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1. Executive summary

This Statement of Intent (SOI) has been prepared by the Bay of Plenty District Health Board (the DHB) to meet the requirements of sections 42 and 39(8) of the New Zealand Public Health and Disability Act 2000 and section 139(1) of the Crown Entities Act 2004. This document is intended to outline for Parliament and the general public the performance that the Bay of Plenty District Health Board will deliver during 2010/11 and contains forecasts for 2011/12 and 2012/13¹.

In the current economic environment of increasing fiscal restraint, this Statement of Intent sets out our strategic direction for the next three years. This includes the outcomes we aim to deliver and the investment we will make in our organisation to make this successful. Although the work within our DHB is diverse, and the linkages are complex, as an organisation we strive to actively support our population towards achieving healthier and more independent lives. Accordingly, this Statement of Intent has been developed in conjunction with government expectations, local priorities, legislative compliance and public sector accountability.

In this SOI we outline our intentions to utilise Government funding to address a range of commitments as well as address the Minister of Health's expectations to provide better, sooner, more convenient healthcare through increasing elective discharges, reduced cancer waiting times and reduced emergency department waiting times. We intend to build on our established culture for clinical leadership and engagement to ensure higher quality, safer and more productive service delivery into the future.

1.1 Government priorities

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.

¹ To meet the requirements of section 39 of the New Zealand Public Health and Disability Act 2000 and section 139(1) of the Crown Entities Act 2004.

The release by the Ministry of Health in September 2009 of the Request for Expression of Interest for the Delivery of Better, Sooner, More Convenient Primary Health (EOI) encapsulates Government's 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.² The EOI is the catalyst for social transformation of Māori communities.

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 Zealander's 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.

1.2 Our priorities

In the last few years Bay of Plenty DHB has experienced strong growth, not only in capital works (with a major redevelopment of the Tauranga Hospital site) but in funding primary and community initiatives in order to deliver on our vision of *Healthy, thriving communities*. We recognise the very different fiscal environment facing the public health sector and New Zealand as a whole and will this year focus on improving models of care, improving hospital productivity, service quality and overall patient experience.

Without doubt the challenges affecting the New Zealand health sector are great but we will meet those challenges and make positive differences to the health outcomes of our resident population by continuing to foster a culture of innovation, challenging old ways of doing things and

² National Maori Coalition – Expression of Interest: Implementing Whānau Ora to deliver better, sooner, more convenient primary health care for Maori and high needs populations

strengthening partnerships within, across and beyond the health sector.

We 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.

1.2.1 More responsive hospital and specialist services

During 2010/11 we will continue to focus on ensuring that our patients are able to access high quality hospital services when needed.

An initiative to improve acute flow is underway. The 'Shorter Stays' initiative represents a significant 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.

Increasing acute demand has the potential to impact on our performance of elective volumes. Elective surgery is an area of utmost importance for us and will be a major focus, together with service waiting times, during 2010/11 and beyond. Maximising theatre utilisation (particularly at Whakatane Hospital) and utilising elective surgical capacity across the Midland region will be our most immediate response in this regard.

Improving the quality and safety of our health services is a priority for Bay of Plenty DHB. 'Health Excellence' is our organisational commitment to performance excellence utilising an internationally recognised framework, namely Baldrige Health Criteria for Performance Excellence. The Health Excellence framework is a practical tool to guide continuous improvement and our journey to a culture based on quality outcomes. It enables our performance to be

measured against other high performing organisations.

Our priority to deliver more responsive hospital and specialist services will be augmented by appropriate infrastructure and hospital facilities. 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 to be completed in mid 2011.

1.2.2 Regional and national service configuration

The five Midland DHBs have embarked on the development of a regional Clinical Services Plan (CSP) that focuses on clinical and financial sustainability across the whole Midland region.

The CSP will describe a 10 year plan for regionally led, collaborative community and hospital services in the Midland Region, taking a whole-of-system approach. The plan will take a long-term (20 year) view of health needs across the Midland population and will match that 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.

The challenge for us is 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.

1.2.3 Clinical workforce sustainability, leadership and engagement

The proportion of the population 65+ years is 29% higher for us than that for New Zealand as a whole and is predicted to grow by 84.3% during the period 2006 to 2026. Our ageing clinical workforce (both in primary and secondary settings) is an acute threat to health service sustainability.

Similarly, we compete nationally and internationally for a limited pool of skilled people. Our recruitment and retention strategies must be robust to minimise the risk of compromised patient outcomes from long term clinical vacancies and reduce the personnel costs that flow from high cost, short-term cover for those vacancies.

The Bay of Plenty Clinical School is our strategic response to the need for a clinically sustainable workforce into the future. The School offers a range of training and research opportunities for a number of medical student/intern clinical placements, nursing students and allied health trainees in a range of disciplines and locations. Positive clinical placements enable us to foster long lasting relationships with our trainee clinicians and showcase the DHB as an employer of choice.

Further, we continue to strengthen clinical leadership and a culture for enduring clinical/management partnerships by:

- identifying and training clinicians that show promise as leaders
- extending opportunities for clinical leaders to inform planning and funding decisions through our technical advisory group structure.

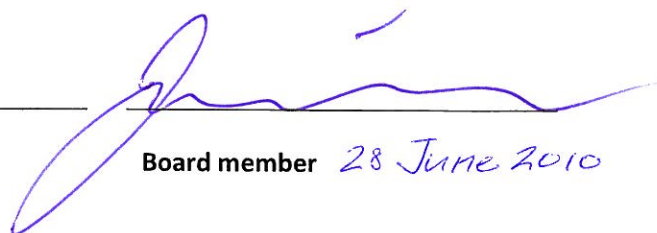
1.2.4 Better, sooner more convenient primary health care

Supporting our Primary Health Organisation (PHO) partners preparing and implementing business cases in accordance with the EOI process will be a priority for us during 2010/11. Similarly, the shifting of secondary services to more convenient

primary settings continues 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.



Mary Hackett
Board Chairperson



Board member 28 June 2010

2 Operating Environment

2.1 Strategic context

This SOI has been prepared within a wider strategic context for health set by Government. In particular the Government is committed to better, sooner, more convenient health care for all New Zealanders.

The New Zealand Health Strategy, the New Zealand Disability Strategy and other strategies listed below provide the context and guidance for policy and planning at national, regional and local levels.

The New Zealand Health Strategy sets the strategic direction for all health services in New Zealand. It establishes a vision for health services, principles for planning and provision of services and it outlines objectives for the health of the population. In particular it focuses on tackling inequalities in health. The five priority service delivery areas included in the New Zealand Health Strategy are:

- Public health
- Primary health care
- Reducing waiting times for public hospital elective services
- Improving the responsiveness of mental health services
- Accessible and appropriate services for people living in rural areas.

The New Zealand Disability Strategy aims to improve the ability of people experiencing disability to participate in community life. The Strategy supports the underlying philosophy of valuing every individual and is intended to move New Zealand towards becoming an inclusive society.

The Māori Health Strategy (He Korowai Oranga) supports Māori aspirations to take control of their own health. It upholds the structures based around Whānau, Hapū and Iwi. It recognises that there is a range of community groups in Māori society, which make valuable contributions to the advancement of Whānau health. He Korowai Oranga contributes to improving the socio-economic and health status of Māori. It also calls

for reforms that will serve to value Māori solutions and integrate the delivery of health services that underpin the broader population health goals of Māori.

The Primary Health Care Strategy aims to see local populations enrolled in a primary health care service that improves health, keeps people well and is accessible.

The Treaty of Waitangi is New Zealand's constitutional document. The Government is committed to fulfilling its role as a Treaty partner. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure). Based on this understanding, Māori and the Crown (including Crown entities such as District Health Boards) will have a shared role in implementing health strategies for Māori, and will relate to each other in good faith, with mutual respect, co-operation and trust.

The national strategies described above, the Minister's Annual Letter of Expectations, and our local priorities provide the context for strategic planning within our DHB.

2.2 Population environment and health profile

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

Covering 9,669 square kilometres, our 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. Eighteen Iwi are located within the Bay of Plenty District Health Board area.

2.2.1 Population

Our population has the second fastest 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 our population resides in the Western Bay of Plenty.

Like the national population, our population is ageing, with the highest percentage increasing occurring in the 65+ years 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%. Our ageing demographic 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 that 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, the 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%.

About a quarter of our population live in areas with high NZDep 06 scores (which are associated with poorer health). About one in seven people live in areas with low scores (associated with better health).

Overall our population is markedly over represented in high deprivation scores.

2.2.2 Health Profile

Our health profile is generated through a comprehensive Health Needs Assessment (HNA) that describes our population and their health status. The health and disability status of the population in our district, together with input from the community and stakeholders, help ensure that we select long-term strategic outcomes to meet the health needs of our population. Our current District Strategic Plan (DSP) was developed in 2006 and responds to the Act and addresses local need and priorities.

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

- Higher rates of avoidable hospitalisation
- Disease of the respiratory system, bronchitis and asthma amongst infants and young children, adults and older people.
- Children and youth have significantly higher rates of hospitalisation and death due to accidental injuries. These include burns (more than double national rates), falls, accidental poisoning and road traffic accidents.
- Chronic obstructive airways disease amongst adults that is 10% higher than national rates.
- Whooping cough and acute bronchitis amongst infants and young children (especially amongst Māori infants)
- Cellulitis amongst adults (45-64 years)
- There is a large and disproportionate burden of disease related to diabetes (including diabetes renal failure) and its long term complications for Māori.
- Cardiovascular disease, including ischaemic heart disease and strokes disproportionately affect Māori.
- 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.

Māori children and youth in the Bay of Plenty also have substantially worse indicators for asthma, oral health, teenage pregnancy and acute rheumatic fever (and chronic rheumatic heart disease) that are amongst the highest in the world.

2.3 Bay of Plenty DHB operating environment

This section provides a summary of the key factors (internal and external) that impact on our DHB and influence the decisions we make.

2.3.1 Health sector wide factors³

The population is changing

Population growth, diversity and redistribution is creating a variety of pressures. Population growth to 2026 is expected to be concentrated on urban centres and there will be much less growth in smaller centres and rural areas and in some cases the population will decline. The population is ageing, as a result of rising life expectancy and lower birth rates.

Factor	Implications
Urban growth	Requirement for ongoing investment in services, workforce and facility development in urban centres
Provincial and rural decline	Increasing pressure on clinical sustainability due to declining patient numbers and workforce supply
Increasing ethnic diversity	Demand for greater flexibility and a range of culturally responsive services
Evolving family structure	Decreased access to informal care and increased demand for support services
Ageing population	The nature of required services is likely to shift toward an emphasis on chronic conditions and toward increasing complexity

Increasing prevalence of chronic conditions

A growing proportion of the population, particularly amongst the adult population, is living with a chronic condition (i.e. diabetes, heart disease or chronic respiratory disease). Chronic conditions tend to be long in duration and slow to progress. The growth in these conditions is largely attributable to changes in people's lifestyles and behaviours.

Factor	Implications
Growth in the number of people living with chronic conditions	Acute services will increasingly accommodate patients whose needs are more complicated New models of care to focus on managing conditions and preventing acute exacerbations through the use of more proactively planned care in a primary/community based setting and the promotion of Whānau led care This will mean impacts on workforce

³ Adapted from Ministry of Health document – Final Draft Trends in Service Design and New Models of Care – A Review

	availability, investment in information technology and primary/community infrastructures
Increased incidence of multiple complex symptoms and co-morbidities	Care is likely to require greater use of interconnected multidisciplinary teams. Providers will need to co-ordinate services and communicate more efficiently with each other.
Greater chance of chronic conditions linked to lifestyle choices	National decisions will have to be made on the appropriate levels of investment into interventions which help prevent the onset and progression of these conditions as well as interventions which promote healthier lifestyles.

Decrease in the rate of funding growth

The Government has identified that the rate of growth in funding of the public health and disability sector is unsustainable. One of the impacts of the global financial situation is a significantly lower rate in the growth of funding for the public health and disability sector.

Factor	Implications
Ageing population	Funding will need to increase, or be redistributed between service areas. The health care expenditure on services for those aged 65 years and over will increase.
New technologies and models of care	People will expect access to new technologies. This will require new funding or robust prioritisation processes (including disinvestment and reallocation decisions) or current services may need to be reconfigured. New technologies and models of care may be more efficient, but their introduction usually requires upfront investment in infrastructure and development.
Global demand for health workers	There is international competition for health workers. This places increasing pressure on organisations to offer competitive wages and conditions and to consider alternative approaches in their use of technology and the make-up of their workforce.
A decrease in the rate of funding growth	There will be a need to: - Increase efficiencies within existing services

(after a recent period of increases)	<ul style="list-style-type: none"> - Redistribute existing funding - Find ways to leverage resources and staff with other sectors - Find better ways of prioritising resources and providing care for those who need it most
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Health inequalities persist

The benefits of an improvement in health status are not equitably shared across population groups. Good health relies on the determinants of health as well as health services.

Factor	Implications
Inequalities in health status continue, with potential for disparities to worsen	<p>There will be a need to:</p> <ul style="list-style-type: none"> - Effectively and appropriately design services - Maintain an appropriate skill set within the workforce, and ensure a focus on cultural responsiveness - Determine the most appropriate resource distribution within the health sector and across government
Long-term and intergenerational inequalities	Long-term planning and commitment required with emphasis on 'joined up' approaches across sectors (health, housing, education and social services). Improved access to health services (from prevention to cure) will be a priority

Health workforce shortages are worsening

Workforce shortages are a key challenge to the health system's ability to provide a full range of accessible, high-quality health services. This presents an even more significant challenge in rural areas where recruitment and retention of health professionals can be comparatively more difficult than it is in urban areas.

Factor	Implications
International demand and an ageing workforce	There will be a need to make better use of the workforce we have available and look for alternatives such as:
Decreased hours/availability as a result of:	<ul style="list-style-type: none"> - Invest in technology to support new ways of working (e.g. telemedicine) - Regional and national collaboration - Employment of supervised but unregulated staff
- Regulated maximum working hours	
- Changing lifestyle	Making greater use of patients'

preferences	own personal resources (i.e. self-management, expert/lay support and Whānau/family care)
Scarcity of support from informal carers	Alternative support networks need to be created or developed
Super-specialisation of some medical professions	The pool of generalist professionals will become smaller, at a time when demands for general skills will be increasing. Staff development will be affected (i.e. training)
Rural workforce shortages	There will be a need to consider reconfiguration or clustering of services to provide clinical sustainability. Investment in telemedicine, information technology and cross-organisational arrangements will be required.

New technologies are being developed

In the past 60 years, medical technology has advanced in ways unimaginable to previous generations. Technological advances have expanded the capabilities of medical care, but they have also been a key cause of rising health costs.

Factor	Implications
Ongoing introduction of new diagnostic tools/tests and new therapeutics	Initial and ongoing costs are often high. Some of these are necessary to support strategic priorities. Improved access for evaluation will be required
More accessible information for patients and clinicians	The way information is accessed will change for both patients and health workers
Increased communication options and speed for patients and clinicians	The way patients and health workers communicate will change particularly with the increasing use of secure electronic interactions (voice, video or email)
Continued growth in research and knowledge	Ongoing need for guidelines and decision support for clinicians to assist the assimilation of research into practice
Increased understanding of need and service impacts	Analysis of appropriate information will be necessary to identify the people most in need as well as to support quality improvement and research

Public expectations rising

People are taking a more active interest in their health, are better informed about their conditions and are more aware of options for treatment than in the past.

Factor	Implications
Patients will be better informed	Patients will have higher expectations of health professionals. They will be better placed to take more of a lead in their own care
Ongoing expectations of highly personalised services	There must be a balance between the needs of the individual and the needs of the broader population
Availability of new technologies	There are likely to be increased disparities between publicly funded services and those funded by private insurance or directly by patients in terms of which new technologies are more likely to be available
Ongoing expectations of health as a 'civil right'	Health is likely to remain high on the political agenda. There will be implications for the workforce (likely to require greater regulation to ensure safe services)
Increased diversity in expectations	There will be an increasing need for more culturally responsive and diverse services

2.4 Reporting to the Minister of Health

Bay of Plenty DHB is required to provide to the Minister (via the Ministry of Health) the following:

1. A District Annual Plan by 30th June for the 2010/11 financial year
2. An Annual Report (including financial statements) within 90 days of year end
3. A Crown Funding Agreement
4. Quarterly reports against CFA accountability indicators
5. Quarterly reports against those indicators detailed in the DHB Non-financial Monitoring Framework for 2010/11 (including indicators in the Policy Priorities, Systems Integration and Ownership dimensions).

As well as health sector accountabilities, Bay of Plenty DHB is also accountable to the Government

through this Statement of Intent, the monitoring of which is overseen by the Office of the Auditor General. DHBs reproduce and report against the Statement of Forecast Service Performance section of the Statement of Intent in their Annual Reports.

