



Office of Hon Pete Hodgson

MP for Dunedin North

Minister of Health
Minister for Land Information

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Dr Judith Aitken
Acting Chair
Capital & Coast District Health Board
Private Bag 7902
WELLINGTON

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FOR ACTION BY
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Dear Dr Aitken

Capital & Coast District Health Board: 2006/07 District Annual Plan

This letter is to advise you that I have signed Capital & Coast District Health Board's (C&CDHB's) District Annual Plan (DAP) for the 2006/07 year. The Board has my support for the implementation of this plan. I wish to express my appreciation to the Board, management and staff for all the effort that has gone into producing the plan and the efforts made to manage your services within the funding available in 2006/07.

I am disappointed, however, that C&CDHB has not been able to present acceptable plans for the outyears. I expect C&CDHB to provide a DAP next year that can be supported for the full three years.

C&CDHB will continue to receive in 2006/07 the early payment arrangements that you benefited from in 2005/06. The Ministry of Health (the Ministry) may review this privilege during the year, along with C&CDHB's position on the Monitoring and Intervention Framework.

I acknowledge and accept the commitment that the Board and management of C&CDHB have made to me in the DAP that an operational break even position will be achieved in 2006/07. I understand that the planned surplus of \$13M relates to the proceeds of asset sales. You will be aware that in terms of the New Zealand Public Health and Disability Act, DHBs are required to apply these sale proceeds to capital projects, and that they cannot be used to offset operational deficits.

I am aware that you have set yourselves challenging plans in 2006/07 requiring the achievement of significant cost savings, efficiencies and possible service reconfigurations.

In order to address the risks around achievement of your 2006/07 DAP, I request that you include in the commentary that you send to the Ministry with your monthly financial results:

- explanation of any significant adverse variances to budget on a line item basis, and
- actions that you will be taking to reverse any adverse trends and achieve your plan.

I understand that Ministry officials also intend to request monthly meetings or teleconferences with C&CDHB staff to discuss the monthly results. The results of this additional monitoring will be taken into consideration when the DHB's status on the Monitoring and Intervention Framework and continued receipt of the early payment incentive are considered during the 2006/07 year.

Risks

I note the risks and associated mitigation strategies you have identified. I expect C&CDHB to continue to manage its financial risks and live within its allocated funding. Where your DHB identifies severe risks of any type I expect you to notify the Ministry of them along with your strategies for mitigating them.

Electives

Improving elective services is a priority in 2006/07. I realise there are many challenges inherent in the management of elective services, however it is important that there is transparency in the system. People have the right to know when they have been promised surgery that they will get it within a specified timeframe, or if they cannot be offered treatment what their options are. It is also important that we deliver services in cost effective ways, so that more people can receive treatment.

I am pleased that you were able to agree to a revised recovery plan with the Ministry that enabled you to achieve compliance with the Elective Service Performance Indicators across all services by 30 September 2006. Thank you for this commitment. I appreciate the progress that has been made and I look forward to hearing of C&CDHB's ongoing compliance with the indicators.

Getting ahead of the curve – The Chronic Disease Burden

I am pleased your DAP addressed the prevention and management of long-term conditions. As you are aware, the burden of chronic or long-term conditions bears most heavily on Māori, Pacific, and high deprivation groups and delivers unequal health outcomes including premature death. We need to get better at preventing and managing long-term conditions among these groups. The Primary Health Care Strategy and Healthy Eating Healthy Action provides you with the tools to do this. I encourage you to include in your planning for 2007/08 explicit links between your plans around chronic care

management and your efforts to reduce inequalities, and activity in primary care/community settings.

Capital

In August 2005 the Cabinet Business Committee authorised the Minister of Finance and myself to approve up to \$43M of additional equity and new lending from the health capital budget for the New Regional Hospital project. Please accept this letter as advice of the approval of the additional \$43M of new funding and the establishment of a new project total of up to \$346M. I look forward to the project being completed on time and on budget.

Please note that sign off on the 2006/07 DAP does not indicate approval for any other capital projects requiring equity or new lending, or self-funded projects that require the support of the National Capital Committee. Approval of such projects is dependent on both the completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round also.

Service Configurations

My approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. I expect you to comply with the requirements of the Operational Policy Framework and to advise the Ministry where any proposals may require my approval.

Miscellaneous Funding Issues

Please note that by approving your 2006/07 DAP I am not approving any additional funding for C&CDHB's insurance costs, primary maternity service, new water reservoir or the historical FRS3 claim of \$1.7M. Officials have advised that they will report to me on the historical FRS3 claim later in the year when I consider funding allocations related to the 2005 asset revaluation.

This letter should be attached to the copy of the signed plan held by the Board, and a facsimile of the letter should be attached to all copies of the Plan made available to the public or any other third party. I wish you all the best in the achievement of your plan.

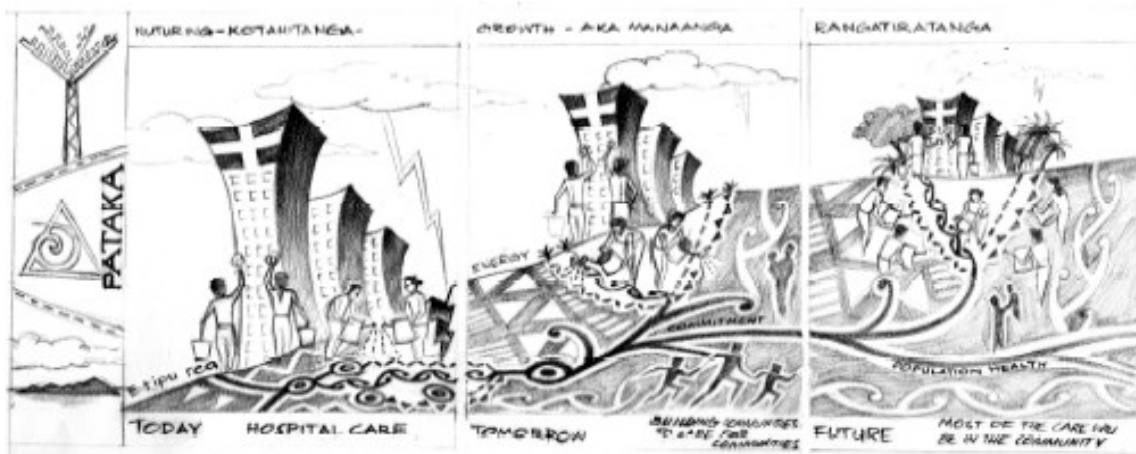
Yours sincerely



Hon Pete Hodgson
MINISTER OF HEALTH

**District Annual Plan
 2006/09**

“Accelerating Change”



Statement from Chairman and CEO

This District Annual Plan details our commitment to delivering on our District Strategic Plan, and on the Minister's priorities and expectations. To achieve these commitments, over the next 3 years we must accelerate change in how we work.

This accelerated pace will require C&C DHB, other DHBs in this region, the Ministry of Health and our communities to work together to maintain and improve the health and independence of the people we serve. To achieve this intent, C&C DHB is working to deliver on its health goals of reducing disparities and reducing the incidence and impact of chronic disease. While the populations we serve are healthier and more independent compared to national averages, we recognise we must continue to be responsive to the changing needs of these populations. This responsiveness is particularly focused on better meeting the needs of Maori, Pacific and low income populations.


We are committed to maintaining our break-even position. In past years, C&C DHB has successfully managed within its budgets. A key factor for this success has been efficiency gains made across the organisation, and especially in the hospital and health services. However, in light of our new hospital facilities and our small secondary population base, the reality is that we must accelerate change, particularly in our hospital and health services, in order to maintain this position.

We are looking at all aspects of our business to determine how we can be more cost effective while continuing to achieve our goals and priorities. Trade-offs and prioritisation will be increasingly required over this period, to ensure that our commitments are realised. Our way forward includes a range of efficiency initiatives, regionalisation and sub-regionalisation initiatives, as well as service reconfigurations, investments and proposed national policy changes.

This plan requires both the Board and the Minister of Health to agree to a range of innovative proposals which will ensure that C&C DHB continues to improve the health and independence of the people we serve, while maintaining a financially sustainable position. These initiatives include the following proposals which may require public consultation:

- ◆ Changing the local configuration of hospital and health services and service delivery models to maintain clinical and financial viability
- ◆ Review of small tertiary services and other specialist services
- ◆ Renal, Oncology and Cardiology demand management

This document provides both the Board and the Minister of Health with a high level summary of our plans over the next 3 years. It also includes detailed planning information required by the Minister of Health and the Ministry of Health. This DAP was developed in accordance with the provision of Section 39 of the New Zealand Public Health and Disability Act 2000.



Bob Henare
Chairman
Capital & Coast DHB

Date: 06/06/06



Margot Mains
Chief Executive
Capital & Coast DHB

Date:

District Annual Plan Approval


Signatories

The Capital and Coast District Health Board's District Annual Plan is approved on:



Hon Pete Hodgson
Minister of Health

Date: 6/11/6



Bob Henare
Chairman
Capital & Coast DHB

Date:

Structure of the District Annual Plan

This District Annual Plan is structured in three parts.

Part One – Executive Summary

This provides the Board and the Minister of Health with a high level summary of our plans over the next 3 years. It focuses on how we will achieve positive outcomes as outlined in our District Strategic Plan and Statement of Intent. It presents our options for accelerating change so that we achieve our medium to long-term health goals and priorities. It includes key performance measures to enable the Board and the Minister to monitor progress and highlights the key risks we face in delivering this change.

Part Two – Our Detailed Plans

This contains more detailed information on our initiatives and programmes and also details how we will deliver against the Minister’s expectations.

Part Three – Background and Financial Information

This includes all of the other information required by the Minister and Ministry of Health in a DHB District Annual Plan.

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1. Executive Summary

Our District Strategic Plan (DSP) provides the strategic direction and framework for the first part of our District Annual Plan (DAP), in which we summarise our intentions for the next three years. Part 1 of the DAP is devoted to providing high level information on our initiatives to accelerate change over the next three years. This also includes a section on our high level performance measures and key risks to the delivery of this plan.

1.1 Outcomes Framework - Strategic Direction

Over the next three years we will focus on six major strategies to achieve our health goals. We will continue with on-going work to advance the Minister's priorities and those identified in the New Zealand Health Strategy and the New Zealand Disability Strategy. The DAP is about accelerating change in order to deliver our DSP and the Minister's expectations. The following high level outcomes have been developed during the course of our strategic planning process. Our outcomes (health goals) are:

Reduced disparities in health status

Reduce illness and disease among high health need populations such as Māori, Pacific peoples, refugees and new migrants, so there is less difference in the health of people across the district.

Reduced incidence and impact of chronic conditions

Reduce the number of people who develop an on-going illness or disease and when an illness or disease does develop, reduce the impact on people's lives to maximise opportunities for independence and maintain or improve their quality of life, particularly for high health need populations.

Our Vision	Better health and independence for people, families and communities.		
Our High Level Outcomes (Health Goals)	Reduced disparities in health status	Reduced incidence and impact of chronic conditions	
Our Strategies	Focusing on people through integrated care	Supporting and promoting healthy lifestyles	Working with our communities
	Developing our workforce	Updating our hospitals	Managing our money
Our Mission	Together, improve the health and independence of the people of the District		
Our Values	Focusing on people and patients	Innovation	Living the Treaty
	Professionalism	Action	Excellence

1.2 The Challenges

1.2.1 The Health Needs of our District

On average, our people enjoy better health, and live longer, than people in other districts of New Zealand. There are however, inequalities in health status between various ethnic and social groups, particularly for Māori, Pacific and low-income populations. [Further information on our health needs assessment is included in Part 3 of this document.]

Our population is ageing and there is an increasing burden of chronic conditions. There is also increasing demand for health and disability services, and rising expectations from the people we serve. We must continue to maintain and improve the health status of the people we serve, recognising that we must change the way we work in order to enhance and improve our responsiveness to the changing needs of these populations.

1.2.2 Financial management

One of the foremost challenges for this DHB is to maintain services and compliance with government strategies and policies within available resources. In past years, C&C DHB has successfully managed within its budgets. A key factor for this success has been efficiency gains made across the organisation, and especially in the hospital and health services. Over the past 3 years, at least \$6m in efficiency savings has been achieved each year. In 2005/2006, our plans include achieving significant efficiency initiatives (refer to Financial Section 3).

We are working towards a finalised three year budget that shows the following results:

	06/07	07/08	08/09
	\$m	\$m	\$m
Operating result	\$0	\$0	(\$14)
Property disposals	\$13	\$1	\$0
DHB result	\$13	\$1	(\$14)

To achieve these breakeven results over the next 2 years and achieve against the NRH Business Case will require extensive change.

We must accelerate our change programmes to ensure that we can make the required change in order to address the required savings in the out-years. We must also change the ways in which we work, in order to maintain financial sustainability into the future. The degree of change is reflected in the initiatives outlined in the key priorities section (Section 1.5), particularly those outlined under the “Managing our money” priority area (Section 1.5.4).

1.2.3 Workforce

Our workforce intentions in this plan are driven by the need to develop new and innovative service models that will be effective in reducing the incidence of illness and in improving the independence of our local population. At the same time increasing demand for health workers is intensifying pressure on workforce supply, a trend that will require us to improve the efficiency in the way we deploy our workforce across the continuum.

We are assisted in our approach by national and regional workforce initiatives outlined in DHBs’ national Future Workforce Programme which includes national initiatives to improve infrastructure (information and education) and retention.

At a local level we are focusing on developing the primary care workforce, supporting the community and home care workforce development, and increasing capacity in the Māori health workforce and Pacific health workforce. Progress in these areas is essential to reducing the disparities that exist in our local community. We are also actively pursuing the development of new and expanded roles, such as Care Managers and Nurse Practitioners, to support the integration of services and our ability to turn around the incidence of chronic illness through more flexible and timely interventions.

The ability of the future workforce to meet the demand for services will to a very great extent depend on how efficiently we deploy our workforce resources. Workforce development will therefore include on-going benchmarking to ensure that staffing levels and the skills mix are appropriate to the setting and the outcomes. This process is supported by specific activity to improve our workforce information and HR information systems.

As an employer we are focused on retaining the workforce by supporting the development of quality human resource management on the part of those in leadership roles, and creating a positive environment for staff.

1.2.4 Hospital and Health Services

The Hospital and Health Services provided by our DHB also face a large range of challenges. We face the challenge of trying to provide tertiary services with a small secondary population in a clinically and financially sustainable way. We are also confronted with the expectation of being the “provider of last resort”. Recent examples of this expectation relate to Emergency Department and regional services.

In addition, we face the challenge of working within hospital facilities that are being redeveloped, as well as meeting the cost of more modern infrastructure, increased subspecialisation, new drugs and technology, and costs of compliance in the future. To maintain clinically and financially viable hospital and health services we will, over the next three years:

- ◆ review and implement modern processes via The Patient Journey;
- ◆ implement new systems to facilitate processes e.g.: the Electronic Health Record (EHR) and Picture Archive Computer System (PACS) projects;
- ◆ review our organisational structure to ensure we are configured and incentivised to move to a financially sustainable position;
- ◆ work on increasing our revenues to support the services we provide e.g.: ACC, Non Eligible Income, and contributions from other DHBs to support our regional services;
- ◆ review the effectiveness and efficiency of the services we provide via benchmarking with other like service providers and move towards more effective and efficient services;
- ◆ work with other DHBs to provide small, regional services on a sub-regional and regional basis to maintain this viability in the future; and
- ◆ configure our services to provide the volumes that we are contracted to provide. C&C DHB is providing a level of services to other DHBs in excess of the amount of funding allocated to them.

A further challenge is that while implementing these changes, we must maintain clinical quality in the services we continue to provide.

The local configuration of our hospital and health service must also be reviewed to ensure that services are not duplicated and to maintain clinical and financial viability. In particular, we are proposing that the services provided from the Kenepuru campus are outpatient, day surgical, elective and rehabilitation focused, and that the Wellington campus will focus on emergency, trauma, acute services and complex diagnostics. Kapiti will remain as an outpatient facility with 2 maternity beds and a base for community services. This service configuration proposal has evolved from the service configuration model agreed by the C&C DHB Board and the Ministers of Health and Finance in 2002 as part of the approved business case for the hospital facilities in this district.

We will work in partnership with all stakeholders, MoH, other DHBs, our community, and our staff to address these challenges.

1.2.5 Impact of government policy

There is also the challenge of continuously improving productivity and cost effectiveness while maintaining and improving the quality of services provided. We are focused on improving “the patient journey” of the people we serve through our hospitals. We are also focused on developing and maintaining an integrated approach to hospital and health services, and to the other services we fund in this district.

Our DHB also faces challenges related to the impact of government policy in our sector and other sectors. Recent examples of these impacts include:

- ◆ considerable pressure across a number of health professional groups to receive a “pay jolt” similar to that recently implemented for NZNO nurses employed in hospitals. There is also pressure from primary and community providers to achieve pay parity with NZNO nurses;
- ◆ escalated construction costs in the Wellington region, due to the number of government funded construction projects occurring over the past few years;
- ◆ increased costs related to the Holidays Act and potentially related to changes to the minimum wage;
- ◆ introduction of the FRS-3 (Property, plant and equipment) accounting standard with partial additional funding to implement this standard; and
- ◆ delays in responding to child oral health facility funding issues across the health and education sector.

1.2.6 Summary

Given these challenges, a number of initiatives are identified in this plan. Many of the required changes are already in the process of being implemented, through these initiatives and ‘business as usual’ processes. However, change will also require partnering with other DHBs, particularly those in the central region. In some instances, national policy changes will also be required, such as fully funding changes to the Holidays Act and other government policies that impact on the health sector.

The initiatives outlined in this plan are identified as those which C&C DHB can implement within our district, and those which require regional or national involvement. Initiatives that require public consultation as required by the operating policy framework are also identified.

1.3 Decision-making principles

Our current framework utilises the following principles to prioritise the allocation of resources for health and disability support services:

- ◆ Effectiveness (will the service result in health gains?).
- ◆ Equity (will it help reduce gaps and differences?).
- ◆ Value for money (is there evidence that it works and is cost effective?).
- ◆ Achieving Whanau ora (will it help improve Māori health and self determination?).

During 2004/05 the areas for preferential funding identified by our Community and Public Health Advisory Committee were:

- ◆ Shift resources into primary health care services;
- ◆ Shift resources into preventative care;
- ◆ Shift resources into areas which will benefit the health of Māori, Pacific peoples, and low income populations in high NZ Dep areas; and
- ◆ Limit the resources spent on surgery in secondary/tertiary care in favour of the shifts detailed above.

1.4 Planning assumptions

Given the significant challenges we face, we have established, and are working within, the following planning assumptions. These assumptions extend on those that were outlined in our DSP, and recognise the accelerated change that is required over the next 3 years.

- ◆ To improve health and independence we must change the way that services are currently delivered
- ◆ We have the ability to shift money from hospital services to community services
- ◆ We have the ability to discontinue or stop providing health and disability services for which we are not funded and/or seek funding from other DHBs
- ◆ C&C DHB will include a strong tertiary provider, where this is clinically and financially sustainable
- ◆ Deficit must be eliminated in partnership with the owner
- ◆ One-off mechanisms for addressing this deficit are now limited (e.g. asset revaluations)
- ◆ Savings made in community-based funding initiatives will be reinvested into community health and disability services (funding from private laboratory tests)
- ◆ We have grown, and will continue to grow, our primary and community providers to maintain and improve the health of the people of our district.

Further financial planning assumptions are included in Part Three of this DAP.

The following table shows the funding trends for the DHB since the year 2001/02 and the expected trend to the year 2008/09. A number of changes occurred over that time including the introduction of PBF and the devolution of older people services. It is clear (notwithstanding PBF and devolution of additional services) that there has been a significant increase in services funded in the community. There have also been increases in hospital services funding. The expected average rate of funding growth for community and hospital services for the next 3 years is between 2 and 3%.

Funding Trends 2001/02 – 2008/09

Expenditure Category	Year							
	2001/02 Actual \$000s	2002/03 Actual \$000s	2003/04 Actual \$000s	2004/05 Actual \$000s	2005/06 Forecast \$000s	2006/07 Budget \$000s	2007/08 Budget \$000s	2008/09 Budget \$000s
Provider arm	251,099	268,114	291,403	310,868	333,394	358,783	373,339	393,207
Community -mental health	9,037	11,688	15,282	18,652	20,773	23,529	24,329	25,083
Community public Health**				1,938	600	268	277	286
Community- primary care	72,623	77,573	82,261	89,693	87,580	94,928	98,156	101,198
Community- Disability Support Residential Care Hospitals & Rest Homes			20,201	28,127	34,545	34,964	36,153	37,274
Community- Disability Support Other			9,716	13,968	17,524	19,279	19,934	20,552
Community- other community	7,162	12,260	10,134	10,968	14,216	13,793	14,262	14,704
Other IDF Outflows			31,709	35,433	37,374	37,592	38,870	40,075
Total	339,921	369,635	460,707	509,648	546,006	583,136	605,320	632,380

*forecasted year end expenditure

**Public health includes MenzB

1.5 Key priorities for the next 3 years

1.5.1 Reducing disparity in health status

Our health needs assessment shows that the district population has on average a high health status compared with the rest of New Zealand. This average however conceals a significant minority of people with very low health status. As a result, reducing disparities is one of two key health goals in our DSP.

The Board places a high priority on reducing illness and disease among high health need populations such as Māori, Pacific peoples and people who live in areas that are considered to be deprived. There is also a focus on refugees and new migrants.

Over the next three years we will focus on:

- ◆ Continuing Primary Care Development in the district including improving access to after hours care;
- ◆ Improving Māori health by advancing New Zealand Primary Care, New Zealand Health and disability strategies, Māori Health Strategy and Te Plan;
- ◆ Improving Māori workforce capacity and capability in primary/secondary care, Disability Sector and hospital and health service (HHS);
- ◆ Increasing Pacific workforce within mainstream mental health, disability sector and Pacific provider NGOs;
- ◆ Establishing relationships within each of the Pacific communities to enable health outcomes to be improved;
- ◆ Identifying evidence-based indicators to improve service delivery for Pacific peoples across the district;
- ◆ Improving the health status of children (including the oral health status of children);
- ◆ Improving youth participation in health service planning, and improving youth health; and
- ◆ Addressing, maintaining, and/or promoting physical and non-physical accessibility issues.

These plans are either dependent on the investment funding money outlined under the “managing our money” priority or included in our current budgets.

1.5.2 Reduce incidence and impact of chronic disease

The second health goal of our DSP is reducing the number of people who develop an on-going illness or disease, and when an illness or disease does develop, reducing the impact on people's lives. This enables people to maximise opportunities for independence and to maintain or improve their quality of life, particularly for high health need populations.

To address this priority area we are focusing on initiatives related to diabetes, cardiovascular, respiratory diseases and mental health. Over the next three years we will focus on:

- ◆ Reducing the incidence and impact of diabetes on people and their families;
- ◆ Implementing the New Zealand Guidelines Group National Guidelines for cardiovascular risk modification, initially in a community with high proportions of Māori and Pacific peoples;
- ◆ Determining equitable service levels for Māori and Pacific peoples;
- ◆ Improving the respiratory health of the District;
- ◆ Developing mental health services, including an acute and crisis mental health service continuum, integrated mental health information and co-ordination service and addiction treatment service development;
- ◆ Improving access to primary mental health services; and
- ◆ Working intersectorally across a wide range of government and community social service agencies to increase education about mental health needs and to promote early intervention strategies.

These plans are either dependent on the investment funding money outlined under the "managing our money" priority or included in our current budgets.

1.5.3 Focusing on people through integrated care

We will continue to work towards providing services and programmes that are integrated across health provider, geographical, professional and other boundaries, both within the sector and intersectorally. Our focus for 2006/07 is to progress integrated care initiatives in the follow areas:

- ◆ Integrated home and community care;
- ◆ Extending use of the interRAI planning tool to improve care management:
 - ◆ Further developing and bedding in Care Co-ordination Centre functionality;
 - ◆ Reviewing provision of community nursing and allied health services to achieve the best balance between DHB and community provision;
 - ◆ Reviewing ways to better support carers; and
 - ◆ Implementing and extending restorative home-based care packages.
- ◆ Implementing the New Zealand Cancer Control Strategy with a particular focus on palliative care; and
- ◆ Chronic care management.

There are also other integrated care initiatives which are detailed against other priority areas such as after hours services, pharmacy, laboratory and the quality patient journey initiatives.

These plans are either dependent on the investment funding money outlined under the "Managing our money" priority or included in our current budgets.

1.5.4 Managing our money

We are committed to investing in health and disability services in order to accelerate change. These investments contribute to our ability to improve health outcomes, be responsive to changing health needs and maintain a sustainable financial position. Over the next three years we plan to progress initiatives across the following major workstreams to maintain financial sustainability:

Efficient Service Delivery

During 2006/07 we will be reviewing a number of our clinical and support services to ensure that they are being efficiently delivered. This will include:

- ◆ benchmarking of services and resource utilisation;**
- ◆ reviewing theatre productivity;**
- ◆ exploring mental health efficiency gains;**
- ◆ improving our materials management processes;**
- ◆ reviewing our voice and communications services; and**
- ◆ standardising our administrative processes.**

Service Reviews

We will be undertaking some specific service reviews to ensure that the services concerned are both clinically and financially sustainable in the medium term. In 2006/07 we will review:

- ◆ the provision of our smaller tertiary services;**
- ◆ the provider arm community nursing and allied health services to achieve the appropriate balance between community and DHB provision;**
- ◆ our outpatient models of care;**
- ◆ the configuration of greater Wellington region hospital services;**
- ◆ our demand management strategies for renal services, oncology services and cardiology services with other DHBs; and**
- ◆ the current payment of Specialist GMS Subsidies.**

We will also implement final decisions arising from:

- ◆ the review of laboratory services; and**
- ◆ the pharmacy services review.**

Many of these initiatives are focused at the national, regional or sub-regional level. We are committed to proactively working with Hutt Valley DHB on ways we can better work together for the people we serve.

Revenue Realisation

We will be working on issues of sector-wide importance to ensure the equitable pricing of tertiary services and adequate revenue recovery. Regional initiatives will also be pursued, for example, to ensure that we are being appropriately paid for all the services we deliver to non-Capital & Coast residents. To be effective we will be working on the accurate and timely counting of inter-district flows (IDF) volumes for both inpatient and outpatient activity.

Health investment initiatives to deliver on DSP priorities

We are committed to investing in health and disability services in order to accelerate change. These investments contribute to our ability to improve health outcomes, to be responsive to changing health needs and to maintain a sustainable financial position. Although \$19m of new investments was sought from across hospital and community providers as well as other stakeholder groups, we believe that \$2m for investment funding is necessary to address government and DHB priorities and achieve a sustainable financial position. We plan to introduce the following new initiatives in 2006/07:

Area	Priority	Funding
Mental Health	AOD	\$168,000
	Changes in IDF outflows	\$843,595
	Additional acute ward staff	\$580,000
	Community acute services	\$2,210,000
Mental Health Total	Blueprint Funding	\$3,801,595
Cancer	Cancer Control Strategy	\$185,000
Pacific Provider Development	Pacific provider development	\$327,000
Maori Provider Development	Māori provider development	TBA
Other	HEHA initiatives and others	TBA
Tagged Funding	From Ministry of Health	\$512,000
Workforce Development	Workforce primary care nursing	\$170,000
	Workforce Pacific	
	Workforce Māori	
	Workforce Aged Care	
	Workforce primary care	
Primary Care	CVD guidelines implementation	\$75,000
	Primary care in East Porirua	\$400,000
	Kapiti After-hours/ Nursing Service	\$200,000
	ADHD	\$70,000
	Community Paediatrics	\$200,000
	Youth Services	\$120,000
Intersectoral Development	Intersectoral Pool	\$75,000
Palliative Care	Community Palliative Care	\$90,000
Pacific Health	Diabetes Project / Community Initiatives	\$170,000
Māori Health	Whanau Care Service – Phase 2	\$165,000
Aged Care	Disability Competency Training / Supporting Carers, Inter-RAI	\$215,000
Personal Health (HHS)	HDR Brachytherapy	\$250,000
Funded by C&C DHB		\$2,200,000

1.5.5 Developing our workforce

Workforce development will focus on contributing to innovative service delivery models. Within workforce development the objective is that services be provided by the most cost-effective trained workforce. Our workforce plans integrate the actions contained in the national DHB “Future Workforce Plan”. Over the next 3 years we will focus on:

- ◆ Development of capacity in the Māori workforce and in the Pacific workforce with a particular emphasis on primary care and capability around key health priority areas**
- ◆ Retention and development of the primary care workforce**
- ◆ Recruitment and retention of the mental health workforce**
- ◆ Continuing primary care development in the district**
- ◆ Implementing the on-going organisational development and infrastructure development**
- ◆ Supporting effective and efficient deployment of the workforce in line with service configuration**
- ◆ Improving the retention of secondary/tertiary workforces.**

1.5.6 Working with communities

We will work with communities and with agencies which actively participate within them such as local councils, the Ministry of Social Development, Housing New Zealand, SPARC, ACC and local schools to:

- ◆ Improve the environment in which people live, work and play**
- ◆ Encourage healthy behaviours**
- ◆ Identify and optimise opportunities to improve broader social outcomes where they will have a positive impact on communities' health**
- ◆ Develop a DHB Family Violence Intervention project plan and report on progress.**

By building upon the gains we have already achieved through our collaborative working relationships with communities and other agencies, we anticipate that joint service and funding approaches to particular projects will make a valuable contribution to sustainable health and social outcomes across the district.

Over the coming year we will continue to build on the relationships that have evolved with communities and populations in our district. Our specific focus under this priority over the next 3 years is intersectoral work.

We have developed a strategic framework, evaluation methodology and work-plan covering C&C DHB's existing and future intersectoral work for 2006-2008. This plan is expected to ensure that our intersectoral partners contribute to improving the health and independence of the people we serve.

Our intersectoral approach will allow the DHB and our partner-agencies to improve joint outcomes within local communities through better targeted co-ordination of our respective funding and efforts.

1.5.7 Supporting and promoting healthy lifestyles

There are factors such as lifestyle choices and social and community influences over which we potentially could have more control. This could reduce the impact, and potentially the incidence, of illnesses such as diabetes, stroke, and heart diseases that have such a debilitating impact on our populations. We will work with the Regional Public Health Unit of Hutt Valley DHB to implement the public health programme for priority areas.

Over the next 3 years we will continue to work with our regional grouping (with Ministry of Health, Hutt Valley DHB and Wairarapa DHB) to implement a Regional Strategic Plan for public health. Our focus will be on:

- ◆ Improving nutrition, increasing physical activity and increasing breast feeding
- ◆ Reducing the rate of smoking and exposure to environmental tobacco smoke.

These plans are either funded by the Ministry of Health, by Regional Public Health or are included in our current budgets.

1.5.8 Updating our hospitals

We are developing new buildings at Kenepuru and Newtown to ensure staff, patients and visitors have a safe and pleasant environment that meets the needs of a modern healthcare system. We have completed facility development at Kapiti. We are also improving our information system deployment with a particular focus on the hospitals. Over the next three years we will:

- ◆ Complete the new main building at Newtown, the Psychogeriatric Unit at Kenepuru, and refurbish buildings at Newtown and Kenepuru
- ◆ Ensure appropriate levels of system availability for all IT systems in the event of component failure or disaster
- ◆ Provide a single consistent user interface through which important clinical information for a patient can be accessed at the point of care
- ◆ Provide digital radiology images to clinicians
- ◆ Improve the dissemination of information within the DHB through the use of an effective and secure intranet
- ◆ Improve the management of staff through availability and effectiveness of online personnel information
- ◆ Improve the effectiveness and stability of the organisation's financial and materials management.

The capital funding required to complete these plans has been previously approved by the Ministers of Health and Finance.

1.6 Performance measures

In order for the Board and the Minister to monitor our progress we have highlighted key performance measures. These are high level indicators of success for our DHB. They are either from our DSP or DHB Hospital Benchmark information. In summary they are:

Reduced disparity in health status

- ◆ **Ambulatory sensitive hospitalisation, rates by age group and ethnicity**
- ◆ **Mental health services utilisation rate by age group and ethnicity**
- ◆ **Child hearing loss - school entrant testing and pass rate by ethnicity**

Reduced incidence and impact of chronic disease

- ◆ **Chronic disease management: cancer treatment waiting times**
- ◆ **Chronic disease management: diabetes mellitus by ethnicity and follow-up**

Focusing on people through integrated care

- ◆ **Inpatient average length of stay**

Managing our money

- ◆ **Net profit (NPAT)**

Working with communities

- ◆ **The percentage of PHOs with Maori health plans agreed with the DHB**
- ◆ **The percentage of PHOs participating in the PHO management programme**
- ◆ **The % of eligible Maori enrolled in our district PHOs**

Supporting and promoting healthy lifestyles

- ◆ **Oral health – percentage of children caries-free at age five years**
- ◆ **Oral health – mean decayed, missing and filled teeth (DMFT) score at year 8.**

1.7 Risk Management

The nature and complexity of the DHB's activities and responsibilities mean it is exposed to a large number and variety of risks. We manage identified risks through a systematic identification, assessment and mitigation process. Major risks are regularly reported to the management teams within the DHB, Board Committees and the Board. The most significant risks are:

Financial Sustainability

Our financial outlook for the next three years forecasts deterioration of our financial situation, based on our current operating costs and the additional impact of the cost of capital and depreciation on the New Regional Hospital.

Performing to contract and within budget for the Hospital and Health Service is a difficult goal especially when faced with external cost pressures such as medical supplies and multi-employer contract agreements (MECAs). These increasing costs divert funds from current primary health care, community services and new initiatives.

Savings targets have been established to meet financial performance objectives and our medium and long term strategies are based on improved efficiency, service reconfiguration, and realising extra revenue.

