	0	0	0	0	0
Total comprehensive income	**(6,744)**	**(3,336)**	**(1,200)**	**0**	**0**

7.12 GROUP STATEMENT OF CASHFLOW

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Cash flows from operating activities					
Operating receipts:					
Government & crown agency sourced	119,127	122,150	124,783	127,666	130,615
Other	10,883	9,740	10,254	10,488	10,727
Interest received	119	16	33	34	34
Payments to suppliers & employees	(131,665)	(133,701)	(133,556)	(134,663)	(137,910)
Capital charge paid	(669)	(590)	(482)	(500)	(500)
Interest paid	(1,619)	(1,390)	(1,174)	(1,186)	(1,198)
Goods & Services Tax (net)	(28)	0	0	0	0
Net cash flows from operating activities	**(3,852)**	**(3,775)**	**(142)**	**1,839**	**1,768**
Cash flows from investing activities					
Proceeds from sale of property, plant & equipment	348	1,704	0	0	0
Dividends received	0	0	0	0	0
Acquisition of property, plant & equipment	(1,143)	(1,101)	(616)	(175)	(1,250)
Acquisition of intangible assets	(211)	(150)	(200)	(150)	(222)
Investment in joint venture	(294)	(323)	(738)	(1,036)	(51)
Net cash flows from investing activities	**(1,300)**	**130**	**(1,554)**	**(1,361)**	**(1,523)**
Cash flows from financing activities					
Loans drawn down	1,063	0	400	0	0
Equity injected	4,815	3,100	1,200	0	0
Repayment of loans	(135)	(149)	(84)	(84)	(84)
Repayment of equity	(3)	(3)	(3)	(3)	(3)
Restricted fund movement	12				
Net cash flows from financing activities	**5,752**	**2,948**	**1,513**	**(87)**	**(87)**
Net increase / (decrease) in cash held	**600**	**(697)**	**(183)**	**391**	**158**
Cash & cash equivalents at beginning of year	(1,720)	(1,120)	(1,817)	(2,000)	(1,609)
Cash & cash equivalents at end of year	**(1,120)**	**(1,817)**	**(2,000)**	**(1,609)**	**(1,451)**

7.13 SUMMARY COST OF SERVICES STATEMENT

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Expenditure					
Prevention services	3,289	3,263	3,145	3,217	3,292
Early detection & management services	43,522	41,867	41,195	42,146	43,119
Intensive assessment & treatment services	69,121	71,902	73,024	73,482	75,178
Rehabilitation & support services	18,111	18,194	18,898	19,334	19,779
Total expenditure	**134,043**	**135,226**	**136,262**	**138,179**	**141,368**
Income					
Prevention services	2,647	2,504	2,507	2,565	2,624
Early detection & management services	41,497	42,366	42,069	43,040	44,033
Intensive assessment & treatment services	67,333	68,031	70,391	72,015	73,678
Rehabilitation & support services	17,807	18,989	20,095	20,559	21,033
Total income	**129,284**	**131,890**	**135,062**	**138,179**	**141,368**
Net result of service	**(4,759)**	**(3,336)**	**(1,200)**	**0**	**0**
Non Output Class Costs					
Net loss on disposal of discontinued activity assets	(672)	0	0	0	0
Impairment on property valuations	(1,313)	0	0	0	0
Total non output class costs	**(1,985)**	**0**	**0**	**0**	**0**
Net Result of Service	**(6,744)**	**(3,336)**	**(1,200)**	**0**	**0**

7.14 COST OF SERVICES STATEMENT: PREVENTION SERVICES

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Expenditure					
Workforce costs	940	848	811	830	849
Other operating expenses	323	100	158	161	165
External providers	730	947	950	972	995
Inter district flows	0	0	0	0	0
Depreciation & amortisation	98	98	97	99	101
Total expenditure	**2,091**	**1,993**	**2,016**	**2,062**	**2,110**
Allocation of corporate costs	1,198	1,270	1,129	1,155	1,182
Total cost of services	**3,289**	**3,263**	**3,145**	**3,217**	**3,292**
Income	2,647	2,504	2,507	2,565	2,624
Net result of service	**(642)**	**(759)**	**(638)**	**(652)**	**(668)**

