WAIRARAPA DISTRICT HEALTH BOARD

PUBLIC MEETING

Kenepuru Hospital
Raiha Street, Porirua

Friday, 6 December 2013 at 9.15am

	Item	Action	Presenter	Min	Time	Pg
1.	**PROCEDURAL**			5	9.15 am	
1.1	Karakia					
1.2	Apologies	RECORD	Bob Francis			
1.3	Interest Registers	CONSIDER	Bob Francis			
1.4	Conflicts of Interest	RECORD	Bob Francis			
1.5	Minutes	APPROVE	Bob Francis			
1.6	Matters Arising	NOTE	Graham Dyer			
DISCUSSION PAPERS						
2.	Chair Report	RECEIVE	Bob Francis	5	9.20 am	
3.	Chief Executive Report	NOTE	Graham Dyer	15	9.25 am	
4.	Chief Executive Report	NOTE	Judith Parkinson	5	9.40 am	
COMMITTEE REPORT BACKS						
5.	Hospital Advisory Committee	NOTE	Viv Napier	5	9.45 am	
OTHER						
6.	General			5	9:50 am	
7.	Resolutions to Exclude the Public	APPROVE	Bob Francis	5	9.55 am	
CLOSE					10.00 am	

Wairarapa District Health Board

REGISTER OF BOARD MEMBERSHIP INTERESTS
New Zealand Public Health and Disability Act 2000

Board Member	Disclosure Date	Value and /or Nature of Transaction or Interest	Statutory Committee
Bob Francis (Board Chairman)	14/04/08	• Chairman - Pukaha Mount Bruce • Chairman - Wairarapa Healthy Homes • Trustee – Wairarapa Community Transport Trust • Chairman – Aratoi Foundation • Board Member Capital and Coast DHB	Audit and Risk Committee Hospital Advisory Committee Community & Public Health Advisory Committee (Chair) Disability Support Advisory Committee (Chair)
Leanne Southey (Deputy Chair)	06/12/10 27/09/11 12/06/12	• Director, Southey Sayer Limited • Chartered Accountant to Health Professionals including Selina Sutherland Hospital and Selina Sutherland Trust • Trustee, Wairararpa Community Health Trust • Sister-in-Law is employed by WDHB • Member of Trustlands Trust • Director and part owner of Mangan Graphics Ltd	Audit and Risk Committee (Chair) Community & Public Health Advisory Committee Disability Support Advisory Committee
Liz Falkner	14/04/10 18/12/07	• Salaried General Practitioner with Masterton Medical Limited • General Medical Practice in which Doctor Falkner works is a member of the Wairarapa Community PHO. • Medical Advisor – Post Polio Support Society NZ Inc	
Rob Irwin	06/12/10	• Trustee Wairarapa Community Health Trust	Hospital Advisory Committee Audit and Risk Committee
Charles Grant	07/05/12	• Nil	Te Iwi Kainga

Last printed 1/12/2013 10:13:00 PM

Board Member	Disclosure Date	Value and /or Nature of Transaction or Interest	Statutory Committee Membership
Helen Kjestrup	18/12/07 30/08/11	• Clinical Services Manager Masterton Medical Ltd • Shareholder, Property Investment Company – Kjestrup Properties • Assessor for Royal College of GPs for Cornerstones Programme • Member of Compass Quality Board	Hospital Advisory Committee
Rick Long	06/12/10 03/10/11 05/03/13	• Chairman of Wairarapa Community Transport Services Inc • Chairman of Tolley Educational Trust • Trustee for Sport and Vintage Aviation Society • Biomedical Services New Zealand Limited	Audit and Risk Committee Community & Public Health Advisory Committee Disability Support Advisory Committee Clinical Board
Vivien Napier	18/12/07 24/02/09	• RNZ Plunket Society Member • South Wairarapa District Council Deputy Mayor • Director Katson Developments (importing of farm machinery) • Vice President of the Wairarapa Branch Plunket Society	Hospital Advisory Committee (Chair) Audit and Risk Committee
Fiona Samuel	01/10/12	• Nurse Manager at Metlifecare	Hospital Advisory Committee
Janine Vollebregt	14/04/08	• DHB Nurse Educator for the UCOL Undergraduate Maori Students. This 0.4 FTE position is effective from 30 April 2008 to 30 June 2010.	Community & Public Health Advisory Committee Disability Support Advisory Committee (Chair)
Yvette Grace		• Te Oranga o Te Iwi Kainga Maori Relationship Board	
Ron Karaitiana		• ACC Manager in Claims Management • Wife Kylie Smith is currently the DHB liaison from Child Youth & Family • Maori relationships with staff vary from a number of cousins working at DHB • Occasionally plays in a band (potential no risk to the board) • Trust Chairman Akura Lands Trust	Rangitane o Wairarapa Board Director Te Iwi Kainga

Last printed 1/12/2013 10:13:00 PM

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

HUTT VALLEY DHB

Wairarapa and Hutt Valley DHB Executive Leadership Team

Interest register

November 2013

Name	Interest
Graham Dyer *Chief Executive* *Wairarapa and Hutt Valley DHBs*	• Trustee, Bossley Dyer Family Trust • Wife is a Director of i-Management which does consulting and audit work in the Health Sector • Trustee, Hutt Hospital Foundation Trust • Member, Crisp Interim Governance Board • Member, Health Workforce New Zealand
Bridget Allan *Chief Executive,* *Te Awakairaongi Health Network (PHO)*	• Chief Executive, Te Awakairangi Health Network (PHO)
Ashley Bloomfield *Director Service Integration and Development*	• Trustee, AR and EL Bloomfield Trusts • Fellow, NZ College of Public Health Medicine • Board Member, Action on Smoking and Health (ASH) NZ Member • NZ College of Public Health Medicine Finance and Risk Committee • Sister is a nurse at Hutt DHB • Wife was employed at Hutt Family Planning Association clinic during 2009-10
Pete Chandler *Chief Operating Officer*	No interests declared.
Carolyn Cooper *Executive Director, people and Culture*	• Sister in law is an independent member of the Community Labs Group
Judith Parkinson *Finance Manager*	No interests declared.
Helen Pocknall *Executive Director Nursing and Midwifery*	• Board Member, Health Workforce New Zealand
Nadine Mackintosh *Board Secretary*	No interests declared.

Updated November 2013

Richard Schmidt *Executive Officer*	• Member of the Hutt Foundation
Russell Simpson *Executive Director Allied Health, Scientific and Technical*	• Chair, Central Region Directors of Allied Health • Member, Regional Leadership Committee
Jill Stringer *Communications Manager*	• Trustee, Wairarapa Regional All Weather Track Trust • Husband works for Rigg Zschokke Ltd
Iwona Stolarek *Chief Medical Officer*	• Member, ASMS JCC • Husband Andrew Simpson: - Executive Director for Medicine Cancer & Community CCDHB - Executive Member of the Cancer Society Wellington Division - National Clinical Director Cancer Programme – Ministry of Health
Justine Thorpe	• Tihei Wairarapa Programme Director, employed by Compass Health
Cate Tyrer *General Manager Quality and Risk*	• Shareholder and Director of Framework For Compliance Ltd (FFC) • Husband is an employee of Hutt Valley DHB
Stephanie Turner *Director Maori Health*	• Represent Rangitane Iwi on the Wairarapa Cultural Trust (Aratoi) • Establishing member of Pasifika Wairarapa Trust • Director Waingawa Ltd • Director Aroha Ki Te Whanau Trust • Member Cameron Community House Governance Group
Kelvin Watson *3DHB Chief Information Officer*	No interests declared.
Tofa Suafole Gush *Director Pacific Peoples Health*	• Member of the Te Awakairangi Health Board • Husband is an employee of Hutt Valley DHB
Kuini Puketapu *Maori Health Advisor*	• Chair of Board of Trustees, Pukeatua Te Kohanga Reo • Board Member, Te Runanganui o Taranaki Whanui ki te Upoko o te Ika a Maui who has contracts with Hutt Valley DHB to provide health services in the Hutt Valley area and is an approved Whanau Ora provider • Member, Wainuiomata Community Governance Group • Chair, Waiwhetu Medical Group which is a limited liability company affiliated to Te Awakairangi Health PHO • Member, Whanau Ora Regional Leadership Group Whanganui a Tara • Trustee on the Hutt Valley Youth Health Trust t/a Vibe
Glen Willoughby	No interests declared
John Ryan	• Son works for Spotless Services as a cleaner • Cousin works as Orthopaedic Nurse

Updated November 2013

Updated November 2013

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa / HUTT VALLEY DHB	**INFORMATION PAPER** **Date:** 28 November 2013
Author	Graham Dyer, Chief Executive
Subject	**Chief Executive's Report**
RECOMMENDATION It is recommended that the Board **note** the contents of this report.	

This is my last report for what has been a very busy, exciting and challenging year. I would like to thank the staff, our community partners and the Boards for their support throughout 2013. I'd also like to acknowledge outgoing Chair for Wairarapa, Bob Francis, and Board Member Viv Napier and outgoing Board member for Hutt Valley, Peter Glensor, for their governance, advice and support. Their tireless efforts over the years, along with staff and other health providers, have significantly improved the health outcomes for our communities. Thank you.

I look forward to welcoming the new Chair for Wairarapa and new Board members for both districts and to the exciting opportunities 2014 will bring. I'd also like to wish you all well for the upcoming festive season.

1 GOVERNMENT PRIORITIES AND HEALTH TARGETS

1.1 2013/14 Quarter 1 Health Target Results

The Quarter 1 Health Target results have now been published and are included as Appendix One of this report. Wairarapa DHB met or exceeded five of the six targets, and were top performer in the country for the three measures of more heart and diabetes checks, immunisation of eight month babies, and helping smokers to quit. Eighteen DHB's including Wairarapa shared first place for shorter waits for cancer treatment. Wairarapa ranked third for shorter stays in the Emergency Department (ED) and 10th for improved access to elective surgery (we exceeded both these targets).

Hutt Valley DHB met or exceeded four of the six health targets, including shorter stays in ED, improved access to elective surgery and shorter waits for cancer treatments. Hutt Valley DHB was second to Wairarapa in increased immunisation. There have been significant improvements in results for Better help for smokers to quit and More heart and diabetes checks for Quarter 2.

1.2 Regional Roundup

Central TAS have developed a "news round up" on the regional plan programme of work. The round up is based on the quarter 1 report that was submitted to the Ministry on behalf of the region and contains programme highlights and good stories. Hutt Valley DHB has specific mention for exceeding the 80% target in the Stroke programme and Wairarapa for achieving CT and MRI wait time targets, along with Whanganui and MidCentral. The round up is attached as Appendix Two.

1.3 Balanced Scorecard (BSC)

Please find attached as Appendix Three the BSC. This format of the report is already reported to the Hospital Advisory Committee as part of the Chief Operating Officer's report. I thought it would be useful to use the same format to discuss at Board meetings. Your feedback is welcomed.

1.4 Central Region Joint Tobacco Control Purchase Operation (CPO)

The Central Region's three public health units conducted a joint tobacco control purchase operation during the second week of the October school holidays. These operations are one of the actions in the Central Region Tobacco Plan. One hundred and nine premises were visited with five sales of tobacco recorded to minors. The results from across the Central Region are summarised in the table below:

Lower North Island Joint Tobacco Sting Results

	Number of premises visited	Number of sales to underage volunteer
Hawkes Bay DHB district	30	0
Mid Central DHB district	18	0
Wairarapa DHB district	25	0
Hutt Valley DHB district	20	0
Capital & Coast DHB district	16	5

2 IMPROVING PROCESS AND CULTURE

2.1 Health Passport Launch

The Health Passport was launched on 29 November in Wairarapa at Masterton Medical. The Health Passport is a Health and Disability national initiative, an innovative new approach to clearer and easier communication between doctor and patient. The Passport is a document designed to assist nursing and medical staff to understand the care and support needs of people with disabilities. The Passport belongs to the disabled person, is kept and updated by him or her, and comes with the person to hospital. Its position at the end of the bed, and its physical format, ensure it is easily accessible to staff.

FOCUS (Wairarapa's Needs Assessment organisation) have already started using the Passport when visiting clients at home. The Passport is already used in a number of DHBs throughout New Zealand including Hutt Valley DHB. With further development in the sub-region, the passport will be re-launched in the Hutt Valley in the New Year. There has been an emphasis to make the health passport available throughout New Zealand.

3 FINANCIAL SUSTAINABILITY

3.1 Financial Result October 2013

A favourable variance to budget year to date of $189k has been reported for Hutt Valley DHB. The bottom line result at the end of October was a deficit of ($1,244k) compared to a budget deficit of ($1,433k). Further information is contained in the Finance Manager's report to the Finance, Risk and Audit Committee.

Wairarapa DHB has posted a deficit of ($1,261k) for the four months ended 31 October 2013 which is $151k favourable to the planned result YTD. Further information can be found in the Financial Report to the Board.

4 WORKING WITH OUR NEIGHBOURS

4.1 Sub Regional Disability Advisory Group meets November 2013

The Community and Public Health and Disability Support Advisory Committees (CPHAC-DSAC) endorsed on 21 October the selection of the first Sub Regional Disability Advisory Group. The selection was also endorsed by all three Boards October and November meetings. The inaugural meeting of the SRDAG occurred on 15 November 2013 and was chaired by Bob Frances with Dr Ashley Bloomfield present. Margaret Faulkner was nominated by members as interim Chair. She agreed to sit for four meetings while the group finalises the Terms of Reference and builds relationships.

The group gave input on the Draft Plan and endorsed it in principle.

4.2 3DHB Health Services Development (HSD) Programme

Attached as Appendix Four is an update on work undertaken under the 3DHB Health Services Development (HSD) Programme in the month of November 2013, outlining programme highlights, key planned activities and emerging priorities.

5. INTEGRATING HEALTH SERVICES INTO A MORE UNIFIED SYSTEM

5.1 Tihei Wairarapa

The Tihei Wairarapa Integration Programme (The Alliance Leadership team in the Wairarapa) continues to make good progress against its workplan. Of particular note for the last month, is the progress on discussing an improved model of care for the management of diabetes within the district. This model will ensure that the right people are receiving the right service at the right time and that we are using our collective workforce as efficient and appropriate as possible.

The Child Health Executive Group (CHEG) are currently reviewing its terms of reference and have agreed to change its scope from 0-5 year olds to 0-19 year olds to ensure local governance arrangements are in place for the development and implementation of youth initiatives within health. A representative from the Social Sector Trial being initiated in the South Wairarapa will now be a member of this group to ensure the two work programmes are connected.

5.2 Hutt INC

Hutt INC (the Alliance Leadership team operating in the Hutt Valley) had its regular monthly meeting on Thursday 21 November. The main items of discussion were:

- Opportunities around improved management of cardiac referrals
- Finalising several surgical pathways for the Hutt Valley to help patients and GPs have more clarity about treatment path
- Ways to ensure that clinical pathways development takes into account the needs of people with disabilities
- Improving primary care access to elective surgical lists
- Timeframes for extending access to eTree so that primary clinicians can access information about their patients in Wairarapa and Wellington Hospitals.

The group also advised on development of a sub-regional approach to building new clinical pathways, considered work underway in the sub-region around improving the care of frail elderly, gave direction around how best to improve linkages between Hutt INC and the Sub-Regional Clinical Leadership Group, and began the process of re-prioritising its work streams to make sure it focuses on the areas where there is the most to be gained.

5.3 NETP and Primary Health Care

We are continuing to work with Te Awakairangi Health Network (TeAHN) and Compass Health to promote NETP recruitment for 2014. To date Hutt has two definite placements in General Practice, two more interested and potentially a placement with Te Awakairangi. The increase in numbers for the Hutt has been the result of a concerted effort on the part of the Hutt Nurse Director for Primary Health and TeAHN working more collaboratively. Both the DHB and TeAHN have been able to offer small financial inducements to assist in encouraging recruitment. Wairarapa has no external placements so far.

Three Very Low Cost Access Practices (one for Wairarapa and two for Hutt) have submitted cases for employment of new graduates through a Ministry of Health initiative for sustainability of these practices. Notification will be early December. The DHBs and PHOs and the practices have worked closely together on this initiative as well.

5.4 Diabetes Nurses Prescribing and Primary Health Care

We have been working with Diabetes teams across both districts to identify key practice nurses who are ready or keen to undertake further training to become diabetes nurse prescribers. Currently the Nurse Director for Primary Health is gathering information from individual practices about how many are already "ready" to undertake this work, and where others are at with regards to their Post Graduate training.

6. OTHER MATTERS OF INTEREST TO THE BOARD

6.1 Hutt Primary Health Nurse Innovation Fund 2013/14

The Primary Health Nurse Innovation Fund 2013/14 ($40,000) has been promoted to primary health care and applications have closed. Last year's recipient, Silverstream Health Centre (IV Cellulitis Pilot), is exploring options for further initiatives, and has been asked by two DHB services about their ideas following the success of this year's initiative.

6.2 National Health Board Presentation

A meeting was held with the National Health Board on 25 November. Following a tour of the Hutt facility a presentation was given by the 2DHB Chairs and CEO supported by the Deputy Chairs, Director SIDU, Chief Operating Officer and Clinical Leads. The presentation is attached as Appendix FIve. The meeting was very positive and was a great opportunity to promote sub-regional successes, talk about the challenges and next steps.

6.3 Wairarapa Community Forums

Bob Francis and I presented at four community forums, Greytown and Featherston on 7 November and Carterton and Masterton on 12 November. It was pleasing to see a good turnout at each of the meetings and the interest of the community in the future health care in Wairarapa. The forums looked back over the past year of the 3DHB partnership and forward to the next three years. Attendees were given the opportunity to ask questions and also to forward feedback or further questions directly to the Chief Executive. Many questions related to the

future of services in the Wairarapa, and assurances were given that these will remain and be strengthened through co-operative efforts.. The presentation is attached as Appendix Six.

Members of the community felt there needed to be more communication on how health care is changing in Wairarapa and how it will be delivered across the sub-region. We intend to dedicate a Health Highlights article to the questions raised at the forums and to any further questions directed to the CEO@wairarapa.dhb.org.nz email address.

6.4 Blackout, 17 November 2013

In order to calibrate metering equipment, the incoming electrical supply to the Hutt hospital site was 'switched off' for six hours and we operated solely on emergency generators. This occurred at a weekend as energy consumption levels are generally lower. Risk mitigation included:

- Hiring an additional generator
- Increased generator servicing
- Departments completing checks to ensure critical equipment were in the essential switchplates
- Robust staff and patient communications strategy
- Project Team.

On the day, the Emergency Operations Centre was activated, an on-site event response team managed issues and prior to going 'live' an internal and external threat assessment was completed. The event was a resounding success providing an excellent learning opportunity which has resulted in increased organisation resilience.

6.5 Public Hospital Governance in the Asia-Pacific Region: New Zealand District Health Board Case Study

Attached as Appendix Seven for your interest is a case study undertaken by Robin Gauld, Centre for Health Systems, University of Otago. The study aims to describe the context for, and approach to, health system and hospital governance in New Zealand.

