



Bay of Plenty District Health Board  
District Annual Plan 2010/11



BAY OF PLENTY  
DISTRICT HEALTH BOARD  
HAUORA A TOI

## Midland district health boards

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# Office of Hon Tony Ryall

Minister of Health  
Minister of State Services

17 AUG 2010

Mrs Mary Hackett  
Chair  
Bay of Plenty DHB  
Private Bag 12-024  
TAURANGA

Dear Mrs Hackett

## **Bay of Plenty District Health Board: 2010/11 District Annual Plan**

This letter advises you that I have signed Bay of Plenty District Health Board's (DHB) 2010/11 District Annual Plan (DAP) for three years.

### *Clinical and financial sustainability*

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

All DHBs must budget within their allocations and improve financial performance. The DHB's actions to achieve efficiencies and control costs will be important in the current fiscal environment in 2010/11 and the out years. My approval of your DAP does not mean acceptance of your assumptions in the out years.

### *Health targets and priorities*

I appreciate the DHB's emphasis on the Government's health targets and priority areas. The Ministry of Health has advised that it considers there are heightened risks associated with your achievement of the agreed health targets for Shorter stays in Emergency Departments, Improved access to Elective Surgery and Increased Immunisation. I expect that your DHB remains focused on improving performance in these and other health target areas, and that it will work closely with the Ministry of Health, and in particular, the Health Target Champions, to ensure good progress is made.

New Zealanders want better access to a wider range of services closer to home. I expect your DHB to make substantial progress with integrating hospital services into community settings in 2010/11. The DHB will need to keep the Ministry of Health well informed of its progress in this priority area.

I note that your Board plans to work closely with other Midland DHBs as it considers how best to achieve appropriate levels of funding and delivery for vulnerable services such as gynaecology, obstetrics and rural primary services. These need to be accelerated, so that results occur.

*DAP approval*

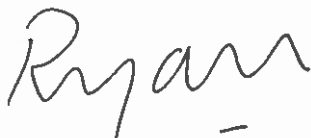
The approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry of Health where any proposals may require my approval.

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

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

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

Yours sincerely

A handwritten signature in black ink, appearing to read 'Ryall', with a horizontal line underneath the name.

Hon Tony Ryall  
**Minister of Health**

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## Executive summary

Government is resolute in its commitment to deliver better, sooner, more convenient healthcare to all New Zealanders. In the face of a financially constrained future, the Minister has clarified that transformational change in the form of new models of care is required across the sector in order to deliver on this commitment.

The release by the Ministry of Health in September 2009 of the Request for Expressions of Interest for the Delivery of Better, Sooner, More Convenient Primary Health (EOI) encapsulates Government's priority intention for a more personalised primary health care system that provides services closer to home, makes Kiwis healthier and reduces pressure on hospitals.

Across New Zealand Māori health status continues to lag behind others. 'Whānau Ora' as an ideology, business model and service strategy continues to gather political momentum in recognising that for Māori, health is not just a manifestation of physical wellbeing, but is more an expression of a desire for a healthy secured future, nurtured by traditional social structures; Whānau, Hapū and Iwi.<sup>1</sup> The EOI is the catalyst for social transformation of Māori communities. Bay of Plenty District Health Board (the DHB) will work in partnership with the Māori Health Rūnanga, the National Māori PHO Coalition, the combined Eastern Bay of Plenty PHOs and other key stakeholders to realise these aspirations.

At the same time as the opportunity presents itself for primary health care to demonstrate its capacity and capability to really effect positive change in New Zealanders health outcomes, our hospitals and specialist services are equally challenged to effect change; improve productivity and value for money without compromising patient safety or service quality.

Without doubt the challenges affecting the New Zealand health sector are great but the DHB will meet those challenges and make positive differences to the health outcomes of its resident population by

continuing to foster a culture of innovation, challenging old ways of doing things and strengthening partnerships within, across and beyond the health sector. It will tackle head on the issues affecting the sustainability of our clinical workforce and implement solutions now, build on our culture of effective clinical engagement and create more opportunities for clinical leadership.

### 1.1 Key challenges

The key challenges facing the DHB are:

- Living within budget
- Delivering elective volumes and improving waiting times
- Better, sooner, more convenient primary health care
- Regional and national service configuration
- An ageing population driving acute demand
- An ageing workforce threatening workforce sustainability

#### 1.1.1 Living within budget

Government expects DHBs to deliver on the national health targets by providing good quality care in a timely manner. It is a clear requirement that these Targets must be achieved while fulfilling the financial commitments of the DHB. The DHB will do this by:

- Evaluation and consolidation of services provided
- Close understanding and monitoring of costs
- Maximising service delivery
- Driving for efficiency and best value
- Regional and national cooperation.

#### 1.1.2 Delivery of elective volumes and improving waiting times

Increasing acute demand has the potential to impact on DHB performance of elective volumes. An initiative to improve acute flow is underway. The "Shorter Stays" initiative represents a significant

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<sup>1</sup> National Maori Coalition – Expression of Interest: Implementing Whanau Ora to deliver better, sooner, more convenient primary health care for Maori and high needs populations p6

commitment of clinical and management time with project team members from across the health sector.

It is anticipated that short term efficiencies and demonstrable improvements against the Elective Surgery and Emergency Department waiting time targets will be realised from focusing in the first instance on hospital processes. More sustainable long term efficiencies will be realised from taking a "whole of system" approach; understanding what is driving unprecedented levels of acute demand and the role of the primary sector in managing it.

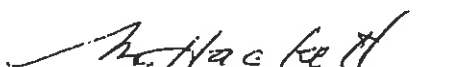
Elective surgery is an area of utmost importance for the Board and will be a major focus, together with service waiting times, during 2010/11.

#### 1.1.3 Better, sooner, more convenient primary health care

Supporting our PHO partners preparing and implementing business cases in accordance with the EOI process will be a priority for the DHB during 2010/11. Similarly, the shifting of secondary services to more convenient primary settings continues also as a core focus for 2010/11. The need for innovative and transformational solutions to primary sector capacity and capability (particularly in terms of workforce and provider sustainability, service fragmentation and financial pressures) will be a fundamental but not insurmountable challenge.

#### 1.1.4 Regional and national service configuration

DHBs in the Midland region are developing a regional clinical services plan to ensure that collectively we can provide clinically sustainable, financially affordable services to our joint populations without compromising local access. Effective clinical networks, comprehensive clinical engagement and leadership are critical to delivering on this outcome.



Mary Hackett  
Board Chairperson



Phil Cammish  
Chief Executive Officer



Hon Tony Ryall  
Minister of Health

#### 1.1.5 An ageing population driving acute demand

An ageing population and the increasing burden of long term conditions are amongst the factors which contribute to a rising demand for health services.

The predicted increase in the ageing population (an 84.3% increase in over 65 year olds over the next 20 years) in the Bay of Plenty and the subsequent impact on health services cannot be underestimated.

A more strategic approach to understanding and managing long term conditions (particularly those affecting the frail elderly) is critical as a response to reduce acute hospital presentations by this population group.

#### 1.1.6 An ageing workforce threatening workforce sustainability

It has been established that an increase in the older population has crucial labour market implications around the current and future caregiver workforce.

The proportion of the population 65+ years is 29% higher for the DHB than that for New Zealand as a whole and is predicted to grow, by 84.3% during the period 2006 to 2026.

Accordingly, there is a need for urgent focus on this issue at all levels (national, regional and local) to develop innovative approaches (either in the form of new models of aged care or workforce utilisation and development strategies) in order to deliver on the DHB's vision of healthy, thriving communities.

# Introduction

## 2.1 Vision and Values

### Our vision

*Healthy, thriving communities. Kia Momoho Te Hapori Oranga*

### Our mission

*Enabling communities to achieve good health and independence and ensure access to high quality services.*

### Our values

**Cultural** – we will acknowledge, preserve and promote mana atua, mana tūpuna, mana whenua and mana tangata

**Accountability** – we are accountable to our communities and the government

**Collaboration** – we will work with others and value the contribution we will make

**Flexibility** – we will allow for the variation in needs and solutions required for different communities

**Integrity** – we will be honest, forthright and open in our transactions, planning and deliberations

**Good employer** – we will be a good employer by building relationships of mutual trust and respect with staff. We will strive to become an employer of choice

**Evidence-based** – we will ensure all decisions are based on information as to what works, when, for whom and by whom

**Knowledge** – we will work with others to build and share knowledge

## 2.2 Treaty of Waitangi

The DHB recognises the Treaty of Waitangi as the founding document of New Zealand and acknowledges the special relationship between Māori and the Crown under the Treaty.

The demography of the district plays a key role in determining DHB priorities. Māori health has particular emphasis within the DHB District Strategic Plan. This is viewed as an obligation under the Treaty of Waitangi and reflects the following principles:

- Inequalities in health affect the entire population
- Māori are best qualified to determine the actions to reduce inequalities that affect Māori.

### 2.2.1 Treaty of Waitangi Principles

#### Partnership

Working together with Iwi, Hapū, Whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

#### Participation

Involving Māori at all levels of the sector in planning, development and delivery of health and disability services.

#### Active Protection

Ensuring Māori enjoy at least the same level of health as non-Māori and safeguarding Māori concepts, values and practices.<sup>2</sup>

<sup>2</sup> Source: He Korowai Oranga, MOH, 2001

### **2.2.2 New Zealand Public Health and Disability Services Act 2000**

The New Zealand Public Health and Disability Services Act (NZPHD Act) Part 1 makes explicit: “Treaty of Waitangi provisions require District Health Boards to establish mechanisms to enable Māori to contribute to decision making and participate in the delivery of health and disability services.”

The three Treaty of Waitangi principles of partnership, participation and protection underpin the DHBs decision-making, planning and funding processes. Central to the Treaty relationship and effective implementation of the Treaty articles, is our affirmation that Māori have an important role in determining their own aspirations and priorities for health. The DHB recognises its responsibility to work with Māori to achieve the objectives of this District Annual Plan for 2010/11.

### **2.2.3 He Korowai Oranga Strategy**

*He Korowai Oranga* sets the direction for Māori health development over the next 10 years. The Treaty principles of Partnership, Protection and Participation are threaded throughout *He Korowai Oranga*.

## Operating environment

### 3.1 Overview of the Bay of Plenty population

The Bay of Plenty DHB is one of 21 district health boards in New Zealand.

Covering 9,669 square kilometres, the DHB serves a population of 202,193 and stretches from Waihi Beach in the north east to Waihou Bay on the East Cape and inland to the Kaimai and Mamaku ranges. These boundaries take in the major population centres of Tauranga, Katikati, Te Puke, Whakatane, Kawerau and Opotiki. It has the second fastest population growth rate of all New Zealand's district health boards. Total population growth in the planning period 2006 to 2026 is forecast to be 25.5% higher than that for New Zealand as a whole.

The majority of the growth is expected to be in the western Bay of Plenty region (particularly Tauranga City) with the eastern Bay of Plenty expected to experience a static or declining population. In this regard, 77% of the DHB population reside in the western Bay of Plenty.

Like the national population, the population of the DHB is ageing, with the highest percentage increase occurring in the 65+ years age group compared with New Zealand as a whole. The proportion of the population 65+ years is 29% higher than that for New Zealand as a whole and is predicted to grow by 84.3% during the period 2006 to 2026. This is particularly acute in the western Bay of Plenty with the figure approaching 46%. The ageing demographic of the DHB has obvious and very serious implications for health services into the future, particularly in terms of workforce sustainability.

The population who identify as Māori is 67% higher than for New Zealand as a whole and residents in rural locations is 49% (much higher than for New Zealand as a whole).

Unlike the western Bay of Plenty, eastern Bay of Plenty has a relatively youthful population with a third of the population under 30 years compared to a national average of 28%.



In the DHB about a quarter of the population live in areas with high NZDep06 scores (which are associated with poorer health). About one in seven people live in areas with low scores (associated with better health).

Overall the DHB population is markedly over represented in high deprivation scores.

### 3.2 Key health trends

Analysis of the health needs of the people of the Bay of Plenty has indicated the following priorities:

- Disease of the respiratory system, bronchitis and asthma amongst infants and young children, adults and older people
- Chronic obstructive airways disease amongst adults
- Whooping cough and acute bronchitis amongst infants and young children (especially amongst Māori infants)
- Cellulitis amongst adults (45-64 years)
- Diabetes renal failure
- Gastroenteritis for infants and young children
- Skin conditions for youth and adults
- Otitis media for infants, young children, younger adults and older people
- Schizophrenic disorders for youth and young adults
- Unstable angina for older adults

### 3.3 Funding allocations for 2010/2011

Overall, total funding allocated to the DHB for 2010/11 is \$542.077M (\$523.503 in 2009/10).



*The population of 65+ years is 29% higher than that for New Zealand as a whole and is predicted to grow by 84.3% during the period 2006 to 2026*

Government Priority Funding has been targeted at a number of areas identified by the Minister and includes:

- Maintaining per capita expenditure on community pharmaceuticals
- A requirement to increase by 2% the funding allocated to first contact patient care
- A requirement to increase by 1.73% funding allocated to improve the quality of age related residential care
- An expectation that DHBs must meet the full cost of any renegotiated agreements within the funding provided.
- A continued focus on improving the quality of age related residential care

### 3.4 Prioritisation

The fiscal environment facing the health sector now and in out years means prioritisation processes must be particularly robust to ensure we deliver the Government's commitment to better, sooner, more convenient healthcare for all New Zealanders.

The challenge is to protect vital services that have contributed to population health gain while continuing to live within our means. In meeting this challenge the Board has developed 10 strategic prioritisation principles to guide investment and/or service reconfiguration decisions during 2010/11. They are:

#### **Workforce**

Workforce (capacity, capability and development) is critical to long term service sustainability.

#### **Strategic priority areas confirmed**

Priority areas identified during the Board's 2009/10 District Strategic Plan review remain appropriate as ongoing priorities (Māori Health, Child & Youth Health, Primary Care and Population Health).

#### **Leadership and innovation**

Service providers that we fund must be able to demonstrate effective leadership, agility and innovation.

#### **Maintaining service coverage**

Maintaining service coverage is critical to sustaining long term population health. Wholesale service cuts are not an option. Innovation in service delivery is the key.

#### **Consolidation and evaluation**

Our response to the more constrained financial environment will be to move from service development to consolidation and evaluation. More specifically, efficiency gains will be identified by addressing non-performance, consolidating service delivery where appropriate and eliminating service duplication. Service redesign, if appropriate, will occur on a cost neutral basis.

#### **Value for money**

Services must offer value for money. Investment decisions should be geared toward those services that deliver the greatest gain for the largest number of people and can demonstrate long term sustainability.

#### **Inter-sectoral collaboration**

The DHB has a significant role to play in influencing greater inter-sectoral collaboration. Even if a particular service is not funded by the DHB (but by another revenue stream) we should remain interested in how it contributes to overall population health.

### **Community expectations**

Community expectations will be managed by being open and transparent about the realities of the new fiscal environment and what that means for health services.

### **Manage the risks of prioritisation**

Prioritisation processes must effectively respond to and manage risk. In particular, there is a need to ensure that key relationships endure and that provider capability is maintained. Similarly, we must understand the longer term implications (particularly financial) of realising short term savings. Demand for health services may shift toward the more acute end of the continuum as a result of short term prioritisation decisions.

In addition to these principles, prioritisation at an output or service level is guided by a comprehensive evaluation framework that applies weighted criteria to ensure we are making good funding decisions.

As noted above, the DHB response to the tightening fiscal environment will be to consolidate, evaluate (and reconfigure if appropriate) existing services over active service development. In this regard the Evaluation Framework will be applied proactively on or before service renewal and retrospectively, at service conclusion.

## **3.5 Service coverage: planning and changes**

The Midland DHBs are collaborating to develop a Midland Regional Clinical Services Plan. Regional service planning will be reflected in the development of strategic, annual and other plans at the district level, while at the same time ensuring better defined and managed clinical pathways for health service users. Further detail is provided in the Midland Region and Regional Planning section of this plan.

### **Service Change**

The DHB is looking to implement service changes in the 2010/11 year with more services provided locally. Fewer patients will have to travel to other DHB's for treatment in the areas of infectious disease, HIV, haematology, oncology, and chemotherapy. These service changes will be negotiated with other DHB's so as not to destabilise Midland-wide clinical networks.

## Strategic priorities

### 4.1 National priorities

The Minister of Health has outlined his expectations for the 2010/11 year which enables us to plan and prioritise activity for the coming year. National health targets have also been set by the Minister.

The Minister’s expectations together with the national health targets reinforce the Government’s commitment to a public health system that delivers better, sooner, more convenient healthcare for all New Zealanders.

For the 2010/11 year, the Minister’s expectations and priorities for District Health Boards include:






- Exhausting all options to make sufficient efficiency gains to deliver on agreed financial results.
- Achievement of health targets within agreed timeframes
- Work closely with primary and community providers to develop new models of care that keep people well, reduce avoidable hospital admissions and readmissions, shift hospital services to primary settings when appropriate and improve referral and prescribing practice
- Improve retention of permanent clinical staff, reduce vacancy rates and strengthen clinical leadership and networks
- Identify and implement those productivity improvements, quality improvements, procurement and shared back office functions that will deliver a significant improvement in hospital productivity and service safety and quality to generate additional savings in 2010/11
- Identify those services that can have the largest impact on improving Māori health status
- Work with the Ministry and the National Health Board to implement cabinet decisions relating to national services,

regional services planning, workforce, IT and national shared service functions.


The DHB’s plans for 2010/11 incorporate Government’s priorities and the table below references where each Government priority is more specifically discussed within this Plan:

Minister’s Expectations	DAP Reference
Deliver agreed financial results	See pages 68–81
Achievement of health targets	See page 8
Shift secondary services to more convenient primary care settings, new models of care that keep people well	See pages 36-47
Clinical workforce retention, leadership and engagement	See pages 60-68
Productivity improvements, quality improvements, procurement and shared back office functions	See pages 25-36, 60-68 and Appendix A
Whānau Ora: improving Māori health status	See pages 47-51
National services, regional service planning, workforce, IT and national shared service functions	See pages 11-24, Appendix E

## 4.2 Health targets

Health target	Long term target	Local target	
 <p>Shorter stays in Emergency Departments</p>	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours	<b>95%</b>	of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
 <p>Improved access to Elective Surgery</p>	The volume of elective surgery will be increased by an average of 2,000 discharges per year (compared with the recent average increase of 1,400 per year)	Bay of Plenty District Health Board agree to a minimum of 8357 total elective surgical discharges in 2010/11 (excluding cardiology and dental)	
 <p>Shorter waits for Cancer Treatment Radiotherapy</p>	Everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010	<b>100%</b>	of patients in category A, B and C wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excludes category D patients).
 <p>Increased Immunisation</p>	85 percent of two year olds are fully immunised by July 2010; 90 percent by July 2011; and 95 percent by July 2012.	<b>75%</b>	of two year olds (Māori) are fully immunised by July 2011
		<b>85%</b>	of two year olds (all ethnicities) are fully immunised by July 2011
 <p>Better help for Smokers to Quit</p>	80 percent of hospitalised smokers are provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95% by July 2012. Similar target for primary care will be introduced from July 2010 or earlier, through the PHO Performance Programme.	<b>90%</b>	of hospitalised smokers are provided with advice and help to quit by July 2011



	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years	<b>53%</b>	Increased percent of the eligible adult population (Māori) have had their CVD risk assessed in the last five years.
		<b>49%</b>	Increased percent of the eligible adult population (Pacific) have had their CVD risk assessed in the last five years
		<b>66%</b>	Increased percent of the eligible adult population (other ethnicity) have had their CVD risk assessed in the last five years
		<b>65%</b>	Increased percent of the eligible adult population (all ethnicities) have had their CVD risk assessed in the last five years
	Increased percent of people with diabetes attend free annual checks	<b>56%</b>	Increased percent of people with diabetes (Māori) attend free annual checks
		<b>74%</b>	Increased percent of people with diabetes (other ethnicity) attend free annual checks
		<b>68%</b>	Increased percent of people with diabetes (all ethnicities) attend free annual checks
	Increased percent of people with diabetes have satisfactory or better diabetes management	<b>72%</b>	Increased percent of people with diabetes (Māori) have satisfactory or better diabetes management
		<b>85%</b>	Increased percent of people with diabetes (other ethnicity) have satisfactory or better diabetes management
	<b>83%</b>	Increased percent of people with diabetes (all ethnicities) have satisfactory or better diabetes management	

### 4.3 District Strategic Plan priorities

The DHB endeavours to positively influence population health through:

- *Healthy children, youth and families*
- *Healthy, independent and dignified ageing*
- *Healthy Maori*
- *Health and independence for people with disabilities*
- *Improved health and independence for people with chronic conditions; and*
- *Health Equity*

The population health approach is considered in the DHB as a unifying force for the entire spectrum of health system interventions. It is an approach to health that focuses on the underlying factors that affect and predispose the health status of a population or sub-groups of a population. These factors are referred to as the 'determinants of health.'<sup>3</sup>

This Plan focuses on implementation of the District Strategic Plan as it relates to:

- Health targets
- Ministerial priority areas as specified in the annual Minister's Letter of Expectations
- Key financial requirements
- Significant service changes
- Service coverage exceptions

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<sup>3</sup> Income and social status; education; working and living conditions; social environments; personal health practices; healthy child development; gender; social support networks; employment; physical environments; biological and genetic endowment; coping skills; health services; culture

- How the DHB will put into practical effect the Minister's requirement to 'live within our means' and actions to achieve focused delivery on government policy priorities and maximum value for money.

## The Midland region and regional collaboration

### 5.1 The Midland region

Bay of Plenty DHB is part of the Midland group of DHBs. The Midland region covers 56,738km<sup>2</sup>, and comprises 21% of the New Zealand land mass. The combined resident population provisional estimate of Midland region<sup>4</sup> in 2009 is 829,030, which is around one fifth of the New Zealand population. The five DHBs share commonalities and some marked demographic regional differences.

The Midland region covers a large rural area and has its share of metropolitan areas too. This diversity presents challenges in service delivery and additional barriers to accessing health services for people travelling from remote rural locations.

The proportion in rural and urban areas in the Midland DHBs is reasonably consistent, with 22% of the Midland population living in rural areas and 78% in the urban areas.

### 5.2 Government priorities

*Regional service plans that ensure clinical viability and financial affordability*

Regional service planning will assist DHBs to develop their strategic, annual and capacity plans at the district level, while at the same time ensuring better defined and managed clinical pathways for health service users.

<sup>4</sup> Statistics NZ



Bay of Plenty  
[www.bopdhb.govt.nz](http://www.bopdhb.govt.nz)



Lakes  
[www.lakesdhb.govt.nz](http://www.lakesdhb.govt.nz)



Tairāwhiti  
[www.tdh.org.nz](http://www.tdh.org.nz)



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



Waikato  
[www.waikatodhb.govt.nz](http://www.waikatodhb.govt.nz)

### 5.3 Regional collaboration

The Midland DHBs are currently developing a Clinical Services Plan (CSP) for the Midland region. This will be reflected in the development of strategic, annual and other plans by the Bay of Plenty DHB (and other Midland DHBs).

#### 2010/11

The Midland region is currently implementing two vulnerable services plans in the areas of obstetrics/gynaecology and rural primary care. These services were identified as initial focus areas based on work that was completed in early 2009.

An obstetrics/gynaecology clinical network has been established to support capacity to work regionally to support obstetrics/gynaecology services. Implementing the action plan will be a key focus for the obstetrics/gynaecology network once clinical leadership of the network has been established.

Rural primary care issues are less amenable to regional solutions. Rural primary care vulnerable services action plans have consequently been progressed at individual DHB level by Lakes, Tairāwhiti and Waikato DHBs, focusing on supporting rural primary care to maintain service coverage.