Workforce

Our ability to recruit and retain staff in key clinical positions and across all health practitioners' groups, e.g. medical, nursing and allied health is under increasing pressure. This may impact on our ability to progress some important service changes. We are focusing on retaining our workforce by supporting the development of quality human resource management practices, especially by our leaders, and creating a positive environment for staff.

Growing service expectations

There is an increasing expectation in the community at large that we deliver an extended range and volume of health and disability services. Demand for services is outstripping the available funding. There is a risk that, as the population ages, we are unable to adequately meet all the health and disability needs of our district while maintaining our clinical and financial viability as an organisation.

Avian influenza pandemic

Uncontrolled transmission of avian influenza in the community would impact on staffing capacity in both the hospital and community settings and on our ability to provide hospital services to an increased number of acutely and severely ill patients. We are working with our communities to establish sites and staffing arrangements for community-based assessment centres and with regional and national agencies to ensure preparedness and a co-ordinated approach.

2. Our Detailed Plans

In this section we outline our detailed plans for the next three years. In some instances the focus is only on 2006/07 as completion of this work is required to determine our direction for the next three years. The information is structured against our key priorities outlined in Part 1 and meets the Minister's priorities and Ministry's expectations. Where initiatives relate to more than one priority area, they are cross-referenced. Targets for performance measures in each priority area will be set in conjunction with the Ministry of Health.

The Minister's Priorities

The Minister of Health conveys priorities and expectations for the year to the DHB as a part of the planning package issued by the Ministry - these are:

- ◆ **Getting 'ahead of the curve' on the chronic disease burden**
- ◆ **Child and youth services**
- ◆ **Continue the Primary Health Care Strategy rollout**
- ◆ **The health of older people**
- ◆ **Infrastructure**
- ◆ **Health information strategy**
- ◆ **Health workforce and**
- ◆ **Cost effectiveness.**

Our High Level Outcomes (Health Goals) are:

- ◆ **Reduced disparities in health status**
- ◆ **Reduced incidence and impact of chronic conditions (reducing the amount of on-going illness and its impact on peoples' lives).**

Our Strategies to achieve these outcomes are:

- ◆ **Focusing on people through integrated care**
- ◆ **Managing our money effectively**
- ◆ **Developing our workforce**
- ◆ **Working with communities**
- ◆ **Supporting and promoting healthy lifestyles**
- ◆ **Updating our hospitals.**

2.1 Reduced disparities in health status

Our Health Needs Assessment shows that the district population has on average a high health status compared with the rest of New Zealand. This average however conceals a significant minority of people with very low health status. As a result reducing disparities is one of two main themes in our District Strategic Plan (DSP).

Both the Board and management have focused on reducing disparities as a priority, and the Reducing Inequalities Intervention Framework and the Health Equity Assessment Tool (HEAT) have become intrinsic parts of the DHB's prioritisation process.

2.1.1 Continue the primary health care strategy roll out

Primary health care is a key lever in improving health outcomes, reducing avoidable hospital admissions and addressing inequalities. C&C DHB supports accessible, affordable and appropriate primary health care services and a primary care approach, consistent with the Government's Primary Health Care Strategy that supports community participation and includes a strong population health focus. Population health includes attention to the wider determinants of health (health promotion), prevention and early intervention.

Primary Health Organisations (PHOs) are a key mechanism for implementing the Primary Health Care Strategy. In addition to PHOs a range of implementation strategies have been developed by the DHB to improve health and reduce inequalities. These are described in various sections of the DAP, including the Māori, Pacific, child health, youth, older people, mental health, disability, cardiovascular, respiratory, diabetes, integrated care and population health sections. A framework for primary health care in the district has been developed and is available at www.ccdhb.org.nz.

2005/06 brought important new programmes requiring major effort from the primary care sector. The implementation of a National Immunisation Register, the MeNZB campaign to offer vaccination to everyone aged under 20 years, a more complicated influenza vaccination programme and new developments in primary mental health care all required significant energy, resource and focus.

Our emphasis in 2006/07 is on consolidation. The Primary Care Strategy requires time to 'bed in' and realise the benefits of better linkages within the health sector with communities, and across other sectors. This year's DAP recognises the achievements to date and the need for a considered, locally relevant approach to support sustainable, integrated, tailored and effective services for all populations within our community.

Primary care capacity, particularly in Kapiti and Porirua, achieving and maintaining low cost access and After Hours care remain a challenge at this time. A district-wide approach to After Hours care is in progress.

During 2006/07, existing programmes and services will be reviewed and refined using contract management and relationship management in the light of community and provider feedback, information on effectiveness from monitoring reports and data analysis.

We will continue to actively support community participation in PHOs through workshops, meetings with PHO Boards and other community stakeholders, sharing information and evaluation tools.

We will continue to work towards free primary care services for under six year olds through expanding services in Eastern Porirua and providing capitation top-up to providers who already provide low cost services that are usually free for under six year olds.

Each year the DHB meets with the Regional Immunisation Co-ordinating Group to plan the local influenza campaign with the aim of increasing coverage, particularly for those who are >65 years and with chronic medical conditions. We will improve the uptake in influenza vaccination for adults >65 years enrolled in PHOs from results achieved in 2005/6.

Primary Health Care Rollout - District Annual Plan Initiatives

What	Continue Primary Care Development in the District
Who	Senior Portfolio Manager Primary Care
How	<ul style="list-style-type: none"> ◆ Work collaboratively with Director Primary Care Nursing and other portfolio managers within the DHB and ensure co-ordination of DHB work with PHOs and other sectors; ◆ Support quarterly PHO Advisory Group meetings and opportunities for PHO participation in DHB strategic planning; ◆ Provide support for primary care team development particularly in priority areas such as general practice teamwork, Māori health, Pacific health, chronic illness management and integrated care developments; ◆ Improve linkages across hospital and primary care interface including Whanau care services and Pacific services in HHS, mental health, home and community-based services; ◆ Expand primary care capacity to improve access for high needs populations; ◆ Primary care workforce development – supporting capacity and capability; ◆ Support work to address After-Hours accessibility in the district.
When	<p>Quarter 1</p> <ul style="list-style-type: none"> ◆ Implement reduced fees for 45-65 year olds. <p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Support PHO Performance management in PHOs ◆ Implement initiatives to expand primary care capacity in Porirua East and Kapiti ◆ Continue implementation of primary mental health service initiatives ◆ Continue medication management service developments in PHOs, in collaboration with clinicians and pharmacists ◆ Strengthen chronic illness management – increase uptake of Care Plus and initiatives to improve self-management, cardiovascular risk assessment, asthma management in high risk groups and palliative care ◆ Review Māori Health Plans and impact of PHOs on primary care utilisation by Māori and avoidable admissions ◆ Quarterly PHO Advisory Group meetings. Continue joint planning and projects across PHOs e.g. through Porirua Health Cluster ◆ Provide primary care teams, PHO staff and governance useful support, information and resources to achieve their goals and participate in DHB planning through formal response to monitoring reports, PHO website, and regular newsletters ◆ Support Māori provider model of integrated care and Tamariki Ora ◆ Review progress and update Primary Care Framework.

What	Develop and improve primary health care nursing capacity to optimise service delivery in the primary sector and integrated care sector
Who	Director of Nursing (Primary)
How	<ul style="list-style-type: none"> ◆ Develop nursing leadership capability with the primary care sector ◆ Continue to implement direct entry for nurse graduates into primary health care ◆ Support nurse-led services and advanced nursing roles. <p>(Connected strategies: Primary Health strategy, Investing in Health, HWAC, Development of Māori and Pacific Health Workforce)</p>
When	<p>Quarters 1-4</p> <p>Continue primary care rotation for graduate nurse programme.</p> <ul style="list-style-type: none"> ◆ Continue to implement clinically applied programme to reflect specific needs of older-persons' health strategy. ◆ Support uptake of nursing post-graduate education with a particular focus on primary health care ◆ Continue to work with Māori and Pacific nurses in relation to workforce development ◆ Develop nurse-led services, expanded roles for nurses, and using nursing resources in innovative ways, improving practice to align nursing to community needs ◆ Develop and provide a nurse-led support service to assist with after hours care in the Kapiti region ◆ Work across agencies toward a nurse-led initiative in child and family health in Wellington South ◆ Develop advanced nurse practice roles, in particular, nurse practitioner development ◆ Continue to support quality initiatives and frameworks with primary health care nurses ◆ Support research and scholarship within primary health care nursing ◆ Develop clinical skills in chronic diseases management especially in geographical area of high needs.

2.1.2 After hours Care

After hours care is designed to meet the needs of patients which cannot be safely deferred until regular general practice services are next available. Capital & Coast DHB, in common with other DHBs, faces a number of issues in relation to after hours services delivery, including:

- ◆ Increasing reluctance of GPs to provide after hours care - especially overnight care
- ◆ Increasing number of emergency department attendances, including a large number that could be appropriately treated in a primary care setting.

In 2005/06 the Kenepuru Accident & Medical Centre opened providing access to primary-led after hours care integrated with secondary care for the northern Wellington suburbs, Kenepuru and Kapiti. We also established a project including all stakeholders to look at the feasibility of establishing a co-located after hours service in Wellington and after hours services at Kapiti as part of a district-wide after hours strategy.

By early 2006/07 we will have reported on the feasibility of a co-located model of after hours care in Wellington and on options to improve access to after hours care for Kapiti. Depending on business cases and recommendations from those reports we will begin to plan and implement service developments.

What	Continue to improve access to After Hours care
Who	Director of Integrated Care
How	Depending on business cases and recommendations.
When	<p>Quarter 1</p> <ul style="list-style-type: none"> ◆ Report for after hours services finalised <p>Quarters 3-4</p> <ul style="list-style-type: none"> ◆ Planning for after hours services implementation begins.

2.1.3 He Korowai Oranga and Whakatātaka

Improving the health status of Māori and reducing disparities is a priority health objective identified in the New Zealand Health Strategy (NZHS), He Korowai Oranga (HKO), and Te Plan¹ for long term implementation.

It is well documented that Māori have a higher burden of disease and poor access to health and disability services when compared to other population groups. Māori are an 'at risk and high need' population and the DHB is committed to addressing the needs and reducing the risk through services and systems that produce optimal benefits for Māori. A complex relationship links deprivation, ethnicity and socio-economic status to poor health through unemployment /poverty, poor housing, low educational achievement and the impacts of attitudes based on prejudice. Meeting these needs will require a range of collaborative intersectoral approaches and further reorientation of current services to more strengths-based and health outcome focused models.

Reduced disparity in health status is the priority for the out years and the Māori Health Development Group (MHDG) will continue working across Planning & Funding and the HHS, support the growing relationships between the Māori Partnership Board and the communities and maintain sector links at local, regional and national level.

¹ C&C DHB Māori Health Plan

We will remain focused on the Māori health priority gain areas of cardiovascular disease, cancer, diabetes, obesity, well child and oral health. We will support consolidation of existing services and continue to support the rollout of the Primary Health Care Strategy in both reduced costs for more people and a shift towards population health approaches. Prevention, early detection and improved management and co-ordination of services will be a continued focus to support national, regional and local strategic direction.

For 2006/07, the focus for workforce will be to understand who, what and where our Māori workforce is. Secondly, the DHB will support our workforce to develop and progress to their maximum potential. The development of a database that holds all workforce information for the central region will be progressed. This is key to informing the future direction and investment in the health workforce.

Improving the cost effectiveness of services continues to be a challenge to C&C DHB. High performing services that make a positive impact on the health outcome of its population for the least amount of money are the ideal. The MHDG will focus on opportunities that result in 'value for money'.

Throughout 2006/07, the C&C DHB Māori Health Strategy – Te Plan 2007-12 will be developed in consultation with our key stakeholders. Māori health providers will receive support to build the capacity and capability, and a responsiveness framework that guides and measures Māori health improvement will be developed and consulted on.

Initiatives to improve equity and access include work on increasing access to income, a cardiovascular pilot programme and six monthly monitoring of utilisation by DEP and ethnicity.

What	Improving Māori health by advancing the New Zealand Primary Care, Health and Disability Strategies, Māori Health Strategy and Te Plan.
Who	Director Māori Health, Director of Planning and Funding, Senior Portfolio Manager Secondary & Tertiary Care
How	<ul style="list-style-type: none"> ◆ Maintain strong relationships with providers, agencies and communities ◆ Improve access for Māori to health and disability services within the community and HHS ◆ Support increased Māori/Māori provider capacity and capability ◆ Enable health and disability services to respond better to Māori ◆ Encourage collective responsibility towards improved Māori health outcome.
When	<p>Quarters 1-3</p> <ul style="list-style-type: none"> ◆ Review progress of all Well Child services (Tamariki Ora) ◆ Implement stage 2 of Whanau Care Services (HHS) through increasing capacity – subject to funding ◆ Support the development of a Central Region social marketing strategy. <p>Quarters 1-4</p> <ul style="list-style-type: none"> ◆ Invest in the capacity and capability of Māori providers and/or Māori specific initiatives. ◆ Develop a Patient Navigator Service for Māori and Pacific People – Implementing the New Zealand Cancer Control Strategy ◆ Further develop the Māori Health Strategy - Te Plan 2007-12. <p>Quarter 4</p> <ul style="list-style-type: none"> ◆ Review Disability Support Services (DSS) – Care Manager and Cardiac Liaison services within Māori Health Services (HHS)

Māori workforce

During 2006/07, the focus will be on consolidating baseline workforce information and reviewing workable recruitment and development approaches. A responsiveness framework that guides and measures Māori health improvement will be developed and consulted on.

In 2005/06 C&C DHB led the Central Region Māori Workforce Profile project on behalf of five district health boards. This project is supported by Māori Provider Development Service (MPDS) funding and aims to capture the makeup and skill mix of the Māori workforce within the central region.

In 2006/07 C&C DHB will lead Phase 2 of this project which aims to establish a fully operational and accessible regional workforce database. MPDS funding enables the DHB to lead a Leadership and Management training project on behalf of the Central Region.

We will continue to focus on raising the awareness of health as a career option to Māori by strengthening our relationships with universities, polytechnics and community organisations.

What	Improve Māori workforce capacity and capability in primary/secondary care, DSS and HHS
Who	Director Māori Health, Director of Human Resources, Director of Planning and Funding, Chief Operating Officer
How	<ul style="list-style-type: none">◆ Implement the Māori Health Workforce Plan and the Māori Provider Development Framework◆ Develop and/or implement effective recruitment approaches to attract Māori into the sector◆ Identify changes in the internal HHS environment that would support the DHB's ability to attract and retain Māori staff◆ Support Māori career progression and on-going developments.
When	Quarters 1-4 <ul style="list-style-type: none">◆ Implement Phase 2 (Database development) of the Central Region Māori Workforce Profile Project◆ Progress development of the framework to improve mainstream service responsiveness to Māori.◆ Implement the Central Region Leadership and Management programme.

Further investment

The following table describes the projected investment in 'By Māori, for Māori' and 'Māori specific' services over next three years (2006/07 to 2008/09) and includes Future Funding Track (FFT) increases for current services and contracts. Additional investment for 2007/08 and 2008/09 has been projected based on our Māori health policy, which is approved by the Board and our Māori health strategy, and is subject to the annual prioritisation process within available funding.

In 2006/07 the DHB is funded for a FFT of 2.93% and the DHB has allocated 3.43% with the extra 0.5% being applied to whanau care services. Similarly, in 2007/08 the FFT is 3.4% and the DHB has allocated 3.9% and in 2008/09 the FFT is 3.1% and the DHB has allocated 3.6%.

Projected investment in 'By Māori, for Māori' and 'Māori specific' services

	2005/06		2006/07		2007/08		2008/09	
	\$		\$	% Inc	\$	% Inc	\$	% Inc
By Māori for Māori	2,768,251		2,860,422	3%	2,971,978	4%	3,078,970	4%
Māori Specific	3,283,164		3,557,479	8%	3,696,221	4%	3,829,285	4%
Total	6,051,415		6,417,901	6%	6,668,199	4%	6,908,254	4%

2.1.4 Pacific Health

The Health Needs Assessment and national data benchmarks demonstrate that there are major areas of concern for Pacific within the district, such as high ambulatory sensitive/avoidable hospitalisation rates, poor child health capture in the areas of vision, hearing and oral health, high child and adult admission rates for respiratory disorders and cellulitis, diabetes-related conditions and poor cardiothoracic service utilisation.

The C&C DHB Pacific Action Plan (2003-2007) identified a number of determinants that can create barriers and contribute to disparities for the Pacific population that resides in our district. The aim of the Pacific Action Plan was to create a solid foundation which would provide a platform from which to start addressing some of these barriers.

We want to build on the foundations that have already been laid across our district with relation to Pacific peoples. Our focus is an Ethnic Specific approach that incorporates three overarching strategic priorities: workforce, research and development and relationship management. The focus of the Pacific team is the whole of family approach and recognising the role of Pacific communities in working towards better health outcomes. There are three key principles driving our approach that will provide tangible health and social outcomes:

- ◆ working with families
- ◆ working with communities
- ◆ working with government.

We will work with the Primary Care team and PHOs to become more responsive to their registered Pacific populations, and address equity and access issues, through the development of Pacific Plans, workforce development and building, supporting and nurturing Pacific providers through business development support, Information Technology development and workforce development. We will provide opportunities for research and development that will become the evidence base for Pacific initiatives.

Relationship building with key stakeholders internally and externally (government departments, PHOs, Pacific providers and other agencies) is an integral part of the responsiveness process and is key to producing baseline plans that will lead to tangible outcomes. We will maintain linkages with seven Pacific island communities (Samoa, Tonga, Tokelau, Niue, Fiji, Cook Islands, Tuvalu) that will enable Pacific participation in planning, design and delivery of programmes across the sectors and continue to develop linkages to the wider Pacific community.

The following tables summarise our key Pacific Health initiatives:

What	Workforce development - increase Pacific workforce within mainstream Mental Health, Disability Sector and Pacific Provider NGOs
Who	Manager Pacific Health
How	<ul style="list-style-type: none"> ◆ Track number of Pacific Registered Nurses (RNs) currently in nursing programmes ◆ Track number of other Pacific students studying in health ◆ Provide opportunities for training and development into and within the health care system (including Primary Care) ◆ Implement actions for Pacific Youth identified in the C&C DHB Pacific documents such as Pacific Workforce Action Plan and Pacific Youth Strategic Plan.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Identify potential Pacific RN graduates for 2007 <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Actively recruit Pacific graduates to work in HHS and Primary Care <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Report to Board/Community and Public Health Advisory Committee (CPHAC) on numbers of Pacific staff employed across C&C DHB district. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Report on outcomes of intersectoral initiatives specifically targeted to Pacific youth

What	Relationship Management - establish relationships within each of the Pacific communities to improve health outcomes.
Who	Manager Pacific Health
How	<ul style="list-style-type: none"> ◆ Develop a Whole of Community Framework where each Pacific community will develop small initiatives that they will drive from within ◆ Develop a multi-sectoral approach that integrates with community planning.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Identify community specific initiatives <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Phased implementation of community specific initiatives <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Evaluation of initiatives related to health outcomes

What	Research & Development - identify evidence-based indicators to improve service delivery for Pacific peoples across the district
Who	Manager Pacific Health
How	<ul style="list-style-type: none"> ◆ Analyse existing information to be used as a benchmark for developing specific Pacific strategies and new initiatives across the age span/life cycle ◆ Work with other specialties and services to develop research specific to Pacific
When	Quarter 1:

	<ul style="list-style-type: none"> ◆ Analyse results of diabetes initiative in Porirua and Strathmore <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Publish results of data collected from the Pacific Support Service within the HHS
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What	Improving Health Outcomes
Who	Manager Pacific Health
How	<ul style="list-style-type: none"> ◆ Collect data from Pacific health providers and PHOs on numbers of Pacific diabetics ◆ Collect information on numbers of Pacific people with 'Pre Metabolic Syndrome' ◆ Continue the diabetes project in the community ◆ Follow up on all Pacific people admitted with diabetes-related conditions to C&C DHB provider arm ◆ Work with families of at-risk Pacific children captured through birth and paediatric wards ◆ Work with Pacific communities to support education and exercise programmes.
When	<p>Quarter 2</p> <ul style="list-style-type: none"> ◆ Report on diabetes project <p>Quarter 4</p> <ul style="list-style-type: none"> ◆ Analyse and report on data collected and report on community initiatives.

2.1.5 Child Health

Building on a child health summit held in 2003/04, the DHB completed comprehensive reports on maternity services and child health in 2004/05. A medium-term plan for maternity and child health was developed and is being implemented over 2005/08.

As a district, we have relatively low avoidable admission rates for children (compared to national averages), except for Pacific children. Maternity outcomes are generally better than the national average but there are disparities, particularly for mothers and babies in Porirua, and Māori and Pacific mothers and babies. Evidence in 2005/06 shows an improvement in low birth weight (LBW), particularly for Māori, and in breastfeeding rates. Pacific children have higher rates of hearing loss.

The emphasis is on population health approaches to improve child health, and actions to reduce inequalities remain a key focus for 2006/08. A community paediatrician position and district-wide child health advisory group will build co-ordinated leadership to support the next phase of development.

In 2005/06, implementation of the National Immunisation Register (NIR) and provision of MeNZB immunisation drew together a strong team and built good community linkages with a focus on child health. We want to build on the success of these programmes to improve childhood immunisation and support other child health programmes. To achieve improved immunisation coverage we will continue to meet at least quarterly with key stakeholders including Outreach Immunisation Service (OIS) providers and PHO immunisation co-ordinators to review NIR/Datamart Reports and identify actions to improve coverage particularly in priority groups.

We have set baseline targets to achieve at least 80% immunisation coverage at 1 year (5 month immunisation) and at least 80% immunisation coverage for MeNZB in children aged 1-4 years. The intention is to review these baselines in October 2006 when the DHB can accurately estimate the NIR birth cohort baseline at 1 year of age. We will be aiming to make positive progress towards the 95% national coverage target over the planning period.

We will also implement hearing tests for neonates when the policy is finalised and funding provided.

What	Improve the health status of children
Who	Senior Portfolio Manager, Primary Care
How	<p>Reduce:</p> <ul style="list-style-type: none"> ◆ avoidable admissions ◆ family violence and improve recognition of child abuse ◆ low birth weight babies and improve breastfeeding rates ◆ exposure to second hand smoke ◆ childhood obesity ◆ hearing and vision loss, improve screening coverage. <p>Improve:</p> <ul style="list-style-type: none"> ◆ access and effectiveness of health services to tamariki Māori, Pacific children, children in low income families, refugee children and children with disability ◆ childhood immunisation coverage ◆ service delivery in PHOs, through integrated care initiatives with hospital, Māori providers, Pacific providers, NGOs, consumer groups and public health providers

	<ul style="list-style-type: none"> ◆ initiatives/approaches that are already successful ◆ targeting of investment to areas requiring improvement, particularly to reduce asthma admissions for Pacific children, improve pregnancy and postnatal support in Porirua and for Māori whanau and Pacific families ◆ childhood nutrition and physical activity ◆ quality and utilisation of data available for evaluation: utilisation of primary care, Well Child/tamariki ora coverage, immunisation coverage, breastfeeding rates, district-specific hearing and vision testing results, oral health, admissions and mortality.
When	<p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Establish community paediatrician position to provide leadership on child health service integration, focus on prevention, obesity programme, morbidity and mortality review and child abuse service co-ordination ◆ Continue project with Work & Income and other agencies to improve income and employment and reduce disparities in access to income for Māori and Pacific families ◆ Continue and evaluate skin infection project workstreams – improve hand-washing facilities in schools; increase community-based awareness of prevention of skin infection and improve access to relevant resources and services ◆ Continue initiatives to reduce obesity in children, improve nutrition and promote physical activity through school-based programmes, iwi, Porirua Health Cluster etc, community-based initiatives ◆ Work with PHOs, communities, NGOs and public health providers to strengthen health promotion activities to improve child health ◆ Improve uptake of neonatal Hepatitis B immunisations and BCG ◆ Continue to resource interventions aimed at reducing admissions in Pacific children ◆ Continue participation in housing and health (insulation) projects ◆ Utilise the NIR to identify accurate baseline immunisation data for the district ◆ Continue to meet quarterly with the Regional Immunisation Co-ordinating Group and bi-monthly with key stakeholders and PHO Immunisation Co-ordinators to review NIR/Datamart Reports and identify actions to improve coverage ◆ Continue to fund and support OIS providers to reach priority groups who are not immunised (funding dependent).

2.1.6 Oral Health

The oral health status of children in the district is declining and the gap between Māori and Pacific children and others is widening.

Access to the School Dental Service (SDS) before age five is low. Wellington SDS facilities are outdated in design, run-down, and, in many situations, do not comply with practice standards and guidelines. Workforce shortages have existed in the Wellington SDS for several years, resulting in significant delays in the routine examination and treatment of enrolled children.

There are insufficient private dentists with DHB contracts in some parts of the district to provide local access to funded dental care for all adolescents. Currently fewer than 50% of the adolescents in the district utilise publicly funded oral health care.

The joint review of SDS with Hutt Valley DHB submitted its recommendations to DHBNZ and the Ministry in October 2004. The aims identified in the School Dental Services Review provide a good framework for strategic planning for oral health services in the district.

The aim going forward is to design a service delivery model to:

- ◆ provide universal access to oral health care for children
- ◆ reduce the inequalities in access and outcome
- ◆ minimise social and cultural barriers to child oral health care
- ◆ focus on health promotion and disease prevention, as well as providing operative dental care
- ◆ ensure facilities are accessible to the people with the greatest need and the service can implement solutions to address local communities' needs
- ◆ be able to integrate into the primary care framework and match the key directions of the Primary Health Care Strategy.

The establishment of PHOs has provided the infrastructure, such as age/sex registers, to more effectively provide both routine and preventive treatments. Currently most children commence dental care from the SDS at age five. By this time many of them have established dental disease.

What	Work with Regional Public Health Oral Health Promotion Team to further develop oral health promotion strategies aimed at increasing enrolment of children into the School Dental Service, especially early enrolment of children beginning at age 2.5 years.
Who	Oral Health Portfolio Manager
How	<p>Work with Regional Public Health to:</p> <ul style="list-style-type: none"> ◆ increase work with pre-school groups and providers to provide oral health education and increase enrolment ◆ further engage with Māori and Pacific Health Providers to increase enrolment ◆ educate care givers and other health providers on oral health matters for pre-school age children ◆ further promote public health programmes outside of oral health, like Healthy Eating/Healthy Action, to improve the oral health of children. <p>Note: An increase in oral health promotion is dependent on additional funding from the Ministry of Health for SDS.</p>
When	<p>Quarters 1–2:</p> <ul style="list-style-type: none"> ◆ work with RPH to further develop the strategy and implementation plan to increase enrolment into the SDS

	Quarters 3–4: <ul style="list-style-type: none"> ◆ implement the plan and evaluate enrolment figures of children age 5 years.
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2.1.7 Youth Health

What	Improve youth participation in health services planning and improve youth health.
Who	Senior Portfolio Manger Primary Care
How	<ul style="list-style-type: none"> ◆ Strengthen youth participation in the DHB and PHO planning ◆ Increase youth friendly services and affordable primary care for youth ◆ Support innovative, youth-led initiatives in health promotion ◆ Improve appropriate information resources for young people and access to free sexual health services ◆ Take a broad approach to youth health that includes intersectoral collaboration, working with local government, iwi, public health providers (particularly Regional Public Health), schools and community groups to address issues affecting young people.
When	Quarters 1-4 <ul style="list-style-type: none"> ◆ Work with youth advisory group to complete an action plan for 06-08. ◆ Develop youthfocus on C&C DHB website, in collaboration with youth health advisory group, youth/school health services and young people in community ◆ Initiative(s) based on youth advisory group advice ◆ Increase investment in youth-led and youth-friendly primary care services. Support outpatient clinics for chronic disease management in youth-friendly settings ◆ Produce information resource on free sexual health services in a youth-friendly style, with specific attention to the needs of rangatahi, young people from the Pacific and refugee communities.

2.1.8 Progressing the New Zealand Disability Strategy

Promoting the participation of people with disabilities is a challenge for everyone involved in the delivery, management, and governance of health and disability services in the DHB. We have developed a framework for the implementation of the New Zealand Disability Strategy entitled Promoting Participation. Key actions for change priorities identified in that document are:

- ◆ Disability competency training
- ◆ Physical access
- ◆ Communication and access to information
- ◆ Employment opportunities
- ◆ Community and consumer engagement.

During 2005/06, we have taken many steps to implement the principles of the New Zealand Disability Strategy, including surveys, audits of accessibility, disability equity training and policy and procedure reviews such as our equal opportunity policy. Development of our new regional hospital is subject to compliance with mandatory building regulations and standards as well as offering an opportunity to upgrade service delivery in terms of the needs of people with disabilities.

During 2006/07, we will continue to take actions to identify and eliminate barriers to participation by people with disability through concepts such as universal design and the accessible journey.

A disability issues component has been added to management orientation programmes in HHS and we are planning to develop disability competency training programmes that will be available to community health and disability services providers.

We are committed to ensuring that people with a lived experience of disability deliver this training and are planning to facilitate a ‘train the trainer’ programme to build this capacity.

The upgrade of the C&C DHB website provides an opportunity to improve the content and the way information is made available. Work will continue towards improving the collection and use of data about the impact of people’s impairments on their accessing and using health and disability support services.

The collection of numbers of employees in the provider arm who self-identify as having a disability has begun. Analysis of these figures will begin when they have reached significant numbers.

We will continue to build links with the many different and diverse population groups in the district including Māori, people from Pacific Island nations, immigrants and refugees.

What	Progress the objectives of the NZDS in 2006/07 - address, maintain, and/or promote physical and non-physical accessibility issues
Who	Disability Policy Advisor, Executive Management Team
How	<p>Promoting Participation outlines the implementation process for the New Zealand Disability Strategy across five priority areas for the period up to June 2007:</p> <ul style="list-style-type: none"> ◆ Disability competency training ◆ Physical access ◆ Communication and access to information ◆ Employment opportunities ◆ Community/consumer engagement. <p>Progress has been made in all these areas but we are looking for continual improvement.</p> <p>An Interpreters’ Service Policy has been authorised which includes accessing, booking, and guidelines to using NZ Sign Language interpreters.</p>
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Assess (through surveys and audits) the accessibility of primary and community provider facilities for compliance with the access requirements of the Building Act including NZS 4121:2001, the Building Code, and the Human Rights Act. <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Provide up to date information, training, and continuing education for clinical and ‘first contact’ staff (staff who deal with the public) in order to increase their awareness and understanding of the needs of people with disabilities. <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Ensure that reliable statistics are collected and analysed on the number and percentage of employees who have a disability. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Encourage educational and training providers of health professionals to

	<p>include disability competence components in their programmes</p> <ul style="list-style-type: none">◆ Identify 'hard to get at' communities and individuals within the disability community and design and use consultation processes to reach these people.
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2.1.9 Implementing the Health of Older People Strategy by 2010

Key to our implementation of the Health of Older People Strategy has been an emphasis upon integrating health and disability services across the continuum. The achievements that have been made in the past year around the roll-out and on-going development of the Care Co-ordination Centre, on-going implementation of the New Zealand Disability Strategy, and a comprehensive review of palliative and end of life care services within the C&C DHB, have all contributed – in some instances directly; in others more indirectly – to improved service delivery for older people within the district.

The development of a greater range of high quality community-based services will support consumer preferences to age in place, and should improve health and social outcomes for older people. Our Health Needs Assessment notes that the older age groups have some avoidable hospital admissions related mainly to cardiovascular and respiratory diagnoses.

Co-ordination of care for older people becomes ever more complex as their care is spread across primary, disability, mental health, community and secondary/tertiary services. Accessing multiple services and providers with different service descriptions and access criteria sometimes results in:

- ◆ Services gaps
- ◆ Service fragmentation and duplication between services
- ◆ A lack of emphasis on health promotion, early intervention, and rehabilitation.

Much of our service development is therefore related to implementing integrated service delivery that ensures care is well planned and managed across the continuum (see sections on Integrated Home and Community Care - 2.3.1, and Palliative Care - 2.3.4).

In future years older people's services will require further review and development. The older population will grow rapidly from 2010, and changes will be required to take account of population changes and new service models as they emerge.

One priority from previous workplans that remains outstanding, relates to developing appropriate and appropriately integrated services for people with mental illness 'graduating' into the over 65 age group – and therefore potentially spanning both Mental Health and Health of Older People services. Priority will be given to scoping this issue, with a view to developing an integrated approach to the care co-ordination (i.e. across Mental Health and Health of Older People), likely building upon the successful development of the Care Co-ordination Centre. Such scoping would be undertaken across existing Mental Health, Health of Older People and Integrated Care teams within the Planning and Funding Directorate.

2.1.10 Performance measures

The relevant national performance measures for our outcome of “Reduced disparities in health status” are:

HKO-01	Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain
POP-12	Progress towards the national target of 95% of two year olds fully immunised
SER-03	Primary Health Organisations participating in the PHO Performance Management Programme
PAC-02	Engagement and participation of Pacific peoples in DHB decision-making and the development of strategies and plans that include goals for Pacific health gain
HKO-02	Development of Māori health workforce and Māori health providers
HKO-04	DHBs will set targets to increase funding for Māori Health and disability initiatives
POP-05	Oral health – percentage of children caries-free at age five years
POP-06	Oral health - mean DMFT score at year eight
POP-08 (a)	Improving the health status of people with severe mental illness (total)
POP-08 (b)	Reducing repeat acute mental health admissions
POP-13	Ambulatory sensitive admissions - children and older people - discharge rate per 1000 population
RIH-01	Progress toward further incorporating health inequalities concepts and actions into overall policy, planning, funding and service provision
RIS 01	Service Coverage
SER-01	Accessible and appropriate services in Primary Health Organisations
SER-04	Low or reduced cost access to first level primary care services
PAC-01	Progress towards the implementation of priority areas identified in the Pacific Health and Disability Action Plan
HKO-03	Improving mainstream effectiveness

2.2 Reduced incidence and impact of chronic conditions

To address this priority area we are focused on initiatives related to diabetes, cardiovascular, respiratory diseases and mental health. Also see the reducing disparities (section 2.2), integrated care (section 2.3) and healthy lifestyles (section 2.7) initiatives sections.