2.5 Major Capital Investments

In accordance with section 141(1)(g) of the Crown Entities Act 2004 the Bay of Plenty DHB will consult with the Minister on any significant developments not covered in this SOI.

3 What we do

3.1 Performance objectives

Bay of Plenty District Health Board is one of twenty-one DHBs in New Zealand established on 1 January 2001 in accordance with section 19 of the New Zealand Public Health and Disability Act 2000 (the Act). The objectives of DHBs are covered by section 22 of the Act as follows:

- (1) Every DHB has the following objectives:
 - (a) To improve, promote and protect the health of people and communities
 - (b) To promote the integration of health services, especially primary and secondary health services
 - (c) To promote effective care or support for those in need of personal health services or disability support services
 - (d) To promote the inclusion and participation in society and independence of people with disabilities
 - (e) To reduce health disparities by improving health outcomes for Māori and other population groups
 - (f) To reduce, with a view to eliminating, health outcomes disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders
 - (g) To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of services
 - (h) To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services
 - (i) To uphold the ethical and quality standards commonly expected of

providers of services and of public sector organisations

- (j) To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations
 - (k) To be a good employer in accordance with section 118 of the Crown Entities Act 2004
- (2) Each DHB must pursue its objectives in accordance with its district strategic plan, its annual plan, its statement of intent, and any directions or requirements given to it by the Minister under section 33 of this Act or section 103 of the Crown Entities Act 2004, or under section 107 of the Crown Entities Act 2004.

3.2 The scope of our work

We receive population based funding from the Government. This means funding is allocated on the basis of the following:

- The number of people living in our district
- The population's historic utilisation of health services
- The ethnicity and socio-economic status as measured using the New Zealand Deprivation Score (2006 census) their rurality and an adjuster for 'unmet need'.

The DHB's Planning and Funding division is responsible for planning, promoting and undertaking service contracting with organisations including our own hospital services at Tauranga and Whakatane. Our DHB also contracts services from other providers, including other DHBs who often provide more specialist services. One example is the provision of specialist paediatric treatment, only offered at three centres across the country. Also purchased from other DHBs are tertiary level services, services with high complexity such as cardiac surgery and neuro-surgery.

Some services are funded and contracted directly by the Ministry, for example breast and cervical screening as well as the provision of disability support services for people aged less than 65

years. Our DHB is responsible for monitoring and evaluating service delivery, and this includes auditing the full range of funded services.

The role of our DHB covers most of the health and disability services provided in our district. In this section we detail our agreed priority areas.

3.3 DHB ownership interests

Bay of Plenty DHB is a Crown Entity with ownership of:

- Tauranga Hospital which is a level 4/5 facility, providing medical, surgical, paediatrics, obstetrics, gynaecology and mental health services. 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.
- Whakatane Hospital which 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.
- District nursing services located in both Tauranga and Whakatane.
- Needs Assessment and Coordination Services (Support Net) for people with life-long and age-related disabilities.
- Public Health Unit (Toi Te Ora) providing a range of health promotion and screening services NIR, HIV screening and smokefree programmes.
- School Dental and Adolescent Health Services based in Tauranga and Whakatane.
- Corporate offices in Tauranga for the Chief Executive and members of the DHB Executive Management Team and their staff.
- HealthShare – ownership shared with Midland DHBs – Waikato, Lakes, Taranaki, Tairāwhiti.

3.4 Key outcomes and priorities for our DHB

The Bay of Plenty DHB vision is one of *“Healthy, Thriving Communities”*. Our District Strategic Plan (DSP) identifies five long term health goals (as set out below) to address the health needs of our communities:

1. Healthy children, youth and families
2. Healthy, independent and dignified ageing
3. Healthy Māori
4. Improved health and independence for people with chronic conditions
5. Health equity

Our Outcomes Framework tells our performance story and demonstrates how our local population health outcomes contribute to and align with the overarching national outcomes for society and for the health system, as described in the New Zealand Health Strategy.

Our full Outcomes Framework is included in **Appendix A**.

To deliver on the national outcomes for society and the health system our DHB focuses on:

- Child and Youth Health
- Chronic Conditions
- Health of Older People
- Mental Health
- Primary Health Care
- Hospital and Specialist Services
- Palliative Care
- Māori Health
- Public Health

Our Outcomes Framework identifies long term population health outcomes for each of these focus areas as well as performance measures so we can gauge whether we are progressing towards those outcomes, and ultimately our long term health goals, as articulated in our District Strategic Plan (DSP).

Similarly, each focus area within our Outcomes Framework describes the specific services we provide, the impacts (or intermediate outcomes)

our services are designed to have and how we measure whether our services are having the desired impact. We expect to achieve the desired impact in the medium term, generally between three to five years.

Below the service level we describe the specific outputs we purchase. Further, we describe the desired effect of a collection of outputs as the 'intervention intent'. We expect the intervention intent to be realised in the short term, generally between one and two years.

The outputs are specifically colour coded within our Outcomes Framework to describe the relevant output class to which they relate.

Green for the Public Health Services Output Class

Blue for the Primary and Community Services Output Class

Red for the Hospital Services Output Class

Purple for the Support Services Output Class

Orange for the Capability Output Class

Overall our Outcomes Framework represents a series of performance stories and establishes clear and logical links between government priorities, our population health outcomes, focus areas, services (and their desired impacts) and outputs.

3.5 How we aim to meet the Government's priorities

The Minister of Health's Annual Letter of Expectations is sent to all DHBs and identifies the Minister's specific expectations and priorities for the coming year. These expectations, in addition to national health and disability strategies and our strategic priorities (set out in the DSP), enables our DHB to plan and prioritise activity for 2010/11. Set out below are the Minister's expectations and priorities for 2010/11, together

with an explanation of how our DHB will respond to those expectations and priorities:

3.5.1 Deliver on agreed financial results.

Our DHB continues its commitment to manage expenditure within the funding provided and live within our means. Accordingly, we are committed to maintaining breakeven results during the coming three financial years.

3.5.2 Better, sooner, more convenient primary health care

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.

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.

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.

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

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.

Our DHB will work with its PHO partners to progress the new models of care proposed in the respective business cases. The specific contributions we intend to make to progressing the 'Better, Sooner, More Convenient Primary Health Care' imperative are specifically included within chapter 7 of our District Annual Plan for 2010/11.

3.5.3 Clinical workforce sustainability, leadership and networks

The Minister has highlighted the need for DHBs to improve retention of permanent clinical staff, reduce vacancy rates and strengthen clinical leadership and networks.

Our DHB is committed to strengthening clinical leadership and a culture for enduring clinical/management partnerships. Our 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 supports this approach.

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

Our 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 employs to secure a sustainable workforce.

3.5.4 Improved hospital productivity, quality and procurement. Shared back office functions

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.

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. 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.

Our 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.

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

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.

3.5.5 Identify those services that can have the largest impact on improving Māori health status

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.⁴

The EOI is the catalyst for social transformation of Māori communities. Our 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. Our specific contribution to advancing the EOI business cases is set out in more detail in section 3.10.

The Minister of Health has agreed to a set of national Health Targets to focus the efforts of DHBs and make more rapid progress against key national priorities. These Health Targets are included within the selection of performance measures and are also clearly identified in our District Annual Plan for 2010/11.

⁴ National Maori Coalition – Expression of Interest: Implementing Whānau Ora to deliver better, sooner, more convenient primary health care for Maori and high needs populations p6

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

Our SOI aligns with Government priorities and our Statement of Forecast Service Performance includes outputs in these key areas. Similarly, Government priorities closely align with our vision and long term strategy to achieve “*Healthy, Thriving Communities*”.

Our DHB undertakes a number of activities and performs a wide range of interventions that lead to services provided to our people. The vast majority of these are delivered consistently every year and can be considered to be ‘Business as Usual’. This SOI outlines a framework to measure the benefits/impacts of these interventions which will assist in improving the quantity, quality and coverage of services funded and provided by our DHB over time.

The outcomes described below are consistent with the purposes of the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000.

3.6 Key Mechanisms for Intervention

Our DHB:

- **FUNDS** health and disability services through the contracts we have with providers
- **PROVIDES** hospital and specialist services that covers medical and surgical services, mental health, older person’s health, and
- **PROMOTES** community health and wellbeing through health promotion, health education and population health programmes.

To ensure our interventions are relevant to our communities, coordinated and ensure best value

for money, before making funding, provider or promotion decisions we:

- **PLAN** in consultation with key stakeholders (Iwi, PHOs and NGOs) and our community, the strategic direction for health and disability services within our district.⁵
- **PLAN** in collaboration with other DHBs, regional and national stakeholders.

⁵ For more information on our strategic directions, you can view our District Strategic Plan (DSP) on our website www.bopdhb.govt.nz

4 Output Class Areas and Statement of Forecast Service Performance

4.1 Statement of Forecast Service Performance

Section 142 of the Crown Entities Act 2004 requires DHBs to provide measures and forecast standards of output delivery performance. The actual results against these measures and standards will be presented in the Bay of Plenty District Health Board Annual Report 2010/11. The measures presented in the Statement of Forecast Service Performance are non-financial measures only.

DHBs must provide these measures and standards of output delivery performance under aggregated output classes. There are four output classes for 2010/11 and they are detailed below.

4.2 Output Classes

There are four output classes that are applicable to all DHBs:

1. Public Health Services
2. Primary and Community Health Services
3. Hospital Services
4. Support Services

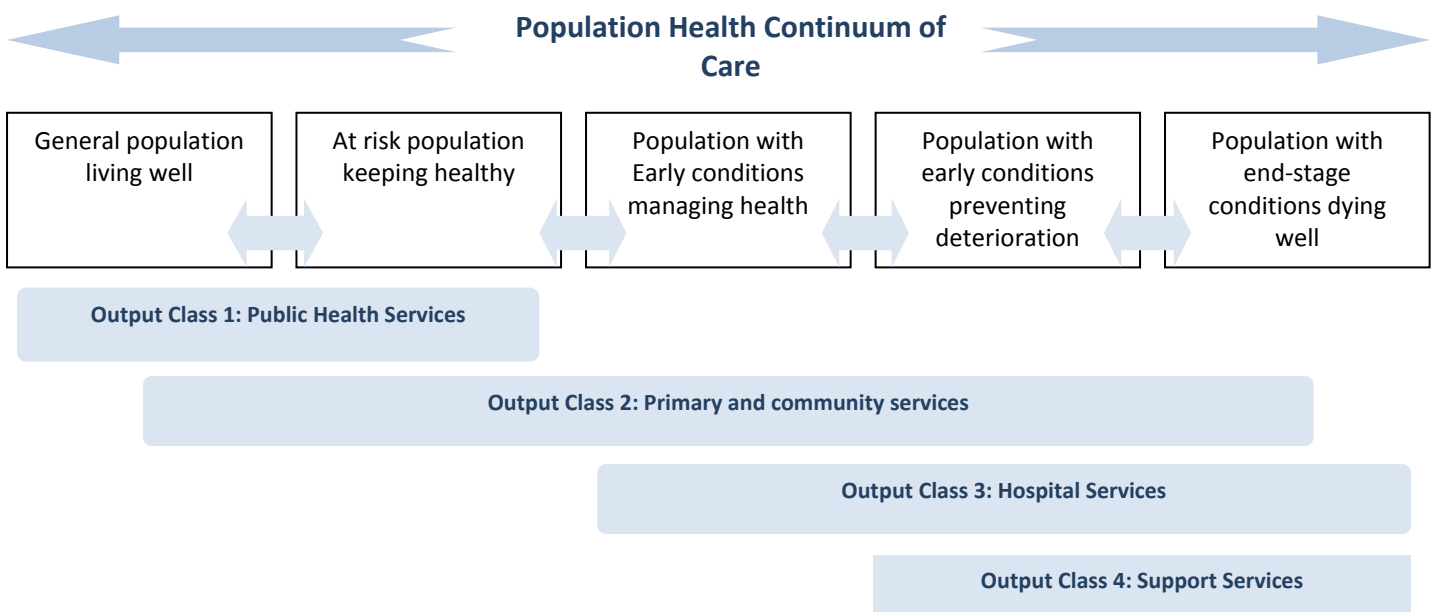
For each output class there are agreed national output performance measures and targets.

One of the functions of this SOI, and in particular the Statement of Forecast Service Performance is to show how the DHB will evaluate and assess what services and products we deliver to others in 2010/11.

In preparing this SOI we have described in more detail than previous years the breadth and depth of services funded by our DHB. It is anticipated that further refinement of the Statements of Forecast Service Performance will occur in 2011/12 particularly in the development of robust measures of service quality (effectiveness, safety and patient experience).

Where possible, we have included past performance (baseline data) along with each performance target to give the context of what we are trying to achieve and to better evaluate our performance.

The model set out below depicts the relationship between Output Classes and specific stages within the Population Health Continuum of Care.



4.3 Public Health Services

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

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public health services include health promotion to ensure that illness is prevented and equality in health status is achieved; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protection services such as immunisation and screening services.

Public health services are the domain of many organisations across the region including:

- Ministry of Health, principally as a funder of public health services, and also a regulator and planner of Regional Public Health. The Ministry of Health is also a provider of services.
- Toi Te Ora Public Health, the regional public health unit for both the Bay of Plenty DHB and Lakes DHB, as a provider of services.
- District Health Boards, in both funding and provision.
- Primary Health Organisations, mainly in the area of provision of primary health care services, but with some public health functions such as immunisation, screening and health promotion.
- A significant array of private and non-governmental organisations, including Māori and Pacific providers.
- Sport Bay of Plenty and Mataatua Sports Trust.
- Local and regional government, with some coordination with central government agencies at a strategic level through Community Outcomes Bay of Plenty (CoBOP).

Toi Te Ora Public Health is the regional public health service owned and operated by the DHB, providing public health services to both Bay of Plenty and Lakes DHBs, although these public health services are centrally funded by the Ministry. The remaining public health services are provided by non-governmental organisations (NGOs), including a significant number of Māori public health providers.

These services include environmental health, communicable disease control, tobacco control and health promotion programmes. In addition, the DHB has supported population health programmes such as promoting influenza vaccination, supporting physical activity programmes across the Bay of Plenty, and the Tauranga Safe City project.

4.3.1.1 STATEMENT OF FORECAST SERVICE PERFORMANCE

Public Health Services Output Class

This section outlines the Public Health services we intend to deliver to our population.

These outputs are aggregated into the following main areas of performance in the Public Health service output class: **Health Promotion and Education services; Statutory and Regulatory Services; Population Based Screening Programmes; Immunisation services**

Main areas of performance in Public Health Service output class	Main measures of performance	VOLUMES		
		Baseline – 2008/09	2009/10	2010/11
1. Health Promotion and Education services include: Healthy Communities Health Promoting Schools Nutrition and Physical Activity Sexual Health Early Child Health (Well Child) Injury Prevention Mental Health Prevention of Alcohol and Other Drug Related Harm Tobacco Control	Quantity: <ul style="list-style-type: none"> ▪ No of schools participating in Health Promoting Schools programme ▪ No's of population calling Quitline for smoking cessation support ▪ No's of families participating in Active Families programmes ▪ No of Māori infants fully breastfeeding at 3 months ▪ No's of schools participating in a Rheumatic Fever prevention throat swabbing programme ▪ No's of children who receive a Before School Check 	70	72	90
	Quality measures (effectiveness): <ul style="list-style-type: none"> ▪ Percentage of hospitalised smokers provided with advice and support to quit ▪ Percentage of enrolled smokers offered support and advice to quit in primary care 	No baseline data ⁷ .	80%	90%
2. Environmental Health and Compliance (includes services that: <ul style="list-style-type: none"> ▪ Support people to live in an environment enabling of a healthy lifestyle, ▪ Reduce the incidence and impact 	Quantity: <ul style="list-style-type: none"> ▪ No's of communicable disease investigations in BOP/Lakes DHBs ▪ No's of environmental health inspections of Early Childhood Centres in BOP/Lakes DHBs ▪ No's of controlled purchase operations carried out on tobacco retailers in BOP/Lakes DHBs 	1,000	1,250	1,250
		25	28	28
		180	180	200

⁶ Period January 2009 to December 2009

⁷ New Health Target introduced 2009/10

⁸ New PHO Performance Programme target. Introduced 2010/11

<p>of infectious disease,</p> <ul style="list-style-type: none"> Ensure a physical environment that protects, promotes and improves public health 	<ul style="list-style-type: none"> No's of alcohol compliance investigations in BOP/Lakes DHBs 	120	120	120
<p>3. Population Based Screening Programmes (some screening programmes may only be provided by some DHBs – e.g. regional breast cancer screening services and screening co ordination)</p>	<p>Quantity:</p> <ul style="list-style-type: none"> Number of infants screened for neonatal hearing loss⁹ Number of women screened for HIV as part of routine¹⁰ antenatal bloods 	<p>No baseline data No baseline data</p>	<p>606 3,072</p>	<p>2,661 3,070</p>
	<p>Quality measures (effectiveness):</p> <ul style="list-style-type: none"> Percentage of Māori eligible women screened for breast cancer Percentage of Pacific eligible women screened for breast cancer Percentage of Māori eligible women screened for cervical cancer Percentage of eligible adult population who have had a cardio-vascular risk assessment recorded in the last 5 years Percentage of eligible Māori population who have had a cardio-vascular risk assessment recorded in the last 5 years 	<p>40.3% 50.0% 53.4% 59.6% 49.0%</p>	<p>52.0% 58.0% 65.0% 63.0% 53.0%</p>	<p>61.0% 64.0% 70.0% 65.0% 53.0%</p>

⁹ Dependent upon actual birth rate in BOP

¹⁰ Dependent upon actual birth rate in BOP

4. Immunisation Services	Quality measures (effectiveness): <ul style="list-style-type: none"> ▪ Percentage of children aged 2 to 3 who have been provided with all vaccinations (total population) ▪ Percentage of children aged 2 to 3 years who have been provided with all vaccinations (Māori population) ▪ Percentage of over 65 years flu vaccinated 	69%	78%	85%
		62%	75%	75%
		69% ¹¹	71%	72%

¹¹ Baseline figure covers period from 1 February to 30 September 2009

4.4 Primary and Community Services

Primary and community healthcare services comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. It includes general practice, community and Māori health services, pharmacist services, community pharmaceuticals and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

A strong primary health care system (as outlined in the Primary Health Care Strategy) is central to improving New Zealander's overall health, and to reduce health inequalities between different groups. New Zealand is experiencing an increasing prevalence rate of long-term conditions including diabetes and cardiovascular disease. Some groups of New Zealanders suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. Long-term conditions require an increased focus across the primary/secondary interface to ensure that people at risk are recognised early and conditions managed effectively.