A draft CSP identifying 3 to 4 vulnerable services will be prepared by 1 July 2010. Development of actions to address the vulnerabilities identified in these areas will progress over the course of 2010/11. This process will review the prior work that was completed in early 2009 that identified vulnerable services and will determine if these services need to be further addressed by the CSP.

It is expected that a final Midland region CSP will be available by 30 September 2011.

#### 2011/12 and beyond

The Midland region will develop a 10 year plan for regionally led, collaborative community and hospital services in the region, taking a whole-of-system approach. It will take a long-term (20 year) view of

health needs across the population and will be matched to future clinical service provision and infrastructure requirements.

The plan will examine services that are currently vulnerable (or may become so) because of workforce, demand growth or funding issues.

It will include an assessment of the status quo financial situation of Midland DHBs, likely cost growth and changes required to “live within our means” regionally. It will include a five to ten year financial forecast.

The Ministry of Health’s Role Delineation Model will be used to inform the development of future service configuration. The final plan will include both primary and hospital services and provide a regional roadmap to enable DHBs in the Midland region to make critical strategic decisions about the future delivery of specialist health and disability support services, for example, in relation to:

- the distribution of 24/7 acute and elective secondary services;
- the distribution of tertiary services;
- future capital investment decisions; and
- changes to models of care, levels of care, or locus of care required to improve quality and live within the available resources.

The final output will provide a suggested high level future configuration of services.

Workforce is an important area for consideration of regionalisation initiatives. For example at the regional level a ‘two providers – one service’ approach to Regional Forensic Services have been adopted by Midland, with a collaboration formed between Waikato DHB and Hauora Waikato. A governance group, formed in February 2008, will work with the Midland Regional Forensic Psychiatry Development group to lead the development of a new integrated model of care and progress the Midland Regional Forensic Futures Plan 2008 – 2013. Clinical leadership will be provided by the position of the Midland Regional Forensic Director.

## 5.4 Challenges to the regional approach

There are challenges for the Midland DHBs in taking a regional planning approach particularly in respect to ensuring health needs assessment doesn't become an "averaging" exercise.

For example the projected population growth in Midland by 2026 is 11%. This however masks the fact that the region is disparate and whilst Bay of Plenty is projected to grow by 27%, Tairāwhiti's growth projection is negative 3%.

Bay of Plenty's population is relatively elderly; Tairāwhiti and Lakes populations are relatively youthful. Tairāwhiti, Lakes and the eastern Bay of Plenty have proportionately high levels of deprivation. Proportions of Māori differ markedly across the region. Regional planning therefore must take into account local specific needs to ensure an accurate reflection of the "real" population and the health needs of particular population groups.

The very nature of the population differences and different growth rates means the Midland DHBs attract demographic funding at very different rates. This creates pressure with some DHBs having funds to apply to areas of growth and development (e.g. the Midland Renal Plan) whilst other DHBs have no capacity to invest in expanding services unless they substantially dis-invest. These challenges are not insurmountable but require effective mechanisms to be in place to support DHBs as they work in the new environment.

For the 2010-11 year a number of Midland regional developments are planned (see section headed "How we're going to get there"). Each development has related actions, the implementation timelines for which may vary somewhat across the DHBs.

## 5.5 Where we want to be

### 5.5.1 Midland Regional Clinical Services Plan

The CSP having been developed in conjunction with clinical communities across the Midland region will be put through a detailed consultation process early in the 2010/11 year.

The consultation will culminate in the selection of 2-3 vulnerable services for detailed regional service planning. These services will have action plans developed to ensure their ongoing clinical sustainability and financial viability.

### 5.5.2 Regional Asset Management Plan

The District (DAMP) and Regional (RAMP) Asset Management Plans will be completed and submitted to the Ministry by the end of August 2010. The focus of this asset management planning work will be on clinical services and capacity planning at the district, regional and national levels. The DAMPs and RAMPs will be a reflection of this work up to the end of August; however they will not fully draw on the outcomes of the clinical services and capacity planning work conducted in 2010. It is likely RAMPs and DAMPs will be updated again in 2011 to reflect the impact this planning has on future asset requirements.

A draft national AMP (NAMP) was produced at the end of 2009 however this will probably not progress further until after the completion of the CSP.

The external consultant costs of completing the 2009 AMP were divided equally across the five Midland DHBs and absorbed into normal operating costs. It is likely the same approach will be followed for the 2010 RAMP.

### 5.5.3 Midland nursing workforce

The Midland region Directors of Nursing are working together to develop a model and process for a single clinical nursing procedure manual across the five DHBs. This would promote clinical nursing practice as well as reduce the workload for each individual DHB in developing and maintaining clinical procedures.

Part of the project will include submitting a proposal for funding to the Ministry of Health to improve access to evidence based nursing practice. This would add a further benefit of standardising nursing practice around the best available evidence and hence lead to improved patient safety and improved patient outcomes.

## 5.5.4 Midland Regional Mental Health Network

### Eating Disorders

The Midland Region Eating Disorders Strategic Plan was signed off by the Ministry of Health in August 2009. The outcome sought for 2010/11 is to have a robust continuum of care from primary through to tertiary services for clients who enter diagnosed with an eating disorder.

### NGO Programme for the Integration of Mental Health Data (PRIMHD)

The Ministry of Health NGO PRIMHD compliance project commenced in 2008 with NGO providers who were submitting Mental Health Information National Collection (MHINC) data electronically.

The outcome sought for 2010/11 is that all contracted NGOs will have mapping completed and will be reporting electronically to NZHIS.

### Mental Health Workforce Development

The Midland DHBs Workforce Development Coordinator role funded through Te Pou has worked closely with the five Midland DHBs.

Phase 3 to 5 will commence in 2009 and will continue in 2010/11 with the Ministry of Health providing funding for two full time equivalents (FTEs) to assist NGOs to comply.

## 5.5.5 Midland Chronic Care and Disease Management Information System Programme

The programme formed in 2009/10 will continue under the leadership of the Programme Manager.

Phase 1 of the work plan will be completed and deliver agreed standards by which access to a shared set of clinical information will be achieved, a privacy framework, and a stock take of current solutions for transfer of care and clinical decision support.

Phase 2 of the work plan will deliver improved connectivity to Midland region agencies and shared access to a core set of clinical information.

## Midland service plan implementation

The objectives outlined below briefly express where we want to be and what we want to achieve in 2010/11 in relation to Midland service plan implementation.

- Midland primary health care nurses will be well educated in the management of diabetes, CVD risk assessments, performing diabetes annual reviews, identifying and assisting their patients with diabetes to manage their condition well.
- Outcomes of the Midland Cardiac Rehabilitation Services Plan will be able to be determined via the use of a database.
- Agreed cardiac patient journeys need to be mapped and service improvement recommendations made.
- The Midland Renal Plan will be accepted and implementation agreed.

### HealthShare

Each of the five Midland DHBs has a shareholding interest in HealthShare Limited, a DHB joint venture company that specialises in both routine and issues-based quality-audit of service providers. HealthShare reports back to the participating DHBs throughout the year ensuring contractual obligations and standards are met by contracted providers.

### Midland Cancer Network<sup>5</sup>

This Midland Cancer Network (the Network) takes a common sense approach to health needs assessment specific to cancer control; the Midland Strategic Cancer Plan; service and patient mapping work streams; care coordination; high risk genetic assessment; adolescent/young adult oncology; haematology; palliative care services and national IS work.

The following section “How we’re going to get there” describes the actions that the Network will be undertaking during 2010/11 to reduce the rate and effect of cancer across the region.<sup>6</sup>

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<sup>5</sup> Midland Cancer Network geographical area includes Bay of Plenty, Lakes and Waikato with an open invitation to Tairāwhiti and Taranaki. The Network works with community, primary and hospital organisations to undertake system wide improvement across the cancer continuum – primary, prevention, screening and early detection, diagnosis and treatment, rehabilitative and supportive care, palliative/end of life care and research/surveillance.

### **Regional information service planning**

The DHB is part of a regional information service planning response and as such aims to contribute to three regional information goals as below:

1. Provide integrated/shared information to enhance health care planning and improve population health outcomes
2. Collaborate to reduce costs and enhance risk mitigation within information areas
3. Provide technical and information support for shared service initiatives in non-IT areas.

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<sup>6</sup> Actions that the Network plans to undertake to reduce cancer waiting times during 2010/11 can be found in the section headed "More responsive hospital and specialist services".

## 5.6 How we're going to get there – our performance story for 2010/11

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Services that are clinically sustainable and financially viable across the Midland Region</b>	The development of a Midland Clinical Services Plan	<ul style="list-style-type: none"> <li>• “whole of region” view of vulnerable services plus regional response</li> <li>• Evaluation of existing clinical networks and identification of new ones</li> <li>• Integration with national work where appropriate</li> <li>• Stakeholder engagement and feedback formally built into ongoing planning process</li> </ul>	<ul style="list-style-type: none"> <li>• Effective clinical networks</li> <li>• Improved opportunities for clinical leadership</li> <li>• Robust clinical engagement and greater opportunities for socialisation of the plan</li> <li>• Consideration of new models of care that are regionally sustainable (both clinically and financially)</li> <li>• Regionally consistent District Strategic Plans</li> <li>• Common District Strategic Plan timeframe</li> </ul>	<ul style="list-style-type: none"> <li>• Draft Midland Clinical Services Plan submitted to the Ministry of Health for approval by September 2010</li> <li>• Prioritised work programme agreed for implementation of CSP</li> <li>• Coordination of regional work streams</li> </ul>	\$50,000k <sup>7</sup>
<b>Reduce the incidence and impact of cancer</b>	Implementing the Midland Cancer Network Strategic Plan 2010-2014	<ul style="list-style-type: none"> <li>• Complete Midland cancer service development fund initiatives<sup>8</sup> <ul style="list-style-type: none"> <li>- Midland Cancer Network is the lead for national development of a lung cancer pathway utilising Map of Medicine (UK)</li> <li>- Complete the Midland lung cancer early detection project</li> <li>- Complete the feasibility project on the Somerset Cancer Registry (UK) utilising national Cancer and Palliative Care Patient Management High Level Requirements (Dec. 2009)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Effective lung cancer pathway for the region</li> <li>• Better treatment outcomes through early detection of lung cancer</li> </ul>	<ul style="list-style-type: none"> <li>• Lung cancer clinical pathway</li> </ul>	\$550,000 <sup>9</sup>  2010/11 service development fund initiative revenue

<sup>7</sup> Pro rated across the Midland region

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Reducing inequalities at every stage of the cancer continuum</b>	Ongoing investment in the Midland Cancer Network	<ul style="list-style-type: none"> <li>• Implement recommendations from Māori breast cancer waiting time audit</li> <li>• Complete the Midland lung cancer early detection project</li> <li>• Ensure all new proposals have evidence of the Health Equity Assessment Tool (HEAT) and/or Whānau Ora tool</li> <li>• Improve regional cultural competency of frontline staff</li> <li>• Complete development of a regional supportive service directory</li> </ul>	<ul style="list-style-type: none"> <li>• Better service quality for Māori breast cancer patients</li> <li>• Reduced waiting times</li> <li>• Culturally appropriate cancer services</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in health inequalities for Māori breast cancer patients</li> </ul>	Actions to be carried out within the \$550,000 CFA allocated to the Network
<b>Improve early detection</b>	National Guidelines for Suspected Cancer in Primary Care	<ul style="list-style-type: none"> <li>• Scope regional implications of phase 1 priorities in the national implementation plan for the Guideline for Suspected Cancer in Primary Care</li> <li>• Consider feasibility/eligibility of being a bowel cancer screening demonstration site and work with national bowel cancer team</li> </ul>	<ul style="list-style-type: none"> <li>• Earlier detection of cancers</li> <li>• Better clinical outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Possible demonstration site for bowel cancer screening</li> </ul>	Actions to be carried out within the \$550,000 CFA allocated to the Network

<sup>8</sup> Revenue received 2009/10 for these initiatives; Map of Medicine pilot \$90,775; early detection lung cancer \$30,000; Somerset Cancer Registry feasibility study \$90,000

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Better end of life care</b>	Implementing the New Zealand Palliative Care Strategy	<ul style="list-style-type: none"> <li>• Complete and implement the Midland Palliative Care Plan 2010-2015 within available resources               <ul style="list-style-type: none"> <li>- Facilitate and coordinate the implementation of end of life Liverpool Care Pathway programme</li> <li>- Facilitate and coordinate the implementation of the Midland specialist palliative care education framework and plan for generalist nurse and carers (2008)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• A supported and dignified end to life</li> </ul>	<ul style="list-style-type: none"> <li>• Liverpool Care Pathway implemented for patients requiring palliative care</li> <li>• Palliative Care Education framework developed</li> </ul>	Actions to be carried out within the \$550,000 CFA allocated to the Network
<b>Better cancer treatment and more equitable access to cancer services</b>	Developing appropriate infrastructure to support optimal delivery of cancer services	<ul style="list-style-type: none"> <li>• Complete the feasibility project on the Somerset Cancer Registry (UK) utilising national Cancer and Palliative Care Patient Management High Level Requirements (Dec.2009)</li> <li>• Continue developing multidisciplinary meetings (MDMs) within available resources</li> <li>• Implement regional PET-CT variance committee</li> <li>• Develop Midland genitourinary and gynaecology multidisciplinary work groups within available resources.</li> </ul>	<ul style="list-style-type: none"> <li>• Better treatment outcomes</li> <li>• Easier access to cancer services</li> </ul>		Actions to be carried out within the \$550,000 CFA allocated to the Network

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Nationally consistent cancer control responses</b>	Participating in a national response to cancer control	<ul style="list-style-type: none"> <li>• Midland Cancer Network is the lead for national development of a lung cancer pathway utilising Map of Medicine (UK)</li> <li>• Participate in national joint initiative to develop an implementation plan for the Guidance of Supportive Care Services for Adults (2008)<sup>10</sup></li> <li>• Support the development of the national lung cancer work group as required</li> <li>• Work with the national bowel cancer team as required</li> <li>• To participate in national activities related to cancer control as appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced inequalities through aligned and consistent national cancer services</li> </ul>		Actions to be carried out within the \$550,000 CFA allocated to the Network
<b>Improved patient safety and patient outcomes</b>	Midland clinical nursing practice across the region	The development of a Midland Nursing Procedure Manual	<ul style="list-style-type: none"> <li>• Consistent clinical nursing practice across the region</li> <li>• Consistent patient care for those patients accessing regional services</li> <li>• An improved patient experience when accessing shared services across the region</li> </ul>	<ul style="list-style-type: none"> <li>• Midland Nursing Procedure Manual</li> </ul>	Absorbed within normal work.

<sup>10</sup> Central Cancer Network (lead network) on behalf of the regional cancer networks is submitting a RFP to the Ministry and achievement of this initiative is dependent on Ministry approval. If another organization is successful we would still support this initiative.

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<p><b>People with experience of mental illness and addiction experience trustworthy agencies that work across boundaries and enable service users to lead their own recovery</b></p>	<p>Achieving PRIMHD compliance through the Midland Regional Mental Health Network PRIMHD Implementation Plan</p> <p>Implement the Midland Regional Eating Disorders Strategic Plan</p> <p>Implement “Lets Get Real”</p>	<ul style="list-style-type: none"> <li>• Implement Phases 3 to 5 of the PRIMHD compliance project</li> <li>• Progress provision of tertiary beds with NDSA</li> <li>• Source Midland Region Eating Disorders FTEs</li> <li>• Midland Workforce Coordinator will run Lets Get Real workshops to clinical Provider Arm services</li> </ul>	<ul style="list-style-type: none"> <li>• More accurate patient data</li> <li>• Robust care continuum from primary through to tertiary services for clients with an eating disorder.</li> <li>• Better treatment outcomes.</li> <li>• Better access to more timely, coordinated care</li> </ul>	<ul style="list-style-type: none"> <li>• PRIMHD compliant information systems for the Midland region</li> <li>• 2 FTEs</li> <li>• Workshops run</li> </ul>	<p>\$678,238</p>
<p><b>Patients are better able to manage their long term conditions</b></p>	<p>Ongoing implementation of the Midland Diabetes Implementation Plan</p>	<ul style="list-style-type: none"> <li>• A suitable course is developed and available for Midland primary health care nurses that is accessible across the region and supported by Directors of Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Primary health care nurses are well educated in the management of long term conditions</li> <li>• Patients are better able to manage their conditions</li> </ul>	<ul style="list-style-type: none"> <li>• Course developed and taking enrolments</li> </ul>	
<p><b>Improved health outcomes for cardiac rehabilitation patients</b></p>	<p>Ongoing implementation of the Midland Cardiac Service Plan</p>	<ul style="list-style-type: none"> <li>• Stock take of Midland cardiac rehabilitation services undertaken and recommendations distributed to stakeholders including Midland Chronic Conditions Information System Programme to assist identification of information system needs</li> </ul>	<ul style="list-style-type: none"> <li>• Awareness of the scope and depth of Midland Cardiac Rehab services</li> <li>• Identification of service gaps that compromise accessibility</li> <li>• Efficiency gains from identifying service duplication</li> </ul>	<ul style="list-style-type: none"> <li>• Agreement on recommendations to inform future information system development</li> </ul>	

<b>A reduction in the incidence and impact of long term conditions.</b>	Continued implementation of the Midland Chronic Conditions Information System	<ul style="list-style-type: none"> <li>Phase 1 and 2 implemented</li> </ul>	<ul style="list-style-type: none"> <li>Better coordination of care through primary and secondary</li> <li>Improved connectivity to Midland region agencies</li> <li>Shared access to clinical information</li> </ul>	<ul style="list-style-type: none"> <li>Privacy framework</li> <li>Stock take of current solutions for transfer of care and clinical decision support</li> <li>Core set of clinical information</li> </ul>	
<b>Seamless cardiac patient journeys</b>	Ongoing implementation of the Midland Cardiac Service Plan	<ul style="list-style-type: none"> <li>Stakeholder groups are formed</li> <li>Cardiac patient journeys to be mapped and agreed</li> <li>Agree service improvement initiatives</li> </ul>	<ul style="list-style-type: none"> <li>More consistent and efficient cardiac services</li> <li>More timely cardiac interventions</li> <li>Better service experiences for cardiac patients</li> </ul>	<ul style="list-style-type: none"> <li>Patient journeys mapped</li> </ul>	
<b>Seamless renal patient journey</b>	Midland Renal Plan is accepted and implementation agreed	<ul style="list-style-type: none"> <li>Midland Renal Plan is submitted to GMs P&amp;F for final approval</li> <li>Implementation process is agreed</li> </ul>			
<b>Improved performance by health service providers</b>	Healthshare audits of health service providers across the Midland region	<ul style="list-style-type: none"> <li>Undertake audits and report findings based on agreed audit programme</li> <li>Meet with Midland DHBs six monthly to review audit processes and programmes</li> </ul>	<ul style="list-style-type: none"> <li>Better performing health providers</li> <li>Better health outcomes for service users</li> </ul>	<ul style="list-style-type: none"> <li>Audits in accordance with agreed audit programme</li> </ul>	\$1,015,541

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<p><b>The right people, with the right skills, in the right place to deliver effective health care.</b></p>	<p>Developing and implementing Midland approaches to workforce development</p>	<ul style="list-style-type: none"> <li>• Maintain current Midland learning and development initiatives with new initiatives being investigated and established</li> <li>• Liaise with Midland Learning &amp; Development Consultants to ensure that the content of the Midland Leadership programmes meet requirements and are delivered as per schedule</li> <li>• Collaborate with regional and national DHBs and educational institutions to leverage cost-effectiveness and quality of Learning and Development resources</li> <li>• Ensure appropriate utilisation of CTA funding</li> <li>• Provide opportunities to senior medical staff to maximise their continuous medical education.</li> <li>• Work collaboratively with regional DHBs on overseas recruitment projects</li> <li>• Collective advertising and sharing of the Midlands recruitment website – zest4life</li> <li>• Joint presentation on international recruitment projects through Zest4life</li> <li>• Launch an investigation into the feasibility of a regional electronic talent pool</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in staff turnover</li> <li>• Greater productivity</li> <li>• Improved patient outcomes</li> <li>• Safer patient care</li> <li>• Improved quality of patient care</li> <li>• Better staff engagement</li> <li>• More opportunities for aspiring clinical leaders to flourish</li> </ul>		

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<p><b>Better health outcomes for patients through effective access and sharing of health information.</b></p>	<p>Midland regional information system development</p>	<p><b>Midland Connected Health</b></p> <ul style="list-style-type: none"> <li>Progress the Midland Connected Health business case through the approval process and implement the network to support regional projects and their IT solutions</li> </ul> <p><b>Chronic care management</b></p> <ul style="list-style-type: none"> <li>Progress the Chronic Care Management Work plans</li> </ul> <p><b>Oral health solution</b></p> <ul style="list-style-type: none"> <li>Progress the business case for implementing an oral health solution across the region</li> </ul> <p><b>Regional clinical solution</b></p> <ul style="list-style-type: none"> <li>Investigate the feasibility of implementing a regional or sub-regional clinical system</li> </ul>	<ul style="list-style-type: none"> <li>Supports the implementation of the Primary Care EOI Business Cases</li> <li>Supports the delivery of the priorities expressed in the Midland IS Work plan and the National Health IT Plan</li> <li>Provides the foundation for regional and national ICT service provision</li> <li>Enables services to be provided to all health providers</li> <li>Reduced cost of service provision and reduces ICT costs to sector participants</li> <li>Robust, reliable connectivity for all regional stakeholders</li> <li>Introduces new brand of 'one health', leveraging 'one.govt' and national Connected Health consistent with regional and national IT priorities.</li> <li>Improved health sector collaboration</li> </ul>	<ul style="list-style-type: none"> <li>Regional service distribution points at Tauranga and Hamilton</li> <li>Connectivity layer established (adequate leads and speeds)</li> </ul>	<p>\$2.8m<sup>11</sup></p>

<sup>11</sup> Overall Midland investment

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<p><b>A smoke free Midland population</b></p>	<p>Midland Regional Smokefree Initiative</p>	<ul style="list-style-type: none"> <li>• Develop and implement 3 year strategic work programme</li> <li>• Establish strategic reference group to provide advice and support to achieving the vision</li> <li>• Work with CEOs, DHB Boards, Iwi relationship groups and Ministry of Health to prioritise smoke free developments</li> <li>• Engage with wider public and private sectors to promote Midland Smokefree Vision</li> </ul>	<ul style="list-style-type: none"> <li>• Better length and quality of life</li> <li>• Reduced disability</li> <li>• More participation and independence</li> <li>• Greater awareness of the health risks associated with smoking</li> <li>• Reduced inequalities</li> <li>• Increased workforce productivity</li> </ul>	<ul style="list-style-type: none"> <li>• 90% of hospitalised smokers will be provided with help to quit by July 2011</li> <li>• 80% of patients attending primary care will be provided with help to quit by July 2011</li> <li>• 400-600 Māori, Pacific and pregnant women patients at Tauranga Hospital are given brief advice, NRT therapy and referred to a community quit agency</li> <li>• 40-60 Māori and Pacific ex-smokers trained in Kaihautu Auahi Kore leadership-peer support roles in their whānau</li> <li>• 2% reduction in the number of Year 10 students in the Bay of Plenty schools identifying as non-smokers by July 2011</li> </ul>	<p>\$150,000</p>

## More responsive hospital and specialist services

### 6.1 Overview of secondary care across the district

Secondary care in the district is provided from two key facilities being Tauranga Hospital and Whakatane Hospital.

Tauranga Hospital is a Level 4/5 facility, providing a full range of services including medical, surgical, paediatrics, obstetrics, gynaecology and mental health. Tauranga Hospital is also a base for a range of associated clinical support services and allied health such as rehabilitation, speech therapy, physiotherapy, stroke and cardiac support, district nursing and drug and alcohol programmes.