7.15 COST OF SERVICES STATEMENT: EARLY DETECTION & MANAGEMENT SERVICES

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Expenditure					
Workforce costs	6,398	6,222	6,621	6,774	6,930
Other operating expenses	2,197	1,709	1,818	1,860	1,903
External providers	29,377	29,433	29,336	30,013	30,706
Inter district flows	1,910	1,855	1,617	1,654	1,692
Depreciation & amortisation	115	25	53	54	56
Total expenditure	**39,997**	**39,244**	**39,445**	**40,355**	**41,287**
Allocation of corporate costs	3,525	2,623	1,750	1,791	1,832
Total cost of services	**43,522**	**41,867**	**41,195**	**42,146**	**43,119**
Income	41,497	42,366	42,069	43,040	44,033
Net result of service	**(2,025)**	**499**	**874**	**894**	**914**

7.16 COST OF SERVICES STATEMENT: INTENSIVE ASSESSMENT & TREATMENT SERVICES

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Expenditure					
Workforce costs	25,239	26,211	26,110	26,191	26,310
Other operating expenses	10,530	11,260	13,681	13,096	13,943
External providers	233	806	843	1,088	1,113
Inter district flows	23,097	22,632	22,943	23,473	24,014
Depreciation & amortisation	546	508	501	482	471
Total expenditure	**59,645**	**61,417**	**64,078**	**64,330**	**65,851**
Allocation of corporate costs	9,476	10,485	8,946	9,152	9,327
Total cost of services	**69,121**	**71,902**	**73,024**	**73,482**	**75,178**
Income	67,333	68,031	70,391	72,015	73,678
Net result of service	**(1,788)**	**(3,871)**	**(2,633)**	**(1,467)**	**(1,500)**

7.17 COST OF SERVICES STATEMENT: REHABILITATION & SUPPORT SERVICES

	2011/12 Actual $000	2012/13 Forecast $000	2013/14 Projection $000	2014/15 Projection $000	2015/16 Projection $000
Expenditure					
Workforce costs	790	753	924	945	967
Other operating expenses	482	615	621	636	650
External providers	14,287	14,365	15,336	15,690	16,052
Inter district flows	1,688	1,564	1,666	1,704	1,743
Depreciation & amortisation	0	0	0	0	0
Total expenditure	**17,247**	**17,297**	**18,547**	**18,975**	**19,412**
Allocation of corporate costs	864	897	351	359	367
Total cost of services	**18,111**	**18,194**	**18,898**	**19,334**	**19,779**
Income	17,807	18,989	20,095	20,559	21,033
Net result of service	**(304)**	**795**	**1,197**	**1,225**	**1,254**

MODULE 8: APPENDICES

APPENDIX 8.1: MONITORING FRAMEWORK PERFORMANCE MEASURES

2013/14 Non-Financial Monitoring Framework

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

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

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

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership

Performance measure	2013/14 Performance expectation/target				2013/14 Target CCDHB	HVDHB	Wairarapa
PP1: Workforce – Improving clinical leadership	Report progress of DHB work to improve clinical leadership and engagement across all levels of the DHB and the Regional Training Hubs.						
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	Māori			3.58%	3.84%	**4.71%**
		Total			3.58%	3.84%	**4.71%**
	Age 20-64	Māori			3.20%	4.14%	**4.57%**
		Total			3.20%	4.14%	**4.57%**
PP7: Improving mental health services using relapse prevention planning	Adult 20+				95%	95%	**95%**
PP8: Shorter waits for non-urgent mental health and addiction services	Mental Health Provider Arm						
	Age	<= 3 weeks			<=8 weeks		
		CC	HV	W			
	0-19	70%	70%	**80%**	90%	95%	**95%**
	20-64	80%	75%	**80%**	95%	95%	**95%**
	65+	80%	75%	**80%**	95%	95%	**95%**
	Total	80%	70%	**80%**	95%	95%	**95%**
	Addictions (Provider Arm and NGO)						
	Age	<= 3 weeks			<=8 weeks		