2.2.1 Diabetes

2005/06 has been a year of consolidation after substantial investment to improve the local diabetes team infrastructure, expand clinical capacity across the district and improve our ability to monitor progress using annual check, retinal screening and podiatry data.

What	Reduce the incidence and impact of diabetes on people and their families.
Who	Senior Portfolio Manager Primary Care
How	<p>Prevention</p> <ul style="list-style-type: none"> ◆ Collaboration with local government, public health providers, schools, communities, PHOs and providers to support action at policy level, on environmental factors and to improve access to good nutritional and physical activity options. <p>Improved detection and treatment</p> <ul style="list-style-type: none"> ◆ Increase uptake of annual checks through provider specific feedback, support for initiatives to reduce inequalities in access to diabetes care. <p>Self / Whanau management</p> <ul style="list-style-type: none"> ◆ Support local innovation and approaches working well in the district and internationally. Support child and youth-specific initiatives, Māori-led, Pacific-led initiatives and those focused on groups with high prevalence of diabetes.
When	<p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Work with Porirua health cluster to implement Healthy Eating, Healthy Action (HEHA) project, building a city-wide social marketing and environmental approach and strengthening action developed in PHOs, schools and communities ◆ Work with South, East and City PHO (SECPHO) to further develop HEHA initiatives, strengthening action with primary care, Māori communities, Pacific communities, youth and refugee communities ◆ Continue to work with all PHOs to improve co-ordination of prevention programmes and improve detection and uptake rates for annual checks, retinal screening, podiatry, Care Plus. Link diabetes services with services for people with primary mental health services and NGOs/providers offering residential support ◆ Continue to work with providers on Whanau models of care and innovative Māori specific approaches (Section 2.1.3) ◆ Support Pacific family models of care and Pacific-led services (Section 2.1.4) ◆ Improve diabetes support and appropriateness of services for children and youth with diabetes through increased diabetes nurse educator resource and clinical and support services in youth-friendly settings ◆ Evaluation and report on impact of investment 2003-06 by trend analysis in diabetes detection, indicators of diabetes management and diabetes-related

	avoidable admissions.
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2.2.2 Cardiovascular diseases

Cardiovascular Disease (CVD) is the major cause of death, being responsible for 40% of deaths in the district. In a New Zealand study of heart failure outcomes for Māori and non-Māori over a ten year period, mortality from heart failure was more than 8.8 times higher among Māori men aged 45-64 years and 3.5 times higher among Māori aged 65 years and over. Pacific peoples have the highest hospitalisation rate for rheumatic fever, over nine times that of others (19 per 100,000, 45 cases, compared to 2 per 100,000). The Māori hospitalisation rate is just over five times that of non-Māori (9 per 100,000, 54 cases) (Ministry of Health 2001). Over an 18 months period, the Board has developed its policy framework for CVD which includes:

- ◆ Constant real levels of funding for cardiovascular services will continue
- ◆ The balance of funding between community and hospital services should be adjusted towards prevention and primary services
- ◆ The relative expenditure between community and hospital services being adjusted gradually without sudden or large annual re-allocations
- ◆ Agreement that to the extent that resources are limited, movement towards parity is best achieved on a population basis by prioritising (in order) Māori, Pacific people and peoples living in areas classified as NZ Dep deciles 9-10
- ◆ Confirming development of 'by Māori, for Māori' and 'by Pacific, for Pacific' services as a significant strategy to achieve parity, respond to user preferences and support whanau and community development
- ◆ Promoting equitable levels of access to services, recognising there are significant disparities in access to services and health outcomes, particularly for Māori and Pacific people.

The priorities for implementation during 2006/07 include:

What	Implementation of the New Zealand Guidelines Group National Guidelines for cardiovascular risk modification, initially in a community with high proportions of Māori and Pacific peoples.
Who	Senior Portfolio Manager Primary Care
How	<ul style="list-style-type: none"> ◆ Contribute to funding for components required to be able to implement guidelines in Porirua East ◆ Intersectoral and co-ordinated action to implement HEHA and increase access to smoking cessation ◆ Support smokefree lifestyles/environments.
When	<p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Work with PHOs, Māori providers, iwi and Māori communities, Pacific providers and communities, Porirua City Council, Porirua Healthlinks, Regional Public Health, Sport Wellington Region, SPARC, NHF, churches and schools to develop innovative approaches to reduce cardiovascular risk factors ◆ Increase Pacific smoking cessation services ◆ Support initiatives for youth promoting a smokefree lifestyle and programmes, developed regionally with public health providers, primary care, Well Child providers and PHOs to reduce exposure to second hand smoke in homes.

What	Develop advocacy services in the Hospital and Health Services that will support and assist Pacific peoples to make informed choices and access mainstream health services that are appropriate to their needs, in a timely manner.
Who	Manager Pacific Health
How	Establish service
When	<p>Quarter 1: Establish advocacy services for:</p> <ul style="list-style-type: none"> ◆ Transport: facilitating attendance at clinic appointments ◆ Language: ensuring interpreters are available ◆ Facilitation: participating in discussions with providers on treatment choices. <p>Quarters 2-3:</p> <ul style="list-style-type: none"> ◆ Implement new services.

What	Develop advocacy services in the Hospital and Health Services that will support and assist Māori to make informed choices and access mainstream health services that are appropriate to their needs, in a timely manner.
Who	Manager Māori Health Development
How	Implement service.
When	<p>Quarters 1-4: Implement advocacy services for:</p> <ul style="list-style-type: none"> ◆ Transport: facilitating attendance at clinic appointments ◆ Language: ensuring interpreters are available ◆ Facilitation: participating in discussions with providers on treatment choices.

2.2.3 Respiratory Health

Respiratory conditions account for more than 10% of morbidity in the age group from 0 to 19 years. Pacific people are affected by Chronic Obstructive Respiratory Disease (CORD) at a higher rate than other ethnic groups.

What	Improve respiratory health within the district
Who	Senior Portfolio Manager Primary Care
How	<ul style="list-style-type: none"> ◆ Reduce exposure to second-hand smoke and smoking ◆ Reduce admissions in children with asthma ◆ Reduce admissions with CORD, influenza, asthma in adults.
When	<p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Strengthen smoking cessation services (see Section 2.7.3) ◆ Support smokefree hospital campus and ensure smoking cessation support is offered in hospital ◆ Continue to contribute to housing and health projects in Wellington, Porirua and Kapiti, insulating low income housing and researching healthy heating options. <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Joint planning across the district and region for influenza immunisation campaign. Support PHO participation in PHO Performance Framework tracking and supporting influenza coverage in over 65 year olds. Support PHO-led initiatives for people living with chronic illness to improve uptake in high risk groups. ◆ Pacific-specific initiative to reduce asthma admissions in Pacific children ◆ Continue 'winter programme' for CORD and Māori-specific asthma programme in primary care.

2.2.4 Improving Mental Health

Capital & Coast DHB has developed a comprehensive plan for mental health and addiction services entitled *“The Journey Forward”*. This plan provides the vision and direction for most of the specific mental health and addiction treatment service developmental activity in our district for the next five years. The plan signals the need to:

- ◆ Co-ordinate existing services, including primary care, in a way that will be much more responsive and accessible to people’s needs
- ◆ broaden the focus of planning and leadership to the whole population’s mental health needs to ensure better prevention and promotion
- ◆ recognise, value and actively use the knowledge and wisdom of consumers, their families and informal supporters, established and respected community groups and agencies who promote general health and well-being.

A mental health leadership group is in place to assist in leading the changes outlined in the Journey Forward. The leaders’ group has established seven workstreams to focus on specific areas of improvement.

A further key strategic document relevant to this DAP is Mental Health and Addictions Strategic Plan 2006 – 2009. Working regionally with the six lower North Island DHBs provides opportunities to:

- ◆ ensure consistency of acceptable service quality for consumers accessing services across DHB boundaries
- ◆ find economies of scale when developing regional specialist services, and when there is a common need across the region for a particular type of service
- ◆ share knowledge and expertise between DHBs.

Regional approaches to planning provide a narrow but important niche between local DHB and national intentions. A regional service development plan, informed by district and national needs, will be produced in 2006.

The national plan, Te Tahuu, sets the overall direction for service developments and national initiatives that will support our district developments. Both *The Journey Forward* and this DAP are aligned with the intent of Te Tahuu.

Our priorities for mental health and addiction services in 06/07 will be:

- ◆ maintaining the general movement of the sector towards valuing relationships with consumers, their families and social support agencies - allowing for the provision of treatment and support within the context of people’s wider life experiences and aspirations
- ◆ building relationships and understanding with the wider community. Encouraging positive community dialogue about where responsibilities lie for the mental health of our communities
- ◆ building the capacity to better value and support mental health practitioners in their work – and health practitioners who work with mental health consumers.

Quantitative expectations include:

- ◆ Narrowing the gap between current provision and blueprint targets
- ◆ Updating and building on data about the needs of the district’s population – currently and projected for the future
- ◆ Improving access to services – reducing waiting times and acute services over-occupancy

- ◆ **Continuing work on what are useful and useable outcomes from mental health service delivery.**

The Journey Forward has established the following objectives for this DAP.

What	Acute and Crisis Services.
Who	Mental Health Business Manager and Planning and Funding Mental Health Manager
How	<ul style="list-style-type: none"> ◆ Develop an acute and crisis service continuum that is responsive, maintains safe normalising environments, promotes recovery values, values diversity, is staffed by teams with a broad range of competencies, and provides a broad range of interventions appropriate to service users' needs ◆ Spend blueprint allocation to strengthen local acute clinical capacity and to set up new community acute services ◆ The Regional Rangatahi Adolescent Inpatient Service has high and increasing occupancy and utilisation by referring DHBs. A key focus for 06/07 year will be to work with all levels of mental health service management and networks in the central region to advocate for appropriate referral, improved utilisation of alternatives to hospital and improved participation in governance with regard to this service.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Complete detailed design and tender for new acute ward ◆ Establish more robust linkages between the Māori mental health service and adult inpatient services to ensure improved planning and community connections ◆ Implement community acute services – part of these services will have specific focus for Māori. <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Involving local consumer leaders, adapt proven models of consumer peer-run crisis and acute support services for use in C&C DHB. <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Produce revised map of acute/crisis continuum that will result in improved access, relevant service contracting and comprehensive information reporting. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Review acute access to child and youth services. Improve linkages with other services.

What	Co-ordination and Information.
Who	Planning and Funding Mental Health Manager
How	<ul style="list-style-type: none"> ◆ Develop an integrated information and co-ordination service ◆ The information service will be focused on providing information on mental health services to the public, consumers, referrers and providers ◆ The co-ordination service will reflect wellness and recovery principles and will have the capacity to develop individualised support packages ◆ The information and co-ordination service will complement and enhance the total service delivery framework ◆ The local component of the mental health line will be re-scoped with a view to being extended to an 0800 24-hour open access information and support

	service.
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When	<p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Finalise integrated service model ◆ Develop specification for information system ◆ Scope the development of the local mental health line to 0800 access and 24 hours information and support service. <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Complete business case. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Select and contract provider with a view to commencing service in 2007/08.
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What	Addiction Treatment Service Development.
Who	Planning and Funding Mental Health Manager and Mental Health Business Manager
How	<ul style="list-style-type: none"> ◆ Develop a service development plan for addictions that includes the range of services to be provided, priorities and an implementation plan mapped against the Mental Health Commission’s Blueprint and Blueprint funding. The plan will be consistent with and reflect regional addiction treatment developments ◆ C&C DHB will establish partnerships with the Wellington City Council and other agencies to address the needs of homeless people. The capacity of the opioid treatment service will be increased ◆ There is scope for considerable capacity building although it is envisaged that much of this will be in the NGO sector and that C&C mental health service will continue to focus on the complex end of the service spectrum ◆ Methadone places - new funding that is immediately available will improve quality (with the appointment of an Addictions Specialist) and assist the opioid treatment service to meet its contracted targets by eliminating the current waiting list. <p>Inpatient detox is provided via Ward 5 at Kenepuru Hospital. Integration between the community-based services and inpatient detox is poor and the inpatient service currently receives limited support from community-based Addiction Services. In agreement with Medical –Surgical services we plan to develop an inpatient Detox liaison nurse position and will explore ways of improving Addictions Specialist cover for Ward 5.</p>
When	<p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Increase opioid treatment service capacity by 20 places and reduce waiting list ◆ Establish sub regional child and youth Alcohol and Drug service based on multi-systemic therapy principles. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Develop an inpatient detoxification liaison nurse position and explore ways of improving Addictions Specialist cover for Ward 5. ◆ Finalise Addiction Treatments Plan. ◆ Implement first stages of plan.

What	Improving Access to Primary Mental Health Services.
Who	Mental Health Business Manager and Planning and Funding Mental Health Manager
How	<ul style="list-style-type: none"> ◆ Develop options for an integrated framework for primary care, C&C DHB mental health services, and mental health service NGOs, including the development of evidence-based pathways for common mental illnesses. This will ensure all parts of the mental health system are working in a cohesive way to meet the wider community's health needs and priorities.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Board approve options for an integrated service framework. <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Map framework to community mental health teams, PHOs and NGOs. <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Develop evidence-based and concept-based pathways – to include self-help and peer-support options ◆ Using process mapping methodology (on-going mental health workforce development project (MHWDP) resource group initiative) review the child and youth allocation assessment process to improve access. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Begin trial and evaluation of pathways.

What	Promotion and Prevention.
Who	Mental Health Business Manager and Planning and Funding Mental Health Manager
How	<ul style="list-style-type: none"> ◆ Strengthen cross-agency working together and work intersectorally across a wide range of government and community social service agencies to increase education about mental health needs and to promote early intervention strategies. A particular focus will be on engaging Child and Youth and their representative agencies.
When	<p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Establish a Regional Youth Court Liaison Service to provide specialist advice to the Youth Courts; training, mentoring and support for Justice liaison staff; complete court ordered assessments; and a critical link with the adolescent/youth mental health services and Alcohol & Drug services through the Central Region ◆ Establish partnership with C&C DHB intersectoral manager and child and youth advisory groups. Agree objectives and a work programme ◆ Stocktake current promotion/prevention and child and youth services.

What	Working Towards Recovery.
Who	Mental Health Business Manager and Planning and Funding Mental Health Manager
How	<ul style="list-style-type: none"> ◆ HHS workforce development will focus on the recruitment and retention of quality staff and the provision of training for Team Leaders to develop leadership and management skills. We will implement strategies for addressing staff shortages, particularly medical, nursing and cultural service staff. Strategies for recruiting and retaining Māori and Pacific staff will be revamped and career pathways will be developed for smaller professional groups of staff ◆ The role of the mental health support worker in the context of nursing shortages is important. Ensuring delineation of roles and establishing clear processes to ensure proper supervision and oversight of this element of the workforce is paramount in maintaining effective service delivery. Engaging the wider NGO workforce in partnership delivery of services is a major challenge the service will tackle over the next three years ◆ Partnership with the unions to explore more efficient and effective rostering models that achieve broader coverage and flexibility within both inpatient and community areas is desirable ◆ Reconfigurations of teams and units of service delivery will be evaluated and implemented to ensure alignment to deliver services from both the new national strategy and local revision of service configuration. These developments will include consideration of the senior clinical structure necessary to support and enhance service systems and standards ◆ Links will be enhanced with the Medical School, School of Nursing and other clinical training organisations such as Massey and Victoria Universities for staff development and research purpose ◆ We will participate in a regional mental health recruitment and retention plan and ensure that knowledge and skills relating to understanding and practicing recovery based approaches are valued and built upon. This will be done through workforce development (practitioner training and development), strengthening the voice and capacity of consumers to lead their own recovery (particularly through peer-support research and development), and engaging families and other supporters of recovery approaches ◆ We will use the MHWDP national resource group methodology process to engage and map the wider mental health sector system change across the seven workstreams.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Support the development of a peer support and service development network locally. ◆ Establish regular forums to support NGOs in maintaining service development and to meet the aims of <i>The Journey Forward</i>. <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Support five staff to attend the National Mental Health Leadership Programme. <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Deliver a training programme to primary care workers on the benefits of recovery approaches. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Develop local workforce training and development plan to align with regional

	<p>plan</p> <ul style="list-style-type: none"> ◆ Review regional consumer-run case management service in Hawkes Bay.
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What	Quality and Evaluation.
Who	Regional Planning and Funding Mental Health Managers
How	Developing a three year benchmarking and quality programme at a regional level.
When	<p>Quarter 4</p> <ul style="list-style-type: none"> ◆ Develop a three year benchmarking and quality programme.

What	Reducing disparities.
Who	Planning and Funding Mental Health Manager, Regional Planning and Funding Managers
How	<p>The range, quality and availability of services for Māori will be increased by:</p> <ul style="list-style-type: none"> ◆ Providing better co-ordination between Māori providers across C&C DHB and HVDHB (many cover both areas) ◆ Evaluating existing services that work for Māori to provide key learning for future services ◆ Establishing, with <i>The Journey Forward</i> Māori reference group, ideal pathways for Māori through mental health and addictions service frameworks ◆ Working intersectorally to meet the needs of homeless people, many of whom are Māori, with mental health and addictions needs in Wellington City initially and then in other areas, such as Kapiti. ◆ Enabling Māori mental health services to strengthen working relationships with community providers to increase options for tangata whaiora.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Evaluate Menengapai service for outcomes. Build on successful aspects of this service ◆ Support the collaborative development (with WCC, Housing NZ, community agencies and others) of hostel shelter for Wellington's inner city homeless ◆ Agree, with <i>The Journey Forward</i> Māori reference group, ideal pathways for Māori through mental health and addiction services (as a sub-regional project) ◆ Identify and plan regional priorities from <i>Te Puawaitanga</i> baseline information. <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Assess homelessness/mental health needs in Kapiti ◆ Develop Regional Pacific plan and recommendations for addressing Pacific gaps across the Mental Health sector. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Support the development of Māori community crisis respite and acute community services, or equivalent ◆ Commence one regional initiative to improve Pacific people's services.

Changes in the allocation of mental health inter-district flows have negatively affected the revenue C&C DHB receives for a number of regional mental health services. The changes are not based on robust data, and are being reviewed by central region DHBs. The MoH has

allocated \$800,000 in additional blueprint to allow C&C DHB’s funding arm to purchase additional specialist mental health services, to compensate for the withdrawal of funding from other regions.

However, further analysis may change the 06/07 IDF flows, and have a flow-on impact on the use of blueprint funding. Therefore C&C DHB has agreed the following points with the MoH:

- ◆ that the central region GMs will invite the MoH, if necessary, to assist with resolving the regional mental health IDF change issues
- ◆ that if further analysis (or changes to IDF flows) demonstrate that C&C DHB needs to invest an additional \$800k in mental health to maintain the local ringfence then C&C DHB will do this. For the avoidance of doubt, both of us agree that if analysis shows that the other DHBs in the region have removed previous MH flows, and that this removal results in a ringfence shortfall, then the requirement for additional investment falls on the other DHBs.

2.2.5 Performance measures

Relevant national performance measures for the outcome of “Reduced incidence and impact of chronic conditions” are:

SER-02	Care Plus Enrolled Population
POP-01	Diabetes
POP-02	Cardiovascular disease
POP-03	Stroke
POP-08 (a)	Improving the health status of people with severe mental illness (total)
POP-08 (b)	Reducing repeat acute mental health admissions
QUA 01 (b)	Results for people with enduring severe mental illness.

Note that C&C DHB does not have information systems in place that will allow routine collection of the QUA 1b set of information. To ensure reporting requirements are met, C&C DHB will undertake patient notes audits and will report in the findings of these audits.

2.3 Focusing on people through integrated care

We will continue to work towards providing services and programmes that are integrated across health provider, geographical, professional and other boundaries, both within the sector and intersectorally. Our focus for 2006/07 is to progress integrated care initiatives in the follow areas:

- ◆ **Integrated home and community care:**
 - ◆ Extending use of the interRAI planning tool to improve care management
 - ◆ Further developing and bedding in Care Co-ordination Centre functionality
 - ◆ Reviewing the provision of community nursing & allied health services to achieve the best balance between DHB and community provision
 - ◆ Reviewing ways to support carers better
 - ◆ Implementing and extending restorative home-based care packages including a continued focus on workforce development
- ◆ Palliative care
- ◆ Mental health (Section 2.2.4)
- ◆ After hours services (Section 2.1.1)
- ◆ Pharmacy (Section 2.4.5)
- ◆ Laboratories (Section 2.4.4)
- ◆ The Quality Patient Journey – improving quality and efficiency through clinical systems and process redesign (Section 2.4.5)
- ◆ Chronic care management (Section 2.3.2).

2.3.1 Integrated home and community care

2005/06 saw many of the core elements of the Integrated Home & Community Care programme established, for example the:

- ◆ Care co-ordination Centre
- ◆ Care Manager positions
- ◆ Completion of a pilot of the interRAI – MDS assessment and care planning system for home and community service
- ◆ Development of models of care for Specialist Older Persons and Stroke services (the on-going implementation of these services is being managed by the provider arm) and
- ◆ Developing and commissioning more flexible community-based packages of care, particularly in terms of home-based nursing, allied health, and support services.

2006/07 will see a bedding down and consolidation of the changes we have made and building capacity incrementally over time. Specifically we will gradually increase the services that could be accessed through the Care Co-ordination Centre/Care Managers and we will continue to work with our home and community services to transition those services into a more flexible and restorative 'package approach'.

Currently funding and provision of some home and community services occurs through the DHB's Provider Arm (Community Health and Community Therapies services). Continued development of a restorative 'package approach' to home and community services is an on-going developmental process. This will see more home and community services delivered by community-based providers and a change to the service delivery focus of the DHB's provider arm.

To ensure that this change of focus is planned, staged and managed, the goal and pathway for services currently provided by the DHB will be established through a review process (see Section 2.4.5).

We will continue to pilot and roll out the interRAI across a number of services. To support this we will establish a combined Care Manager/interRAI training position. This will be based at the Care Co-ordination Centre and will provide initial and on-going training/support for services as they start to use this system.

We will monitor the implementation of the Stroke and Specialist Older Persons' service and will work with the provider arm to assist the Older Persons' service to provide appropriate support for the Integrated Care programme.

We will continue to progress the Supporting Carer's project which aims to clarify the role and responsibilities of C&C DHB in supporting informal carers, and to identify service initiatives that meet the needs of both carers and clients.

We will also begin the evaluation process for the Integrated Care programme as a whole and establish an on-going service advisory group for the Care Co-ordination Centre and home and community services.

What	Embed the restorative 'package approach' to home and community services.
Who	Manager Aged Care & Disability
How	◆ Continue to increase the 'package approach' to home and community services.
When	Quarters 1-4 ◆ Increase the expenditure on packages, increase capacity of community providers to provide packages.

What	Increase the use of InterRAI.
Who	Programme Manager Integrated Care
How	◆ Scope and pilot use of InterRAI with a further 2-3 services.
When	Quarters 1-2 ◆ Scope and plan pilots in 2-3 services for example, Assessment Treatment and Rehabilitation (ATR), Community Health and Palliative care services Quarters 3-4 ◆ Complete pilots and establish process for roll out within those services for 2007/08.

What	Progress the Supporting Carers Project.
Who	Manager Aged Care & Disability
How	◆ Dependent on recommendations and business case to be presented at the end of 2005/06.
When	◆ Commence evaluation of Integrated Care Programme.

What	Increase the services to be accessed through the Care Co-ordination Centre.
Who	Manager Aged Care & Disability
How	Investigate the feasibility, practicality and appropriateness, and trial an increasing range of services that could be delivered through the Care Co-ordination Centre. For example this may include: <ul style="list-style-type: none"> ◆ Medication management services ◆ Specific specialist assessments e.g. geriatrician/equipment ◆ ACC services (through Care Manager ACC contracted assessments) ◆ Services provided by other NGOs ◆ Community Palliative care services ◆ Intersectoral services ◆ Mental Health services (in conjunction with The Journey Forward programme).
When	Quarter 1 <ul style="list-style-type: none"> ◆ Establish Care Managers as ACC contracted assessors Quarters 2–4 <ul style="list-style-type: none"> ◆ Investigate and trial other services.

2.3.2 Care Management Framework

C&C DHB has a large number of initiatives in place to support and treat people with chronic illnesses. These include:

- ◆ Congestive Heart Failure (CHF) service in Porirua
- ◆ Primary care diabetes program
- ◆ Cardiovascular disease guidelines implementation working group
- ◆ Care Plus
- ◆ Renal disease services such as home dialysis
- ◆ A variety of NGO and PHO contracts.

However C&C DHB does not have a consistent, clearly articulated framework for the delivery of chronic care management across the spectrum of prevention, early intervention, supporting self-care, care management and case management.

C&C DHB intends to develop, jointly with PHOs, an agreed framework for future development and delivery of chronic care programs.

What	Chronic Care Management Framework.
Who	Director Integrated Care
How/when	Quarters 1–3 <ul style="list-style-type: none"> ◆ Develop agreed framework for chronic care management Quarter 4 <ul style="list-style-type: none"> ◆ Map existing programs to framework and identify priorities and approach for future developments.

2.3.3 Implementing the New Zealand Cancer Control Strategy

Cancer is the second most common cause of death after cardiovascular disease. Approximately 29% of the population dies as a result of cancer. Cancer control strategies involve a broad spectrum of the health sector from Public Health prevention and screening, through diagnosis and treatment, to palliative care and disability support. The Ministry of Health has co-ordinated the development of a national cancer control strategy, published in 2003. The strategy has a broad range of goals and significant depth of objectives. During 2006/07 we will:

- ◆ Support the development of care co-ordination roles that facilitate access for patients to cancer treatment, support, rehabilitation, and palliative care services; and improve the links between primary, secondary and tertiary cancer services (with a particular emphasis on Māori and Pacific patients)
- ◆ Provide support for establishing regional cancer networks, which could include: administrative personnel to assist in the set-up and co-ordination of meetings and telecommunications/video conferencing equipment
- ◆ Continue to support multi-disciplinary teams across patient pathways
- ◆ Continue our prevention and promotional activities.

What	Develop a Patient Navigator Service for Māori and Pacific People.
Who	Business Manager Corporate Support, Project Manager Planning and Funding, and Manager Planning and Funding
How	<ul style="list-style-type: none"> ◆ The patient navigator will provide support to people through: addressing problems with transport, difficulties with attending outpatient clinics and questions/fears related to the outpatient attendance; providing interpreters for the outpatient visit, if required; and attending outpatient visits to help with interpretation/explanation of service options and advocating on the person's behalf, if desired.
When	<p>Quarter 1</p> <ul style="list-style-type: none"> ◆ Service design and consultation <p>Quarter 2</p> <ul style="list-style-type: none"> ◆ Recruitment <p>Quarter 3</p> <ul style="list-style-type: none"> ◆ Service establishment <p>Quarter 4</p> <ul style="list-style-type: none"> ◆ Service evaluation.

What	Provide support for further development of a regional cancer network.
Who	Project Manager Planning and Funding and General Manager Planning and Funding
How	<ul style="list-style-type: none"> ◆ Further develop linkages with regional community and hospital-based cancer service providers through identifying and attending established regional network meetings. Provide support to establish new regional networks if/when necessary. Such networks will aid in the development and implementation of local and regional cancer control strategies.
When	<p>Quarters 1-4</p> <ul style="list-style-type: none"> ◆ Attend regional cancer network meetings, providing support if/when

	necessary.
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What	Reduce the cancer risk factors in our population, improve early detection and decrease incidence of cancer.
Who	Senior Portfolio Manager, Primary Care
How	<ul style="list-style-type: none"> ◆ Use collaborative efforts with public health providers, NGOs, PHOs and community groups. This includes joint planning with Regional Public Health, collaborative planning and implementation with Cancer Society, primary care providers and community stakeholders in Healthy Eating, Healthy Action, tobacco control, SunSmart promotion, and promotion of screening outcomes ◆ Focus on appropriate promotion for particular subgroups and maintain a focus on reducing inequalities in screening uptake and cancer outcomes ◆ Link to existing areas of work: PHO Performance Framework and breast screening, cervical screening, Māori Health Plan, Pacific Action Plan, Regional Public Health Plan etc.
When	<p>Quarter 1</p> <ul style="list-style-type: none"> ◆ Improve linkages between PHOs and Breast Screen Aotearoa (BSA) programme. Develop a joint plan to reduce barriers to BSA service in areas of low uptake and for populations with high risk and low coverage, involving PHOs <p>Quarter 2</p> <ul style="list-style-type: none"> ◆ Review initial PHO Performance indicators related to BSA and cervical screening <p>Quarters 1-4</p> <ul style="list-style-type: none"> ◆ See tobacco control section 2.7.3 ◆ See healthy eating healthy action section 2.7.2 ◆ Support innovative and collaborative programmes in PHOs to promote cancer screening and provide accessible information about prevention strategies in a range of formats and languages.

2.3.4 Palliative care

In 2004/05 we completed a review of palliative and end of life care in C&C DHB. The review highlighted the changing patterns of diseases causing death, and highlighted opportunities to better recognise and respond to palliative needs for all people diagnosed with life-limiting illness.

During 2006/07, we will continue to implement the improvements identified as recommendations in the review of palliative care. These changes are expected to include:

- ◆ Continue to increase the ability of people to chose to die at home by improving the availability of suitable homecare and respite care services for people in their last year of life, particularly Māori, Pacific Peoples, and people from other ethnicities who do not commonly access hospice services for their end of life care
- ◆ Changes to funding of residential care for palliative patients to reflect the intensive nature of caring for people with very high needs in these settings
- ◆ Extending the role of specialised palliative care services in delivering expert liaison and education to health professionals who provide care to palliative patients such as general practitioners and registered nurses
- ◆ Commence a stock-take of specialist and non-specialist palliative care nursing services to establish the best configuration of these services
- ◆ Piloting the use of InterRAI with palliative care services.

What	Improve palliative and end of life care services.
Who	Manager Aged Care & Disability
How	<ul style="list-style-type: none"> ◆ Introduce community palliative education and liaison role ◆ Scope and identify service options to ensure that the palliative needs of people living in aged residential care are recognised and responded to appropriately ◆ Stock take of specialist and non-specialist palliative care nursing to determine optimal service configuration. ◆ Continue development of the package approach for home and community services, ensuring the needs of people living with life-limiting illness are addressed.
When	<p>Quarter 1</p> <ul style="list-style-type: none"> ◆ Extended role of specialist palliative care in delivering liaison, and education <p>Quarter 2</p> <ul style="list-style-type: none"> ◆ Commence review of palliative care nursing services <p>Quarter 4</p> <ul style="list-style-type: none"> ◆ Improvement in availability of home and community care services for people in their last year of life, including homecare and residential care contracts.

2.3.5 Performance measures

The relevant national performance measures are:

POP-14	Radiation oncology and chemotherapy treatment waiting times.
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2.4 Managing our money

This section outlines the major financial initiatives planned over the next three years to achieve financial sustainability. The major workstreams include:

Efficient service delivery

- ◆ **Benchmarking**
- ◆ **Theatre productivity**
- ◆ **Mental health efficiency gains**
- ◆ **Materials management**
- ◆ **Voice and communications services review**
- ◆ **Standardisation of administration**

Service reconfigurations

- ◆ **Rationalise TAS and P&F functionality**
- ◆ **Review of small tertiary services and other specialist services**
- ◆ **Laboratory project**
- ◆ **Community & allied health review**
- ◆ **Review of outpatient models of care**
- ◆ **Reconfiguration of greater Wellington hospital services**
- ◆ **Introduce demand management strategies for renal services, oncology services and cardiology services**
- ◆ **Implement the outcomes of the pharmacy services review**
- ◆ **Review the current payment of Specialist GMS Subsidies.**

Revenue realisation

- ◆ **Influencing national policy such as advocating for equitable pricing of tertiary services and adequate revenue to fund FRS3 revaluations**
- ◆ **Regional initiatives such as seeking equitable sharing of the cost of capital for the New Regional Hospital on a utilisation basis.**
- ◆ **Ensure accurate and timely counting of IDF volumes**
- ◆ **Receiving payment from regional DHBs for actual volumes of non-caseweight services delivered**
- ◆ **Improving non-CFA Revenue through more accurate counting and billing.**

Many of these initiatives are focused at the national, regional or sub-regional level.

2.4.1 Efficient service delivery

Benchmarking

In 2002 the organisation completed a benchmarking exercise as part of the New Regional Hospital business case and project. This information has been used as a measurement basis from this time and has led to significant improvements in human resource use, practically within nursing by use of the NHPPD (Nursing Hours Per Patient Day). The benchmark becomes an indicator of good practice standards, and is used both as a resource allocation and planning tool as well as a reporting KPI (Key Performance Indicator).

Further benchmarking activity undertaken since 2002 has helped the organisation improve understanding and to develop robust and well-supported benchmarks. This has included both external and internal activity.

External benchmarking

The CEO has taken a national health leadership role for benchmarking and in particular between the major tertiary hospitals. This has led to further improvement of existing benchmark activities and added additional New Zealand data to the comparative set. There have also been major gains from standardisation of definitions and counting methods. These outcomes will lead to improved ability by all DHBs to share comparative information, thereby enabling a greater capacity to learn from each other and implement the most beneficial processes and procedures.

Internal Benchmarking

C&C DHB has completed another organisation-wide benchmarking exercise both in support of - the external benchmarking and to support the DAP budget initiatives. The outcome of this will allow comparison to previous work, providing:

- ◆ Recognition of improvements
- ◆ Measures of change and its effectiveness
- ◆ Signals of areas where improvement may be achieved
- ◆ A comparison basis for review with other DHBs
- ◆ Information required for C&C DHB to support the national work.