6.6 Review of the New Zealand Standards on Accessibility

On 20 October 2013, Hon Maurice Williamson, Minister for Building and Construction, and Minister Tariana Turia announced that the Ministry of Business, Innovation and Employment will be carrying out a major review of disability access.

The review will look into how New Zealand Standard 4121, which outlines how buildings can be made accessible to disabled people, aligns with the Building Code. And it will look at how the Building Code more generally represents the needs of disabled people.

The Ministry of Business, Innovation and Employment is now working with the Office for Disability Issues to determine the scope of the review

Meanwhile, the Christchurch Central Recovery Plan's new transport chapter 'An Accessible City' has just been released.

This new chapter states that the buildings, open spaces, streets and facilities within the central city will be safe, accessible and people friendly. It rightly recognises that a more accessible and safer built environment will benefit everyone, becoming more accessible not just to disabled people, but also to older people, those with young children, and people with temporary mobility issues.

6.7 Parliament to consider a Disability Commissioner role in the Human Rights Commission

The creation of a dedicated Disability Commissioner role in the Human Rights Commission is one step closer to happening. On 5 November 2013, Parliament agreed that the Human Rights Amendment Bill be referred to the Justice and Electoral Select Committee. If passed, the Bill will advance New Zealand's implementation of Article 33 of the United Nations Convention on the Rights of Persons with Disabilities. Article 33 requires independent monitoring of the Convention.

6.8 United Nations Universal Period Review

New Zealand's second report under the United Nations Universal Periodic Review has been released and was submitted to the Office of the High Commissioner for Human Rights on 4 November 2013. The review looks broadly across how New Zealanders can enjoy and exercise the range of human rights, particularly those rights specified in various United Nations treaties which New Zealand has ratified. In the New Zealand report, disability issues again feature as a priority, with the recommendations highlighting on-going implementation of the New Zealand Disability Strategy and the United Nations Convention on the Rights of Persons with Disabilities. The examination of New Zealand on its report will be held in Geneva on 27 January 2014.

6.9 Communications Update

I have included as Appendix Eight the projects and initiatives the DHBs' Communications Team have been working on since the last Board meeting. As the teams are now working more closely across the 2DHB and 3DHB space, I have decided to combine the Hutt and Wairarapa Communication updates. Your feedback is welcomed.

6.10 Official Information Act Requests

Attached as Appendix Nine are details of requests for information the DHB has received under the Official Information Act since the last Board meeting and our responses.

How is My DHB performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

2013/14 QUARTER ONE (JULY–SEPTEMBER) RESULTS

www.health.govt.nz/healthtargets

Shorter stays in Emergency Departments

95%

		Quarter one performance (%)	Change from previous quarter
1	West Coast	100	–
2	South Canterbury	97	–
3	Wairarapa	96	▼
4	Counties Manukau	96	–
5	Waitemata	96	–
6	Whanganui	96	▼
7	Tairawhiti	96	–
8	Nelson Marlborough	95	▼
9	Auckland	95	–
10	Hutt Valley	95	▼
11	Canterbury	94	–
12	Taranaki	94	▼
13	Hawke's Bay	93	–
14	Northland	92	–
15	Southern	90	▼
16	Bay of Plenty	90	–
17	Lakes	90	▼
18	Waikato	87	▼
19	Capital & Coast	86	–
20	MidCentral	85	▼
	All DHBs	93	–

Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

This quarter, four smaller hospitals have been added to the Shorter Stays in Emergency Departments target (see the website for further details).

Improved access to Elective Surgery

100%

		Quarter one performance (%)	Progress against plan (discharges)
1	Lakes	123	▲
2	Northland	118	▲
3	Waikato	116	▲
4	Counties Manukau	114	▲
5	Hutt Valley	113	▲
6	Taranaki	112	▲
7	Bay of Plenty	108	▲
8	South Canterbury	107	▲
9	Waitemata	104	▲
10	Wairarapa	103	▲
11	Canterbury	102	▲
12	Auckland	100	▲
13	West Coast	100	▼
14	MidCentral	100	▼
15	Whanganui	100	▼
16	Southern	98	▼
17	Hawke's Bay	95	▼
18	Capital & Coast	94	▼
19	Nelson Marlborough	94	▼
20	Tairawhiti	93	▼
	All DHBs	105	▲

Improved access to elective surgery

The target is an increase in the volume of elective surgery by at least 4000 discharges per year. DHBs planned to deliver 38,629 discharges for the year to date, and have delivered 1964 more.

Shorter waits for Cancer Treatment

100%

		Quarter one performance (%)	Change from previous quarter
1	Northland	100	–
1	Waitemata	100	–
1	Auckland	100	–
1	Counties Manukau	100	–
1	Lakes	100	–
1	Bay of Plenty	100	–
1	Tairawhiti	100	–
1	Hawke's Bay	100	–
1	Taranaki	100	–
1	MidCentral	100	–
1	Whanganui	100	–
1	Capital & Coast	100	–
1	Hutt Valley	100	–
1	Wairarapa	100	–
1	Nelson Marlborough	100	–
1	West Coast	100	–
1	South Canterbury	100	–
1	Southern	100	–
19	Canterbury	99.7	–
20	Waikato	99.5	–
	All DHBs	99.9	–

Shorter waits for cancer treatment

The target is all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy. Six regional cancer centre DHBs provide radiation oncology services. These centres are in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin. Medical oncology services are provided by the majority of DHBs.

During quarter one 2013/14, three patients who were ready-for-treatment waited longer than four weeks, one for radiotherapy and the other two for chemotherapy.

Increased Immunisation

90%

		Quarter one performance (%)	Change from previous quarter
1	Wairarapa	97	▲
2	Hutt Valley	94	▲
3	Auckland	94	▲
4	South Canterbury	94	▲
5	MidCentral	94	–
6	Southern	94	▼
7	Canterbury	93	–
8	Capital & Coast	92	–
9	Hawke's Bay	92	▼
10	Counties Manukau	91	–
11	Waitemata	90	▼
12	Nelson Marlborough	90	▲
13	Taranaki	90	–
14	Lakes	89	▲
15	Bay of Plenty	88	–
16	Whanganui	88	▼
17	Tairawhiti	87	▼
18	Waikato	87	▲
19	Northland	86	▲
20	West Coast	85	▼
	All DHBs	91	–

Increased immunisation

The national immunisation target is 90 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by July 2014 and 95 percent by December 2014. This quarterly progress result includes children who turned eight-months between July and September 2013 and who were fully immunised at that stage.

Better help for Smokers to Quit

95%

	Change from previous quarter	Hospitals
	▲	99
	–	98
	–	99
	▲	93
	–	99
	–	98
	▼	94
	–	95
	–	95
	–	96
	–	97
	–	96
	▼	96
	–	96
	▲	96
	▼	93
	–	96
	–	95
	–	97
	▲	95
	–	96

90%

		Quarter one performance (%)	Primary care	Change from previous quarter
1	Wairarapa	98		▲
2	South Canterbury	83		▲
3	Hawke's Bay	81		–
4	MidCentral	77		▲
5	Northland	77		▲
6	Bay of Plenty	75		–
7	Whanganui	74		▲
8	Nelson Marlborough	73		▲
9	Capital & Coast	68		▲
10	Taranaki	67		▲
11	Hutt Valley	64		▲
12	Waikato	62		▲
13	Lakes	61		–
14	Southern	60		▲
15	Counties Manukau	59		▲
16	West Coast	58		▲
17	Tairawhiti	56		▲
18	Auckland	51		▲
19	Waitemata	47		▲
20	Canterbury	37		▲
	All DHBs	60		▲

Better help for smokers to quit

The target is 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of patients who smoke and are seen by a health practitioner in primary care, are offered brief advice and support to quit smoking.

More Heart and Diabetes Checks

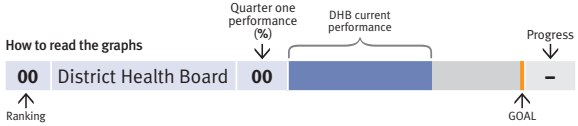
90%

		Quarter one performance (%)	Change from previous quarter
1	Wairarapa	82	▲
2	Counties Manukau	81	▲
3	Auckland	80	▼
4	Capital & Coast	78	▲
5	Whanganui	77	▲
6	Northland	76	▲
7	Taranaki	76	▲
8	MidCentral	75	▲
9	Waikato	75	▲
10	Hawke's Bay	73	–
11	Bay of Plenty	72	–
12	Waitemata	72	–
13	Tairawhiti	70	▲
14	South Canterbury	68	▲
15	Lakes	68	▲
16	West Coast	64	▲
17	Southern	64	–
18	Nelson Marlborough	59	▲
19	Hutt Valley	56	▲
20	Canterbury	36	▲
	All DHBs	69	▲

More heart and diabetes checks

This target is 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved by July 2014.

How to read the graphs



Health target results are sourced from individual DHB reports, national collections systems and information provided by primary care organisations.

This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

New Zealand Government

REGIONAL SERVICES PROGRAMME

Regional Round Up

July 1 – September 30 213

A word from the Regional Services Plan (RSP) Programme Sponsor, Kevin Snee:

"It's been a highly productive quarter, with all projects 'on track' to achieve their milestones. It's expected that there will be obstacles and risks associated with complex projects such as these, so if we didn't have some amber and the occasional red traffic light, we would have to wonder whether we were challenging ourselves enough.

Particular mention has to go to Whanganui DHB who have made significant gains in the areas of cardiovascular health – see the good news story for more about this."

Quarterly Report Snapshot

The Traffic Light System shows:

83% Green

16% Amber

1% Red

(Across both high level and individual projects.)

RSP Overall Project Status

Project	Traffic Light	On Track
Rheumatic Fever	G	✓
Electives	A	✓
Cancer	G	✓
Cardiovascular	A	✓
Stroke	G	✓
Mental Health and Addiction	G	✓
Radiology	A	✓
CRISP	R	✓
Workforce	G	✓

Good News in Whanganui!

Whanganui DHB, along with the Wanganui Regional PHO (WRPHO) and its local GPs, have made a dramatic improvement in the number of cardiovascular risk assessments being done in the Whanganui region.

Up until recently, the intervention rate for cardiovascular assessment rates was around 50% below the national average, which had a flow-on effect to the state of the wider Whanganui population's overall health and wellbeing.

The Cardiac Network facilitated a meeting between primary and secondary care providers to highlight this concern and as a result the DHB changed their clinical practices and undertook an audit of existing coding practices. The WRPHO has also facilitated an increase in the number of cardiac risk assessments in the community.

Thanks to the commitment of all those involved, the intervention rate for the year ended June 2013 is now 6.38 per 10,000 (up from 4.20) – very close to the national average of 6.41 per 10,000 – and their target is 6.5 per 10,000.

This shift in activity has resulted in Whanganui moving to the 10th spot on the national ranking, and 2nd regionally (after Nelson/Marlborough).

Whanganui DHB and WRPHO are committed to continuing to work closely together to improve cardiovascular health.

REGIONAL SERVICES PROGRAMME

Regional Round Up

July 1 – September 30 213

Huge Strides in the Area of Stroke

For such a new group, in place for just one year, the Stroke programme is making significant progress towards its milestones and targets. Already definitions and service expectations have been agreed by the Stroke steering group which is led by the highly focused and energetic neurologist, Ana Ranta, who also chairs several other stroke-related groups at a national and regional level.

The national target is to admit 80% of stroke patients to an acute stroke unit. The three DHBs who currently collect data and have acute stroke units are sitting at 66.4%. When all Central Region DHBs are taken into account (with or without acute stroke units), the actual transfer rate to an acute stroke unit is 45.6%. So there is still plenty of work to do to reach the national target of 80%, but this committed group are well on their way to helping the Central Region achieve their targets.

Hutt Valley DHB are worth particular mention because not only are they are exceeding the national 80% target – at 83% - but they are also exceeding the national target of 6% of patients presenting with ischaemic stroke being thrombolysed – at 6.3%. MidCentral DHB is not far behind with 71.1% of stroke patients being transferred to an acute stroke unit and an impressive 10.8% of ischaemic stroke patients being thrombolysed. In fact, the region as a whole is exceeding the 6% target – at 7%. Further work is being done in the area of thrombolysis with a sub group being formed to work on a Regional Thrombolysis pathway.

Snippets from Mental Health

Face-to-face meeting for Demential Pathways working group proves a success

Despite being in existence for nearly a year, those involved in the Dementia Pathways working group got together in person for the first time recently. The meeting was well received by everyone involved, with best practice tips and shared understandings of common issues being gained.

This important meeting will help ensure ongoing traction in the Mental Health and Addiction programme of work.

Clinicians and Consumers get a say in Residential Addiction Services

Psychiatrist Dr Tom Flewett, Capital and Coast DHB, leads the Residential Addiction Services working group, providing highly focused leadership. In particular, survey work and focus groups are being used with both clinicians and consumers of addiction services to better understand what is working well and what more can be done to improve services.

Highlighting Health of Older People

Colourful posters and brochures are being widely circulated in Whanganui to highlight their *"Too many medicines?"* pilot headed by the Whanganui District Health Board (WDHB) and Whanganui Regional Health Network (WRHN).

The pilot is all about raising awareness and reducing harm resulting from people taking a lot of pills and a combination of them that might not be working well together. The pilot encourages patients to discuss their medicines with their doctor and/or pharmacist, while emphasising the importance of continuing to take their medicines until advised differently.

The pilot is targeting older people who tend to be given more medicines, for different conditions, and sometimes by different doctors. Once herbal, Māori and over-the-counter medicines are factored in, it's important to stop and check that everything is working well. Symptoms such as dizziness, confusion, nausea, constipation, incontinence, and a tendency to fall, can indicate it would be worthwhile checking medicines.

A working group of representatives from across the Central Region (including from the WDHB and WRHN) have been working on the service launch for some months.

REGIONAL SERVICES PROGRAMME

Regional Round Up

July 1 – September 30 213

Key outcomes and progress have been made in each of the RSP projects:

Highlights by Project	
Rheumatic Fever	The target is to reduce the Central Region's 3 year average of first episode hospitalisations for rheumatic fever by 10% and the project is on track to achieve this. Prevention programme plans are in their final stage of draft and a sponsor and clinical champions are in place and engaged.
Electives	The Electives project is focused on facilitating a regional approach to addressing key issues such as the sustainability of elective services, inequalities to access quality services, and the need for increasingly efficient services. The key outcome is to achieve the target of a four month wait time for elective services by December 2014. This quarter the project achieved the signing of back to back contracts with the Central Region DHBs and began the Expressions of Interest process for Facilitators. Next steps focus on clinical sponsor roles, communications strategy and workshops.
Cancer	The target is to meet the radiation oncology four week wait time consistently. The target was met in Q1 for Capital & Coast, Mid Central DHB, where the data is collected. A business case for chemotherapy e-prescribing is being prepared along with system requirements. A national solution may be developed – the regional team will keep a watching brief on developments.
Cardiovascular	See the good news story above for more information about Whanganui. Of particular note is the improvement in Whanganui's cardiac surgery standardised intervention rate which now sits at 6.38 per 10,000 population compared to 4.20 (year ending December 2012) and a national rate of 6.41. The rest of the region continues to work on improving intervention rates.
Stroke	See more detail in the "Huge Strides in the Area of Stroke" article. The Stroke steering group have made significant progress this quarter, achieving all its milestones to date. The national target is to transfer 80% of admitted stroke patients to an acute stroke unit. Currently the three DHBs who have acute stroke units and collect data are sitting at 66.4% and the region as a whole is sitting at 45.6%. A sub group is also being formed to work on a Regional Thrombolysis pathway.

REGIONAL SERVICES PROGRAMME

Regional Round Up

July 1 – September 30 213

Highlights by Project	
Mental Health and Addiction	Individual projects in the Mental Health and Addiction Services programme of work are tracking well. There has been an increased focus in High and Complex Needs and Maternal and Perinatal Services after a request for additional reporting from the Minister's office. The project is now aware of a plan being developed for National Forensic Mental Health plan which may have implications for Regional Services Planning and service delivery. Other key milestones include a first face to face meeting held recently and some clinician and consumer focused feedback on addiction services. See the “Snippets in Mental Health” for more information.
Radiology	Central Region as a whole has achieved their CT wait time targets and three of the DHBs (Wairarapa, Whanganui and MidCentral) have achieved their MRI WTI wait time targets. Work is continuing with CRISP to eliminate the need to transfer images around the region. Sonographer analysis and data collection has started to improve the patient experience.
CRISP	The CRISP team are now in an implementation and delivery phase, and continue to work closely with the Central Region DHBs and progress the individual projects. Central Service Infrastructure implementation is two thirds complete and will be finished by the end of the year. Clinical Portal is progressing well with the vendor team now co-located at Central TAS. The Patient Administration System is progressing well with regional licensing agreements now in place. A Radiology Information System ‘model office’ is now ready.
Workforce	The Workforce project is tracking well with a focus on planning for the future with a well-trained, well-planned (right skills in the right places) workforce, using tools such as e-learning and the Training Hub.