Performance measure	2013/14 Performance expectation/target				2013/14 Target		
					CCDHB	HVDHB	Wairarapa
		CC	HV	W			
	0-19	70%	80%	**70%**	95%	95%	**95%**
	20-64	70%	70%	**70%**	95%	90%	**95%**
	65+	75%	75%	**70%**	95%	90%	**95%**
	Total	70%	75%	**70%**	95%	90%	**95%**
PP10: Oral Health- Mean DMFT score at Year 8	Mean year 1 (2013)				0.67	0.81	**1.19**
	Mean year 2 (2014)				0.67	0.81	**1.15**
PP11: Children caries-free at five years of age	Ratio year 1 (2013)				69%	69.85%	**62%**
	Ratio year 2 (2014)				69%	69.85%	**64%**
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1 (2013)				70%	85%	**85%**
	% year 2 (2014)				85%	85%	**85%**
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1 (2013)				65%	65%	**85%**
	0-4 years - % year 2 (2014)				85%	85%	**85%**
	Children not examined 0-12 years % year 1 (2013)				15%	15%	**5%**
	Children not examined 0-12 years % year 2 (2014)				15%	15%	**5%**
PP18: Improving community support to maintain the independence of older people	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan				>95%	>95%	**>95%**
PP20: improved management for long term conditions (CVD, diabetes and Stroke)[18]	>70 percent of high-risk ACS patients accepted for coronary angiography will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')				>70 percent of high-risk ACS patients accepted for coronary angiography will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')		
Focus area 1: Cardiovascular Disease	>95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection				>95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection		
Focus area 2: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed				6 percent of potentially eligible stroke patients thrombolysed		
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway				80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway		
Focus area 3a: Diabetes – Management	Maintain or improve appropriate management of microalbuminuria or				Maintain or improve appropriate management of		

[18] Subject to data availability and quality

Performance measure	2013/14 Performance expectation/target	2013/14 Target		
		CCDHB	HVDHB	Wairarapa
(MICROALBUMINURIA AND ON AN ACEi OR ARB)	overt nephropathy in patients with diabetes.	microalbuminuria or overt nephropathy in patients with diabetes. ***Baselines to be developed with primary care and MOH***		
Focus area 3b: Diabetes – Management (HbA1c)	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control.	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control. ***Baselines to be developed with primary care and MOH***		
PP21: Immunisation coverage (previous health target)	95 percent of two year olds are fully immunised	95%	95%	**95%**
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.			
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.			
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan.			
PP25: Prime Minister's youth mental health project	Provide a written stocktake, gaps analysis and actions being considered,			
PP26: The Mental Health & Addiction Service Development Plan	Provide gaps analysis and report against SDP milestones			
PP27: Delivery of the children's action plan	Demonstration site DHBs to report on actions and progress to support the successful establishment and on-going operation of Children's Teams	All DHBs to report on stocktake of services , gaps analysis and actions being considered across the care continuum to support vulnerable pregnant women, children and parents All DHBs to provide updates on actions to help reduce child assaults identified in the Annual Plan		
PP28: Reducing Rheumatic fever	Provide a progress report against DHB's rheumatic fever prevention plan			
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 10% lower than the average over the last 3 years	2.8 per 100,000	4.4 per 100,000	**0**
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	<95%	128%	**115%**
	Age 45-64	<95%	106%	**<95%**
	Age 0-74	<95%	116%	**104%**
SI2: Delivery of Regional Service Plans	A single progress report on behalf of the region agreed by all DHBs within that region			
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage			

Performance measure	2013/14 Performance expectation/target	2013/14 Target		
		CCDHB	HVDHB	Wairarapa
SI4: Standardised Intervention Rates (SIRs)	major joint replacement	**21.0 per 10,000**		
	cataract procedures	**27.0 per 10,000**		
	cardiac surgery (a target intervention rate of 6.5 per 10,000 of population) *If previous rate of 6.5 per 10,000 or above -maintain this rate.*	6.2 per 10,000	6.5 per 10,000	**6.5 per 10,000**
	percutaneous revascularization (a target rate of at least 11.9 per 10,000 of population)	**11.9 per 10,000**		
	coronary angiography services (a target rate of at least 33.9 per 10,000 of population)	**33.9 per 10,000**		
SI5: Delivery of Whānau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers.			
OS3: Inpatient Length of Stay	Elective LOS	3.21	3.21	**3.43**
	Acute LOS	4.30	4.60	**4.22**
OS8: Reducing Acute Readmissions to Hospital	% total pop	8%	≤7.4%	**≤6%**
	% 75 plus	11.5%	≤9.9%	**≤7.1%**
OS10: Improving the Quality of Data Submitted to National Collections	National Health Index (NHI) duplications - *Greater than 3.00% and less than or equal to 6.00%*	National Health Index (NHI) duplications - *Greater than 3.00% and less than or equal to 6.00%*		
	Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI. - *Greater than 0.50% and less than or equal to 2%*	Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI. - *Greater than 0.50% and less than or equal to 2%*		
	Standard vs. edited descriptors - *Greater than or equal to 75.00% and less than 90.00%*	Standard vs. edited descriptors - *Greater than or equal to 75.00% and less than 90.00%*		
	Timeliness of NMDS data - *Greater than 2.00% and less than or equal to 5.00% late*	Timeliness of NMDS data - *Greater than 2.00% and less than or equal to 5.00% late*		
	NNPAC Emergency Department admitted events have a matched NMDS event - *Greater than or equal to 97.00% and less than 99.50%*	NNPAC Emergency Department admitted events have a matched NMDS event - *Greater than or equal to 97.00% and less than 99.50%*		
	PRIMHD File Success Rate - *Greater than or equal to 98.0% and less than 99.5%*	PRIMHD File Success Rate - *Greater than or equal to 98.0% and less than 99.5%*		
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan			