What	Accurately deploy nursing staff.
Who	Director of Nursing and Midwifery
How	<ul style="list-style-type: none"> ◆ Use new predictive planning tool that can assist in accurate staff deployment. ◆ C&C DHB and the "Emendo" company have been running a pilot using the "CapPlan tool". CapPlan is a predictive planning tool that can predict within 95% accuracy the number of beds being utilised by the hospitals, over time frames from 3 days - 6 months in advance. This allows for more accurate deployment of staff related to workload, and assists in the overall planning of acute and elective cases. <p>Key Performance Indicators:</p> <ul style="list-style-type: none"> ◆ Achievement of NHPPD benchmark targets ◆ Bed day targets ◆ Length of stay reductions ◆ Theatre cancellations

	◆ Reduction in the number of medical outliers
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When	<p>Quarter 1</p> <ul style="list-style-type: none"> ◆ Pilot evaluated and decision made about purchase of CapPlan systems. If capex approved, implement across all inpatient services as outlined in project plan and change business processes <p>Quarter 2</p> <ul style="list-style-type: none"> ◆ Evaluate and set targets.
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What	<p>Improve use of nursing resources through benchmarking and the use of an internal pool of nursing staff.</p> <p>Analyse the current nursing budget against the NHPPD targets with emphasis on reducing casual and overtime usage without compromising safety and quality and with a focus on mental health.</p>
Who	Director of Nursing and Midwifery
How	<ul style="list-style-type: none"> ◆ Benchmarking the nursing ratios against other Mental Health DHBs and development, implementation and evaluation of tools ◆ Establish a permanent pool of nurses.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Mental Health Nursing Acuity tool developed. ◆ Approval of business case to establish a permanent pool <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Mental Health Nursing Acuity tool implemented ◆ Evaluate recruitment recommendations ◆ Implement permanent pool to achieve a reduction in casual and agency use <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Mental Health Nursing Acuity tool evaluated ◆ Evaluate permanent pool in relation to costs.

Theatre productivity

What	Increase operating theatre productivity.
Who	Chief Operating Officer
How	◆ Implementation of efficiency initiatives identified in 05/06 review.
When	On-going.

Mental health efficiency gains

What	Mental health efficiency gains.
Who	Director Quality & Integrated Care/ Director of Nursing
How	<ul style="list-style-type: none"> ◆ Benchmark NHPPD staffing against similar services and reduce to benchmark ◆ Review overhead levels in mental health ◆ Develop strategies for alternative models of provision within community

	<p>services</p> <ul style="list-style-type: none"> ◆ Review team productivity ◆ Protect and enhance IDF revenue ◆ Review use of properties and team structures.
When	Reduce current operating loss to break even over 3 years.

Materials management

What	Materials Management.
Who	Chief Operating Officer
How	♦ Achieving reductions in the cost of clinical and non-clinical supplies through standardisation, regional and national contestable purchasing, practitioner feedback and inventory management.
When	On-going.

Administration costs review

A project commenced in the 2005/06 year that is linked to both the Patient Journey and to the implementation of the Electronic Health Record, is the administration standardisation project. This project aims to achieve efficiencies through the application of common processes, worker ratios, roles and templates to administrative staff who support clinical work.

What	Administration Standardisation.
Who	Director Integrated Care
How	♦ Implement standardised processes, ratios and templates arising from EHR and service reviews ♦ Manage administrative staffing down through management of change protocols and sinking lid policies.
When	Quarter 1 – 2

Voice and communications services review

What	Voice and communications services review.
Who	Chief Operating Officer
How	♦ Review use of cell phones, pagers and PDAs and identify opportunities to rationalise use and generate savings/better value for money.
When	2006/07.

2.4.2 Service reconfigurations

Service reconfigurations involve finding a different way of delivering a service to meet the population's health needs more effectively.

Regional

Our regional shared support services agency (TAS) does not usually deliver its full plan in any budget year, giving an opportunity to recover some expenditure. If other DHBs were agreeable then the programme for next year could be reduced, resulting in savings. Considerable analytical and project support is available to the region both through TAS, local DHB staff, PHARMAC and DHBNZ. A review of regional work, Planning and Funding directorates, PHARMAC and DHBNZ expenditure may also produce additional savings.

What	Review provision of regional analysis/audit for planning & funding functions.
Who	Director, Planning and Funding
How	<ul style="list-style-type: none"> ◆ Review of TAS programmes and functions through Regional GMs and CEOs ◆ Subject to agreement of central region DHBs.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Identify issues and solutions <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Agreement to recommendations following review <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Implement recommendations.

Review of small tertiary services and other specialist services (requires public consultation)

What	Review of small tertiary services and other specialist services.
Who	Chief Operating Officer
How	<ul style="list-style-type: none"> ◆ As part of our HHS strategic planning we are reviewing small tertiary services and other specialist services (e.g. dermatology) to ensure that they are financially and clinically viable. We will focus this review on services where clinical viability is compromised by the size of the service and the cost of transporting patients to other centres is less than the cost of delivering services in C&C DHB. We will no longer provider tertiary services for which we are not funded for (e.g. electro physiology).
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Agree funding for electro physiology services with other DHBs or finalise plans for this service to be provided by another DHB ◆ Agree funding for HDR Brachytherapy services with other DHBs or finalise plans for this service to be provided by another DHB. <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ Complete review of other small tertiary and secondary services.

2.4.3 Sub-regional initiatives

Laboratories

During 2005/06, we continued to work through the integrated Laboratory project. This project established a memorandum of understanding between the provider arm laboratory services of Hutt Valley DHB and C&C DHB. Both DHBs jointly completed a request for proposal (RFP) for the provision of community laboratory services across both DHBs.

We anticipate that in early 2006/07 we will establish integrated provision of community laboratory services. To support this initiative, we also anticipate that by mid 2006/07 we will have established a single data repository for all laboratory results for both Hutt Valley and C&C DHBs. This will be provided by the electronic health record software supplier (Orionhealth), who provide the electronic health record solution to both Hutt Valley and Capital and Coast.

What	Integrated community laboratory service and data repository
Who	Director Integrated Care
How	<ul style="list-style-type: none"> ◆ Depending on the evaluation of responses to the RFP, the successful responder will be contracted to provide the community laboratory service ◆ Once the community laboratory service supplier is contracted, the development of the data repository can commence. (Note this is also dependent on the progress of the electronic health record project in general).
When	<p>Quarter 1-2:</p> <ul style="list-style-type: none"> ◆ Successful responder to RFP contracted. <p>Quarter 2-3:</p> <ul style="list-style-type: none"> ◆ Data repository established.

2.4.4 Local initiatives

Review of out patients models of care

What	Outpatients Model of Care: ensuring best balance between primary and secondary delivery of these services is achieved.
Who	Chief Operating Officer, Director Planning and Funding
How	◆ Review with input from primary providers.
When	Quarter 1: ◆ Form project group and identify issues Quarter 2: ◆ Implement changes.

Reconfiguration of greater Wellington hospital services (may require public consultation)

The sub-region has three hospitals serving a small area and population. In addition to proposing changes to how services are delivered across C&C DHB hospital facilities, it is also necessary to seek efficiencies that may be gained through a reconfiguration of services across the three hospitals in the greater Wellington region. For example, acutes may be focused on Newtown and electives on Hutt and Kenepuru.

This service configuration proposal has evolved from the service configuration model agreed by the C&C DHB Board and the Ministers of Health and Finance in 2002 as part of the approved business case for the new hospital facilities in this district.

What	Changing the local configuration of hospital and health services to maintain clinical and financial viability.
Who	Chief Operating Officer
How	As part of our HHS strategic planning we are moving towards hospital and health services that are configured across our campuses with the following focus: ◆ Kapiti – outpatient services and a base for community nursing as well as other health organisations (e.g. Hora Te Pai) ◆ Kenepuru – outpatient, day services, elective services and rehabilitation services ◆ Newtown – acute, emergency, trauma services and complex diagnostic modalities.
When	There is no significant service reconfiguration planned at Kapiti over the next 3 years. Quarter 1: ◆ Consolidate all overnight staffing at Kenepuru Hospital from 11:00-8:00am to reflect workloads during this time ◆ Confirm planning for future location of outpatient services over the next 3 years ◆ Complete business case for increasing elective surgical services at Kenepuru. Quarter 2: ◆ Complete review of maternity bed numbers at Kenepuru Hospital with a view to maintaining status quo or increasing bed numbers by 1 bed (current plans

	<p>are to increase bed numbers by 2)</p> <ul style="list-style-type: none">◆ Complete assessment of locating all acute admissions at Newtown Hospital (i.e. no longer admitting acute patients directly to Kenepuru inpatient areas). <p>Quarter 3:</p> <ul style="list-style-type: none">◆ Confirm the location of CT scanning services across Kenepuru and Wellington Hospital (i.e. review current plans include introducing CT scanning service at Kenepuru).
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Managing demand for renal, oncology and cardiology IDF services (requires public consultation)

C&C DHB is providing a level of services to other DHBs that exceeds the amount of funding allocated by them. In part this is due to the funding methodology that uses historical information and does not allow sufficient growth. In part it is due to a lack of active regional planning for tertiary service access and service development.

During 2006/07 we shall provide regular reports to other DHBs on levels of service provision and engage actively with them to plan the future volume and configuration of services provided. If DHBs do not wish to fund service growth we will work with them to manage service access to meet available revenue.

What	Renal, oncology and cardiology demand management.
Who	Chief Operating Officer
How	<ul style="list-style-type: none"> ◆ Develop, in consultation with affected DHBs, clinicians and consumers, explicit criteria to manage the growth in renal, oncology and cardiology services to an appropriate level
When	Quarter 1: Quarter 2:

Repositioning of community health nursing and community therapies

Repositioning of community health nursing and community therapies services through continued implementation of initiatives associated with the integrated home and community care project.

What	Repositioning of community health nursing and community therapies to achieve the appropriate balance between community and DHB provision.
Who	Director Integrated Care
How	Develop and implement a plan to achieve an optimal balance for ownership of community nursing and allied health services between C&C DHB and the community and primary care sector Use the restorative 'package approach' in a planned, staged and managed way. Ensure planning covers off risk to after hours service delivery and potential fragmentation of specialist and training services.
When	Quarter 1: <ul style="list-style-type: none"> ◆ Scope, develop draft plan Quarter 2-Quarter 3: <ul style="list-style-type: none"> ◆ Consult and finalise Quarter 4: <ul style="list-style-type: none"> ◆ Commence transition of services.

Pharmacy

In today's environment of chronic disease, polypharmacy and an ageing population, pharmacist skills can greatly contribute to improving health outcomes, reducing hospital and

long term care admissions, providing guidance for safe prescribing and supporting compliance services.

In 2005/06 we reviewed the way pharmacy services are delivered to our population. The review aimed to develop a strategy for the future supply of pharmacists' services within C&C DHB, and to develop pharmacists' services which improve health outcomes, reduce disparities, reduce hospital and long term care admissions, enhance access and care in the community and ensure best use of resources.

During 2006/07 we will be implementing the outcomes of the review. Services will be built around prioritised local patient and population needs guided by national strategies. The services will:

- ◆ Be patient-focused
- ◆ Ensure good, safe prescribing
- ◆ Provide easy access to dispensing services
- ◆ Ensure efficient supply of medication
- ◆ Provide good information and support for patients
- ◆ Be affordable within the funding constraints of the DHB.

What	Implement the outcomes of the Pharmacy Services Review.
Who	Manager Planning & Funding Operations
How	◆ Establish new services and change existing services.
When	<p>Quarter 1-Quarter 2:</p> <ul style="list-style-type: none"> ◆ Commence transition of services <p>Quarter 1-Quarter 4:</p> <ul style="list-style-type: none"> ◆ Implement new services <p>Quarter 2-Quarter 3:</p> <ul style="list-style-type: none"> ◆ Roll out new national Pharmacy Agreement.

Specialist GMS subsidies

We will review the current GMS subsidies paid to specialists with a view to ensuring that our investments in this area are providing value for money and are targeted to high needs populations.

What	Review the current payment of specialist GMS subsidies.
Who	Manager Planning and Funding Operations
How	◆ Review the current investment in specialist GMS subsidies and determine how best this funding should be utilised.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Review current expenditure and make recommendations <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Implement recommendations.

Quality improvement

C&C DHB will build on previous years' successes, including:

- ◆ Achievement of accreditation and certification in 2004
- ◆ Development of the C&C DHB quality framework² including:

² The CCDHB quality framework describes the overall CCDHB approach to quality assurance, quality improvement and clinical governance, including structures, processes and philosophy. Specific actions to be taken each year are described in the DHB annual quality plan, and in the quality plans developed by each clinical area.

- ◆ The development of an integrated online policy database (Silent One) and
- ◆ the development of a comprehensive set of organisational policies
- ◆ a network of quality facilitators spanning all services
- ◆ the Quality Improvement Group – which acts as the governing body for clinical quality improvement issues
- ◆ the set of Protected Quality Assurance activity (PQAA) clinical audit activities
- ◆ quality quest
- ◆ events and complaints reporting and analysis
- ◆ serious and sentinel event review processes
- ◆ regular quality audits
- ◆ departmental quality plans.

The organisation-wide priority developments for 2006/07 are:

- ◆ Improve Serious & Sentinel Events Management processes
- ◆ Implement The Patient Journey: redesign of clinical systems & processes to standardise care, improve quality and reduce errors
- ◆ Develop processes for organisation-wide acknowledgement of staff quality achievements and performance excellence.
- ◆ Review data collection processes about reportable events, compliments and complaints and patient satisfaction in relation to usefulness of current reporting to all levels of the organisation
- ◆ Improve Silent One search functionality to enhance access to policies
- ◆ Audit ethnicity data collection.

Service specific plans

In addition to these proposed organisational priorities, services will prepare service-specific development plans meeting the following standards.

Required:

- ◆ Plans include quality measurements including clinical audit processes and Australasian Council for Healthcare Standards (ACHS) or other quality indicators
- ◆ Plans include organisational & service-specific audit & certification/accreditation schedules
- ◆ Each service/department has quality group as part of infrastructure
- ◆ Plans identify key service delivery risks and put in place projects to mitigate risks
- ◆ Plans contain quality improvement project goals
- ◆ Plans contain strategies for reviewing and learning from complaints and adverse events.

Preferred:

- ◆ Plans include mechanisms for consumer input to quality/service improvement
- ◆ Plans include projects to support The Patient Journey approach to improving clinical processes and systems
- ◆ Plans address the components identified in the Improving Quality national strategy.

What	Improve Serious & Sentinel Events Management processes.
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Who	Director, Quality & Integrated Care/Quality Manager
How	<ul style="list-style-type: none"> ◆ Improve timeliness of C&C DHB's response to S&S events ◆ Improve communication processes involved in management of S&S events, including notification to senior management staff and electronic access to constantly up-dated information ◆ Improve mechanisms for dissemination of learning from S&S events ◆ Consider opportunities for greater disclosure of events to patients.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Review policy & processes <p>Quarter 2: I</p> <ul style="list-style-type: none"> ◆ Implement revised processes

The Quality Patient Journey

The patient journey project is about conscious redesign of care processes and systems by the people involved in providing that care (and their consumers) so that processes are standardised, patient-centred, efficient and effective. The workstream will use a variety of redesign tools including:

- ◆ Plan, Do, Study, Act (PDSA)
- ◆ Process mapping
- ◆ Care tracking
- ◆ Value stream mapping
- ◆ Standardisation
- ◆ Lean thinking principles.

The use of these tools is intended to create an organisation that delivers high quality services in a proactive manner. The patient journey will include not only how the DHB provides services internally, but also the processes that occur outside the DHB provider arm: the quality patient journey begins and ends at the individual's own home.

What	The Quality Patient Journey – improving quality and efficiency through clinical systems and process redesign.
Who	Director, Integrated Care/Chief Operating Officer
How	<ul style="list-style-type: none"> ◆ Create a small team of project co-ordinators who can assist services in mapping processes and understanding the patient experience of care within and across services ◆ Support services using this team and funding to backfill current team leader/members ◆ Institute a patient journey interest group to spread ideas through the organisation ◆ Integrate into the leadership and management curriculum ◆ Develop and maintain relationship with external leaders in the field ◆ Develop organisation competencies in process mapping, PDSA (Plan, Do, Study, ACT) rapid cycle quality improvement, care tracking, and value stream mapping through a standing redesign team, developmental workshops and action learning ◆ Pilot and learn from care redesign in 4 services.

When	Quarter 1: <ul style="list-style-type: none"> ◆ Launch patient journey work stream. Quarter 2: <ul style="list-style-type: none"> ◆ Commence redesign of two services. Quarter 3-4: - <ul style="list-style-type: none"> ◆ Commence redesign of a further 2 services.
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Implementation of better quality processes is expected to reduce complaints and serious events and improve patient safety.

What	Develop processes for organisation-wide acknowledgement of staff quality achievements and performance excellence.
Who	Director, Quality & Integrated Care/Quality Manager
How	<ul style="list-style-type: none"> ◆ Review Quality Quest processes, including timing, to ensure maximum benefit for the organisation ◆ Develop process for capturing 'good news' quality stories, identifying high-performing staff and acknowledging their achievements through an employee recognition program ◆ Improve connection between Quality Improvement Group (QIG) and leaders (professional/service) in the organisation.
When	Quarter 2: <ul style="list-style-type: none"> ◆ Complete review Quarter 3: <ul style="list-style-type: none"> ◆ Implement new processes

What	Improve reportable event collection and reporting.
Who	Director Quality & Integrated Care/Quality Manager
How	<ul style="list-style-type: none"> ◆ Review data collection processes about reportable events, compliments and complaints and patient satisfaction in relation to usefulness of current reporting to all levels of the organisation ◆ Implement electronic reportable event software and processes.
When	By end Quarter 4.

What	Improve Silent One – policy database search functionality.
Who	Director Quality & Integrated Care/Quality Manager
How	◆ Move to newer version of Silent One. Install on dedicated server.
When	By end Quarter 4.

Improving elective services including orthopaedics

Access to elective assessment and treatment continues to be a priority for C&C DHB. During 2005/06 we have continued to focus on improving performance against Elective Services

Performance Indicators (ESPI). The DHB is committed to Elective Services compliance and implementing recovery plans by 30 September 2006.

An action plan is currently being implemented to support the improvement in performance with a focus on the development of standardised systems and processes to support sustainable improvement, access criteria for first specialist assessments (FSA), prioritisation of patients referred for treatment and access to theatre for elective surgery. Strategies are also under development to increase capacity to meet the funded elective volumes which include increasing the number of theatres at Kenepuru.

The orthopaedic initiative has also provided the opportunity to improve access to surgery for patients requiring joint surgery.

The focus for 2006/07 will be on strengthening processes that have been implemented, continuing to work with the Senior Medical Staff to ensure they support what is required to maintain performance, monitoring and audit.

Link to DSP	Improve waiting times.
What	Maintain improved access to specialist assessment, ensuring compliance with national waiting times standards.
Who	Chief Operating Officer/Director Planning and Funding
How	<ul style="list-style-type: none"> ◆ Work with primary care providers to develop alternative care plans for patients that do not meet the access criteria ◆ Continue to strengthen triage processes and monitor standards of referrals with appropriate referral back to primary care ◆ Monitor waiting times and waiting lists to ensure lists are current ◆ Complete 6 monthly audits of elective service processes to identify and implement quality improvement strategies.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Continue work with specialties relating to active referral management ◆ Review and update clinic templates to support achievement of funded volumes and FSA criteria <p>Quarter 2 & 4:</p> <ul style="list-style-type: none"> ◆ Complete 6 monthly review and updating of wait lists ◆ Audit processes which support the management of wait lists ◆ On-going review of waiting list management processes ◆ Identify and implement quality improvement activities to support organisational objectives and KPIs.

Link to DSP	Improve waiting times.
What	Continue to implement strategies which support the performance and management of the surgical wait list.
Who	Chief Operating Officer/Director Planning and Funding
How	<ul style="list-style-type: none"> ◆ Ensure prioritisation and patient selection supports access for the patients with the highest level of need or ability to benefit ◆ Improve pre-assessment processes to ensure the impact of late cancellations on theatre utilisation and throughput is minimised ◆ Determine the options for increasing the viability of Kenepuru and increasing elective surgical capacity.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Develop regular reports relevant to the clinical staff which support the monitoring of actual procedures performed against clinical treatment thresholds ◆ Implement standardised processes and practices with the booking clerks which support appropriate management of theatre lists ◆ Develop and implement an action plan to support the outcome of decisions made relating to the future of Kenepuru ◆ Implement changes to the pre-assessment process <p>Quarter 2&4:</p> <ul style="list-style-type: none"> ◆ Audit processes and practice which support the management of surgical waiting lists ◆ Review certainty and actual treatment thresholds and implement identified changes ◆ Review waiting lists and categorisation of patients to ensure waiting lists remain current.

Link to DSP	Improve waiting times.
What	<p>Orthopaedic and Cataract initiatives:</p> <p>Achieve base volume and extra planned volume of hip and knees for the Orthopaedic Initiative</p> <p>Achieve base volume and extra planned volume of Cataract procedures for the Cataract Initiative</p> <p>Identify areas for capacity building and process improvement that will ensure the targets for 06/07 are met.</p>
Who	Chief Operating Officer/Director Planning and Funding
How	<ul style="list-style-type: none"> ◆ Production plans reflect requirements to achieve base and additional volumes ◆ Implementation of the ESPI recovery plan and recommendations for improvement ◆ Implementation of actions within the Productivity and Efficiency Plan (P&E Plan) to support capacity increase.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Implement strategies to support delivery of base and additional joint volumes ◆ Confirm specific actions to support improvement against ESPIs for Orthopaedic and Ophthalmology Services. <p>Quarter 1-4:</p> <ul style="list-style-type: none"> ◆ Monitor performance against targets ◆ Identify opportunities and actions to support improved performance.

2.4.5 Revenue realisation

Influencing national policy

There are a number of issues which are impacting on our DHB's ability to live within the available funding, and some of these are outside of our direct control. We will need to look for ways to pro-actively manage these issues and achieve outcomes which assist us with our objectives of living within the available funds but still achieving improved health outcomes for our population. Some of these issues are national and some are regional.

What	Influencing national policy.
Who	Chief Executive Officer
How	<ul style="list-style-type: none"> ◆ Working with Ministry officials and other DHB CEOs to resolve national and regional issues that are adversely affecting C&C DHB's ability to manage funding such as policies related to FRS3 implementation, DHB insurance, seismic insurance adjustors, PHARMAC purchasing non-pharmaceutical supplies for DHBs, and national service delivery models for oncology and cardiology.
When	On-going

National pricing

Prices and tertiary adjustors are set by national processes. The issues are complex, information is of variable quality and good dedicated analytical resource scarce. Developing good processes has been a challenge for DHBs and the MoH. There is an opportunity to improve both the analysis and the decision-making which in our view will lead to increased revenue for C&C DHB.

What	Influence National Pricing Project.
Who	Director Planning and Funding
How	<ul style="list-style-type: none"> ◆ Support national processes by supplying resource, good data and on-going debate. The first goal will be to retain the equivalent of the "smoothing" element of the present arrangement and then to ensure full compensation for removal of the tertiary adjustor and full implementation of realistic national prices. The methodology will involve: ensuring good analytical resource on the workstreams (Planning and Funding); continued work by tertiary pricing group (CEO), raising issues at CEO meetings (CEO) and at the DHBNZ Service Funding Group (SFG) (Planning and Funding).
When	On-going

Non case-weighted discharge wash-ups

Wash-ups are already in place for inpatient case-weighted discharge (CWD) services. There are no wash-ups in place currently for non-CWD services. Increases in referrals for non-CWDs from other DHBs were \$1.4m more than base revenue in 04/05. This unfunded cost was exceptional and due to information issues. We anticipate growth over base to be closer to \$0.5m in the future. This additional revenue will be obtained through IDF wash-ups. At present the DHB is receiving no revenue for these volumes. In addition, if this activity is above overall (local and IDF) activity, it is estimated that this can be delivered at 50% marginal costs. It would

then be worth promoting IDF in these activities. We have identified improvement in data quality which enables wash-ups to be done.

What	Introduce Non-CWD Wash-ups.
Who	Director Planning and Funding
How	<ul style="list-style-type: none"> ◆ Introduce IDF wash-ups for non-CWDs.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Agreement to non-CWD wash-ups with other regional DHBs <p>Quarter 1-4:</p> <ul style="list-style-type: none"> ◆ Seek to influence entire sector to move to non-CWD washups for out years.

Regional initiatives

C&C DHB is providing a level of services to other DHBs in excess of the amount of funding allocated by them. In part this is due to the funding methodology that uses historical information and does not allow sufficient growth. In part it is due to a lack of active regional planning for tertiary service access and service development.

During 2006/07 we shall provide regular reports to other DHBs on levels of service provision and engage actively with them to plan the future volume and configuration of services provided.

If DHBs do not wish to fund service growth we will work with them to manage service access to meet available revenue.

What	Ensure accurate and timely counting of IDF volumes.
Who	Chief Operating Officer
How	<ul style="list-style-type: none"> ◆ Ensure through appropriate policy, systems and training that all IDF services are accurately identified, coded and invoiced (specifically renal, oncology and cardiology) ◆ Provide regular reports to Central Region DHBs on: <ul style="list-style-type: none"> ○ Levels of access ○ Service growth expectations ○ Service supply issues ◆ HHS Management to meet regularly with Central Region DHB funders to provide information and plan for service provision and development.
When	<p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Provide reports, face to face meetings, obtain agreement on access and funding levels.

The NRH requires considerable investment by C&C DHB. Other DHBS using our HHS services should also contribute to this investment. National IDF prices will be insufficient to accommodate the collection of this “fair” contribution.

What	Premium from regional DHBs to contribute to increased capital charge costs with new hospital facilities.
Who	Director Planning and Funding

How	<ul style="list-style-type: none"> ◆ Regional GMs and CEOs to agree to fund a proportion of the NFH capital charge increased costs to recognise that 39% of admissions are for the non-C&C DHB population. ◆ Subject to agreement of the Central Region DHBs.
When	Quarters 1-4: on-going.

Local initiatives

We continue to look for ways of delivering services which provide more value for money and deliver better health outcomes for our population.

What	Maximise the collection of non-CFA revenue by accurate and timely counting of invoices for ACC, Breast Screening, private patients and CTA funded services.
Who	Chief Operating Officer
How	<ul style="list-style-type: none"> ◆ Ensuring through appropriate contract management policy, systems and training that all services provided for ACC contracts are accurately identified, coded and invoiced. ◆ Ensuring through appropriate policy, systems and training that all breast screening services provided for Breast Screen Aotearoa are accurately identified, coded and invoiced. ◆ Maximise the revenue available to the hospital by coding for services (mainly out-patient) through appropriate policy, systems and training to ensure that all out-patient events are coded for month end reporting.
When	On-going

2.4.6 Performance measures

QUA-01 (a)	Quality systems
SER-06	Continuous Quality Improvement – Elective Services
SER-05	The proportion of laboratory and pharmaceutical transactions with a valid NHI.

2.5 Developing our workforce

The health sector faces an international shortage of medical, nursing/midwifery, allied health, technical and other community-based workforces. C&C DHB’s workforce strategies reflect the need to adapt the mix of workforce skills and numbers to meet the changing needs of our population, to reduce disparities in health status among our population, and to take advantage of the opportunities afforded by new technologies and service models.

Workforce development is undertaken across the range of service development and funding activity outlined elsewhere in the DAP. These include a continuing focus on the following workforce strategies:

- ◆ Development of capacity in the Māori workforce and in the Pacific workforce with a particular emphasis on primary care and capability around key health priority areas
- ◆ Retention and development of the primary care workforce
- ◆ Recruitment and retention of the mental health workforce
- ◆ Continuing primary care development in the district
- ◆ Implementing the on-going organisational development and infrastructure development
- ◆ Support effective and efficient deployment of the workforce in line with service configuration
- ◆ Improve the retention of the secondary/tertiary workforces.

2.5.1 Developing workforce infrastructure

Actions to improve retention of the health workforce include improved engagement, and more positive internal working environments including a staff recognition programme; continued development of the leadership and management capability through the Leadership Programme with particular emphasis on supporting people in clinical leadership roles with a specific programme.

- ◆ Delivery of upgraded tools and information (including the human resource (HR) information systems and rostering tools) required to underpin efficient deployment across the continuum
- ◆ Implementation of stage 2 of the Central Region workforce profile project and Māori Health leadership programme (subject to MoH funding)
- ◆ Implementation of the mental health primary and secondary care workforce initiative in line with the regional mental health plan
- ◆ Delivery of targeted improvements in Pacific nursing numbers.

2.5.2 National and regional – Future Workforce Plan

C&C DHB’s workforce plans integrate the actions contained in the national DHB “Future Workforce Plan”. Under the plan there are also five major national workforce work streams (medical, nursing/midwifery, allied health; technical and unregulated workforces). Recommendations from these work streams will be integrated into plans through the year.

Future Workforce outlines three priority areas which are reflected in all workforce activity and in the organisation development programme. These encompass: fostering supportive environments and positive cultures; enhancing people strategies; and education and training.

What	Implement the on-going organisational development and infrastructure
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	development.
Who	Director Human Resources
How	<ul style="list-style-type: none"> ◆ Continued development of in-house leadership, clinical leadership and management development programmes ◆ Development of HR information capability and tools to assist managers in workforce deployment and management ◆ Improve recruitment capability and processes including through regional collaboration ◆ Implement national DHBNZ Future Workforce Plan.
When	<p>Quarters 1-2:</p> <ul style="list-style-type: none"> ◆ Implement new clinical leadership programme; implement management information kiosk; complete implementation of new rostering and time and attendance system; establish programme for DHB Workforce Steering Group to improve workforce co-ordination and workforce plan implementation. Upgrade central candidate management process through online recruitment capability; implement regional nursing recruitment portal and overseas/local promotion programme <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Implement a regional learning and development programme to build on the Training Stocktake completed under the national Future Workforce Plan <p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Support national DHB leadership development programme; complete upgrades to HRIS system to support online recruitment ◆ Work with DHBNZ and sector on implementation of national Health Workforce Information programme. Implement selected Health and Hospital initiatives outlined in the Future Workforce Plan.

What	Support effective and efficient deployment of workforce in line with service configuration.
Who	Chief Operating Officer, Director of Nursing, Management Team
How	<ul style="list-style-type: none"> ◆ Analysis and evaluation of appropriate benchmarks with services, across all occupational and professional categories, to configure full-time equivalents (FTEs) in line with service models.
When	<p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ On-going service by service evaluations and incorporation into service planning.

What	Improve retention of the secondary/tertiary workforces.
Who	Director Human Resources; Director Nursing/Midwifery, Management Teams
How	<ul style="list-style-type: none"> ◆ Through the development of initiatives that will support C&C DHB's overall retention strategy including processes to improve employee participation in decision-making, improved workload management, improved access to professional mentoring and support on shift; strengthened leadership skills ◆ Career development process

	<ul style="list-style-type: none"> ◆ Acknowledgement of staff through specific initiatives.
When	<p>Quarter 1: Implementation of an internal career development service; consolidation of the staff discounts (health savings) programme; implementation of the service based recognition programme; implementation of staff “health education and well-being programme”</p> <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Implementation of a “valuing staff” recognition programme for individual and team contribution and achievement.

2.5.3 Performance measure

HKO-02	Development of Māori health workforce and Māori health providers.
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2.6 Working with Communities

Interaction with our community occurs on a number of levels. At the governance level the Board members are elected from the community and additional members are appointed by the Minister of Health, including Māori and Pacific members.

We have established a governance relationship with Māori, and there are numerous layers of interaction flowing from that. In addition, the Board's Statutory Advisory Committees have members appointed from the community. We have also established a Pacific Strategic Co-ordination Group to provide expert advice to C&C DHB.

Working, and building partnerships and relationships, with our communities has been a key focus over the past few years. We will continue to build on these relationships and partnerships.

Over the coming year we will continue to build on the relationships that have evolved with communities and populations in our district. Our specific focus under this priority over the next 3 years is intersectoral work.

2.6.1 Intersectoral strategy

C&C DHB has made significant progress over the last 2 years in developing intersectoral approaches with government agencies and local authorities across the Wellington, Porirua and Kapiti territorial local authorities (TLAs).

In November 2005, C&C DHB appointed a Portfolio Manager within the Planning and Funding unit to develop a strategic framework and evaluation methodology to ensure this work further developed in a targeted and effective manner. This approach has two key areas of focus:

- ◆ Participation in local policy, planning and service delivery amongst social service providers as a means of positively influencing social determinants of health; and**
- ◆ Developing collaborative approaches with other agencies where linked service provision improves the sustainability of health outcomes across communities.**

By strengthening our relationships with local representatives of agencies such as the Ministry of Social Development (MSD), Housing New Zealand Corporation (HNZC), Police, Child, Youth and Family (CYF), ACC, Te Puni Kokiri (TPK) and the Ministry for Pacific Island Affairs (MPIA), C&C DHB will be well placed to influence holistic thinking across sectors around community wellness and well-being. Furthermore, the strengthening of relationships with local government will allow C&C DHB to fully participate in the Community Outcomes and LTCCP planning processes across our communities.

In strengthening these relationships, we will be working alongside Regional Public Health (RPH) and our region's PHOs to ensure our intersectoral work is well-connected and leverages off one another's efforts to best effect in the community. This will support our joint implementation of Healthy Eating, Healthy Action (HEHA), injury prevention activity and other joint initiatives.

We see opportunities for leveraging off relationships to jointly fund activities which see greater returns for the funds invested than we could have achieved on our own. We will proactively seek out these opportunities.