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

Wairarapa Hospital Operational Services

Monthly Balanced Scorecard October 2013

KEY PERFORMANCE INDICATORS 2013/2014

PATIENT EXPERIENCE

		Oct-13		Period	
		Target	Month	YTD	QTR2
Shorter Stays in Emergency Departments		95%	**96%**	96%	**96%**
Improved Access to Elective Surgery		100%	**96%**	101%	**105%**
Better Help for Smokers to Quit		95%	*	95%	*
		Target	Month	Target	YTD
Mental Health Relapse Prevention Plans	Jun-13	95%	**93%**	95%	**93%**
HONOS Compliance - Community	Oct-13	55%	**83%**	55%	**79%**
Inpatient Falls Causing Harm		2	**1**	9	**11**
Medication Errors		1	**2**	2	**6**

* Data Issue

WAITLISTS

	Waitlist Patients (ESPI5 and ESPI2)			
	Target	Month	Booked	Unbooked
Waiting >150 Days for Outpatient FSA (ESPI2)	0	**0**	0	0
Waiting >150 days for Treatment (ESPI5)	0	**22**	0	22

HEALTHY WORKPLACE

	Oct-13		Period	
	Target	Month	Target	YTD
Staff Turnover Voluntary % (Headcount)	10.0%	**9.6%**	10.0%	**11.4%**
Sickness Absence - % Paid Hours Worked	2.5%	**2.3%**	2.5%	**2.8%**
Number of Staff having >200 hrs leave balance			52	**44**

MOH Performance Measures | MOH Health Targets

PROCESS & EFFICIENCY

		Oct-13		Period	
		Target	Month	Target	YTD
Inpatient Acute Readmission Rate	Sep-13	8.0%	**9.8%**	8.0%	**8.8%**
Mental Health Acute Readmission Rate	Sep-13	8.0%	**0.0%**	8.0%	**0.0%**
Acute Inpatient Length of Stay		3.4	**3.3**	3.4	**3.2**
Elective/Arranged Inpatient Length of Stay		3.8	**2.8**	3.8	**3.6**
Elective/Arranged Day of Surgery Admission		95%	**96%**	95%	**97%**
Ward Bed Utilisation - Daily (Incl Weekends)		85%	**84%**	85%	**84%**
Ward Bed Utilisation - Weekdays Only		85%	**85%**	85%	**84%**
Theatre Session Utilisation (Time in Theatre)		85%	**66%**	85%	**77%**
Theatre Sessions Starting on Time		90%	**97%**	90%	**93%**
Acute Patients impacting on Elective Sessions		U/D	**5**	U/D	**21**
Cancelled on Day of Surgery - Patient		3	**5**	13	**25**
Cancelled on Day of Surgery - Hospital		12	**27**	56	**83**
Cancelled on Day of Surgery - Percentage		5.0%	**10.6%**	5.0%	**7.7%**
Outpatient DNA (FSA & Followup)		125	**132**	485	**569**
Outpatient DNA (FSA & Followup) - DNA Rate		6.2%	**6.5%**	6.2%	**7.3%**

VALUE FOR MONEY

	Oct-13		Period	
	Target	Month	Target	YTD
Total Caseweight	494	**207**	1,978	**1,838**
Elective Caseweights	108	**41**	432	**424**
Acute Caseweights	386	**165**	1,546	**1,414**
Outpatient FSA Volumes	504	**620**	2,015	**2,462**
Outpatient FU Volumes	642	**622**	2,568	**2,223**
Hospital FTEs inc overtime	431	**417**	431	**421**
Hospital Operating Costs ($'000)	5,287	**5,391**	21,336	**21,385**
Hospital Personnel inc outsourced ($'000)	3,300	**3,181**	13,347	**13,117**

KEY: N/A = Not available U/D = Under Development

Key Issue | Alert | Good News

3DHB Health Service Development Programme Report 27 November 2013

October Programme Highlights;

- *Sub-regional approach to Clinical Pathways* - The three DHBs are moving forward with the implementation of Clinical Pathways Project which will adopt the Canterbury Pathways methodology and web based tools. This pathway solution is now implemented, or in the process of being implemented in all the South Island DHBs and 10 Australian health authority areas. An implementation group has developed a detailed implementation plan, budget and timeframes and it is expected that implementation will commence from early 2014. The implementation plan will make provision for both the development of new pathways (involving significant service change and undertaken by clinical working groups) and the localisation of already developed 'business as usual' pathways to incorporate local referral information. All pathways will be hosted on a sub regional pathways website and accessible to clinicians in hospitals through Concerto and General Practice through Medtech. The Canterbury Pathways team is planning a two day workshop early in 2014, bringing together clinical leads from across the 3 DHBs, the three Alliance Leadership Teams (ALTs) and the Clinical Leadership Group (CLG) to orientate to the Canterbury Pathways package and showcase a number of examples of clinical pathway development.
- *Integrated Sub-regional Service Design* – There is an ongoing piece of work that will conclude by Christmas to provide clarity to the clinical work streams on the specific details and decisions required to establish a ~~single~~ sub regional single service. Some of the clinical work stream such as ENT and Gastro have been working towards how they might operate as a sub-regional service across the three DHBs and the intention of this project is to provide guidance on how this could occur e.g. what key components needs to be considered such as the patient journey through a single service, clinical pathways and e-referral, to single triage process and single waitlist etc. This work will be presented back to the CLG in the New Year.
- *Sub Regional Radiology* - The 3DHB Executive has endorsed the Radiology Steering Group recommendations to progress towards a sub regional service and approach across both community and hospital referred diagnostic radiology so that a whole of system approach is considered. Project management resource to progress this work has been confirmed within SIDU starting early December and the Steering Group will also be meeting in December to consider and approve the Project Scope and deliverables.
- *Child Health* –.Two new work streams have bee established -acute care and primary/secondary interface and are tasked with delivering the service design to support a single seamless child health service for the sub-region.
- *ENT*- Finalised ENT Clinical Pathways have been uploaded onto the Hutt Pathway websites and when the sub regional pathways website is enabled early in the New Year will be available sub regionally. Workshops have been held to develop clinical pathways for four common paediatric ear health issues and these will be further developed and agreed by the Clinical working group and also made available sub regionally. Opportunities to further progress ENT toward single service design will be further considered once the outcome of the sub regional single service design work is known.

Benefits Tracking;

- CLG reviewed a comprehensive list of reporting that is available that could be utilised with the Benefit Realisation Driver Diagram. This is being fine tuned with first draft of a score care due to the December CLG meeting.

Key Planned Activities/Emerging Priorities;

- *Clinical Pathways* – lock in Clinical Pathways training days for the New Year, establish sub regional Clinical Pathways Governance Group, confirm project budget, complete contractual agreement with Vendor.
- *Integrated Sub-regional Service Design*- concludes series of workshops by mid December 2013. Draft concept paper developed for February CLG and clinical work streams.
- *ENT* - Finalising current projects by end of December 2013.
- *Gastroenterology* - Confirming clinical information required to inform single service project design.
- *Child Health* - Confirming the new Steering Group to oversee the new work streams and work streams to meet end November confirm project plan and milestones.
- *Orthopaedics* – Background for concept paper progressing, meeting with operational and clinical end November to confirm direction.
- *Radiology* – Sign off of Project Scope and deliverables by Steering Group. Project Manager to commence early December.
- *ICT* – A 3D ICT project group has been established to define the detail and implementation required to progress 3D projects. There is significant progress in this area as we progress options for single service design, and the ICT solutions that are needed.

  Emerging Priorities - Dermatology, ICU/HDU, Anaesthetics, Secondary Obstetrics.

New Risks/Concerns and Mitigation;

N/A

Communication;

- 3D staff newsletter for October was completed and circulated.

Working as 3 DHBs: progress, challenges and next steps

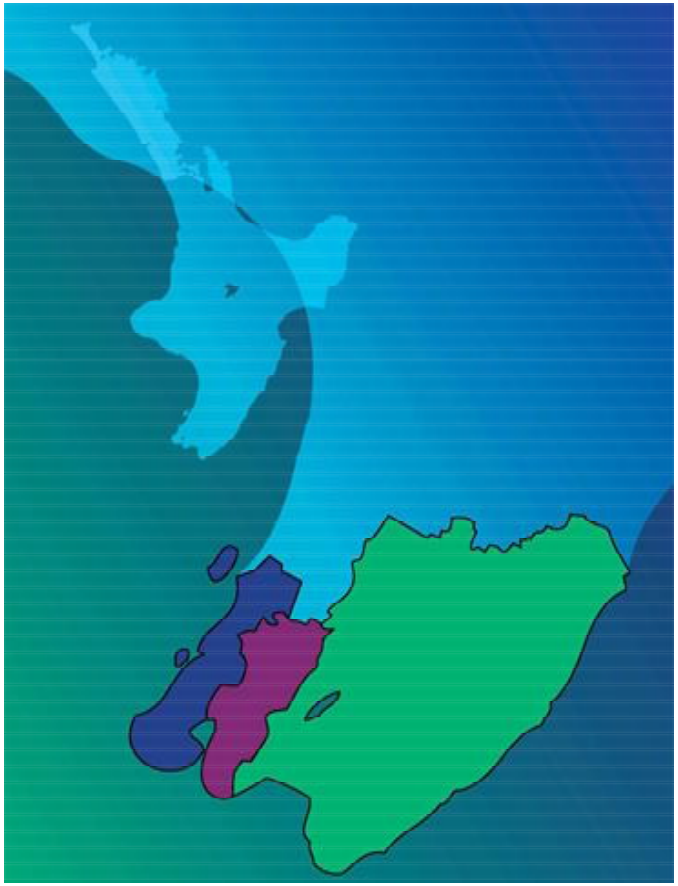
Graham Dyer, CE Wairarapa and Hutt Valley DHBs

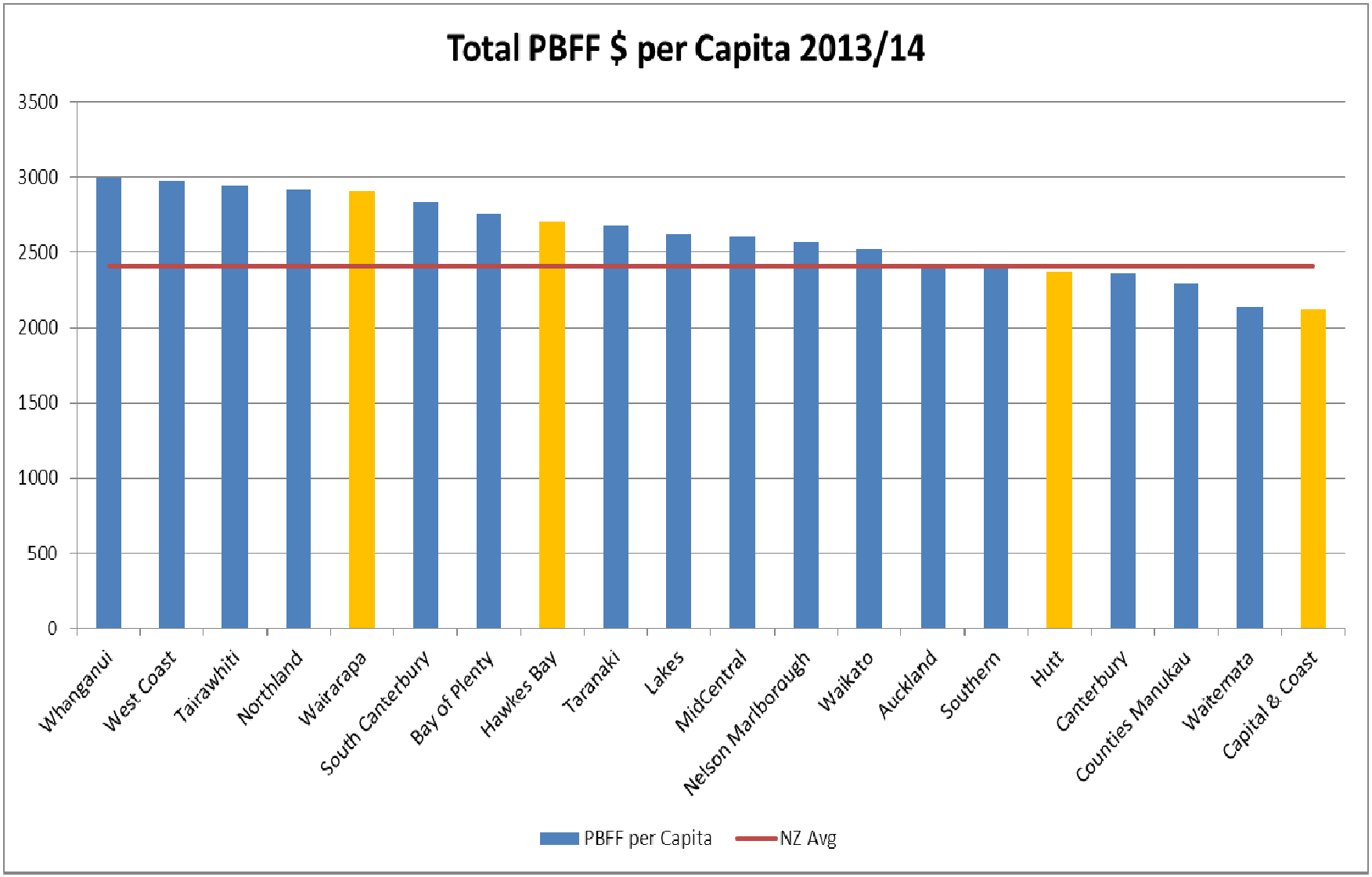
Debbie Chin, Interim CE Capital & Coast DHB

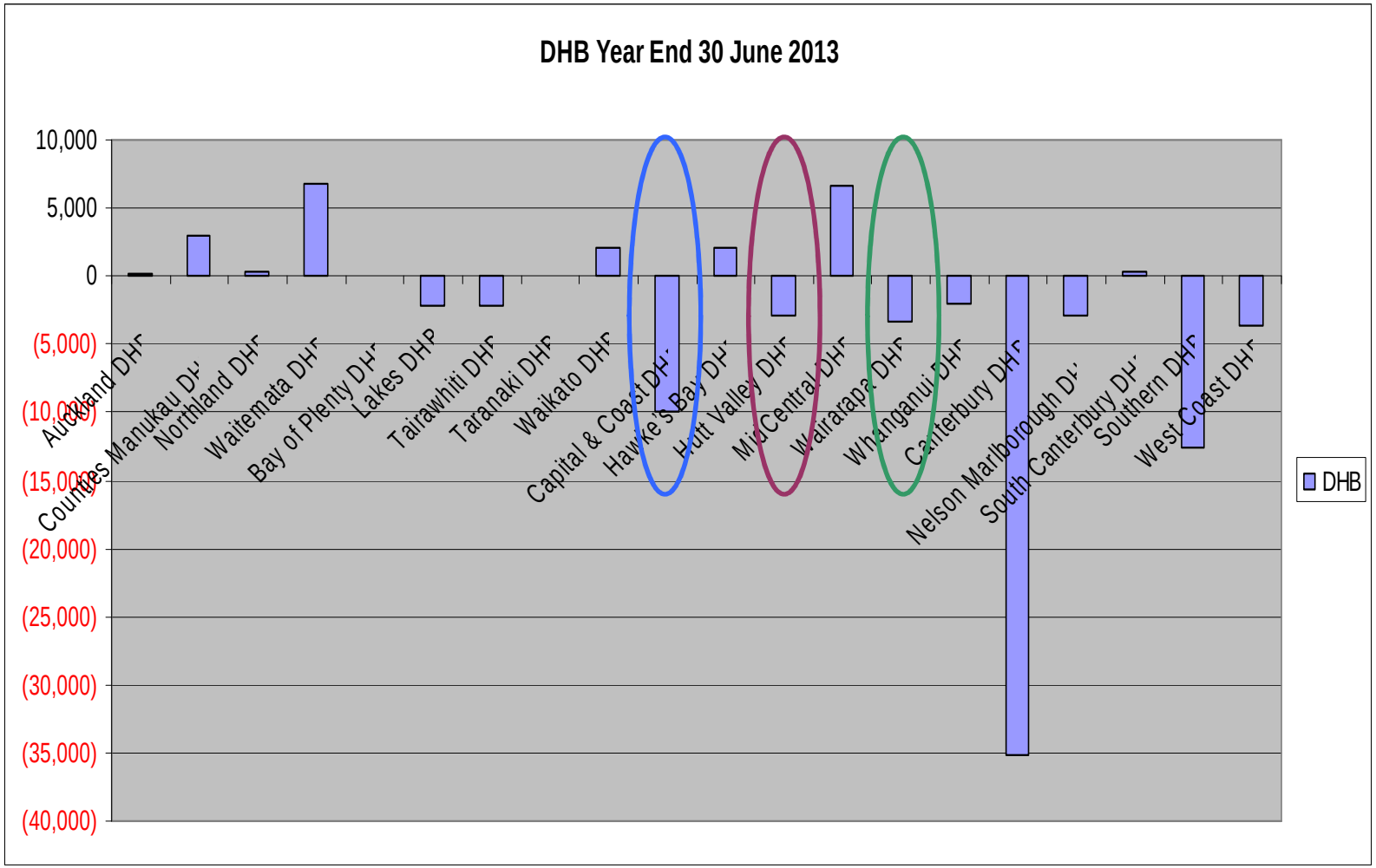
25 November 2013

Our 3 DHBs

- Combined population of 485,000
  - Wairarapa 40,000
  - Hutt Valley 145,000
  - CCDHB 300,000
- Combined funding $1.5B pa
- 4 hospitals:
  - Wairarapa 84 beds
  - Hutt 331 beds
  - Keneperu & Wellington Regional 600 beds plus175 mental health




Total PBFF $ per Capita 2013/14
3500
3000
2500
2000
1500
1000
500
0
Whanganui
West Coast
Tairawhiti
Northland
Wairarapa
South Canterbury
Bay of Plenty
Hawkes Bay
Taranaki
Lakes
MidCentral
Nelson Marlborough
Waikato
Auckland
Southern
Hutt
Canterbury
Counties Manukau
Waitemata
Capital & Coast
PBFF per Capita
NZ Avg


DHB Year End 30 June 2013
10,000
5,000
0
(5,000)
(10,000)
(15,000)
(20,000)
(25,000)
(30,000)
(35,000)
(40,000)
Auckland DHB
Counties Manukau DHB
Northland DHB
Waitemata DHB
Bay of Plenty DHB
Lakes DHB
Tairawhiti DHB
Taranaki DHB
Waikato DHB
Capital & Coast DHB
Hawke's Bay DHB
Hutt Valley DHB
MidCentral DHB
Wairarapa DHB
Whanganui DHB
Canterbury DHB
Nelson Marlborough DHB
South Canterbury DHB
Southern DHB
West Coast DHB
DHB

3D Governance

- Hutt Valley DHB and CCDHB have shared Chair
- Cross-over of Board Membership and single Crown Monitor (HV and CC DHBs)
- Single combined CPHAC-DSAC since Feb 2013
- HACs and FRACs now have joint session monthly
- Boards meet together twice yearly
- Sub-regional Pacific Strategic Health Group
- Sub-regional Disability Advisory Group

3D clinical leadership

- Sub-Regional Clinical Leadership Group established over 3 years ago, initially just senior doctors
- Added DONs and DAHs and subsequently senior executives to support decision-making and implementation
- Work underpinned by 'Triple Aim'
- Identified a number of services for 3 DHB prioritisation (vulnerability / suitability / "readiness" criteria)
  - ENT
  - Child Health
  - Gastroenterology
  - Mental Health (high complexity 2°/3°/NGOs +)
- Primary care membership (linked to our 3 ALTs) added this year

3D Clinical Program

- Driver Diagram – Separate hand out

Clinical Merges

	WDHB & HVDHB	Joint	CCDHB
Executive	CEO DON CMO DAH COO Pacific Alliance	EDSIDU EDP&C EDCorp EDMaori	CEO DON CMO DAH COO Pacific Alliance
Directorates			
Surg W&C		Orthopaedics Gen Surg ENT (etc.)	
Directorates Medical	Surg W&C Medical	Gastro Respiratory Gen Gem (etc.)	Surg W&C Medical
M Health	M Health	CAMHS Forensic AOD (etc.)	M Health
Clin Supt	Clin Supt	Radiology Laboratory (etc.)	Clin Supt

Characteristics of 3D Services

- Single clinical lead across 3DHB's
- Single management lead across 3DHB's
- Single booking and prioritisation system
- Single acute roster

These are consistent with themes in the 3D plan

Also require local facility management for day to day oversight (e.g. Wairarapa and Hutt Hospital Managers)

3D Executive Program

- Combined planning and funding Dec 2012 into SIDU under single Director – FTE reduction and $500K pa saving – Enabler for VFM reviews
- Single ED People and Culture March 2013, standardised employment practices / policies / procedures
- Wairarapa and Hutt Exec Team and providers combined April 2013 – $1.5mil saving to date
- Single IT service mid-2013 under 3D CIO
- ED Corporate Services bringing together finance, information, property services

Executive Options

	WDHB & HVDHB	Joint	CCDHB
Executive	CEO DON CMO DAH COO Pacific Alliance	CEO DON CMO DAH COO Pacific Alliance EDSIDU EDP&C EDCorp EDMaori	CEO DON CMO DAH COO Pacific Alliance
Surg W&C		Orthopaedics Gen Surg ENT (etc.)	
Medical		Gastro Respiratory Gen Gem (etc.)	
M Health		CAMHS Forensic AOD (etc.)	
Clin Supt		Radiology Laboratory (etc.)	