APPENDIX 8.2: STATEMENT OF ACCOUNTING POLICIES

Reporting entity

Wairarapa District Health Board (the 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 2014 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 NZIFRS 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 2014.

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.
- 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 were first adopted for the year ended 20 June 2012.

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.

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.

APPENDIX 8.3 GLOSSARY OF TERMS

Term	Meaning
ACS	Acute coronary syndrome (ACS) refers to any group of symptoms attributed to obstruction of the coronary arteries.
Activity	In the context of Strategic Planning, Activities refers to the tasks, duties, projects, systems or processes that the planning entity uses to convert its Inputs (see Inputs) into Outputs (see Outputs).
ALOS	Average Length of Stay - a way of monitoring how long it takes for a particular health service to be delivered, from admission to discharge.
ALT	Alliance Leadership Team – the central decision making hub of an Alliance Contract, which provides a single flexible funding pool for doctors, nurses, pharmacists and other health professionals to pursue collaborative healthcare initiatives programmed by the Ministry of Health.
AMP	Asset Management Plan
AOD	Alcohol and Other Drugs
A/R	Wairarapa DHB Audit and Risk Committee
ASH	Ambulatory sensitive hospital admissions (ASH) are those admissions (mostly acute) that are considered by expert opinion to be potentially avoidable through interventions in out-of-hospital settings. They are an outcome indicator used to evaluate access to primary health care (e.g., GP visits).
B4SC	Before School Checks - one of the services offered under the Well Child/Tamariki Ora programme. This check occurs at age 4 to ensure any health issues that may affect learning are identified prior to the child beginning school.
BSMC	Better, Sooner, More Convenient – the name of the Government's initiative to promote increased primary/specialist integration and collaboration. The original BSMC discussion document, produced by health minister Tony Ryall, can be found online at: http://www.national.org.nz/files/__0_0_health_lowres.pdf
CAMHS	Child & Adolescent Mental Health Services.
CAP	The Children's Action Plan (CAP) provides a high level programme framework for the Government's White Paper for Vulnerable Children (2012). It outlines a range of cross-government interventions targeting vulnerable children who are at risk of harm now or in the future.
CCDHB	Capital & Coast District Health Board. The district health board covering Wellington, Porirua and Kapiti (excluding Te Horo, Otaki and Otaki Forks Census areas) Territorial Authorities
CEO	The Chief Executive Officer (CEO) holds the highest possible delegation from a District Health Board (under the Public Health and Disability Act) for management matters relating to that DHB
CFO	Chief Financial Officer. The COO holds a delegation from the CEO, usually for matters relating to routine management of financial information services.
COO	Chief Operating Officer. The COO holds a delegation from the CEO, usually for matters relating to routine management of hospital health services (HHS).