There is a strong desire to see C&C DHB's intersectoral work grounded in a strong evidence base. To this end, the development of formative, process and outcome evaluation methodologies alongside the Intersectoral Strategy, will provide confidence to a wide range of stakeholders in the value of C&C DHB's collaboration across the social sector. During 2006/07 we will:

What	Develop a strategic framework, evaluation methodology and work-plan covering C&C DHB's existing and future intersectoral work for 2006-2008.
Who	Senior Portfolio Manager – Intersectoral Strategy
How	<ul style="list-style-type: none"> ◆ Complete our intersectoral strategic framework for 2006 – 2008 ◆ Stocktake and evaluate progress to date around the substantial amount of existing intersectoral activity across the DHB, linking this to the Health Needs Analysis for the district, the “reducing inequalities framework” and health indicator trends ◆ Pull together existing and future intersectoral work into a co-ordinated work plan for 2006- 2008. This will pay particular attention to how best to support the range of existing intersectoral projects in the region ◆ Develop internal intersectoral evaluation methodologies in line with Paul Duignan's OIWA Analysis framework.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Presentation of finalised intersectoral strategic framework. ◆ Completion of stock take of existing intersectoral projects, linked to Health Needs Analysis work. ◆ Completion and circulation of 2006-2008 Intersectoral work-plan. <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Finalisation and circulation of intersectoral evaluation methodologies.

What	<p>Development of intersectoral approaches and projects across the DHB by: providing facilitation services to other portfolio or service managers, and linking them to opportunities with other agencies developing key projects within the intersectoral portfolio that influence wider community health outcomes.</p>
Who	Senior Portfolio Manager – Intersectoral Strategy
How	<ul style="list-style-type: none"> ◆ Enhance our senior level participation in local strategic forums across the region ◆ Renegotiate MoU with MSD, with a particular focus on developing joint projects around workforce development, disability allowance uptake across the region and family violence co-ordination ◆ Build upon our strong existing relationships with other government agencies by developing MoU's where opportunities for collaboration will improve health and broader social outcomes ◆ Build upon existing collaborative projects, and identify new ones that will actively impact on either social determinants of health and/or improving the sustainability of health outcomes through linked services.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Renegotiation of MSD MoU ◆ Enhanced C&C DHB representation at regional forums. <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Identify opportunities for MoUs and co-funding initiatives with other agencies.

	<p>Quarter 3:</p> <ul style="list-style-type: none">◆ Report back on how we have supported existing intersectoral projects.◆ New collaborative activities underway. <p>Quarter 4:</p> <ul style="list-style-type: none">◆ Formative evaluation around new projects circulated.
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2.6.2 Minimise family violence

We will implement the Family Violence Prevention strategies as an intersectoral project. Implementation and on-going provision will be managed through a Family Violence Intervention Steering Group (FVISG) responsible for maintaining the relationships with the relevant agencies and reviewing and reporting on audit results.

What	Implement the Family Violence Prevention strategies.
Who	Senior Portfolio Manager – Intersectoral Strategy
How	<ul style="list-style-type: none"> ◆ Develop a DHB Family Violence Intervention project plan and report on progress.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Official written policies are in place ◆ Referral information related to family violence services is on public display such as in posters and brochures ◆ DHB collaborates with Māori community organisations and providers to ensure the family violence programme is culturally competent ◆ Formal training plan in place for regular on-going family violence education for DHB staff in maternity, emergency, child health and sexual health services ◆ Quality assurance and clinical audit procedures in place that ensure the clinical assessment policy for identifying child abuse and neglect is implemented ◆ Formal internal evaluation procedures in place to monitor the quality of the family violence programme. <p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ All Family Violence Intervention Policies are on Silent One database ◆ Draft audit tools trialled ◆ Provision of training plan to HHS Management team for approval ◆ Preliminary audit to test “identification of child and partner abuse” tools ◆ Evaluation: FVISG approve evaluation plan. <p>Quarter 3:</p> <ul style="list-style-type: none"> ◆ All policies are completed ◆ Audit tools confirmed ◆ Provider training plan commenced ◆ Confirm “identification of child and partner abuse” screening tools ◆ FVISG to develop proposal for information pathway. <p>Quarter 4:</p> <ul style="list-style-type: none"> ◆ Audit of referral information ◆ Audit of cultural environment ◆ “Identification of Child and Partner Abuse” screening tools in use ◆ Evaluation of programme.

2.7 Supporting and promoting healthy lifestyles

2.7.1 Population and determinants of health

We are a part of a regional grouping (with Ministry of Health, Hutt Valley DHB and Wairarapa DHB), implementing a Regional Strategic Plan for public health. The joint decision-making model has worked well to co-ordinate the Ministry of Health's funding and planning with the priorities of the DHB. Collaboration amongst public health providers and PHOs has built good working relationships and strengthened population health capacity within PHOs.

During 2006/07, we need to review progress on the strategic plan and continue to build local provision with communities through public health providers, PHOs and through intersectoral action.

Much work is already in progress, some developed in partnership with Regional Public Health and other public health providers, some with other key agencies including local government, the Ministry of Social Development, Housing NZ and some generated through the NGO sector, community groups, schools, and PHOs. All projects have a strong focus on inequalities.

C&C DHB has actively supported the upskilling of providers, health professionals, community members in PHOs and other agencies in principles of health promotion and sharing health sector tools developed to tackle inequalities.

A clustered approach to the prevention of diabetes, obesity, cancer and cardiovascular disease has been implemented. Similarly, actions across youth/alcohol and drug/suicide prevention/reducing inequalities work are synergistic. Some key projects, like Income and Health, have an impact on all areas.

During 2006/07 we intend to build on the social environments approach, particularly focusing on links between health, safety, social inclusion and well-being for low income population groups, Māori, Pacific populations and refugee communities.

To achieve this, we will build on existing area-based approaches (Wellington, Porirua, Kapiti); ethnic-specific approaches and settings-based programmes.

There are now several active projects across sectors. During 2006/07, we will draw this action together into a strategic framework and work to document the impact of the sum of these activities. (See section 2.6.1– intersectoral)

We have a strong focus on HEHA strategy implementation. In building the action, the DHB will work with others to strengthen current, successful programmes and support community-based initiatives, particularly for children and youth in low income communities, for people living with chronic illness and for people with disability. In all areas, collective action to influence social and environmental determinants of nutrition and physical activity levels is supported, in addition to support for specific programmes with particular community groups.

We continue to work with other agencies to reduce tobacco use and support smokefree environments.

2.7.2 Improve nutrition and promote physical activity

Nutrition plays a major role in the three leading causes of death in New Zealand. Poor nutrition is also a key factor in the prevalence of obesity, Type 2 diabetes, cancer, hypertension and dental disease. Thus an improvement in nutrition would decrease the diet-related burden of illness and disease on individuals, particularly those living in more deprived areas. It would also save major costs in health care.

The government's HEHA framework calls for a more integrated approach to addressing nutrition, physical activity and obesity, highlighting the importance of influencing both individual/whanau behaviour and our environment.

In 2006/07 we will:

- ◆ work with local and regional partners, linking to national initiatives and international evidence to ensure effective use of resources and co-ordination across sectors in implementing HEHA and look to strengthen local links with Ministry of Education, MSD and SPARC
- ◆ continue to optimise resource use through a 'clustered' approach to the prevention of obesity, cardiovascular disease, diabetes and cancer with co-ordinated planning while supporting tailored approaches linking effectively with different audiences, families/whanau and diverse communities.

What	Improve nutrition and increase physical activity and breast feeding rates.
Who	Senior Portfolio Manager, Primary Care
How	<ul style="list-style-type: none"> ◆ Work with public health providers, local government, NGOs, PHOs, schools, whanau and communities, SPARC and other agencies to improve food choices, access to good nutrition and levels of physical activity ◆ Support nutrition and physical activity focus for health promotion in PHOs ◆ Improve food security for low-income families by working with Work and Income and other groups to improve access to income support where indicated.
When	<p>Quarter 1:</p> <ul style="list-style-type: none"> ◆ Implement two HEHA projects, co-funded by the Ministry of Health with Porirua PHOs and in South Wellington with SECPHO. <p>Quarter 1-4:</p> <ul style="list-style-type: none"> ◆ Work with Work and Income and other agencies to improve access to income support, employment and food security ◆ Increase the number of health promoting schools ◆ Work with Porirua's PHOs and the Porirua Cluster to address environmental determinants affecting nutrition and to promote physical activity. Work with all PHOs to use evidence-based as well as innovative approaches in implementing nutrition and physical activity promotion plans. ◆ Continue to support Healthy Lifestyles Pasifika, Pacific elderly programme and other Pacific-led projects to improve nutrition and activity levels. (Section 2.1.4). ◆ Support community-based programmes to improve nutrition in whanau and Māori communities. ◆ Implement agreed work programme with Regional Public Health to implement HEHA strategy (targeting Māori, Pacific peoples, deprived communities, early child care centres and schools) ◆ Work with Kapiti District Council, Kapiti PHO, Sport Wellington, Regional Public Health and other agencies to complete Kapiti's Physical Activity Action Plan (Quarter 2) and begin implementation (Quarter 3-4).

What	Collaborative work programme with Regional Public Health and other key
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	agencies/providers.
Who	Senior Portfolio Manager, Primary Care
How	<ul style="list-style-type: none"> ◆ Work with Regional Public Health, local government, other agencies and providers on shared work programmes and key projects.
When	<p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Continue and evaluate impact of Serious Skin Infection project ◆ Homeless Prevention Strategy (with a particular but not exclusive focus on Wellington) ◆ Support Post-vention Project implementation in C&C DHB community ◆ Support implementation of Refugee Health and Well-being Action Plan.

2.7.3 Reducing tobacco, alcohol and other drug abuse

What	Reduce the rate of smoking and reduce exposure to tobacco smoke.
Who	Senior Portfolio Manager Primary Care
How	<ul style="list-style-type: none"> ◆ Joint planning with Ministry of Health, Regional Public Health and links with key stakeholders in tobacco control through participation in Regional Forum ◆ Facilitate training opportunities ◆ Maintain focus on tobacco control and smoking cessation in PHO contracting, particularly in Health Promotion plans, C&C DHB newsletters and communications.
When	<p>Quarters 1-4:</p> <ul style="list-style-type: none"> ◆ Work with Ministry of Health to support Pacific model for smoking cessation ◆ Support smokefree events ◆ Work with public health, Well Child and Tamariki Ora providers, midwives, primary care providers and PHOs to reduce second-hand smoke exposure in homes ◆ Support Regional Public Health in Smokefree Porirua project.

2.8 Updating our hospitals

2.8.1 New Regional Hospital

We are developing new buildings at Kenepuru and Newtown to ensure staff, patients and visitors have a safe and pleasant environment that meets the needs of a modern healthcare system. We have completed facility development at Kapiti. We have also completed the short stay unit and blood cancer centre in Newtown.

Over the next three years we will complete the new main building at Newtown, the psychogeriatric unit, and refurbish buildings at Newtown and Kenepuru. Our plan for the new regional hospital involves:

- ◆ Moving some services (such as rehabilitation, outpatient and community health services) into the community, where this can be done safely, so that hospital services can focus on serious illness and emergencies
- ◆ Using technology to record, co-ordinate and share health information through the use of an enhanced electronic health record
- ◆ Developing consistent systems and processes such as those for admissions, treatment, and discharge
- ◆ Locating services that work together near each other and
- ◆ Improving hospital buildings so they meet the future of hospital care in the district.

Planning for the new hospital has been integrated as far as possible into the normal business process and the detailed planning has been undertaken by operational staff in accordance with an agreed planning brief. There will be progressive migration of services, which needs to be supported by detailed operational, commissioning, and change strategies to support effective occupancy.

Link to DSP	Improving hospital buildings to meet future needs in the district.
What	<p>The objectives for 2006/07 are:</p> <ul style="list-style-type: none"> ◆ To let the sub-trades for the main building at Newtown ◆ To complete the psychogeriatric building at Kenepuru ◆ To implement the Picture Archive Computer System (PACS) system across all C&C DHB sites.
Who	Project Director, Project Manager and Team
How	The main construction contract for Newtown has been let to Fletcher Construction who will tender the sub-trades progressively through the calendar year 2006. For Kenepuru, the psychogeriatric building tender will be let with works commencing as soon as possible after that. A regional process to select the preferred provider has been successfully concluded and Kodak will implement the first PACS installation at C&C DHB during the year.
When	<p>Quarter 1:</p> <p>Newtown: Let building services sub-trades Preparatory contract complete</p> <p>Kenepuru Progress the psychogeriatric building Resolve outstanding planning issues</p> <p>PACSImplementation strategy finalised and infrastructure installedTest environment in</p>

	Radiology department
Quarter 2:	
Newtown	<ul style="list-style-type: none"> Let architectural sub-trades Commence mechanical hydraulics installations Concrete and structure continues
Kenepuru	<ul style="list-style-type: none"> Complete the psychogeriatric building Migrate patients from K1 to new Replace Hi Prevac sterilisers
PACS	<ul style="list-style-type: none"> Implementation at Newtown Infrastructure connections for Kenepuru and implementation
Quarter 3:	
Newtown	<ul style="list-style-type: none"> High voltage works commences Zone 1 tower cladding commences Structure complete to level H First mechanical plan installation
Kenepuru	<ul style="list-style-type: none"> Residual upgrade works Relocate dental from existing site
Quarter 4:	
Newtown	<ul style="list-style-type: none"> Podium weather-tight Zones 1 and 3 Wards weather-tight Zones 1 and 3 (interstitial area remains open) Plan rooms closed level H
2007/08	
Newtown	<ul style="list-style-type: none"> Fit out continues Commissioning plans in place Complete refurbishment plan
2008/09	
Newtown	<ul style="list-style-type: none"> Building complete Commissioning complete Hospital Services migrates Demolition commences

2.8.2 Information system development

In order to deliver on the Health Information Strategy and WAVE recommendations we are working through our ICT service provider, HIQ Limited, to implement a robust and scalable IT

infrastructure that provides a platform for information exchange and collaboration within the sector. This platform is consistent with the national network strategy action zone and provides both Taranaki and C&C DHBs with secure, internet-based accessibility to systems and health information. A secure network link between the two DHBs provides a high level of connectivity which the central region DHBs' regional network initiative will further extend. The platform will also be leveraged to:

- ◆ support the key ISSP initiative of consolidating systems and implementing an effective multi-site disaster recover strategy
- ◆ implement a common results repository that will contain results data across the region accessible to any authorised stakeholder
- ◆ support implementation of a regional diabetes system.

The implementation of a web-based Electronic Health Record and Patient Management System underpins progress on the other action zones and the other key ISSP initiatives. These systems are being implemented in close collaboration with Hutt Valley DHB to ensure regional consistency. They will provide a platform for:

- ◆ integration with National Health Index (NHI) and Health Provider Index (HPI) (when available)
- ◆ collection of the outpatient and community datasets
- ◆ implementation of an ePrescribing solution
- ◆ extension of the DHBs' discharge summaries to non-inpatient areas
- ◆ improved decision support.

What	Ensure appropriate levels of system availability for all IT systems in the event of component failure or disaster.
Who	General Manager, HIQ
How	<ul style="list-style-type: none"> ◆ Documented disaster recovery strategy and plan in place ◆ Utilise computer rooms in Newtown and New Plymouth to provide failover capability between sites for critical systems ◆ Ensure redundancy of critical systems and components.
When	On-going.

What	Provide a single, consistent user interface through which important clinical information for a patient can be accessed at the point of care.
Who	COO, C&C DHB
How	<ul style="list-style-type: none"> ◆ Replace the current patient management system with a stable, web-based platform ◆ Replace the current clinical record system with a web-based clinical portal that can be accessed through an internet connection ◆ Integrate clinical systems, including scanned medical records, to provide access through a single user interface.
When	Quarter 2: <ul style="list-style-type: none"> ◆ Replace current systems On-going: Integrate clinical systems.

What	Provide digital radiology images to clinicians.
Who	COO
How	<ul style="list-style-type: none"> ◆ Implement digital radiology equipment and an information system to support the capture and clinical use of digital radiology images ◆ Replace the current radiology information. ◆ Integrate digital radiology images with the Electronic Health Record.
When	<p>Quarter 1 06/07: Implement digital radiology equipment and PACS system</p> <p>Quarter 2: Replace current systems</p> <p>On-going: Integrate clinical systems.</p>

What	Improve the dissemination of information within the DHB through the use of an effective and secure intranet.
Who	HR Director
How	<p>Implement a new intranet toolset to support the ability of authorised users to publish content to selected groups of individuals</p> <p>Implement collaboration tools that support the use of secure workspaces for document and information sharing.</p>
When	<p>Quarter 1: Implement collaboration tools</p> <p>Quarter 4: Implement new intranet</p>

What	Improve the management of staff through availability and effectiveness of online personnel information.
Who	HR Director
How	<ul style="list-style-type: none"> ◆ Implement a standard staff rostering tool integrated with the HR system ◆ Implement online management reporting.
When	<p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Implement staff rostering tool ◆ Implement online management reporting.

What	Improve the effectiveness and stability of the organisation's financial and materials management.
Who	CFO
How	<ul style="list-style-type: none"> ◆ Replace current financials and materials management systems.
When	<p>Quarter 2:</p> <ul style="list-style-type: none"> ◆ Replace financial and materials management systems.

3. Background and Financial Information

This section includes information required by the Ministry and Minister of Health. It also includes our financial information.

3.1 Planning environment

This section contains all other information required by the Ministry of Health. It begins with information on our planning environment, relationships, prioritisation and financial information.

3.2 Treaty of Waitangi

We recognise the Treaty of Waitangi as New Zealand's founding document and as such we acknowledge the special relationships between Māori and the Crown under the Treaty. C&C DHB is committed to assisting the Crown with meeting its obligations as a Treaty partner. C&C DHB recognises and respects the principles of the Treaty of Waitangi, and is committed to working under the auspices of the treaty within the framework of the New Zealand Public Health and Disability Act 2000. C&C DHB considers the Treaty principles to be a fundamental driver toward achieving better health outcomes for Māori. The Treaty of Waitangi principles as they apply to this DHB are:

Partnership

Working with iwi, hapu, whanau and Māori communities to develop strategies for Māori health gain and appropriate delivery of health services.

Participation

Establishing and maintaining strategies and processes that involve Māori in the development and delivery of services, to ensure that services address Māori health needs while reflecting and responding to Māori values and customs.

Protection

Supporting the development of Māori providers, encouraging and empowering iwi, hapu and whanau and Māori communities to help maintain and improve Māori health status and safeguard Māori cultural concepts, values, and practices.

3.3 Role of Board

The DHB Board is responsible for the governance of the DHB. Seven members were elected in 2004 as part of the triennial local authority election process and the Minister of Health appointed four additional members. The Board's mandate is detailed in the New Zealand Public Health and Disability Act 2000. The DHB Board has all the powers necessary for the governance of the DHB, and is responsible to the Minister of Health. The DHB affirms commitment to "best practice" governance. This includes routine and regular consultation and engagement with stakeholders and acknowledging the DHB's obligations under the Act. The Board's key responsibilities include:

- ◆ Approving proactive and reactive strategies
- ◆ Setting long-term strategic direction consistent with the government's objectives
- ◆ Developing with management and approving the District Annual Plan and other accountability documents
- ◆ Monitoring the performance of the DHB and appointing its CEO
- ◆ Corporate governance

- ◆ **Maintaining the relationships with the Minister, Parliament, Māori and the public**

The DHB will continue to develop training programmes for Board members in any of the following areas:

- ◆ Obligations and duties of a Board member
- ◆ Treaty of Waitangi issues
- ◆ Māori health issues
- ◆ Population health and reducing inequalities.

3.3.1 Board members

The current Board of the DHB was constituted in December 2004. The new Board is constituted of the elected members (7 members) as part of the triennial election in October 2004 and members appointed by the Minister of Health (4 members) and the Board members are:

Bob Henare (Chair)	Margaret Faulkner
Judith Aitken (Deputy Chair)	Ruth Gotlieb
Brendon Bowkett	Kiri Parata
Ruth Bradwell	Fuimaono Karl Pulotu-Endemann
Peter Dady	Helene Ritchie
Kenneth Douglas	

3.4 Māori Partnership Board

The DHB continues to work with Iwi/Māori at a governance level. At this level Iwi/Māori are represented by the Māori Partnership Board. The Māori Partnership Board is made up of representatives from Te Atiawa, Te Atiawa ki Whakarongotai, Ngati Toa and Rauru Tetere (Wellington Taurahere Grouping). We have a written agreement in place with the partnership board that outlines our commitment to working together to improve Māori health and the health of the wider DHB community.

During 2004 we worked with the Māori partnership board to strengthen our Māori health policy infrastructure. One particularly significant achievement has been the joint development of a Māori health policy for our DHB. The policy puts in place clear and mutually agreed expectations of DHB staff and contracted providers in relation to Māori health. In 2005 we mutually developed and agreed a joint action plan with the Māori Partnership Board. As a result of this plan a 'Māori health indicators' dashboard' has been jointly developed to better enable joint monitoring of key Māori health indicators relevant to our district.

The priority for the partnership board is to give strategic advice to the DHB about regional health issues that impact on local Māori communities. The Partnership Board have communicated the following priorities as their priorities for 2006. We have used these priorities to help shape our high level strategy and relevant activity in 2006/07.

Fostering Māori Development

- ◆ Māori provider development
- ◆ Māori workforce development
- ◆ Māori service development
- ◆ Support the implementation of Te Plan

Reducing disparity

- ◆ **Improve access to services**
- ◆ **Develop Māori models of care**

Building robust relationships

- ◆ **Strengthen MPB relationship with Board**
- ◆ **Strengthen MPB relationship and processes for engagement with key stakeholders**
- ◆ **Strengthen MPB communication with key stakeholders**
- ◆ **Strengthen relationships between MPB members**
- ◆ **Strengthen relationships with Pacific leaders**

Improving mainstream responsiveness/effectiveness

- ◆ **Promote Tino Rangatiratanga and Māori cultural values and beliefs**
- ◆ **Enable a Treaty of Waitangi understanding**
- ◆ **Set relevant standards and expectations of mainstream providers in relation to their performance**
- ◆ **Effectively monitor and evaluate mainstream services (focus on PHOs)**
- ◆ **Monitor the implementation of Te Plan**
- ◆ **Support the implementation of DHB's Māori Health Policy**
- ◆ **Monitor key milestones with DHB.**

We will continue to work closely with the partnership board on key matters in 2006/07 and onwards.

3.5 Board Committees

We have established seven Board committees, including three statutory advisory committees, which assist the Board in carrying out its functions. The role of these committees is in accordance with the New Zealand Public Health and Disability Act 2000. The committees are:

- ◆ **Community and Public Health Advisory Committee (CPHAC)**
- ◆ **Disability Support Advisory Committee (DSAC)**
- ◆ **Hospital Advisory Committee (HAC)**
- ◆ **Finance, Risk and Audit Committee (FRAC)**
- ◆ **Remuneration Committee. (RC)**

3.6 Our people

The last census was completed in 2001 and the projected population of the district at June 2005 is approximately 272,400. Approximately 67% of the district's population resides in Wellington city, 19% in Porirua and 14% in Kapiti.

Among the people of the district, the Māori and Pacific population is much younger than other groups, as it is made up of more children and fewer elderly people.

Our health needs assessment has identified several key characteristics of the district's population that will influence the planning and funding of health services such as:

- ◆ The district population is ageing
- ◆ Life expectancy continues to rise
- ◆ 81.5% of the district population is in the 'other' ethnic group (non-Māori, non-Pacific), 10.5% are Māori and 8% are Pacific.

There are three distinctly different territorial local authorities within the district:

- ◆ Kapiti has a low percentage of people aged 15-45 and a high number of people over 60. The population is dominated by the 'other' ethnic group, who make up nearly 90% of the population. The Māori and Pacific ethnic groups are composed of mainly children and younger adults. The majority of the Kapiti population live in NZDep 3 to 7 areas (relatively less deprived).
- ◆ Porirua has a high percentage of children under 15 and lower than national average of people over 60. Approximately 23% of the population are Māori and 20% are Pacific people. The Māori and Pacific populations are young in comparison to other ethnicities. Approximately 37% of the Porirua population live in areas classified as NZDep 10 and 29% live in NZDep 1 areas.
- ◆ Wellington has a higher percentage of people aged 20-40 and a low percentage of people in the under 15 and over 60 groups. Almost 90% of the population are in the 'other' ethnic group. The Māori and Pacific populations are relatively small, with very few people aged over 60. 26% of Wellington's population live in the least deprived areas (NZDep 1).

By 2016, our population will change as number of people in some age groups will increase and will decrease in some age groups. Over the next ten years:

- ◆ The number of people aged over 65 in the district will increase by 32% and
- ◆ The number of people aged under 14 in the district will decrease by 10%.

3.6.1 Ethnicity profile

Approximately 31% of the district's population are non-European, including 10.5% Māori, 8% Pacific, 8% Asians, and 4.5% other ethnicities. The proportion of Māori in the district at 10.5% is lower than that in New Zealand as a whole (14%). Pacific people make up 8% of the district's population compared to 5% nationally. The district's population is growing slowly overall, at a rate predicted to be around 0.6% each year. The Māori population is expected to experience faster growth, at 1.2% each year.

3.6.2 Health needs and key issues

On average, our people enjoy better health and live longer than people in other districts of New Zealand. This is likely to be largely a result of the overall population being less deprived than the New Zealand population. It is difficult to identify particular conditions where the district's population is healthier as there are subgroups with poor health, and differences in access to health services skews results. The health needs assessment has identified the following priorities, which support the priorities of the various strategies of the Government:

- ◆ Māori health (as the Māori population carries a higher burden of disease compared to 'other' ethnic groups)
- ◆ Pacific health (as the Pacific population carries a higher burden of disease compared to 'other' ethnic groups)
- ◆ Cardiovascular diseases (the greatest burden of disease and represents 40% of mortality in the district)
- ◆ Cancer (the second greatest burden of disease and represents 28% of mortality in the district)
- ◆ Diabetes (morbidity and mortality from diabetes is increasing rapidly, and Māori and Pacific people are disproportionately affected)
- ◆ Population health (income, employment, housing etc. as determinants of health status affecting smoking, nutrition, obesity and physical activity)
- ◆ Suicide (death by suicide has increased by 15% in the years from 1988 to 2000 and suicide accounted for 19% of all youth (15-24 years) deaths in the district)
- ◆ Respiratory health (respiratory conditions account for 15% of hospitalisations in the 1-19 years age group);
- ◆ Disability (1 in 5 New Zealanders has a disability. The rate is the same for Māori and 1 in 7 Pacific people have a disability. 60% of people with disabilities have more than one disability)
- ◆ Child and youth health (especially respiratory diseases, hearing, oral health, avoidable hospitalisations, cellulitis and teenage pregnancy)
- ◆ Health of older people (the population aged over 65 years is predicted to increase by over 10% in the next five years, and by 2021 will account for over 15% of the district's population); and
- ◆ Mental health.

3.6.3 Māori health profile

Māori make up 10.5% of the district's population (compared to 14% of the New Zealand population). 35% of the Māori population live in the most deprived areas (NZDep 9 and 10).

In the district, Māori admission rates for avoidable hospitalisations are lower than for Māori elsewhere in New Zealand, but they are still higher than the rates for the 'other' ethnic groups for all age groups and particularly for the youngest and oldest age groups. The relative risk is highest for the 45 – 64 age group who are 2.2 times more likely to be admitted with an avoidable condition or preventable injury than the 'other' group. Māori are 1.2 times more likely to be admitted to hospital than 'other' groups.

Māori people have a higher burden of disease compared to 'other' groups. Heart conditions and diabetes affect Māori approximately 20 years before people in 'other' groups. The overall incidence of cancer is higher in Māori compared with non-Māori.

3.6.4 Pacific health profile

63% of Pacific people live in the most deprived areas (NZDep 9 and 10). Pacific people's admission rates for avoidable hospitalisation are lower than for Pacific people in the country in all age groups except for the rate of the 1 -14 age group, which is slightly above the national rate. These are however, still significantly above those for 'other' ethnic groups in the district.

Pacific people's admission rates for unavoidable hospitalisations are consistently highest in each of the territorial authorities of the district. Pacific people suffer from heart attacks and angina at a much younger age than 'other' ethnic groups. Admission rates for asthma are very high for Pacific children. Pacific people are affected by chronic obstructive pulmonary disorder (COPD) at a higher rate than 'other' ethnic groups. Diabetes-related hospital admission rates for Pacific people are higher than for 'other' ethnic groups.

3.6.5 Disability profile

The disability population profile information provided below has been sourced from the 2001 New Zealand Disability survey. This survey provides an overview of disability in New Zealand and covers people living in both households and residential care facilities:

- ◆ One in five New Zealander has a disability. This figure has not changed from 1996/97 survey
- ◆ One in five Māori has a disability and the rate for Pacific peoples is one in seven
- ◆ Disability increases with age:

Age group	% reported as having a disability
0 to 14 years	11%
15 to 44 years	12%
45 to 64 years	25%
65 years and over	54%

- ◆ The rates for Māori in some age groups are higher than the national rates. 33% of Māori aged 45 to 64 years reported a disability compared with 25% of the total population in the same age group. 65% of Māori aged 65 years and over reported a disability compared with 54% of the total population and
- ◆ The disability rates for males and females are the same.

3.7 Our Planning Process

The DAP for 2006/07 reflects our commitment to improving the health and independence of the populations we serve. The DAP describes the activities we intend to undertake in order to achieve the strategic goals and objectives identified in the draft DSP. The 2006/07 DAP has a three-year focus for activities to advance priorities and strategies of the DSP (and includes a budget for the three years). The DAP is the primary accountability document of the DHB. External factors influencing the District Annual Plan include:

- ◆ The Operational Policy Framework (OPF) - quasi-regulatory framework for DHBs
- ◆ The Service Coverage Schedule (SCS) – the basket of services DHBs are obliged to fund, provide, or organise for their resident population
- ◆ Indicators of DHB Performance (IDPs) - DHBs' performance is measured, compared and communicated using these indicators
- ◆ The Minister's letter of expectations - the Minister of Health conveys annual expectations to DHBs and the Ministry also issues planning guides each year, which include 'must-haves'.

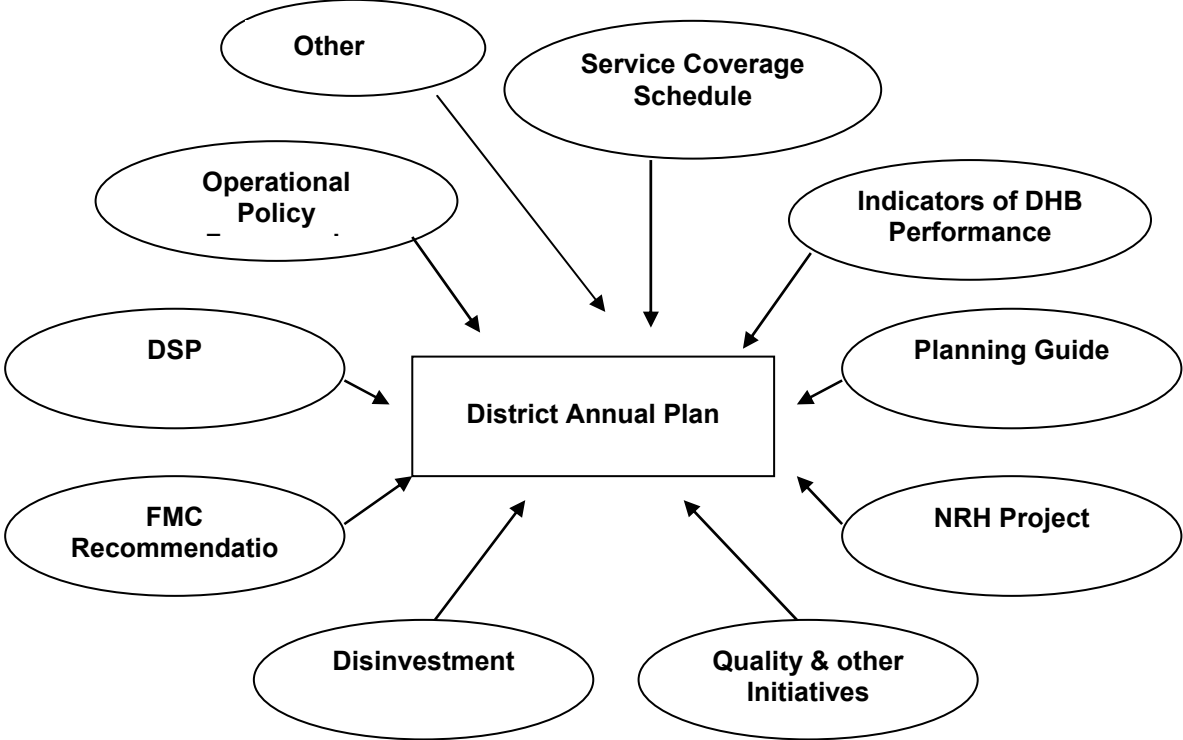
Other external factors influencing the DAP are: priorities developed by various DHBs through District Health Boards New Zealand (DHBNZ); referral trends; and the prioritisation process of other DHBs who refer patients to the DHB (IDF).

Six PHOs are now operational and health promotion, prevention and maintenance work done by these PHOs may assist in reducing avoidable hospitalisation, improving the health of the enrolled population and promoting health issues including self-management. These activities of PHOs will influence the DAP.

Internal factors influencing the District Annual Plan include:

- ◆ priorities of the District Strategic Plan (DSP)
- ◆ change management programmes of the New Regional Hospital Project
- ◆ quality initiatives for the year and other annual objectives.

The influences that guide DAP can be illustrated as below:



The DAP is aligned to the Government’s health and disability strategies, and influenced by the revenue available to the DHB. The DHB is also required to develop a Statement of Intent which is a high-level summary of the DAP.