There are 326 beds at Tauranga Hospital, including the Special Care Baby Unit, Maternity and Mental Health. Approximately 209 beds are available for medical and surgical patients (including critical care and coronary care) with a further 58 for children and older people. Twenty four beds are designated for mental health patients.

Tauranga Hospital serves one of the fastest growing populations in the country and the campus has undergone significant development in recent years to enable the DHB to grow health services to match. Project LEO has seen the construction of a new wing of high quality which includes theatres, outpatients department and maternity unit.

Government has recently approved the Tauranga Hospital 'East Wing' development which, when completed, will house the Intensive Care, Cardiac Care and High Dependency units. The total number of beds within these units will accordingly increase from 18 to 40 to keep pace with population growth across the district. The Medical Day Stay Unit will also be expanded to treat medical patients from the Emergency Department. Construction is planned for completion in mid 2011.

Tauranga Hospital is the base for clinical and medical trainees with the establishment of the Clinical School. Training and placement programmes have been implemented with clinical trainees reporting positively on the quality of their placement.



Whakatane Hospital is a Level 3/4 facility, providing medical, surgical, paediatrics, obstetrics, gynaecology and mental health services. Like Tauranga Hospital, Whakatane Hospital is also a base for a range of associated clinical support services and allied health such as rehabilitation, speech therapy, physiotherapy, stroke and cardiac support, district nursing and drug and alcohol programmes.

There are 123 beds at Whakatane Hospital, including the Special Care Baby Unit, Maternity and Mental Health. Approximately 67 beds are available for medical and surgical patients with a further 14 designated for children and elderly patients.

Whakatane Hospital services a population that has a large proportion of lower socio-economic communities many of which are rural and isolated. Campus redevelopment is scheduled to occur during 2011 to 2014.

It is envisaged that Whakatane Hospital will be a key base for clinical and medical trainees in the future, as the Clinical School becomes more established. Some training and placement programmes are already underway.

## 6.2 Government priorities

*-Reduced waiting times for cancer treatment and in emergency departments*

*-Increased elective surgery discharge volumes year on year.*

## 6.3 Where we want to be

In response to the Minister's expectations the DHB Provider Arm has developed four strategic direction statements that describe ultimate outcomes in terms of the hospital and specialist services it provides. They are:

1. To provide high quality care and manage the growth in demand through innovation; interdepartmental, community and intersectoral collaboration; teamwork and fiscal accountability.
2. The patients' healthcare experience will be positive as a result of support for patient safety, rights and quality of care.
3. To continue to develop our services through professional leadership, clinical engagement and a culture of learning.
4. To develop the skills and knowledge of our workforce and be an employer of choice.

### 6.3.1 Improved access to elective surgery

The Minister has set an expectation that the annual increase in elective surgical discharges will improve, and in so doing will increase access and reduce waiting times. The DHB's targets for 2010/11 are already ahead of what the Ministry of Health expects for a population of our size. Our goal is to maintain that same level of access, while focusing on issues of equity, referral management, monitoring and reporting to ensure we're on track to reach our goal.

A stock take of both local and regional capacity has also been undertaken in a bid to ensure that volumes planned for delivery can be accommodated, and if unable to within current facilities that alternative strategies are explored and actioned if required.

In terms of regional capacity, the Midland region is progressing the development of a regional Elective Surgical Services Plan for inclusion within the CSP to enable critical strategic decisions to be made about 24/7 acute and elective secondary services. The regional Elective Surgical Services plan will encourage sharing of resources and expertise.

The initial steps of this work involve an analysis of:

- comparative access levels
- referral pathways
- the role of clinical networks
- regional reporting
- the mix of elective delivery standard intervention rates

In addition to the regional work that is being undertaken the DHB has completed a local Elective Surgical Services Plan (ESSP).

In summary the ESSP describes the actions planned to grow elective surgery services in line with forecast demographic growth. Further, it also includes a capacity stock take (bed and theatre utilisation rates) both in the public and private sector and possible impediments to realising the additional capacity required to deliver on target. The ESSP outlines strategies for promoting sustainable increases in capacity.

The DHB plans to provide a minimum of 7,288 elective surgery base discharges and 1069 additional discharges during 2010/11. These figures reflect the national approach being applied for 2010/11 which initiates a pathway to more equitable investment in elective surgery by 2015/16, and achieves overall an increase in DHB bases of at least 2000 discharges in 2010/11.

The following table describes planned CWD volumes for DHBs within the Midland region.

DHB of domicile (inpatient) <sup>12</sup>	MoH based planned CWD volume (elective)	MoH additional planned CWD volume (elective)	DHB additional planned CWD volume (elective)	Total planned CWD volume (elective)
Waikato	10,503	3,710	762	14,975
Lakes	3,017	1,045	0	4,062
Bay of Plenty	8,680	1,827	0	10,507
Tairāwhiti	1,902	521	0	2,423
Taranaki	3,945	1,280	0	5,225

<sup>12</sup> Excludes dental and cardiology.

### 6.3.2 Shorter stays in Emergency Departments

Length of stay in Emergency Departments is an important quality indicator. Both medical and nursing literature have linked long stays and overcrowding in emergency departments to negative clinical outcomes (including increased mortality) and longer inpatient lengths of stay. Overcrowding can also lead to compromised standards of privacy and dignity.

Acute presentations have previously compromised the ability of the DHB Provider Arm to do elective work and have resulted in longer than desired lengths of stay in the Emergency Department.

The Minister expects DHBs to achieve a maximum 6 hours length of stay for Emergency Department patients who are admitted to a ward.

The DHB is committed to achieving the target by the end of 2010/11 through the ongoing implementation of our 'Shorter Stays in ED' Delivery Plan. The leadership structure set out below describes the key roles/positions within the DHB driving implementation of the Delivery Plan.

Champion	Person	Role within the DHB
Corporate Champion (Steering Group Chair)	Phillip Balmer	Chief Operating Officer
Clinical Champion	John Kyndon	Medical Director
Steering Group Members	Julie Robinson Derek Sage Michelle Merrick Kerrie Freeman Philippa Edwards Andy Humphrey Carol Garden Julie Williams Amohaere Tangitu	Director of Nursing ED Clinical Director Decision Support Advisor Service Improvement Leader Change Manager GP Liaison Communications Manager Hospital Coordinator Māori Health Director

A number of enabling and improvement initiatives have already been implemented and have delivered demonstrable improvements against this health target throughout 2009/10.

However, the final push to reach target and more importantly, to deliver a sustainable and efficient emergency service in the long term requires a ‘whole of system’ approach.

In this regard, the DHB’s ‘Shorter Stays’ initiative is underway and is driven by the overall aim of improving the quality and timeliness of acute services across the whole continuum of care. Three multi-disciplinary, cross sector work streams have evolved from the initial think tank plenary as follows:

**Pre-load work stream** – the number and complexity of patients seeking acute care

**Contractility work stream** – (within the emergency department) the ability of the system to accommodate these patients, including the physical and human resources and the processes for getting things done

**After load/discharge work stream** – the ease of getting the patient to the next phase of care, most notably into a hospital bed, as well as discharge processes back to the community.

The following Work Stream Leads have led interdisciplinary groups which have investigated and prioritised many possible actions and have now moved to implementation (key actions detailed as ‘short term actions’ to be completed within 12 months). Work stream Leads are responsible for achieving these actions.

Working Group	Areas of Responsibility/Work Programme	Lead
Preload Work Stream	Pre-ED: the number and complexity of patients seeking acute care	Andy Humphreys – GP Liaison
Contractility Work Stream	Within ED: the ability of the system to accommodate these patients, including the physical and human resources and the processes for getting things	Derek Sage – Clinical Director ED, Clinical Support Services Medical Leader

	done	
Afterload Work stream	Post ED: the ease of getting the patient to the next phase of care, most notably into a hospital bed.	Julie Williams – Hospital Coordinator

It is anticipated that short term efficiencies and demonstrable improvements against target will be realised from focusing in the first instance on hospital processes. However, the more sustainable long term efficiencies will be realised from taking a “whole of system” approach; understanding what is driving unprecedented levels of acute demand and the role of the primary sector in managing it.

Short term actions for implementation during 2010/11 are outlined below in section 6.4.

### 6.3.3 Shorter waits for cancer treatment

Access to specialist cancer treatment and symptom control is essential in reducing the impact of cancer. Indicators that mark quality of treatment are restricted by information availability/data collection. Waiting time for treatment has been chosen as a representative indicator. There is evidence to support the view that treatment delays are associated with poorer treatment outcomes. The six week target will change to four weeks in December 2010.

With the exception of radiation treatment, all cancer services are based within the cancer centres at Tauranga and Whakatane Hospitals. Chemotherapy treatment is delivered within these centres and radiation oncology referral, assessment and booking for treatment also occurs locally. Patients then travel to Waikato Hospital for radiation treatment.

Both BOPDHB and Lakes DHB rely heavily on Waikato DHB for radiation oncology services, which reinforce the need for strong and effective clinical relationships across the region if we are to achieve target. The work of the Midland Cancer Network (the Network) is critical in this equation.

The Network has a leadership, facilitation and coordination function in bringing together and working with stakeholders across organisational and service boundaries to reduce the incidence, impact and inequalities

of cancer. The success of the continuum of care in meeting patient needs rests in its ability to work across services. Integration is critical.

The strategic aims for the Network are to:

1. Share knowledge and information to enable informed decision making
2. Facilitate regional service quality improvement leading to better, sooner, more convenient services
3. Support innovation and infrastructure development to reduce inequalities and build capacity and capability

The Midland priority cancer control initiatives for 2010/11 include work in the following areas:

- Meeting the shorter waits for cancer treatment health target in relation to radiotherapy
- Improving indicator of DHB performance (IDP) measure for waiting times for chemotherapy and improving waiting times and access to medical oncology
- Tumour stream development for priority cancers (lung and bowel)
- Completion of cancer service development initiatives as per the Ministry of Health CFA.

## 6.4 How we're going to get there – our performance story for 2010/11

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
Improved health, faster rehabilitation and recovery	Improving access to elective surgery	<p><b>Planning &amp; Process:</b></p> <ul style="list-style-type: none"> <li>proactive planning of acute surgery by increasing access to acute theatres and related roster review for SMO in orthopaedics to decrease cancellation rate of elective Orthopaedics.</li> <li>Redesign of pre-assessment process (including greater primary sector involvement)</li> <li>Reducing the overflow of internal medicine cases into surgical wards</li> <li>Defining acute and elective pathways</li> </ul> <p><b>Workforce:</b></p> <ul style="list-style-type: none"> <li>Maintaining full anaesthetic staffing</li> <li>Maintaining surgical nursing levels in line with additional surgical bed capacity</li> </ul> <p><b>Capacity:</b></p> <ul style="list-style-type: none"> <li>Utilising regional capacity</li> <li>Utilising private capacity</li> <li>Increasing theatre utilisation at Whakatane Hospital by 17.6% by:               <ul style="list-style-type: none"> <li>Introducing start and finish times</li> <li>Directing a larger demographic area to Whakatane Hospital for elective procedures</li> <li>Meet surgical production plan and increase surgical discharges by 102+</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Better, sooner, more convenient health care</li> <li>Reduced lengths of stay</li> <li>Better clinical outcomes</li> <li>More efficient theatre utilisation</li> <li>Increased day surgery rates and day of surgery admissions</li> <li>Reduced incidence of hospital acquired infection</li> <li>Reduction in readmission rates</li> <li>Improved patient experience</li> <li>Greater certainty</li> <li>Less rework</li> <li>Reduction in inappropriate referrals</li> <li>Reducing waiting times in some specialities</li> </ul>	<ul style="list-style-type: none"> <li>Decrease cancellation rate (Target &lt;5 per month)</li> <li>Surgical production plan will be met each month (8303 elective surgical discharges)</li> <li>CWDs 11,139</li> <li>ESPI compliance achieved</li> <li>Meet or exceed SIR for elective surgery as outlined in the PV schedule.</li> <li>Improve day of surgery admission rate by 9% (target 90%)</li> <li>Increase day surgery rate from 57% to 61%</li> <li>Improve theatre utilisation at both Tauranga and Whakatane</li> </ul>	\$48,909,787

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
		<ul style="list-style-type: none"> <li>- Implement productive theatre</li> <li>• Reduce bed days for elective and arranged patients with specific projects focusing on DRGs I04 (knee replacements), J64 (Cellulitis), G07 (Appendectomy), J11 (I&amp;D Abscess)</li> <li>• Limiting the number of IDF's to those services not provided locally</li> </ul> <p><b>Elective waiting times:</b></p> <ul style="list-style-type: none"> <li>• All specialities to target a 4 month maximum waiting time between FSA and treatment</li> <li>• Close monitoring of all referrals, FSA and treatments lists.</li> <li>• Individualising SMO support to manage long waiting lists</li> <li>• Directing greater volume of orthopaedic elective surgery to Whakatane Hospital following appointment of Orthopaedic surgeon in July 2010.</li> <li>• Investigating opportunities to reduce follow-ups.</li> </ul>		Hospitals (from 82% to 85% at Tauranga Hospital) and (from 68% to 85% at Whakatane Hospital)	
<b>Improved health, faster recovery</b>	Shorter stays in Emergency departments <ul style="list-style-type: none"> <li>- Efficient Emergency Department services</li> <li>- Better management of acute care in the Primary sector</li> <li>- Improved patient journey through</li> </ul>	<ul style="list-style-type: none"> <li>• Improved information available to patients presenting to ED (implement by July 2010)</li> <li>• Foster relationships between hospital doctors and GPs through the set up of a group to develop integrated clinical care pathways (Setup group by July 2010)</li> <li>• Develop integrated clinical care pathways (commence July 2010)</li> <li>• Strengthen arrangements for</li> </ul>	<ul style="list-style-type: none"> <li>• Change community mindset from accessing ED as provider of first choice to accessing primary care for primary care conditions</li> <li>• Develop productive clinical relationships between hospital and primary care specialists to enable joint development of initiative such as integrated clinical</li> </ul>	<ul style="list-style-type: none"> <li>• Will achieve waiting time target.</li> <li>• Reduction in unnecessary ED attendances (5%)</li> </ul>	\$9,763,879

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
	secondary care services	<p>referral of walk-ins and non-registered patients to primary health care providers (implement by August 2010)</p> <ul style="list-style-type: none"> <li>• Develop referral arrangements between ED and primary care (commenced consultation April 2010)</li> <li>• Develop frequent attender care plans with primary care (commence consultation July 2010)</li> <li>• Increase the profile of the Community Response Team (review July 2010)</li> <li>• Improve referral rates to Coordinated Primary Options (commenced April 2010, review July 2010)</li> <li>• Implement acute clinics for access by GPs (implement July 2010)</li> <li>• Survey patients quarterly to ascertain reasons for presenting to ED and not GP (inaugural survey March 2010 and quarterly thereafter)</li> <li>• Ongoing audit and monitoring of breaches of 6 hour target and discussion with key operational staff (commence July 2010 and ongoing)</li> <li>• Review current escalation plan, aligning with Safe Staffing Healthy Workplaces activity (commence July 2010)</li> <li>• Pilot Surgical Admission and</li> </ul>	<p>care pathways and management of patient groups such as frequent attenders.</p> <ul style="list-style-type: none"> <li>• Maximise current opportunities for referral (i.e. Community Response Team and Coordinated Primary Options)</li> <li>• Improve acute flow, positively impacting occupancy and length of stay through initiatives such as: SAPU, discharge by 11, escalation plan, stranded patient etc.</li> <li>• Improved community confidence in self-management</li> <li>• Improved flow through the wards</li> <li>• Better management of acute demand</li> <li>• Better understanding of what drives ED presentations</li> <li>• Better clinical outcomes post discharge resulting in reduced readmissions</li> <li>• Reduced lengths of stay</li> <li>• Identification of expected discharge date on admission</li> <li>• Improved discharge planning</li> </ul>		

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
		<p>Planning Unit in ED (May 2010 and evaluate August 2010)</p> <ul style="list-style-type: none"> <li>• Review Medical Assessment and Planning Unit to determine if efficiencies are being achieved (commence July 2010)</li> <li>• Develop and signoff ED standard operating procedures, formalising responsibilities and implement ED streaming (Signoff May 2010, commence streaming implementation July 2010)</li> <li>• Pilot 'discharge by 11' initiative and then roll out across all wards (pilot commenced March 2010, other wards to follow post evaluation July 2010)</li> <li>• 'Stranded patient' initiative (commence July 2010)</li> <li>• Trial 'discharge lounge' in 1d composite ward, evaluate and consider rollout across other wards (Trial May 2010, plan for further rollout July 2010)</li> <li>• Redirect non-acute presentations to the eastern Bay of Plenty Integrated Family Health Centre<sup>13</sup></li> <li>• Investigate opportunities for joint management of ED on the Whakatane site as part of the IFHC development (Eastern PHOs business case)</li> </ul>			

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs		For this level of investment
<b>Reducing the impact of strokes</b>	Organised stroke service	<ul style="list-style-type: none"> <li>• Introduce an Organised Stroke Service that is supported with appropriate clinical staff resource and a dedicated ward capable of providing the acute and rehabilitation stages within the Provider Arm</li> <li>• Support in the community post discharge</li> </ul>	<ul style="list-style-type: none"> <li>• Improved ALOS and quality of care indicators</li> <li>• A more seamless service experience for stroke patients</li> </ul>	<ul style="list-style-type: none"> <li>• Dedicated stroke beds and associated services</li> </ul>		≈\$600k
<b>Reducing the impact of cancer</b>  <b>People with cancer or at risk of cancer are diagnose and managed better and earlier</b>	Shorter waits for cancer treatment (particularly for priority cancers : lung and bowel)	<p>Implement recommendations from the Midland lung cancer service and patient mapping recommendations within available resources</p> <p>Complete service and patient mapping of colorectal cancer and implement service improvements within available resources:</p> <ul style="list-style-type: none"> <li>- Continue to focus on improving colonoscopy capacity and capability</li> <li>- Work with the national bowel cancer team</li> </ul>	<ul style="list-style-type: none"> <li>• Improved access to more timely treatment and care</li> <li>• Better treatment outcomes</li> <li>• Improved colonoscopy services</li> </ul>	Oncology first attendances	832	
				Oncology follow ups	5,226	
				Oncology first attendances (paeds)	10	
				Oncology follow ups (paeds)	151	
				IV chemotherapy cancer – specialist paediatric oncology	54	
				Oncology - radiotherapy	7,435	
<b>Reducing the incidence and impact of cancer</b>	Improving waiting times for medical oncology/chemotherapy services	<p>Complete and implement the Midland Non-Surgical Cancer Treatment Services Plan 2010-2015 within available resources:</p> <ul style="list-style-type: none"> <li>- Apply Lean Thinking methodology to Midland medical oncology and ambulatory chemotherapy and implement</li> </ul>	<ul style="list-style-type: none"> <li>• Improved access to more timely treatment and care</li> <li>• Better treatment outcomes</li> <li>• Better access to drug treatments</li> <li>• Greater collaboration across cancer centres in the Midland Region</li> </ul>			

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
		improvements within available resources - Develop regional pharmacy oncology service model			

## Better, sooner, more convenient Primary Health care

### 7.1 Overview of Primary Health care services across the district

The district has five Primary Health Organisations (PHOs).<sup>14</sup>

In addition to the PHOs, the district has many other provider organisations which contribute to our solid primary health infrastructure.

The extent of available primary care services has grown considerably over the last five years particularly in relation to the management of long term conditions such as diabetes, cardiovascular disease and cancer.

### 7.2 Government priorities

Government's goal is for the primary care sector to make a larger contribution to the health system as the primary point of access to a wider range of publicly funded services. Implementation of the Government's objectives must position the primary sector to contribute to its full potential in the health system. A shift in policy and implementation settings can help drive the changes needed to improve the configuration of services and models of care.

### 7.3 Shifting secondary services to more convenient primary care settings

The Government has highlighted the need for large scale transformational improvements in the configuration of services and models of care within the primary health setting. The primary health response to this challenge, presents both opportunities and risks, particularly in light of current financial constraints.

- *Development of Integrated Family Health Centres*
- *Nurse walk in clinics*
- *Extended hours*
- *Improved access to urgent care*
- *Improve care for the frail elderly*
- *Improved access to diagnostics*
- *Shifting services between professional groups*
- *Shifting services between settings*
- *Prevention as a central theme of service development*

Workforce retention and development is a significant strategic challenge for the primary health sector. Understanding primary sector capability, in terms of workforce, systems, attitudes and agility is critical if we are to offer secondary services in more convenient primary care settings.

Both the DHB and our PHO partners across the district are committed to the devolution imperative and in this regard effective links between primary and secondary health care continue to grow and strengthen. An appropriate example of this commitment is the creation during 2009/10 of the Primary Care Technical Advisory Group; a clinically led (GP), multi-disciplinary and cross jurisdictional team whose function is to identify services suitable for devolution. The Primary TAG leads the planning required in the devolution process including necessary approaches to change management.

<sup>14</sup> Western Bay of Plenty PHO; Nga Mataapuna Oranga PHO, Te Ao Hou PHO; Kawerau PHO, Eastern Bay of Plenty PHO

The DHB has during recent years successfully shifted a number of services to primary care from secondary care. These include: the skin lesions service; community podiatry; mental health high and complex needs pilot service; Community Primary Options (CPO); CPO Primary Mental Health Services, COPD Rehabilitation services.

The collective impact of these initiatives has been to reduce hospital waiting lists and reduce demand on secondary services, thereby freeing up capacity, improving access to services for the community and assisting to strengthen the capacity and capability of primary care.

Strong clinical leadership has been integral to the successful devolvement of these services.

## 7.4 Expression of Interest

The Request for Expressions of Interest (EOI) for the Delivery of Better, Sooner, More Convenient Primary Health Care was released by the Ministry of Health in September 2009 and invited proposals from eligible primary health care providers and/or primary health organisations.

The Ministry required proposals to outline how transformational primary health care initiatives would be implemented to:

- Improve people's health and contribute to the achievement of national Health Targets;
- Lead to the establishment of Integrated Family Health Centres in appropriate locations that support multidisciplinary ways of working;
- Provide a wider range of health services in primary care settings that are more responsive to the needs of the community;
- Reduce acute demand on publicly-funded hospital services;
- Better manage patients with chronic conditions to support those people living in the community to live well and have their social and healthcare needs supported;
- Incorporate Whānau Ora approaches where appropriate
- Demonstrate a commitment to continuing service improvement and development to better meet the needs of communities

- Achieve the above objectives in a way that is cost effective and assures quality and safety for users of the services.

Expressions of Interest were submitted by all of the 5 PHO's within the Bay of Plenty district. The three Eastern Bay of Plenty PHO's (Te Ao Hou PHO, Kawerau PHO and Eastern Bay of Plenty PHO) submitted a joint Expression of Interest together with Healthcare New Zealand.

Similarly, Western Bay of Plenty PHO submitted an Expression of Interest as well as Nga Mataapuna Oranga PHO as part of the National Māori Coalition EOI.

## 7.5 Business Cases

Of the nine successful proposals identified for the first wave of business case development, two were from PHOs within the DHB region. Specifically, the EOI submitted by the three Eastern Bay of Plenty PHO's and the National Māori Coalition EOI, (the Māori Coalition) (which includes both Kaupapa Māori PHOs in the district; Nga Mataapuna Oranga PHO and Te Ao Hou PHO).

The Western Bay of Plenty PHO Expression of Interest was fundamentally premised on the development of integrated clinical care pathways (ICCP) but was not chosen to progress. Notwithstanding this, the DHB will be progressing the development of ICCPs as a clinically led, integrated and whole-of-system approach to transforming the Bay of Plenty health system as this is also an integral part of the business case submitted by the Eastern Bay of Plenty PHO's. Those PHOs in the district progressing their business cases will be key stakeholders in the ICCP process together with the DHB and Western Bay of Plenty PHO.