Term	Meaning
CPHAC	Community and Public Health Advisory Committee - one of the three advisory committees that DHBs are required to establish under the NZ Public Health and Disability Act .
CPSA	District Health Boards are responsible for funding community pharmacy services to 900 community pharmacies in New Zealand through the Community Pharmacy Services Agreement (CPSA). The Pharmacy Services Advisory Group (PSAG) was set up to provide advice on operational aspects relating to the Agreement and a review group advises on any necessary changes.
CRISP	The Central Region Information Systems Plan (CRISP) is a major Information and Communication Technology (ICT) work programme within the Central Region RSP. This programme will deliver a range of clinical information systems, and includes the development of a Central Region ICT Strategy.
CRTAS	Central Region Technical Advisory Services
CVD	Cardiovascular Disease - a class of diseases that involve the heart or blood vessels (arteries, capillaries, and veins)
DCIP	The Diabetes Care Improvement Package (DCIP) is a community and primary care based programme, building on core diabetes services that were already being provided, to improve outcomes for people with diabetes. The package may differ between DHBs, depending on the needs in the area. DHBs may choose to deliver this through innovative nurse-led services such as practice clinics, patient group education or community outreach, which may include the up skilling of staff.
DHB	District Health Boards (DHBs) were established by the Public Health and Disability Act to pursue the Act 's objectives. The Act also outlines the breadth of functions that DHBs have for the pursuit of their objectives.
DLT	Directorate Leadership Team - in the Wairarapa and Hutt Valley DHB bilateral restructure (March 2013), three directorates were created, each led by directorate leadership teams (DLTs).
DSAC	Disability Services Advisory Committee - one of the three advisory committees that DHBs are required to establish under the NZ Public Health and Disability Act .
ECE	Early childhood education (also early childhood learning and early education) refers to the formal teaching of young children by people outside the family or in settings outside the home. "Early childhood" is usually defined as before the age of normal schooling.
ED	Emergency Department
EQI	The Endoscopy Quality Improvement Programme (EQI) is a workforce development programme which aims to ensure all New Zealanders receive the same high standard endoscopy care, no matter where they live in the country. The programme is operationally based at the Bay of Plenty DHB, headed by clinical leaders Dr. David Theobald and Jenni Masters. The programme has been piloted at Waitemata, Lakes, Wairarapa and Canterbury DHBs and will be rolled-out nationally in stages, starting February 2013.

Term	Meaning
ERAS	Enhanced Recovery after Surgery (ERAS) programmes are also known as fast-track, rapid or accelerated surgery. The approach is evidence-based and involves a selected number of individual interventions that, when implemented as a group, demonstrate a greater impact on outcomes than would be the case if they were implemented individually. The underlying goal of ERAS is to enable patients to recover from surgery and leave hospital sooner, by minimising the stress responses on the body during surgery.
ESPIs	Elective Services Patient Flow Indicators - There are six ESPIs which the MOH uses to monitor the performance of DHB elective services within hospital & specialist services: - DHB services that appropriately acknowledge and process all patient referrals within 10 working days - Patients waiting longer than six months for their first specialist assessment (FSA) - Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT) - Patients given a commitment to treatment but not treated within six months - Patients in active review who have not received a clinical assessment within the last six months - The proportion of patients treated who were prioritised using nationally recognised processes or tools
ESPWP	The Elective Services Productivity and Workforce Programme (ESPWP) has been established with Cabinet approval to support and promote significant transformations in elective services productivity, and seeks proposals from DHBs to enhance elective services surgical discharges and productivity, patient outcomes, and cost effectiveness. The ESPWP supports the Government's policy of increasing average elective discharges nationally by 4000 per year, and there is a particular focus on DHBs who would need to increase their average discharges by more than 25% to meet their local demand over the next years.
FCT	The Faster Cancer Treatment (FCT) programme is part of the National Cancer Programme led by the Ministry of Health. It aims to improve the quality and timeliness of services for patients along the cancer pathway, and links with other programmes of work that will improve cancer diagnostic and treatment services.
FMIS	Finance Management Information System
GP	General Practitioner
HAC	Hospital Advisory Committees – responsible for monitoring the financial and operational performance of hospitals and related services
HBL	Health Benefits Limited. HBL is a shared services organisation set up to help DHBs deliver quality healthcare at a lower cost by working smarter and reducing duplication and administrative costs. HBL is owned by the New Zealand Government and is mandated to find ways of delivering greater quality to health delivery through more efficient processes.