Impacts for Boards

- Need greater streamlining and 3D focus
- More blurring of financial boundaries
- Focus increased on quality and access for local population, and overall affordability
- Greater focus on accountability measures

Service Actions from 3D Plan

- Combine Laboratories
- Visiting specialists to Wairarapa
- Single Radiology Department
- Funder VFM process
- Single services / reduce acute rosters
- Standardise ‘exceptional circumstances’
- Development of 3D mental health approach by Feb 2014
- Supporting each other on radiology & electives, moving to a single ‘production plan’

Challenges

- Working with 5 key ‘constituencies’ at the same pace: Ministry/NHB, communities, Boards, clinicians & managers
- Support from clinicians variable but gaining momentum
- Still required to produce 3 Annual Plans, and monitored on 3 sets of indicators
- 3 different elective services intervention rates – would like to move to a single rate across the three

- Regional tertiary hospital supported by the Central Region
- Acute/elective split
- Services closer to the patient
- Retain all campuses/hospitals - Best use of campuses
- Single services
- Single management structure
- 3D breakeven
- Single plan/KPIs

Health in the Wairarapa 2012/15

Bob Francis, Wairarapa DHB Chair

Graham Dyer, CEO Wairarapa and Hutt Valley DHBs

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

A 2012 picture

- Clinical leaders say we need more joined up services
- Development of community based (primary) care services (Tihei Wairarapa)
- Golden hour – have we got the right service in the right place, at the right time?
- Access to services across the region
- Excellent achievement against most measures of performance except financial
- Wairarapa DHB residual deficit of $3M pa – punching above our weight, mostly stand alone services

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

What we know

- Ideal population size for full range of efficient, effective health services is 500,000
- We need all the capacity in the 4 hospitals in the region to manage current and future demand (Wairarapa, Hutt, Kenepuru and Wellington)
- Wairarapa Hospital must also be able to respond to major events and provide frontline trauma care
- No business decision takes precedence over patient and staff safety and quality of care
- Primary Care is key to future development

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

2012/13 – a year of change

- Joint Annual Plan 2012/13 required (Wairarapa, Hutt Valley and Capital & Coast DHBs)
- 3DHB partnership approach agreed (October 2012)
- Plan approved by the Minister of Health
- Boards and identities of the 3DHBs remain separate – local accountability

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

HUTT VALLEY DHB

Capital & Coast
District Health Board

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

What does 3DHB Partnership mean?

- Services, operations and management of the 3DHBs will gradually integrate as opportunities arise
- Take advantage of new opportunities in modern health and medical practice
  - Improve equitable access of patient care
  - Meet increasing demand for services
  - Strengthen workforce
  - Ease financial pressures
  - Take confidence from our collective strength.

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

HUTT VALLEY DHB

Capital & Coast
District Health Board

What is the 3DHB Plan?

- Gradual integration of provider arms
  - first Hutt Valley and Wairarapa, then all three
- Greater shared support services across 3DHBs
  - Director People and Culture appointed
    - Alignment of HR processes
  - Service Integration and Development Unit Director appointed and team established
    - Alignment of planning processes
  - Information services function being established.
    - Joined-up technology

2DHBs

- A single CE and senior leadership team
- Retention of both boards to ensure local accountability
- Appointment of the Wairarapa Hospital Manager to ensure onsite service leaders are supported
- 'single service over several sites' approach
  - CSSD, Theatres, Therapies, electives
  - Directorates cover both sites
    - Medical & Community
    - Surgical, Womens and Childrens
    - Mental Health and Addictions

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

3DHB Programme

The 3DHB work programme is driven by the Clinical Leadership Group (which includes the CEs) and supported by SIDU

Clinical

- Active involvement of clinicians in the planning and development of services. Sub regional Senior Medical and multidisciplinary teams working together
- Active projects: ENT, gastroenterology, child health, orthopaedics, palliative care, amalgamation Hutt and Wellington hospital labs, sub-regional radiology service

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

3DHB Programme

Enabling

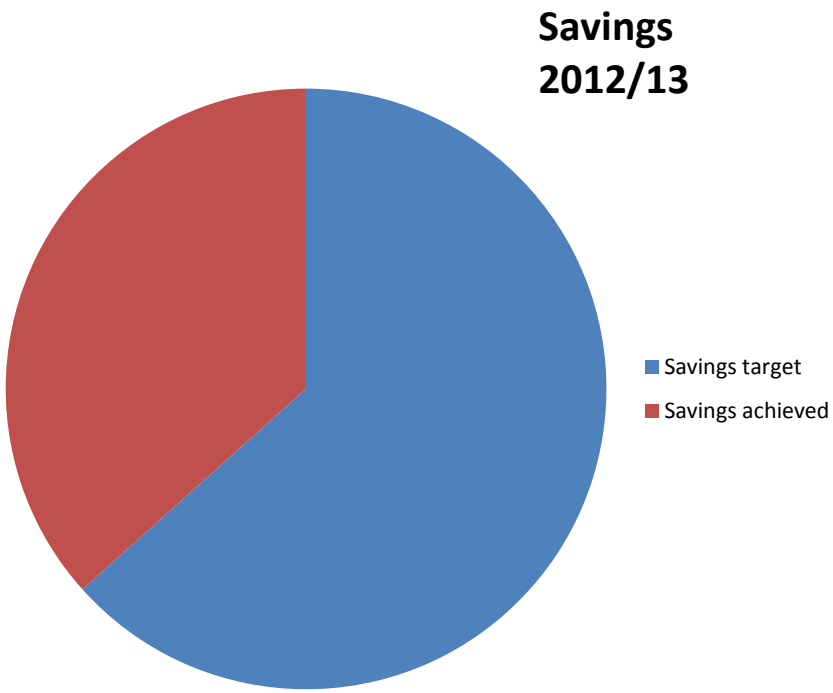
- Joint Service Integration and Development Unit (SIDU)
- Payroll, HR, Public Health, Facilities, Comms, Finance, IT either in place or moving towards a 3DHB focus.
  - 3DHB consideration for all future vacant positions
  - Eg: Allied Health educator appointed across 3 DHBs
- alternative approach to managing IDFs across 3 DHBs
- The 3 DHBs have committed to a $7.2 million deficit position across our collective catchment for 2013/2014, with an aim for a breakeven position in future years.

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

$o how did we go 12/13?

- Budget $3.1m deficit
- Actual $3.398m deficit

- Savings target $2.458m
- Savings achieved $1.421m



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

A day in the life of WDHB 2012

52	Emergency Dept attendances
24	Admissions to hospital (5 at other hospitals)
11	Theatre operations
1 - 2	Children are born
106	Outpatient / Allied Health appointments
97	Community nurse contacts
101	Radiology examinations
24	Counseling sessions for alcohol and drug addictions
404	> 65 year olds in Aged Residential Care
748	> 65 year olds supported at home
1,517	Community Pharmacy Scripts*
3,455	Community Pharmaceutical items*
762	General Practice visits

* Per working day

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

Health Targets

Last quarter we met or exceeded all targets

- ED 2nd — Exceeded
- Electives 19th — Met
- Immunisation 6th — Exceeded
- Cancer Wait times 1st= — Met
- Better help for smokers to quit 1st — Exceeded
- More Heart and Diabetes Checks 2nd — Exceeded

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

What we did well

Public Health

Breastfeeding education and promotion – 66% babies fully breastfed at 3 months (Target 57%)

Breastfeeding record broken at the 'Big Latch On' - 48 Wairarapa babies were latched on at 10.30am along with more than 1400 other mums and babies nationwide. A Public Health and community initiative.

Family violence intervention: Target 170, achieved 192

Number of Before School Checks: Target 90% Achieved 81% (% 4 year olds checked before they turn 5).

Oral Health

Increased pre-school enrolments by 30% since 2009

Hospital

Emergency Department: The Wairarapa ED Higher User Group project was set up to manage high users and reduce ED presentations. Between May and August 2013 numbers fell from 325 to 189.

Rehab:

- Clinical indicators are above the national benchmark.
- The role of the Psycho-geriatric Specialist nurse has been established and together with the Clinical Nurse Specialist for the Older Person, provides good back up for patients going home. This team also prevents unnecessary admissions.
- Length of stay is shorter and they have performed some fantastic results with stroke patients.

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

What we did well

Maternity:

- Increasing Midwife Lead Maternity Carer (LMC) numbers
- Appointing 2 Core midwives as pregnancy and parenting educators – classes started 23rd October
- Increased meal sizes and afternoon teas for women
- Allocated pregnancy scanning sessions
- Developing a flowchart with ED manager to improve care for pregnant women and improve communication to Midwife LMCs

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

What we did well

Medical/Surgical Ward

- Achieved 5 month wait time for electives
- Increased activity - 542 (10%) more patients in last 5 years
- Electronic referral system for SLT and dietician now in place
- Changed towel size to assist with the reduction in weight of laundry for washing (and therefore cost reduction).
- Four *competent* nursing portfolios completed.
- Introduced new Nursing Care Plan format.
- More electric beds for hospital wide use. (Now only 6 adult manual beds in use)
- Average Length of Stay reduced over last 5 years from 4.31 days to 3.75.

Allied Health

New Hand Therapy clinic won the *Across DHB Collaboration Award* at the 2013 Allied Health Scientific Technical and Awards.

District Nursing

100% positive feedback from students evaluation of their community placements.

Evening tutorials for support workers in oncology, wellness, Kahukura, Maori protocol, health of the older person, grief, challenging behaviours and Parkinsons Disease.

Positive report from ACC audit .

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

What we did well

- Dr Andreas Leinfellner, paediatrician, successfully completed his Vocational Practice Assessment (VPA). He is the third of our non-NZ trained senior doctors to successfully go through this process and is now fully registered in NZ as a consultant.

- After years of extra-mural study five Wairarapa nurses are celebrating the completion of their masters degrees

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

What will the future hold?

- Strengthening Wairarapa Hospital services
  - 3DHB radiology and imaging service
  - Integration of Emergency Management Teams (joint policies, protocols and approach)
  - Investigation of integration of Family Violence Intervention Teams
  - Rapid Cycle Initiatives
    - Surgical throughput
    - Discharge process
    - Scope of practice/clinical leadership.
- Putting patient safety and quality of care first – defining what should be done where (HDU, Theatres, visiting outpatient services, primary care)
- Building on our strengths – development of an 'elective hub'
- Bringing services close to home where possible
- Social Sector Trials extended to the Wairarapa
  - (Initiative led by the Ministry of Social Development, involving agencies including Health, Education, Justice and the New Zealand Police)
- Step up the pace of development in primary care
  - Integrated Family Health Networks

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

What will the future hold?

- Integrated Family Health Centres/Networks: “A new way of working to create a patient-centred model of care with facilities provided to support the delivery and development of health services”

- IFHCs tend to have three main areas of focus:
  1. improving the patient experience
  2. tailoring care more effectively – delivered by a range of healthcare professionals
  3. freeing up resources for more proactive care

- The IFHC ‘model’ is completely flexible, but levels of integration can include:
  - multidisciplinary teams within the IFHC
  - integration with other health care professionals working in the community (district nurses, allied health professionals, clinical pharmacists, social care professionals etc.)
  - integration with secondary care

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

What will the future hold?

- Integrated Family Health Centres/Networks: “A new way of working to create a patient-centred model of care with facilities provided to support the delivery and development of health services”

- IFHCs tend to have three main areas of focus:
  1. improving the patient experience
  2. tailoring care more effectively – delivered by a range of healthcare professionals
  3. freeing up resources for more proactive care

- The IFHC ‘model’ is completely flexible, but levels of integration can include:
  - multidisciplinary teams within the IFHC
  - integration with other health care professionals working in the community (district nurses, allied health professionals, clinical pharmacists, social care professionals etc.)
  - integration with secondary care

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

Mythbusters

How may of these have you heard?

• The hospital is going to close	False
• More treatment will happen out of hospitals in General Practice	True
• The maternity unit will close	False
• Services are being downgraded	False
• Wellington is trying to take over again	False
• Soon we'll only be a clearing station…. just treat and transfer	False
• We'll have to travel for everything but basic surgery	False
• There are too many managers	False

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

Information, suggestions & feedback

- What is your vision for the future of health in the Wairarapa?
- What is the best way of keeping you informed?
- Suggestions and feedback

  ceo@wairarapa.dhb.org.nz

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

Public Hospital Governance in the Asia-Pacific Region: New Zealand District Health Board Case Study

Robin Gauld, Centre for Health Systems, University of Otago

Land area	268,021 km^2
Population	4.489 million (Oct 2013)
Ethnic composition	67% European; 15% Māori; 10% Asian; 7% Pacific people;1% other
Capital city	Wellington
Live births per woman	2.1
Infant mortality rate per 1000 live births	5.5
Life expectancy at birth (m/f)	79.4/83
Total health expenditure as % of GDP	10.3
Government expenditure as % of total health expenditure	82.7
Total health expenditure per capita (US$PPP)	3182
Practising physicians per 1000 population	2.6

Sources: latest available data (Statistics NZ; OECD Health Data 2013)

This paper aims to describe the context for, and approach to, health system and hospital governance in New Zealand. It has three sections. First, it backgrounds the New Zealand health system. Second, it describes governance of hospitals and the local health system in five of New Zealand's 20 District Health Board regions: Counties Manukau; Bay of Plenty; Hawkes' Bay; Hutt Valley; and Southern. Third, the paper discusses performance measurement and monitoring.

1. Country and Health System Context and Description

New Zealand is a developed country with a long history of transparent, democratic government. A single house of Parliament sits in the capital city, Wellington. General elections are held every three years. Since introduction in 1996 of a mixed-member proportional representation system, multi-party coalition governments have been led by either the National or Labour parties. Both parties are centrist in orientation, with National more towards the 'right' and Labour the 'left'. The present National-led government has been in place since 2008. The National party dominates the Cabinet, which is the Executive branch of government and key decision-making forum, with members of coalition partners also represented. Government policy generally requires cross-party consensus.

As an OECD member, New Zealand might be considered a 'mid-range' economy in that GDP per capita at around $US30,000 (in 2012) is somewhat below that of wealthier OECD countries. New Zealand's capacity to fund public health care is constrained by this, as well as the various other factors that typically challenge developed-world policy makers.

New Zealand's population of 4.4 million is spread over two main islands and other outlying islands. A third of the population reside in Auckland city in the north of the North Island. Around a quarter live in the larger South Island. Many smaller cities and towns are spread throughout the country. This creates challenges for health service planning and access. Life expectancy in 2011 was 81.2 years (83 for females; 79.4 for males). Yet there remain considerable inequalities, with life expectancy of Māori and Pacific people up to a decade shorter than other New Zealanders and a higher incidence of various diseases.

In 2013, total health expenditure was 10.2% of GDP placing New Zealand above the 2011 OECD average of 9.3% (NZ was 10.3 in 2011). Government funding was around 83% of this. Public hospitals, which are free of patient charges and accessible to all New Zealand permanent residents,[i] dominate and provide all major trauma and acute services, with private hospitals providing only non-urgent and elective procedures. Public hospital employees, including all health professionals, are salaried but around 40% of medical specialists work in dual practice meaning they also work in a private practice and hospital where income is fee-for-service and considerably higher than for comparable public work. Private patients pay full cost, with many funded by private health insurance which around a third of New Zealanders subscribe to. Patients often seek private care in order to avoid the waiting lists that characterise public hospital services, or to experience the more 'hotel like' private hospital environment. A portion of private (and public) patients are funded by the Accident Compensation Corporation (ACC), which is a government-mandated insurance scheme funded by employment levies to pay for accident and injury victims. In contrast with hospital care, primary medical care is largely privately provided. Most general practitioners (GPs) own their own practices. Their income, however, is a mix of government-funded capitation per patient enrolled, along with direct patient charges per consultation. Additional government funding is also provided for special services for patients with chronic disease, to reduce access barriers for selected patients, and for health promotion. ACC also subsidises primary medical and other care for accident and injury patients.

2013 marked the 75th anniversary of the Social Security Act 1938, in which the foundations of the health care system were created.[1] This Act was designed to establish welfare services for all New Zealanders. For health care this meant a 'national health system' in which services were to be universally accessible, free from access barriers, focused on preventive rather than curative care, and fully integrated. A compromise between the government and resistant medical profession at the time led to the arrangements outlined above – of dual medical practice, and largely public hospitals and private primary medical care retaining the right to directly charge patients, albeit with a government subsidy. These arrangements have meant different incentives in a health system with different service delivery compartments, but also that it has not been possible to deliver on the original 1938 goals.

Over the years, the health system has endured various restructurings, especially in the period from the late-1980s to 2000s.[2] The health care delivery system today features 20 regional District Health Boards (DHBs), enacted under the New Zealand Public Health and Disability

[i] Non-residents are charged when hospitalised or treated at a public hospital emergency department. They also pay the full unsubsidised cost when visiting a GP or after-hours clinic.

Services Act 2000.[ii] Each DHB has the essential characteristics of an integrated local health system in that it is responsible for services for a defined population and geographical area: hospitals are one component of the DHB system. DHBs are individually governed by an 11-member Board, seven of whom are elected locally and four appointed by the government including the Chair and Deputy Chair. These Boards are unusual in a democratic sense, in that they are accountable primarily to the government rather than electors.[3] A Board, therefore, oversees development of a local plan for implementing government policy; it has limited capacity to voice concern about government policy, while potentially taking the blame for difficult decisions that may impact on the local population. A Board is subject to various levels of sanction, set out in the 2000 legislation, from appointment of a Crown Monitor to work with an underperforming Board through to dismissal of the entire Board and replacement by a Commissioner.[4]

The DHB Board appoints the Chief Executive who, in turn, is responsible for all operational matters. DHBs must plan for the health care needs of their populations. In this regard, they must conduct needs assessments and provide an appropriate range of services to meet these needs. They must also work within government policy, including delivering on government goals and targets and providing a prescribed set of services. DHBs own public hospitals which form part of their 'provider arm' and purchase primary care, disability support, mental health, public health and other community based services from available and appropriate providers. Each DHB is required under legislation to have three sub-committees that govern different areas of activity: a public health committee; disability support services committee; and a hospital advisory committee.[iii] Each of these committees features elected and appointed DHB members.