During 2004, we revised the Health Needs Assessment of our resident population. During 2005 we revised the DSP and consulted with our resident population about the DSP as required by the Act. The DSP was revised based on the Health Needs Assessment, information we have about needs, disparities and provider capability, evidence of service outcome, community feedback and changes in our environment.

3.8 Prioritisation

The prioritisation process is informed by the District Strategic Plan which in turn informs the annual planning processes and budget cycles. It aims to:

- ◆ implement a process for approving changes to the model of service delivery within the provider arm (including new technology and CAPEX proposals where changes in resource allocation are likely to arise)
- ◆ ensure that management processes and decisions are well co-ordinated and properly documented around funding
- ◆ ensure that funding decisions are transparent and are supported by robust analysis, are subject to careful review/consideration, are guided by the principles of the Treaty of Waitangi and by the relevant strategies, and are consistent with the Decision Making Framework.

At a management level, we use a Funding Management Committee (FMC) to operate a prioritisation process, which enables resource allocation for the whole DHB. The types of decisions which are considered by FMC are:

- ◆ The allocation of funding across the DHB as part of the DAP process (including the Price Volume schedule for the HHS)
- ◆ Significant funding initiatives/proposals
- ◆ Service changes requiring new or reallocated resources (in particular core services)
- ◆ Demand driven activity exceeding budget including HHS services with un-contracted volumes
- ◆ Service disinvestments (note contract terminations are not necessarily disinvestments)
- ◆ New technology investments including new procedures and hospital pharmaceuticals. The Medication Review Committee will make recommendations to FMC on the introduction of new HHS pharmaceutical investments
- ◆ CAPEX decisions which imply new services or increased utilisations
- ◆ Policies with increased resource implications
- ◆ Contract negotiation briefs, which are outside of the delegation of the Planning & Funding Management Team.

The FMC recommends funding decisions to the Board where these exceed the delegated authority of the CEO. Disinvestment decisions, which are expected to have significant community impact, are recommended to the Board for decision. The FMC meets monthly or more often if required.

3.9 Collaboration

We work collaboratively with other agencies to perform the DHB's role for the community and government. This collaboration occurs at various levels including strategic and operational. We currently have inter-agency relationships with the Mental Health Commission and other mental health advocacy organisations, disability agencies and Government agencies including Child, Youth and Family, Housing, Education, ACC, the Ministry of Social Development and the Department of Corrections.

We work collaboratively with Wellington City Council, Porirua City Council, Kapiti Coast District Council, Greater Wellington Regional Council, schools, Sports Wellington, SPARC and many other NGOs.

We actively participate in intersectoral forums for key government initiatives such as the youth offending strategy and the prison health project. We also participate in a number of national and regional initiatives to improve health workforce development. These initiatives include

membership of the workforce development sub-group of DHBNZ, the DHBNZ National Leadership and Development programme, and participation in regional human resource processes and the Regional Māori Workforce Plan.

Our relationships with Healthlinks in Porirua and Kapiti are important and strategic relationships. Key directions agreed in the draft DSP ensure their continuing involvement in key projects within their respective regions. In Wellington, we are working very closely with the Wellington City Council and health sector related groups to devise mechanisms for closer collaboration.

3.9.1 National

Ministry of Health

At a national level, we work closely with the Ministry of Health. Contact with the Ministry is predominantly through the designated DHB Account Manager. We actively participate in national projects led by the Ministry of Health, which include:

- ◆ Cancer working party
- ◆ National benchmarking exercise
- ◆ Haemophilia working party
- ◆ Primary care
- ◆ Ministry of Health/Dept of Corrections Working Group
- ◆ Whanau ora
- ◆ Pacific national GMs meetings.

At a national level, we also participate in projects for pricing, and work with the Health Sponsorship Council.

District Health Boards New Zealand (DHBNZ)

All DHBs support DHBNZ and continue to participate in DHBNZ activities. DHBNZ's role is to support DHBs and to provide co-ordination of activity at a national level. DHBNZ maintains links with central agencies and works to confirm sector priorities through the Health Sector Work Plan and the DHBNZ Annual Plan. DHBNZ is active in a range of areas including primary health, workforce development, industrial relations, funding and accountability, service frameworks, pricing and prioritisation tools and information.

DHB Chief Executive Forum

The Chief Executive Officer regularly attends and actively participates in discussion at the DHB CEO forum.

3.9.2 Regional

Regional DHB Forums

There are a number of forums promoting regionalisation across DHB functions and services. Regional DHB Boards meet annually and there are more frequent meetings of regional Chairs/CEOs. There are also more regular meetings of senior managers across the DHBs to promote and implement regional collaboration and co-operation.

Public health

We are working with the Ministry of Health, Wairarapa DHB and Hutt Valley DHB to implement a Regional Public Health Strategy. The aim is to provide an integrated approach to the provision of public health services in the region. Joint planning with Regional Public Health and regular collaborative forums align the work of Regional Public Health with the DHB's priorities, optimising links with PHOs, local government, providers and communities. A key risk around this strategy is ensuring that the Regional Public Health Strategy priorities align with the DHB's priorities.

We are a member of Wellington Regional Public Health Steering Group, which identified the following priorities for service delivery:

- ◆ Tobacco control
- ◆ Active lifestyle and nutrition
- ◆ Alcohol and drug
- ◆ Reducing inequalities
- ◆ Māori community
- ◆ Pacific community
- ◆ Child and youth health

Mental health

Our representative participates in the Central Region Mental Health and Addiction Network (CRMHAN). This group is a key vehicle for achieving a collaborative approach to mental health service planning and delivery amongst the six central region DHBs.

Collaboration with Hutt Valley DHB

At a regional level, we work closely with Hutt Valley DHB to improve quality and service provision for the DHBs' respective populations. Both DHBs work collaboratively on a number of areas including human resources, information management, finance and operations.

Educational institutions

We work closely with a variety of educational providers. In particular, the DHB has developed strong relationships with Massey University, Whitireia Community Polytechnic and the Wellington School of Medicine.

Local Government

There are on-going working relationships with the territorial authorities within the region. The Chairman and CEO regularly meet with the Mayor/CEO of each council to discuss priorities and work programmes implemented to achieve improved health outcomes for the people of this region. This includes input into each council's long-term community priorities. We also participate in the Wellington Leaders' Forum which is a forum for all local territorial authorities and government agencies. We work with the Porirua City Council actively supporting strategic initiatives to improve health and with the Porirua Health Care Cluster. We have had

involvement in the Kapiti Physical Activity steering group led by the Kapiti Coast District Council.

Joint ventures

Central Region's Technical Advisory Services Limited (TAS) was incorporated on 6 June 2001 under the Companies Act 1993. It is wholly owned by the six central region District Health Boards – C&C DHB, Hutt Valley DHB, Wairarapa DHB, MidCentral DHB, Whanganui DHB and Hawkes Bay DHB.

The purpose of TAS is to support the effective functioning of District Health Boards so they can meet the objectives of the New Zealand Health Strategy and the Act. TAS supports DHBs with health information, service planning and external service audit functions. TAS primarily provides support to the Planning and Funding Divisions of the six central region DHBs. In addition, TAS has at times provided co-ordination and analytical support for some other projects such as benchmarking of services.

3.9.3 HealthIntelligence (HIQ Ltd)

During 2004/05, we established HIQ Ltd, which is a joint venture between C&C DHB and Taranaki DHB. HIQ Ltd supports the health and information management strategies of both DHBs, maximising the quality and the quantity of the ICT services delivered for the money that is invested. HIQ provides the highest possible quality of ICT support (tools and advice) to the DHBs and their stakeholders.

3.10 Consultation

We have established a consultation and engagement guideline. This management guideline is available on our website: www.ccdhb.org.nz.

3.10.1 Relating to the community

Interaction with our community occurs on a number of levels. At the governance level the Board members are elected from the community and additional members are appointed by the Minister of Health, including Māori and Pacific members.

We have established a governance relationship with Māori, and there are numerous layers of interaction flowing from that. In addition, the Board's Statutory Advisory Committees have members appointed from the community. We have also established a Pacific Strategic Co-ordination Group to provide expert advice to C&C DHB.

The Board has developed formal relationships with Community Reference Groups, which provide expert knowledge about particular communities. These may be geographic communities such as Porirua, ethnic communities such as the Pacific community, or a community of interest such as people with disabilities.

C&C DHB also works with the Intersectoral Community Action for Health (ICAH) projects in Kapiti and Porirua to improve community engagement in these communities. These ICAH projects are specifically funded by the Minister of Health.

C&C DHB also works alongside a number of community stakeholders across our district. These may be established groups such as Grey Power or health-focused groups such as the Porirua Health Centre of Excellence. C&C DHB employs a community consultation advisor to assist with our engagement with communities. This advisor is particularly focused on building

relationships in the Wellington region, recognising the diverse range of populations in this part of our district.

We will actively engage with providers of health services and look forward to working with them in a co-operative way for the benefit of the population. In areas of important policy development and for significant projects, we anticipate direct community and provider input. This may be in the form of providing opportunities for input on early development of papers/ideas, or to comment on draft papers or to have involvement in working parties. The basis of these relationships will be the sharing of perspectives and information, transparency, mutual respect and understanding.

PHOs are required to actively engage with communities and support community participation in governance, planning, service delivery and evaluation. The result of these processes should be a network of community involvement at all levels of the organisation, from working with the Board on high level strategic decisions to working with staff on details of implementation. The ultimate responsibility for service performance, access and finance rests with the staff, management and Board of the DHB.

3.10.2 Relationship with Māori

The DHB as an agent of the Crown is committed to the principles of the Treaty of Waitangi, in particular Māori participation and partnership in health planning and services, and the protection of Māori well-being. In consultation with the region's Māori population, we have developed a process to ensure an effective governance relationship between Māori and the DHB Board. There is a Māori Partnership Board that advises the Board on a monthly basis in accordance with their agreed work programme. Māori are also appointed to the Board's various Statutory Advisory Committees. This ensures that meaningful representation and consultation occurs with iwi/Māori and also provides opportunities for Māori to influence decision-making.

3.10.3 Advisory groups

We have established advisory groups for Pacific, mental health, older peoples health, youth health and PHOs which guide service development issues and develop priorities for their respective services.

3.11 Pandemic planning

Planning for an influenza pandemic is focused on three broad areas :

- ◆ The management of large numbers of patients with influenza-like illness
- ◆ Support and education for DHB staff who may be afflicted themselves, or who may be caring for influenza patients
- ◆ The other measures needed to continue providing essential health services during a pandemic characterised by an large increase in demand for resources, and a depleted workforce.

The planning is well advanced and is based on the scenario developed by the Ministry of Health. Projects are being undertaken in conjunction with a wide range of health providers - including primary and private providers, key community groups, other emergency services and Civil Defence Emergency Management Groups, and neighbouring District Health Boards.

The Ministry of Health has requested that copies of plans be provided to them by 31 March, and it is expected this target will be met. It is expected that plans will be available for public distribution in the near future following review of our plans in light of an on-going number of national projects.

3.12 Financial Environment and Information

3.12.1 Financial Assumptions

Funding Assumptions	<p>Overall volumes for the Hospital and Health Services (HHS) are not materially different from the price volume schedule (total) for 2005/06. The overall price increase for the HHS is in line with FFT.</p> <p>National prices are to be paid for IDFs and local volumes where applicable in line with FFT.</p> <p>A price uplift of 2.93% has been applied to mental health services.</p> <p>Any increase in expenditure on PHOs driven by further primary care strategy policy implementation by the MoH will be met by the Ministry through wash-ups.</p> <p>Increase in PHARMAC's pharmaceutical nominal budget due to Primary Care Strategy changes will be passed on to DHBs by the Ministry as actual funding increases.</p> <p>Increase in DSS expenditure related to Income & Asset testing policy changes will be fully funded by the MoH and any expenditure over current levels of funding will be funded by washups.</p> <p>Pharmac's proposals to ringfence pharmaceutical rebates/pharmaceutical expenditure and/or carry forward underspends to future periods will not be approved.</p> <p>There will be an agreement reached within the central region to correct the regional mental health services base volume data errors which were used in the IDF calculations.</p>
Depreciation	Rates based on economic life in accordance with the DHB policy.
Capital Charge	8% as per current policy.
New Debt	New debt will be financed by the Crown Health Financing Agency. Capex items not funded from operating cash flow are financed via debt & equity.
Interest Rate	<p>CFA forecast rates are used in the plans are as follows:</p> <p>2006/07 6.85%</p> <p>2007/08 6.85%</p> <p>2008/09 6.85%</p> <p>These rates are for new debt; existing term debt is running at 5.88%.</p>
Foreign Exchange	<p>NZD/USD 0.6600</p> <p>NZD/AUD 0.8700</p> <p>NZD/EU 0.5200</p> <p>Prices should be adjusted where there are known FX clauses providing price variability around the assumptions to be provided. Large assets purchases >\$100k will need individual exchange rate assumptions. Budgeted rates reflect that current exchange rates are over valued.</p>
Supplies	All known price increases are incorporated into this DAP, any inflation increase to be offset by standardisation policy and procedures.

Personnel	<p>Government support for MECA settlement above what was allowed for in DAP within the DHB's FFT.</p> <p>Central allowance for Individual Employment Agreement (IEA) and Collective Agreements negotiated. Budgets to include clinical career pathways and grade step increases.</p> <p>The central allowance is based on HR industrial relation projections for the sector and the DHB specific industry contracts provide a budget to cover all labour cost increase.</p>
Capital Expenditure (CAPEX)	CAPEX is limited to items of an urgent legal and safety nature, minor CAPEX, infrastructure CAPEX and items with a payback under 1.5 years.
New Regional Hospital	The Minister has approved the financing of \$303 Million plus an additional funding of \$43 million to meet escalating costs plus \$42m of capitalised interest to make up total project costs.
DRG ICD version	06/07 policy: ICD 10 v3, AR-DRG v5.0 WIES 11a
Holidays Act	The impact of moving from the statutory 3 to 4 weeks annual leave has been recognised beginning in the 2006/07 year although eligibility to staff is not available till 1 April 2007.
Alterations	Any alteration to this plan will require Funding Management Committee (FMC) (for funding), Capex Review Group (CRG) (for CAPEX) and CEO (for FTE) approval.
Sustainable budget	The budget to contain all cost savings within identified costed initiatives and cost centres.

3.12.1.1 Asset revaluations

Background

The DHB revalued buildings in the 2003/2004 financial year. This led to \$1.7million additional costing for the DHB in 2004/2005 and directly led to the \$1.6 million deficit in that year.

The P&L effects from increased capital charge and depreciation valuations at this time were funded for other DHB's. The capital charge cost was matched by revenue which provided both an accounting and cash flow net breakeven result. While funding for depreciation (as a non-cash entry) provided additional cash to the DHBs, this additional cash was used by DHBs to reduce debt or equity. This same process was used to fund valuation completed in 2005/2006.

Assumption

CCDHB recognises the requirement to receive full revenue funding for capital charge and depreciation of \$1.7 million in 2005/06 and from 2006/07 due to asset revaluations. This is recorded under Other Revenue as the DHB is committed the increase revenue to offset this adverse expense.

3.12.1.2 PSA Settlement

Background

Recent health sector industrial relation negotiations with members of the PSA collective have led to a settlement greater than the DHBs' funding tracks (FFT). DHBs have worked with the Ministry in relation to this settlement and additional funding has been signalled.

At the time of completion of the DAP financials the funding required had not been received or confirmed in the funding package. The total expected by C&C DHB is \$8.8 million from 2006/07.

Assumption

C&C DHB has assumed full revenue funding from 2006/07, of \$8.8 million, for the cost of the PSA settlement over FFT.

3.12.1.3 Non Case Weight (CWD) wash-ups

Background

Currently there is not a provision for addressing over or under delivery of non-CWD volumes against funded levels when delivering to other DHBs. C&C DHB has identified a significant amount of unfunded volumes due to over delivery against the contracted funded volumes.

A process is in place to perform the adjustment for CWD volumes and C&C DHB recognises the same or similar process should be in place for non-CWD volumes. The cost to C&C DHB is approximately \$2.9 million. While C&C DHB has planned for the wash-up process to be in place from 2008/09, work will be undertaken to implement a wash-up process for 2007/08.

Assumption

C&C DHB has assumed a wash-up process to be in place and to receive revenue funding of \$2.9 million for the currently unfunded delivery of non-CWD volumes from 2008/09.

3.12.1.4 Regional Capital Tertiary Premium

Background

The New Regional Hospital Development (NRH) will significantly upgrade the facilities of C&C DHB. This redevelopment will add significant additional fixed assets (\$346 million project cost) to the balance sheet. The funding costs for these assets will be incurred by way of interest, depreciation and capital charge (IDCC). These costs are currently included within population-based funding (PBFF) calculated on an average cost of capital basis. The cost to fund the new facility will be significantly greater than the average cost and therefore C&C DHB will incur cost greater than revenue received.

While C&C DHB's plans recognise a deficit of \$14 million in 2008/09 (as per the NRH business case) this is not the full additional operating and IDCC costs of the NRH. Savings of \$15 million are expected (as per the NRH business case) and have been included in this plan.

It is recognised that C&C DHB is the Central Region Tertiary provider and as such has planned and is upgrading facilities (NRH) to ensure that these services can continue to be provided. However, the improved facilities and improved service delivery will add significant cost to C&C DHB, which should be recognised by the region.

Assumption

C&C DHB has assumed it will receive revenue funding by way of a regional capital tertiary premium, of \$6.0 million from 2008/09 to recognise the cost of the improved regional tertiary facilities.

3.12.1.5 Tertiary Adjustor/Medical & Surgical Prices

Background

Significant work has been undertaken by DHBs and the MoH to review pricing for Medical & Surgical services and to review the appropriate funding mechanisms to replace or remove the

tertiary adjustor currently being funded. The results of this work have not yet been factored into prices.

Assumption

C&C DHB has assumed it will receive additional revenue of \$3.0 million from 2007/08 to recognise the increased prices for medical & surgical volumes after the changes to the tertiary adjustor.

3.12.1.6 Personnel costs

Background

C&C DHB has recognised that to achieve improved efficiencies and reduced cost of service delivery, all costs must be reviewed and savings achieved where appropriate.

Bench-marking, service delivery redesign and reconfigurations, changes to models of care, reduced use of outsourced staff and other initiatives to ensure the efficient use of human resources while maintaining safe and quality service delivery, are among cost-reducing techniques being implemented.

Personnel are a significant portion of the cost to the DHB and therefore make up the major portion of current and future service delivery.

The DHB proposes to maintain FTE levels from the 2006/07 year. This will include changes to current staffing levels as well as a reduction in the use of outsourced staff and will also affect the ability of the DHB to provide additional services.

Assumption

C&C DHB has assumed the maintenance of personnel costs at the level of FFT from 2006/07 though a number of efficiency measures.

3.12.1.7 Haemophilia Blood products

Background

DHBs have recognised that the cost of provision of services to haemophilia patients is being incurred out of proportion to PBFF. While a change to the funding mechanism is being reviewed, C&C DHB are currently unclear how this will be implemented. However, it has been assumed that the unfunded portion of the cost currently being incurred will be removed from the DHB and funded by the NZ blood service through the pooling of all revenue to the blood service from all DHBs.

Assumption

C&C DHB has assumed that the \$2 million unfunded portion of haemophilia blood costs will not be incurred from 2006/07.

3.12.1.8 Water Reservoir

Background

During NRH planning, and emergency management procedure reviews, the supply of water during an emergency situation has been assessed. Previous reliance on Wellington City Council (WCC) water supply, and water supply recovery, has been identified as insufficient or non-existent and therefore does not meet the needs of continued operation of the DHB's facilities and service delivery.

The cost to establish sufficient emergency water supply for the Wellington area has been assessed by the WCC. C&C DHB have been required to contribute \$3 million towards the project which essentially builds a reservoir close to the Newtown hospital site.

The C&C DHB board have approved this essential project but are unable to provide the required funding. The cost of the C&C DHB contribution has not been included in the plan. Asset ownership will be vested in the WCC. Revenue line is also not included, relating to the Board's commitment to obtain non-health revenue for this project.

Assumption

C&C DHB has assumed that \$3 million of additional revenue will be required in 2006/07 to allow the agreed contribution to the WCC water reservoir project and that if the revenue is not received the project will not proceed. Therefore, no cost or revenue has been included.

3.12.1.9 Insurance Premium

Background

C&C DHB has benchmarked insurance premium costs across all DHBs and identified that due to the risks associated with the Wellington region C&C DHB is paying an amount of \$1.6 million (in relative terms) more than all other DHBs.

While C&C DHB has reviewed the risk, insurance cover and investigated all options, to date no significant reduction in the premium has been achieved. A number of requests for additional funding from the MoH to offset this cost have not been successful to date.

The sector is currently reviewing options for self-insurance, combining risk and creating a captive entity to reduce premium costs. C&C DHB has been an active member contributing to, and is committed to supporting this project. C&C DHB also notes that the MoH fully supports this project.

The savings and/or funding target for C&C DHB remains at \$1.6 million and this assumption has been included in the plan. If the C&C DHB's own options to reduce the premium cost plus the DHBs' collective options do not achieve this saving, C&C DHB will again request funding to offset the cost of insurance above the sector benchmark level.

Assumption

C&C DHB has assumed that \$1.6 million insurance cost reduction will be achieved from 2006/07.

3.12.1.10 Materials Management

Background

CCDHB has implemented a number of initiatives associated with purchasing, stock management, standardisation and product usage. These initiatives are expected to save the DHB \$2.6 million mainly in the expenditure area of clinical supplies.

Assumption

C&C DHB has assumed a saving of \$2.6 million on clinical supply costs.

3.12.2 Asset Management Plan

We have been actively working on refining our asset management strategy as part of a collaborative approach by the health sector which the Ministry of Health, DHBNZ and the DHB Chief Financial Officers (CFO) Forum are leading.

A draft asset management plan was completed and presented to the MoH in October 2005. The Board is currently reviewing/updating this plan and is on target to complete this updated asset management plan (AMP) by October 2006 in line with the Ministry's requirements.

An internal steering group has been over-viewing the project including: strategic resource implications, software upgrades, user needs and in particular the encouragement of internal collaboration as a precursor to inter-DHB collaboration as part of a new sector-wide capital investment framework.

The work completed during 2005/06 includes developing AMP at clinical group level and an asset to date has shown that the DHB is well positioned to build on its current asset management infrastructure.

3.12.3 Property Disposal Plan

Porirua - Anticipated disposal: During the 2006/07 financial year

This site is made up from the combination of the old Porirua Mental Hospital site and the old Kenepuru General and Maternity Hospital sites. The rationalisation of these sites to meet the current and perceived future needs of the Board, has resulted in a proposed subdivision into 15 separate lots. Five of these lots totalling 45.7 hectares will be retained. The other ten lots totalling 47 hectares are available for disposal.

The Minister of Health raised a number of concerns about the effect that disposal of this surplus land would have on the continued viability of alternative health suppliers, particularly those who contract part or all of their services to Capital & Coast DHB. Detailed investigation work has established that it is technically feasible to either overcome or at least substantially alleviate the reasons for the concerns as raised. But it has not been possible to identify the availability of the funding needed to implement the works required. The Board's capital budget is fully committed to the New Regional Hospital project and the replacement of obsolete and worn out medical equipment. However, when the Board became aware of the underlying support within the local community for moving the Porirua Hospital Chapel onto land that was to be retained, it endeavoured to facilitate a fund-raising initiative led by local ministers and supported by the Porirua Hospital chaplains. Should this fund-raising be successful it is anticipated that the balance of the cost will be available from within existing budgets.

Blood Centre Building Anticipated disposal: Not before the 2007/08 financial year.

This is a building that was designed and built in 1989/90 specifically for the processing of blood products. Since 1998 it has been leased to the New Zealand Blood Service (NZBS). The current term of the lease expired on 30 June 2005 with a right of renewal for a further 4 years. However NZBS has chosen not to renew its lease either for the 4 year term or for all the space it has historically occupied. This has necessitated negotiating a new lease, but this is yet to be finalised. C&C DHB have already occupied part of the surplus floor space and it is possible that it will be successful in obtaining a new contract that will require the balance of the vacated area.

Keeping the building fully occupied will help with any future disposal, but before that process can be implemented the decision to dispose of the property will need to be ratified. Last year it was thought that it might be possible to transfer the property to another Crown Entity (either the Residual Health Management Unit or to NZBS itself). The disposal process cannot commence until the occupational status of the building has been established

175 Adelaide Road Anticipated disposal: During the 2007/08 financial year.

This property comprises an extensively modified house and a partly covered car sales yard on the balance of the land. It was formerly the outpatient clinic for the sexual health services, but it now houses the Diabetes Service and associated laboratory. It will not be available for disposal until the New Regional Hospital Development is complete and the occupying service is transferred back onto the main hospital campus.

Paraparaumu Hospital Site (Part) - Anticipated disposal: During the 2006/07 financial year

The surplus land comprises the balance of the old Paraparaumu Hospital site not occupied by the new (2003) Kapiti Health Centre. It is 1.3 hectares in area with a redundant District Nurse base covering part.

Following consultation with the resident population and the subsequent Ministerial approval to continue with the disposal process, it has been established that three of the four original lots do in fact have to be offered back to their original owners (or their immediate successors in title). As all the original owners are now deceased, attempts are now underway to locate their successors in title. Should these successors also be deceased (or not wish to re-acquire the property) the land will be entered into the Treaty of Waitangi protection mechanism

No further assets sales other than that of land and buildings mentioned above are anticipated by this plan.

3.12.4 Capital Expenditure

This year's business planning round for CAPEX followed previous patterns, where demand significantly outstripped available funding. A total of \$63m of requests were received for CAPEX for the 2006/07 year (compared to only \$47m requests in the previous year). Requests for the next 5 years totalled \$134m compared with only \$106m projected (for 5 years) last year. Hence, this year's requests for CAPEX funds put additional pressure on limited internal funding available.

This year's CAPEX allocation followed the same process as in the previous year. Each request was supported by a short justification. The plan was reviewed and reduced down to its present value after a detailed process of consultation by the Executive Team and Senior Management Team representing all the service areas. Only items of a legal & safety nature, or essential to service delivery, or essential to support the District Annual Plans (DAP)/District Strategic Plan (DSP) or yielding a very fast payback have been included to be funded from the free/internal cash flow.

As a result of receiving a significantly larger number of high priority items this year, including additions to services &/or new capital expenditure, a separate category of CAPEX items was identified which has been requested to be funded by new Equity. These projects will only be implemented, when additional funding required to cover both CAPEX and operating expenditure for them has been approved/finalised.

3.12.4.1 Key Issues

The CAPEX for 2006/07 requires \$21.5 million (excluding NRH). This is to be fully financed by expected internally generated funds.

Additionally, a further \$21.3 million worth of CAPEX has been identified, which is expected to be funded by new capital as indicated above.

The aim when setting the plan was to provide expenditure that closely matched with the organisation's depreciation while identifying additions which need new capital. The plan has limited the CAPEX to the barest minimum, by postponing some projects to 2007/08 and out years. No provision has been allowed for contingencies or unforeseen breakdown of clinical and other equipment. This poses a degree of risk to the uninterrupted provision of services (and hence to the overall profitability). The DHB hopes to actively manage this risk by critically evaluating each project within the plan prior to final approval and implementation, thus, maintaining a tight rein over funds actually deployed for CAPEX.

The other risk to the plan is the escalation of costs, leading to potentially adverse financial performance to plan, thus eroding the capability to fund the CAPEX via internal cash flow. The DHB will nevertheless actively manage any cost increases to ensure planned results are met.

Due to timing and lead times in obtaining capital items a provision for rollover of \$12.6 million into the 2007/08 year has been made. This rollover will need to be managed carefully to ensure the DHB remains within its cash allocations.

New Regional Hospital

The accumulated expenditure for the New Regional Hospital (NRH) project up to the end of 2005/06 is forecast to be around \$123 million including capitalised interest (COI) of \$8 million. The expenditure forecast for 2006/07 is \$70 million including COI and \$65 million excluding COI. The combined expenditure for 2007/08 and 2008/09 is \$169 million and \$149 million respectively.

Direct funding for this project by the Crown does not include capitalised interest and is consequently financed from operating cash flow and is hence itemised separately.

Asset Management Planning

The Asset Replacement Plan (AMP) which was recently finalised is currently being further developed via an asset stock take and development of AMP's at Clinical Group level, once these are all established the annual capex planning process will be linked to these plans and the financial systems for future planning and asset replacement/allocation.

3.12.4.2 Analysis of 2006/07 CAPEX Plan:

The entire cash flow budget by department and type is summarized below and includes the rollover from the 2005/06 year.

CAPEX funded from internal/free cash-flow** (\$ in millions):				
Category	2006/07	2007/08	2008/09	TOTAL
Ambulatory	0.76	0.38	0.52	1.66
Medical & Surgical Services	8.88	4.32	5.91	19.11
Technical services/Operations	1.27	1.52	1.42	4.21
Womens' Health	1.01	0.12	0.30	1.42
Child Health	2.86	1.23	1.55	5.64
Mental Health	0.50	0.25	0.59	1.34
Clinical Support Services	5.11	0.72	3.04	8.87
Hospital Health Service (HHS)	1.01	0.55	0.35	1.90
ICT/HIQ	7.92	1.70	2.67	12.29
Planning & Funding/Finance/H R/Misc.	2.43	0.04	0.18	2.65
Misc/Minor Capex	2.34	2.17	2.07	6.58
Roll overs B/F(Estimates only)*		12.60	5.00	17.60
Less:Roll overs C/F (Estimates only)	-12.60	-5.00	-3.00	-20.60
TOTAL CAPEX EXCLUDING NRH	21.48	20.59	20.60	62.67
New Regional Hospital (NRH)	64.50	95.23	53.64	213.36
Capitalisation of Interest (NRH)	5.78	8.06	12.01	25.85
TOTAL CAPEX PURCHASES	91.76	123.88	86.25	301.89
Category	2005/06	2007/08	2008/09	TOTAL
Medical Equipment	13.93	13.42	15.26	42.60
IT Equipment	6.53	5.16	2.89	14.59
Building/Civil Works	0.88	1.65	1.79	4.31
Other Equipment	0.14	0.36	0.67	1.17
TOTAL CAPEX EXCLUDING NRH	21.48	20.59	20.60	62.67
New Regional Hospital (NRH)	64.50	95.23	53.64	213.36
Capitalisation of Interest (NRH)	5.78	8.06	12.01	25.85
TOTAL CAPEX PURCHASES	91.76	123.88	86.25	301.89
*Roll-overs brought forward from 2005/06 (\$11.9m) are included in the respective service areas and pending confirmation of actual amounts in July 2006.				
** Includes two projects which require additional funding (reflected in the list of Capex with additional funding) - reflected here, as they were deemed "committed projects".				

ROLLOVER – Capex not spent as of 30 June from 2005/06

- ◆ \$11.9m (subject to revision based on actual rollovers as at 30 June 2006)

The \$11.9m relates to projects that are expected to be in progress and committed as of 30 June 2006. It includes the following projects detailed in the previous year's business plan:

- ◆ Anaesthesia Workstations x 2 (Medical/Surgical) - \$300k
- ◆ Anaesthesia Workstations x 4 (Medical/Surgical) - \$150k
- ◆ Telemetry Unit for Cardiothoracic (Medical/Surgical) - \$103k
- ◆ Linear Accelerator Replacement Project (prior year's unspent balance) - \$100k
- ◆ Neurosurgery Image Guidance Navigation System (Medical/Surgical) - \$520k
- ◆ Clean room for Stem Cell Transplantation Unit (Medical/Surgical) - \$175k

- ◆ Replacement Patient Monitoring Equipment for Kenepuru Post Anaesthesia Care Unit (PACU) - \$100k
- ◆ ENT Theatre Microscopes (Medical/Surgical) - \$111k
- ◆ Ultrasound PIA Fetal Database (Women's Health) - \$100k
- ◆ Replacement Infant Incubators (Child Health) – \$280k
- ◆ Genie Database: Clinical & Laboratory (Child Health) - \$205k
- ◆ Replacement Incubators (Child Health) - \$300k
- ◆ Replacement Infusion Pumps (Child Health) - \$150k
- ◆ Replacement of the Digital Image Analysis System “Cytovision “ at genetics (Child Health) - \$460k
- ◆ Relocation/Replacement of Ward 27 (Mental Health) - \$250k
- ◆ Roche LightCycler Lease due for renewal in Apr 2006 (Laboratories) - \$110k
- ◆ Replacement of the CT (Back-up unit) - \$1,300k
- ◆ IT Infrastructure CAPEX (prior year's unspent balance) - \$1,282k (also included in and described in detail below)
- ◆ EHR/PMS Replacement (Hospital Health Services) - \$1,471k
- ◆ HR Online (Corporate) - \$431k

3.12.4.3 CAPEX Overview

NEW PROJECTS FOR 2006/07 (FINANCED FROM INTERNAL FUNDS)³:

REPLACEMENT OF KENEPURU ENDOSCOPY EQUIPMENT - AMBULATORY \$240K

The purchase will replace the current endoscopes at Kenepuru Hospital, which are at the end of their useful life. Endoscopic equipment is essential to the provision of gastrointestinal endoscopy.

- ◆ Completion – 3rd Quarter

REPLACEMENT OF DURESS SYSTEM - MENTAL HEALTH \$150K

This project is to replace the duress system at the Haumietiketike National Unit which houses 11 intellectually disabled offenders with challenging and complex behaviours. The unit requires replacement of its existing duress system.

- ◆ Completion – 1st Quarter

EQUIPMENT FOR COMMUNITY LABORATORY CONTRACT - LABORATORY \$2,124k

This is to purchase additional equipment required to support service delivery if C&C DHB's joint proposal for tender of community laboratory services is successful. This process will see a change in arrangements for this group of services. C&C DHB is submitting a response to the RFP in a joint arrangement with Hutt Valley DHB and other strategic partners. RFP applies to volumes from October 2006.