The three key goals from the national Primary Health Care Strategy are:

- **Transparent national priorities** – DHBs, Primary Health Organisations (PHOs) and the Ministry focused on national health priorities and working collaboratively to improve sector performance.
- **Collective stewardship and governance** – Communities and PHOs engaged to identify population needs and target responses consistent with national priorities
- **Enhanced delivery** – A continuum of accessible services focused on reducing the incidence and impact of chronic conditions.

Our district has five Primary Health Organisations (PHOs).¹²

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.

The Government expects that the primary care sector will make a larger contribution to the health system as the primary point of access to a wider range of publicly funded services. The Request for Expressions of Interest (EOI) for the Delivery of Better, Sooner, More Convenient Primary Health Care represents the fundamental mechanism for delivering on Government expectations in this regard.

Accordingly, we intend working closely with our PHO partners during 2010/11 to assist in progressing their business cases by:

- Exploring new models of contracting together with the risks/benefits/costs of any new models
- Understanding the financial implications, affordability and sustainability of the business case
- Contributing to the planning for Integrated Family Health Centres, Whānau Ora networks and Whānau Ora centres
- Participating in the development of an Outcomes/Performance Measurement Framework
- Developing and agreeing a joint work programme
- 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.
- Identifying and devolving appropriate community and primary Māori services, including navigation services that extend into secondary care.

¹² Western Bay of Plenty PHO; Nga Mataapuna Oranga PHO, Te Ao Hou PHO; Kawerau PHO, Eastern Bay of Plenty PHO

4.4.1.1 STATEMENT OF FORECAST SERVICE PERFORMANCE

Primary and Community Services Output Class

This section outlines the Primary and Community services we intend to deliver to our population. Some of these services are provided by us while others are funded by us through a range of contracts and provided by PHOs and other NGOs. These services include personal health services, mental health services, Māori and Pacific health services and disability support services

These outputs are aggregated into the following main areas of performance: **Primary Health Care; Oral Health Services, Primary and Community Care Programs; Pharmacist Services; Community Referred Test/Diagnostic Services, Community Mental Health Services.**

Main areas of performance in Primary and Community Service output class	Main measures of performance	VOLUMES		
		Baseline - 2008/09	2009/10	2010/11
Primary Health Care Services (GP services)	Quantity:			
	<ul style="list-style-type: none"> ▪ The number of people enrolled with a primary health organisation ▪ No of consultations - PHO general medical services for casual patients 	191,756 n/a	197,101 73,447	200,846 107,201
	Quality measures (effectiveness):			
	<ul style="list-style-type: none"> ▪ High needs population enrolled 	4,723	3,946	4,020
Oral Health Services (includes school based dental services, adolescent dental visits, basic dental care for adult mental health consumers in residential care, emergency dental care for	Quantity:			
	<ul style="list-style-type: none"> ▪ No's provided with oral health services: <ul style="list-style-type: none"> - pre-school children - primary school children ▪ No's of 5 year old children examined ▪ No's of Year 8 children examined ▪ No's of adolescents examined 	5,342 22,091 1,706 2,784 8,114	6,005 22,623 No target set No target set 9,925	8,200 22,687 1,850 2,940 9,922

<p>low income adults, emergency dental care for low income adults, orthodontic services for children of low income families</p>	<p>Quality measures (effectiveness):</p> <ul style="list-style-type: none"> ▪ Percentage of eligible adolescent population utilising DHB funded dental services ▪ A reduction in the number of enrolled preschool and primary school children overdue for their scheduled examination 	<p>56%</p> <p>1,568</p>	<p>68%</p> <p>No target set</p>	<p>70%</p> <p>3,700</p>
<p>Primary and Community Care Programmes</p>	<p>Quantity:</p> <ul style="list-style-type: none"> ▪ Number of patients enrolled in Care Plus <ul style="list-style-type: none"> - Western Bay of Plenty PHO - Eastern Bay of Plenty PHO - Nga Mataapuna Oranga PHO - Kawerau PHO 	<p>2,221</p> <p>Nil</p> <p>Nil</p> <p>Nil</p>	<p>3,959</p> <p>469</p> <p>17</p> <p>290</p>	<p>≥3,959</p> <p>≥469</p> <p>≥17</p> <p>≥290</p>
	<p>Quality measures (effectiveness):</p> <ul style="list-style-type: none"> ▪ The proportion of the eligible population that is enrolled in Care Plus <ul style="list-style-type: none"> - Western Bay of Plenty PHO - Eastern Bay of Plenty PHO - Nga Mataapuna Oranga PHO - Kawerau PHO ▪ An increase in the percentage of people in all population groups estimated to have diabetes accessing free annual checks ▪ Percentage of Māori infants fully breastfeeding at 6 weeks ▪ Percentage of Māori infants fully breastfeeding at 3 months 	<p>Nil</p> <p>Nil</p> <p>Nil</p> <p>Nil</p> <p>Māori: 51%</p> <p>Other:69%</p> <p>Total:65%</p> <p>67%</p> <p>49%</p>	<p>64%</p> <p>35%</p> <p>3%</p> <p>79%</p> <p>Māori:54%</p> <p>Other:72%</p> <p>Total:67%</p> <p>74%</p> <p>57%</p>	<p>≥64%</p> <p>≥35%</p> <p>≥3%</p> <p>≥79%</p> <p>Māori:56%</p> <p>Other:74%</p> <p>Total:68%</p> <p>74%</p> <p>57%</p>

Pharmacist Services	Quantity: <ul style="list-style-type: none"> No's of dispensed items Expenditure on Community Pharmaceuticals per enrolled population (by PHO – refer PPP) 	3,024,813	3,478,573	3,903,801
Community Referred Test/Diagnostic Services (includes laboratory tests, radiological services for cardiology, neurology, audiology, endocrinology, respiratory, pacemaker physiology tests, antenatal screening)	Quantity: <ul style="list-style-type: none"> No's of tests – community laboratory¹³ No's of community referrals for radiological diagnostics (relative value unit)¹⁴ No's of community referred tests - cardiology¹⁵ No's of community referred tests – audiology¹⁶ 	n/a ¹⁷ 51,043 2,434 6,971	1,765,887 55,212 2,224 7,123	2,932,085 54,638 2,217 7,123
	Quality measures (effectiveness): Community Laboratory Tests <ul style="list-style-type: none"> Increase the percentage of routine tests completed within 48 hours Increase the percentage of urgent tests completed and communicated within either 3 hours of receipt of the sample at the lab or the timeframe determined by the Laboratory Clinical Board for that particular type of test Tauranga Hospital Laboratory Tests: <ul style="list-style-type: none"> Routine haematology tests completed within 12 hours Routine microbiology tests completed within 3 working days Whakatane Hospital Laboratory Tests: <ul style="list-style-type: none"> Urgent tests completed within 4 hours Routine histology completed within 72 hours Priority grade specimens within 72 hours 		90% 80% 100% 100% 100% 100% 100%	90% 80% 100% 100% 100% 100%

¹³ PUC CS02002

¹⁴ PUC CS01001

¹⁵ PUC CS04001

¹⁶ PUC CS04003

¹⁷ No baseline data available. Unit of measure differs between 2008/09 and 2009/10

	<ul style="list-style-type: none"> ▪ Fine needle aspiration samples within 24 hours ▪ Cytology specimens within 7 working days ▪ Samples requiring decalcification within 10 working days 		<p style="text-align: right;">100%</p> <p style="text-align: right;">100%</p> <p style="text-align: right;">100%</p>	<p style="text-align: right;">100%</p> <p style="text-align: right;">100%</p> <p style="text-align: right;">100%</p>
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4.5 Hospital Services

Hospital services output class comprises services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include:

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

4.5.1 Acute Services

Acute services are for illnesses that have an abrupt onset. They may or may not lead to a hospital admission. The symptoms leading to the need for acute hospital services are usually of short duration, rapidly progressive, and the need for care is urgent. While a proportion of acute services can never be prevented (for example, people who suffer from an acute episode of appendicitis) there is a number of causes that could be prevented by:

- Better self-management by the individual with the problem (for example, an acute asthma attack);
- Better, more convenient Primary Care (for example, annual diabetes checks preventing episodic diabetes complications leading to a need for acute services);
- Earlier specialist review and intervention (for example, patients with sleep apnoea a condition which causes them to fall asleep while driving and which lead to heart and lung failure) can be rapidly managed through early diagnosis and intervention by a 'specialist sleep service' that works with the patient's GP;

- Better coordination and integration of care (for example, older people who are on multiple medications having their medicines managed in the community by pharmacists, GPs, home care workers, NASC and geriatricians);
- Better palliative care coordination in the community (for example, a person with a long-term condition at the end of life [within six months of death] can receive supportive care through hospice to enable better pain management and symptom control and preventing admission to hospital).

4.5.2 Improved access to elective surgery

The Midland DHBs are working collectively to ensure equitable access to elective services that impact patients' quality of life through either early intervention (for example, removal of an obstructed gallbladder so that the patient does not have repeat attacks of abdominal pain/colic) or through corrective action (for example, major joint replacements to relieve pain and improve mobility). The 2010 Minister of Health's Letter of Expectations indicated the requirement for an extra 1400 elective surgical discharges across the country in the coming financial year and beyond. Further, the government expects DHBs to work collaboratively across regions to provide access to sustainable and quality elective surgical services that enables equitable access for all New Zealanders. DHBs are required to submit a plan to the Ministry of Health to indicate how they will meet the government's funding approach. The Midland DHB Planning and Funding teams are working together to develop a collective regional elective services plan that links to the Midland Regional Clinical Services Plan (MRCSP) and that supports greater sharing and maximisation of resources, flexibility in the delivery of elective surgical services and improved overall productivity in line with government expectations and commitments.

The benefits of this collective Midland elective services approach include:

- Reduction in unmet surgical health needs across the Midland population

- Greater collaboration and cooperation of clinical networks
- Creating value by developing and implementing processes and incentives to ensure efficient, effective and equitable use of resources
- Clinical and management partnerships in driving change forward

In order to realise the Plan, the implementation phase of a collective Midland elective services approach needs to be driven by GMs Planning and Funding in partnership with Chief Operating Officers and with clinical leaders.

Elective services (booked surgery) are for patients who do not require immediate hospital treatment. Also, procedures needing more intervention, coded as 'Acute-arranged', are classified as electives. The Midland DHBs including our DHB is committed to meeting the Government's expectations around elective services, particularly the key principles underlying the electives system:

- **Clarity** – where patients know whether or not they will receive publicly funded services
- **Timeliness** – where services can be delivered within the available capacity, patients receive them in a timely manner; and
- **Fairness** – ensuring that the resources available are directed to those most in need.

In managing Elective Services our DHB will focus on the following areas:

Patient Flow Management

The Midland DHBs will comply with required standards on Elective Services Patient Flow Indicators (ESPis), which demonstrate that the DHB is managing patients in accordance with the three principles (clarity, timeliness and fairness), matching their commitments to capacity, and meeting the 6 month timeframe for provision of assessment and treatment.

Level of Service

The Midland DHBs will ensure that the hospital(s) provide the amount of elective operations, procedures and assessments agreed to in our District Annual Plan. We will review the key operations we perform to ensure we are

delivering the right level of service for the people in our region. We will demonstrate innovative strategies, or alternative delivery options aimed at increasing elective capacity, including initiatives across the primary/secondary interface.

Order of Service

The Midland DHBs are committed to making sure that patients are assessed and prioritised for surgery on a consistent basis, and that they then receive surgery according to the priority they were given.

Non-admitted

Patients being referred for hospital care come under three different codes of care: First Assessments, Follow-up assessments and Pre-admission assessments. The following describes these codes of care in more detail:

- **First assessments** involve face-to-face client contact (including telemedicine) by registered medical practitioner or nurse practitioner for first assessment for that client for that condition for that speciality. This includes follow-up of a post-discharge patient who received their inpatient treatment in a different DHB unless seen in an outreach clinic from that service. The client received treatment, advice, diagnostic or investigative procedures at a healthcare facility, is not admitted, does not receive a general anaesthetic, and the specialist's intent is that they will leave that facility within hours from the start of the consultation.
- **Follow-up Assessments** involve subsequent face-to-face client consultation by registered medical practitioner or nurse practitioner for the same condition in the same speciality. This does not include follow-up of a post-discharge patient who received their inpatient treatment in a different DHB unless seen in an outreach clinic from that service. The client receives treatment, therapy, advice, diagnostic or investigative procedures at a healthcare facility, is not admitted, does not receive a general anaesthetic, and the specialist's intent is that they will leave that facility within three hours from the start of the consultation. Service is provided in a

ward and/or at a designated outpatient clinic or other suitable setting.

- **Pre-admissions assessments** involve attendance at a clinic where the purpose is to complete medical or 'fit for anaesthetic' assessment prior to an elective procedure.

4.5.3 Emergency Department (ED) attendances

Our DHB is addressing a number of strategies to decrease waiting times in the Emergency Department and is committed to achieving the target by the end of 2010/11 through the ongoing implementation of our 'Shorter Stays in ED' Delivery Plan.

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, our '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.

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 in section 6.4 of our District Annual Plan.

4.5.3.1 STATEMENT OF FORECAST SERVICE PERFORMANCE

Hospital Services Output Class

This section outlines the hospital-based services we intend to deliver to our population. It also outlines those hospital services we intend to fund others to provide for our population. Hospital services include all personal health services, mental health services, Māori health services, services for older people and disability support services provided through Bay of Plenty DHB's hospital provider arm and through other DHBs via interdistrict flows (IDFs).

These outputs are aggregated into the following main areas of performance in the Hospital service output class: **Mental Health Services; Electives Services; Acute Services; Maternity Services; Assessment, Treatment and Rehabilitation Services**. For more detail, please refer to our Price-Volume Schedule (PVS).

Main areas of performance in Hospital Services output class	Main Measures of Performance	Volumes		
		Baseline - 2008/09	2009/10	2010/11
Mental Health Services (includes addiction services, specialist mental health & addiction services, specialist community mental health services)	Quantity :			
	Addiction Services			
	▪ No. of people accessing methadone treatment ¹⁸	n/a ²²	119.5	199
	Community Mental Health Services			
	▪ No's of people treated (incl specialities)	6,601	7,101	7,601
	▪ % of Māori population (0-19 years) accessing services	n/a	2.5%	2.55%
	▪ % of relapse prevention plans completed			
	- Child and Youth	70 %	72%	90%
	- Adult	80 %	89%	90%
	- AOD	83%	92%	90%
- Total	77 %	87%	90%	
Specialist Mental Health & Addiction Services				
▪ No of available bed days – acute mental health inpatients ¹⁹	20,802	10,709	23,377	
▪ No of available bed days – mental health inpatients (older people) ²⁰	4,054	3,651	3,654	
▪ No of available bed days – intensive care inpatient beds ²¹	4,906	1,823	6,276	

¹⁸ PUC MHCS29.2

¹⁹ PUC MHIS01

²⁰ PUC MHIS02

	Quality measures (effectiveness): <ul style="list-style-type: none"> ▪ Alcohol and drug service waiting times (working days): <ul style="list-style-type: none"> - Inpatient detox²³ 	10	10	9
Electives Services (inpatient, outpatient)	Quantity: <ul style="list-style-type: none"> ▪ No's of surgical and medical discharges ▪ No's of day case discharges²⁴ ▪ No's of FSAs²⁵ 	8,832	9,220	9,458 ²⁶
	Quality measures (effectiveness): <ul style="list-style-type: none"> ▪ Elective services patient flow indicators (ESPIS) ▪ Elective and arranged day of surgery admissions (percentage of elective and arranged surgery on a day of surgery admission basis)²⁷ ▪ Elective and arranged day surgery (proportion of elective and arranged day surgery undertaken on a daycase basis) 	100%	100%	100%
	Quality: <ul style="list-style-type: none"> ▪ Cancer treatment waiting times (radiation and chemotherapy) ▪ 30 day mortality rate ▪ Reduced elective and arranged inpatient length of stay²⁹ 	6 weeks	6 weeks	5 weeks
		≤1.81	≤1.81	≤1.81 ³⁰
		4.35	4.35	4.0 ³¹

²¹ PUC MHIS09

²² Differing unit of measure between 08/09 and 09/10

²³ Inpatient detox waiting time is the time from detox to the date admitted for detox as an inpatient

²⁴ BOPDHB Provider Arm volumes only

²⁵ Includes Inter-District Flows. FSA's means first specialist appointment.