DHBs are funded by the Ministry of Health and receive a fixed per annum allocation which they are expected to live within. Around two-thirds of total DHB funding (NZ$14.665 billion in 2013/14) is distributed via a population-based formula, designed to reflect the needs of different population groups that reside in their respective catchment areas.[5] The composition of different DHB communities – some with older populations, others with more rural or Māori and Pacific people – means there is around a 25% difference in per capita funding between DHBs. This means that some DHBs seem to have greater difficulty in balancing their budgets than others, with the implication that some have more financial flexibility and capacity to invest in new service initiatives, while others are perpetually looking to curtail services and find efficiency gains. Those producing a deficit are doubly-punished as they borrow from the government to fund a shortfall and pay interest on this. Producing a balanced budget, and planning how they will deliver services within their funding allocation is, therefore, a key driver of DHB activity. The remainder of funding, outside the population-based formula, comes directly to DHBs from the Ministry for specific purchased services.[iv]

[ii] Legislative changes in 1992 saw funding and responsibility for the service needs of those with permanent disability moved into the health budget. Income support for such people continues to be provided via the social services portfolio.
[iii] Several DHBs have combined these committees into one or two.
[iv] This includes national services including disability support services, public health services, some screening programmes, mental health services, elective services, Well Child and primary maternity services, Māori health services and postgraduate clinical

DHBs perform their governance and service delivery roles within a complex administrative, financial and legislative context that requires interaction with, and pursuit of the goals of, a series of national agencies (see Box). The complexity, further described below, has come about initially through creation of 20 regional planning and purchasing systems in 2000; previously, there was a single national purchaser – the Health Funding Authority. In 2001, the government of the day introduced Primary Health Organisations (PHOs), aimed at improving primary care organisation and service delivery. Initially, there were over 80 PHOs. Mergers required by the government elected in 2008 mean there are presently around 30. In principle, DHBs and PHOs both serve important roles. In practice, the arrangements have embedded historic divides between primary and hospital service provision and created for convoluted and parallel planning processes and accountability arrangements that collide with present policy directions focused on regional planning and integration.

Key organizations in New Zealand's health system (2013)
National level:
Pre-2008 and ongoing:
* Ministry of Health
* Pharmac
* National Health Committee
New since 2008:
* National Health Board (a business unit of the Ministry of Health)
* IT Health Board
* Health Workforce New Zealand
* Health Quality and Safety Commission
* Health Benefits Limited
Local level:
* 20 District Health Boards with associated public hospitals
* 32 Primary Health Organisations
* 12 regional Public Health Units
* Other contracted health and disability support service providers
New since 2008:
* 9 pilot Integrated Family Health Centres
* Alliance Leadership Teams in each DHB

A new government elected in 2008 launched a review of the health system resulting in a new strategic direction, while promising no major restructuring.[6] Essentially, the government is aiming to reduce duplication and fragmentation across the 20 regions, improve coordination and collaboration between regions, and drive improved performance in areas such as quality improvement, service integration, and patient access to services. It is also working to better coordinate health IT and workforce planning, areas previously given inadequate national

---

education and training. In 2013/14, some NZ$2.84 billion was directly allocated to such services. See http://www.health.govt.nz/new-zealand-health-system/funding (accessed Oct 2013).

policy attention. This means new initiatives are being laid upon existing foundations, while these foundations (the DHBs) are being required to gradually coalesce. Lastly, the government has emphasised 'clinical governance and leadership' as pivotal to all planning and management activities.[7] This has meant a gradual increase in the number of health professionals sitting on boards of government agencies and collaborating with managers in their respective DHBs and other agencies.

In line with the above, DHBs have several lines of vertical accountability upwards to the government, as well as to their local communities. The Ministry of Health is the chief policy advisor to the government, as well as DHB funder. It sets and monitors key goals for the health system, and oversees the sector on behalf of the government. The Ministry also houses the National Health Board (NHB) which is its operational arm. NHB therefore has responsibility for performance of DHBs. The NHB's Board reports directly to the Health Minister. Its 'business units' include the Health IT Board (responsible for national coordination of health IT developments), Health Workforce NZ (charged with workforce planning and clinical training), and the Capital Investment Committee (which oversees capital investment planning in the DHB sector). The independent government-funded Health Quality and Safety Commission has responsibility for promoting patient safety and presides over a series of national programmes, from medications safety and falls prevention to training of a series of DHB-based health professional 'improvement champions'. Pharmac is the national drug-buying agency which subsidises community prescribed medicines and purchases all DHB hospital-prescribed drugs. The reconfigured National Health Committee is the government's 'health technology assessment' advisor, while Health Benefits Limited's aim is to look for 'back office' DHB functions that may lead to savings when nationally provided for, such as the purchase of medical supplies. Finally, 12 regional public health units monitor and control disease outbreaks and other health risks, and undertake health promotion activities.

This complex organisational system means there is a mix of plans and policies produced by the various agencies that DHBs need to respond to. For each DHB, the response is brought together in its Annual Plan which provides a detailed description of the challenges faced by the DHB, intentions for the year ahead, how it intends to configure and improve services, and milestones for achievement of particular goals. Each DHB's plan is unique to its circumstances, but produced with a relatively high level of Ministry of Health oversight and contains standard information expected by the Ministry. This includes the strategic priorities for the DHB, the 'intervention logic' that then underpins the planning process and, in turn, the DHB priorities (examples of these are in Appendix 1). DHBs with a history of 'poorer' performance, especially financial but also managerial and organisational, are subject to considerably higher levels of scrutiny in a process that can take several weeks to reach agreement on. Final sign-off for Annual Plans is by the Minister of Health who also outlines in a letter to the DHB specific expectations for delivery of agreed goals. In this way, the Annual Plan is a key accountability document.

Legislative changes of 2010 demand increased horizonal accountability in requiring DHBs to plan regionally, especially for specialty services that are difficult to staff, but also to ensure that activities are coordinated in areas such as IT, strategy and service development. This has created considerable inter-regional activity, which four regional agencies assist with, and

underpinned the merging of some DHB functions. Naturally, there are challenges associated with this such as when DHBs have pre-existing arrangements in place that require adjustment in order to more closely interface with one another.

The post-2008 National Party-led government has also worked to implement its 'better, sooner, more convenient' (BSMC) pre-election policy.[8] Two mechanisms have been pursued for this. First, replacement of a series of DHB targets with six new Health Targets (see Appendix 2). These are aimed specifically at improving hospital efficiency and service access, as well as increasing immunisation rates and provision of screening services. A crucial difference with the six targets is that they are publicly-reported each quarter, designed for tracking progress over time and to reveal performances of different DHBs. The targets are a key government accountability and performance monitoring device and have driven DHBs to focus much of their activity on the targeted areas.

Second, in 2010, the government launched a series of nine pilot BSMC initiatives representing different locations and populations. For example, one features a group of Māori PHOs; another is based on the West Coast of the South Island where there are substantial geographical challenges for providing service coverage (especially hospital and emergency services), high levels of deprivation, and difficulties with health professional workforce retention; another works across the greater Auckland metropolitan area. The BSMC pilots are intended to stimulate new care delivery models, including better integration of primary and hospital care, provision of some specialist medical services in primary care settings, expanded scope of GP services along with advanced diagnostic capacity, better use of allied health care professionals (such as nurses with prescribing rights), and improved after hours access for patients. The BSMCs have all required an 'alliance' governance structure – a concept adapted from the construction industry - with a 'whole of system' focus. Thus, the 'Alliance Leadership Team' brings together professionals from both DHB hospitals and PHOs, who pool resources from their respective organisations to facilitate services developments designed on the principle of what will work best from the patient perspective. From mid-2013, the government required development of an Alliance in each DHB, creating additional momentum for horizontal planning and service coordination.

To sum up, the various arrangements outlined above mean there are multiple central government strategy documents that DHBs have to respond to, along side of specifications for providing required health services. A list of these government documents is in Appendix 3. These central-driven requirements are reflected at the local level in the range of DHB-specific documents also listed in Appendix 3. Added to this are the more recent horizontal planning documents and initiatives.[9] Against this framework, DHBs have a reasonable level of autonomy in terms of how they configure services meaning no two are alike, and so long as they deliver on core government policy requirements. Thus, a considerable number of external, government-dictated factors have a bearing on DHB governance and planning, while there is reasonable control over the internal environment.

The next section describes the five DHBs selected for the New Zealand country case study.

2. Five DHB cases: descriptions, strategic approaches, and performance

Methods

Descriptive information on the five DHBs is in Table 1. The five were selected based on various criteria: representation of different regions in New Zealand, including urban and rural, North and South Islands, socio-economic status of served population, and the author's knowledge of the diverse management systems, strategies, and challenges faced by each.

The CEO of each DHB was approached regarding the study. On agreement to participate, interviews with key personnel suggested by the CEO in each DHB were undertaken through a mix of in-person during site visits and by phone. Comprehensive notes were taken as a record of interview conversations.

A search was conducted for publicly-available information generated by national agencies and the five DHBs, with a focus on government expectations, strategic planning, accountability and performance monitoring. A list of these is in Appendix 3. Academic and gray literature was also searched.

Ethical approval was granted by the University of Otago and the study protocol reviewed by the Ngāi Tahu Research Consultation Committee.

Table 1: Five DHBs' Descriptive Information

DHB	Population	Area (km^2)	Geography	Budget $million (2012/13)	Staff (2012/13)
Counties Manukau	501,000	552	Urban	1.300	6200
Bay of Plenty	214,200	9,700	Mixed urban/rural	622	3000
Hawke's Bay	155,000	14,164	Mixed urban/rural	436	2500
Hutt Valley	140,000	916	Urban	420	2200
Southern	305,000	62,000	Mixed urban/rural	844	4500

Sources: DHB websites (accessed Jul-Oct 2013)

Five DHB strategic approaches and organisational systems

As noted, DHBs have considerable autonomy in terms of how they are structured internally and plan and organise services, so long as they deliver on national policy goals. The autonomy means there is much variation across the DHB sector. The interviewees routinely stated that the key drivers of their activities included: the government's six Health Targets; deliverables outlined in their Annual Plan with a particular emphasis on meeting of financial goals; and the Minister's annual 'Letter of expectations'. Interviewees from all five DHBs noted that:

- there were a considerable number of centrally-driven areas of compliance (driven by reporting requirements) and expected activity coming from the various agencies;

- there seemed to be an almost endless flow of documents and information coming from central agencies;
- some of this information was given limited attention, as DHBs were often undertaking the activities listed;
- some central agencies and their work were more highly regarded than others;
- central agencies sometimes showed a lack of leadership around issues facing DHBs, meaning DHBs had to develop their own responses. Examples included the regionalisation process, subject of a November 2013 Audit Office report, health workforce planning, development of Alliance Leadership Teams, and topics such as water flouridation.

The sections below describe the strategic directions and organisation of the five DHBs, highlighting points of difference.

Counties Manukau DHB (CM) is one of New Zealand's largest and serves an urban area in South Auckland characterised by high levels of deprivation and higher than average Māori and Pacific populations. Its population is also younger than average. CM's Middlemore Hospital is a major academic tertiary medical centre. CM has a number of challenges for planning and pressures on hospital services driven by deprivation, living conditions and chronic diseases. Its response has been to focus on quality improvement in hospital and associated services, and develop integrated community-based services. The DHB has an aim of being the best healthcare system in Australasia by 2015, and a strong focus on achievement of this. It has used the title of 'Counties Manukau Health' to represent the whole of system approach to planning and service delivery aimed for, bringing together resources from the hospital, PHO and other service providers to ensure that services are provided at an appropriate care level and location with back up and support from other providers within the CM and wider region. In 2013, the CM Board approved a series of 12 'system level' measures including a mix of process, quality of care and outcome indicators so it could benchmark its performance against these.

CM's leadership model is similar to the four others discussed below in that there is a strong focus on clinical governance, with shared professional and managerial decision-making within service directorates.

In terms of quality improvement, CM has taken a number of steps. In 2010, it created Ko Awatea – an institute dedicated to promoting health care innovation and improvement. This functions as a training centre for health professionals, hosts research groups, and also is home to multiple improvement advisors and campaigns. Ko Awatea is a formal partner with the Boston-based Institute for Healthcare Improvement (IHI), has adopted several of its programmes, including use of the Triple Aim[10] to underpin strategy development, and runs various IHI training camps that are open also to staff from other DHBs. In some ways, Ko Awatea functions as a national quality improvement champion. At CM, it has presided over significant programmes including a 20,000 days campaign, aimed at saving this number of hospital bed days over a year through better community care and patient safety. In 2013, CM announced that 23,000 days had been saved.[11] Other initiatives include reduction of central-line infection rates through following standard procedures, as well as in-house clinical

leadership development programmes and organisation of major conferences in partnership with IHI.

From 2012, CM has reoriented service organisation around four localities which represent different population groups in the district as part of its strategy to reduce hospital pressure and improve population health. The four localities are each based around a PHO, are clinically-led and structured as 'alliances'. The aim is to integrate services for high-need populations, especially those with chronic diseases and other health risks, coordinate care in primary care settings and link with other service providers including housing, welfare and various non-government social service agencies. The strategy involves hospital and community-based health professionals working closely together to ensure their efforts are coordinated and directed at the right patients and sharing resources to do so. Where appropriate, hospital care is being devolved into PHO settings. In this way, the DHB is working to deliver on the government's 'better, sooner, more convenient' policy, while pursuing its own goals of reducing hospital demand.

Regionally, CM collaborates through the Northern Alliance, a regional shared services agency that works on behalf of two other Auckland DHBs and a fourth DHB that serves the region north of Auckland. These four DHBs have in common use of IHI's Triple Aim and a series of other initiatives designed to share service delivery and combine back office functions.

Bay of Plenty DHB (BOP) features two main hospitals, a major secondary hospital with some tertiary capacity in Tauranga, and a smaller hospital in Whakatane around an hour drive away with common leadership and management systems across the region and a 'one service, two sites' philosophy. The DHB also hosts a clinical school and pursues the Triple Aim.

BOP's vision statement is: 'Healthy, Thriving Communities'. A focus for the DHB in recent years has been on improving clinical leadership, patient flow and allocation of resources in the hospital setting, as well as promoting better community health. The DHB features three PHOs. Each PHO represents quite different communities – for example, one is urban; another features high proportions of Māori living in rural areas with high health needs. The DHB and PHOs serve a population that has high levels of deprivation, concentrated particularly within the higher than average proportion of Māori. BOP also has an older population than average.

In terms of hospital services, the DHB has developed a Clinical Board with broad representation of professional groups along with management representation. This has oversight of quality, clinical leadership and service organisation activities and is chaired by the Chief Medical Officer. An aim has been to improve clinical-managerial collaboration and development of a shared vision. Clinical Board activities include contributing to the development of the DHB's 'balanced scorecard', included in Appendix 4, and driving improvements in theatre start times from 39 to 80% of operations starting on time. Leadership of clinical services is joint, with a nurse, doctor and administrator working in partnership with shared accountability for financial and clinical performance.

The DHB has developed an integrated operations centre which provides real-time centralised data on patient flow, bed occupancy and service demand. This permits 'whole of hospital'

planning and has helped with allocation of ward staff and rostering, as well as improving discharge planning and patient flow from the emergency department. Other initiatives include a 'care capacity and demand management' programme and use of 'trendcare' software, which assists with forecasting service demand and creation of a 'transit lounge' for patients requiring observation but not necessarily hospitalisation. The DHB has placed considerable emphasis on quality improvement, using both CQI methods and Baldrige criteria to provide a focus.

In terms of working to better integrate care, induce behavioural changes amongst professionals, and reduce clincal practice variation, the DHB has launched the 'Bay Navigator' website which features clinical pathways to be used by primary and hospital-based professionals. As part of the regionalisation programme, this will be integrated with the 'Map of Medicine' pathways initiative facilitated for five Midlands DHBs by their shared services agency, Health Share Limited, meaning all five will use common clinical pathways. Finally, the DHB has issued a series of 'position statements' spelling out its stance on various health risks such as alcohol and tobacco and health inequalities, and intent to reduce their burden through working with other agencies and the community.

Regionally, BOP collaborates with four other DHBs through Health Share Limited around issues and services that benefit from a regional approach. In 2012/13, such services included facilitation of regional service planning and reporting; Clinical Service Network facilitation; Maternity Quality and Safety regional programme; Workforce Development support; including the Midland Training Network; Regional clinical information systems development support; and the Midland Smokefree programme.

Hawkes Bay DHB (HB) serves a mixed urban and rural population with high concentrations of deprivation, inequality and Māori people. Its vision is for "Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequalities within our community".

The main Hastings Hospital provides comprehensive secondary level care and certain tertiary specialty services. It is not uncommon for patients requiring advanced care to be transported to another DHB, such as Capital and Coast in Wellington, by ambulance or air. This means HB must pay the other DHB for services provided in a budgetary process known as 'inter-district flows', which creates challenges.[v] For example, HB is working to curtail such expenditure as it seeks to stay within budget and would prefer to employ fulltime clinical staff in areas such as vascular surgery. However, a stumbling block resulting from the regionalisation process is that surgeons in other DHBs will only support a certain number of vascular surgeons raising questions about whether HB should have one. A lack of central guidelines in this area does not assist the situation.

In common with other DHBs, the starting point for HB's planning is the IHI Triple Aim. In mid-2014, HB will launch a comprehensive Quality Improvement and Patient Safety strategy aimed at promoting 'wellness' in the community, improving peoples' experience of health care, working with the HB community, and leadership and workforce development. There

[v] Inter-district flows (IDFs) are a considerable source of income and expenditure for most DHBs.

has been a strong focus in HB on clinical governance and leadership, with significant resource put into both restructuring the DHB in line with clinical governance principles as well as ensuring financial resources have been available to support building a clinical leadership focus. Like other DHBs, HB has created a 'clinical council'. However, in contrast with some DHBs, it has given this considerable powers including capacity to veto planning and funding decisions. The council also features strong primary care representation. These initiatives have breathed life into clinical leadership, with health professionals able to scrutinise and influence planning decisions leading to some important planning changes. For example, a significant proposed rebuild of a mental health facility was rejected by the clinical council for the fact that its design had not taken account of the future model of care for patients with mental health needs. The planning and funding department now have a seat on the clinical council and there is much closer involvement of health professionals in the planning and resource allocation processes. Leadership inside the hospital and across the wider DHB is, again, based on partnerships between professionals and administrators - from the Executive Team through to clinical service directorates.

To improve integration with primary care, the DHB was the first in New Zealand to appoint a Chief Medical Officer, Primary Care who sits on the Executive Leadership Team and, therefore, works closely with the CMO Hospital and other clinical and administrative leaders. From 2012, HB has invested additional resource into developing cross-sector service delivery approaches with appointment of a General Manager, Integration. As with other DHBs, HB has invested in development of clinical pathways to support the integration process. At the time of writing, HB was continuing to work through the requirement to develop an alliancing structure, given that it already had in place a whole of system planning and service delivery strategy involving hospital-based, PHO and other professionals. It did not wish for an additional administrative structure.