- ◆ Completion – 2nd Quarter

CAPITAL MAINTENANCE PROJECTS – TECHNICAL SERVICES \$890K

These are estimated costs to meet essential repair and maintenance work (which are of a capital nature), as most of the building and plant are over 20 years old. This would ensure

³ Note: Part of the capital expenditure for these projects will be incurred in 2007/08 (ie. as part of the \$12.6 million roll-over into 2007/08)

timely action is taken to keep essential infrastructure operating, thus minimising the risks posed to the provision of uninterrupted patient care at the DHB.

- ◆ Completion – 1st, 2nd, 3rd & 4th Quarters

COMPLAINTS & REPORTABLE EVENTS SOFTWARE PROGRAMME – QUALITY UNIT \$165K

This project is to purchase the RL Solutions software package to replace the current Access 97 database. This will increase ability to cope with surges in reporting and provide data with integrity. The complaints and reportable event processes are a vital part of the organisation's risk management strategy and are subject to legal requirements contained in several relevant Acts of Parliament and contract requirements with MoH.

- ◆ Completion – 1st Quarter

TREATMENT PLANNING SYSTEM LICENCES – CANCER CENTRE \$145k

Purchase of 2 additional licences to the Radiation Treatment Planning System to cope with increasing patient numbers, radiation doses and complexity of treatments. The radiation treatment planning system is an essential clinical system that is used to design radiotherapy treatments for 98% of patients having radiation treatment in the Wellington Cancer Centre.

- ◆ Completion - 1st Quarter

EMERGENCY TRANSPORT SYSTEM – CHILD HEALTH \$220K

This is to purchase 2 Neonatal Emergency Transport Systems to replace 2 units that are due for replacement. The Neonatal Emergency Transport System is a purpose built, totally integrated, self-contained mobile NICU used to retrieve or transport sick infants from one hospital/unit to another.

- ◆ Completion – 3rd Quarter

ULTRASOUND MACHINE REPLACEMENT – RADIOLOGY \$467K

Purchase of 2 ultrasound machines to replace current machines that are at the end of their economic life. These machines are required for the provision of a high quality and timely diagnostic service to all patients and referrers throughout the hospital and externally to ACC and community-referred radiology referrals. The machines are transferable to the New Regional Hospital.

- ◆ Completion – 3rd Quarter

MOBILE X-RAY MACHINE REPLACEMENT – RADIOLOGY \$110K

This proposal is to replace 2 old mobile x-ray machines which are at the end of their economic life. These machines are used to x-ray patients who are too unstable to be transported to radiology and are a core component of the Radiology Service's Mass Casualty Plan. Replacement will ensure continuity of service and maintenance of legislative requirements of the National Radiation Laboratory.

- ◆ Completion – 2nd Quarter

GENERAL X-RAY ROOM REPLACEMENT – RADIOLOGY \$160K

Replace the oldest of the three plain film imaging equipment used in Radiology for outpatient and community-referred radiology. Replacement of the Room 3 general X-ray room is consistent with the strategic direction for the Radiology Service as it will allow for the continuation of a high quality and timely diagnostic service to plain film radiography referrers. It is transferable to the NRH or ED Radiology.

- ◆ Completion – 2nd Quarter

PORIRUA CHAPEL RELOCATION – OPERATIONS \$295K

This project is to relocate the existing Porirua Chapel from Chapel Rd to Upper Main Drive for mental health site use. A cost and scoping study has been developed already. The feasibility of the relocation has been proven. This is part of satisfying the requirement of the community consultation process and the Minister's request prior to disposal of the Porirua site.

- ◆ **Completion – 2nd & 4th Quarters**

USER DEVICE GROWTH – ICT/HIQ \$1,954K

Purchase of critically needed end user devices to support departmental growth and increased usage. This includes; terminals, PC's, laptops, monitors, PDA's, data projectors, printers, video conferencing, and any other ICT-related equipment that maybe required by the business. It also includes the back-end equipment including servers, software licenses and other required infrastructure required to run these devices. This project also has links with the approved Electronic Health Record and PACS projects implementations.

- ◆ **Completion – 1st, 2nd, 3rd & 4th Quarters**

IT INFRASTRUCTURE UPGRADE – ICT/HIQ - \$2,897K

This is the 5th year of the 5-year IT plan approved in 2002/03 to upgrade the IT infrastructure. The project will ensure that the DHB has the infrastructure required to maintain basic information needs now and in the immediate future. This will enable a higher level of service delivery, sound management and delivery of internet and intranet facilities, and delivery of hand-held remote applications.

- ◆ **Completion – 1st, 2nd, 3rd & 4th Quarters**

DEVELOPMENT AND TEST ENVIRONMENT – ICT/HIQ - \$187.5K

This proposal is focused at creating a development and staging environment suitable for each type of application currently being developed or supported by ICT.

- ◆ **Completion – 1st Quarter**

NEW GL / ASSET MANAGEMENT / MATERIALS MANAGEMENT SYSTEMS – CORPORATE \$1,500K

This is the 2nd year of a two year programme to replace C&C DHB's financial and materials management systems. The current legacy systems are supported at minimum levels by the vendors and are difficult to modify and integrate with other systems due to their age and technology. Access to financial and materials management information is critical to decision-making, and with the current systems this had been a challenge for a considerable period of time. The key outcomes are as follows:

- ◆ **To provide an effective resource management tool for C&C DHB in the 'procure to pay' process**
- ◆ **To provide improved and new functionality to support sound financial advice to the business**
- ◆ **To improve online resource planning and asset management capability, and**
- ◆ **To provide necessary support to realise efficiency benefits of technology developments**
- ◆ **Completion – 2nd Quarter**

INTER-RAI ROLL OUT – PLANNING & FUNDING \$142K

This is to provide a longer-term contract with the application supplier for inter-RAI incorporating increasing users, some application development, and purchase of appropriate servers to host the application and provide disaster recovery. The Inter-RAI is the core tool for the new Care Manager Service that is being expanded through 2005/06, and the Care Co-ordination Centre that went live in September 2005.

- ◆ **Completion – 1st Quarter**

REPLACEMENT OF ANAESTHESIA WORKSTATION – MED/SURG SERVICES \$1,676K

The purchase will replace 10 of the current systems which are at the end of their economic life. Anaesthesia workstations are essential equipment for the provision of anaesthetic services. It is a mobile piece of equipment which can be moved to the NRH.

- ◆ Completion – 1st & 2nd Quarters

CATH LAB PROCESSOR UNIT – MED/SURG SERVICES \$250K

Purchase of an additional electronic digital image processor to cope with rising demand for inpatient angiography by our tertiary referrers.

- ◆ Completion – 2nd Quarter

WARD 31 SDU MONITORING EQUIPMENT REPLACEMENT – MED/SURG SERVICES \$372K

This is to replace the current SDU monitoring equipment which is at the end of its useful life. It is used to monitor cardiac and thoracic surgery patients.

- ◆ Completion – 1st Quarter

CAVITRONIC ULTRASONIC SURGICAL ASPIRATOR (CUSA) REPLACEMENT – MED/SURG SERVICES \$350K

This purchase will replace the current CUSA which is at the end of its economic life. The CUSA (Cavitronic Ultrasonic Surgical Aspirator) is a sophisticated piece of equipment which utilises ultrasonic vibration to break up hard tumours allowing them to be removed by suction aspiration. This is basic equipment used in neurosurgery for excising brain and spinal tumours.

- ◆ Completion – 1st Quarter

THEATRE INSTRUMENT REPLACEMENT – MED/SURG SERVICES \$100K

This project is to replace ageing general theatre instrumentation. Surgical instruments are essential in ensuring the provision of surgical services.

- ◆ Completion – 2nd Quarter

THEATRE MANAGEMENT SYSTEM (ORSOS) UPGRADE/REPLACEMENT – MED/SURG SERVICES \$120K

Upgrade or replacement of the current theatre management information system in order to be more compatible with new IT platforms. A theatre management system is essential for operational requirements for efficient theatre management and to supply essential data to the organisation on the management of patients within the service.

- ◆ Completion – 1st Quarter

IMAGE INTENSIFIER – MED/SURG SERVICES \$250K

This proposal is to purchase an additional image intensifier to cope with increasing workload. The image intensifier is an essential piece of equipment used inter-operatively to take X-rays of objects placed inside the body or in fractures.

- ◆ Completion – 2nd Quarter

REPLACEMENT NEONATAL INFORMATION MANAGEMENT SYSTEM (NIMS) / PERINATAL INFORMATION MANAGEMENT SYSTEM (PIMS) DATA SYSTEMS – WOMEN'S HEALTH \$370K

Purchase of an information management system that will replace both the above ageing systems.

The new database will interface with the planned patient management systems and Electronic Health Records (EHR). A perinatal and neonatal information management system is basic to any tertiary maternity and neonatal service for clinical information.

- ◆ Completion – 4th Quarter

REPLACEMENT COLPOSCOPY DATABASE – WOMEN’S HEALTH \$170K

This is to replace the current Access 97 database with a new database which interfaces with the planned patient management systems and Electronic Health Records (EHR). Replacement will enable the capture of all the information required to report on the Women’s Health Colposcopy contract as required by the Ministry.

- ◆ Completion – 4th Quarter

PHYSIOLOGICAL MONITORS – CHILD HEALTH \$180K

Replacement of aged monitors in the Neonatal Intensive Care Unit (NICU). This forms part of a planned move over 5 years to replace old/obsolete monitors and purchase additional monitors in a phased manner. A physiological monitor is a multi-parameter monitor with smart alert device that identifies physiological deterioration before it becomes clinically apparent. These are essential to the provision of the child health service.

- ◆ Completion – 2nd Quarter

PURCHASE NEONATAL VENTILATORS – CHILD HEALTH \$140K

This project is to replace old ventilators in NNU. This is part of a 5 year plan to replace old/obsolete ventilators and also to purchase an additional unit. The neonatal ventilator is a dedicated life-support machine which is specially designed to meet the many and varied challenges that face clinicians when caring for the tiniest and most difficult to treat babies.

- ◆ Completion – 3rd Quarter

LARGE VOLUME INFUSION DEVICES – CHILD HEALTH \$212.5K

Purchase of large volume infusion devices to replace old units. Volumetric infusion devices are designed to provide a safe, reliable and accurate I/V infusion therapy that is easy to use and easy to maintain.

- ◆ Completion – 1st Quarter

AUTOMATED TB SYSTEM – LABORATORY \$110K

This purchase is to replace the laboratory’s BD Bactec TB 460 machine with a BD MGIT 960 TB Culture System. This equipment is used to identify tuberculosis and minimises the time it takes to detect positive cultures. Isolation of tuberculosis is essential for susceptibility testing, required for identification of antibiotic resistant strains. Supports prompt initiation of appropriate treatment by the respiratory service.

- ◆ Completion – 4th Quarter

PATIENT BED REPLACEMENT – HOSPITAL HEALTH SERVICES (HHS) \$400K

This is Stage 3 of the 3 stage project to replace patient beds within C&C DHB. The project will ensure that the DHB has the required number of beds to maintain basic hospital needs now and in the immediate future. This will allow a higher level of service delivery and sound management.

- ◆ Completion – 1st Quarter

DATA WAREHOUSE – BUSINESS INFORMATION OFFICE \$490K

To implement a data warehouse that is specifically structured to enhance querying and reporting for DHB data collected in transaction-based systems. The new Electronic Health

Records (EHR) will require data to be pulled from outside sources. As from 1 July 2006 there is a new data requirement from the MoH that all non-admitted activity is submitted to a national collection. This requirement requires purchase units to be derived on each attendance and this business transformation is best carried out in a data warehouse environment.

NEW ITEMS TO BE FUNDED IN 2006/07 ONLY IF ADDITIONAL FUNDING/REVENUE IS OBTAINED:

CAPEX funded from additional funds (Equity/Debt):				
Category	2006/07	2007/08	2008/09	TOTAL
Ambulatory	0.24	0.06		0.30
Medical & Surgical Services	7.81	1.05		8.86
Mental Health	10.00	5.00		15.00
Clinical Support Services	2.22			2.22
Hospital Health Service (HHS)	0.68			0.68
Planning & Funding/Finance/H R/Misc.	0.38			0.38
TOTAL ADDITIONAL CAPEX	21.34	6.11	0.00	27.44
Category	2005/06	2007/08	2008/09	TOTAL
Medical Equipment	10.28	1.11		11.38
IT Equipment	1.06	0.00		1.06
Building/Civil Works	10.00	5.00		15.00
Other Equipment				0.00
TOTAL ADDITIONAL CAPEX	21.34	6.11	0.00	27.44

NEONATAL HEARING SCREENING EQUIPMENT – AMBULATORY \$150K

Purchase 6 hearing screening devices for the proposed C&C DHB Newborn Hearing Screening Program, which is a combined initiative of the audiology, otolaryngology and neonatology departments.

SCOLIOSIS SPINAL MONITORING EQUIPMENT – MED/SURG SERVICES \$130K

This is to purchase new Intra-operative Spinal Cord Monitoring Equipment for the orthopaedic department to improve quality of patient care. Intra-operative spinal cord monitoring has become the international gold standard.

THIRD LINEAR ACCELERATOR – MED/SURG SERVICES \$4,950K

This proposal is to purchase a 3rd linear accelerator and make associated service configuration changes to increase radiation treatment capacity to meet demand. The Planning & Funding Department and the National Cancer Treatment Working Party use population-based models to define the demand for radiation treatment. Population growth and rising cancer incidence mean the demand for radiation treatment will continue to increase.

HDR BRACHYTHERAPY SERVICE PHASE 1 & 2 – MED/SURG SERVICES \$2,300K

Purchase clinical equipment and create an advanced procedure room for the provision of a High Dose Rate (HDR) Brachytherapy Service. Brachytherapy (BT) is the administration of radiation from a radiation source or device placed in close proximity to a tumour. From 2006/07 C&C DHB will be expected to provide HDR BT services for gynaecological cancers for the people served by Midcentral and C&C DHBs, and for prostate cancer and other indications, excluding breast cancer, for Midcentral, C&C DHBs, and for the South Island DHBs. Additional revenue will be required, including from other DHBs, to fund this new service.

NAVIGATION KNEE EQUIPMENT/COMPUTER – MED/SURG SERVICES \$150K

To purchase navigation knee equipment and computer for total knee joint replacement surgery. Navigation assisted knee procedures have been established to provide precise bone cuts during total knee joint replacements. This provides minimal loss of bone, adequacy and balanced placement of knee prosthesis. It allows for less invasive surgery, better patient care and quicker recovery.

INSTRUMENT TRACKING SYSTEM FOR STERILE PRODUCTION CENTRE (SPC) – MED/SURG SERVICES \$200K

This is to replace the current ageing instrument tracking system with a Quality Control Total Traceability Instrument Tracking System, which will allow instrumentation to be tracked from purchase to end of life and through its daily usage. This is essential to ensure effective management, distribution, tracking and planning of expenditure for instrumentation, staffing and department operation is made.

RELOCATION/REPLACEMENT OF WARD 27 – MENTAL HEALTH \$10,000K

This is to upgrade the Mental Health Acute Ward to address and minimise risk posed to the DHB. The DHB is in close contact with the MoH in regard to its implementation and funding.

CAP-PLAN CAPACITY MANAGEMENT SYSTEM IMPLEMENTATION – CORPORATE \$381K

Implementation of the CaP-Plan bed management system. This will provide the organisation with a system to assist with capacity planning and forecasting, managing staffing and resources to meet acute and elective inpatients and therefore support maximising the efficient use of resources.

INTEGRATED LABS REPOSITORY – CLINICAL SUPPORT SERVICES \$100K

C&C DHB and HVDHB are currently undergoing a joint request for proposal process for an integrated community laboratory service. An integrated laboratory data repository is required to support the successful applicant with an infrastructure that supports the integration of laboratory data across HVDHB and C&C DHB. This proposal is for the integrated laboratory data repository to be jointly established by HVDHB and C&C DHB.

NEW WEB-BASED ORDERLY SYSTEM – HOSPITAL HEALTH SERVICES (HHS) \$190K

Purchase an ORDS dispatch system with improved functionality. The proposed redevelopment would include a web-based “ordering” facility which would be accessible from networked PCs and portable devices throughout the hospital campus. This would ensure that orderly services are managed more efficiently and effectively.

3.12.5 Debt & Equity

Equity drawing

Equity is drawn in the plan as follows:

Equity Type	2006/07	2007/08	2008/09	Total
Equity for Capex	\$15m	\$6m		\$21m
Equity for NRH Project		\$14m		\$14m
Equity Receivable(NRH)		\$16m	\$53m	\$69m
Equity - Deficit support			\$14m	\$14m
Total	\$15m	\$36m	\$67m	\$118m

Equity is drawn for Capex items which are over and above base depreciation. Equity is drawn for the NRH so that the project is financed with the maximum amount of debt v equity. The P&L deficit in 2008/09 is financed by equity.

3.12.6 Borrowing

The net interest cost on the Core CHFA debt of \$170 million is currently at 5.88%, and the plan assumes new debt is financed at 6.85%.

A \$196 million facility with the CHFA is in place to finance the NRH project and \$55 million was drawn against this as at March 2006.

Future drawings under this facility contain a number of conditions precedent which need to be satisfied prior to any further debt draw down, one being a sign off of this DAP.

A \$35m working capital facility is in place with the ASB Bank which provides temporary funding for the NRH project till term finance can be obtained from the CHFA.

An on-demand equity receivable of \$86 million from the MoH is also available to finance the NRH.

This receivable is drawn at the conclusion of the project in line with agreement of the MoH, and has a shielding effect on the capital charge payable, with the charge not payable until drawn.

A receivable balance of \$17 million remains at 30 June 2009 and represents the final payment due on the NRH project to the current budget of \$346m.

3.12.7 Gearing and Financial Covenants

The Balance sheet has a covenant that limits the Debt to Debt plus Equity ratio to a maximum of 65%. The plan has the following 30 June levels:

Financial Covenant	2005/06	2006/07	2007/08	2008/09
Debt/Debt plus Equity	60%	61%	63%	62%

While the limit is 65%, headroom is allowed to cater for seasonal variations and unforeseen financial events.

The plan first draws debt to maintain ratios at close to limits and then more expensive equity to maintain balance sheet covenants.

The CHFA have a cash flow covenant which essentially tests whether operating cash flow is adequate to cover capex, and exempts any new capex, which is covered by debt or equity. Given that depreciation in the plan exceeds base capex and the P&L is running at breakeven for the first two years with the \$14million deficit in the 2008/2009 year covered by deficit support, the ratio is thus compliant.

The ASB Bank has the same balance sheet ratio and we are currently negotiating with them an operating or cash flow covenant.

3.12.8 Asset Revaluations

All buildings, plant and equipment and land are to be revalued at 30 June 2006. It is difficult to determine what the outcome will be from these valuations until the valuations are complete.

The implications to equity can be quite large, and consequently have impacts on the level of capital charge payable and the gearing of the balance sheet, which affects the mix of debt and equity. The plan assumes a write up in buildings and land and this is discussed in the financial assumptions section of this plan.

The opening equity of the plan may alter materially and consequently the DHB reserves the right not to be penalised through inaccurate budget estimates of the capital charge payment

due to changes in the underlying the equity balance that is beyond its control at time of writing this plan.

3.12.9 Assumptions

- ◆ \$69 million of the \$86 million crown equity receivable is collected in 2006/07 & 2008/09 with the balance of \$17m drawn in 2009/10.
- ◆ The payment of the Ministry of Health revenue is in the month in which the services are provided.
- ◆ The plan assumes the Crown Financing Agency as the DHB's sole banker will be available to meet the funding requirements of the DHB including the NRH project.
- ◆ The Board has a working capital facility with the ASB bank and this is limited to one month's provider's revenue, being \$35 million, to manage fluctuating cash flow needs for the DHB and the NRH project.
- ◆ Deficit support is available to cover the operating deficits in 2009/10, amounting to \$14 million.

3.12.10 Accounting policies

The accounting policies adopted are consistent with those used in the prior year. A full statement of accounting policies is contained in the 2006/07 – 2008/09 Statement of Intent.

3.13 Financial Statements

3.13.1 Forecast Statements of Financial Performance

Capital & Coast DHB					
Statement of Financial Performance					
Budget for the Three Years Ending 30 June 2009					
	Actual	Forecast	Plan	Plan	Plan
	2004/05	2005/06	2006/07	2007/08	2008/09
	(000s)	(000s)	(000s)	(000s)	(000s)
REVENUE					
Government and Crown Agency Sourced	542,184	576,908	612,083	641,347	668,525
Patient / Consumer Sourced	2,797	2,736	3,375	3,095	3,096
Other Income	14,086	15,502	26,688	24,273	24,334
TOTAL REVENUE	559,067	595,146	642,146	668,715	695,955
OPERATING COSTS					
<i>Personnel Costs</i>					
Medical Staff	62,685	69,779	72,924	75,270	77,853
Nursing Staff	79,628	88,372	104,957	108,335	112,052
Allied Health Staff	27,967	31,930	38,993	40,248	41,629
Support Staff	5,465	5,849	6,071	6,267	6,482
Management / Administration Staff	37,860	38,017	36,872	38,194	39,468
Total Personnel Costs	213,605	233,947	259,817	268,314	277,484
<i>Clinical Costs</i>					
Outsourced Services	9,839	9,898	8,075	7,696	7,746
Clinical Supplies	74,083	78,920	73,484	77,245	81,284
Total Clinical Costs	83,922	88,818	81,559	84,941	89,030
<i>Other Operating Costs</i>					
Hotel Services, Laundry & Cleaning	9,117	10,014	9,283	10,161	10,237
Facilities	22,471	11,594	13,462	26,122	43,309
Transport	2,866	3,074	2,945	3,190	3,246
IT Systems & Telecommunications	11,124	16,616	16,180	17,895	17,054
Interest & Financing Charges	9,762	9,293	10,467	14,015	19,360
Professional Fees & Expenses	2,902	2,517	2,582	2,318	2,343
Other Operating Expenses	6,903	6,004	6,817	7,049	7,106
Democracy	658	521	537	697	549
Provider Payments	197,359	212,613	225,457	233,121	240,312
Internal Allocations	(0)	(3)	-	-	-
Total Other Operating Costs	263,162	272,243	287,730	314,568	343,516
TOTAL COSTS	560,689	595,007	629,106	667,823	710,030
NET SURPLUS / (DEFICIT)	(1,622)	139	13,040	892	(14,075)

Capital & Coast Provider		Actual	Forecast	Plan	Plan	Plan
Statement of Financial Performance		2004/05	2005/06	2006/07	2007/08	2008/09
Budget for the Three Years Ending 30 June 2009		(000s)	(000s)	(000s)	(000s)	(000s)
REVENUE						
Government and Crown Agency Sourced		22,256	22,337	30,553	29,485	29,511
Patient / Consumer Sourced		2,797	2,736	3,375	3,095	3,096
Other Income		13,994	15,500	23,851	24,272	24,334
Funder Arm Sourced		314,696	337,696	353,652	373,528	393,395
TOTAL REVENUE		353,743	378,269	411,431	430,380	450,336
OPERATING COSTS						
<i>Personnel Costs</i>						
Medical Staff		62,681	69,779	72,924	75,270	77,853
Nursing Staff		79,628	88,372	104,957	108,335	112,052
Allied Health Staff		27,967	31,930	38,993	40,248	41,629
Support Staff		5,465	5,849	6,071	6,267	6,482
Management / Administration Staff		35,609	35,813	34,771	35,903	37,134
Total Personnel Costs		211,350	231,743	257,716	266,023	275,150
<i>Clinical Costs</i>						
Outsourced Services		9,411	9,304	7,587	7,070	7,120
Clinical Supplies		74,082	78,918	73,484	77,245	81,284
Total Clinical Costs		83,493	88,222	81,071	84,315	88,404
<i>Other Operating Costs</i>						
Hotel Services, Laundry & Cleaning		9,096	9,996	9,267	10,144	10,220
Facilities		22,328	11,470	13,314	25,998	43,185
Transport		2,815	2,992	2,866	3,107	3,163
IT Systems & Telecommunications		11,082	16,571	16,146	17,856	17,014
Interest & Financing Charges		9,762	9,293	10,467	14,015	19,360
Professional Fees & Expenses		2,272	2,089	2,207	1,940	1,965
Other Operating Expenses		6,768	5,889	6,715	6,919	6,977
Democracy		404	398	442	601	453
Internal Allocations		(2,279)	(2,353)	(2,426)	(2,392)	(2,392)
Total Other Operating Costs		62,248	56,345	58,998	78,188	99,945
TOTAL COSTS		357,091	376,310	397,785	428,526	463,499
NET SURPLUS / (DEFICIT)		(3,348)	1,959	13,646	1,854	(13,163)

Capital & Coast Governance & Funding Administration					
Statement of Financial Performance					
Budget for the Three Years Ending 30 June 2009					
	Actual	Forecast	Plan	Plan	Plan
	2004/05	2005/06	2006/07	2007/08	2008/09
	(000s)	(000s)	(000s)	(000s)	(000s)
REVENUE					
Funder Arm Sourced	5,297	5,232	5,257	5,213	5,306
TOTAL REVENUE	5,297	5,232	5,257	5,213	5,306
OPERATING COSTS					
<i>Personnel Costs</i>					
Medical Staff	3	-	-	-	-
Nursing Staff	0	1	-	-	-
Allied Health Staff	0	-	-	-	-
Support Staff	0	-	-	-	-
Management / Administration Staff	2,252	2,204	2,101	2,291	2,334
Total Personnel Costs	2,255	2,205	2,101	2,291	2,334
<i>Clinical Costs</i>					
Outsourced Services	427	593	488	627	627
Clinical Supplies	1	2	-	-	-
Total Clinical Costs	428	595	488	627	627
<i>Other Operating Costs</i>					
Hotel Services, Laundry & Cleaning	20	19	16	17	17
Facilities	142	124	147	123	123
Transport	51	82	79	83	83
IT Systems & Telecommunications	43	44	34	39	39
Interest & Financing Charges	-	-	-	-	-
Professional Fees & Expenses	629	428	376	378	378
Other Operating Expenses	136	114	102	130	130
Democracy	256	122	94	96	95
Internal Allocations	2,279	2,350	2,426	2,392	2,392
Total Other Operating Costs	3,556	3,283	3,274	3,258	3,257
TOTAL COSTS	6,239	6,083	5,863	6,176	6,218
NET SURPLUS / (DEFICIT)	(942)	(851)	(606)	(963)	(913)

Capital & Coast Funds Statement of Financial Performance Budget for the Three Years Ending 30 June 2009	Actual 2004/05 (000s)	Forecast 2005/06 (000s)	Plan 2006/07 (000s)	Plan 2007/08 (000s)	Plan 2008/09 (000s)
REVENUE					
Government and Crown Agency Sourced	513,799	547,646	577,871	606,222	633,370
TOTAL REVENUE	513,799	547,646	577,871	606,222	633,370
OPERATING COSTS					
<i>Other Operating Costs</i>					
Provider Payments	508,227	546,008	575,187	603,349	630,408
Internal Allocations	2,904	2,606	2,685	2,873	2,962
Total Other Operating Costs	511,131	548,614	577,872	606,222	633,370
TOTAL COSTS	511,131	548,614	577,872	606,222	633,370
NET SURPLUS / (DEFICIT)	2,668	(968)	(1)	0	(0)

3.13.2 Forecast Statements of Financial Position

Capital & Coast DHB						
Statement of Financial Position						
Budget for the Three Years Ending 30 June 2009						
		Actual	Forecast	Plan	Plan	Plan
		2004/05	2005/06	2006/07	2007/08	2008/09
		(000s)	(000s)	(000s)	(000s)	(000s)
Non Current Assets						
	Land	20,161	26,025	26,025	26,025	26,025
	Buildings	104,551	164,873	154,934	144,090	364,973
	Clinical Equipment	24,362	19,310	35,375	39,397	79,550
	Information Technology	6,840	9,121	13,608	7,959	5,525
	Work in Progress (Incl NRH)	60,977	57,344	122,626	230,910	10,000
	Other Fixed Assets	3,437	4,768	4,430	3,642	3,354
	Investment in Associates	2,134	9,046	14,101	17,980	20,875
Total Non Current Assets		222,462	290,487	371,099	470,003	510,302
Current Assets						
	Cash	(30,460)	-	-	-	-
	Prepayments	468	319	322	327	331
	Accounts Receivable	29,022	27,470	26,445	30,298	34,546
	Inventories	4,609	5,692	5,692	5,692	5,692
	Equity Receivable	86,000	86,000	86,000	70,000	17,000
	Other Current Assets	4,382	4,463	4,463	4,463	4,463
Total Current Assets		94,021	123,944	122,922	110,780	62,032
Current Liabilities						
	Trade Creditors & Accruals	35,561	40,714	41,923	43,924	46,072
	Current Provisions & Payables	26,984	28,098	30,098	32,099	34,099
	GST & Tax Provisions	6,035	4,333	2,656	3,916	4,516
	Current Private Sector Debt	11,095	-	3,567	-	-
	Current Crown Debt - CHFA	-	53,000	113,433	-	-
	Capital Charge Payable	470	728	500	696	1,157
Total Current Liabilities		80,145	126,873	192,177	80,635	85,844
Net Current Assets		13,876	(2,929)	(69,255)	30,145	(23,812)
NET FUNDS EMPLOYED		236,338	287,558	301,844	500,148	486,490
Term Liabilities						
	Non Current Private Sector Debt	147	31,363	15,000	15,000	15,000
	Non Current Crown Debt - CHFA	104,000	117,000	119,609	297,023	283,440
	Restricted & Trust Funds Liability	114	126	126	126	126
	Non Current Provisions & Payables Personnel	3,950	3,941	3,941	3,941	3,941
Total Term Liabilities		108,211	152,430	138,676	316,090	302,507
Net Assets		128,127	135,128	163,168	184,058	183,983
General Funds						
	Crown Equity	205,243	206,243	221,242	241,242	255,242
	Revaluation Reserve	17,061	22,925	22,925	22,925	22,925
Retained Earnings						
	Retained Earnings - Funds	2,600	1,632	1,631	1,632	1,631
	Retained Earnings - GFA	(942)	(1,794)	(2,400)	(3,362)	(4,275)
	Retained Earnings - Provider	(95,834)	(93,879)	(80,230)	(78,379)	(91,540)
Total Retained earnings		(94,176)	(94,040)	(80,999)	(80,109)	(94,184)
Total General Funds		128,127	135,128	163,168	184,058	183,983
NET FUNDS EMPLOYED		236,338	287,558	301,844	500,148	486,490

Capital & Coast Provider / Governance & Funding Administration					
Statement of Financial Position					
Budget for the Three Years Ending 30 June 2009					
	Actual	Forecast	Plan	Plan	Plan
	2004/05	2005/06	2006/07	2007/08	2008/09
	(000s)	(000s)	(000s)	(000s)	(000s)
Non Current Assets					
Land	20,161	26,025	26,025	26,025	26,025
Buildings	104,551	164,873	154,934	144,090	364,973
Clinical Equipment	24,362	19,310	35,375	39,397	79,550
Information Technology	6,840	9,121	13,608	7,959	5,525
Work in Progress (Incl NRH)	60,977	57,344	122,626	230,910	10,000
Other Fixed Assets	3,437	4,768	4,430	3,642	3,354
Surplus & Trust Assets	2,134	9,046	14,101	17,980	20,875
Total Non Current Assets	222,461	290,487	371,100	470,003	510,303
Current Assets					
Cash	(47,484)	(10,463)	(10,463)	(10,463)	(10,463)
Prepayments	468	319	323	327	331
Accounts Receivable	19,167	15,134	14,109	17,963	22,210
Inventories	4,609	5,692	5,692	5,692	5,692
Equity Receivable	86,000	86,000	86,000	70,000	17,000
Other Current Assets	4,382	4,463	4,463	4,463	4,463
Total Current Assets	67,142	101,145	100,124	87,982	39,233
Current Liabilities					
Trade Creditors & Accruals	14,894	23,081	24,290	26,291	28,438
Current Provisions & Payables	26,984	28,098	30,098	32,099	34,099
GST & Tax Provisions	2,422	799	(878)	382	982
Current Private Sector Debt	11,095	-	3,567	-	-
Non Current Crown Debt - CHFA	-	53,000	113,433	-	-
Capital Charge Payable	470	728	500	696	1,157
Total Current Liabilities	55,865	105,706	171,010	59,468	64,676
Net Current Assets	11,277	(4,561)	(70,886)	28,514	(25,444)
NET FUNDS EMPLOYED	233,738	285,926	300,214	498,517	484,859
Non Current Liabilities					
Non Current Private Sector Debt	146	31,363	15,000	15,000	15,000
Non Current Crown Debt - CHFA	104,000	117,000	119,609	297,023	283,440
Restricted & Trust Funds Liability	114	126	126	126	126
Non Current Provisions & Payables Personnel	3,950	3,941	3,941	3,941	3,941
Total Non Current Liabilities	108,210	152,430	138,676	316,090	302,507
General Funds					
Crown Equity	205,243	206,243	221,242	241,242	255,242
Revaluation Reserve	17,061	22,925	22,925	22,925	22,925
Retained Earnings					
Retained Earnings - GFA	(942)	(1,793)	(2,399)	(3,362)	(4,275)
Retained Earnings - Provider	(95,834)	(93,879)	(80,230)	(78,378)	(91,540)
	(96,776)	(95,672)	(82,629)	(81,740)	(95,815)
Total General Funds	125,528	133,496	161,538	182,427	182,352
NET FUNDS EMPLOYED	233,738	285,926	300,214	498,517	484,859