²⁶ Consisting of 8303 surgical discharges and 1155 medical discharges. Note that 2010/11 volumes are comprised of 13,545 surgical FSAs and 7138 medical FSAs.

²⁷ Includes arranged day of surgery admissions which may not be elective

²⁸ Standardised rate (excludes IDF's). Includes arranged day surgery which may not be elective

²⁹ Standardised elective and arranged inpatient length of stay (excludes IDFs)

³⁰ Standardised mortality rate (excludes IDF's)

³¹ Standardised elective and arranged inpatient length of stay (excludes IDF's)

Acute Services (emergency department, inpatient, outpatient)	Quantity:			
	<ul style="list-style-type: none"> ▪ No's of Emergency Department attendances³² ▪ No's of inpatients³³ ▪ No's of bed days³⁴ 	59,969	63,171	63,171
		30,923	32,175	32,819
		97,719	103,733	105,808
	Quality measures (effectiveness):			
	<ul style="list-style-type: none"> ▪ % of ED attendances with an ED length of stay less than 6 hours 	n/a ³⁶	87%	95%
	<ul style="list-style-type: none"> ▪ Reduced acute inpatient length of stay³⁵ ▪ Acute readmissions to hospital rate 	4.58	4.58	4.26
		≤7.79%	≤7.79%	≤7.79 ³⁷
Maternity Services³⁸ (includes DHB non-specialist antenatal consults, post-natal stays in a primary maternity facility, specialist neo-natal services, labour and delivery services, first obstetric consults, subsequent obstetric consults, maternity inpatient DRG's, maternity outpatients first specialist appointments, maternity outpatient follow-up services, amniocentesis, foetal medicine/anomalies clinics)	Quantity:			
	<ul style="list-style-type: none"> ▪ No's of deliveries ▪ No's of first obstetric consults³⁹ ▪ No's of subsequent obstetric consults⁴⁰ 	2,692	2,845	2,845
		n/a	1,149	1,242
		n/a	1,355	1,255
	Quality measures (effectiveness):			
	<ul style="list-style-type: none"> ▪ Reduced caesarean section rate 	20.6%	25.5%	23.0%
	<ul style="list-style-type: none"> ▪ Established breastfeeding at discharge 	No baseline data	100%	100%
	<ul style="list-style-type: none"> ▪ Neo natal length of stay 	5.76	6.86	6.50
	<ul style="list-style-type: none"> ▪ Post natal length of stay 	2.40	2.49	2.49
Assessment Treatment and Rehabilitation Services⁴¹ (includes inpatients, outpatients, domiciliary assessments and education sessions)	Quantity:			
	<ul style="list-style-type: none"> ▪ No's of patients 	386	456	470
	<ul style="list-style-type: none"> ▪ Discharged home 	272	305	314
	<ul style="list-style-type: none"> ▪ No's of AT&R inpatient bed days⁴² 	n/a	9,490	9,680
	<ul style="list-style-type: none"> ▪ No of AT&R outpatient attendances⁴³ 	n/a	2,068	2,068

³² BOPDHB Provider Arm volumes only. Includes admitted and 'non admitted' attendances.

³³ Tauranga and Whakatane Hospitals only. Acute and arranged CWDs discharge numbers.

³⁴ Acute and arranged CWDs discharge bed days. Tauranga and Whakatane Hospitals only

³⁵ Standardised acute inpatient length of stay (excludes IDFs)

³⁶ New health target introduced 2009/10

³⁷ Standardised acute readmissions rate (excludes IDF's)

³⁸ Volumes and measures for Tauranga and Whakatane Hospitals only

³⁹ PUC W03002

⁴⁰ PUC W03003

⁴¹ Includes BOPDHB funder and Ministry direct. Excludes ACC funded events

⁴² PUC HOP214

⁴³ PUC HOP215

Allied Health Services (includes podiatry, prosthetic eye services, family information services, patient transport services, air ambulance services, occupational therapy, orthoptist services, physiotherapy)	Quantity:			
	<ul style="list-style-type: none"> ▪ No of occupational therapy contacts⁴⁴ ▪ No of Physiotherapy contacts⁴⁵ ▪ No of Podiatry contacts⁴⁶ 	n/a ⁴⁷ n/a ⁴⁸ n/a ⁴⁹	4,745 15,499 2,887	5,189 16,595 2,872

⁴⁴ PUC AH01003

⁴⁵ PUC AH01005

⁴⁶ PUC AH01006

⁴⁷ Inconsistent units of measure between years

⁴⁸ Inconsistent units of measure between years

⁴⁹ Inconsistent units of measure between years

4.6 Support Services

Support services comprise services that are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services.

Bay of Plenty DHB's aim is to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. The role of these services is to ensure that these needs are met through a range of integrated services. Our DHB has taken a 'restorative' approach to these services and had introduced InterRAI (International Resident Assessment Instrument) home-based support tool to ensure people who need support services receive them in a timely way and that they meet the person's assessed need.

4.6.1.1 STATEMENT OF FORECAST SERVICE PERFORMANCE

Support Services Output Class

This section outlines the Support services we intend to deliver to our population. Each aggregate includes people with long-term disabilities; people with mental health problems and people who have age-related disabilities.

These outputs are aggregated into the following main areas of performance in the Support service output class: **NASC Services; Palliative Care Services; Rehabilitation Services; Home Based Support Services; Aged Residential Care Bed Services; Life Long Disability Services (may be specific to some DHBs only); Respite Care Services; Day Services**

Main areas of performance in Support Services output class	Main measures of performance	Volumes		
		Baseline – 2008/09	2009/10	2010/11
Needs Assessment and Support Coordination (NASC) Services	Quantity: ▪ No's of assessments completed ⁵⁰	4,545	4,691	4,840
	Quality measures (effectiveness): ▪ referral to first contact within 2 working days ▪ referral to assessment (days) ▪ Accuracy (InterRai)	100% 5.17 98%	100% 5.00 98%	100% 4.70 98%
	Quality measures (patient experience): ▪ High level of satisfaction with NASC service (measured by increase in positive feedback/decrease in number of complaints)	20 complaints	18 complaints	17 complaints
Palliative Care Services (includes palliative assessment and care coordination, palliative care community services, palliative specialist nursing services, and intensive end of life support services)	Quantity: ▪ No's of patients assessed and supported ▪ Liverpool Care Pathway	590 1 programme	609 1 programme	616 1 programme
	Quality measures (effectiveness): ▪ Liverpool Care Pathway is used in all palliative care situations by funded provider	100%	100%	100%
	Quality measures (Whānau/family experience): ▪ Increase Whānau/family satisfaction with palliative care services	95%	95%	95%

⁵⁰ PUC HOP2004

Home Based Support Services (includes Restorative Home Based Support Services, household management and personal care services, supported living programmes, Māori disability support services, ageing-in-place services)	Quantity: <ul style="list-style-type: none"> ▪ No's of home based support services (HBSS) hours <ul style="list-style-type: none"> - Restorative home based support services (levels 1 & 2)⁵¹ n/a⁵⁵ 3,000 7,761 - Household management services⁵² n/a 240,068 276,525 - Personal care services⁵³ n/a 293,135 361,757 ▪ No's of packages of care <ul style="list-style-type: none"> - Mainstream 41 39 39⁵⁶ - Kaupapa Māori 10 10 10 ▪ No's going into Aged Residential Care (ARC) ≈670 (includes subsidised and non-subsidised) 700 720 ▪ No's of carer support days⁵⁴ n/a 15,110 13,885 			
	Quality measures (effectiveness): <ul style="list-style-type: none"> ▪ Ratio of total \$ spent on HBSS/ARC 0.36:1 0.38:1 0.37:1 			
	Quality measures (patient experience): <ul style="list-style-type: none"> ▪ Reducing no's of complaints 1 complaint 1 complaint 0 complaints 			
Aged Residential Care Bed Services	Quantity: <ul style="list-style-type: none"> ▪ No's of bed days; <ul style="list-style-type: none"> - hospital⁵⁷ n/a⁶⁰ 202,250 233,089 - rest home⁵⁸ n/a 191,976 193,585 - dementia⁵⁹ n/a 31,787 40,751 			
	Quality measures (effectiveness): <ul style="list-style-type: none"> ▪ Ratio of ARC beds/population over 65 1:10.06 1:10.09 1:9.99 			
	Quality measures (safety):			

⁵¹ PUC HOP1004 & HOP1005

⁵² PUC HOP1009

⁵³ PUC HOP1010

⁵⁴ PUC HOP1013

⁵⁵ Inconsistent units of measure between years

⁵⁶ Reduction in number of packages of care between 2008/09 and 2010/11 offset by increased investment in Aged residential care beds.

⁵⁷ PUC HOP1006

⁵⁸ PUC HOP1033

⁵⁹ PUC HOP1032

⁶⁰ Inconsistent units of measure between years

	<ul style="list-style-type: none"> All ARC facilities provide clear evidence of an implemented Quality Plan <p>Quality measures (patient experience):</p> <ul style="list-style-type: none"> Reducing no's of complaints about ARC services 	n/a	n/a	100%
		3 complaints	3 complaints	2 complaints
Respite Care Services	<p>Quantity:</p> <ul style="list-style-type: none"> No's of respite care hours⁶¹ No's of respite care days <ul style="list-style-type: none"> Mainstream Kaupapa Māori Flexi respite 	n/a	n/a	42,414
		1,925	2,219	3,256
		766	1095	1460
		159	256	256
Day Services (includes Day Programmes for older people and Koroua and Kuia support services)	<p>Quantity:</p> <ul style="list-style-type: none"> No's of day service attendances <ul style="list-style-type: none"> Mainstream Kaupapa Māori 	6,845	7,898	7,898
		340	340	340
Allied Health Services (includes dietetics/dietician services, social work, speech therapy)	<p>Quantity:</p> <ul style="list-style-type: none"> No of Dietetics/dietician contacts⁶² No of social work hours⁶³ No of speech therapy contacts⁶⁴ No of clients receiving home oxygen service⁶⁵ 	n/a ⁶⁶	2,624	2,736
		n/a	3,661	4,174
		n/a	1,893	1,784
		n/a	202	202

⁶¹ PUC HOP213

⁶² PUC AH01001

⁶³ PUC AH01007

⁶⁴ PUC AH01008

⁶⁵ PUC DOM102

⁶⁶ Inconsistent units of measure between years

<p>Community Mental Health Services (includes specialist community mental health services : dual diagnosis services, community services for older people, child & youth day services, older persons day hospital programmes, child & youth wrap around services, child & youth acute packages of care)</p> <p>AND</p> <p>(community mental health services : intensive treatment at home service, dual diagnosis, adult community support, activity based recovery services, vocation, peer, and residential support services, supported landlord service, Tamariki and Rangitahi services,</p>	<p>Quantity:</p> <ul style="list-style-type: none"> ▪ No of occupied bed days - Housing Recovery Services (Daytime/Responsive night support)(Daytime/awake night support)⁶⁷ ▪ No of bed days – Kaupapa Maori residential rehabilitation level III⁶⁸ 	<p>n/a</p> <p>n/a</p>	<p>29,779</p> <p>4,380</p>	<p>29,200</p> <p>4,380</p>
<p>Addiction Services (includes social detox beds and detoxification services, residential treatment alcohol & drug, Kaupapa Māori alcohol & drug services, Kaupapa Māori dual</p>	<p>Quantity:</p> <ul style="list-style-type: none"> ▪ No of bed days – social detox service⁶⁹ ▪ No of bed days – residential drug and alcohol treatment 	<p>n/a⁷⁰</p> <p>n/a⁷¹</p>	<p>n/a</p> <p>5,091</p>	<p>196</p> <p>5,475</p>

⁶⁷ PUCs (MHCR03 & MHA25) (MHCR04 & MHA24) (MHIS03)

⁶⁸ PUC MHCR15

⁶⁹ PUC MHCR06

⁷⁰ Inconsistent units of measure between years

⁷¹ Inconsistent units of measure between years

diagnosis services, and opioid treatment services)				
District Nursing Services (includes professional nursing service, specialist community nursing service, home oxygen, stomal and continence services, home help, 'meals on wheels', personal care, enteral feeding services, orthotics)	Quantity: <ul style="list-style-type: none"> ▪ No of District nursing contacts⁷² ▪ No of clients receiving stomal service⁷³ ▪ No of clients receiving the continence service⁷⁴ ▪ No of 'Personal care' service hours⁷⁵ 	n/a ⁷⁶	65,230	70,579
		n/a	466	468
		n/a	1,814	1,818
		n/a	4,436	11,986

⁷² PUC DOM101

⁷³ PUC DOM103

⁷⁴ PUC DOM104

⁷⁵ PUC DOM107

⁷⁶ Inconsistent units of measure between years

5 Organisational Capability

5.1 National and Regional Collaboration

Working collaboratively with others, both across the sector and with other health and social service providers is integral to the success of our DHB in achieving the goals set out in our DSP. We are committed to sharing resources with regional DHBs and providers as well as collaborating with the Ministry, DHBNZ⁷⁷, NGOs⁷⁸ and other service providers in order to achieve specific outcomes.

Our DHB is committed to working with other providers in order to influence the social determinants of health that are external to the health system to achieve the best health outcomes for the population.

5.1.1 National

At a national level our DHB works with the education and justice sectors to improve outcomes for the Bay of Plenty population through health, nutrition, physical activity and mental health initiatives; crossing the sectors in an effort to meet shared goals.

Similarly, we are committed to a number of national programmes, which will improve the health of the community, including B4 School Checks, Newborn Hearing Screening and the Human Papillomavirus Immunisation programme. There are a number of other national programmes such as the National Value for Money Programme, National Procurement Programme and Workforce groups that our DHB is focused on to ensure our clinical and financial sustainability.

5.1.2 Regional

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).

⁷⁷ DHBNZ (District Health Boards New Zealand) has the overall purpose of assisting DHBs in meeting their objectives and accountabilities to the Crown.

⁷⁸ NGOs (Non-Governmental Organisations) for more information on NGOs go to <http://www.moh.govt.nz/ngo>

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 June 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.

5.2 Workforce sustainability and organisational health

Workforce development and strong organisational health are central to our DHB to ensure that we provide high quality effective services and meet the continued challenges of the health needs of our community. Through supporting flexibility and innovation; providing leadership and skill development opportunities; and being a ‘good employer’ our DHB aims to be a preferred employer of health workers. As a ‘good

employer’ we have a number of policies that promote equity, fairness and a safe and healthy work environment. These policies address:

- Fair and transparent recruitment to ensure we meet current and future workforce needs and retain staff
- Our zero-tolerance of all forms of harassment and bullying
- Equitable training and development opportunities for all employees
- The management and disclosure of adverse events to ensure a safe, quality working environment.

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

Our 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.

Our remuneration policy forms part of an overall employment relations strategy for employees covered by individual employment agreements that includes defining the role of employees, performance management and appropriate reward mechanisms. Approximately 89% of DHB employees are covered by salary scales and terms and conditions in National MECAs.

Within the DHB Provider Arm staff turnover rates average approximately 8% per year. We have been successfully addressing staff retention over the last 5 years and have seen a steady decline in staff turnover from 17.84% per annum in 2003/04 to the present rate.

During 2010/11 we will continue to develop our clinical leaders and senior managers and provide appropriate training to realise their full leadership capabilities.

Our DHB intends growing both its research and teaching capacity and capability through an ongoing emphasis on the Bay of Plenty Clinical School.

Similarly, we will continue to foster our culture of innovation by supporting opportunities for workforce innovation. A recent example of such innovation is the establishment of a nurse endoscopist position.

The full scope of our intended actions in relation to workforce sustainability, clinical leadership and engagement can be found in our District Annual Plan for 2010/11.