### 7.5.1 PHO reconfiguration plans

With regard to the business case submitted by the combined Eastern Bay of Plenty PHOs' (the Eastern PHOs), the first action to progress the business case *kaupapa* will be the merger of the Eastern PHOs. The new organisational structure will increase capacity, decrease overheads, be a platform for devolution and provide better patient access and coordination across the region. The new legal entity (which has been created in anticipation of the merger) is Te Tokotoru Hauora PHO, a

charitable not-for-profit company with ownership and governance derived from the existing PHOs.

With regard to the two PHOs presently existing in the Western Bay of Plenty (Nga Mataapuna Oranga PHO and western Bay of Plenty PHO), there are no plans for reconfiguration. However, it is to be noted that Western Bay of Plenty PHO has an enrolled population of 143,000 (presenting approximately 70% of the DHB population) and Nga Mataapuna is a Kaupapa Māori PHO closely aligned to the business case being progressed by the Māori Coalition.

### 7.5.2 DHB endorsement

The DHB has expressed its qualified support of the Māori Coalition business case and acknowledges that the business case sets out the process for ongoing engagement to be led by local affiliated members of the Māori Coalition. Further, the DHB acknowledges the strength of the alignment between the business case, the Better, Sooner, More Convenient Strategy and in particular, the Eastern PHOs business case.

However, the level of financial detail supporting the business case is not sufficient enough for the DHB to determine whether it is affordable. The DHB anticipates that a more detailed financial plan will be produced to support the Māori Coalition's work programme and in particular, its commitment to a cost neutral position for 2010/11.

Similarly, with the Eastern PHOs business case, DHB support is qualified by the need for more robust financial analysis particularly in relation to:

- Identifying the source of implementation funding
- Establishing appropriate project costs over the initial 16 months of implementation
- Agreement and careful evaluation of the savings attributed to the Provider Arm and the assumptions used particularly with regard to sunk/stranded costs
- Identifying opportunities to maximise Care Plus revenues and utilise PHO reserves
- Identifying where staff can be costed on a marginal basis, for example through accommodation in existing premises
- Including ED impacts in the modelling

## 7.6 Where we want to be

*The kaupapa for the Eastern PHOs business case is "A people centred, whanau ora approach to health and wellness in the eastern Bay of Plenty where success is enabling people and their families to be healthy and resilient. We seek to achieve this through a stronger whanau and integrated community health system that bridges our traditional community primary and secondary divides."*

*The kaupapa for the National Maori PHO Coalition business case is:*

*"Whanau Ora models of care that transform the way the primary health care sector delivers high quality and effective services to Māori and high needs populations."*

The DHB, as a partner organisation to the Eastern PHOs in the business case development phase of the EOI process, has committed significant 'in kind' resource (clinical and planning and funding expertise). Our role as a partner organisation is to assist the Eastern PHOs to realise their *kaupapa* on the basis that it will address health equity and ultimately deliver better health outcomes for the population of the eastern Bay of Plenty.

The DHB has been involved at each level of Business Case development including:

<b>Structuring up the work plan to develop the business case Steering Group</b>	The DHB was part of a workshop held to structure the workplan and steering group for the business case development.
	The DHB General Manager: Planning & Funding, General Manager Maori Health: Planning & Funding and Chief Operating Officer are members of the Steering Group overseeing the development of the Business Case.
<b>As work stream leads</b>	Particularly in areas of DHB overlap. The DHB provides the clinical lead in the primary/secondary integration work stream and planning and funding joint lead in the purchasing/accountabilities/funding work stream.
<b>As stakeholders</b>	Where discussion documents from each of the work streams will be shared with the DHB.

The model proposed by the Eastern PHOs is toward a system driven by common outcomes, underpinned by Whānau Ora, and better integration and coordination through an integrated family health network across the layers of:

- Self and home-based care
- NGO and community based services
- General practice
- Primary/secondary integration and Integrated Family Health Centres, and The associated oversight, governance and connecting networks<sup>15</sup>

<sup>15</sup> Combined Eastern Bay of Plenty PHOs/Healthcare NZ – Expression of Interest for the Delivery of Better, Sooner, More Convenient Primary Health Care in the Eastern Bay of Plenty (October 2009)

Similarly, the Māori Coalition *kaupapa* describes Whānau Ora models of care as needs-based and premised on the following elements:

- Single or managed point of entry;
- Whānau Ora needs assessment and goal oriented plan;
- Assigned kaimahi/case manager;
- Integrated service delivery, coordination and management;
- Planned exit or discharge; and
- Achievement of Whānau Ora outcomes.

### 7.6.1 Integrated Family Health Centres

Workforce sustainability (and in particular an ageing GP workforce) is a critical issue affecting primary health care. The Eastern PHOs EOI responds to this issue by proposing the amalgamation of practices with smaller sized enrolled populations. This strategy would realise demonstrable efficiency gains through either physical or virtual shared back office functions (such as shared HR, payroll, IT, PMS systems etc).

The IFHC would be underpinned by a Whānau Ora ideology and would provide integrated and co-located primary, secondary and community services that could attend to outpatient follow-up and some services that reduce reliance on hospital services.

### 7.6.2 Whānau Ora ‘satellite’ centres

Both the Eastern PHOs and Māori Coalition business cases propose the development of Whānau Ora centres.

Similarly, both business cases call for a move to more outcome based contracts and single point of entry to achieve a more consistent care pathway. Defining meaningful measures of population outcomes will be a major but not insurmountable challenge.

Specifically, the Māori Coalition EOI envisages the devolution of appropriate community and primary Māori services, including navigation services that extend into secondary care. The DHB will work with the Māori Coalition to identify potential pilot sites for developing Whānau Ora Centres, (particularly across the eastern Bay of Plenty), to implement the

Whānau Ora Strategy.

### 7.6.3 Integrated Clinical Care Pathways

The ICCP process recognises that the DHB has only one budget for publicly funded health care, so there should be one Bay of Plenty Health System as opposed to various providers delivering health services. Our approach to developing ICCP will seek to leverage off and learn from the Canterbury health system experience with an ultimate goal to establish and monitor Bay of Plenty wide care pathways that chart how patients with certain conditions should be best managed.

An ICCP represents a trusted clinical agreement as to what essential information needs to be obtained from the patient, what action needs to be taken, and by whom. Similarly, it describes when action needs to be taken (including essential investigations) and why referral to a specialist should proceed.

Our ICCP process will be:

- Patient centred
- Community sensitive
- Clinically led
- Action orientated
- Principles, process and values driven

The ICCP process will address where care is best provided, whether that is in the community or within a hospital campus, thus addressing the Minister's requirement to shift secondary services to more convenient settings.

### 7.6.4 Business Case Implementation

The DHB will work with our business case partners to stock take current contracts and identify those where aggregation can address barriers to Whānau Ora. The DHB will work with PHOs to:

- identify impact areas in which we expect to see change
- develop meaningful indicators and measures
- agree principles such as responsibility for showing evidence of outcomes,

- focus on learning and to cover factors such as result longevity, unintended outcomes, adverse consequences and benefit redistribution.

Although the plans for implementation of both business cases (Eastern PHO's and Māori Coalition) are still evolving, the Eastern PHO's together with the DHB have identified the following high level focus areas to guide work plan development for 2010/11. They are:

1. Merger of the three Eastern PHO's
2. Establishment of the Alliance Leadership Team
3. Establishment of the Clinical Governance Group (including Terms of Reference)
4. Whānau Ora
5. ICCP Process and its application within the business case
6. 'Whole-of-systems' approach to include:
  - Immunisation
  - Integrated family health network (IFHN)
  - Transition of services to the IFHC – COPD and diabetes
  - Acute admissions (including After Hours services and long term condition care)
7. Integrated Family Health Centre
8. PPP targets and the possible creation of an Alliance Contracting Team
9. Unregulated workforce development.

### 7.6.5 Governance Arrangements

Implementation of the business cases relating to both the Eastern PHOs and the Māori Coalition is governed by the Alliance Leadership Team (ALT). The ALT is made up of the following key positions:

- Bay of Plenty DHB (GM Planning & Funding, Maori GM Planning & Funding, Chief Operating Officer)
- Eastern Bay of Plenty PHO (CEO)
- Kawerau PHO (CEO)

- Te Ao Hou PHO (CEO)
- Te Tokotoru PHO (Executive Chair)
- Healthcare NZ (CEO)
- National Māori PHO Coalition
- Clinical representative from the PHOs and the DHB.

## 7.7 How we're going to get there – our performance story for 2010/11

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<p><b>Supporting a well population through early intervention, treatment and support</b></p>	<p>Business case implementation<sup>16</sup></p>	<p><b>The DHB will:</b></p> <ul style="list-style-type: none"> <li>• Work with the Eastern PHOs to:               <ul style="list-style-type: none"> <li>- develop an alliance based model of contracting</li> <li>- understand the risks/benefits/costs of the alliance model of contracting particularly in terms of the DHB's legislative and contractual obligations in accordance with the Crown Funding Agreement</li> </ul> </li> <li>• Work with the Eastern PHOs to fully understand the financial implications, affordability and sustainability of the business case</li> <li>• Contribute to the planning for the Whakatane Integrated Family Health Centre with Whānau Ora underpinnings and assist the Eastern PHOs in submitting necessary capital bids</li> <li>• Contribute to the planning for the Whānau Ora centres</li> <li>• Using the district wide health needs assessment, work with the Eastern PHOs to identify key population health outcomes with</li> </ul>	<ul style="list-style-type: none"> <li>• Better, sooner, more convenient primary health care</li> <li>• Reduction in demand for acute secondary services</li> <li>• Improved immunisation rates across the eastern Bay of Plenty</li> <li>• Health services 'closer to home'</li> </ul>	<ul style="list-style-type: none"> <li>• 1 single PHO</li> <li>• Integrated Family Health Centre (Whakatane) included in the redevelopment plans for Whakatane Hospital</li> <li>• 2 Whānau Ora centres</li> <li>• 1 governance structure</li> <li>• 1 clinical governance structure</li> <li>• 1 Iwi governance structure</li> <li>• Agreement on how to co-ordinate funding flows through both business cases</li> </ul>	<p>\$ unknown</p>

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
		<p>a focus on PPP targets for immunisations, diabetes/CVD, smoking, screening (breast/cervical/diabetes)</p> <ul style="list-style-type: none"> <li>• Develop and agree a joint work programme as between the Eastern PHOs and the DHB.</li> <li>• Work with the Eastern PHOs and the Bay of Plenty Polytechnic to develop a qualification for the unregulated health workforce.</li> </ul>			
<p><b>Healthy mothers, healthy babies and healthy children</b></p>	<p>Business case implementation - Māmā, Papa and Pēpi, programmes</p>	<p><b>The DHB will:</b></p> <ul style="list-style-type: none"> <li>• Contribute to the development of a new and integrated care pathway/package of care for mama, papa and pēpi including: <ul style="list-style-type: none"> <li>- Changes needed to existing funding models</li> <li>- Development of outcomes-based incentives</li> <li>- Identifying service fragmentation through existing service stock takes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Increased immunisation rates among Māori children</li> <li>• Reduction in potentially avoidable hospitalisations</li> <li>• Increases in healthier lifestyle choices by pregnant women and mothers of young children</li> </ul>	<ul style="list-style-type: none"> <li>• Māmā, Papa and Pēpi programmes</li> </ul>	<p>\$ unknown</p>
<p><b>Increasing prevention and improving management of long term conditions experienced by Māori and high needs populations</b></p>	<p>Long Term Conditions Framework</p>	<p><b>The DHB will:</b></p> <ul style="list-style-type: none"> <li>• Contributing to the development of an integrated system of care focusing on improving self management and the delivery of integrated health and social services to Whānau</li> </ul>	<ul style="list-style-type: none"> <li>• Shorter stays in emergency departments due to advanced and planned case management</li> <li>• Shorter waits for cancer treatment due to improved referral pathways and partnered relationships with clinicians</li> <li>• Increases in healthier lifestyle choices and compliance (e.g. completed risk assessments and annual</li> </ul>	<ul style="list-style-type: none"> <li>• Long term conditions framework</li> </ul>	<p>\$ unknown</p>

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
			checks) <ul style="list-style-type: none"> <li>Targeted and culturally effective services</li> </ul>		
<b>Networks of high quality Whānau Ora service providers</b>	Whānau Ora centres  Local Whānau Ora networks	<b>The DHB will:</b> <ul style="list-style-type: none"> <li>Identify and devolve appropriate community and primary Māori services, including navigation services that extend into secondary care</li> </ul>	<ul style="list-style-type: none"> <li>Health services closer to home and reaching the high needs population</li> <li>Culturally appropriate health services that are easily navigated by Māori and contribute to a more seamless patient journey and better health outcomes for Māori</li> </ul>	<ul style="list-style-type: none"> <li>Local Whanau Ora Network</li> </ul>	\$ unknown
<b>An Outcomes Framework to inform an alliance contracting base</b>	Explore new models of contracting (including alliance contracting)	<b>The DHB will:</b> <ul style="list-style-type: none"> <li>Work with the Māori Coalition to: <ul style="list-style-type: none"> <li>Develop an alliance model of contracting</li> </ul> </li> <li>Understand the risks/benefits/costs of alliance contracting particularly in terms of the DHB's legislative and contractual obligations in accordance with the Crown Funding Agreement</li> <li>Participate in the development of an Outcomes/Performance Measurement Framework</li> </ul>	<ul style="list-style-type: none"> <li>A significant reduction in health inequalities for Maori</li> </ul>		\$ unknown
<b>'Whole-of-systems' approach to Whānau Ora</b>	Affordability of business case  Policy framework for implementing the business	<b>The DHB will:</b> <ul style="list-style-type: none"> <li>Work with the Māori Coalition to fully understand the financial implications, affordability and sustainability of the business</li> </ul>			

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
	case	case <ul style="list-style-type: none"> <li>• Assist the Māori Coalition in developing and strengthening collaborative relationships at all levels (particularly with Iwi, Māori providers, clinicians and other government agencies)</li> <li>• Develop and agree a joint work programme as between the Māori Coalition and the DHB</li> <li>• Work with the Māori Coalition to identify pilot sites for implementation of the Whānau Ora Strategy</li> </ul>			
<b>Bringing health services ‘closer to home’</b>	Shifting of services to more convenient primary care settings	<b>The DHB will:</b> <ul style="list-style-type: none"> <li>• Continue to devolve services to more convenient primary care settings in accordance with the Bay of Plenty District Health Board Devolution Plan and as identified through the ICCP process. Services which will be considered for potential devolution may include, but are not limited to:               <ul style="list-style-type: none"> <li>- District nursing</li> <li>- Nurse led clinics (chronic pain clinic)</li> <li>- GP’s undertaking patient follow-up’s ordinarily completed by specialists</li> <li>- GPSI schemes (mirena insertions, otitis media, rectal bleeding, breast cancer management, referral management, management</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• The provision of health services closer to home</li> <li>• Greater opportunities for self-management of health conditions</li> <li>• Fewer people progressing to more chronic stages of disease</li> <li>• More productive hospital services</li> <li>• More cost effective health services</li> </ul>	<ul style="list-style-type: none"> <li>• Shift secondary services to more convenient primary care settings as identified through the ICCP process.</li> </ul>	

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
		of some ENT conditions) <ul style="list-style-type: none"> <li>- Spirometry</li> <li>- Joint injections</li> <li>- Treatment for polymyalgia</li> <li>- First specialist appointments (supported by Clinical Management Plans)</li> <li>- Sexual health clinics</li> <li>- Joint social worker for oncology</li> <li>- Electronic referrals and diagnostic access</li> </ul>			
<b>Integrated care – Right time, right place, right people for the right price</b>	Integrated clinical care pathways	<b>The DHB will:</b> <ul style="list-style-type: none"> <li>• Establish a governance group to oversee the development and monitoring of Care Pathways</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• The provision of health services closer to home</li> <li>• Greater opportunities for self-management of health conditions</li> <li>• Fewer people progressing to more chronic stages of disease</li> <li>• More productive hospital services</li> <li>• More cost effective health services</li> </ul>		

## Whānau Ora: improvement of Māori health status

### 8.1 Whānau Ora

Across New Zealand Māori health status continues to lag behind others. 'Whānau Ora' as an ideology, business model and service strategy continues to gather political momentum in recognising that for Māori, health is not just a manifestation of physical wellbeing, but is more an expression of a desire for a healthy secured future, nurtured by traditional social structures; Whānau, Hapū and Iwi.<sup>17</sup>

Whānau Ora influences a Whānau's 'way of being' and affects all decisions made, it is the driving ideology for governance, resource allocation and service configuration designed to meet the needs of Whānau.<sup>18</sup>

Providing new insights, with new avenues of thinking on how to build stronger and more strategic organisations is a key objective of the Whānau Ora bulk funding concept. The DHB is attuned to this thinking, and has been investing in key strategic initiatives to meet health needs and improve health outcomes for the people who live in the district. The two key initiatives are Iwi Health Plans and He Pou Oranga Tangata Whenua Determinants of Health. Toi Ora - optimum health and wellbeing is the ultimate goal of the Bay of Plenty District Health Board for Māori. Whānau Ora is inextricably linked to Toi Ora.

The overall aim of *He Korowai Oranga* is Whānau Ora; supporting Māori Whānau to achieve health and well being within Te Ao Māori (Māori world) and New Zealand society. Individual healthcare needs to be considered within a cultural context, effective health and disability services should be co-ordinated around the needs

and realities of Whānau and incorporate Māori cultural values, beliefs and practices.

Whānau Ora services delivered within the DHB provide a range of general health education/promotion, advisory, liaison and co-ordination activities. Whakatātaka<sup>19</sup> sets out to achieve change within all District Health Boards, to ensure District Health Board activities are directed at improving Māori health rather than ad hoc programmes and initiatives. It seeks to build on the strengths and assets within Whānau and Māori communities. The DHB has a strong commitment to these goals and a desire for increased collaborative activity to get there.

The bulk funding concept is ideally suited to Māori and strongly supports a Māori holistic model and wellness approach and more significantly emphasises that Whānau plays a central role in well being of Māori individually and collectively.

### 8.2 Te Ēkenga Hou

Te Ēkenga Hou is the DHB strategic plan that consolidates our philosophy and direction with regard to Māori health and the priority given to reducing Māori health inequalities across the DHB area.

Te Ēkenga Hou encompasses three distinct themes to inform DHB processes for planning, funding and delivering Māori health services. They are:

1. Tino Rangatiratanga
2. Tuituinga Pou Hauora
3. He Ranga Hua Hauora

<sup>18</sup> National Maori PHO Coalition Expression of Interest for Better, Sooner, More Convenient Primary Health Care (October, 2009)

<sup>19</sup> Māori Health Action Plan 2006-2011 (Ministry of Health)

## 8.3 Where we want to be

### 8.3.1 Tino Rangatiratanga

Tino Rangatiratanga is the theme that represents Māori self-determination.

During 2010/11 the DHB (via its Māori Health Planning and Funding Unit) will continue to work with Iwi in developing and implementing Iwi Health Plans that provide a framework for Māori to determine meaningful and relevant health goals and outcomes for their people with a clear course to achieve them.

### 8.3.2 Tuituinga Pou Hauora

Tuituinga Pou Hauora is the theme that reinforces the need for mainstream health services to be responsive to the unique needs of Māori.

The DHB responded to this theme by developing and implementing He Ritenga, an audit tool designed to measure the responsiveness of mainstream health services to Māori within 5 domains; service delivery, planning, governance, intersectoral initiatives and workforce development.

He Ritenga has proven its success and usefulness in auditing secondary services and during 2010/11 the DHB intend to build on this success and expand its application within the primary sector. Further, the DHB will continue to share what it has learned in implementing He Ritenga and to this end remains committed to training other Midland DHBs in its application.

### 8.3.3 He Ranga Hua Hauora

He Ranga Hua Hauora is the theme that relates to building capacity and capability amongst kaupapa Māori providers.

Māori Health services often centre on behaviour and lifestyle changes, the health outcomes of which can take a longer time to realise. He Pou Oranga Tangata Whenua Determinants of Health framework (He Pou Oranga) is outcome focused. It has been adopted by the Board and Rūnanga, validates tangata whenua principles, and defines and measures

Māori health and well being from a Māori worldview. The development of He Pou Oranga is testament to the strength of the partnership that exists between the Board and the Rūnanga.



## 8.4 How we're going to get there – our performance story for 2010/11

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Whānau Ora/Toi Ora</b>	Tino Rangatiratanga – encouraging Māori self-determination	<ul style="list-style-type: none"> <li>• Iwi health plans - Support development of Iwi health plans to shift thinking from an operational-contract management focus to a strategic Iwi development framework.</li> </ul>	<ul style="list-style-type: none"> <li>• Better health outcomes for Māori</li> <li>• More opportunities for Māori to self-manage their conditions</li> <li>• More holistic approach to contracting</li> <li>• Greater awareness of how lifestyle changes can contribute to Whānau Ora</li> </ul>	<ul style="list-style-type: none"> <li>• Support to Iwi who completed Phase 2 to implement their Iwi Health Plans within existing resources</li> <li>• Better collaboration with other social agencies beyond the health sector</li> </ul>	No specific funding allocated (utilising internal and existing resources)
<b>Whānau Ora/Toi Ora</b>	Tuituinga Pou Hauora – ensuring mainstream health services are responsive to the unique needs of Māori	<ul style="list-style-type: none"> <li>• Undertake He Ritenga audits of Medical Services, Women, Child &amp; Family Services, Clinical and Non-Clinical Support Services, and the remaining services within Regional Community Services<sup>20</sup></li> <li>• Strategic plan developed for Secondary Māori Health Services (to address the Māori population accessing both mainstream and kaupapa services)</li> </ul>	<ul style="list-style-type: none"> <li>• Better health outcomes for Māori</li> <li>• Mainstream services are more culturally responsive</li> <li>• Whānau are appropriately engaged in the journey to Whānau Ora</li> </ul>	<ul style="list-style-type: none"> <li>• Audit at least 2 services utilising the He Ritenga framework</li> </ul>	\$85k

<sup>20</sup> The services identified will be audited against He Ritenga during the period 2010 to 2013

<b>Whānau Ora/Toi Ora</b>	He Ranga Hua Hauora – capacity and capability of kaupapa Māori providers	<ul style="list-style-type: none"> <li>Effectively promote and administer the CTA Hauora Māori Training Fund</li> <li>Utilise Korite (BOPDHB Māori Workforce Development Plan) as the key document guiding national and regional discussions on Māori workforce development</li> <li>He Pou Oranga Tangata Whenua Framework incorporated into processes as relevant</li> </ul>	<ul style="list-style-type: none"> <li>The right people, with the right skills, in the right place to deliver effective kaupapa approaches to healthcare</li> <li>The He Pou Oranga Tangata Whenua framework is aligned with the Whānau Ora Strategy</li> </ul>	<ul style="list-style-type: none"> <li>85% student retention in training programmes</li> <li>Consistent approaches to Māori workforce development nationally, regionally and locally</li> </ul>	<p>Allocated CTA funding in accordance with the CFA agreement</p> <p>No specific funding allocated (utilising internal resources)</p>
<b>Whānau Ora/Toi Ora</b>	Participate in and contribute to the National Māori PHO Coalition Business Case development and implementation	Refer chapter – “Better, sooner, more convenient primary health care”			\$ unknown

## Reducing the incidence and impact of long term conditions

### 9.1 Overview

Chronic diseases, such as cardiovascular disease, diabetes, respiratory disease and cancers are a priority because they impose a significant additional burden on disadvantaged and disenfranchised populations and health services. As the population ages, and lifestyles change, these conditions are likely to increase significantly.