Hutt Valley DHB (HV) is located in the greater Wellington urban area. Its population is characterised by high levels of inequality, deprivation, and concentrations of Māori and Pacific people. The Hutt Hospital is a major trauma centre that provides several tertiary level services. More advanced services and support is provided by the Wellington Hospital, a half hour drive away in the neighbouring Capital and Coast DHB region. HV is presently in considerable transition as a result of regionalisation. While it and the neighbouring Wairarapa DHB remain separate legal entities, they have effectively merged in a process that formally commenced in late-2012. Wairarapa is one of the smallest DHBs and HV long provided various services and support. There had previously been a joint Allied Health Director between the two DHBs.

The 'merger' of Wairarapa and HV means two separate Boards remain but the management and clinical leadership systems have been brought together: there is now a single CEO, Executive Leadership Team, and single 'diamond' leadership structure in each clinical directorate that includes Allied Health, Medical, Nursing and Administrative leaders working in a partnership and reporting to a hospital manager in each of the two hospitals – Wairarapa and Hutt. In addition, the two DHBs are working closely with Capital Coast on regional services integration. The surgery department is now common to all three DHBs, with other services set to follow. A Service Integration Development Unit is working to facilitate activities.

At the Board level, there is considerable collaboration and cross-fertilisation with common members from the three DHBs of Board sub-committees, and a common Board Chair of HV and Capital Coast. There is also joined-up activity of various support services such as information technology. These three DHBs, along with two others in the Central Region (including HB), are contributors to the Central Region Information Systems Plan (CRISP) which aims for a regional IT solution. Wairarapa was a pilot 'better, sooner, more convenient' site, so has an alliance structure in place. Hutt had a pre-existing Primary Secondary Strategy Group so the foundations for an alliance had been laid. A focus of these alliances has been sustainability of primary care, and clinical pathways for specific conditions such as respiratory and cellulitis. A shared care electronic record has been a focus in the Wairarapa. HV also has Māori partnership boards to facilitate activities to improve Māori health in the community.

HV has concentrated on system improvement at Hutt Hospital. The Triple Aim, again, underpins its planning, meaning the hospital is focused on what happens in the community with an aim of reducing admissions. The Hutt emergency department was a pilot site in the mid-2000s for the Optimising the Patient Journey project, initiated by the government Quality Improvement Committee (an HQSC precursor). This means it applied and continues to use 'lean' methods to improve patient flows. Today, it has an integrated Operations Centre, with similarities to BOP's. This provides centralised data on hospital activities via a series of dashboards, enabling patients to be tracked from the time they first arrive at the emergency department including how long they wait at various points in the service delivery process, where they are in the hospital at any point in time, and where beds in the hospital are free should a patient require admission. The aim is that the hospital function in a 'conveyor belt' fashion, and that professionals adjust their schedules (such as ward rounds) to ensure maximum bed utilisation.

HV has developed a balanced scorecard for performance monitoring. Comparable with that of other DHBs, this includes a range of real-time data such as performance against the Health Targets, average length of stay, staff sick days, patient no-shows for outpatient appointments, elective procedures, readmissions, and so forth. HV interviewees noted that getting the measures right was not straightforward, especially around quality which is a key focus. Questions were raised by interviewees of how staff morale might be measured, given that this is a driver of high quality service, and how integration might best be measured given the focus on this.

Southern DHB (SDHB) serves the largest geographical area of any DHB. It features two main hospitals in Dunedin (home of the Dunedin School of Medicine, University of Otago) and Invercargill (also an Otago University teaching site but smaller city and hospital) some 2.5 hours drive away. Along with another Dunedin-based hospital and one in the resort of Queenstown, these hospitals are managed through the DHB's 'provider arm'. A series of smaller hospitals and health centres in towns around the region are managed by community-owned companies and trusts and deliver services on contract to the DHB.

SDHB was formed in 2010 as a result of a merger between the former Southland (Invercargill Hospital) and Otago (Dunedin Hospital) DHBs. The merger process has proven challenging,

partly due to the vast area the DHB covers, but also as it meant bringing together the cultures of two different hospitals and developing common organisational systems. SDHB's area also creates challenges in terms of access to specialist and diagnostic services for many living in outlying areas, as well as emergency services. The merger has brought with it the demand for a rural health strategy, under development at the time of writing. This is likely to involve a mix of facility and service redevelopment and telehealth.

SDHB has experienced sustained difficulties in delivering services within budget. Indeed, most years it faces a 'deficit' meaning planned-for services, including forecast acute and emergency care, cannot be delivered within government funding. This means the DHB must borrow additional interest-bearing funds from the government. Thus, its financial situation is a key driver of planning and means there is limited scope for investing in new clinical or other services initiatives. It has also been a source of tensions between the DHB and government and within the DHB. The financial situation means a 'Crown Monitor' has been assigned to the DHB for several years to scrutinise aspects of finance and planning and report directly to the Minister of Health.

The merger, and focus on building common systems, means SDHB now has an Executive Leadership Team that draws administrative and clinical leaders from both hospital sites, and common clinical services directorates. These are led by in a triumvirate partnership structure including medical, nursing and adminstrative leaders, again drawn from both sites. While the SDHB has a Chief Medical Officer who is Invercargill-based, the Medical Director of Patient Services (effectively CMO of Dunedin Hospital) is Dunedin-based. The SDHB Board is intended to provide members from across the region in that four of the seven elected members are selected by voters from the Otago region and three from Southland.

The core of the present SDHB strategy is expressed in its Southern Way statement, which aims for 'Patients at the centre of everything we do, to create a high performing organisation with a focus on quality, become a single unified DHB, and provide financially and clinically sustainable services'. Guiding the quality improvement strategy is a variant of IHI's Triple Aim contained in the DHB's Performance Excellence and Quality Improvement Strategy. Known as the 'four fold' aim, this has the additional aim of building excellence in teaching and research, encapsulating the teaching component of its hospital and other services and medical school links. Finally, SDHB's activities must align with those of the South Island Health Alliance which is coordinating regionalisation activities and has produced a detailed plan for service development across the five South Island DHBs.[9] This has implications in areas such as IT, where SDHB initiatives must align with directions in the South Island plan.

3. Performance measurement, monitoring and outcomes

The discussions above imply a range of strategic policy areas being promoted by different central agencies that could be considered when seeking to measure performance of the New Zealand health system, DHBs and their hospitals. Added to this, the five DHBs canvassed for this study have each developed their own measurement approaches. This section looks, first, at central government measurement of DHBs. Second, it discusses the DHBs' approaches. Third, it considers other measurement initiatives and plans.

Government measurement

At the highest level, DHB hospital performance is measured by the six quarterly-reported Health Targets although only some of these appear specific to hospitals. Even those pertaining to electives and emergency services require some joint planning with primary care if a DHB is to improve its performance. This aside, the targets provide a simple measure for assessing sector performance and stimulating competition amongst the DHBs.

Beyond the targets, measurement is more complex and there is no specific set of easily accessible indicators to track different dimensions of performance. Probably the best location for performance information is the Ministry of Health's Annual Report to Parliament which incorporates the Director-General's report on the state of public health.[12] The report is comprehensive and contains information on financial performances of the DHBs. The 2013 report, for example, noted that eight DHBs performed poorly but collectively the DHBs' financial performances improved against financial targets and they continued to reduce their deficits. The Report notes that the Ministry and National Health Board work closely with those DHBs in difficult financial circumstances.

The Annual Report describes progress on multiple policies, such as developing integrated services or national approaches to health IT, providing useful information but limited easily accessible data for monitoring and tracking performance over time. It lists progress on many different health care issues, such as cardiovascular disease, diabetes and cancers and features numerous tables and graphs around burden of disease, comparative expenditure, inequalities, service access and so forth. Performance against various specific outputs and outcomes is described, such as ambulatory sensitive hospital admissions and improving survival after cancer or heart attack/stroke. Many of the data are placed in comparative international context, such as New Zealand being in the 'best third' of OECD countries on an indicator (see table 2 below for an example). However, the 260-page report means that gaining an overall picture of performance is an involved and challenging process.

The methods for collating and publicly-reporting data have changed over time. For several years the Ministry produced quarterly DHB Hospital Benchmark Information reports which provided a snapshot of performances by DHB.[13] Included were a series of 15 quality and safety, efficiency and process, organisational health, and financial indicators used to rank and compare DHBs. These reports were discontinued in 2010, with emphasis placed on the six Health Targets, and the DHBs expected to produce their own performance monitoring methods – further discussed below. This means it is now difficult to obtain a clear picture of Average Length of Stay, for example, without going to each DHB.[vi] Various routine data such as bed to population ratios, and staff to patient ratios are not necessarily collected by

[vi] ALOS for all hospitals is expressed in the 2013 Ministry of Health Annual Report as having "…decreased overall since 2002. Total average length of stay decreased between 2002 and 2012, from 4.4 to 4.0 days. Average length of stay for surgical procedures decreased from 5.6 to 5.0 days, while for medical procedures it decreased from 3.8 to 3.5 days" (p227).

DHB or reported,[vii] although the DHBs do collectively report some 23 process, cost and staffing indicators to DHB Shared Services which are not publicly available.

When it comes to quality and patient safety, the HQSC has worked to develop a set of simple measures and to support DHBs in their reporting in this area. In 2012, following public consultation, it released an initial set of quality and safety indicators. These provided an overall portrayal of New Zealand health care in international comparative context, as well as country-wide data in areas such as medical error, avoidable readmissions, cancelled surgeries, screening rates and some socio-economic analyses.[14] Where DHBs were ranked, these were anonymised. A key HQSC release is its annual Sentinel and Serious Events report which lists by DHB the number of serious patient harms reported.[15] In 2012, a series of four Quality and Safety Markers was launched for falls, hand hygiene, perioperative harm and central line associated bacteraemia.[viii] These are reported by DHB with an aim of improving compliance and in turn quality improvement and cost savings with indicators for these also reported. Initial components of an Atlas of Variation, derived from the US 'Dartmouth Atlas', were released in 2012.[ix] HQSC is supporting DHBs in developing Quality Accounts, required of them from 2012/13, which detail how each approaches quality and safety, where improvements might be made, and results of efforts.[16] A final area of HQSC activity is its programme to support Consumer Engagement, a ministerial expectation of every DHB. In late-2013, it was announced that HQSC would develop a measure of patient-reported care quality, probably along the lines of the US Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys.[x]

Table 2: 30-day in-hospital mortality rate after a heart attack or stroke, 2009

Event	30-day in-hospital case fatality rate per 100 patients		OECD ranking
	New Zealand	OECD average	
Heart attack (acute myocardial infarction)	3.2	5.4	Best third of OECD countries
Ischaemic stroke	5.4	5.2	Mid third of OECD countries
Haemorrhagic stroke	21.1	19.0	Mid third of OECD countries

Note: Rates are age–sex standardised to the OECD population (45+ years).

Source: OECD 2011 from MOH report, 2013, p221.

[vii] For example, the Ministry of Health was asked whether the following data were collected: "Basic indicators: a. Infrastructure: hospital bed population ratios, staff population ratio; doctor: nurse ratio, doctor/nurse bed ratio; b. Equity in utilization: outpatient and inpatient by wealth / income/expenditure quintiles; c. Throughput: outpatient visits and discharges per FTE doctors / nurses". The response (8 November 2013) was that this information is no longer collected.

[viii] For more information see http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers/ (accessed Oct 2013)

[ix] For more information see http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/ (accessed Oct 2013)

[x] For more information see http://www.hqsc.govt.nz/our-programmes/consumer-engagement/work-streams/consumer-engagement/ (accessed Oct 2013)

DHB level measurement

As noted, each of the five DHBs has a bespoke 'balanced scorecard' (examples are in Appendix 4) that enables performance to be tracked against benchmarks, but also reports a range of measures in its Annual Plan, Annual Report, planning and other documents. The scorecards contain a range of information, from staff absentee and turnover rates through to performance on the Health Targets, average length of stay and hospital readmissions. CM has been working on 'system level' measures to drive improvement in agreed-upon areas with benchmarks set using a mix of national and international data (see Appendix 5). Data gathered during the 2012 Clinical Governance Assessment Project and through interviews for this paper suggests all 20 DHBs assess their own performance based on local clinical, executive team and Board preferences, with limited cross-fertilisation of the measurement development process.[17] However, DHBs are required to submit standard information to the Ministry of Health as per Table 3 below. The Crown-funding agreement and Indicators of DHB performance reports list progress on key deliverables that the DHB has contracted for with the Ministry. The Annual Plans of all DHBs describe how their priorities will be delivered upon and the key milestones (performance indicators) per quarter, each of which is used to hold the DHB to account for performance. Appendix 6 provides an example set of indicators for acute services.

Table 3: DHB Reporting to the Minister of Health

Reporting	Frequency
Information requests	Ad hoc
Financial reporting	Monthly
National data collections	Monthly
Risk reporting	Quarterly
Health Target reporting	Quarterly
Crown-funding agreement non-financial reporting	Quarterly
Indicators of DHB performance	Quarterly
Annual report and audited statements	Annually

Other initiatives and current plans

Various projects have sought to produce alternative approaches to measuring New Zealand's health system and hospital performance. Most relevant to this paper is the 'Public Hospital Performance Project', led by a university research group funded by the Health Research Council. This drew on the National Minimum Data Set (NMDS), a routine hospital discharge dataset containing unique patient identifiers. The project developed around 180 indicators of hospital performance, showing varied performances by hospital and over time. At least one journal article has been published from this project, anonymously ranking DHB hospitals around aspects of equity, efficiency and effectiveness in care delivery.[18] Other unpublished findings suggest that hospital performance improved by 3-5% between 2007-09 as measured in three areas of efficiency: technology change; technical efficiency; and allocation of staff and resources. Another project, illustrative of those using the NMDS, found Māori patients

were 16% more likely to be readmitted to hospital or to die within 30 days of discharge.[19] A further project developed a balanced scorecard for the entire New Zealand health system assessing performances against national and international benchmarks across 64 indicators in five categories: healthy lives; quality; access; efficiency; and equity. This gave an overall score of 71%, but a notably poor score of 57% for equity and 64% for access to health care.[20]

At the time of writing (November 2013), a government-commissioned working group had produced a draft Integrated Performance and Incentive Framework and invited public comment on this.[21] Based on the Triple Aim and taking a 'whole of system' approach to health care delivery, this detailed over 60 indicators intended to build joint accountability of hospital and primary care services. The package includes indicators for processes, quality of care, outcomes, and resource utilisation (such as staff ratios) and would see DHBs potentially scored on each indicator. Data for some indicators are available (such as average length of stay), for others data are either in need of work (polypharmacy in over 65 year olds), or not yet available (for example, patient reported measures of care quality).

4. Conclusion

Health system and hospital governance in New Zealand exhibits characteristics that stem from historical developments as well as recent policy directions. These make for complexity but also permit considerable flexibility at the local level to pursue innovative service delivery solutions. Notably, hospital governance is devolved. However, it is also intertwined with other components of the local, regional and national health system. Recent emphasis has been on closer links with primary care with aims of reducing pressure on hospital services but also with a view to planning for projected increases in demand driven by population ageing and chronic diseases.

The emphasis in recent years on performance improvement has stimulated activities in each of the five DHBs covered in this paper, particularly around quality and process improvement and involving health professionals in this. While the Health Targets have been a key driver of this, the focus on meeting goals has sometimes come at the expense of focusing on other process issues.

The strengths of the New Zealand system are many and include the capacity to innovate locally, the focus on quality and process improvement, and the whole of system approach to planning that sees hospitals as a part of the local system that must work in partnership with other community providers.

The challenges for the system, as outlined in this paper, would arguably be the complexity of coordinating multiple national agencies and accompanying policies and directives, regional planning arrangements and networks, and local DHBs, PHOs and other providers. One consequence of the complexity is that measurement of performance is similarly complicated. Six targets provide straightforward insights but not a comprehensive description of performance. The proposed Integrated Performance and Incentive Framework should go some way towards addressing the shortcomings. A 2013 stocktake located some 300 unique health datasets, illustrating that New Zealand is awash with health data.[22] Yet these data have remained under-utilised. Various independent projects have worked to develop methods of

performance analysis. More work in this area is required in order to better understand the performance and efficiency of different DHB hospitals and the New Zealand health system per se.

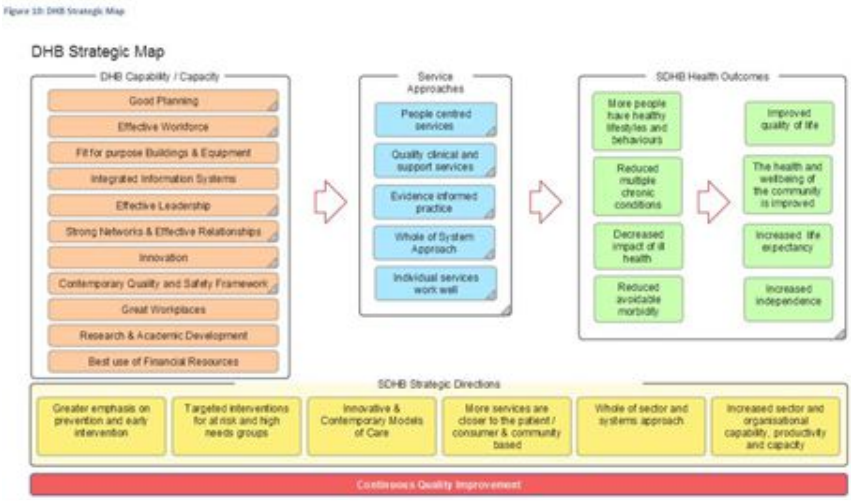
Acknowledgements: I am grateful to the five DHBs for providing information and for their participation in this project. Thanks also to Dr Brett Maclennan, Department of Preventive and Social Medicine, University of Otago, for assistance with data collection.