5.3 Building capability

The Health and Disability services sector has managed significant changes over the last two decades and the fast pace of change will increase in the future. For our DHB a significant change driver is the increased service demand arising from an ageing population that is facing an increasing burden of chronic diseases and multiple health issues.

Change is also being driven by workforce shortages and an ageing workforce. We are committed to ensuring the culture within our DHB supports the change required to achieve our vision of *'Healthy, Thriving communities'* notwithstanding the pace of change. Our DHB will continue to foster a culture of adaptability, innovation, quality, openness, transparency and teamwork. These qualities will help the DHB remain sustainable, keep improving the health status of and reduce inequalities for the Bay of Plenty population. We will be regarded as an employer of choice.

The focus will remain on improving the way patients are cared for, both in the hospitals and in the community to better manage acute demand and the burden of long-term (chronic) conditions. With the economic downturn and funding constraints of 2010/11 and beyond, it is clear that maintaining service coverage and investing in value areas will require greater efficiency, savings, and reprioritisation across the system. The capping of staffing levels for administration staff and managers at the end of 2008 adds additional pressure to make better use of existing resources and work smarter.

Our well established Service Improvement Unit aims to improve patient outcomes and patient safety by freeing up staff time for patient care. Time will be freed up by eliminating waste and

improving systems. The staff dealing with the daily realities of work in healthcare will be given tools and support so they can lead service improvements. Service improvements will be delivered within the organisation's quality framework (Health Excellence).

5.4 Information services

The strategic direction our DHB takes towards its ICT services reflects not only our vision of *'Healthy, Thriving Communities'*, but also the implications and requirements of national and regional information strategies. Accordingly our approach to ICT services incorporates the requirements of the Health Information Strategy of New Zealand (HIS-NZ) an information framework aimed at contributing to achievement of the Government's broad Health Strategies.

Our DHB also recognises that it must be a part of a regional response and as such aims to contribute to three regional information goals:

- provide integrated/shared information to enhance health care planning and improve population health outcomes
- collaborate to reduce costs and enhance risk mitigation within information areas
- provide technical and information support for shared service initiatives in non-IT areas

A comprehensive description of our ICT actions is included in the District Annual Plan for 2010/11 but the major projects for progression during 2010/11 are listed below:

1. Progress the Midland Connected Health business case (as sector lead implementation of the national Connected Health Programme) by:
 - implementing regional service distribution points (at Tauranga and Hamilton);
 - establishing the connectivity layer (adequate leads and speeds)
2. Planning and implementation of a regional network infrastructure involving all 5 Midland DHBs to deliver a shared information system without compromised service at any geographical point.

5.5 Quality and safety

Our DHB recognises that for continuous quality improvement to be successful it must be based on the provision of comprehensive risk management processes and systems which provide the foundation for patient safety.

'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 is *'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 our DHB performance to be measured against other high performing organisations.

During 2010/11 we will begin the implementation of our Health Excellence Strategic Plan starting with a number of services within our Provider Arm undertaking comprehensive self-assessments against the Baldrige Health Care Criteria for Performance Excellence.

Our implementation programme for Health Excellence during 2010/11 will generate a greater organisational commitment to Health Excellence, improved workforce engagement, build on our culture of learning and innovation and offer a framework for regularly reviewing business performance.

5.6 Subsidiaries

Our DHB has no subsidiaries.

6 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 SOI commits the DHB to underlying breakeven results for the period 1 July 2010 to 30 June 2013.

6.1.1 Prospective statement of Financial Performance for the three years ended 30 June 2011 – 2013

\$m	Actual 2009	Estimate 2010	2011	2012	2013
Revenue					
Government Revenue	547.8	582.8	597.7	618.0	638.6
Other Revenue	10.1	6.1	5.3	5.5	5.7
	557.9	588.9	603.0	623.5	644.3
Expenditure					
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
Total Expenditure	558.0	590.3	603.5	623.5	644.3
Total	(0.1)	(1.4)	(0.5)	0.0	0.0
Adjustment for Mental Health Ring Fence					
Ring fence	1.9	1.4	0.5	0.0	0.0
Underlying Result surplus/(deficit)	1.8	0.0	0.0	0.0	0.0

6.1.2 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.

6.2 Financial Performance by Arms

The DHB operates three arms.

6.2.1.1 Funds

The DHB receives, within the 'Funds' arms, 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.

6.2.1.2 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' arm by the Funding and Planning Division.

6.2.1.3 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.

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.

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

6.3 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.

6.4 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.

6.4.1 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	Revenue is allocated using a Population Based Funding Approach and this is

of Plenty between 2% and 3% per annum. This exceeds the amount currently included in Ministry of Health, Statistics New Zealand and Treasury estimates.	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.
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6.4.2 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.

6.4.3 Net Inter-district Flows

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	There is an established

be able to deliver IDF volumes to Bay of Plenty residents due to change in their services or population/volume growth	national process for changes to IDFs.
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6.4.4 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 increases in volumes result in increased costs.	Some services are purchased on a capitated, risk share or fixed basis to reduce the DHB's exposure to unexpected increases in demand driven volumes.

6.4.5 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.

6.4.6 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.

6.5 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.

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

\$m	Actual		Estimate		
	2009	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
Total Net Cashflow	5.2	(5.7)	0.0	0.0	0.0

6.6 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.

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

\$m	Actual		Estimate		
	2009	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
Equity	65.0	69.1	82.5	89.4	94.7

6.6.2 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.

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

All debt is unsecured.

\$m	Actual	Estimate			
	2009	2010	2011	2012	2013
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 drawn	15.0	21.7	22.8	11.0	9.7
Current & Long-term repaid	6.5	0.0	1.0	0.2	0.9
Net Equity injections	10.1	5.5	13.9	6.9	5.2

6.7 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			
	2009	2010	2011	2012	2013
Annual	12.6	13.8	15.4	17.2	18.0
Depreciation					
Tauranga	10.0	37.8	42.1	26.2	23.4
Campus and other					
Strategic					
Regular	10.6	13.1	9.0	9.0	9.0
Capital					
Expenditure					
Total Capital	20.6	50.9	51.1	35.2	32.4
Expenditure					

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.

6.7.1.1 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.

6.7.1.2 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.

6.7.1.3 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.

6.7.1.4 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.

6.8 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.

6.9 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.

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
Revenue	557.9	588.9	603.0	623.5	644.3
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)	-	-	-	-	-
Total Operating Expenditure	536.2	567.3	576.2	592.6	611.5
Surplus/(Deficit) before Interest, Depreciation and Capital Charge	21.7	21.6	26.8	30.9	32.8
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
NET SURPLUS/(DEFICIT)	(0.1)	(1.4)	(0.5)	(0.0)	0.0

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
Crown equity at end of period	65.0	69.1	82.5	89.4	94.6

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
CROWN EQUITY	65.0	69.1	82.5	89.4	94.6
CURRENT ASSETS:					
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
	25.4	20.2	20.3	20.4	20.3
CURRENT LIABILITIES:					
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)
NON CURRENT ASSETS:					
Fixed Assets	166.8	203.8	239.6	257.6	271.9
Investments	0.2	0.2	0.2	0.2	0.2
	167.0	204.0	239.8	257.8	272.1
NON CURRENT LIABILITIES:					
Borrowings & Provisions	65.8	84.1	106.9	118.0	127.7
NET ASSETS	65.0	69.1	82.5	89.4	94.6

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
OPERATING CASHFLOWS					
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
INVESTING CASHFLOWS					
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)
FINANCING CASHFLOWS					
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
Net increase/(decrease) in cash held	14.6	22.4	29.7	10.6	6.3
Add opening cash balance	5.2	(5.7)	0.0	0.0	(0.0)
CLOSING CASH BALANCE	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
REVENUE					
Government Revenue	281.0	298.0	302.0	313.4	324.9
Other Revenue	7.5	6.0	5.1	5.3	5.5
	288.5	304.0	307.1	318.7	330.4
EXPENSES					
Personnel Costs	172.9	178.9	183.8	190.2	196.8
Outsourced Services	26.0	25.6	20.0	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	307.1	318.7	330.4
SURPLUS/(DEFICIT)	0.7	2.9	0.0	0.0	0.0

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
REVENUE					
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
EXPENSES					
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
SURPLUS/(DEFICIT)	0.6	(2.0)	0.0	0.0	0.0

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
REVENUE					
Government Revenue	523.2	556.8	573.3	592.7	612.5
EXPENSES					
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
Māori 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
SURPLUS/(DEFICIT)	(1.4)	(2.3)	(0.5)	0.0	0.0

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
COMMITMENTS					
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
TOTAL COMMITMENTS	156.4	175.9	162.6	157.2	157.6
CONTINGENT LIABILITIES	-	-			

Consolidated Statement of Comprehensive Income	2008/09	2009/10	2010/11	2011/12	2012/13
	\$M	\$M	\$M	\$M	\$M
	Actual	Forecast	Plan	Plan	Plan
REVENUE					
Government Revenue	547.8	582.8	597.4	618.0	638.6
Finance Income	1.0	0.6	0.8	0.8	0.9
Other Revenue	9.1	5.5	4.5	4.7	4.8
EXPENDITURE					
Employee Costs	177.6	183.6	188.5	195.1	201.9
Outsourced costs	26.2	25.9	20.3	20.7	21.1
Clinical Supplies	38.6	43.8	45.7	46.0	47.9
Infrastructure and Non Clinical	30.5	32.4	30.9	31.8	32.6
Payments to Non DHB Providers	263.3	281.6	290.5	299.00	308.0
Interest	4.0	4.7	5.8	7.0	7.7
Depreciation and Amortisation	12.6	13.8	15.4	17.2	18.0
Capital Charge	5.2	4.5	6.1	6.7	7.1
TOTAL EXPENDITURE	588.0	590.3	603.2	623.5	644.3
Share of Profit of Associates	0	0	0	0	0
NET SURPLUS/(DEFICIT)	(0.1)	(1.4)	(0.5)	0.0	0.0
OTHER COMPREHENSIVE EXPENDITURE					
Loss on Revaluation of Land & Building	5.3	0	0	0	0
TOTAL COMPREHENSIVE INCOME/(DEFICIT)	(5.4)	(1.4)	(0.5)	0.0	0.0

6.9.1 Output Class definitions

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

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public health services include health promotion to ensure that illness is prevented and

equality in health status is achieved; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, individual health protection services such as immunisation and screening services.

Primary and community healthcare services comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. It includes general practice, community and Māori health services, pharmacist services, community pharmaceuticals and child and adolescent oral health and dental services. These

services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

Hospital services comprise services that are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated with 'facilities' classified as hospitals to enable co-location of clinical expertise and specialised equipment. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the

range of secondary preventive, diagnostic, therapeutic and rehabilitative services

- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services

Emergency Department services including triage, diagnostic, therapeutic and disposition services.

Support services comprise services that are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services.

Prospective Summary of Revenues and Expenses by Output Class			2010/11	2011/12	2012/13
			\$000	\$000	\$000
			Planned	Planned	Planned
Public Health Services:					
Total Revenue			8.7	9.1	9.4
Total Expenditure			8.7	9.1	9.4
Net (Surplus)/Deficit			0.0	0.0	0.0
Primary & Community Healthcare Services:					
Total Revenue			175.5	181.9	188.7
Total Expenditure			175.5	181.9	188.7
Net (Surplus)/Deficit			0.0	0.0	0.0
Hospital Services:					
Total Revenue			309.8	321.2	333.0
Total Expenditure			310.1	321.2	333.0
Net (Surplus)/Deficit			(0.3)	0.0	0.0
Support Services:					
Total Revenue			106.3	110.2	114.2
Total Expenditure			106.5	110.2	114.2
Net (Surplus)/Deficit			(0.2)	0.0	0.0

6.9.2 Reporting Entity

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

Bay of Plenty DHB is a public benefit entity, as defined under NZIAS 1.

The financial statements of Bay of Plenty DHB for the year ended 30 June 2009 comprise Bay of Plenty DHB and Bay of Plenty DHB’s interest in associates.

Bay of Plenty DHB’s activities involve funding and delivering health and disability services and mental health services in a variety of ways to the community.

The financial statements were authorised for issue by the Board on 24 September 2009.

6.9.3 Statement of Compliance

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

6.9.4 Basis of Preparation

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

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

The accounting policies set out below have been applied consistently to all periods presented in these financial statements.

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

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

6.9.5 Basis for Consolidation

Associates

Associates are those entities in which Bay of Plenty DHB has significant influence, but not control, over the financial and operating policies.

The financial statements include Bay of Plenty DHB’s share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When Bay of Plenty DHB’s share of losses exceeds its interest in an associate, Bay of Plenty DHB’s carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Bay of Plenty DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Business combinations involving entities under common control

A business combination involving entities or businesses under common control is a business combination in which all of the combining entities or businesses are ultimately controlled by the same party or parties both before and after the

business combination, and that control is not transitory.

Bay of Plenty DHB applies the book value measurement method to all common control transactions.

6.9.6 Foreign Currency

Foreign currency transactions

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

6.9.7 Budget figures

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

6.9.8 Financial instruments

Non derivative financial instruments

Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments are recognised initially at fair value plus, for instruments not at fair value through profit or loss, any directly attributable transaction costs. Subsequent to initial recognition non-derivative

financial instruments are measured as described below.

A financial instrument is recognised if the Bay of Plenty DHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if the Bay of Plenty DHB's contractual rights to the cash flows from the financial assets expire or if the Bay of Plenty DHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Regular purchases and sales of financial assets are accounted for at trade date, i.e., the date that the Bay of Plenty DHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if the Bay of Plenty DHB's obligations specified in the contract expire or are discharged or cancelled.

Cash and cash equivalents

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

Accounting for finance income and expense is explained in a separate note.

Available-for-sale financial assets

Where Bay of Plenty DHB has investments in equity securities they are classified as available-for-sale financial assets. Subsequent to initial recognition, they are measured at fair value and changes therein, other than impairment losses, and foreign exchange gains and losses on available-for-sale monetary items are recognised directly in equity. When an investment is derecognised, the cumulative gain or loss in equity is transferred to profit or loss.

The fair value of equity investments classified as available-for-sale is their quoted bid price at the statement of financial position date.

Instruments at fair value through profit or loss

An instrument is classified as at fair value through profit or loss if it is held for trading or is designated as such upon initial recognition. Financial instruments are designated at fair value

through profit or loss if the Bay of Plenty DHB manages such investments and makes purchase and sale decisions based on their fair value. Upon initial recognition, attributable transaction costs are recognised in profit or loss when incurred. Subsequent to initial recognition, financial instruments at fair value through profit or loss are measured at fair value, and changes therein are recognised in profit or loss.

Loans

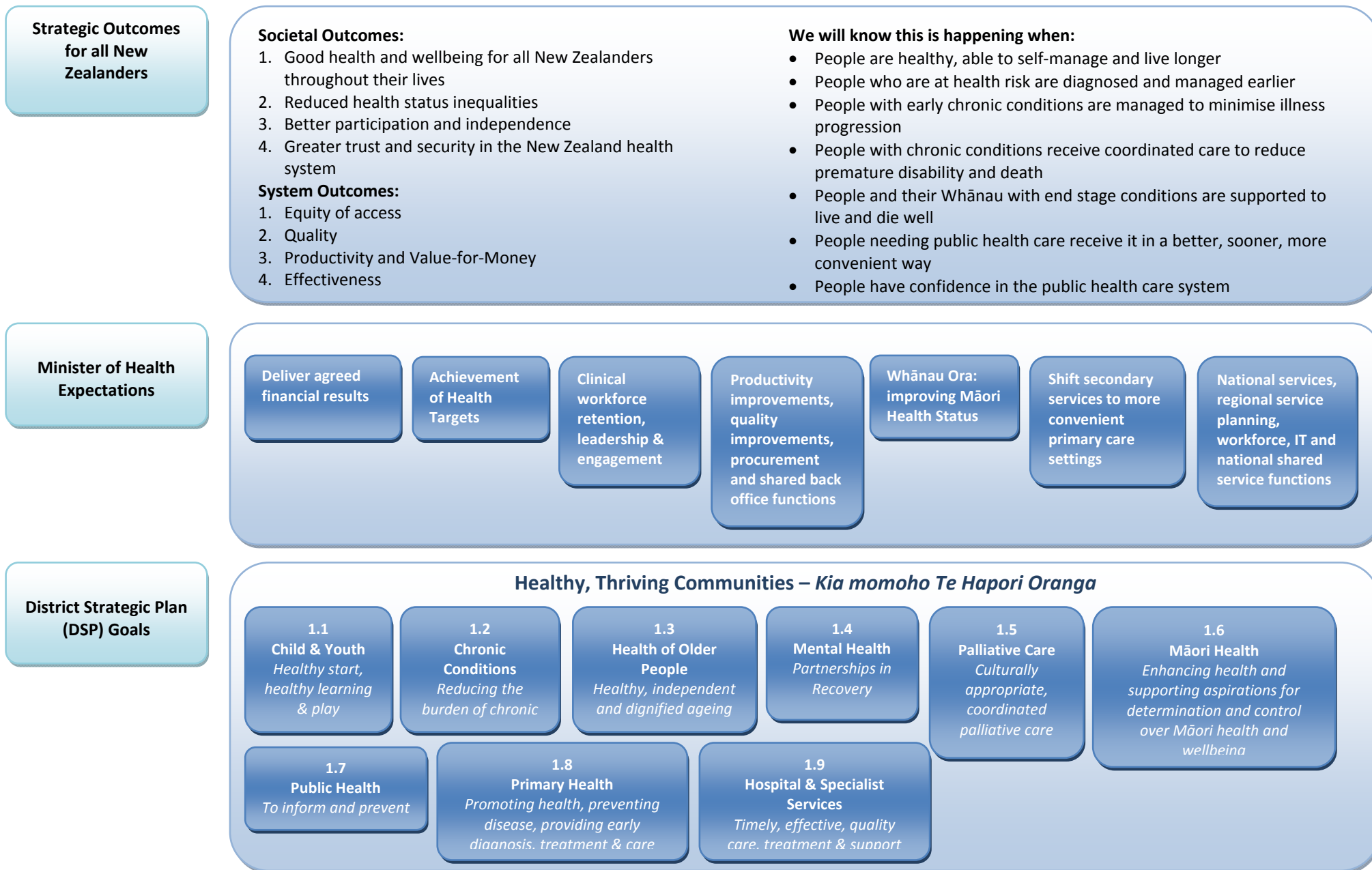
Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.