Nationally, prevalence rates of most chronic conditions appear to be increasing. The emphasis needs to be on better prevention of smoking, obesity and cancer, and on how and where patients with chronic conditions are managed, which must be more in primary and community settings.

Locally, Māori are over represented in our long term condition statistics. Diabetes hospitalisation rates for Māori in the Bay of Plenty district are significantly higher than those for non-Māori. Similarly, the rates of hospitalisations for leg/foot/toe amputations for Māori with diabetes are significantly higher than those for non-Māori. The same applies in both hospitalisation and mortality rates for adult cardiovascular disease, ischaemic heart disease and cancer.

A strategic and sustained focus on chronic conditions will help relieve the burden of acute demand, help reduce inequalities and improve overall health. In this effort the DHB will work closely with kaupapa Māori and mainstream PHOs and other key stakeholders.

### 9.2 Government priorities

Smoking kills an estimated 5,000 people in New Zealand every year, and smoking related diseases are a significant opportunity cost to the health sector. Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care.

The national health target ‘better help for smokers to quit’ is designed to prompt providers to routinely ask about smoking status as a clinical ‘vital sign’ and then to provide brief advice and offer quit support to current smokers. There is strong evidence that brief advice is effective at prompting quit attempts and long term quit success. The quit rate is improved further by the provision of effective cessation therapies – pharmaceuticals, in particular nicotine replacement therapy (NRT), and telephone or face-to-face support.

*Better help for smokers to quit*

*Better diabetes and cardiovascular services*

Diabetes is important as a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of a health service for people in most need.

### 9.3 Where we want to be

The overall goal for 2010/11 is to ensure that long term condition services (including diabetes services) are strategically placed to ensure adequate coverage and access is maintained, particularly for high needs populations.

To achieve our goal specifically in relation to diabetes, better engagement with and coordination between secondary and primary/community diabetes service providers is required. The foundation work for improving engagement and cross-sector connectivity was laid in 2009/10 with a DHB facilitated Diabetes Strategic Planning day. Actions will be progressed during 2010/11.

With regard to tobacco control a number of initiatives have been instigated during 2009/10 that will be expected to yield significant gains in 2010/11. These initiatives have included:

- Development of clinical and supporting IT systems in both general practice and hospitals to better identify and record smokers and provide brief advice, offering of NRT and referral to community-based quit programmes;
- The appointment of a General Practice Smokefree Champion; a GP who works across the BOP with general practice personnel and systems to increase smoking quit attempts;
- Delivery of training in smoking cessation interventions to health practitioners in the community, primary and secondary sectors, with a focus on providers working with Māori patients (60% of clinical staff in the DHB Smokefree Hospitals have been trained in ABCs, 650 community, primary and secondary staff have undertaken Quitcard training, with 75% of those 650 trained in the last 6 months);
- Currently Opotiki and Western Bay of Plenty District Councils have adopted Smokefree Public Places policies and Toi Te Ora Public Health Unit is currently engaging with Kawerau, Tauranga and Whakatane District Councils; A large increase in the number of

trained Quit Card providers, particularly in community-based services;

- Establishment of the Bay of Plenty Tobacco Control Steering Group with a clinical, strategic and community focus to align with Ministry priorities.



## 9.4 How we're going to get there – our performance story for 2010/11

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<p><b>A reduction in the incidence and impact of long term conditions.</b></p>	<p>Better diabetes and cardiovascular services</p> <ul style="list-style-type: none"> <li>- Improved access for those with long-term conditions to multi-disciplinary services</li> <li>- Improved management of people with long term conditions in the primary care sector</li> <li>- Identification of at-risk individuals through appropriate and timely screening</li> </ul>	<p><b>Management</b></p> <ul style="list-style-type: none"> <li>• Increased primary care capability to manage patients requiring insulin therapy</li> <li>• Increased diabetes training for health support workers such as Māori hauora staff</li> <li>• Provide validated patient self management and education</li> <li>• Developing shared care/clinical care pathways</li> <li>• Increase the scope of responsibilities for home based support workers</li> <li>• Assistive technologies to enable remote care for our rural and isolated populations</li> </ul> <p><b>Detection</b></p> <ul style="list-style-type: none"> <li>• Health promotion and preventative activities</li> <li>• Continued implementation of Midland Chronic Conditions Information System</li> </ul>	<ul style="list-style-type: none"> <li>• Earlier diabetes detection</li> <li>• Improved HbA1c levels</li> <li>• Better coordination of care through primary and secondary</li> <li>• Better length and quality of life</li> <li>• Reduced disability</li> <li>• More participation and independence</li> <li>• Reduced inequalities</li> <li>• Increased workforce productivity</li> <li>• Increased engagement with DAR and CVD risk assessment</li> </ul>	<ul style="list-style-type: none"> <li>• 65 percent of the eligible population will have their cardiovascular disease (CVD) risk assessed in the last five years</li> <li>• 68 percent of people with diabetes will attend free annual checks</li> <li>• 83 percent of people with diabetes will have satisfactory or better diabetes management</li> </ul>	<p>Diabetes \$4,395,721</p>

<p><b>Early identification of at risk smokers</b></p> <p><b>Better and earlier management of people who smoke</b></p>	<p>Better help for smokers to quit through:</p> <ul style="list-style-type: none"> <li>- More accurate data capture</li> <li>- Solid clinical leadership</li> <li>- Comprehensive organisational systems</li> <li>- More training</li> <li>- Better integration between primary and secondary health care settings</li> </ul>	<p><b>Data Capture</b></p> <ul style="list-style-type: none"> <li>• Organisational roll out of electronic discharge summaries that confirm ABC smoking cessation support given</li> <li>• Implementing a 'flagging' system within hospitalised smokers notes which requires ABC's to be delivered to patient before enabling electronic discharge summary to be produced</li> <li>• Monthly auditing of patient notes by ward/department to determine whether ABC's delivered</li> </ul> <p><b>Clinical Leadership</b></p> <ul style="list-style-type: none"> <li>• Smokefree Link Nurses appointed within each ward/department</li> <li>• Add requirement to deliver ABC's to KPIs/performance plans for clinical staff</li> <li>• GP Smokefree Champion to engage with all primary care providers to introduce ABC to all clients who smoke</li> </ul> <p><b>Systems Improvements</b></p> <ul style="list-style-type: none"> <li>• Improve visibility of Smokefree Coordinators (SFCs) by being present at nursing handovers within Emergency Department and Admissions Planning Unit</li> <li>• Implement an Inreach Patient Smoking Cessation transition service that enables whānau self-management to quit targeting Māori, Pacific and pregnant women in hospital.</li> </ul>	<ul style="list-style-type: none"> <li>• Better length and quality of life</li> <li>• Reduced disability</li> <li>• More participation and independence</li> <li>• Greater awareness of the health risks associated with smoking</li> <li>• Reduced inequalities</li> <li>• Increased workforce productivity</li> </ul>	<ul style="list-style-type: none"> <li>• 90% of hospitalised smokers will be provided with help to quit by July 2011</li> <li>• 80% of smoking patients attending primary care will be provided with help to quit by July 2011</li> <li>• 80% of nurses, doctors and allied staff will have received ABC smoking cessation training by December 2010</li> <li>• 400-600 Māori, Pacific and pregnant women patients at Tauranga Hospital are given brief advice, NRT therapy and referred to a community quit agency</li> <li>• 40-60 Māori and Pacific ex-smokers trained in Kaihautu Auahi Kore leadership-peer support roles in their whānau</li> <li>• 2% reduction in the number of Year 10 students in the Bay of Plenty schools identifying as non-smokers by July 2011</li> <li>• 600 to 660 people domiciled within the district will have access to intensive smoking cessation services, the majority of which will be Māori</li> <li>• 120 controlled purchase</li> </ul>	<p>Tobacco Action Plan \$375,200</p>
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		<p><b>Training</b></p> <ul style="list-style-type: none"> <li>• Ongoing ABC training of clinical staff by: <ul style="list-style-type: none"> <li>- Compulsory training of new clinical staff during organisational induction programme</li> <li>- Training of existing clinical staff coordinated by Learning Plus and DHB Smokefree Coordinators</li> <li>- Utilising the DHB e-learning tool within primary health care setting (focusing particularly on Māori providers)</li> </ul> </li> </ul> <p><b>Primary/Secondary integration</b></p> <ul style="list-style-type: none"> <li>• GP Smokefree Champion to offer ongoing CME sessions to primary clinical staff (GP's and practice nurses) regarding smoking cessation</li> <li>• Increase volume of electronic discharge summary referrals to GP's to enable comprehensive smoking cessation support in the primary setting.</li> <li>• Improved engagement with other primary health care providers (such as Lead Maternity Carers) for ABC training and induction in the use of hospital systems for accurately capturing/recording that ABC's given</li> <li>• Utilising the 'Man Alive' CVD risk assessment programme in the eastern Bay of Plenty to deliver ABC's and thereafter arrange</li> </ul>		<p>operations carried out on tobacco retailers in the BOP district.</p> <ul style="list-style-type: none"> <li>• One more district council in the Bay of Plenty will adopt a smoke-free public places policy</li> </ul>	
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		<p>comprehensive cessation support.</p> <ul style="list-style-type: none"><li>• Primary and secondary clinicians linked through quarterly meetings of the Tobacco Control Steering Group led by the Tobacco Control Project Manager</li><li>• Close monitoring of primary care performance by Tobacco Control Project Manager</li></ul>			
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## Child and youth health

### 10.1 Overview

There are steady numbers of children within the Bay of Plenty district (and in particular across the eastern Bay of Plenty) born into areas of high deprivation. Māori children are over represented in families living in these areas and this is reflected in the utilisation of acute secondary services and rates of ambulatory sensitive (avoidable) hospital admissions.

Immunisation is a very cost-effective health intervention; it can prevent a number of diseases. Immunisation not only provides individual protection, but also population-wide protection by reducing the incidence of disease and preventing them spreading to vulnerable people. New Zealand’s current immunisation rates are low by international standards and are not sufficient to prevent or reduce the impact of vaccine preventable diseases such as measles and whooping cough.

Improving immunisation coverage continues to be a key priority for BOPDHB. By working with PHO information systems and the National Immunisation Register a more targeted approach will be delivered, focusing on those children most at risk of vaccine preventable infectious disease.

### 10.2 Government priorities

*Better immunisation rates – 85% of two year olds fully immunised by July 2010*

### 10.3 Where we want to be

#### Immunisation

While immunisations rates across the Bay of Plenty district have been incrementally increasing over recent years we still have one of the lowest immunisation rates across the country sitting currently at 76% overall, and 70% for Māori.

For 2010/11 BOPDHB is committed to achieving the government target of 85% of two year olds fully immunised and in particular improving immunisation rates of ‘at risk’ children through a comprehensive redesign of outreach immunisation services.

BOPDHB has worked with the eastern Bay of Plenty PHOs and the National Maori PHO Coalition to ensure that the 2 year old immunisation national health target is accorded priority in their respective primary care business cases. BOPDHB has collaborated with other Midland DHBs in the setting of our local targets to ensure we contribute to achieving 90% immunisation coverage across the region.



Our local target for 2010/11 is 85%, a 7% increase on our 2009/10 target of 78%. It has been settled in consultation with our Midland partners and recognises a decline rate of 9.1% across the Bay of Plenty district. Midland DHBs will continue to share immunisation best practice and innovations to progress toward the regional target.

BOPDHB will also participate in the Ministry of Health/DHBs initiative of 3-monthly teleconferences with intervening work as necessary, to achieve 95% coverage of two year olds by July 2012.

Overall our 2010/11 objective for immunisation services is to create an integrated, 'whole of systems' approach across the continuum of care through integrated IT systems and more effective collaboration between primary care (PHOs, Hauora and mainstream providers), Public Health (Toi te Ora, IMAC) and the Ministry of Health (Plunket, midwives). This integrated approach to immunisation will be overseen by the Immunisation Advisory Group which includes representatives from each of the stakeholders described above.

### **Oral Health**

In 2009, the Ministry of Health approved funding of \$6.5 million for Bay of Plenty DHB to implement the plan to improve oral health services that was outlined in the Oral Health Business Case. In addition a further \$1.6 million was made available for ongoing operational funding to support increased volumes of services provided to a greater number of enrolled children and adolescents

In 2010 the implementation of the business case will continue, the DHB plans to:

- Increase the number of preschool children enrolled with the service, from 6,800 to 7,500
- Increase the number of adolescents enrolled in an oral health service, from 8,800 to 11,000
- Reduce the percentage of preschool and school age children that are not seen according to recall criteria

## 10.4 How we're going to get there – our performance story for 2010/11

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Reduced incidence of vaccine preventable infectious disease in children</b>	<ul style="list-style-type: none"> <li>Childhood Immunisation</li> <li>Youth and adult immunisation for high risk groups</li> </ul>	<ul style="list-style-type: none"> <li>Develop and implement good systems for monitoring and recall of overdue immunisations</li> <li>Social marketing programme – implement a programme of awareness amongst health care staff and the community of immunisation issues</li> <li>Increase opportunistic immunisation and increase immunisation venues (Child Assessment unit/Paediatric inpatient wards/outpatients/hauora clinics)</li> <li>Re-focus the outreach immunisation programme to focus on low uptake areas.</li> <li>Investigate change to existing funding models to more incentivised arrangements (outcomes based funding model)</li> </ul>	<ul style="list-style-type: none"> <li>Fewer parents declining to have their children immunised</li> <li>Increased uptake of immunisation</li> <li>Increased awareness of immunisation issues in community</li> <li>Better coordination of community contracts, and greater transparency</li> </ul>	<ul style="list-style-type: none"> <li>85% of 2 year old children up to date with their age-appropriate vaccinations</li> <li>75% of two year olds (Māori) are fully immunised by July 2010</li> <li>HPV targets met</li> </ul>	\$2,989,957
<b>Reduced incidence of oral disease and dysfunction in children and youth</b>	<ul style="list-style-type: none"> <li>Implementation of the Oral Health Business Case</li> </ul>	<ul style="list-style-type: none"> <li>Construction of 4 new fixed chair clinics</li> <li>Purchase 5 new mobile dental units</li> <li>Increasing the number of dental assistants to 17.5 FTER</li> </ul>	<ul style="list-style-type: none"> <li>Increase the coverage of the school dental service</li> <li>Increased enrolments into the school dental service</li> <li>Improvement in oral health status for children and adolescents.</li> </ul>	<ul style="list-style-type: none"> <li>Increase the number of preschool enrolled with the service to 7,500</li> <li>Increase the number of adolescents enrolled with the service to 11,000</li> </ul>	≈\$6.9m

## Better performing, more sustainable organisations

### 11.1 Government priorities

#### Improving hospital productivity

Getting the best health value for every dollar spent is more important than ever, given the current financial situation. The emphasis for DHBs is to ensure health resources are used to maximum patient benefit by shifting resources from the back office to front-line services, enhancing clinical leadership, streamlining bureaucracy and improving hospital productivity by creating more shared services both regionally and nationally where that enhances quality and efficiency.

*Improving hospital productivity*  
*Workforce sustainability*  
*Clinical leadership and engagement*  
*'Living within our means'*  
*Quality, safety and continuous improvement*

#### Workforce Sustainability, clinical leadership and engagement

A stable, well prepared and knowledgeable workforce that understands and responds to the specific needs of the DHB population is essential to improved health outcomes for all, especially Māori. Further, attempting to make fundamental changes to the health system for the sector to 'live within its means' will require strong clinical engagement and leadership.

Equally as important is a need to implement effective strategies geared at the recruitment and retention of clinicians to minimise the risk of compromised patient outcomes from long term clinical

workforce vacancies and reduce personnel costs that flow from high-cost, short term cover for those vacancies.

Developing clinical leaders or more opportunities for clinical leadership within the sector will improve clinical staff morale and workforce engagement. Staff who are engaged and demonstrating effective leadership within an organisation are more likely to stay longer.

#### 'Living within our means'

The current economic and fiscal environment is a significant planning consideration for 2010/11. Continuing pressure on Vote Health for the foreseeable future means a lower funding growth path for DHBs. Better managing labour cost growth, costs of consumables and non-clinical consumables, implementation of information systems, and management of our assets both from a local and regional perspective, are all components of 'living within our means' from an infrastructure perspective.

#### Quality, safety and continuous improvement

DHBs are expected to encourage an organisation wide commitment to quality improvement and quality assurance initiatives, and to develop an environment that fosters a quality improvement ethic and quality improvement initiatives.

Further, DHBs must encourage quality improvement across the wider sector through ensuring that other funded providers demonstrate a commitment to, and implement, quality standards appropriate to the size and scope of their organisation.

## 11.2 Where we want to be

### 11.2.1 Improving hospital productivity

Driven by a patient centred approach, the DHB will continue its commitment and dedication to improving hospital productivity, service quality and overall patient experience during 2010/11.

Performance reporting will play an important part in terms of informing DHB decision making to improve productivity.

In terms of procurement the DHB has worked constructively on several fronts, local, regional and national during 2009/10 and expects this collaborative approach to continue during 2010/11.

At a local level the DHB has identified larger medical consumable spend suppliers and developed preferred supplier agreements. This has not only attracted significant cost savings based on current product volumes and range but will also provide certainty around prices going forward for budget holders.

At a regional level, the DHB is a member of the Midland Supply Group which is made up of Procurement Managers from Waikato, Lakes, Taranaki and Tairāwhiti District Health Boards. This group has been in existence for several years and investigates opportunities for collective procurement.

The DHB has participated in several large tenders including physiology implantation services and ACC provider services and leads several productive initiatives including nutritionals, patient monitoring systems, general and medical waste and patient hoists.

At a national level the DHB has joined in collaborative initiatives around woundcare, syringe drivers and fuel and has supported all-of-government initiatives around stationery, MFD's, vehicles and IT. Our latest commitment at national level is to lead a tender process for ultrasound machines for those DHBs who wish to participate.

The DHB is also a strong participant in DHBNZ's Project 45, a joint initiative of the 21 DHBs to realise \$45 million in savings for 2009/10 and \$50 million in 2010/11. The DHB is on track to deliver

its part of the savings and is committed to a coordinated approach to procurement.

### 11.2.2 Workforce sustainability, clinical leadership and engagement

The health and disability workforce is key if we are to meet the increasing challenges in the sector. We need to be more proactive and take positive steps to improve workforce capability and capacity across the sector.

While DHBs collectively have made progress over the last couple of years around workforce issues, acceleration is needed and new national arrangements should support this. While there is much DHBs can do individually, many changes need national action, including the important area of workforce substitution.

The DHB employs over 2,800 staff (full time equivalents). Approximately 40% identify as New Zealand European and 11% as Māori. The majority of staff employed are health professionals.

Within the DHB Provider Arm staff turnover rates average approximately 8% per year.

The DHB is committed to strengthening clinical leadership and a culture for enduring clinical/management partnerships. Provider Arm structure reflects these partnerships with a triumvirate leadership model adopted for each service cluster made up of a business, medical and nurse leader. A strong Clinical Board at a governance level and Clinical Governance Committee at Provider Arm level further support this approach.

Technical advisory groups present a useful tool for clinically led, cross-sectoral advice to inform planning and funding decisions.

Organisational structure enables clinical leadership, accountability and decision making at all levels.

Nurturing a connection between the secondary students of the Bay of Plenty and careers in the health sector; placing an emphasis on the learning environment of the Clinical School both from a teaching and research perspective; and improving the engagement

of staff are all key strategies the DHB deploys to secure a sustainable workforce.

### **11.2.3 Living within our means**

In response to the Minister's expectation that DHBs will control the growth of labour costs, it has been assumed that as approximately 89% of DHB employees are covered by salary scales and terms and conditions in National MECAs, employment costs arising from MECAs and their renewal processes must be sustainable. Other controllable costs include the escalation from FTE growth (both clinical and non-clinical) as well as costs associated with the provision of 24/7 services and related HR systems.

### **11.2.4 Quality, safety and continuous improvement**

Improving the quality and safety of our health services is a priority for the DHB. 'Health Excellence' is our organisational commitment to performance excellence utilising an internationally recognised framework, namely Baldrige Health Criteria for Performance Excellence.

*The vision for Health Excellence -  
"Striving to achieve the highest quality  
healthcare"*

The framework is a practical tool to guide continuous improvement and our journey to a culture based on quality outcomes. It enables DHB performance to be measured against other high performing organisations.