References

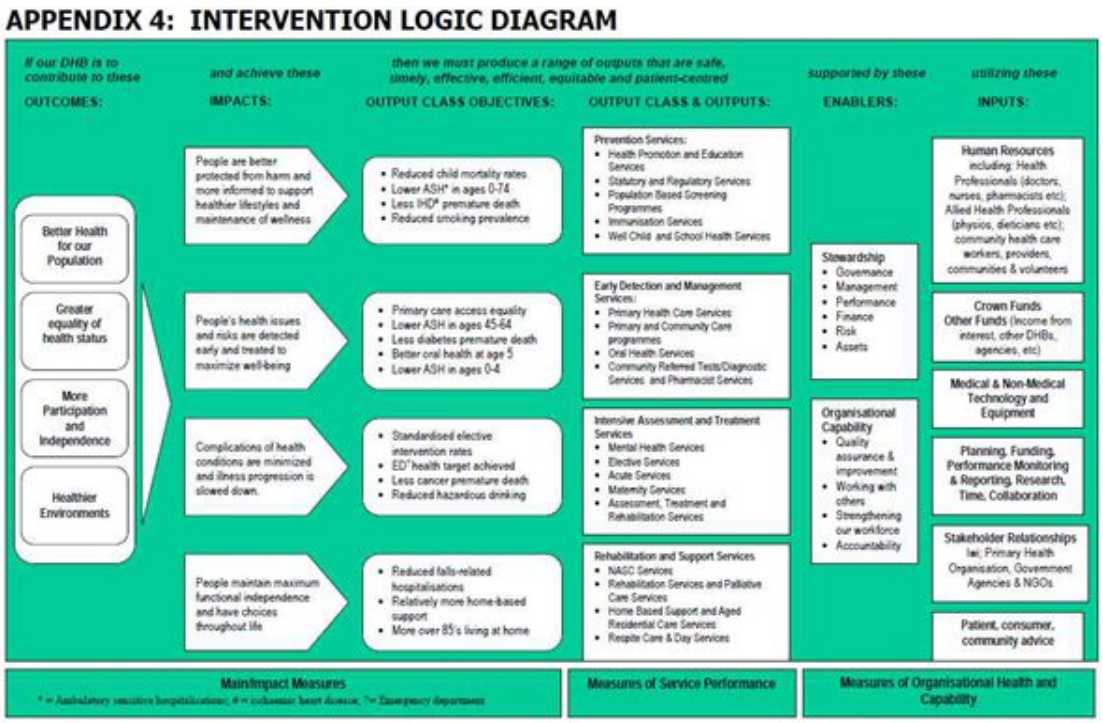
1. Gauld R. Questions about New Zealand's health system in 2013, its 75th anniversary year. *New Zealand Medical Journal* 2013;126(1380):1-7.
2. Gauld R. New Zealand's post-2008 health system reforms: Toward re-centralization of organizational arrangements. *Health Policy* 2012;106:110-13.
3. Gauld R. Are elected health boards an effective mechanism for public participation in health service governance? *Health Expectations* 2010;13:369-78.
4. Adam B. The Challenges of Running a District Health Board. In: Gauld R, editor. *Continuity amid Chaos: Health Care Management and Delivery in New Zealand*. Dunedin: University of Otago Press, 2003.
5. Penno E, Gauld R. How are New Zealand's District Health Boards funded and does it matter if we can't tell? *New Zealand Medical Journal* 2013;126(1376):1-14.
6. Ministerial Review Group. *Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand*. Wellington: Minister of Health, 2009.
7. Ministerial Task Group on Clinical Leadership. *In Good Hands: Transforming Clinical Governance in New Zealand*. Wellington: Ministerial Task Group on Clinical Leadership, 2009.
8. Ryall T. *Better, Sooner, More Convenient: Health Discussion Paper by Hon Tony Ryall MP*. Wellington: National Party, 2008.
9. South Island Alliance. *South Island Regional Health Services Plan 2012-2013*. Christchurch: South Island Alliance Programme Office, 2012.
10. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)* 2008;27(3):759-69.
11. Counties Manukau District Health Board. *20,000 Days Campaign: From Small Revolutions to Big Change*. Auckland: Ko Awatea and Counties Manukau DHB, 2013.
12. Ministry of Health. *Annual Report for the year ended 30 June 2013 including the Director-General of Health's Annual Report on the State of Public Health*. Wellington: Ministry of Health, 2013.
13. Ministry of Health. *DHB Hospital Benchmark Information.* . Wellington: Ministry of Health, 2010.
14. Health Quality and Safety Commission. *Describing the Quality of New Zealand's Health and Disability Services*. Wellington: Health Quality and Safety Commission, 2012.

15. Health Quality and Safety Commission. *Making Our Hospitals Safer - Serious and Sentinel Events 2011/2012*. Wellington: Health Quality and Safety Commission, 2012.
16. Health Quality and Safety Commission. *Quality Accounts: A Guidance Manual for the New Zealand Health and Disability Sector*. Wellington: Health Quality and Safety Commission, 2012.
17. Gauld R, Horsburgh S. *Clinical Governance Assessment Project: Final Report on a National Health Professional Survey and Site Visits to 19 New Zealand DHBs*. Dunedin: Centre for Health Systems, University of Otago, 2012.
18. Davis P, Milne B, Parker K, Hider P, Lay-Yee R, Cumming J, et al. Efficiency, effectiveness, equity (E3). Evaluating hospital performance in three dimensions. *Health Policy* 2013;112:19-27.
19. Rumball-Smith J, Sarfati D, Hider P, Blakely T. Ethnic disparities in the quality of hospital care in New Zealand, as measured by 30-day rate of unplanned readmission/death. *International Journal for Quality in Health Care* 2013;in press.
20. Gauld R, Al-Wahaibi S, Chisholm J, Crabbe R, Kwon B, Oh T, et al. Scorecards for health system performance assessment: the New Zealand example. *Health Policy* 2011;103:200-08.
21. Integrated Performance and Incentive Framework Expert Advisory Group. *Integrated Performance and Incentive Framework: Description and Outline of Potential Measures. 30 September*. Wellington: Integrated Performance and Incentive Framework Expert Advisory Group, 2013.
22. Atalag K, Adler R, White C, Lovelock K, Gauld R, Gu H, et al. *Value of New Zealand Health Data (VNZHD) Project Phase 1: Final Report*. Wellington: New Zealand Trade and Enterprise, 2013.

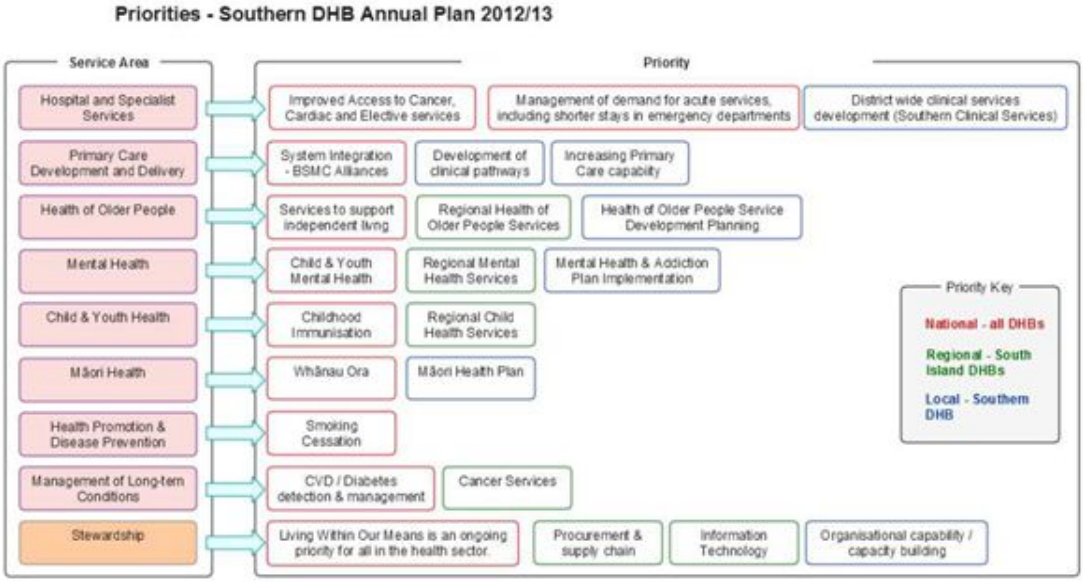
Appendix 1: Examples of DHB Strategic Maps, Intervention Logic and Priorities



Source: Southern DHB

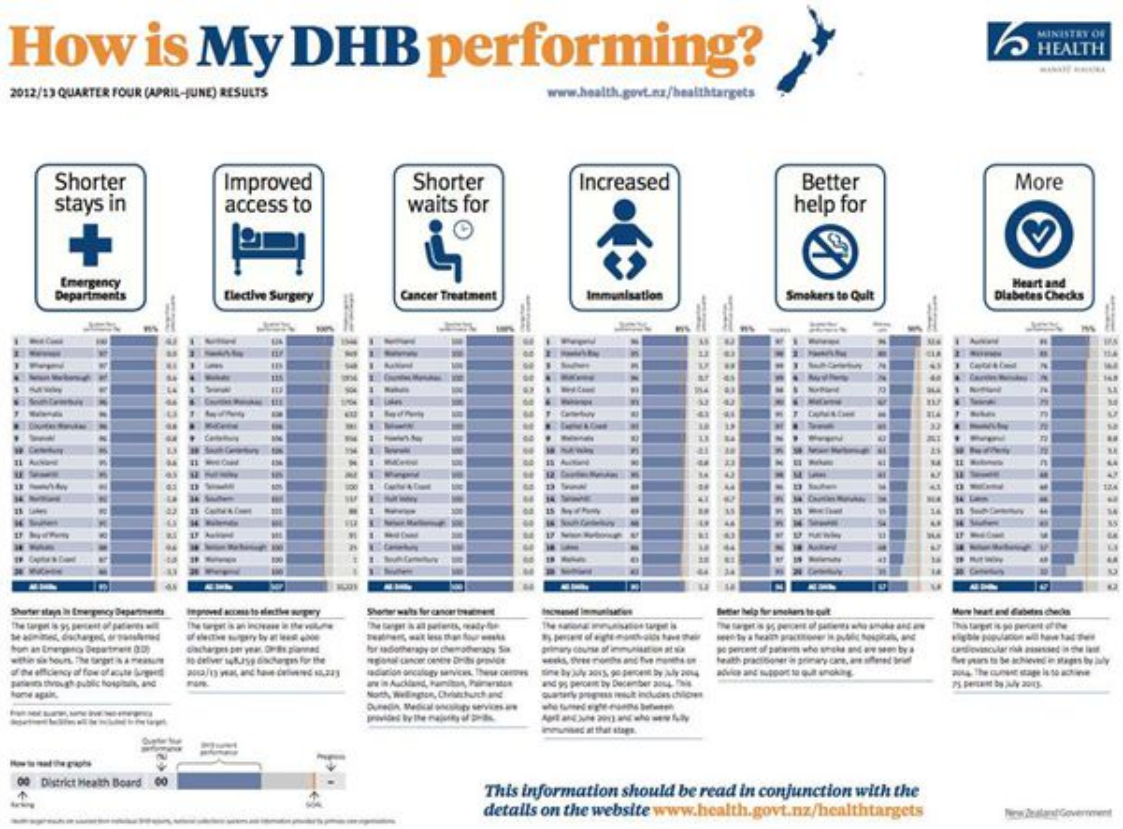


Source: Hawke's Bay DHB



Source: Southern DHB

Appendix 2: Health Targets



Appendix 3: Documents Relating to DHB Goals, Structures, Policies, Services and Accountability Arrangements (ca 2010-)

Central Government Documents

Minister of Health

- Expectations around improved access to services 2012/13 and beyond
- Letter of Expectations for DHBs and their subsidiary entities 2012/13
- Letter of Expectations for DHBs and their subsidiary entities 2013/14

Ministry of Health

- My DHB (http://www.health.govt.nz/new-zealand-health-system/my-dhb)
- DHB health targets 2013/14 (http://www.health.govt.nz/new-zealand-health-system/health-targets)
- DHB health targets 2010/11, 2011/12, 2012/13 (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/menumh/Accountability+Documents)
- Targeting Diabetes and Cardiovascular Disease: Better Diabetes and Cardiovascular Services (April 2011)
- Targeting More Elective Operations: Improved access to elective surgery (March 2011)
- Targeting Emergencies: Shorter stays in emergency departments (March 2011)
- Targeting Immunisation: Increased immunisation (March 2011)
- Targeting Shorter Waits for Cancer Treatments: Better waits for cancer treatment radiotherapy (April 2011)
- Targeting Smokers: Better help for smokers to quit (April 2011)
- We are targeting better health services (March 2011)
- Better, sooner, more convenient health care in the community (May 2011)
- DHB Planning Package 2012/13 (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/445)
- DHB Planning Package:
  2011/12 (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/387)
  2010/11 (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/387)
  (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/menumh/Accountability+Documents)
  - Annual Plan Guidance 2012/13 (November 2011)
  - Annual Plan Guidance:
    2011/12 (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/387)
    2010/11 (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/410)
  - Operational Policy Framework 2013/14 (August 2013)
  - Operational Policy Framework:

2012/13
(http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/445)
2011/12
(http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/387)
2010/11
(http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/410)

- Service Coverage Schedule 2013/14 (November 2012)
- Service Coverage Schedule:
  2010/11
  (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/410)
  2011/12
  (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/387)
  2012/13
  (http://www.nsfl.health.govt.nz/apps/nsfla.nsf/pagesmh/445)
- Non-Financial Monitoring Framework and Performance Measures 2012/13
- Non-Financial Monitoring Framework and Performance Measures: 2011/12
  (http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/459)
  2010/11
  (http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/317)

- Requirements and Guidelines for Using Financial Templates 2013/14 (December 2012)
- Requirements and Guidelines for Using Financial Templates:
  2012/13 (http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/200)
  2011/12 (http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/200)
- Service Change: Rules, principles and processes for District Health Boards (January 2011)
- Accountability Documentation and Guidelines
  (http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/173)
- Guidelines for DHBs: resources for planning, consultation and analysis
  (http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/172)
- Guidance for Integrated Paediatric Palliative Care Services in New Zealand (September 2012)
- Bone Marrow Transplant Services in New Zealand for Adults: Service improvement plan 2011 (September 2011)
- New Zealand Maternity Standards (July 2011)
- National Plan for Child Cancer Services in New Zealand (November 2010)

National Health Board

- Regional Services Planning (February 2012)
- Trends in Service Design and New Models of Care: A review (August 2010)

Health Workforce NZ

- Workforce Innovations (June 2011)
- Retention Initiatives (June 2011)

Health IT Board

- Towards better access to information about our health (July 2011)
- National Health IT Plan (September 2010)

Health Benefits NZ

- Who's Eligible? Identifying and managing ineligible patients: a guide for health professionals (November 2011)

Health Quality and Safety Commission

- Quality Accounts: A guidance manual for the NZ health and disability sector (July 2012)
- Root Cause Analysis for Clinical Incidents: A practical guide (May 2012)
- Reporting and Reviewing Adverse Events Involving Users of Mental Health Services (December 2012)
- New Zealand Health and Disability Services – National Reportable Events Policy 2012 (March 2012)

State Services Commission (in conjunction with Ministry of Health)

- Resource for Preparation of District Health Board Governance Manuals (August 2010)

DHB Documents

Southern DHB

- SDHB Policy Statement: Delegation of Authority 2011
- SDHB Governance Manual 2012
- SDHB Annual Plan 2012/13 with Statement of Intent 2012/15
- SDHB Statement of Intent 2011/12
- SDHB Statement of Intent 2010/11-2012/13
- Māori Health Action Plan 2013/14
- Health of older people (June 2011)
- Health of young people in the Southern District: Health outcomes (2011), Health determinants (2012)
- Otago/Southland Local Cancer Network Cancer Plan 2010/11 – 2012/13
- Performance Excellence and Quality Improvement Strategy
- Mental Health and Addictions Plan 2012-15
- Tobacco Control Plan 2011-14
- South Island Regional Health Services Plan 2012/13
- South Island Health Services Plan 2011-12 Implementation Plan Supplement

Hutt DHB

- HVDHB Annual Plan 2012/13
- HVDHB Annual Plan 2011/12
- HVDHB Annual Plan 2010/11
- HVDHB Statement of Intent 2012/13 – 2014/15
- HVDHB Statement of Intent 2010/11 – 2012/13

- HVDHB Māori Health Action Plan 2013/14
- HVDHB Māori Health Action Plan 2012/13
- HVDHB Health of Older People Strategic Action Plan 2010 to 2016
- Central Region Regional Services Plan 2011/12
- Central Region Māori Health Action Plan May 2011
- Workforce Strategy

Hawke's Bay DHB

- Hawke's Bay DHB Governance Manual 2010
- Hawke's Bay DHB Governance Manual 2010 Schedule of Amendments
- HBDHB Annual Plan 2012/13
- HDDHB Statement of Intent 2012-2015
- HBDHB Māori Health Strategy (August 2011)
- HBDHB Māori Health Plan 2012/13
- HBDHB Pacific Health Action Plan
- HBDHB Improving the Health of Older People in Hawke's Bay
- Hawke's Bay Health Status Review 2010
- Central Region Regional Services Plan 2011/12
- Central Region Māori Health Action Plan May 2011

Bay of Plenty DHB

- BoPDHB Annual Plan 2011/12 with Statement of Intent 2013/14
- BoPDHB Annual Plan 2012/13
- BoPDHB Annual Plan 2010/11
- BoPDHB Statement of Intent 2012/15
- BoPDHB Statement of Intent 2010/13
- BoPDHB Māori Health Plan 2012-13
- BoPDHB Māori Health Plan 2013-14
- BoPDHB nine Position Statements
- BoPDHB Maori Workforce Development Plan
- Midland Regional Services Plan 2013-14
- Midlands DHBs Regional Services Plan 2012/13

Counties Manukau DHB

- CMDHB Annual Plan 2012/13
- CMDHB Annual Plan 2011/12
- CMDHB Annual Plan 2010/11
- CMDHB Statement of Intent 2012-15
- CMDHB Statement of Intent 2011-14
- CMDHB Statement of Intent 2010/11
- Regional Information Strategy 2010-20
- CMDHB Māori Health Plan 2012-13

- Determinants of Health for Children & Young People in the Northern DHBs (Nov 2012)
- Health Needs Assessment of Asian People Living in the Auckland Region (Aug 2012)
- The Health Status of Children and Young People in the Northern DHBs (Nov 2011)
- Regional Information Strategy 2010 to 2020

DOCUMENTS PERTAINING TO DHB PERFORMANCE

Central Government Documents

Ministry of Health

- How is my DHB performing 2012/13
- How is my DHB performing 2011/12
- How is my DHB performing 2010/11
- Caseload Monitoring Report 2012/13
- Caseload Monitoring Report 2011/12
- Caseload Monitoring Report 2010/11
- Elective Services Patient Flow Performance Indicators 2010-12
- DHB Sector Financial Reports 2013-14
- DHB Sector Financial Reports 2012-13
- DHB Sector Financial Reports 2011-12
- DHB Sector Financial Reports 2010-11

Health Quality and Safety Commission

- Serious and Sentinel Events 2010/11

DHB Documents

Southern DHB

- SDHB Annual Report 2012
- SDHB Annual Report 2011
- SDHB Annual Report 2012
- SDHB Serious and Sentinel Events 2011-12
- Performance results for SDHB as at 31 Dec 2012
- Performance results for Southern PHO as at 31 Dec 2012
- SDHB Monthly Board Meeting Reports: Financial and Advisory Committee Reports
  (May 2010 – present)
- SDHB Hospital Advisory Committee monthly meeting monitoring and performance reports: Patient Services, KPIs, Financial Performance, Nursing and Midwifery, Human Resources, Information Systems (June 2010 – present)