Other financial liabilities

Other financial liabilities are initially measured at fair value, net of transaction costs, they are subsequently measured at amortised cost using the effective interest method, with interest expense recognised on an effective interest basis

Appendix A : Our Outcomes Framework

6.10 Overarching focus areas – national alignment



6.11 Child & Youth Health

Population health outcomes:

- More babies are born healthy
- Health barriers to learning and play are minimised

1.1
Children and Youth
'Healthy start, healthy learning and play'

Impact measures:

We will know this is happening when:

- Baby birth weights are in normal ranges
- The incidence of preventable childhood disease is reducing

To achieve these outcomes we will focus on:

1.1.1
Oral Health
Improving self confidence, removing barriers to healthy nutrition

1.1.2
Birth & Motherhood
Setting the scene, delivering & supporting a healthy mother and baby

1.1.3
Childhood Immunisation
Reducing the incidence of preventable childhood diseases

1.1.4
Sexual health
Supporting informed consent and reducing the incidence of sexually transmitted disease

1.1.5
Paediatric secondary services
Culturally appropriate, timely paediatric care

1.1.6
Screening
Opportunity is taken to identify and reduce barriers to a healthy lifestyle

Key impacts:

Children and youth will have:

- Better nutrition through better oral function
- Improved oral hygiene
- Improving access over time a fluoridated water supply

1.1.1
Oral Health
*Improving self-confidence,
 removing barriers to healthy
 nutrition*

We will know this is happening when:

- Consumption of sugar-based drinks is decreased
- Breastfeeding rates are increased
- All children understand and implement correct oral hygiene measures
- An increasing number of communities and local authorities wish to pursue fluoridation
- There is a reduction in the number of decayed, missing or filled teeth
- Increase the percentage of children who are caries free

To achieve these impacts we must provide these services groups

1.1.1.1
School based dental services
Improving oral health in school age children

1.1.1.2
Adolescent dental services
Improving oral health in adolescents

1.1.1.3
Specialist dental services
Orthodontic and oral surgical services

Intervention intent

We will know these services are effective when:

- All schools and pre-schools are 'water only'
- All parents are aware of healthy nutrition practices for children
- Oral hygiene messages are consistent, visible and targeted
- Information and support is provided to communities who wish to promote fluoridation

By purchasing these outputs:

1.1.1.1.1
School based dental services

- School based dental visits
- Special dental services for children and adolescents

1.1.1.2.1
Adolescent dental services

- Adolescent dental visits
- Basic dental care for adult mental health consumers in residential care
- Administration of adolescent dental health services

1.1.1.3.1
Specialist dental services

- Emergency dental care for low income adults
- Orthodontic services for children of low income families

We will know these outputs are delivered successfully when:

- Expected service volumes are met
- Service specifications are met
- Service coverage targets high need populations

Impacts/Intermediate Outcomes:

Expectant mothers will:

- Be well informed and supported
- Have health conditions identified early
- Have referrals made to appropriate support agencies
- Receive immunisation and breastfeeding support

1.1.2
Birth and motherhood
Setting the scene, delivering and supporting a healthy mother and baby

Impact measures:

We will know this is happening when:

- The incidence of preventable childhood disease and injury reduce (age specific ASH rates)
- Mothers report favourably on support and care

To achieve these impacts we must provide these service groups

1.1.2.1
Prenatal services
Setting the scene for a new baby

1.1.2.2
Post natal services
Specialist support and care

1.1.2.3
Support in the home
Supporting mother and baby in family life

1.1.2.4
Birthing
Mother and baby are well after birth

1.1.2.5
Specialist Care
Specialist care results in a satisfactory outcome for mother and child

Intervention Intent

We will know these services are effective when:

- Delivery specialist confirm mothers are informed and aware
- Specialist support and LMC's confirm appropriate referral
- Mother and baby receive excellent birth care and support
- Mother is aware of importance of breastfeeding

By purchasing these outputs

1.1.2.1.1
Prenatal services
 • Pregnancy & parenting education
 • Neonatal home care

1.1.2.2.1
Post natal services
 • Postnatal stays in a primary maternity facility (mother & baby)
 • Specialist neonates

1.1.2.3.1
Support in the home
 • Strengthening families (Incredible Years programme)
 • Support services for mothers & their pepi

1.1.2.4
Birthing
 • Maternity facility - fees for labour and delivery
 • Maternity facility – fees for post natal
 • **First obstetric consults**
 • **Subsequent obstetric consults**
 • **Maternity inpatient DRGs**

1.1.2.5.1
Specialist Care
 • Maternity outpatient first specialist appointments
 • Maternity outpatient follow ups
 • Amniocentesis
 • Rhesus clinics – multidisciplinary clinics
 • Foetal medicine/anomalies clinics

1.2.1.1.1
Prenatal courses and information
DHB non-specialist antenatal consults

1.1.2.2.2
Lactation Clinic
 • Breastfeeding & lactation clinics
 • Mothercraft unit

We will know these outputs are delivered successfully when:

- Expected service volumes are met
- Service specifications are met
- 98% of delivering mothers have attended antenatal courses
- 100% of at risk mothers and babies receive support in the home

Impacts/intermediate outcomes:

- There is a reduction in the incidence and impact of vaccine preventable childhood diseases

1.1.3
Childhood Immunisation
Reducing the incidence of preventable childhood diseases

Impact measures

We will know this is happening when:

- Immunisation rates improve

To achieve these impacts we must provide these service groups

1.1.3.1
General Childhood Immunisation
Immunising against common childhood infectious disease

1.1.3.2
Rheumatic Fever Immunisation
Immunising children to prevent chronic disease progression

1.1.3.4
Outreach immunisation services
Reaching out to immunise 'at risk' populations

1.1.3.5
HPV Immunisation

Intervention Intent:

We will know these services are effective when:

- Immunisation targets are met
- Barriers to access and uptake are identified and action taken to overcome
- All providers have capacity to promote immunisation
- Caregivers are knowledgeable regarding the benefits of immunisation
- Targeted rural families are reached and immunised

1.1.3.1.1
General childhood immunisation

- Immunisation projects and programmes set up
- Immunisation

1.1.3.2.1
Rheumatic fever immunisation

- Well child – Rheumatic fever prevention

1.1.3.4.1
Outreach immunisation services

- Outreach immunisation services provided

1.1.3.5.1
HPV Immunisation

- HPV programme
- HPV programme (communications)

We will know these outputs are delivered successfully when:

- Expected service volumes are met
- Service specifications are met
- Immunisation messages are consistent, targeted and visible
- All schools and pre-schools implement Health (Immunisation) Regulations 1995
- Service coverage targets most at need population

Impacts/Intermediate Outcomes:

- Adolescents are aware of and demonstrate good sexual health knowledge

1.1.4
Sexual Health
*Supporting informed consent
and reduced incidence of
sexually transmitted infections*

Impact measures:

We will know this is happening when:

- Teen pregnancy is within national norms
- Sexually transmitted infections in adolescents are within or below national accepted levels
- Evidence of informed consent to sexual activity is apparent

**To achieve this impact
we must provide these
service groups**

1.1.4.1
**Sexual Health Clinics
accessible to adolescents**
*Adolescents are able to access
sexual health advice and
support*

Intervention Intent:

We will know these services are effective when:

- Adolescents are aware of and access clinics
- Utilisation rates are met
- Peer review of service is acceptable

**By purchasing these
outputs**

1.1.4.1.2
**Sexual health clinics
accessible to adolescents**

- *School based sexual health clinics*
- *Youth sexual health services*

**We will know these outputs are delivered
successfully when:**

- Expected service volumes are met
- Service specifications are met
- Service coverage targets 'high need' youth.

Impacts/Intermediate Outcomes:

- Children with acute, life changing and life limiting conditions receive appropriate specialist treatment, care and support

1.1.5
Paediatric Secondary Services
Culturally appropriate, timely, effective specialist paediatric care

Impact measures:

We will know this is happening when:

- Professional peer review supports care pathways
- Whānau, caregivers and children report favourably on treatment and care
- Care is coordinated across multiple providers

To achieve this impact we must provide these service groups:

1.1.5.1
Paediatric medical services

1.1.5.2
Paediatric surgical services

1.1.5.3
Paediatric oncology services

Intervention Intent:

We will know this is happening when:

By purchasing these outputs:

1.1.5.1.1
Paediatric medical services

- Specialist paediatric cardiac – inpatient services
- Specialist paediatric cardiac - 1st attendance
- Specialist paediatric endocrinology – 1st attendance/sub attendance
- Specialist paediatric haematology
- Specialist paediatric neurology
- Paediatric medical inpatients
- Paediatric medical outpatients (1st & sub attendances)
- Paediatric acute assessments
- Paediatric community programme
- Specialist paediatric respiratory

1.1.5.2.1
Paediatric surgical services

- Paediatric surgical services
- Paediatric outpatients (1st & sub attendances)

1.1.5.3.1
Paediatric oncology services

- Specialist paediatric oncology
- Specialist paediatric oncology (1st & subsequent attendances)
- IV chemotherapy – specialist paediatric oncology

We will know these outputs are delivered successfully when:

- Expected service volumes are met
- Service specifications are met
- Service coverage targets ‘high need’ populations

Impacts/Intermediate Outcomes:

- Children with potential or actual health issues are identified and referred for treatment.

**1.1.6
Screening**
The opportunity is taken to identify and reduce barriers to a healthy lifestyle

Impact measures

We will know this is happening when:

- All children are screened for health issues

To achieve this impact we must provide these service groups

**1.1.6
Regular health checks**
Opportunity is taken to identify and reduce barriers to a healthy lifestyle

We will know these services are effective when:

- All school aged children receive checks
- Referring health professionals report favourably on referral service and advice
- Inter agency professionals have confidence in screening and referral processes
- Whānau/caregivers follow advice of health

By purchasing these outputs

**1.1.6.1
Regular health checks**

- Well Child checks
- B4 School checks
- Preschool health services
- Well Child – school aged services (0-5)

**1.1.6.1
Regular health checks**

- Child protection services
- Early childhood development support
- Family violence project coordination

We will know these outputs are delivered successfully when:

- Expected service volumes are met
- Service specifications are met
- Service coverage targets 'high need' populations

6.12 Health of Older People

Population health outcomes:

- More people over 65 live in their own homes and continue to participate in their community
- Health barriers to positive ageing are minimised

1.3 Health of Older People *Healthy, independent and dignified ageing*

We will know this is happening when:

- The average age of entry to ARC facilities increases
- The need for home based support increases
- Over 65 community participation increases
- Older people are more visible

To achieve those outcomes we will focus on:

**1.3.1
Home and community support**
Older people remain in their home and participate in the community

**1.3.2
Secondary services for older people**
Specialist care and support

**1.3.3
Residential Care**
Residential care for those unable to stay in their home

Impacts/Intermediate Outcomes

By focusing on Home and Community Support:

- More people over 65 live at home for longer and continue to participate in their community.

1.3.1
Home and Community Support
Older people remain in their home and participate in their community

Impact measures

We will know this is happening when:

- Community participation by people over 65 increases

To have the desired impact we will provide these service groups:

1.3.1.1
Home Support
Enabling older people to remain in their home

1.3.1.2
Carer Support
Supporting the carers

1.3.1.3
Day programmes
Enabling interactions

1.3.1.4
Information, advice & support

1.3.1.5
Orthotic assessments

Intervention Intent:

We will know these services are effective when:

- There is a reduction in the number of avoidable acute presentations of those over 65 years
- Carers are supported and able to continue caring

1.3.1.1.1
Home support

- Independence first scheme
- Restorative home based support level 1
- Restorative home based support level 2
- Home based support – household management
- Home based support – personal care
- Quality improvement initiatives
- Ageing place – bed day
- NASC discretionary funding
- Respite care
- Supported living – older people
- Maori disability support services – liaison service
- Rural travel

1.3.1.2.1
Carer support

- Carer support
- Respite care

1.3.1.3.1
Day programmes

- Day care
- Koroua and kuia support services

1.3.1.4.1
Information, advice & support

- DIAs
- Information & advisory
- DIAs national contracts
- Travel assistance
- Visitor service

1.3.1.5.1
Environmental support

- Orthotic assessments
- Orthotics/prosthetics
- Environmental support

We will know these outputs are delivered effectively when:

- Expected service volumes are met
- Service specifications are met
- Service coverage targets most at need populations
- People receiving services comment favourably
- Day programme attendance rates increase
- Respite utilisation rates increase

Impacts/Intermediate Outcomes

By focusing on secondary services for older people:

- Those over 65 with acute, life changing and life limiting conditions receive appropriate specialist treatment, care and support.

1.3.2 Secondary Services for Older People *Specialist care and support*

Impact measures:

We will know this is happening when:

- Acute readmissions reduce
- Those older people needing acute care and/or their families report favourably on the care/treatment received

To have the desired impact we will provide these service groups

1.3.2.1
Services to restore ability
Able to return home

1.3.2.2
Services to minimise the risk of readmission
Safe in the home

1.3.2.4
Needs Assessment services
Arranging the right level of care

Intervention Intent:

We will know these services are effective when:

- Acute readmissions reduce

By purchasing these outputs

1.3.2.1.1
Assessment, treatment and rehab services
Inpatients, outpatient clinics, domiciliary assessments and education sessions

1.3.2.2.2
Rapid Response Team
(includes gerontology nurse-led rapid response team)

1.3.2.4.1
Needs Assessments
(includes initial, complex, reassessments and reviews)

1.3.2.1.2
Transitional Care
Facility based level 2

We will know these outputs are delivered effectively when:

- Expected service volumes are met
- Service specifications are met
- Favourable comments from older people and their Whānau about the quality of care/service received
- Evidence of quality plans in place

Impacts/Intermediate Outcomes:

By focusing on residential care older people will receive a level of care appropriate to their needs.

1.3.3
Residential Care
Residential care for those unable to continue living in their own homes

Impact measures:

We will know this is happening when:

- Acute readmissions reduce
- Residential care facilities exceed national standards
- Residents and Whānau/family report favourably on the quality of their care/care of their loved one.

To have the desired impact we will provide these service groups:

1.3.3.1
Rest Home Level Care
Short and long term residential care

1.3.3.2
Hospital Level Care
Greater level of care for older people

1.3.3.3
Maori Liaison Services
Coordinating care for Maori

1.3.3.4
Dementia services

Intervention Intent:

We will know these services are effective when:

- For those aged over 65 hospital admissions are reduced.

By purchasing these outputs

1.3.3.1.1
Rest Home Level care
Aged residential

1.3.3.2.1
Hospital Level Care
Transitional care beds

1.3.3.3.1
Maori Liaison Services
MAOR0113

1.3.3.4.2
Dementia services
Residential care (dementia)

We will know these outputs are delivered correctly when:

- Expected service volumes are met
- Service specifications are met

6.13 Hospital and specialist services

Population Health Outcomes:

- Delivering the best patient experience possible for people needing acute, specialist and high priority treatment

1.9
Hospital and Specialist Services
*Timely, effective, quality care,
treatment and support*

We will know this is happening when:

- Demand is managed in a prioritised, clinically appropriate and financially sustainable manner
- Service delivery, productivity, timeliness, quality and cost benchmarks are met or exceeded
- Favourable comment is received from stakeholders including patients

**To have the
desired impact we
will provide these
service groups**

1.9.1
Surgical Services

1.9.2
Medical Services

1.9.2
Emergency Services

1.9.4
Allied Health

Impacts/Intermediate Outcomes:

By focusing on surgical services:

- Required surgical interventions will be safe, assist treatment and recovery and contribute to a better quality of life for the patient.