### 11.3 How we're going to get there – our performance story for 2010/11

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Improving hospital productivity</b>					
<ul style="list-style-type: none"> <li>• <b>The financial sustainability of the DHB is improved</b></li> <li>• <b>The impact of sudden trauma or illness requiring immediate secondary level care is mitigated</b></li> <li>• <b>People at risk of illness or injury are diagnosed and managed earlier</b></li> <li>• <b>People with early conditions are treated and managed earlier and illness progression is reduced</b></li> </ul>	<p>Integrated clinical care pathways</p>	<ul style="list-style-type: none"> <li>• <b>Ensure appropriate clinical engagement/ownership of project across both primary and secondary care settings</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Better, sooner, more convenient health care</b></li> <li>• <b>Good opportunity for clinical leadership</b></li> <li>• <b>More seamless patient journey from primary to secondary care when necessary</b></li> <li>• <b>More timely and appropriate patient treatment</b></li> <li>• <b>Better clinical outcomes</b></li> <li>• <b>Improved patient experience</b></li> <li>• <b>Reduction in acute demand</b></li> <li>• <b>Reduction in inappropriate referrals</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Decrease length of stay for elective and arranged inpatients by 8.2% and acute inpatients by 7.1% over 2008/2009 baseline.</b></li> <li>• <b>11.1% increase in day of surgery admission rate.</b></li> <li>• <b>Increase Whakatane Hospital theatre utilisation by over 17% and Tauranga by 3%</b></li> <li>• <b>Performance Monitoring framework in place</b></li> </ul>	

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Workforce sustainability, clinical leadership and engagement</b>					
<ul style="list-style-type: none"> <li>• <b>The right people, with the right skills, in the right place to delivery effective healthcare</b></li> <li>• <b>A motivated and committed workforce</b></li> <li>• <b>Effective delivery of health services based on best practice and cost efficiency</b></li> </ul>	<ul style="list-style-type: none"> <li>• Primary care</li> <li>• DHB Staff engagement</li> <li>• Māori workforce development</li> <li>• Mental health workforce development</li> <li>• Clinical school</li> <li>• Research</li> <li>• Clinical leadership across disciplines</li> <li>• Clinical leadership across primary and secondary care</li> <li>• Change management and process improvement through user groups to support patient focused facility development</li> <li>• Releasing Time for Clerical Excellence</li> </ul>	<ul style="list-style-type: none"> <li>• Undertake further leadership development of clinicians and senior managers</li> <li>• Continued support for the implementation of Korite</li> <li>• Identification of training to support development of clinical leadership capabilities</li> <li>• Grow research capacity and capability</li> <li>• Grow clinical teaching capacity and capability</li> <li>• Support opportunities for workforce innovation e.g. nurse endoscopist</li> <li>• Robust change management to ensure staff leadership and engagement for facility redesign</li> <li>• Improvements to workflows as a result of process improvement</li> <li>• Change management and process improvement through user groups to support Project LEO, Whakatane Campus Redevelopment and other facility developments</li> <li>• Pilot programme in partnership with PSA</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in staff turnover</li> <li>• Better treatment outcomes</li> <li>• Greater productivity</li> <li>• Improved patient outcomes</li> <li>• Reduced sick leave</li> <li>• Increased opportunities for revenue enhancement e.g. research</li> <li>• Safer patient care</li> <li>• Improved quality of patient care</li> <li>• Robust change management to ensure staff leadership and engagement for facility redesign</li> <li>• Improvements to workflows as a result of process improvement</li> <li>• Implementation of patient centred booking</li> <li>• Reduction in DNA rates</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical involvement at all levels of the DHB including Executive Management</li> <li>• Robust clinical involvement in the Regional Clinical Services Plan</li> <li>• Improved staff engagement</li> <li>• Documented process redesign support by agreed change management principles</li> <li>• Completed and evaluated pilot with recommendations for further rollout.</li> </ul>	

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>‘Living within our means’</b>					
<b>The financial sustainability of the DHB is improved</b>	<ul style="list-style-type: none"> <li>Labour cost growth</li> </ul>	<ul style="list-style-type: none"> <li>Implement Time and Attendance monitoring to capture attendance at work and leave when taken</li> <li>Implement productivity measures to ensure FTEs deployed match throughput</li> <li>Implement findings of staff satisfaction (PULSE) survey to improve retention</li> </ul>	<ul style="list-style-type: none"> <li>More productive workforce</li> <li>Reduced staff turnover</li> <li>Fostering a culture of innovation</li> </ul>	<ul style="list-style-type: none"> <li>Maintain staff turnover at 8%</li> </ul>	
	<ul style="list-style-type: none"> <li>Reduce the growth of spending on clinical and non-clinical consumables through:               <ul style="list-style-type: none"> <li>National and regional procurement</li> </ul> </li> <li>Prioritisation of clinical services</li> </ul>	<ul style="list-style-type: none"> <li>Seek clinical and non-clinical alliances regionally and nationally to support cost reduction</li> <li>Reduce IDF costs by reducing the number of procedures sent out of district where these can be done locally</li> <li>Support PHARMAC across a range of initiatives to better manage hospital and community pharmaceutical budgets</li> <li>Participate in a single national approach to health procurement by implementing the National Health Procurement Strategy</li> </ul>	<ul style="list-style-type: none"> <li>Improved ability to reinvest in additional health services</li> <li>Better, sooner more convenient services</li> </ul>	<ul style="list-style-type: none"> <li>Reduced cost of consumables</li> </ul>	

If we want this outcome	Then we will focus on	And we will undertake these initiatives/activities	That will lead to these impacts	And will deliver these outputs	For this level of investment
<b>Quality and Safety</b>					
<b>The highest quality healthcare</b>	Implementation of the Health Excellence Strategic Plan	<ul style="list-style-type: none"> <li>Implementation of the Health Excellence Communications Plan</li> <li>Identify and agree on key opportunities for improvement through robust use of Self Assessment against the Baldrige Health Care Criteria for Performance Excellence</li> </ul>	<ul style="list-style-type: none"> <li>Organisational commitment to Health Excellence</li> <li>Improved workforce engagement</li> <li>Identification of opportunities for continuous improvement</li> <li>A culture that fosters innovation and learning</li> <li>Leaders are visible and model the value and behaviours expected of a high performing organisation</li> <li>Business performance is reviewed regularly</li> <li>Sustainable, healthy organisation</li> </ul>	<ul style="list-style-type: none"> <li>Health Excellence Communications Plan</li> <li>3 services pilot the Baldrige assessment tool (at least 1 of which must be a clinical service)<sup>21</sup></li> <li>Service plans developed to include improvement actions evolving from self assessment process.</li> </ul>	
	Tracking system implementation	<ul style="list-style-type: none"> <li>Implement acute coding at real time in operating theatre</li> <li>Implement instrument process tracking to patient</li> </ul>			

<sup>21</sup> All 3 self assessment must be completed by June 2012

	Releasing time to Care – The Productive Ward	<ul style="list-style-type: none"> <li>Facilitation and implementation across all wards in Whakatane and Tauranga Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>Increased patient direct time</li> <li>Increased focus on direct patient care</li> </ul>	<ul style="list-style-type: none"> <li>Measureable improvements in the safety, reliability and efficiency of care delivered to the patient</li> </ul>	
	Referral Management	<ul style="list-style-type: none"> <li>Undertake a pilot referral management project in the eastern Bay of Plenty</li> <li>Assess for organisational roll out</li> </ul>	<ul style="list-style-type: none"> <li>Improve referral quality and timeliness</li> </ul>	<ul style="list-style-type: none"> <li>Complete pilot</li> <li>Pilot report noting future recommendations.</li> </ul>	

## Prospective Statement of Financial Performance

The DHB continues its commitment to manage expenditure within the provided funding and live within our means. The DHB is therefore committed to maintaining breakeven results during the coming three financial years (excluding adjustments for the Mental Health Reserve Ring Fence, which requires a cyclical deficit).

Many cost increases impact the DHB at greater rates than provided for in the Funding Envelope, such as staff increases dictated by National Multi-Employer Collective Agreements and costs impacted by the weaker exchange rate. The DHB will cover this by carefully assessing the services provided to ensure best value for money.

This District Annual Plan commits the DHB to underlying breakeven results for the period 1 July 2010 to 30 June 2013.

### 12.1.1 Prospective Statement of Financial Performance for the three years ended 30 June 2011 - 2013

\$m	Actual 2009	Estimate 2010	2011	2012	2013
<b>Revenue</b>					
Government Revenue	547.8	582.8	597.7	618.0	638.6
Other Revenue	10.1	6.1	5.3	5.5	5.7
	<b>557.9</b>	<b>588.9</b>	<b>603.0</b>	<b>623.5</b>	<b>644.3</b>
<b>Expenditure</b>					
Employee Costs	177.6	183.6	188.6	195.1	201.9
Outsourced Costs	26.2	25.9	20.5	20.7	21.1
Clinical Supplies	42.2	47.1	49.7	50.2	52.3
Infrastructure	48.7	52.1	54.2	58.5	61.0
Payments to Providers					
Personal Health	177.6	189.3	194.7	200.6	206.5
Mental Health	21.8	23.1	23.8	23.9	24.6
Disability Support Services	57.2	62.8	66.4	68.7	70.9
Public Health	2.0	1.6	1.1	1.2	1.2
Māori Health	4.7	4.8	4.5	4.6	4.8
<b>Total Expenditure</b>	<b>558.0</b>	<b>590.3</b>	<b>603.5</b>	<b>623.5</b>	<b>644.3</b>
<b>Total</b>	<b>(0.1)</b>	<b>(1.4)</b>	<b>(0.5)</b>	<b>0.0</b>	<b>0.0</b>
<b>Adjustment for Mental Health Ring Fence</b>					
Ring fence	1.9	1.4	0.5	0.0	0.0
<b>Underlying Result surplus/(deficit)</b>	<b>1.8</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

### 12.1.2 Ring Fence Reserves

The revised 2009/2010 result reflects the partial utilisation of the balance of Mental Health Ring Fence Reserve as carried forward at 30 June 2009. The forecast for 2010/2011 anticipates utilising that surplus fully in that year.

## 12.2 Financial Performance by Output Class

The DHB operates three arms.

### Funds

The DHB receives, within the 'Funds' arm, a Crown appropriation for the purchase of health and disability services. This funding revenue is used to

purchase services from the Non-Government Organisation sector and the DHB.

### Governance and Funder administration

Governance and Funder Administration is the arm that includes the board and governance costs of the DHB along with the costs of administrating the 'Funds' output class by the Funding and Planning Division.

### Provider Arm

This arm includes the health and disability services directly provided by the DHB in the two hospitals under its control and various community services along with the necessary support functions.

\$m	Actual 2009	Estimate 2010	2011	2012	2013
Provider Arm	0.7	2.9	0.0	0.0	0.0
Gov. & Funder Admin	0.6	(2.0)	0.0	0.0	0.0
Funds	(1.4)	(2.3)	(0.5)	0.0	0.0
	<b>(0.1)</b>	<b>(1.4)</b>	<b>(0.5)</b>	<b>0.0</b>	<b>0.0</b>

The national prices, as calculated and advised by the Ministry of Health, have been used to generate the Price Volume Schedule between the Planner/Funder and Provider Arm.

## 12.3 Financial Assumptions

The DHB has made a number of significant assumptions in arriving at its Prospective Financial Performance Statements as summarised in the following table:

Assumption	2011	2012	2013
Revenue	3.680%	\$19.3m	\$19.3m
Sector Cost Increases	1.760%		
Staff Costs (average movement)	1.700%	3.000%	3.000%
Staff Costs (numbers)	-0.280%	0.500%	0.500%
Interest Rate - CHFA	6.300%	6.300%	6.300%
Interest Rate - Working Capital	3.700%	3.700%	3.700%
USD/NZD	0.7000	0.6600	0.6300

The following further assumptions have been made by the DHB:

- The cap on Management and Administration Full Time Equivalents has been reflected in the forecasts
- Cost challenges for the Provider Arm, Planner/Funder and Corporate Support Areas are to be achieved.

## 12.4 Significant Financial Risks

All District Health Boards face pressure to meet additional expenditure which must be managed within allocated funding.

The impact of policy changes are included in a base increase in funding via the Future Funding Track.

In employment negotiations there will be a focus on increased workforce flexibility, increased productivity and wage increases that are affordable.

The DHB will have to manage staff numbers to appropriate levels and may implement changes to service configuration. These efforts will have to be prioritised within the DHB's service priorities and demographics.

### 12.4.1 Crown Revenue

The DHB will continue to operate within the long term revenue provided by Government.

Risk	Mitigation
Outer year forecast revenue may change as a result of Government policy, new initiatives and other factors	Estimates of future revenue have been based on information supplied from the Ministry of Health
Census figures indicate a growth in the population of the Bay of Plenty between 2% and 3% per annum. This exceeds the amount currently included in Ministry of Health, Statistics New Zealand and Treasury estimates.	Revenue is allocated using a Population Based Funding Approach and this is updated as census information becomes available. Adjustments are generally made over a 2 to 3 year period but are not included in the Ministry of Health's demographic adjuster estimates until they occur.

### 12.4.2 Other Revenue

Other revenue is earned from a variety of sources and is expected to continue to grow at a rate approximately equal to inflation.

Risk	Mitigation
The DHB has no long term undertakings for much of this revenue.	The revenue has multiple sources and the risk of significant change is minimised.

### 12.4.3 Net inter-district flows (IDFs)

All DHBs have some instances where people who are resident within a particular DHB's jurisdiction receive services in other districts.

The DHB has significant outflows throughout the year to Auckland City Hospital, Auckland City Children's Hospital and Waikato Hospital for tertiary services and some upper level secondary services. Outflows also occur to Lakes District Health Board for some persons resident in the Murupara/Uruwera areas who may access services at Rotorua Hospital rather than travelling to Tauranga or Whakatane Hospitals. A similar inflow occurs to Tauranga Hospital for people residing in the Waihi area (which is within the Waikato District Health Board region).

The DHB's major inflow is through holiday makers over the Christmas and New Year period in particular.

Risk	Mitigation
New or additional inter-district flows are identified by other DHBs	There is an established national process for identification and wash-up of IDFs
Some DHBs provide services that are not prioritised for purchase by the DHB	Where possible, efforts are made to minimise outflows to other DHBs and access criteria are agreed.
Other DHBs may no longer be able to deliver IDF volumes to Bay of Plenty residents due to change in their services or population/volume growth	There is an established national process for changes to IDFs.

#### 12.4.4 Payments to Providers

Payments are made to health and disability service providers in both the Non-Government Organisation sector and the DHB's own provider arm.

The DHB allocated funding through a Crown appropriation using a robust process to prioritise benefit against health need.

Expenditure on health and disability services within the district is expected to grow in line with long-term revenue growth. The DHB is committed to not expending more funding than is allocated.

Risk	Mitigation
Impacts of new Government initiatives may result in new services being purchased at additional cost.	The DHB would expect to receive additional revenue to meet the additional costs associated with particular Government initiatives introduced outside the DHB's prioritisation process.
Many health and disability services can be demand driven and unmanaged	Some services are purchased on a capitated, risk share or fixed basis to

increases in volumes result in increased costs.	reduce the DHB's exposure to unexpected increases in demand driven volumes.
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#### 12.4.5 Employment Costs

Risk	Mitigation
Employee expectations remain high.	The DHB works to clearly explain the funding available to it for pay increases.
The move to national and regional MECA have made local management of cost growth difficult.	The DHB works to clearly explain to all parties the funding available to the DHB for pay increases. Bargaining is carried out within the Health Sector's 'good faith' process. Some agreements are on a partnership basis.

#### 12.4.6 Operating Costs

DHB operating costs are broken into three classifications:

**Outsourced costs** – those costs related to parts of the services that have been outsourced or subcontracted to third parties.

**Clinical costs** – those costs directly related to the provision of the health and disability services provided by the DHB, including pharmaceuticals and consumables.

**Infrastructural costs** – those costs indirectly related to the provision of health and disability services by the DHB, including transport, hotel services, interest depreciation and capital charge costs.

Each classification has different imperatives around cost growth but as an average increases are expected to remain within the long term revenue growth.

Risk	Mitigation
Cost growth expectations remain high particularly for clinical supplies.	National provider and supplier contracts (including NZ Blood and Pharmac) are often negotiated on a national level.
Approximately \$10-15m of purchases are influenced, directly or indirectly, by movements in the exchange rate, the majority in relation to the United States Dollar.	Purchasing is in New Zealand Dollars wherever possible. Longer term contracts are used to help minimise short-term fluctuations in price. For significant items, purchased in a foreign currency, then foreign exchange hedging is considered and utilised where appropriate.
Fuel prices can have a significant impact on the running costs of more than 300 vehicles.	The DHB has limited ability to control the direct impact of a fuel price increase. The DHB does encourage efficient use of vehicles including carpooling.
Increases in interest rates.	The DHB manages interest rate risk through the use of interest rate hedging and fixed interest mechanisms if appropriate.
The capital charge rate may change.	No change is expected in the current year. The DHB would expect revenue to be adjusted accordingly to neutralise any change in rate.

## 12.5 Prospective Statement of Cashflows

Operating cashflows remain materially cumulatively positive throughout the forecast period.

The operating cashflow surplus along with additional equity and borrowings will be utilised for the significant capital investment currently underway at Tauranga Hospital (Project LEO) and the East Wing together with those being planned for Oral Health Services then future planned development of the Whakatane Hospital site.

Active cash management uses excess cash balances ahead of borrowing or equity injections to delay and reduce the level of borrowing or equity injections.

### 12.5.1 Prospective Statement of Cashflows for the three years ended 30 June 2011, 2012 and 2013

\$m	Actual 2009	Estimate 2010	2011	2012	2013
Operating	7.6	19.2	20.6	23.7	25.2
Investing	(17.0)	(47.3)	(50.3)	(34.3)	(31.5)
Financing	14.6	22.4	29.7	10.6	6.3
<b>Total Net Cashflow</b>	<b>5.2</b>	<b>(5.7)</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

## 12.6 Prospective Statement of Financial Position

The DHB remains in a strong financial position, necessary to service the current and upcoming levels of borrowing required for redevelopment.

The Statement of Financial Position reflects the increased investment in the building infrastructure of the DHB which is partially supported by increased borrowing, increased equity and operating cashflow.

### 12.6.1 Prospective Statement of Financial Position as at 30 June 2011, 2012 and 2013

\$m	Actual 2009	Estimate 2010	2011	2012	2013
Current Assets	25.4	20.2	20.3	20.4	20.4
Current Liabilities	61.6	71.0	70.7	70.8	70.1
Working Capital	(36.2)	(50.8)	(50.4)	(50.4)	(49.7)
Term Assets	167.0	204.0	239.8	257.8	272.1
Term Liabilities	65.8	84.1	106.9	118.0	127.7
<b>Equity</b>	<b>65.0</b>	<b>69.1</b>	<b>82.5</b>	<b>89.4</b>	<b>94.7</b>

### 12.6.2 Equity and long-term debt facilities

The DHB relies on a mix of debt and equity to fund assets utilised in the delivery of health services.

Government policy requires the DHB to source all long-term debt and equity from the Crown through the Crown Health Financing Agency (CHFA). The CHFA facilities are secured by a negative pledge.

The DHB is allowed to maintain a working capital facility with a trading bank. A working capital facility is thus maintained with the Westpac Banking Corporation Limited (Westpac), who also provide transactional banking facilities. The facility consists of a bank overdraft and revolving multi-option credit facility to a maximum of \$20 million. The Westpac working capital facility is secured by a negative pledge. Without Westpac'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;
- Dispose of any of its assets except disposals in certain circumstances in the ordinary course of business; and
- Provide services to or accept services from a person other than for proper value and reasonable commercial items.

The DHB must meet a cash flow cover covenant, under which Earnings Before Interest Tax Depreciation must exceed funding costs by at least 1.75 times.

As at 28 February 2010, the DHB had the following borrowings:

- Westpac \$nil
- CHFA \$82.6m

The commitment to the Tauranga Hospital Redevelopment Project (Project LEO) and other likely infrastructure redevelopments require increased levels of borrowings and equity support. The estimated levels of borrowing and equity support required may fluctuate due to:

1. Stronger or weaker than expected financial performance;
2. Escalation of construction costs and additional compliance costs not foreseen when the business case(s) are prepared;
3. Possible new redevelopment and service configurations; and
4. The need to maintain current equipment replacement programmes.

The DHB remains committed to minimising its reliance on additional borrowings or equity support.

Increased interest costs and capital charge costs from additional borrowings and equity support are to be affordable and must be met from within the operational budget of the DHB.

### 12.6.3 Prospective Estimates of Debt and Equity as at 30 June 2011, 2012 and 2013

All debt is unsecured.

\$m	Actual	Estimate	2011	2012	2013
	2009	2010			
Long-term Debt	65.0	83.1	105.9	116.9	126.7
Equity from the Crown	65.0	69.1	82.5	89.4	94.7
Current & Long-term debt drawn	15.0	21.7	22.8	11.0	9.7
Current & Long-term debt repaid	6.5	0.0	1.0	0.2	0.9
Net Equity injections	10.1	5.5	13.9	6.9	5.2

### 12.7 Asset Management

The DHB is continuing development of its Asset Management Plan, with a view to a more strategic approach to asset maintenance, replacement and investment. The plan reflects the joint approach taken by all District Health Boards and current best practice within the health sector.

The plan itself utilises the framework identified as most appropriate by a joint-District Health Board workgroup and was based on the International Infrastructure Management Manual.

Currently the Board has allocated funding for investment in normal asset replacement and some new assets.

Project LEO, the Tauranga Campus Redevelopment Project, is outside the scope of the normal capital investment and is being funded by a combination of debt, equity and operating cashflows, including cashflows generated from efficiency and effectiveness projects as part of the process reengineering.

\$m	Actual	Estimate	2011	2012	2013
	2009	2010			
Annual Depreciation	12.6	13.8	15.4	17.2	18.0
Tauranga Campus and other Strategic Regular Capital Expenditure	10.0	37.8	42.1	26.2	23.4
Total Capital Expenditure	20.6	50.9	51.1	35.2	32.4

#### Capital Expenditure Business Cases

The DHB understands that approval of the District Annual Plan is not approval of any particular business case. Some business cases will still be subject to a separate approval process that includes Ministry of Health, National Health Board and Treasury officials prior to a recommendation being made to the Minister of Health.

The Board also requires Management to obtain final approval in accordance with delegations prior to purchase or construction commencing.

#### Alternate Funding

As business cases are finalised for presentation to the Board or Ministry, managers will review the most appropriate financing option currently available for the particular item. This may result in items being acquired via donation or leasing options and therefore not being purchased via the capital expenditure programme.

#### Strategic Capital Developments

Provision has been made in the fixed asset additions for the completion of Project Leo, redevelopment of the East Wing of Tauranga hospital, Oral Health Project and Redevelopment of Whakatane hospital.

#### Asset Disposals

The 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 surplus. Some minor asset disposals will occur as part of the regular capital replacement programme.

#### Disposal of land

The approval of the Minister of Health is required prior to the Bay of Plenty District Health Board disposing of land. The disposal process is a protective mechanism governed by various legislation and policy requirements.

#### Revaluations

All Land and Buildings were revalued during the year ended 30 June 2009 the next such review being due as at 30 June 2012.

The revaluation of land and buildings is not expected to produce a material change. The revaluation may add additional costs related to depreciation and capital charge in the financial year 2012/2013, and, as stated no allowance has been made. This is a risk to the commitments should it become evident that the change is likely to be material. This is not considered likely as at the date of preparation of these budgets.

### 12.8 Procedure for Buying Shares

The approval of the Ministers' of Health and Finance is required prior to the Bay of Plenty District Health Board taking a shareholding interest in any entity.

## 12.9 Prospective Detailed Financial Statements

IMPORTANT NOTE: The Prospective Financial Statements have been completed in a manner consistent with accounting policies and procedures that will be used for the annual Financial Statements. The

major accounting policies are disclosed in the DHB's Statement of Intent 2010/2013.