Term	Meaning
HEEADSSS	The HEEADSSS assessment is a screening tool for conducting a comprehensive psychosocial history and health risk assessment with a young person. HEEADSSS also provides an ideal format for a preventive health check. It provides information about the young person's functioning in key areas of their life: H – Home E – Education & Employment E – Eating & Exercise A – Activities & Peer Relationships D – Drug Use/Cigarettes/Alcohol S – Sexuality S – Suicide and Depression S – Safety
HHS	Hospital Health Services - Health services managed and/or delivered by Hospital employees, as opposed to NGOs or community based organisations.
HVDHB	Hutt Valley District Health Board, covering Lower and Upper Hutt Territorial Authorities.
ICC	Integrated Care Collaborative – a CCDHB programme aimed at promoting increased integration and cooperation between primary and specialist services.
IDF	Inter-District Flow - a way of monitoring the funding exchanged between DHBs for services that are provided to each other's populations
IFHN	Integrated Family Health Network - a primary/specialist integration programme underpinning the Wairarapa DHB Tihei Wairarapa Primary Care
Inputs	Resources put into a system, or expended in its operation to achieve an output or result - in a strategic planning context this typically refers to resources within the control of the planning entity, such as funding, staff, time, rental and equipment, but can also include the contribution of other organizations in kind or in cash.
KPI	Key Performance Indicators (KPIs) refer to any essential data collection(s) required for performance monitoring. This data can be used to promote stakeholder accountability, to stimulate a desired level of performance, and to facilitate the effective exercise of routine management control. KPIs can be used to monitor the performance of specific activities, programmes, portfolios, polices or strategies.
LMC	Lead Maternity Carer - Most LMCs are midwives, though GPs and obstetricians may also carry out the role and/or work collaboratively with midwives as needed.
LTC	Long Term Conditions - The National Health Committee defines a long term condition as any on-going, long-term or recurring condition that can have a significant impact on people's lives. Long term conditions include diabetes, cardiovascular disease (including stroke and heart failure), cancer, asthma, chronic obstructive pulmonary disease, arthritis and musculoskeletal disease, dementia and mental health problems and disorders.
MDM	Multi-Disciplinary Meetings (MDMs) are deliberate, regular meetings either face-to-face or via videoconference at which health professionals with expertise in a range of different specialities discuss the options for patients' treatment and care prospectively. Prospective treatment and care planning involves making recommendations in real time, with an initial focus on the patient's primary treatment. MDMs facilitate a holistic approach to the treatment and care of the

Term	Meaning
	patient.
MHP	Māori Health Plans (MHPs) are fundamental planning, reporting and monitoring documents, which underpin the DHB's efforts to improve Māori health and reduce the disparities between Māori and non-Māori. An MHP provides a summary of a DHB's Māori population and their health needs. The plan then documents and details the interventions and actions the DHB plans to undertake to address health issues in order to achieve indicator targets set nationally, regionally and at district level.
NGO	Non-Government Organisation - any legally constituted organisation which operates independently from the government. The term is fairly generic and typically includes a wide variety of community based organisations, including charitable trusts, incorporated societies and commercial service providers.
NIR	The National Immunisation Register (NIR) is a computerised information system that has been developed to hold immunisation details of New Zealand children. The purpose of the NIR is to assist New Zealand to improve its immunisation rates. Improved immunisation coverage will offer individual protection against vaccine-preventable diseases and protection for the community against recurring epidemics.
Outputs	Outputs are the result of Activity (see Activity) - outputs specify the quality, volume and timeliness of the work, goods, or services planned or produced by the planning entity.
Outcomes	Outcomes refer to the contribution of an Activity towards some kind of change for a target population. At the highest level, the New Zealand Health Sector uses a 'Triple Aim' outcomes framework, which seeks a balance between the effects on Population Health, the Experience of Care and the Efficiency of the Healthcare System.
PBFF	Population Based Funding Formula - a method used by the Ministry of Health to determine how New Zealand's health budget ought to be distributed across DHBs.
PCI	Percutaneous Coronary Intervention (PCI), commonly known as coronary angioplasty or simply angioplasty, is a non-surgical procedure used to treat the stenotic (narrowed) coronary arteries of the heart found in coronary heart disease.
PHO	Primary health organisations (PHOs) are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO.
PPP	The PHO Performance Programme (PPP) has been developed by District Health Boards (DHBs), the Ministry of Health and the primary health care sector to support improvements in the health of people enrolled in a Primary Health Organisation (PHO). The Programme aims to: - Encourage and reward improved performance by PHOs in line with evidence-based guidelines - Measure and reward progress in reducing health inequalities by including a focus on high need populations