**1.9.1
Surgical Services**

Impact measures:

We will know this is happening when:

- Standard discharge ratios indicate equitable access or rational variance
- ESPI compliance is achieved
- Nationally recognised prioritisation tools are used
- Patients and referrers express confidence in the service

To have the desired impact we will provide these service groups

**1.9.1.1
First Specialist Attendances**
Assessing the need, benefits and risk

**1.9.1.2
Procedures**
Excellent outcomes from necessary procedures

**1.9.1.3
Subsequent Attendances**
Assessing success

Intervention Intent:

We will know these services are effective when:

- The procedure is successfully completed and complications avoided
- Patient and referrer are aware of results and recommendations within agreed time frames

By purchasing these outputs

**1.9.1.1.1
First Specialist Attendances:**
*Outpatient dental treatment
Pain clinic
Multidisciplinary assessment
General surgery (incl vascular)
Breast operations
Surgical HSC
Cardiothoracic
Ortohinolaryngology
Gynaecology
Neurosurgery
Ophthalmology
Orthopaedics
Fracture clinic
Plastics
Urology
Sexual health*

**1.9.1.2.1
Procedures:**
*Emergency med services
Cardiology – inpatient service
Spec Paediatric endocrinology
Paediatric medical service
Elective services coordination
Gen surgery (inpatient service)
Minor operations
Anaesthesia services
Cardiothoracic services
Ortohinolaryngology
ENT minor operations
Gynaecology
Termination of pregnancy
Gynaecology
Neurosurgery
Ophthalmology
Minor eye procedures
Orthopaedics
Spinal services
Paediatric surgical
Plastic & burns
Urology inpatient services
Vascular services*

**1.9.1.3.1
Subsequent attendances:**
*Pain clinic
General Surgery
Breast operations
Cardiothoracic
Ortohinolaryngology
Gynaecology
Neurosurgery
Ophthalmology
Orthopaedics
Fracture clinic
Gait laboratory
Spinal
Plastics (incl burns)
Urology
Vascular surgery
Sexual health*

We will know these outputs are delivered effectively when:

- Expected service volumes are met
- Service specifications are met
- Average length of stay reduces

Impacts/Intermediate Outcomes:

By focusing on medical services:

- Required medical interventions are safe, assist treatment and recovery and contribute to a better quality of life for the patient

**1.9.2
Medical Services**

Impact measures:

We will know this is happening when:

- Standard discharge ratios indicate equitable access or rational variance
- Nationally recognised prioritisation tools are used
- Patients and referrers express confidence in the service

To have the desired impact we will provide the following services:

**1.9.2.1
First specialist attendances**
Assessing the need, benefits and risk

**1.9.2.2
Procedures**
Excellent outcomes from necessary procedures

**1.9.2.3
Subsequent attendances**
Assessing success

We will know these services are effective when:

- The procedure is successfully completed and complications avoided
- Patient and referrer are aware of results and recommendations within agreed time frames

By purchasing these outputs

**1.9.2.1.1
First specialist attendances:**
 Outpatient dental treatment
 General medicine
 Medical HSC
 Cardiology
 Specialist paediatric cardiology
 Dermatology
 Endocrinology
 Gastroenterology
 Haematology
 Infectious diseases
 Neurology (incl botulinum toxin therapy & metabolic)
 Specialist paediatric neurology
 Oncology
 Specialist paediatric oncology
 Paediatric medical outpatient
 Renal medicine
 Respiratory
 Immunology
 Sleep apnoea
 Clinical genetics

**1.9.2.2.1
Procedures**
 Tissue typing bone marrow donor
 Family options for chronically ill children
 Inpatient dental
 IVF programme
 Sperm freezing
 General internal medical services
 Adult acute assessments
 Cardiology
 Specialist paediatric cardiology
 Dermatology
 Endocrinology & diabetic
 Gastroenterology
 Capsule endoscopy
 Haematology
 IV chemotherapy
 Oral chemotherapy
 Specialist paediatric haematology
 Venereology & HIV
 HIV/Aids viral load testing
 Neurology
 Paediatric surgery
 Nurse led interventions

**1.9.2.3.1
Subsequent attendances**
 General medicine
 Cardiology
 Cardiac education
 Specialist paediatric cardiac
 Dermatology – UV treatment
 Endocrinology
 Gastroenterology
 Haematology (incl chemo)
 HIV
 Neurology
 Oncology
 (radiotherapy/stereotactic radio surgery)
 IV chemotherapy
 Paediatric med outpatient & home visits
 Renal medicine-haemodialysis
 Respiratory education
 Rheumatology
 Immunology
 Pain specialist
 Genetics service

We will know these outputs are delivered effectively when:

- Cancer waiting times are met
- Expected service volumes are met
- Service specifications are met

Impacts/Intermediate Outcomes

By focusing on Emergency Services:

- We will minimise the impact of acute health needs
- Effectively stabilise those in need of acute care

1.9.3
Emergency Services
'Managing acute care'

Impact measures:

We will know this is happening when:

- Patients, referrers and referred units report favourably on service provided

To have the desired impact we will provide the following services:

1.9.3.1
Emergency services

We will know these services are effective when:

- Acute patients are stabilised and referred to appropriate services within clinically prudent timeframes.

By purchasing these outputs:

1.9.3.1.1
Emergency Services

- *Emergency department triage level 2 (including admitted patients)*
- *Emergency department triage level 3 (including admitted patients)*
- *Emergency department triage level 4 (including admitted patients)*
- *Emergency department triage level 5 (including admitted patients)*
- *Emergency department triage level 6 (including admitted patients)*

We will know these outputs are delivered effectively when:

- Waiting time standards are met (ED Health Target)
- Referred units comment favourably on referral process, triage and treatment
- National ED critical benchmarks are met including discharge times
- Patients and referrers express confidence in the service

Impacts/Intermediate outcomes:

- We will restore optimal patient function by providing a range of diagnostic, technical, therapeutic and direct patient care, including support services.

1.9.4
Allied Health
'Support & follow up'

Impact measures:

- We will know this is happening when:
- Patients, referrers and referred units report favourably on service provided

To have the desired impact we will provide the following services:

1.9.4.1
Movement & Strength

1.9.4.2
Caring for the whole person

1.9.4.3
District Nursing

Intervention Intent

We will know these services are effective when:

- Rehabilitation expectations are met
- Issues, barriers, concerns are addressed

By purchasing these outputs

1.9.4.1.1
Movement & Strength

- Occupational therapy
- Orthoptist
- Physiotherapist
- Community services – orthotics
- Orthotics
- Accredited equipment assessment

1.9.4.2.1
Caring for the whole person

- Dietetics/Dietician
- Podiatry
- Social work
- Speech therapy
- Prosthetic eyes
- Psychological services – non mental health
- Youth sexual health
- Family information service
- Hospital at home – cystic fibrosis drugs
- Regional advocacy service for consumer complaints
- Viral STI education
- Family planning service
- Patient transport, travel and accommodation services

1.9.4.3.1
District Nursing

- Professional nursing service
- Specialist community nursing service
- Home oxygen
- Stomal service
- Continence service
- Home help
- Meals on wheels
- Personal care
- Enteral feeding

We will know these outputs are delivered effectively when:

- Waiting time standards are met
- Referred units comment positively on referral process, triage and treatment
- Patients and referrers express confidence in the services

6.14 Chronic Conditions

Population Health Outcomes:

- People adopt habits and lifestyles that promote and maintain their lifelong health
- People with chronic conditions are managed to reduce the impact of their condition on their lives

1.2 Chronic Conditions *Reducing the burden of chronic conditions*

Impact measures:

We will know this is happening when:

- There is a decreased percentage of people (corrected for age) with chronic conditions progressing to more acute phases of disease
- Decreased percentage of those with chronic conditions requiring frequent hospitalisation
- Increased percentage of people who are able to manage their conditions
- Age-standardised mortality rate by ethnicity (Data source = New Zealand Cancer Registry)
- Five year relative survival rate by stage, ethnicity, age group, deprivation level etc
- Age standardised mortality rate by ethnicity shows reducing inequality

To have the desired impact we will provide these service groups

1.2.1
Diabetes care
Detecting earlier and reducing the impact

1.2.2
Cancer care
Detecting earlier and reducing the impact

1.2.3
Respiratory
Reducing incidence and improving management of respiratory disease

1.2.4
CVD
Reducing the incidence and impact of CVD

1.2.5
Healthy Eating, Healthy Action
Taking action to prevent chronic disease

Impacts/Intermediate Outcomes:

By focusing on diabetes care:

- The impact of diabetes on patient's lives will be reduced.

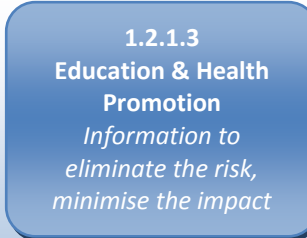


Impact measures:

We will know this is happening when:

- Increasing percentage of diabetics with acceptable blood results
- Rates of retinopathy, nephropathy and neuropathy with diabetes as a contributing factor reduce
- Reduced dependence on renal dialysis
- Reduced requirement for significant medical/surgical intervention
- Greater numbers of early stage diabetes is identified
- A healthy lifestyle that avoids the risk of diabetes and maintains good control is demonstrated by at risk groups

To have the desired impact we will provide these service groups

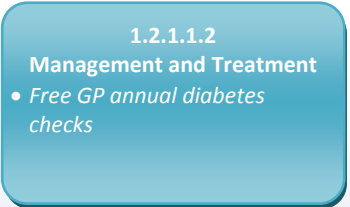


Intervention Intent:

We will know these services are effective when:

- Diabetes screening targets are met
- Greater numbers of early stage diabetes identified
- Treatment is effective of safe
- Patients are able to manage their own condition
- At risk groups are aware of risk reduction techniques and appropriate lifestyle choices.

By purchasing these outputs



We will know these outputs are delivered effectively when:

- Service specifications are met
- Patients are informed of lifestyle choices and management methods

Impacts/Intermediate Outcomes:

By focusing on cancer care:

- The impact of cancer on patients' lives will be reduced
- Cancer survival rates will increase

**1.2.2
Cancer Care**

Impact measures:

We will know this is happening when:

- Cancer is detected earlier
- Treatment is commenced earlier

To have the desired impact we will provide the following services:

**1.2.2.1
Detection**

**1.2.2.2
Treatment**

Intervention intent:

We will know these services are effective when:

- Increased incidence of cancer detected at an earlier stage
- The potential impact of cancer is mitigated, reduced or delayed

By purchasing these outputs

**1.2.2.1.1
Detection**

- *Kimi Hauora Cancer service for McLeod Family*
- *Cervical screening*
- *Breast screening*

**1.2.2.1.2
Treatment**

- *Oncology*
- *IV chemotherapy*
- *Oral chemotherapy*
- *Radiotherapy/stereotactic radio surgery*

We will know these outputs are delivered effectively when:

- Cancer waiting times are met
- Expected service volumes are met
- Screening targets are met
- Maintaining provider accreditation (in terms of quality standards)
- Customer feedback (adverse events/customer satisfaction surveys)

Impacts/Intermediate Outcomes

By focusing on respiratory services:

- The impact of respiratory illness on patient’s lives will be minimised
- The incidence and impact of tobacco related harm is reduced

**1.2.3
Respiratory**
Reducing incidence and improving management of respiratory disease

Impact measures:

We will know this is happening when:

- There is a reduced uptake by denormalising tobacco use
- Increased cessation rates among young people and pregnant women by ensuring culturally appropriate cessation services are available and taken up
- Strengthen and enforcement of the SFE Act by ensuring all premises operate within the bounds of the legislation

To have the desired impact we will provide the following services:

**1.2.3.1
Asthma Service**

**1.2.3.2
Tobacco**

Intervention Intent:

We will know these services are effective when:

- All public outdoor spaces are smokefree
- Tobacco is not supplied to minors
- All public events are smokefree
- All homes and cars are smokefree
- All marae are smokefree tuturu
- All health professionals are aware of and routinely refer smokers to cessation services
- All schools have smoking cessation support available
- All workplaces support staff to quit smoking

By purchasing these outputs:

**1.2.3.1.1
Asthma service**

- *Community asthma services*
- *Asthma management - Maori*

**1.2.3.1.2
Tobacco**

- *Smoking cessation initiative – respiratory*
- *Tobacco control (delivery of training solutions in secondary health)*

We will know these outputs are delivered effectively when:

- Service specifications are met
- Service coverage targets at risk groups

Impacts/Intermediate outcomes:

By focusing on healthy eating, healthy action:

1.2.5
Health eating, healthy action
Taking action to prevent chronic disease

Impact measures:

We will know this is happening when:

- Patients, referrers and referred units report favourably on service provided

To have the desired impact we will provide the following services:

1.9.4.1
Movement & Strength

1.9.4.2
Caring for the whole person

1.9.4.3
District Nursing

We will know these services are effective when:

- Rehabilitation expectations are met
- Issues, barriers, concerns are addressed

By purchasing these outputs

1.9.4.1.1
Movement & Strength

- Occupational therapy
- Orthoptist
- Physiotherapist
- Community services – orthotics
- Orthotics
- Accredited equipment assessment

1.9.4.2.1
Caring for the whole person

- Dietetics/Dietician
- Podiatry
- Social work
- Speech therapy
- Prosthetic eyes
- Psychological services – non mental health
- Youth sexual health
- Family information service
- Hospital at home – cystic fibrosis drugs
- Regional advocacy service for consumer complaints
- Viral STI education
- Family planning service
- Patient transport, travel and

1.9.4.3.1
District Nursing

- Professional nursing service
- Specialist community nursing service
- Home oxygen
- Stomal service
- Continence service
- Home help
- Meals on wheels
- Personal care
- Enteral feeding

We will know these outputs are delivered effectively when:

- Waiting time standards are met
- Referred units comment positively on referral process, triage and treatment
- Patients and referrers express confidence in the services

6.15 Palliative Care

Population Health Outcomes:

- More people are offered a supported, dignified and culturally appropriate end to life

**1.5
Palliative Care**
"A supported, dignified end to life"

We will know this is happening when:

- More people are able to access palliative care services
- Families/Whānau report favourably on the palliative care their loved one received and the bereavement support offered to those left behind.

To achieve these outcomes we will focus on

**1.5.1.
Palliative Care**
Promoting quality of life and a dignified end to life when health cannot be restored

Impacts/Intermediate Outcomes:

- Patients and families/Whānau will have improved access to quality palliative care and support
- Patients and families/Whānau will receive care and support that is responsive to their changing needs through the stages of dying

1.5
Palliative Care
Promoting quality of life and a dignified end to life when health cannot be restored

Impact measures:

We will know this is happening when:

To achieve these impacts we must provide these service groups:

1.5.1
Assessment & Coordination
Right mix of service to meet care and support needs

1.5.2
Hospice Services
Optimal care, support and access to a range of services to support dying with dignity

1.5.3
Intensive end of life support
Specialist end of life care and support

Intervention Intent:

We will know these services are effective when:

By purchasing these outputs

1.5.1.1
Assessment & Coordination

- *Palliative assessment & care coordination services*
- *Long term care*

1.5.2.1
Hospice Services

- *Palliative assessment & care coordination services*
- *Palliative clinical care*
- *Outpatient services*
- *Palliative specialist nursing*

6.16 Primary Health

Population Health Outcomes:

Keeping more people well by:

- Intervening earlier to detect, manage and treat existing health conditions
- Better education and advice so they can manage their own health
- Reaching those who are at risk of developing long term or acute conditions

1.8 Primary Health Care

Promoting health, preventing disease, providing early diagnosis, treatment and care

Impact measures:

We will know this is happening when:

- More individuals manage their own health better
- Continuity of care is seamless and coordinated
- Health care professionals work together to provide a multidisciplinary approach
- Service is accessible, affordable and appropriate
- Service coverage reaches 'high needs' groups

To those outcomes we must focus on:

1.8.1
Primary Health Organisations
Frontline primary care

1.8.2
Diagnostics
Identifying the problem

1.8.3
Non PHO Primary Health Treatment
Frontline primary care

1.8.4
Professional Support
Supporting a sustainable primary care workforce

Impacts/Intermediate Outcomes:

Keeping more people well by:

- Intervening earlier to detect , manage and treat existing health conditions
- Better education and advice so they can manage their own health
- Reaching those who are at risk of developing long term or acute conditions

1.8.1
Primary Health Organisations
Frontline primary care

Impact measures:

We will know this is happening when:

- Standard discharge ratios indicate equitable access or rational variance
- ESPI compliance is achieved
- Nationally recognised prioritisation tools are used
- Patients and referrers express confidence in the service

To have the desired impact we will provide these service groups

1.8.1.1
Health Promotion

1.8.1.2
Improving Access for 'at risk' communities or those with 'high needs'

1.8.1.3
Treatment, support & advice

Intervention Intent:

We will know these services are effective when:

- The procedure is successfully completed and complications avoided
- Patient and referrer are aware of results and recommendations within agreed time frames

By purchasing these outputs

1.8.1.2.1
Improving access

- *First contact services*

1.8.1.3.1
Treatment, support & advice

- *PHO Management Services*
- *PHO flu incentives*
- *Non-capitated GP visits*
- *Community based services*
- *Models of care*
- *COPD pilot*
- *Capitated GP visits*
- *PHO General Medical service for casual patients*

1.8.1.3.1
Treatment, support & advice

- *Podiatry*

We will know these outputs are delivered effectively when:

- Expected service volumes are met
- Service specifications are met
- Average length of stay???