Consolidated Statement of Prospective Financial Performance	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
<b>Revenue</b>	<b>557.9</b>	<b>588.9</b>	<b>603.0</b>	<b>623.5</b>	<b>644.3</b>
Less operating expenditure					
DHB Provider expenditure	267.4	278.9	281.2	288.9	298.6
External provider expenditure	263.3	281.6	290.5	299.0	308.0
Governance & Funding Administration	5.5	6.8	4.5	4.7	4.9
Taxation (may apply to subsidiaries and associates)	-	-	-	-	-
<b>Total Operating Expenditure</b>	<b>536.2</b>	<b>567.3</b>	<b>576.2</b>	<b>592.6</b>	<b>611.5</b>
<b>Surplus/(Deficit) before Interest, Depreciation and Capital Charge</b>	<b>21.7</b>	<b>21.6</b>	<b>26.8</b>	<b>30.9</b>	<b>32.8</b>
Interest	4.0	4.7	5.8	7.0	7.7
Depreciation	12.6	13.8	15.4	17.2	18.0
Capital Charge	5.2	4.5	6.1	6.7	7.1
<b>NET SURPLUS/(DEFICIT)</b>	<b>(0.1)</b>	<b>(1.4)</b>	<b>(0.5)</b>	<b>(0.0)</b>	<b>0.0</b>

Consolidated Statement of Prospective Movements in Equity	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
Crown equity at start of period	60.3	65.0	69.1	82.5	89.4
Surplus/(Deficit) for the period	(0.1)	(1.4)	(0.5)	(0.0)	0.0
Contributions from Crown	10.1	5.5	13.9	6.9	5.2
Distributions to Crown	-				
Revaluation adjustments	(5.3)	0.0	0.0	0.0	0.0
<b>Crown equity at end of period</b>	<b>65.0</b>	<b>69.1</b>	<b>82.5</b>	<b>89.4</b>	<b>94.6</b>

Consolidated Statement of Prospective Financial Position	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
<b>CROWN EQUITY</b>	<b>65.0</b>	<b>69.1</b>	<b>82.5</b>	<b>89.4</b>	<b>94.6</b>
<b>CURRENT ASSETS:</b>					
Bank balances, deposits and cash	5.8	0.1	0.1	0.1	0.1
Receivables	16.4	16.8	16.9	17.0	16.9
Properties intended for sale					
Inventory	3.2	3.3	3.3	3.3	3.3
	<b>25.4</b>	<b>20.2</b>	<b>20.3</b>	<b>20.4</b>	<b>20.3</b>
<b>CURRENT LIABILITIES:</b>					
Payables and Accruals	61.6	71.0	70.7	70.8	70.1
Net Working Capital	(36.2)	(50.8)	(50.4)	(50.4)	(49.8)
<b>NON CURRENT ASSETS:</b>					
Fixed Assets	166.8	203.8	239.6	257.6	271.9
Investments	0.2	0.2	0.2	0.2	0.2
	<b>167.0</b>	<b>204.0</b>	<b>239.8</b>	<b>257.8</b>	<b>272.1</b>
<b>NON CURRENT LIABILITIES:</b>					
Borrowings & Provisions	65.8	84.1	106.9	118.0	127.7
<b>NET ASSETS</b>	<b>65.0</b>	<b>69.1</b>	<b>82.5</b>	<b>89.4</b>	<b>94.6</b>

Consolidated Statement of Prospective Cash Flows	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
<b>OPERATING CASHFLOWS</b>					
Cash inflows from operating activities	550.7	587.7	602.1	622.6	643.3
Cash outflows for operating activities	543.1	568.5	581.5	598.9	618.1
	7.6	19.2	20.6	23.7	25.2
<b>INVESTING CASHFLOWS</b>					
Cash inflows from investing activities	1.0	0.6	0.8	0.9	0.9
Cash outflows for investing activities	18.0	47.9	51.1	35.2	32.4
	(17.0)	(47.3)	(50.3)	(34.3)	(31.5)
<b>FINANCING CASHFLOWS</b>					
Cash inflows from financing activities	25.0	27.2	36.7	17.9	14.9
Cash outflows for financing activities	10.4	4.8	7.0	7.3	8.6
	14.6	22.4	29.7	10.6	6.3
Net increase/(decrease) in cash held	5.2	(5.7)	0.0	0.0	(0.0)
Add opening cash balance	0.6	5.8	0.1	0.1	0.1
<b>CLOSING CASH BALANCE</b>	5.8	0.1	0.1	0.1	0.1
Made up from:					
Balance Sheet Bank and Cash	5.8	0.1	0.1	0.1	0.1

DHB Provider Statement of Prospective Financial Performance	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
<b>REVENUE</b>					
Government Revenue	281.0	298.0	302.3	313.4	324.9
Other Revenue	7.5	6.0	5.1	5.3	5.5
	288.5	304.0	307.4	318.7	330.4
<b>EXPENSES</b>					
Personnel Costs	172.9	178.9	183.9	190.2	196.8
Outsourced Services	26.0	25.6	20.2	20.4	20.8
Clinical Supplies	43.3	47.1	49.6	50.1	52.3
Infrastructure and Non Clinical	45.6	49.5	53.7	58.0	60.5
	287.8	301.1	307.4	318.7	330.4
<b>SURPLUS/(DEFICIT)</b>	<b>0.7</b>	<b>2.9</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

DHB Governance Statement of Prospective Financial Performance	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
<b>REVENUE</b>					
Government Revenue	4.9	5.6	5.3	5.5	5.7
Other Revenue	2.6	0.1	0.2	0.2	0.2
	7.5	5.7	5.5	5.7	5.9
<b>EXPENSES</b>					
Personnel Costs	4.7	4.7	4.7	4.9	5.0
Outsourced Services	0.2	0.3	0.3	0.3	0.3
Clinical Supplies	0.0	0.0	0.0	0.0	0.0
Infrastructure and Non Clinical	2.0	2.7	0.5	0.5	0.6
	6.9	7.7	5.5	5.7	5.9
<b>SURPLUS/(DEFICIT)</b>	<b>0.6</b>	<b>(2.0)</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

DHB Funds Statement of Prospective Financial Performance	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
<b>REVENUE</b>					
Government Revenue	523.2	556.8	573.3	592.7	612.5
<b>EXPENSES</b>					
Personal Health	392.2	415.3	425.2	439.6	454.3
Mental Health	53.2	56.5	57.7	59.2	61.2
Disability Support Services	67.3	74.9	78.8	81.5	84.2
Public Health	2.4	2.0	1.6	1.6	1.7
Maori Health	4.7	4.8	5.2	5.3	5.5
Governance & Administration	4.8	5.6	5.3	5.5	5.6
	524.6	559.1	573.8	592.7	612.5
<b>SURPLUS/(DEFICIT)</b>	<b>(1.4)</b>	<b>(2.3)</b>	<b>(0.5)</b>	<b>0.0</b>	<b>0.0</b>

Consolidated Statement of Prospective Commitments and Contingent Liabilities	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
<b>COMMITMENTS</b>					
Capital commitments	7.3	26.0	12.5	6.0	6.5
Operating lease commitments	6.4	6.4	6.1	6.2	6.1
Other operating	142.7	143.5	144.0	145.0	145.0
<b>TOTAL COMMITMENTS</b>	156.4	175.9	162.6	157.2	157.6
<b>CONTINGENT LIABILITIES</b>	-	-			

## Appendix A - Performance Improvement Actions

Objective	Total Savings Impact (Annualised savings)
<ol style="list-style-type: none"><li>1. <b>Improve Productivity and Quality</b> – with a focus on hospital wards, theatre utilisation, increasing day surgery and Emergency Departments</li><li>2. <b>Achieve financial security</b> – by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings</li><li>3. <b>Enhance regional cooperation</b> – through development of clinical regional service plans and greater regionalisation of shared services and back-office functions.</li></ol>	\$2,810,000

## Appendix B - Governance

### The Board

The Board undertakes the governance role for the DHB and is responsible to the Minister of Health for overall performance. Seven Board members are elected by the community and four are appointed by the Minister to ensure a balance of skills and Māori representation.

### Te Rūnanga Hauora Māori o Te Moana-ā-Toi

Te Rūnanga Hauora Māori o Te Moana-ā-Toi (the Rūnanga) affirms the DHB commitment to the Treaty of Waitangi principles and most importantly recognises that Māori have an important role to play in determining their own aspirations and priorities for health. The Rūnanga is made up of mandated representatives from the 18 Iwi in the region and:

- Provides leadership and strategic direction to the DHB at a governance level
- Assists with the development of the District Strategic Plan
- Provides advice on all matters pertaining to the impact of health and disability services on Māori.

The Rūnanga provides the principal mechanism for enabling Māori to contribute to decision making, participate in the planning and delivery of health and disability services as well as providing an effective forum for consultation and engagement with Whānau, Hapū and Iwi.

### Bay of Plenty Hospitals Advisory Committee (HAC)

The Hospitals Advisory Committee, a statutory committee, monitors the financial and operational performance of hospitals owned by the DHB, and also assesses strategic issues relating to the provision of hospital and specialist services.

### Community and Public Health Advisory Committee (CPHAC)

The role of the Community and Public Health Advisory Committee, a statutory committee, is to advise the Board on the health and disability needs of the DHB's population. The role extends to include advice as to what services should be funded, policies that should be adopted and overall impact of any such services/policies on the population. The Committee also analyse relevant reports and make recommendations accordingly. The Committee must ensure that any advice it provides the Board is consistent with national strategies and government policy.

### Disability Support Advisory Committee (DSAC)

The role of the Disability Support Advisory Committee, a statutory committee, is to inform the Board about the needs of people with disabilities in the DHB region and to prioritise the use of money allocated for those with a disability. The Committee makes sure that the services provided or funded, and the policies adopted, promote the inclusion and participation of people with disabilities in our community in order to maximise their independence.

### Audit, Finance and Risk Management Committee (AFRM)

The role of the Audit, Finance and Risk Management Committee, a statutory committee, is to:

- Provide assurance to the Board that all audit processes required by the Board or by statute are completed
- Ensure that the DHB is financially responsible and accountable
- Review the adequacy of the Board's risk management of the organisation as a whole including:
  - Review of clinical risks and quality control
  - Project risks
  - Operating risks
  - Financial risk

### **Quality Council**

The purpose of the DHB Quality Council is to provide governance for the organisation and advice to the Chief Executive with respect to clinical quality, continuous quality improvement, accreditation and patient safety.

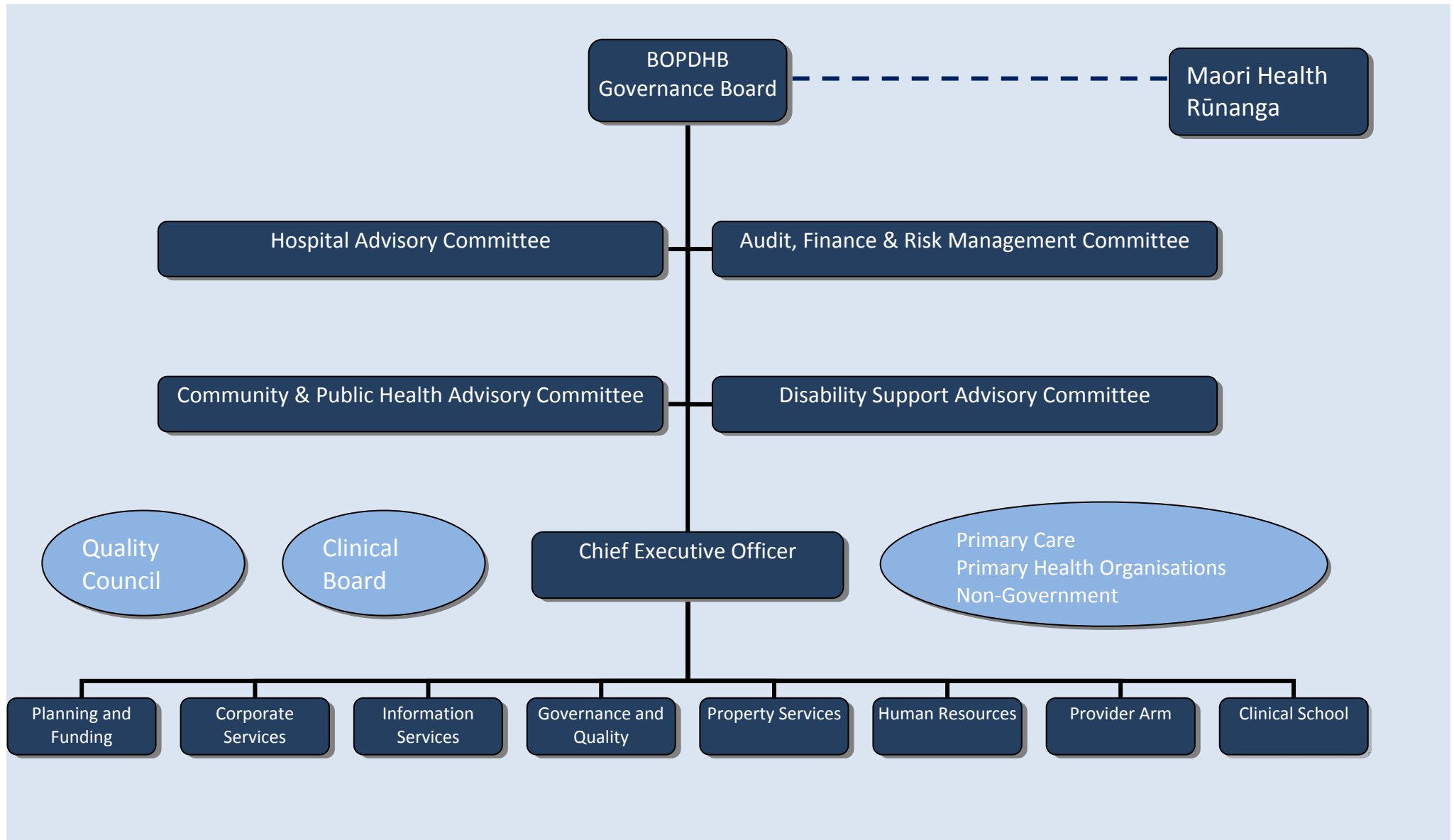
### **Clinical Board**

The Clinical Board provides clinical leadership and advice to the Chief Executive as follows:

- On clinical and health strategies
- On workforce sustainability (including planning, development and education)
- Contributing to organisational strategic planning
- Clinical evaluation of contracted services

The Clinical Board is made up of senior medical and nursing clinicians from across the health sector.

## Organisational Structure



## Appendix C - How we will measure our performance

### The Midland region and regional collaboration

Output measures	Actual 2009/10	Target 2010/11
<p><b>Performance dimension : Meeting service coverage requirements and supporting sector inter-connectedness</b></p> <p><b>Regional service planning</b> DHBs will be expected to collaborate with other DHBs in their region to develop regional service plans.</p>	No similar measure in 2009/10.	<ul style="list-style-type: none"> <li>Submission of CSP by 30 September 2010</li> </ul> <p>DHBs are to report six-monthly as part of quarter 2 and quarter 4 progress toward submission of the CSP.</p>

### More responsive hospital and specialist services

Impact measures	Actual 2009/10				Target 2010/11
<p><b>Performance dimension : Achieving Government's priorities and targets</b></p> <p><b>Health Target</b> – shorter wait times for cancer treatment. Everyone needing radiation treatment will have this within 6 weeks by the end of July 2010 and 4 weeks by December 2010.</p>	Q1 100%	Q2 100%	Q3	Q4	100% Each DHB will be required to complete monthly templates (submitted quarterly) that measure the interval between the patient's FSA and the beginning of radiation treatment along with related measures.
<p><b>Performance dimension : Achieving Government's priorities and targets</b></p> <p><b>Health Target</b> – shorter stays in the Emergency Department (ED) 95% of ED attendances have a length of stay in the ED within 6 hours.</p>		<b>Whakatane Hospital ED</b>	<b>Tauranga Hospital ED</b>	<ul style="list-style-type: none"> <li>To achieve the waiting time target<sup>22</sup></li> </ul>	
	Q1	98%	87%		
	Q2	98%	79%		
	Q3	98%	81%		
	Q4				

<sup>22</sup> Each DHB will be required to submit their numerator data (number of patient presentations to the ED with an ED length of stay less than 6 hours) and their denominator data (number of patient presentations to the ED) to the Ministry separately for each relevant ED facility. DHBs are to provide narrative comment on the quality of their data, steps taken to meet the target and improve the quality of ED care, and any difficulties encountered with implementation of the target.

<p><b>Performance dimension : Achieving Government's priorities and targets</b></p> <p><b>Chemotherapy treatment waiting times</b> Monthly templates that measure the interval between the patient's first specialist assessment (FSA) and the start of chemotherapy treatment.</p>	<p><b>Q1</b></p> <p>100%</p>	<p><b>Q2</b></p> <p>100%</p>	<p><b>Q3</b></p> <p>100%</p>	<p><b>Q4</b></p>	<p>100% of patients will receive chemotherapy within 6 weeks of their first specialist appointment.</p> <p>Qualitative comment on reasons for people with chemotherapy waiting longer than 6 weeks.</p>							
<p><b>Performance dimension : Achieving Government's priorities and targets</b></p> <p><b>DHBs report alcohol and drug service waiting times and waiting lists</b> Waiting time from referral for treatment to the date the client is admitted to treatment, following assessment. District Health Boards will report their longest wait times in days for each month by service type and ethnicity.</p>	<p><b>Longest waiting time in days for each month</b></p>			<p><b>Longest waiting time in days for each month</b></p>			<p>An achieved status will be obtained when all information is reported.</p>					
	<p><b>Q2</b></p>			<p><b>Q4</b></p>								
		Oct	Nov	Dec		Apr	May	Jun				
	Inpatient detox	21	14	24	Inpatient detox							
	Specialist prescribing	1	7	0	Specialist prescribing							
	Structured counselling	2	2	0	Structured counselling							
	Residential rehab	120	80	62	Residential rehab							
<p><b>Performance dimension : Achieving Government's priorities and targets</b></p> <p><b>Improving the health status of people with severe mental illness through improved access</b> The average number of people domiciled in the District Health Board region, seen per year rolling every three months being reported for: Child &amp; youth (aged 0-19) specified for each of the three categories Māori, Other and in total Adults (aged 20-64) specified for each of the three categories Māori, Other and in total Older people (aged 65+) specified for each of the three categories Māori, Other and in total.</p>	<p><b>Target 2009/10</b></p>			<p><b>Actual Q2</b></p>			<p><b>Target 2010/11</b></p>					
		0-19	20-64	65+		0-19	20-64	65+		0-19	20-64	65+
	<b>Māori</b>	.34%	.88%	.07%	<b>Māori</b>	2.5%	4.3%	2.1%	<b>Māori</b>	2.5%	4.4%	
	<b>Other</b>	.16%	.35%	.07%	<b>Other</b>	2.8%	3.0%	2.6%	<b>Other</b>	2.8%	3.0%	
	<b>Total</b>	.23%	.47%	.07%	<b>Total</b>	2.6%	3.3%	2.5%	<b>Total</b>	2.6%	2.6%	0.07%
<p><b>Output measures</b></p>												
<p><b>Performance dimension : Achieving Government's priorities and targets</b></p> <p><b>Health Target</b> – each District Health Board will set an agreed increase in the number of elective surgical</p>	<p>Estimated Surgical CWDs</p>							<p>Estimated Surgical CWDs</p>			<p>11,139</p>	
	<p>Estimated Dental &amp; Cardiology CWDs</p>					<p>717.7</p>		<p>Estimated Dental &amp; Medical CWDs</p>			<p>767</p>	
	<p>Estimated Surgical discharges</p>					<p>8,201</p>		<p>Estimated Surgical discharges</p>			<p>8,201</p>	

discharges, and will provide the level of service agreed												
	Estimated Dental & Cardiology discharges			1,020			Estimated Dental & Medical discharges			1,086		
										25,288		
<b>Performance dimension : Achieving Government's priorities and targets</b>  <b>Delivery of Te Kokiri: The Mental Health and Addiction Plan</b> DHBs are to provide a summary report on progress made towards implementation of Te Kokiri: The Mental Health and Addiction Plan.										No quantitative performance target is set, the performance expectation relates to supply of information as requested.		
<b>Performance dimension : Achieving Government's priorities and targets</b>  <b>Improving mental health services using crisis prevention planning</b> At least 90% of people with enduring mental illness have an up to date crisis prevention plan (NMHSS criteria 16.4) and describe how this is assured.	<b>Q2</b>	<b>Māori</b>	<b>Pacific</b>	<b>Total</b>	<b>Target 2010/11</b>	<b>Māori</b>	<b>Pacific</b>	<b>Total</b>				
	<b>20+ (excl those with addictions only)</b>	90%	100%	90%	<b>20+ (excl those with addictions only)</b>	95%	95%	95%				
	<b>20+ (addictions only)</b>	91%	-	95%	<b>20+ (addictions only)</b>	95%	95%	95%				
	<b>Child &amp; Youth</b>	60%	100%	54%	<b>Child &amp; Youth</b>	95%	95%	95%				
	<b>Total</b>			83%	<b>Total</b>	95%	95%	95%				

<b>Better, sooner, more convenient Primary health care</b>		
<b>Impact measures</b>	<b>Actual 2009/10</b>	<b>Target 2010/11</b>
<b>Performance dimension : Achieving Government's priorities and targets</b>  <b>Implementation of Better, Sooner, More convenient primary health care</b> Those DHBs involved in the development of business cases with successful Expression of Interest providers are required to report on progress of the implementation of those changes as agreed to in their DAP.	No similar measure in 2009/10.	The DHB is to supply a report confirming it has implemented the changes to primary care service delivery models agreed in its DAP, or a report identifying why changes to primary care service delivery models agreed in its DAP have not been implemented, with an associated resolution plan. <sup>23</sup>

<sup>23</sup> Reporting is once a year, as part of the Quarter 4 report



<p>evaluation</p> <ul style="list-style-type: none"> <li>- Report on how Māori Health Plans have been implemented by the PHOs and monitoring by the DHB</li> <li>- Describe whether Treaty of Waitangi training has, or will take place for Board members</li> <li>- Identify at least two milestones from your Māori Health Plan to be achieved in 2010/11 and a report on progress in quarter 2 and report on achievement of these milestones in quarter 4.</li> </ul>		<p><b>Milestone 1: Tino Rangatiratanga</b> - Support Iwi who completed Phase 2 to implement their Iwi Health Plans within existing resources</p> <p><b>Milestone 2: Tuituinga Pou Hauora</b> – Audit at least 2 services utilising the He Ritenga Framework</p>
<p><b>Performance dimension : Achieving Government’s priorities</b></p> <p><b>Improving mainstream effectiveness</b> This indicator is for the DHB Provider Arm DHBs will provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving health outcomes and reducing inequalities for Māori with a focus on improving access to effective services for Māori. DHBs will report on examples of actions taken to address issues identified in the reviews.</p>	<p>Q2 rating = Achieved</p>	<p>Qualitative. DHBs to report complete, comprehensive and timely information on deliverables outlined.</p>
<p><b>Performance dimension : Meeting service coverage requirements and supporting sector inter-connectedness</b></p> <p><b>Increase funding for Māori health and disability initiatives</b> DHBs will set targets to increase funding for Māori health and disability initiatives</p>		<p>Qualitative.</p>

<b>Reducing the incidence and impact of long term conditions</b>										
Impact measures	Actual 2009/10					Target 2010/11				
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
<b>Performance dimension : Achieving Government’s priorities and targets</b>										
	Māori	52%	52%	53%		Māori	53%	53%	53%	53%

<b>Health Target – Better diabetes and cardiovascular services</b> Increase the % of the eligible adult population that have had their CVD risk assessed in the last 5 years (fasting lipids and glucose test).	Pacific	46%	46%	49%		Pacific	49%	49%	49%	49%
	Other	64%	64%	66%		Other	66%	66%	66%	66%
	Total	63%	62%	63%		Total	65%	65%	65%	65%
<b>Performance dimension : Achieving Government’s priorities and targets</b>		<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>		<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
	Māori	42%	39%	41%		Māori	56%	56%	56%	56%
<b>Health Target – Better diabetes and cardiovascular services</b> Increase the % of people with diabetes who have a free annual check	Pacific	42%	42%	n/a		Pacific	n/a	n/a	n/a	n/a
	Other	49%	39%	48%		Other	74%	74%	74%	74%
	Total	47%	46%	46%		Total	68%	68%	68%	68%
<b>Performance dimension : Achieving Government’s priorities and targets</b>		<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>		<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
	Māori	54%	54%	65%		Māori	72%	72%	72%	72%
<b>Health Target – Better diabetes and cardiovascular services</b> Increase the % of people with diabetes who have satisfactory or better diabetes management	Pacific	57%	57%	n/a		Pacific	n/a	n/a	n/a	n/a
	Other	73%	73%	82%		Other	85%	85%	85%	85%
	Total	69%	69%	78%		Total	83%	83%	83%	83%
<b>Performance dimension : Achieving Government’s priorities and targets</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	90%					
	18.85%	17.93%	16.86%		Each quarter DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan.					
<b>Health Target – Better help for smokers to quit</b> 90% of hospitalised smokers are provided with advice and help to quit										

<b>Child and youth</b>								
Impact measures	Target 2009/10				Target 2010/11			
<b>Performance dimension : Achieving Government’s priorities and targets</b>		Mean DMFT Score at Year 8	Percentage caries free	Number examined		Mean DMFT Score at Year 8	Percentage caries free	Number examined
<b>Oral health – Mean decayed missing and filled teeth DMFT score at year 8</b> The total number of permanent teeth of Year 8 children,	<b>Māori</b>	3.08	No target set	No target set	<b>Māori</b>	3.08	24%	1,100

decayed, missing (due to caries) or filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB school dental service. The total number of children who have been examined in the Year 8 group, in the year to which the reporting relates. The data must be broken down by ethnic group (Māori, Pacific, other) fluoridation status of the school area the child attends).	<b>Pacific</b>	3.36	No target set	No target set	<b>Pacific</b>	3.36	30%	40
	<b>Other</b>	1.80	No target set	No target set	<b>Other</b>	1.80	42%	1,800
	<b>Total</b>	2.21	No target set	No target set	<b>Total</b>	2.28	35%	2,940
<b>Performance dimension : Achieving Government's priorities and targets</b>		<b>Mean DMFT score</b>	<b>Percentage caries free</b>	<b>Number examined</b>		<b>Mean DMFT score</b>	<b>Percentage caries free</b>	<b>Number examined</b>
<b>Oral health - % of children caries free at age five years</b> Percentage of children examined by the DHB School Dental Services who are caries free at the first examination after the child has turned five years, but before their sixth birthday, in the year to which the reporting relates. By ethnic group and by fluoridation status (of the school area in which the child attends).	<b>Māori</b>		48.0		<b>Māori</b>	4.60	52	700
	<b>Pacific</b>		19.6		<b>Pacific</b>	4.10	25	50
	<b>Other</b>		65.0		<b>Other</b>	2.10	65	1,100
	<b>Total</b>		57.0		<b>Total</b>	3.07	59	1,850
<b>Performance dimension : Achieving Government's priorities and targets</b>	<b>Total</b>	<b>Māori</b>	<b>Other</b>	<b>Percentage utilisation:</b>	70%			
<b>Oral health – utilisation of DHB funded dental services by adolescent from Year 9 up to and including age 17 years</b>	68%	50%	72%	<b>Denominator population (adolescents):</b>	14,175			
<b>Performance dimension : Achieving Government's priorities and targets</b>	No similar measure in 2009/10					<b>No of pre-school children (0-4 year olds) enrolled</b>	<b>Percentage of pre-school population enrolled</b>	
<b>Oral health – Increase the number of pre-school children enrolled in DHB funded dental services</b>					<b>Māori</b>	2,000	30%	
					<b>Pacific</b>	80	23%	
					<b>Other</b>	4,920	64%	