Term	Meaning
PSSG	Primary Secondary Strategy Group - The first meeting of the Hutt Valley Primary Secondary Strategy Group took place on 17 February 2011. This integrated hospital and community multidisciplinary group will meet monthly. Members are a mix of four hospital and five primary care clinicians, with some senior DHB clinical leaders and managers to help implement clinical decisions. The group's purpose is to improve primary and secondary integration to assist in keeping people of the Hutt Valley well and in the community.
REC	The Regional Executive Committee (REC) is the peak executive and clinical leadership committee in the Central Region Leadership Framework, reporting through to the regional CEOs. It comprises senior management and clinical representatives and consumer representation from across the region and its objective is to ensure that the region takes a co-ordinated approach to planning and delivery.
RGG	Regional Governance Group - All six DHBs within the Central Region have given support to new Regional Governance Arrangements, including the establishment of a Regional Governance Group. This will include the development of a set of principles to guide decisions of the Central Region's regional governance group, including in those principles the principle that the outcome of decisions of that group must not increase inequalities. The new Regional Governance Group is to hold its inaugural meeting in March. One of the Group's first tasks will be to review its terms of reference and re-submit these to the six shareholder boards for approval. Another task is to determine the board composition for TAS.
RSP	Regional Services Plan - since the New Zealand Public Health and Disability Amendment Act was passed in 2010, each DHB region in the country jointly prepares an RSP, which describes in detail how DHBs in the region will plan and work together on a regional basis. The plans are designed to support vulnerable services, give everyone better access to health services, link to the National Health Targets and improve health across the whole region
SBHS	The School Based Health Services (SBHS) programme receives funding from the government for 38,000 young people in all decile 1 and 2 secondary schools, alternative education and teen parent units. However, over the next four years, extra nurses will be embedded in all decile 3 secondary schools, expanding the nurse-led School Based Health Service (SBHS) to a further 18,000 potentially at-risk young people as part of the Prime Minister's Youth Mental Health Project.
SDP	Rising to the Challenge: The Mental Health and Addiction Service Development Plan (SDP) 2012–2017 sets out the Government's vision to guide the mental health and addiction sector, as well as clear direction to planners, funders and providers of mental health and addiction services on Government priority areas for service development over the next five years. The Plan focuses on four key areas: making better use of resources - improving integration between primary and secondary services - cementing and building on gains for people with high needs - delivering increased access for all age groups (with a focus on infants, children and youth, older people and adults with common mental health and addiction disorders such as anxiety and depression

Term	Meaning
SIDU	The Service Integration and Development Unit - the establishment of SIDU in 2012 amalgamated the Planning and Funding functions of the Wairarapa, Hutt Valley and Capital and Coast District Health Boards under a single sub regional directorate.
SRCLG	The Sub Regional Clinical Leadership Group (SRCLG) is led by clinicians from the Wairarapa, Hutt Valley and Capital & Coast District Health Boards, and has developed a significant work programme to develop services across the sub region. This work programme is identified as the '3D' or 3 DHB Health Services Development programme.
TAs	Territorial Authorities – Territorial Authorities are the second tier of local government in New Zealand, below regional councils. There are 67 territorial authorities: 13 city councils, 53 district councils, and the Chatham Islands Council.
TAVI	Transcatheter Aortic Valve Implantation - Catheter insertion of a new aortic valve to treat aortic stenosis. Aortic stenosis occurs when the aortic valve, which separates the main pumping chamber of the heart from the circulation, becomes partially narrowed. This reduces the flow of blood out of the heart. Transcatheter aortic valve implantation may be an alternative to surgical valve replacement in patients for whom conventional aortic valve replacement is not suitable, or who at very high risk.
WCTO	Well Child/Tamariki Ora (WCTO) is a free service that is offered to all New Zealand children from birth to five years. Services include: - Eight checks between 4-6 weeks of age to 4-4.5 years - B4 School Check at 4-4.5 years, including a free eyesight and hearing test - a free Well Child/Tamariki Ora Health Book, with information for parents on protecting and improving their child's health and development.
WDHB	Wairarapa District Health Board, covering Carterton, Masterton, and South Wairarapa Territorial Authorities.
YOSS	Youth One Stop Shops (YOSS) provide a range of accessible, youth-friendly health and social services at little or no cost to young people, including primary health care, sexual and reproductive health, family planning and mental health services. The majority of clients are aged between 15 and 24 years.