Impacts/Intermediate Outcomes:

By focusing on diagnostic services:

- Health professionals have better information to enable good treatment decisions to be made

1.8.2
Diagnostics
Identifying the problem

Impact measures:

We will know this is happening when:

- Health professionals report favourably on timeliness and reliability of requested tests

To have the desired impact we will provide the following services:

1.8.2.1
Laboratory
Fast, accurate diagnostics

1.8.2.2
Radiology
Fast, accurate diagnostics

We will know these services are effective when:

- Access to diagnostic services meets population needs
- Results are processed within agreed timeframes
- Results are accurate
- 'Did not attend' are minimised

By purchasing these outputs

1.8.2.1.1
Laboratory

- *Community laboratory*
Non-scheduled community laboratory tests
- *Community referred tests – cardiology, neurology, audiology, endocrinology, respiratory, pacemaker physiology tests*
- *Lab tests and pharmacy for sexual health services*

1.8.2.2.1
Radiology

- *Community radiology*
- *Community radiology – DHB*
- *Community referred tests - cardiology*

We will know these outputs are delivered effectively when:

- Cancer waiting times are met
- Expected service volumes are met
- Service specifications are met
- Favourable comment...

1.8.2.1.1
Laboratory
Antenatal screening

1.8.2.2.1
Radiology
Secondary maternity – section 88 maternity diagnostic

Impacts/Intermediate Outcomes

Keeping more people well by:

- Intervening earlier to detect , manage and treat existing health conditions
- Better education and advice so they can manage their own health
- Reaching those who are at risk of developing long term or acute conditions

1.8.3
Non PHO Primary Health

Impact measures:

We will know this is happening when:

- Patients have access to non-PHO treatment

To have the desired impact we will provide the following services:

1.8.3.1
Oral health
Urgent oral pain relief

1.8.3.2
Pharmaceuticals
Medicine & advice

1.8.3.3
Maori Primary Health
Increasing access to health care for Maori

We will know these services are effective when:

- Medicine use review reports effective and efficient medicine use
- Patients and other professionals report appropriate treatment
- Services are accessible

By purchasing these outputs:

1.8.3.1.1
Oral health

- Oral health services for low income adults
- Kaupapa Maori oral health services

1.8.3.2.1
Pharmaceuticals

- Hospital dispensing of pharmaceuticals
- Base pharmacy services
- Complex medicine services – high cost antivirals
- Unused medicines
- Pharmacy depot service
- Pharmacist comprehensive medicines management services

1.8.3.3.1
Maori Primary Health

- Mobile Maori nursing service
- Primary health care and community nursing service
- Maori Primary health

1.8.3.3.1
Maori Primary Health
Community transport for rural patients

We will know these outputs are delivered effectively when:

- Service specifications are met
- Service coverage targets areas of need

Impacts/Intermediate outcomes:

- Ensuring a sustainable primary health service for isolated communities

1.8.4
Professional support
Supporting a sustainable primary care workforce

Impact measures:

We will know this is happening when:

- Turnover of rural GP's is minimised
- Rural GP's are able to participate in development opportunities

To have the desired impact we will provide the following services:

1.8.4.1
Rural GP workforce incentives

We will know these services are effective when:

- The Rural clinical workforce stabilises

By purchasing these outputs

1.8.4.1.1
Rural GP workforce incentives

- Rural payment subsidy fee
- Rural workforce retention subsidy
- Workforce retention – CHADS – Te Kaha
- Rural reasonable roster funding subsidy
- Rural premium services (EBOP after hours primary care)
- Rural bonus
- Rural inpatients
- Opotiki Health Centre – services in rural community

1.8.4.1.1
Rural GP workforce incentives

We will know these outputs are delivered effectively when:

- Payment entitlement is correctly assessed and made by due date

1.8.4.1.1
Rural GP workforce incentives

Rural inpatients

6.17 Mental Health & Addiction services

Population Health Outcomes:

- People with experience of mental illness and addiction are able to participate fully in society and in everyday life



Impact measures:

We will know this is happening when:

- People with mental illness and addiction experience trustworthy agencies working across boundaries
- Service users are supported to lead their own recovery
- The community is aware of the importance of Whānau/families in protecting and preserving the mental health and wellbeing of their children.

To achieve those outcomes we must focus on:



Impacts/Intermediate Outcomes:

By focusing on diabetes care:

- People with substance use/misuse issues and/or problematic behaviours are able to regain control and turn their lives around.

1.4.1
Addiction Services
Regaining Control

Impact measures:

We will know this is happening when:

- Those with addiction issues increase participation in the community
- Those with addiction issues have a reducing reliance on alcohol and drug treatment service for higher levels of care and support.

To have the desired impact we will provide these service groups

1.4.1.1
Residential Addiction
Treating Serious Substance Abuse

1.4.1.2
Community Alcohol & Drug
A safe detoxification

1.4.1.3
Comprehensive Treatment & Planning
Creating self leadership

1.4.1.4
Early intervention
Preventing Dependence

Intervention Intent:

- People who experience addiction lead their own recovery through personalised therapies and support
- Numbers of unplanned residential admissions and need for acute intervention reduces.
- Instances of those with new alcohol and drug problems stabilises.

By purchasing these outputs

1.4.1.1.1
Residential Addiction
Detox Service and Beds

1.4.1.2.1
Community Alcohol & Drug

- Residential Treatment
- Community A&D Services
- Kaupapa A&D Services

1.4.1.3.1
Comprehensive treatment & planning

- Community Alcohol & Drug Services
- Support at Court
- Opioid Treatment Services

1.4.1.4.1
Early intervention

- Kaupapa Early Intervention

1.4.1.2.2
Community Alcohol & Drug

- Advocacy & Peer Support
- Child, Adolescent & Youth alcohol & drug Support

1.4.1.3.2
Comprehensive treatment & planning
Methadone Treatment

We will know these outputs are delivered effectively when:

- Service specifications are met
- Quality, Quantity and Service Coverage targets met.

Impacts/Intermediate Outcomes:

By focusing on Specialist MH & A:

- People with acute and/or serious mental health and addiction issues will be treated and stabilised

1.4.2
Specialist Mental Health & Addiction Services
Specialist Treatment and Stabilisation

Impact measures:

We will know this is happening when:

- Discharge to community services is appropriate and timely
- The risk of harm to those with mental health and addiction issues and others is minimised

To have the desired impact we will provide the following services:

1.4.2.1
Acute Services
Stabilisation

1.4.2.2
Specialist Community Services
Specialist Support to remain at home

Intervention intent:

We will know these services are effective when:

- Acute episodes are stabilised
- Specialist care enables those with mental illnesses to remain in the community
- Crises are responded in a timely and effective way
- Access to service meets requirements

By purchasing these outputs

1.4.2.1.1
Acute services

- *Community Mental Health*
- *Intensive Treatment at home*

1.4.2.2.1
Specialist community services

- *Dual Diagnosis*
- *Community Mental Health Service*

1.4.2.2.3

Specialist community services

- *Community Eating Disorder Service*
- *GP Methadone Service*
- *Community Court/Liaison*

1.4.2.1.2
Acute services

- *General Liaison*
- *Acute Inpatients*
- *Older People Inpatients*
- *Child & Youth Inpatients*
- *Intensive Inpatients*

1.4.2.2.2

Specialist community services

- *Infant, Children & Young People Cmnty Service*
- *Eating Disorders*
- *Specialist Mental Health*
- *Dual Diagnosis with Intellectual Disability*
- *Specialist Prison Court Liaison*
- *Child & Youth Intensive and specialist care*

We will know these outputs are delivered effectively when:

- Response is appropriate to age group.
- Service specifications are met
- Average length of stay meets targets
- Service is culturally appropriate and meets the needs of the user and Whānau.
- Timeliness standards met.
- Acute/unplanned admissions within agreed standards

Impacts/Intermediate Outcomes

By focusing on respiratory services:

- People with experience of mental illness are able to enjoy everyday life.

**1.4.3
Community Mental Health Services
Enabling participation in the
Community**

Impact measures:

We will know this is happening when:

- Evidence indicates individual potential is realised.

To have the desired impact we will provide the following services:

**1.4.3.1
NASC**
Assessing need and arranging the right treatment

**1.4.3.2
Residential Care**
Supported living & arranging the right treatment

**1.4.3.3
Community Support**
Supported independent living

**1.4.3.4
Respite**
Caring for the carer

Intervention Intent:

People who experience mental illness:

- Are referred to the right place to receive the right level of care.
- They have family and Whānau that are supported
- The right mix of services is regularly reassessed
- Rehabilitation and treatment transitions are seamless.

By purchasing these outputs:

**1.4.3.1.1
NASC**
• Community Assessments
• Service Coordination

**1.4.3.1.2
NASC**
• Child & Youth Assessments
• Service Coordination

**1.4.3.2.1
Residential Care**
• Day Housing & Recovery Service
• Night Housing Recovery Service
• Community Residential
• Other Residential Support

**1.4.3.2.2
Residential Care**
• Clinical Rehab/Extended Care
• Inpatient Beds

**1.4.3.3.1
Community Support**
• Adult Community Support
• Activity based recovery
• Vocation Support
• Peer Support
• Residential Support
• Supported Landlord
• Community Mental Health
• Tamariki & Rangitahi Service

**1.4.3.3.2
Community Support**
• Child & Young Persons
• Clinical Cmnty Service

**1.4.3.4.1
Respite**
• Kaupapa Maori Residential Care
• Adult Planned Respite
• Older Person Respite
• Adult Crisis Respite
• Child & Youth Respite
• Dual Diagnosis Respite

**1.4.3.3.3
Community Support**
• Peer Support Adults, Families, Youth

We will know these outputs are delivered effectively when:

- Service specifications are met
- Service coverage targets at risk groups

6.18 Public Health

Population health outcomes:

- Population mitigates health risk
- Serious health issues are detected earlier
- Environmental health risk is mitigated

1.7
Public Health
'To inform, prevent and educate'

We will know this is happening when:

- Reported instances of disease are within benchmarked maximums
- Uptake of screening opportunities are maximised
- Reported instances of environmental illness are within benchmarked maximums

To achieve these outcomes we will focus on:

1.7.1
Health Promotion & Education
Information to act on

1.7.2
Screening
Early detection, early treatment

1.7.3
Environmental health & compliance
Keeping our place safe

Impacts/Intermediate outcomes:

By focusing on health promotion and education:

- We will promote and foster the development of environments that support a healthy lifestyle through nutrition
- We will reduce the incidence and impact of diabetes, cardiovascular disease and cancer

**1.7.1
Health promotion and
education
Informing to prevent**

We will know this is happening when:

- The incidence of and impact of tobacco related harm is reduced
- There is a reduced uptake by young people by denormalising tobacco use
- There is an increased awareness of the nutrient value of foods
- There is an increased exposure to advertising for low-fat, salt and sugar products
- There is an increased number of people eating a variety of nutritious foods and eating more fruit and vegetables
- There is an increased consumption of water (over soft drink and juice)
- There are increased rates and duration of breastfeeding
- There are increased rates of walking & cycling for transport
- There are increased rates of people doing some vigorous exercise

To achieve these impacts we must provide these services groups

**1.7.1.2
Information campaigns**

We will know these services are effective when:

- Oral health measures (see Child & Youth – Oral health)
- Smoking cessation measures (see Chronic Conditions – Respiratory)
- All priority settings (schools, pre-schools, marae, workplaces) adopt physical activity guidelines and have access to affordable, available physical activity
- A consistent physical activity message is portrayed by all agencies & sectors
- Older people and people with disabilities are supported by environments that encourage them to be physically active, eat healthy food and maintain a healthy weight
- All public physical activity facilities are routinely maintained and improved
- There is a reduction in the amount of time children spend at the screen

By purchasing these outputs:

**1.7.1.2.1
Stop smoking
campaigns**

**1.7.1.2.2
Immunisation
campaigns**

**1.7.1.2.3
Nutrition & activity
campaigns**

**1.7.1.2.4
Safe alcohol use
campaigns**

We will know these outputs are delivered successfully when:

- Expected service volumes are met
- Service specifications are met
- Service coverage targets high need populations

Impacts/Intermediate outcomes:

- Serious health risk is detected early

1.7.2
Screening
Early detection, early treatment

We will know this is happening when:

- Uptake of screening opportunity meets expectation

To achieve these impacts we must provide these service groups

1.7.2.1
Screening
Early detection, early treatment

We will know these services are effective when:

- Clients are aware of results and preventative treatments
- Clients with unfavourable results are receiving necessary treatments
- Information passed with referral to other health professionals is complete and accurate.

By purchasing these outputs

1.7.2.1.1
Screening

- *Breast screening*
- *Cervical screening*
- *Screening support (enabling access)*

We will know these outputs are delivered successfully when:

- Expected service volumes are met
- Service coverage targets are high
- Client satisfaction is high

Impact/Intermediate outcomes:

- All people live in an environment that is enabling of a healthy lifestyle
- Urban design supports people to live a healthy life
- There is a reduction in the incidence and impact of infectious diseases
- Physical environments protect, promote and improve public health

1.7.3
Environmental health & compliance
Keeping our places safe

We will know this is happening when:

- Housing for low-income people is safe, warm, dry and affordable
- All people live in communities that are safe, inclusive and supportive of healthy lifestyles
- Public health principles are incorporated into urban design
- Surveillance of notifiable diseases is accurate, timely and complete
- Protocol based public health follow-up is conducted for all notified diseases

To achieve these impacts we will provide these service groups:

1.7.3.1
Communicable disease

1.7.3.2
Compliance Checks

1.7.3.3
Environmental Inequalities

1.7.3.4
Environmental Hazards

We will know these services are effective when:

- Safe drinking water is available
- There is a reduction in the incidence and impact from biosecurity & quarantinable incidents
- Health and non-health sectors and general public are knowledgeable about infectious disease prevention
- Food safety measures are understood and implemented in all relevant settings
- The impact of a pandemic is reduced
- National, regional and local policy ensures healthy housing for all

By purchasing these outputs

1.7.3.1.1
Communicable disease
Communicable disease investigations

1.7.3.2.1
Compliance checks

- *Environmental health inspections*
- *Tobacco controlled purchase operations*
- *Alcohol compliance checks*

1.7.3.3.1
Environmental inequalities

We will know these outputs are delivered successfully when:

- Expected service volumes are met
- Service specifications are met
- Compliance checks exceed standard

6.19 Maori Health

Population health outcomes:

- Whānau Ora/Toi Ora

1.6

Māori health

Enhancing Maori health and supporting aspirations for determination and control over Maori health and wellbeing

We will know this is happening when:

- Maori return improving results against the wider determinants of health

To achieve those outcomes we will focus on:

1.6.1

He Ranga Hua Hauora

Right people, right skills, right place, right services

1.6.2

Tino Rangatiratanga

(Maori self-determination)

For Maori, by Maori

1.6.3

Tuituinga Pou Hauora

(Mainstream responsiveness)

Culturally responsive mainstream services

Impacts/Intermediate Outcomes

- Māori have the right capacity and capability to address their health issues

1.6.1
He Ranga Hua Hauora
Right people, right skills, right place, right services

Impact measures

We will know this is happening when:

- Training, development and support is provided

To have the desired impact we will provide these service groups:

1.6.1.1
Workforce and service development
Right people, right services

Intervention Intent:

We will know these services are effective when:

- Service providers report satisfaction with service
- Clients of service report favourably as to service quality

1.6.1.1.1
Workforce and service development
• *Maori provider development scheme*

We will know these outputs are delivered effectively when:

- Providers receive necessary support
- Training and development needs have been identified

Impacts/Intermediate Outcomes

- Whānau Ora for Maori

1.6.2
Tino Rangatiratanga
For Maori, by Maori

Impact measures:

We will know this is happening when:

- Whānau/Hapu health improves
- More health services are delivered by Maori for Maori

To have the desired impact we will provide these service groups

1.6.2.1
Holistic health services

Intervention Intent:

We will know these services are effective when:

- Health issues within Whānau/Hapu are wider determinants facing Whānau/Hapu are addressed

By purchasing these outputs

1.6.2.1.1
Holistic health services

- *Primary health care and community nursing services*
- *Whānau Ora – Maori community health services*

1.6.2.1.1
Holistic health services

Maori health promotion

We will know these outputs are delivered effectively when:

- Expected service volumes are met
- Service specifications are met

Appendix B : Performance Improvement Actions

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