						<b>All</b>	7,000	48%	
<b>Performance dimension : Achieving Government's priorities and targets</b>  <b>Oral health – reduce the number of enrolled pre-school and primary school children overdue for their scheduled examination</b>	No similar measure in 2009/10						<b>No of children (0-12/13 year olds) overdue</b>	<b>No of children (0-12/13 year olds) enrolled</b>	<b>Percentage of enrolled population overdue for their scheduled examination</b>
						<b>Māori</b>	TBA	TBA	
						<b>Pacific</b>	TBA	TBA	
						<b>Other</b>	TBA	TBA	
						<b>All</b>	3,700	30,887	12%
<b>Performance dimension : Achieving Government's priorities and targets</b>  <b>Family violence prevention</b> This indicator will assess the progress a DHB is making towards taking a systematic approach to the identification and intervention of child and partner abuse. Overall score (AUT Hospital responsiveness to family violence, child and partner abuse audit).	169.5/200					DHBs are expected to achieve an overall score of 170/200 in audits for child abuse and partner abuse responsiveness.			
<b>Performance dimension : Achieving Government's priorities and targets</b>  <b>Health Target – 90% of two year olds are fully immunised by July 2011; and 95% by July 2012.</b>		<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>82%</b> of two year olds within the BOPDHB are fully immunised by July 2011.  <b>75%</b> of Māori two year olds within the BOPDHB are fully immunised by July 2011.  Each quarter DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan.			
	<b>Māori</b>	67%	71%	<b>71%</b>					
	<b>Pacific</b>	-	-						
	<b>Other</b>								
	<b>Total</b>	72%	76%	<b>76%</b>					

<b>Performance dimension : Meeting service coverage requirements and support sector inter-connectedness</b>  <b>Improving breast feeding rates</b> Increase the proportion of infants exclusively and fully breast fed at six weeks to 74% or greater, at three months to 57% or greater and at six months to 27% or greater.		<b>6 weeks</b>	<b>3 months</b>	<b>6 months</b>		<b>6 weeks</b>	<b>3 months</b>	<b>6 months</b>
	<b>All Ethnicities</b>	71.8%	57.1%	31.4%	<b>All Ethnicities</b>	74%	57%	32%
	<b>Maori</b>	66.9%	48.6%	24.8%	<b>Maori</b>	74%	57%	27%
	<b>Pacific</b>	80.0%	59.0%	36.5%	<b>Pacific</b>	74%	57%	27%
	<b>Other</b>	74.0%	61.1%	34.6%	<b>Other</b>	74%	57%	35%

<b>Better performing more sustainable organisations</b>		
<b>Impact measures</b>	<b>Baseline 2008/09</b>	<b>Target 2010/11</b>
<b>Performance dimension : Providing quality services efficiently</b>  <b>National patient satisfaction survey</b> [yet to be confirmed by Ministry]	No similar measure in 2009/10	This measure is a place holder for the patient satisfaction survey or similar tool- currently there is no detailed measure in the ownership dictionary as a piece of work in the future of the current survey and consideration of alternative models is yet to take place. A place holder measure is included in the summary tables and diagrams so that the measure is captured in the analysis of reporting burden, but the shape of future surveys and associated measures is yet to be confirmed.
<b>Performance dimension : Providing quality services efficiently</b>  <b>Staff turnover</b> Performance expectations do not apply for this measure. Information only		Staff turnover will be ≤ 8%  No performance expectations. Reported to the Ministry for information only. <sup>24</sup>
<b>Performance dimension : Meeting service coverage requirements and supporting sector inter-connectedness</b>  <b>DHB confirmation and exception reports – risk management</b>		DHBs to report the following information:  Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions and any other gaps in service coverage identified through

<sup>24</sup> Reported quarterly

					the DHB or the Ministry through: <ul style="list-style-type: none"> <li>• Analysis of explanatory indicators</li> <li>• Media reporting</li> <li>• Risking reporting</li> <li>• Formal audit outcomes</li> <li>• Complaints mechanisms</li> <li>• Sector intelligence</li> </ul>	
<b>Performance dimension : Achieving Government's priorities and targets</b>	No similar measure in 2009/10				To receive an achieved rating overall the DHB must demonstrate it has made progress, has identified what has worked and what has not, and has agreed planned actions covering all four identified areas of focus. <sup>25</sup>	
<b>Clinical leadership</b> Each DHB is required to undertake and report on a self-assessment of the work it has undertaken to improve clinical leadership						
<b>Output measures</b>						
<b>Baseline 2008/09</b>						
<b>Performance dimension : Meeting service coverage requirements and support sector inter-connectedness</b>					Intervention rate	292 per 10,000
<b>Elective Services Standardised Intervention Rates (SIRs)</b>					Major joint procedures intervention (rate for Hip and Knee)	21 per 10,000 or 496 joints
<ul style="list-style-type: none"> <li>• For publicly funded casemix included elective discharges in a surgical DRG, a target intervention rate of at least 292 per 10,000 of population will be achieved.</li> <li>• For major joint replacement procedures, a target intervention rate of 21 per 10,000 of population will be achieved (made up of 10.5 per 10,000 of population for hip replacement and 10.5 per 10,000 of population for knee replacement)</li> <li>• For cataract procedures a target intervention rate of 27 per 10,000 of population will be achieved</li> </ul>					Cataract procedures intervention rate	27 per 10,000 or 611 cataracts

<sup>25</sup> The four areas of focus are:

- whether managers and clinical leaders feel valued and recognized for their leadership capability
- whether joint management and clinical relationships are effective
- whether strong and effective engagement is in place at all levels, across management and clinicians, and across disciplines
- whether there is shared ownership of organizational outcomes across management and clinical leadership, and across disciplines.

<ul style="list-style-type: none"> <li>For cardiac procedures a target intervention rate of at least 6.23 per 10,000 of population will be achieved.<sup>26</sup></li> </ul>				Cardiac procedures intervention rate	6.23 per 10,000 or 170 cardiac procedures
				<p>For any procedure where the standardised intervention rate in the 2009/10 financial year or 2010 calendar year is significantly below the target a report demonstrating:</p> <p>What analysis the DHB has done to review the appropriateness of its rate; and</p> <ol style="list-style-type: none"> <li>1. What analysis the DHB has done to review the appropriateness of its rate; and</li> <li>2. Whether the DHB considers the rate to be appropriate for its population; or</li> <li>3. A description of the reasons for its relative under-delivery of that procedure; and</li> <li>4. The actions being undertaken that will ensure the target rate is achieved</li> </ol>	
<p><b>Performance dimension : Providing quality services efficiently</b></p> <p><b>Elective and arranged inpatient length of stay</b> The DHB is expected to reduce average length of stay (ALOS) for elective and arranged inpatients<sup>27</sup></p>	<p><b>Unstandardised Elective and arranged inpatient ALOS</b></p>	<p><b>Standardised Elective and arranged inpatient ALOS</b></p>	<p><b>Reduce standardised length of stay for elective and arranged inpatients by 8.2% to an ALOS of 4.0 days</b> Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.</p>		
<p><b>Performance dimension : Providing quality services efficiently</b></p> <p><b>Acute inpatient length of stay</b></p>	<p><b>Unstandardised Acute inpatient ALOS</b></p>	<p><b>Standardised Acute inpatient ALOS</b></p>	<p><b>Reduce standardised length of stay for acute inpatients by 7.1% to an ALOS of 4.26 days.</b> As well as measuring DHB performance against target for the standardised measure, the target will be</p>		
	3.98	4.35			

<sup>26</sup> DHBs will rates of 6.23 per 10,000 or above in previous years will be required to maintain this rate. DHBs with rates less than 6.23 per 10,000 will be required to increase the level of service to at least 6.23:10,000. By 2011/12 all DHBs will be delivering at a rate of at least 6.5 per 10,000 of population.

<sup>27</sup> It should be noted that situations are conceivable where improvements to services could lengthen inpatient ALOS. In particular, treating increasing numbers of patient as day cases, or moving less complex services into primary care settings will raise the complexity of hospital casemix and could legitimately raise inpatient ALOS. For this reason, it is important to consider ALOS in conjunction with other measures of hospital (and system) performance, such as day surgery rates. A further complication for measurement of ALOS is that current government policy is for greater lengths of stay for new mothers after delivery. For this reason, maternity inpatients are excluded from the main measure, but ALOS for maternity admissions is nevertheless calculated as a subsidiary measure for information only.

<p>The DHB is expected to reduce average length of stay (ALOS) for acute inpatients</p>	<p>4.40</p>	<p>4.58</p>	<p>converted to an unstandardised rate to facilitate DHB measurement of performance between quarters. DHBs are to state their year end target. The Ministry will assume that 25% of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.<sup>28</sup></p>
<p><b>Performance dimension : Providing quality services efficiently</b></p> <p><b>Theatre productivity</b> Actual list time/booked</p>	<p>Whakatane Hospital Main theatres current theatre utilisation rate = 68%</p>	<p>Tauranga Hospital main theatres current utilisation rate = 82%</p>	<p>Data on start and end times will be submitted as requested. The proposed measures reflect the outcome of the data requested in one simple measure.</p> <p><b>Target:</b> Whakatane Hospital main theatres resourced theatre sessions utilisation increased from 68% to <b>80%</b></p> <p><b>Target:</b> Tauranga Hospital main theatres resourced theatre sessions utilisation increased from 82% to <b>85%</b></p>
<p><b>Performance dimension : Providing quality services efficiently</b></p> <p><b>Elective and arranged day surgery</b> The DHB is expected to increase the proportion of elective and arranged surgery undertaken on a daycase basis.</p>			<p><b>Target</b> for day surgery rate is <b>60.16%</b> as per ministry guidelines.</p> <p>As well as measuring DHB performance against target for the standardised measure, the target will be converted to an unstandardised rate to facilitate DHB measurement of performance between quarters. DHBs are to state their year end target. The Ministry will assume that 25% of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.<sup>29</sup></p>

<sup>28</sup> Reported quarterly, one quarter in arrears.

<sup>29</sup> Reported quarterly, one quarter in arrears.

<b>Performance dimension : Providing quality services efficiently</b>  <b>Elective and arranged day of surgery admissions</b> The DHB is expected to provide 90% of its elective and arranged surgery on a day of surgery admission (DOSA) basis		<b>Tauranga Hospital</b>	<b>Whakatane Hospital</b>	<b>Target: 90%</b>  The target is 90% of elective and arranged surgery patients (of those who stay for one night or more) will have a DOSA. <sup>30</sup>
	<b>General Surgery</b>	72%	71%	
	<b>Orthopaedics</b>	84%	79%	
	<b>Gynaecology</b>	93%	95%	
	<b>Inpatient dental</b>	95%	100%	
	<b>Vascular surgery</b>	42%	-	
	<b>ENT</b>	90%	-	
	<b>Cardiology</b>	31%	-	
	<b>Plastics &amp; Burns</b>	91%	-	
<b>Performance dimension: Meeting service coverage requirements and supporting sector inter-connectedness</b>  <b>DHB confirmation and exception reports – risk management</b>				DHBs are to report confirming: <ul style="list-style-type: none"> <li>The DHB uses a formal risk management and reporting system to manage DHB risks and report them to its Board.</li> <li>The system meets current Australia/New Zealand Standard requirements relating to risk management</li> <li>How frequently the DHB submits formal risk report updates to its Board (or a Board approved sub-committee)</li> </ul>
<b>Performance dimension : Providing quality services efficiently</b>  <b>Data submitted to national collections</b> Each DHB will improve the quality of data provided to national collections against specified targets.				Measure 1: Timeliness of NMDS Data ≤ 5% Measure 2: NHI duplications ≤ 3% Measure 3: Ethnicity not stated in NHI ≤ 4% Measure 4: Standard vs specific descriptors in the NMDS > 35%
<b>Performance dimension : Providing quality services efficiently</b>  <b>Acute readmissions to hospital</b> The DHB is expected to maintain 28 day unplanned acute readmission rates at the current rate or lower.		<b>Unstandardised acute readmission rate</b>	<b>Standardised acute readmission rate</b>	<b>Target</b> is to maintain the current <b>9.79</b> standardised re admission rate
		9.92	9.79	

<sup>30</sup> In future years this stretch target is expected to increase to 95%

<p><b>Performance dimension : Providing quality services efficiently</b></p>	<p><b>Unstandardised acute mortality rate</b></p>	<p><b>Standardised acute mortality rate</b></p>	<p><b>Target</b> is to maintain current <b>1.81</b> standardised mortality rate</p>
<p><b>Mortality</b> Each DHB is expected to maintain its 30 day mortality rate at the same level, or reduce it, over the year.</p>	<p>1.72</p>	<p>1.81</p>	<p>The DHB is expected to at least maintain the present standardised mortality rate.<sup>31</sup></p>
<p><b>Performance dimension : Providing quality services efficiently</b></p> <p><b>Output delivery against plan</b> Each DHB is expected to deliver hospital outputs to a level in line with planned outputs stated at the year's beginning.</p>	<p>No similar measure in 2009/10</p>		<p>Delivery of hospital outputs as per the Provider Arm Price Volume Schedule</p> <p>To receive an achieved rating overall output delivery must be within 3% of plan, and delivery in the service groups must be within 5% of plan.</p>
<p><b>Performance dimension : Providing quality services efficiently</b></p> <p><b>Capital expenditure to plan</b> Capital expenditure should be delivered in line with plan.</p>	<p>No similar measure in 2009/10</p>		<p><b>Target: capital expenditure in line with plan</b></p> <p>To receive an achieved rating overall capital expenditure for the year to date must be materially in line with the level indicated in DAP financial plans, or changed for good business reasons.<sup>32</sup></p>

<sup>31</sup> Reported quarterly, one quarter in arrears.

<sup>32</sup> Reported quarterly.

# Appendix E Information and Communication Technology

Bay of Plenty District Health Board Prepared 12 March 2010 by GM Information Management, Owen Wallace

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	Project rank/priority	DHB Project Reference #	Planned Start (Month/Yr)	Expected Completion (Month/Yr)	HIS-NZ Action Zone #	Project Type	Significance: National? Regional? Local?	Approx Capital Cost (\$000)	Funding Source	Identify Project reference in DAP. State how project aligns to specific DHB Objectives	Brief Project Description: include comment on: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved
Core Infrastructure - Desktops	1	09CPool	July 2010	June 2011	12	R	L	560	I		Maintaining essential capacity to deliver service
Core Infrastructure – Server & Storage	1	09CPool	July 2010	June 2011	12	R	L	250	I		Maintaining essential capacity to deliver service
Core Infrastructure – Network & Other	1	09CPool	July 2010	June 2011	12	R	L	280	I		Maintaining essential capacity to deliver service
FMIS Upgrade	2	09C01	July 2010	June 2012	12	R	N R	2,000	N		Adoption of multi DHB approach to upgrade or replacement of existing Oracle FMIS <ul style="list-style-type: none"> <li>• Reduced transactional processes &amp; cost</li> <li>• Improved financial analysis, reporting and subsequent performance</li> </ul>
Referral Management System (Incl eReferrals) – Initial Stage	2	09C03	Jan 2010	Dec 2011	8	N	R L	200	I		Implement referral management system <ul style="list-style-type: none"> <li>• reduced manual processes</li> <li>• faster referral process</li> <li>• reduced risk of loss of referrals</li> <li>• faster patient treatment</li> </ul>
eDischarge System	2	09C04	July 2010	June 2011	6	R	R L	70	I		Replace inhouse system with vendor system

Replacement											<ul style="list-style-type: none"> <li>• Improved system capability &amp; robustness</li> <li>• Alignment with regional colleagues</li> <li>• Improved system maintenance</li> <li>• Improved patient care handover</li> </ul>
Clinical Document Upload & Management System	2	09C05	? 2011	? 2012	7	R	R L	200	I		<p>Replace inhouse developed clinical document upload system</p> <ul style="list-style-type: none"> <li>• Improved system capability &amp; robustness</li> <li>• Provision of more complete electronic record</li> <li>• Reduce clinician complaint &amp; frustration</li> </ul>
Primary / Secondary CDR	1	09C06	July 2010	Dec 2010	7	U	R L	100	I		<p>Expand access to DHB clinical data repository to primary</p> <ul style="list-style-type: none"> <li>• Improved quality of care via access to more complete patient information</li> <li>• Ability to share information across care settings</li> <li>• Reduced risk of sentinel event</li> </ul>
Server Room Upgrade	2	09C07	?2011	?2011	12	U	L	100	I		<p>Install dedicated generator &amp; implement heat extraction</p> <ul style="list-style-type: none"> <li>• Improved resilience of infrastructure</li> <li>• Enable regional backup site</li> </ul>
Bar Coding/Scanning Data Capture	5	09C08	?2011	?2012	12	N	L	50	I		<ul style="list-style-type: none"> <li>• Speed up capture of clinical data</li> <li>• Improve data integrity via reduced errors</li> <li>• Reduce manual processes, &amp; improve productivity</li> </ul>

Service Specific – Oral Health	1	09C09	Mar 2010	Sept 2010	7	N	R L	300	I		Implement Titanium system <ul style="list-style-type: none"> <li>• Improved data capture</li> <li>• Reduced manual processes</li> <li>• Improved quality via more complete patient histories</li> <li>• Able to share information across DHB boundaries</li> </ul>
Service Specific - Orthopaedics	4	09C10	?2010	?2011	7	N	L	30	I		Implement service specific database and case management system <ul style="list-style-type: none"> <li>• Electronic note taking</li> <li>• Completeness of record</li> <li>• Improved data integrity</li> <li>• Clinical audit capability</li> </ul>
Service Specific - Endoscopy	4	09C11	?2011	?2012	7	N	L	30	I		Implement service specific database and case management system <ul style="list-style-type: none"> <li>• Electronic note taking</li> <li>• Completeness of record</li> <li>• Improved data integrity</li> <li>• Clinical audit capability</li> </ul>
Clinical Intranet Upgrade	1	09C12	July 2010	Dec 2010	7	U	R L	100	I		Install new version of Healthviews <ul style="list-style-type: none"> <li>• Improved system capability &amp; robustness</li> <li>• Reduce clinician complaint &amp; frustration</li> <li>• Support for product being withdrawn</li> <li>• Alignment with regional colleagues</li> <li>• Enhances regional data sharing</li> </ul>
eOrders System – DHB	2	09C13	?2011	?2012	5	N	R L	300	I		Implement electronic orders engine to integrate with DHB systems and support electronic requesting of laboratory, radiology and other diagnostic tests. <ul style="list-style-type: none"> <li>• Improved record of requested clinical processes</li> </ul>

											<ul style="list-style-type: none"> <li>• Improved data integrity via removal of manual data capture processes</li> <li>• Speeding up requesting process</li> <li>• Improved quality of care</li> <li>• Reduced risk of duplication</li> </ul>
Service Specific – Sexual Health	4	09C15	?	?	7	R	L	30	I		<ul style="list-style-type: none"> <li>• Implement service specific database and case management system</li> <li>• Electronic note taking</li> <li>• Completeness of record</li> <li>• Improved data integrity</li> <li>• Clinical audit capability</li> </ul>
Single Sign On Project	4	09C16	?2011	?2012	12	N	L	100	I		<ul style="list-style-type: none"> <li>• Reduce sign on requirements across multiple systems</li> <li>• Speed up access to clinical data</li> <li>• Remove barriers to system use</li> <li>• Improve user “experience”</li> <li>• Reduce manual processes</li> </ul>
Proximity / BioMetric Logon Project	4	09C17	?2011	?2012	12	N	L	75	I		<ul style="list-style-type: none"> <li>• Improve two factor security</li> <li>• Improve security over access to patient systems</li> <li>• Speed up access to clinical data</li> <li>• Remove barriers to system use</li> <li>• Improve user “experience”</li> </ul>
Midland Connected Health	1	09C18	Apr 2010	Mar 2011	1	N	R	250	N		<ul style="list-style-type: none"> <li>• Implement regional points of presence infrastructure &amp; procure required connectivity</li> <li>• Foundation for regional &amp; national ICT service provision</li> <li>• Enable services to be</li> </ul>

											provided to all health providers <ul style="list-style-type: none"> <li>• Reduced cost of service provision</li> </ul>
Regional Chronic Condition Management System – Initial Stage	3	09C19	?2011	?2012	7	N	R	250	N		Implement first stages of regional chronic condition management system. <ul style="list-style-type: none"> <li>• Improved management of people with chronic conditions</li> <li>• Improved information sharing across care settings</li> <li>• Support for improved service planning &amp; funding initiatives</li> </ul>
Regional PMS / Clinical System	7	09C20	?	?	7	N	R	8,000	N		Replacement of stand alone system with single instance regional system to provide core patient management and clinical information systems.
Trendcare, Rostering Payroll Integration	2	09C21	?2010	?2011	12	N	L	80	I		Integration of Trendcare nursing workforce management system with MicRoster rostering system <ul style="list-style-type: none"> <li>• End to end electronic process from workforce allocation through to payment</li> <li>• Better matching of staff resource to requirements</li> </ul>
Video Conferencing / Telemedicine	1	09C22	Mar 2010	June 2011	12	N	N R L	198	I		Expansion of existing VC capability <ul style="list-style-type: none"> <li>• Provide specialist support to isolated health practitioners</li> <li>• Support regional service provision</li> <li>• Enable patient access to distant specialist services</li> <li>• Enable remote education &amp; professional</li> </ul>

											development • Eliminate travel time & cost
Bed Management & Capacity Planning System	5	10C16	? 2012	? 2013	12	N	R L	350	I		Implement capacity planning & bed management system • Improved resource planning & forecasting • Improved productivity • Improved financial performance
Automated Voice Dictation	8	10C17	?2012	?2013	12	N	L	80	I		Expand voice recognition system • speed up clinical data capture and transcription • reduce manual resource applied to processes
Whakatane Campus Redevelopment	7	10C18	?	?	12	U	L	1,000	N		New core, distribution and access layers of ICT network as part of overall campus redevelopment.
Clinical Audit – Plato replacement	4	10C19	?? 2012	?? 2013	7	R	L	150	I		Procure & implement replacement for Plato • Improved system functionality • Better data capture and use • Improved quality via robust clinical audit process
InterRAI Roll Out	1	10O20	July 10	Sep 10	7	N	N	Opex	M		Extension of BOP InterRAI pilot as part of national project roll out. • Standardised needs assessment process • Improved quality of patient care • Improved data capture
ePrescribing – DHB	7	10C21	?2012	?2013	4	N	R	350	I		Implement electronic prescribing of pharmaceuticals within DHB provider arm. • Decision support to