Capital & Coast Funds		Actual	Forecast	Plan	Plan	Plan
Statement of Financial Position		2004/05	2005/06	2006/07	2007/08	2008/09
Budget for the Three Years Ending 30 June 2009		(000s)	(000s)	(000s)	(000s)	(000s)
Current Assets						
	Cash	17,024	10,463	10,462	10,463	10,462
	Accounts Receivable	9,856	12,336	12,336	12,336	12,336
Total Current Assets		26,880	22,799	22,798	22,799	22,798
Current Liabilities						
	Trade Creditors & Accruals	20,669	17,633	17,633	17,633	17,633
	Current Provisions & Payables	-	-	-	-	-
	GST & Tax Provisions	3,611	3,534	3,534	3,534	3,534
Total Current Liabilities		24,280	21,167	21,167	21,167	21,167
Net Current Assets		2,600	1,632	1,631	1,632	1,631
NET FUNDS EMPLOYED		2,600	1,632	1,631	1,632	1,631
General Funds						
	Crown Equity	-	-	-	-	-
	Retained Earnings - Funds	2,600	1,632	1,631	1,632	1,631
Total General Funds		2,600	1,632	1,631	1,632	1,631
NET FUNDS EMPLOYED		2,600	1,632	1,631	1,632	1,631

3.13.3 Forecast Statements of Cash Flows

Capital & Coast DHB						
Statement of Cashflows						
Budget for the Three Years Ending 30 June 2009						
		Actual	Forecast	Plan	Plan	Plan
		2004/05	2005/06	2006/07	2007/08	2008/09
		(000s)	(000s)	(000s)	(000s)	(000s)
Operating Activities						
	Government & Crown Agency Revenue Received	532,884	561,477	599,839	610,505	599,190
	All Other Revenue Received	28,417	30,562	43,260	41,478	41,570
Total Receipts		561,301	592,039	643,098	651,982	640,760
	Payments for Personnel	(211,405)	(232,843)	(257,817)	(266,313)	(275,484)
	Payments for Supplies	(123,424)	(124,865)	(121,673)	(123,106)	(125,447)
	Interest Paid	(4,890)	(4,400)	(6,210)	(6,161)	(6,169)
	Capital Charge	(6,844)	(4,450)	(4,415)	(7,658)	(12,730)
	GST (net)	3,441	(1,701)	(1,678)	1,260	600
	Other Payments	(198,814)	(211,048)	(225,385)	(220,243)	(189,366)
Total Payments		(541,936)	(579,307)	(617,178)	(622,221)	(608,596)
Net Cashflow from Operating		19,365	12,732	25,920	29,761	32,164
Investing Activities						
	Sale of Fixed Assets	8,870	-	19,340	3,800	665
	Decrease in Investments & Trust Funds	(2,788)	(6,980)	(5,059)	(3,881)	(2,893)
Total Receipts		6,082	(6,980)	14,281	(81)	(2,228)
	Land, Buildings & Plant	(44,253)	(38,662)	(81,290)	(109,928)	(67,423)
	Clinical Equipment	(4,319)	(11,946)	(22,055)	(14,524)	(15,256)
	Other Equipment	(122)	(4,859)	(544)	(362)	(668)
	Informations Technology	(7,976)	(6,916)	(1,544)	(1,285)	-
Total Capital Expenditure		(56,670)	(62,383)	(105,433)	(126,099)	(83,347)
Net Cashflow from Investing		(50,588)	(69,363)	(91,152)	(126,180)	(85,575)
Financing Activities						
	Equity Injections	-	1,000	15,000	36,000	67,000
	Current Private Sector Debt	(6,848)	20,091	(12,811)	(3,566)	-
	Current CHFA	-	-	0	4	(5)
	Non Current Private Sector	6,000	66,000	63,043	63,983	(13,584)
Total Repaid / (Borrowed) Debt		(848)	87,091	65,232	96,421	53,411
Net Cashflow from Financing Activities		(848)	87,091	65,232	96,423	53,411
Net Cashflow		(32,071)	30,460	(0)	3	(0)
Plus: Opening Cash		1,611	(30,460)	1	(0)	0
Closing Cash		(30,460)	(1)	1	3	0
Closing Cash comprises:						
	Balance Sheet Cash	(30,460)	-	-	-	-
	Balance Sheet Operating Overdraft		0	(0)	0	0
Total Cashflow Cash (Closing)		(30,460)	0	(0)	0	0

Capital & Coast Provider / Governance & Funding Administration					
Statement of Cashflows					
Budget for the Three Years Ending 30 June 2009					
	Actual	Forecast	Plan	Plan	Plan
	2004/05	2005/06	2006/07	2007/08	2008/09
	(000s)	(000s)	(000s)	(000s)	(000s)
Operating Activities					
Government & Crown Agency Revenue Received	334,070	369,238	390,486	404,371	423,965
All Other Revenue Received	16,883	18,238	27,227	27,368	27,430
Total Receipts	350,953	387,476	417,713	431,739	451,395
Payments for Personnel	(211,405)	(232,843)	(257,817)	(266,313)	(275,484)
Payments for Supplies	(123,424)	(124,865)	(121,673)	(123,106)	(125,447)
Interest Paid	(4,890)	(4,400)	(6,210)	(6,161)	(6,169)
Capital Charge	(6,844)	(4,450)	(4,415)	(7,658)	(12,730)
GST (net)	2,942	(1,625)	(1,677)	1,260	600
Other Payments					
Total Payments	(343,621)	(368,183)	(391,792)	(401,978)	(419,230)
Net Cashflow from Operating	7,332	19,293	25,921	29,761	32,165
Investing Activities					
Sale of Fixed Assets	8,870	-	19,340	3,800	665
Decrease in Investments & Trust Funds	(2,788)	(6,980)	(5,059)	(3,881)	(2,893)
Total Receipts	6,082	(6,980)	14,281	(81)	(2,228)
Land, Buildings & Plant	(44,253)	(38,662)	(81,290)	(109,928)	(67,423)
Clinical Equipment	(4,319)	(11,946)	(22,055)	(14,524)	(15,256)
Other Equipment	(122)	(4,859)	(545)	(363)	(669)
Informations Technology	(7,976)	(6,916)	(1,543)	(1,283)	0
Total Capital Expenditure	(56,670)	(62,383)	(105,433)	(126,098)	(83,348)
Net Cashflow from Investing	(50,588)	(69,363)	(91,152)	(126,180)	(85,575)
Financing Activities					
Equity Injections	-	1,000	14,999	36,000	67,000
Current Private Sector Debt	(6,848)	20,091	(12,811)	(3,566)	-
Current CHFA	6,000	66,000	63,044	63,982	(13,584)
Non Current Private Sector	-	-	-	(0)	(0)
Total Repaid / (Borrowed) Debt	(848)	86,091	50,233	60,416	(13,584)
Net Cashflow from Financing Activities	(848)	87,091	65,232	96,416	53,416
Net Cashflow	(44,104)	37,021	1	(3)	6
Plus: Opening Cash	(3,380)	(47,484)	(10,463)	(10,462)	(10,465)
Closing Cash	(47,484)	(10,463)	(10,462)	(10,465)	(10,459)
Closing Cash comprises:					
Balance Sheet Cash	(47,484)	(10,463)	(10,463)	(10,463)	(10,463)
Balance Sheet Operating Overdraft	-	-	-	-	-
Total Cashflow Cash (Closing)	(47,484)	(10,463)	(10,463)	(10,463)	(10,463)

Capital & Coast Funds					
Statement of Cashflows					
Budget for the Three Years Ending 30 June 2009					
	Actual	Forecast	Plan	Plan	Plan
	2004/05	2005/06	2006/07	2007/08	2008/09
	(000s)	(000s)	(000s)	(000s)	(000s)
Operating Activities					
Government & Crown Agency Revenue Received	515,385	545,166	577,871	606,222	633,370
All Other Revenue Received					
Total Receipts	515,385	545,166	577,871	606,222	633,370
Payment to own DHB Provider	302,133	337,996	349,801	383,106	441,042
Payment to own DHB GFA	2,904	2,606	2,685	2,873	2,962
Payments to other Providers	198,814	211,048	225,386	220,243	189,366
GST (net)	(499)	77	-	-	-
Other Payments	-	-	-	-	-
Total Payments	503,352	551,727	577,872	606,222	633,370
Net Cashflow from Operating	12,033	(6,561)	(1)	0	(0)
Net Cashflow	12,033	(6,561)	(1)	0	(0)
Plus: Opening Cash	4,992	17,025	10,463	10,462	10,463
Closing Cash	17,025	10,463	10,462	10,462	10,463
Closing Cash comprises:					
Balance Sheet Cash	17,024	10,463	10,463	10,463	10,463
Balance Sheet Operating Overdraft					
Total Cashflow Cash (Closing)	17,024	10,463	10,463	10,463	10,463

3.13.4 Statement of Movements in Equity

Capital & Coast DHB Statement of Movement in Equity Budget for the Three Years Ending 30 June 2009	Actual 2004/05 (000s)	Forecast 2005/06 (000s)	Plan 2006/07 (000s)	Plan 2007/08 (000s)	Plan 2008/09 (000s)
Total Equity at beginning of period	129,750	128,128	135,131	163,169	184,057
Net Results for the period - GFA	(942)	(851)	(606)	(963)	(913)
Net Results for the period - Provider	(3,348)	1,959	13,646	1,854	(13,162)
Net Results for the period - Funds	2,668	(969)	(1)	(0)	-
Equity injections	-	1,000	15,000	19,997	14,001
Revaluation of Fixed Assets	-	5,861	1	(0)	(0)
Total Equity at end of the period	128,128	135,128	163,169	184,057	183,983

Capital & Coast Provider / Governance & Funding Administration Statement of Movement in Equity Budget for the Three Years Ending 30 June 2009	Actual 2004/05 (000s)	Forecast 2005/06 (000s)	Plan 2006/07 (000s)	Plan 2007/08 (000s)	Plan 2008/09 (000s)
Total Equity at beginning of period	129,818	125,528	133,499	161,538	182,426
Net Results for the period - GFA	(942)	(851)	(606)	(963)	(913)
Net Results for the period - Provider	(3,348)	1,959	13,646	1,854	(13,162)
Net Results for the period - Funds	-	-	-	-	-
Equity injections	-	1,000	14,999	19,997	14,001
Revaluation of Fixed Assets	-	5,860	(0)	(0)	(0)
Total Equity at end of the period	125,528	133,496	161,538	182,426	182,352

Capital & Coast Funds Statement of Movement in Equity Budget for the Three Years Ending 30 June 2009	Actual 2004/05 (000s)	Forecast 2005/06 (000s)	Plan 2006/07 (000s)	Plan 2007/08 (000s)	Plan 2008/09 (000s)
Total Equity at beginning of period	(68)	2,600	1,632	1,631	1,631
Net Results for the period - Funds	2,668	(968)	(1)	0	(0)
Equity injections	-	-	-	-	-
Revaluation of Fixed Assets	-	-	-	-	-
Movement in Trust and Special Funds	-	-	-	-	-
Total Equity at end of the period	2,600	1,632	1,631	1,631	1,631

3.14 Reporting to the Minister of Health

3.14.1 Introduction

We will provide the Minister and the Ministry of Health with reports that enable monitoring of the DHB's performance against agreed targets and objectives. The reports the DHB will provide during 2005/06 include:

- ◆ Annual Report
- ◆ Quarterly Reports (including risk report)
- ◆ Monthly Reports
- ◆ Ad Hoc Reports.

3.14.2 Annual Report

The Annual Report is developed based on the performance (including financial) measures agreed in the Statement of Intent. It will be delivered to the Minister of Health within four months of the end of each financial year and tabled in Parliament in accordance with the Public Finance Act. The annual report will incorporate:

- ◆ A report of the DHB's operations
- ◆ Audited financial statements
- ◆ The Auditors' Report
- ◆ Statement of Service Performance
- ◆ Statement of Responsibility.

Audit New Zealand presents an opinion on the accuracy and reasonableness of the financial and non-financial achievements in the Annual Report.

3.14.3 Quarterly Reports

Our quarterly reports will be for hospital benchmarking information, financial and non-financial performance expectations as set out in the Statement of Intent and our District Annual Plan and Crown Funding Agreement. We also report high level risks to the Ministry on a quarterly basis (as per the operational policy framework).

3.14.4 Monthly Reports

We will provide monthly financial reports that contain financial statements including analysis of material variances.

3.14.5 Ad Hoc Reports

We will use our best endeavours to respond to the Minister and Ministry of Health's requests for ad hoc reports (e.g. select committee inquiries, parliamentary questions) as they arise.

3.14.6 Reporting on Māori Health Developments

Māori Participation (HKO-01)

We will report six monthly (in Quarters 2 and 4) on the extent to which local Iwi/Māori are engaged and participate in DHB decision making and on the development of strategies and plans for Māori health gain. Relevant performance indicators are:

- ◆ Percentage of PHOs with Māori health plans (MHP) that have been agreed to by the DHB. Target 100%
- ◆ Percentage of Board members that have undertaken training in Treaty of Waitangi. Target 100%.

Our reports will demonstrate achievements against the Memorandum of Understanding (MoU) between the DHB and our local Iwi/Māori health partners, and describe other initiatives achieved that are an outcome of engagement between the parties and also provide a copy of the MoU. The reports will be endorsed by local Iwi/Māori.

The reports will show how local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring and evaluation. They will show how Māori Health Plans are being implemented by the PHOs and monitored by the DHB (including a list of the names of the PHOs with MHPs). For newly established PHOs, the report will detail on progress in the development of Māori Health Plans. The reports will also describe when Treaty of Waitangi training (including any facilitated by the Ministry of Health) has taken, or will take place for Board members.

Development of Māori health workforce and Māori health providers (HKO-02)

We will report at the end of Quarters 2 & 4 the number (out of total number) of management, clinical, administrative, and other full time equivalents (FTEs) held by Māori, and present a copy of our Māori Health workforce plan. The reports will describe achievements based on key deliverables in our Māori workforce plan.

Improving Mainstream Effectiveness (HKO-03)

We will report in Quarters 2 and 4 to describe the reviews of pathways of care that have been undertaken by our Hospital and Health Services Group in the last 12 months that focused on improving access to effective services for Māori. The report will include example(s) of actions taken to address issues identified in our pathway reviews.

Increased funding for Māori health and disability initiatives (HKO-04)

We have set targets to increase funding for Māori health and disability initiatives. Reports of actual expenditure will be provided in Quarters 2 & 4 to show funding comparisons between periods for:

- ◆ Māori health providers
- ◆ Māori specific services provided within mainstream services to improve Māori health
- ◆ Iwi/Māori-led PHOs
- ◆ mainstream PHO services targeted to improving Māori health
- ◆ DHB Māori workforce or provider Māori workforce development initiatives, which are not funded through the Māori Provider Development Scheme.

3.14.7 Reporting on Pacific Health Developments

Progress on the Pacific Health and Disability Action Plan.

We will provide reports in Quarters 2 and 4 of the financial year on the following:

Pacific Child and Youth Health

- ◆ **The initiatives we have implemented and progressed to improve and protect the health of Pacific children (0-14 years)**
- ◆ **The initiatives we have implemented and progressed to improve the health of Pacific youth (15-25 years).**

Promoting Pacific Healthy Lifestyles and Well-being

- ◆ **The initiatives we have taken and the progress we have made to encourage and support healthy lifestyles.**

Pacific Primary Health Care and Preventative Services

- ◆ **The initiatives we have implemented and progressed to ensure that there are locally available Pacific Primary Health Providers that effectively meet the needs of our local Pacific communities.**

Pacific Health and Disability Workforce Development Plan

- ◆ **The initiatives we have implemented to develop a competent and qualified Pacific health and disability workforce that meets the needs of Pacific peoples.**

Pacific Provider Development

- ◆ **The initiatives we have implemented to develop and support Pacific Health providers' capacity and capability to deliver effectively deliver health services.**

Participation of Disabled Pacific Peoples

- ◆ **The initiatives we have implemented and progressed to deliver disability support and health services that will enable disabled Pacific people to participate fully in our communities.**

Pacific Health and Disability Information and Research

- ◆ **The initiatives we have implemented and progressed to inform policy, planning and service development.**

Participation of Pacific peoples in DHB decision-making (PAC-02)

We will provide reports in Quarters 2 and 4 to show how Pacific peoples are engaged and participate in our DHB decision-making and on the development of strategies and plans which include goals for Pacific health gain. The reports will:

- ◆ **demonstrate that Pacific peoples are engaged and participate in our decision-making on accessibility, equity and resource allocation at a governance and management level; and**
- ◆ **show the number, purpose and outcomes of community participation activities that have been conducted during the reporting period.**

3.14.8 Population Health Reporting

Key Population Health Performance Indicators

During 2006/07 we will report on the following:

Risk reduction - Obesity (POP- 01 to 03)

In Quarter 3 for Calendar Year

- ◆ The number of health promoting schools as a percentage of the total number of schools within our district.

Oral Health (POP-06)

In Quarter 3 for Calendar Year

Key Performance Measures		Actual 04/05	Forecast 05/06	Target 06/07	Target 07/08	Target 08/09
% of children caries free at 5 years						
% caries free at 5 years	Maori	40.1	40.3	45.0	47.0	50.0
	Pacific	34.6	32.9	38.0	40.0	42.0
	Other	69.3	66.8	72.0	73.0	75.0
Mean DMFT Score at Year 8 (Age 13)						
Mean decayed, missing and filled teeth score.	Maori	1.26	1.23	1.10	1.05	1.00
	Pacific	1.30	1.15	1.00	0.95	0.90
	Other	0.77	0.78	0.70	0.70	0.68

Mental Health (POP-08a)

Quarterly - Rolling Annual

- ◆ Ratio of the total number of people domiciled in our district seen per year rolling every three months to the projected population of the district.

This measure looks at the rate at which our range of Mental Health Services are used, and provides an indication of whether services are being provided for the expected number of clients.

Key Performance Measures		Actual 04/05	Forecast 05/06	Target 06/07	Target 07/08	Target 08/09
Mental Health Service Utilisation						
Children & Youth 0-19 Years	Maori	2.0%	2.0%	2.4%	2.9%	3.2%
	Pacific	0.8%	1.0%	1.2%	2.2%	2.4%
	Other	1.8%	1.8%	2.0%	2.1%	2.2%
	All 0-19 Yrs	1.7%	1.7%	2.0%	2.2%	2.4%
Adults 20-64 years	Maori	4.1%	4.1%	4.8%	4.8%	4.9%
	Pacific	1.5%	1.5%	2.4%	2.6%	2.8%
	Other	2.1%	2.1%	2.2%	2.5%	2.6%
	All Adults 20-64Yrs	2.2%	2.2%	2.4%	2.7%	2.8%
Older People 65+ years	Maori	1.5%	1.7%	2.7%	3.1%	3.4%
	Pacific	1.0%	1.4%	2.2%	2.6%	2.9%
	Other	0.8%	0.7%	0.9%	1.1%	1.2%
	All Older People 65+ y	0.8%	0.8%	1.0%	1.2%	1.3%
All Age Groups	Maori	3.1%	3.1%	3.7%	3.9%	4.2%
	Pacific	1.2%	1.3%	1.9%	2.4%	2.6%
	Other	1.9%	1.8%	2.0%	2.2%	2.3%
	All Age Groups	1.9%	1.9%	2.2%	2.4%	2.5%

Mental Health (POP-08a)

Quarterly - Rolling Annual

- ◆ Total number of people domiciled in our district seen per year rolling every three months to the projected population of the district.

Again we have set targets for three age groups, this time 0-19 year olds, 20-64 yrs, and 65+ years; and for three ethnic groups within each age bracket (Māori, Pacific and 'Other'). Our aims are:

- ◆ to provide services to meet projected need; and
- ◆ to reduce the access barriers so that Māori, Pacific and 'Other' groups are able to receive the services they require.

Key Performance Measures		Actual 04/05	Forecast 05/06	Target 06/07	Target 07/08	Target 08/09
Mental Health Service Clients Seen						
Children & Youth 0-19 Years	Maori	244	250	300	350	400
	Pacific	64	80	100	180	200
	Other	922	920	1,030	1,070	1,100
	All 0-19 Yrs	1,230	1,250	1,430	1,600	1,700
Adults 20-64 years	Maori	631	630	750	770	800
	Pacific	176	180	300	320	350
	Other	2,963	2,990	3,120	3,560	3,750
	All Adults 20-64Yrs	3,770	3,800	4,170	4,650	4,900
Older People 65+ years	Maori	12	15	25	30	35
	Pacific	10	15	25	30	35
	Other	215	190	250	290	330
	All Older People 65+ y	237	220	300	350	400
All Age Groups	Maori	887	895	1,075	1,150	1,235
	Pacific	250	275	425	530	585
	Other	4,100	4,100	4,400	4,920	5,180
	All Age Groups	5,237	5,270	5,900	6,600	7,000

Mental Health (POP-08b)

Six Monthly (Qtrs 2 & 4)

- ◆ **The repeat acute admission rate (three or more unplanned repeat admissions during the year).**

Immunisation Rates (POP-12)

Quarterly (Last Qtr & 12 months)

- ◆ Progress towards the national target of 95% of two year olds fully immunised
- ◆ Percentage of eligible newborns born and enrolled on the NIR during the reporting period by ethnicity and at each level of deprivation
- ◆ Percentage of eligible children on the NIR less than two years of age with an 'opt-off' status.
- ◆ Percentage of children on the NIR up to date with immunisation on the day they turned specific age (6, 12, 18, and 24 months) during the reporting period by ethnicity and at each level of deprivation
- ◆ Percentage of children on the NIR up to date with Measles, Mumps, and Rubella (MMR) on the day they turned 18 months during the reporting period (current coverage of MMR in Central South region is ~ 82%)
- ◆ Percentage of 2-3 year old children who have received dose 3 of Diphtheria, Tetanus and Pertussis (DTaP) vaccine (current coverage of DTaP for Central South region is ~ 89%).

Targets:

Achieve at least 80% immunisation coverage at 1 Year (5 month immunisation)

Achieve at least 80% immunisation coverage for MenNZB in children aged 1-4 years

Ambulatory Sensitive Admissions (POP-13)

Six monthly

This measure looks at the hospitalisation rate for specified conditions (e.g. asthma). Ambulatory Sensitive Hospitalisations (ASHs) are potentially preventable, and the rate of admission/discharge provides an indication of access to, and the effectiveness of, primary care services.

We have set targets to reduce ASHs for three age groups: 0-4 year olds, 5-14 yrs, and 65-74 years and for three ethnic groups within each age bracket (Māori, Pacific and 'Other'). Our aims are twofold:

- ◆ to reduce the rate of avoidable admissions overall and
- ◆ to reduce the disparity in hospitalisation rates between Māori, Pacific and other groups.

Key Performance Measures		Actual 04/05	Forecast 05/06	Target 06/07	Target 07/08	Target 08/09
ASH - Discharge Rates per 1000 population						
Children	0-4 Yrs	58.8	58.0	56.7	52.6	51.5
	5-14 Yrs	18.1	17.8	16.8	16.2	15.6
Older People	65-74 yrs	49.2	49.1	48.3	43.6	37.8
ASH - Number of Discharges						
Children	0-4 Yrs	1,037	1,000	965	884	859
	5-14 Yrs	646	632	591	568	541
Older People	65-74 yrs	733	753	763	693	619

Chemotherapy / radiation therapy (POP-14)

Monthly and Quarterly

- ◆ **Monthly templates that measure the interval between the patient’s referral from a medical practitioner to the oncology department, and the beginning of radiation/chemotherapy treatment, will be supplied on time and complete with information (by DHB of domicile)**
- ◆ **We will provide a report updating on progress towards ensuring all patients receive oncology mega-voltage radiation treatment and chemotherapy treatments according to nationally agreed standards**
- ◆ **In the fourth quarter, the report will include information that demonstrates the cancer centre has undertaken a data audit of its waiting time and is satisfied that high quality data is being provided.**

Key Performance Measures	Actual 04/05	Forecast 05/06	Target 06/07	Target 07/08	Target 08/09
Cancer Waiting Times (%)					
Priority C < 4 wks	69.2	72.1	80.0	85.0	90.0
% in each 4-8 wks	23.9	26.7	20.0	15.0	10.0
waiting time 8-12 wks	6.9	1.1	0.0	0.0	0.0
category >12 wks	0.0	0.0	0.0	0.0	0.0
Total %	100.0	100.0	100.0	100.0	100.0
Cancer Waiting Times (Patient numbers)					
Priority C < 4 wks	440	440	576	722	855
patients 4-8 wks	152	163	144	127	95
treated by 8-12 wks	44	7	0	0	0
category >12 wks	0	0	0	0	0
Total Patients	636	610	720	849	950

The forecast figures for Category C priority intervention / treatment times from First Specialist Assessment are based on the assumptions of demand from a 2002 study performed by the Ministry of Health to estimate incidence growth of cancer in New Zealand.

The funding path for a 35% intervention rate has indicated the predicted number of treatments required in the outyears 2006/07, 2007/08 and 2008/09. Waiting time assumptions have been based upon a two year average of 71% Category C priority allocation from the total new treatments started.

The waiting time targets for the following years are predicated on the commencement of the High Dose Brachytherapy Treatment modality before the end of the 06/07 financial year and the timing to have a third Linear Accelerator being operational to support growth in demand.

3.14.9 Quality and Service Issues Reporting

Quality Systems (QUA-01a)

In Quarter 3 we will provide a report which demonstrates an organisation-wide commitment to quality improvement and effective clinical audit. It will include a high level summary (list) of key quality improvement and clinical audit initiatives and results, focusing on those that are effective and/or ineffective against the goals in Improving Quality: A Systems Approach for the New Zealand Health and Disability Sector.

Results for people with enduring mental illness (QUA-01b)

In Quarter 4 we will provide a report outlining results for people with enduring mental illness. It will include details on:

- ◆ The number of adults (20-64 years) with enduring serious mental illness (two years or more in treatment, since the first contact with any mental health service) including the results of an audit of a sample of case files to give an indication of the current outcomes for long-term clients. This will provide estimates of:
- ◆ The number and percentage of long-term clients with up to date crisis prevention plans and a report to describe how this is assured
- ◆ The number and percentage of long-term clients in full time work (> 30 hours)
- ◆ The number and percentage of long-term clients with no paid work
- ◆ The number and percentage of long-term clients undertaking some form of education e.g. university, polytechnic.

Note that C&C DHB does not have information systems in place that will allow routine collection of the QUA 1b set of information. To ensure reporting requirements are met, C&C DHB will undertake patient notes audits and will report in the findings of these audits.

Inequalities in Health Concepts (RIH-01)

We will report progress towards further incorporating health inequalities concepts and actions into overall policy, planning, funding and service provision.

- ◆ In Quarter 1 we will provide a report that shows key areas of inequalities that are identified within its health needs assessment.
- ◆ In Quarter 3 we will report on the actions taken to address the identified inequalities using an appropriate equity tool (such as reducing inequalities intervention framework the health equity assessment tool [HEAT] etc).

Responding to and Resolving Service Coverage Issues (RIS-01)

Each quarter we will report progress achieved towards resolution of gaps in service coverage identified in our District Annual Plan and not approved as long term exceptions. We will also report on any other gaps in service coverage identified by us or the Ministry of Health through analysis of explanatory indicators, Media reporting, Risk reporting, Formal audit outcomes, Complaints mechanisms, and sector intelligence.

3.14.10 Service Effectiveness Reporting

We will report quarterly to the Ministry of Health on the following:

Accessible and appropriate services in PHOs (SER-01)

- ◆ The age-standardised rate of GP consultation per high need person to non-high need person. Reporting will be for the twelve-month period to the end of quarter.
- ◆ The target ratio = 1.0 (to be confirmed).

Care plus enrolled population (SER-02)

- ◆ The ratio or number of each PHO's CarePlus enrolled population to expected enrolled population. We are awaiting an update from the Ministry of Health on the current target.

PHO performance management programme (SER-03)

- ◆ The number and percentage of PHOs participating in the PHO performance management programme (100% target).

Low cost access to first level primary care services (SER-04)

- ◆ The ratio or number of PHO practices that demonstrate that all increased subsidy translate into low or reduced cost access for eligible patients to the number of PHO practices in the District (excludes casual visits). Reporting will be for the twelve months period ending at the end of quarter.

Key Performance Measures	Actual 04/05	Forecast 05/06	Target 06/07	Target 07/08	Target 08/09
CarePlus Coverage					
% of eligible people - CarePlus	0.0	21.0	51.0	61.0	71.0
PHO management programme.					
% of PHOs in Mgmt programme	0.0	100.0	100.0	100.0	100.0
PHO coverage for Maori					
% of Maori enrolled in PHOs	71.0	75.0	80.0	85.0	90.0

Laboratory and pharmaceutical transactions - valid NHI number (SER-05)

- ◆ The number of items dispensed by community pharmacies in the district with a valid NHI number to the total number of items dispensed by community pharmacies in the district. The target at the end of 06/07 is 90%.
- ◆ The number of tests by community laboratories in the district with a valid NHI number to the total number of tests by community laboratories in the District. The target at the end of 2006/07 is 95%. (Reporting will lag by a quarter).

Elective services (SER-06)

We will report six monthly on standardised discharge ratios (SDRs) for 11 elective procedures as published on the Ministry of Health website each quarter (excluding hip and knee replacement and cataracts covered by separate initiatives). Our target is 95% of national average. We will provide a report demonstrating:

- ◆ For any SDR that is more than 5% below the national average, our analysis as to the appropriateness (or otherwise) of the rate
- ◆ The reason that we consider the rate to be appropriate for our populations, or an action plan as to how we will address our relative under-delivery of that procedure.

3.14.11 Cardiovascular Risk Reduction and Service Effectiveness Reporting

We will report quarterly to the Ministry of Health on the following:

Risk reduction – smoking

We will work with the Ministry of Health and others so that on an annual basis we will be able to report the ratio of the number of enrolled persons > 14 years of age with smoking status ever recorded to the number of enrolled person > 14 years of age.

Cardiovascular risk recognition

Similarly, we will work to establish a means of reporting on an annual basis (in Quarter 3) the ratio of the number of people in each target group who have had their 5-year absolute cardiovascular disease (CVD) risk recorded in the last five years to the number of people in each respective group. The target groups are:

- ◆ Māori, Pacific and Indian subcontinent men ≥ 35 years of age
- ◆ Māori, Pacific and Indian subcontinent women ≥ 45 years of age
- ◆ European and other men ≥ 45 years of age
- ◆ European and other women ≥ 55 years of age

Cardiovascular Disease follow up – Statins

We will report annually (for the calendar year) in quarter 3 the ratio of number of persons where the CVD risk is ≥ 15% where statins have been prescribed in the past year to the total number of persons where CVD risk is ≥ 15%.

Cardiac rehabilitation programme

We will report annually (for the calendar year) in quarter 3 the ratio of number of people who have suffered a CVD event who attend a cardiac rehabilitation outpatient programme to the total number of people who have suffered a CVD event.

Organised stroke service

We will report annually (for the calendar year) in quarter 3 the ratio of the number of people who have suffered a stroke event who have been admitted to organised stroke services and remained there for their entire hospital stay to the total number of people who have suffered a stroke event.

Diabetes Management

We will report annually (for the calendar year) in quarter 3:

- ◆ The number of people with type I or type II diabetes mellitus on a diabetes register that had an HBA1c of equal to or less than 8% and at their free annual check during the reporting period
- ◆ Diabetes follow up – increase early recognition & response to individuals with diabetes
- ◆ Diabetic retinopathy screening (target 80%).

Key Performance Measures	Actual 04/05	Forecast 05/06	Target 06/07	Target 07/08	Target 08/09
Diabetes Mellitus - % good control					
HBA1c <= 8%					
Maori %	62.0	59.0	63.0	70.0	77.0
Pacific %	51.0	57.0	60.0	70.0	77.0
Other %	79.0	81.0	80.0	81.0	82.0
Good Control %	<u>73.0</u>	<u>76.0</u>	<u>76.0</u>	<u>79.5</u>	<u>81.0</u>
Diabetes Mellitus - % follow up rates					
Maori %	50.0	37.0	45.0	60.0	75.0
Pacific %	70.0	74.0	80.0	80.0	80.0
Other %	70.0	68.0	70.0	75.0	77.0
Follow-up %	<u>67.0</u>	<u>64.0</u>	<u>67.0</u>	<u>75.0</u>	<u>77.0</u>

Glossary

A&D	Alcohol and Drug
ACC	Accident Compensation Corporation
ACHS	Australasian Council of Healthcare Standards
CAMHS	Child and Adolescent Mental Health Service
CATT	Crisis Assessment Treatment Team
C&C DHB	Capital & Coast District Health Board
CCMHS	Capital Coast Mental Health Service
CFA	Crown Funding Agreement
COO	Chief Operating Officer
CPHAC	Community and Public Health Advisory Board
CQI	Continuous Quality Improvement
CTA	Clinical Training Agency
CWDs	Caseweights
CYF	Children, Youth and Family
DHB	District Health Board
DSS	Disability Support Services
ED	Emergency Department
EHR	Electronic Health Record
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
HEHA	Healthy Eating Healthy Action
HHS	Hospital and Health Services
HIQ	HealthIntelligence
HPI	Health Practitioner Index
HR	Human Resources
IDF	Inter District Flow
IM	Information Management
IS	Information Systems
IT	Information Technology
KPI	Key Performance Indicators
MHINC	Mental Health Information Network Collection
MOU	Memorandum of Understanding
MSD	Ministry of Social Development
NGO	Non-Governmental Organisation
NHI	National Health Index
NMDS	National Minimum Dataset
NRH	New Regional Hospital
OTS	Opioid Treatment Service
PACS	Picture Archive Computer System
PBFF	Population Based Funding Formula
PDSA	Plan, Do, Study, Act
PHO	Primary Health Organisation
PQAA	Protected Quality Assurance Activity
QIG	Quality Improvement Group
SOI	Statement of Intent
TAS	Technical Advisory Service
TLA	Territorial Local Authority
YTD	Year to Date