Hutt DHB

- HVDHB Annual Report 2012

- HVDHB Annual Report 2011
- HVDHB Annual Report 2010
- HVDHB Serious and Sentinel Events 2011-12
- Performance results for HVDHB as at 31 Dec 2012
- HVDHB Monthly Board Meeting Reports: CEO Report (Finance Report), Performance Report (February 2010 – August 2013)
- HVDHB Hospital Advisory Committee monthly meeting monitoring and performance reports: Quality Report, Operational Services Report (February 2010 – August 2013)

Hawke's Bay DHB

- HBDHB Annual Report 2012
- HBDHB Serious and Sentinel Events 2011-12
- Performance results for HBDHB as at 31 Dec 2012
- Performance results for Hawke's Bay PHO as at 31 Dec 2012
- HBDHB Monthly Board Meeting Reports: Financial Report, Human Resources KPIs Quarterly Report, Performance Framework Exceptions Quarterly Report (February 2011 – August 2013)

Bay of Plenty DHB

- BoPDHB Annual Report 2012
- BoPDHB Annual Report 2011
- BoPDHB Annual Report 2010
- BoPDHB Serious and Sentinel Events 2011-12
- Performance results for BOP DHB as at 31 Dec 2012
- Performance results for WBOP PHO as at 31 Dec 2012
- Performance results for EBOP PHO as at 31 Dec 2012
- Performance results for NMOL PHO as at 31 Dec 2012
- BoPDHB Monthly Board Meeting Reports: CEO Report (Financial Results and Forecasts, Health Targets) (September 2012 – August 2013)
- BoPDHB Hospital Advisory Committee monthly meeting COO report: Operational and Performance Results (October 2012 – August 2013)

Counties Manukau DHB

- CMDHB Annual Report 2012
- CMDHB Annual Report 2011
- CMDHB Annual Report 2010
- CMDHB Serious and Sentinel Events 2011-12
- Performance results for CMDHB as at 31 Dec 2012
- Performance results for AHT PHO as at 31 Dec 2012
- Performance results for EHT PHO as at 31 Dec 2012
- Performance results for NHC PHO as at 31 Dec 2012
- Performance results for THC PHO as at 31 Dec 2012

Appendix 4: Balanced Scorecard Examples

Hospital Operational Services

Key Performance Indicators February 2013

KEY PERFORMANCE INDICATORS 2012/2013

PATIENT EXPERIENCE	Feb-13 Target	Feb-13 Month	Period Target	Period QTD
Shorter Stays in Emergency Departments	95%	96%	95%	94%
Improved Access to Elective Surgery	100%	111%	100%	103%
Better Help for Smokers to Quit	95%	95%	95%	97%
	Target	Month	Target	YTD
Mental Health Relapse Prevention Plans	95%	93%	95%	90%
HOHOS Compliance - Inpatient	75%	71%	75%	79%
HOHOS Compliance - Community	55%	70%	55%	69%
Number of Bed Days due to Cellulitis (YTD)		191		1,159
Surgical Site Infections Reported (ave. 1/mth)		3	[8]	11
Patient Falls Causing Harm (ave. 12/mth)		12	[96]	99
Medication Errors (ave. 1/mth)		1	[8]	6

Waiting Lists	Waitlist Patients (ESPI5 and ESPI2) Target	Month	Booked	Unbooked
Waiting >150 days for Inpat. Treatment (ESPI5)	0	62	42	20
Waiting >180 Days for Outpatient FSA (ESPI2)	0	19	15	4

PROCESS & EFFICIENCY	Feb-13 Target	Feb-13 Month	YTD Target	YTD YTD
Acute Inpatient Length of Stay	3.8	3.8	3.8	3.7
Acute Readmission Rate	8%	8%	8%	8%
Elective/Arranged Inpatient Length of Stay	3.5	3.6	3.5	3.3
Elective/Arranged Day of Surgery Admission	93%	96%	93%	96%
Ward Bed Utilisation - Mth including weekends	85%	83%	85%	87%
Ward Bed Utilisation - weekday average	New measure under development			
Funded Theatre Sessions Utilised	95%	95%	95%	92%
Theatre Session Utilisation (Time in Theatre)	85%	83%	85%	82%
Theatre Sessions Starting on Time	90%	90%	90%	89%
Acute Patients impacting on Elective Sessions	U/D	36	U/D	356
Cancelled on Day of Surgery – Patient	U/D	16	U/D	114
Cancelled on Day of Surgery – Hospital	U/D	16	U/D	90
Outpatient DHA (FSA & Followup) – No. Visits	270	466	2276	3746
Outpatient DHA (FSA & Followup) – DHA Rate	5%	8%	5%	8%

HEALTHY WORKPLACE	Feb-13 Target	Feb-13 Month	YTD Target	YTD YTD
Hospital Staff Turnover % (Headcount)	10%	11%	10%	10%
Sickness Absence - % Paid Hours Worked	2.5%	2.4%	2.5%	2.6%
Sickness Absence - Average Days per FTE	6.6	6.8	6.6	6.8
Number of Staff having >24 Mths O/S Leave			215	266
Workplace accidents (staff) [NEW MEASURE]				

VALUE FOR MONEY	Feb-13 Target	Feb-13 Month	YTD Target	YTD YTD
Total Caseweight	1,632	1,621	13,855	14,654
Elective Caseweights	534	529	4,458	4,505
Acute Caseweights	1,097	1,092	9,396	10,149
Outpatient FSA Volumes	1,262	1,176	11,044	10,281
Outpatient FU Volumes	3,034	3,318	26,036	26,412
Hospital FTEs inc overtime	1,558	1,556	1,573	1,580
Hospital Operating Costs ($'000)	14,376	14,048	122,450	124,012
Hospital Personnel inc outsourced ($'000)	10,167	10,102	88,674	90,045

Occupancy = Surgical, Medical, Rehabilitation, Orthopaedic and Plastic Wards only

MOH Health Targets

MOH Ownership Dimension Measures

KEY: N/A = Not available

U/D = Under Development

Good News | Alert | Not Issue

Source: Hutt Valley DHB

Provider Arm Monthly Balanced Scorecard 2012/13

BAY OF PLENTY DISTRICT HEALTH BOARD

KEY PERFORMANCE INDICATORS

PATIENT & QUALITY	Jan-12	Month Jan-13	Month Target	Month Var	Year to date Actual	Year to date Target	Year to date Var
Outpatient DNA Rate	7.3%	7.7%	5.0%	(2.7%)	6.4%	5.0%	(1.4%)
Outpatient DNA Rate MAORI	15.3%	17.9%	5.0%	(12.9%)	15.4%	5.0%	(10.4%)
Waiting > five months for FSA (ESPI 2)	2.7%	2.2%	0.0%	(2.2%)			
Waiting > five months for IP Treatment (ESPI 5)	4.6%	1.9%	0.0%	(1.9%)			
Acute Readmission Rate	11.0%	10.1%	10.0%	(0.1%)	11.1%	10.0%	(1.1%)
Radiology Diagnostic Indicator within 42 days (MRI)	0.0%	32.8%	75.0%	(42.2%)	30.9%	75.0%	(44.1%)
Radiology Diagnostic Indicator within 42 days (CT)	0.0%	78.2%	75.0%	3.2%	74.0%	75.0%	(1.0%)

PROCESS & EFFICIENCY	Jan-12	Month Jan-13	Month Target	Month Var	Year to date Actual	Year to date Target	Year to date Var
ALOS - Elective/Arranged CWD (excl Mat & Neonatal)	3.28	4.00	3.37	(0.64)	3.96	3.37	(0.59)
ALOS - Acute CWD (excl Mat & Neonatal)	4.00	4.08	3.76	(0.32)	4.15	3.76	(0.39)
Discharge by 11:00am	16.9%	14.8%	30.0%	(15.2%)	16.2%	30.0%	(13.8%)
Nurse Hours per patient day	5.49	5.39	5.31	(1.8%)	5.19	5.26	1.3%
Ward Bed Utilisation	84.2%	89.8%	90.0%	0.2%	92.0%	90.0%	(2.0%)
LOS Outlier (long)	2.36%	2.96%	1.5%	(1.5%)	2.80%	1.5%	(1.3%)
Day of Surgery Rate (DOSA)	89.2%	96.0%	95%	1.0%	93.4%	95%	(1.6%)
Daycase Rate - Elective/Arranged	54.8%	60.6%	59.2%	1.4%	57.8%	59.2%	(1.4%)
Smokers referred to Cessation	87.0%	94.5%	95%	(0.5%)	93.7%	95%	(1.3%)
Theatre Session Utilisation (Main Theatres)	93.5%	94.8%	92.0%	2.8%	92.6%	92.0%	0.6%
ED KPI 2	61.0%	36.5%	95.0%	(58.5%)	47.9%	95.0%	(47.1%)
ED 6 hr Target	92.8%	89.4%	95.0%	(5.6%)	90.3%	95.0%	(4.7%)

ORGANISATIONAL HEALTH & MONITORING	Jan-12	Month Jan-13	Month Target	Month Var	Year to date Actual	Year to date Target	Year to date Var
Staff Turnover % (FTE Basis)	0.6%	0.7%	1.5%	0.8%	0.6%	1.5%	0.9%
Sick Leave %	1.7%	1.7%	3.1%	1.4%	3.0%	3.1%	0.1%
% of staff with Annual Leave > 2yrs	0.0%	5.6%	0.0%	(5.6%)	5.5%	0.0%	(5.5%)
Workplace Injury Per 1,000,000 hrs	4.1	3.2	5	1.80	3.5	5	1.47
Mantatory Training Completed < 3 Months	0.0%	62.9%	100.0%	(37.1%)	40.6%	100.0%	(59.4%)

FINANCIAL & CONTRACT PERFORMANCE	Jan-12	Month Jan-13	Month Target	Month Var	Year to date Actual	Year to date Target	Year to date Var
Total Caseweight (includes un-coded)	2,755	2,727	2,796	(2.5%)	21,848	21,776	0.3%
Elective Caseweight (includes un-coded)	624	598	692	(14.5%)	5,967	5,962	(0.1%)
Acute Caseweight (includes un-coded)	2,131	2,161	2,136	1.2%	15,881	15,794	0.5%
Outpatient FSA Volumes	1,300	1,594	1,333	19.6%	11,694	12,066	(3.4%)
Outpatient FU Volumes	3,878	4,237	3,225	31.4%	31,379	29,194	7.5%
FTEs	2,194	2,130	2,161	32	2,170	2,161	(9)
Operating Costs ($000)	8,874	8,718	8,041	323	70,017	66,728	(3,290)
Personnel Costs ($000)	16,113	16,270	15,859	(411)	109,536	109,728	192
Elective Surgical Discharges (excludes un-coded)	513	475	472	0.6%	4365	4274	2.1%

KEY

* Due to changed criteria, no comparison to last year is available

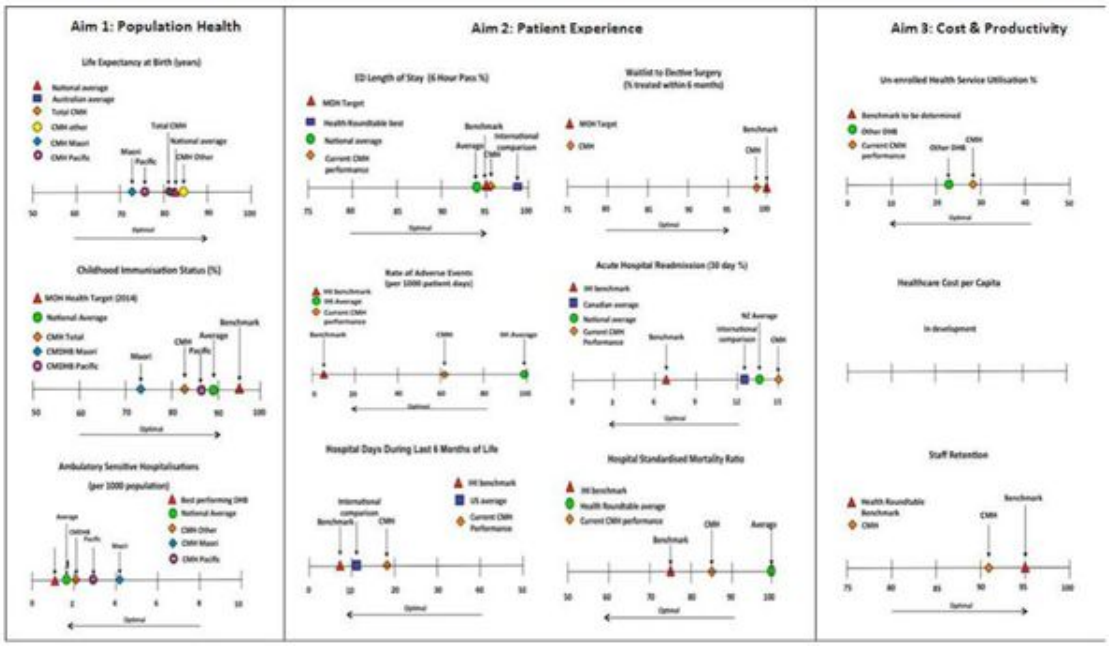
Note: ESPI figures include ungraded. This will be reviewed and they maybe excluded in future

N/A = Not available

U/D = Under Development

Source: Bay of Plenty DHB

Appendix 5: System Level Measures



Source: Counties Manukau DHB

Appendix 6: Indicators of DHB performance

FORECAST SERVICE PERFORMANCE

ACUTE SERVICES

These are services for illnesses that have an abrupt onset, are often of short duration and progress rapidly, for which the need for care is urgent (they may or may not lead to hospital admission). Hospital-based services include emergency departments, short-stay acute assessments and intensive care services. Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of services.

MEASURE	RATIONALE - WHAT THIS MEASURE SHOWS	ACTUAL 2011/12	TARGET 2013/14
People are assessed, treated or discharged from the emergency department (ED) in under six hours.	An indicator of the **timeliness** of ED services and the effectiveness of hospital systems.	89.9%	95%
Number of people presenting at ED.	An indicator of the **quantity** of people accessing ED.	81,342	83,300
The acute readmission rate to hospital. [46]	An indication the **quality** of care received in hospital and post-discharge.	6.63%	≤6.60%
The acute inpatient average length of stay in hospital.	An indication the **timeliness** and **quality** of care received in hospital.	3.94 days	<4.25 days

MATERNITY SERVICES

These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anoesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.

MEASURE	RATIONALE - WHAT THIS MEASURE SHOWS	ACTUAL 2011/12	TARGET 2013/14
The number of births in the DHB region.	An indication of the **quantity** of births.	3526	3500 [47]
New mothers have established breastfeeding on discharge from hospital.	An indication of the **quality** and effectiveness of initiatives promoting breastfeeding.	83%	85%
Baby friendly hospital accreditation is maintained.	A measure of the **quality** of services and facilities for mother and baby.	100%	100%

ASSESSMENT, TREATMENT AND REHABILITATION SERVICES (AT&R)

These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments, (where appropriate) is indicative of the responsiveness of services.

MEASURE	RATIONALE - WHAT THIS MEASURE SHOWS	ACTUAL 2011/12	TARGET 2013/14
Average length of stay for inpatient AT&R services (65 years and over).	An indication of the **quality** and effectiveness of AT&R services.	17.35 days	≤17.35 days
Average length of stay for inpatient AT&R services (under 65 years).		25.0 days	≤25.0 days
AT&R patients have improved functionality on discharge (65 years and over).	An indication of the **quality** and effectiveness of AT&R services. FIM is an international measure of functional gain	16.3	>16.3
AT&R patients have improved functionality on discharge (under 65 years).		26.1	≥26.1
Percentage of patients aged 75 and over (Māori and Pacific People age 55 and over) that are given a falls risk assessment. [48]	The **quantity** of 'at risk' people receiving a falls assessment has a direct correlation to the number of people who have individualised care plans to minimise the risks of a fall.	52.5%	70%

[45] CLAB is one of the quality and safety markers developed by the Health Quality & Safety Commission.
[46] DHB performance measure – 058
[47] Statistics NZ is projecting a declining birth-rate for Southern district.

[48] A falls assessment is one of the quality and safety markers developed by the Health Quality & Safety Commission. The national targeted threshold is 90%.

Southern DHB Annual Plan 2013/14 66 | Page

Appendix Eight - Wairarapa and Hutt Valley Communications Update November 2013

1 External communications / Media

Health Highlights

Monthly column in Wairarapa News, Hutt News and Upper Hutt Leader. November focus:

Wairarapa – New GP Clinical Leader, Public Health team relocation, Board elections

Hutt Valley – Health Passport, Z fundraiser, whooping cough immunisation, Board elections.

Media releases/responses 24 October – 25 Nov 2013

Wairarapa	Hutt Valley
CSSD fire Health Passport Breast screening Patient condition updates x 4 New clinical lead role in Primary Care FPSC – impact on roles HDU Road to recovery story Sterilisers in CSSD upgraded Public Health relocated and rebranded SSE report	District nursing overnights cut back Patient Continence pads Patient condition updates x 3 Privacy breach maternity Tree Hutt 2nd anniversary Wesley Haven rest home Hospital equipment – how many not returned Mental Health report HDU Nurse attacked in ambulance Z Charity Event for Hutt Children's Ward

Community forums

A series of four public meetings held in Featherston, Greytown, Carterton and Masterton had small but interested audiences. The focus was looking back over the last year of the 3DHB partnership, and forwards over the next 3 years. A wide range of questions were asked, the answers to which will form the basis of the next Wairarapa Health Highlights column. The presentation was also sent to local stakeholders.

2 Primary Care – Tihei Wairarapa and Hutt Inc

- Monthly advertising of the 'ED or GP' message, listing after-hours services and Healthline
- Redrafting Tihei Wairarapa communications plan with Justine Thorpe
- Implementing Hutt Inc Communications plan.

3 Working with our neighbours

Sub-Regional (3DHB)

- Communications re: FPSC – working with HBL secondees on communications strategy
- Working with 3DHB Programme team to update online presence

- HDU services at Wairarapa Hospital, as part of the Critical Care workstream for the sub-region
- Operating Theatre services at Wairarapa Hospital, as part of the regional capacity workstream for the subregion
- Work progressing on shared 3DHB workspaces, accessible through our intranets
- First draft of paper proposing a 3DHB Communications function completed
- EOIs for single outsourced print-room function assessed. Shortlisted vendors to present to key staff from the 3 DHBs on December 11
- Advice to the Common Operating Environment project.

2DHB

- Annual Reports for both DHBs completed
- Quality Accounts almost completed
- Work progressing on shared website (retaining site specific URLs)
- Next iteration of organisational structure diagram released (version 7)
- Summer Studentship programme – placements offered
- Preparing for Health Passport launch on both sites
- 'Open for better care' photos and quotes for localised posters
- Hand Hygiene campaign
- Design and assistance for flyers, posters, and patient information
- Preparation for Behavioural Visioning workshop.

Regional

- Coordinated regional feedback to Shared Services on communications strategy for 4 month wait.

4 Internal communications

All staff memos

Wairarapa	Hutt Valley
3DHB Maori Health – proposed changes New 3DHB appointments Preventing SSIs – webinar Trialling Nursing Reference Centre resource tool Emergency generator annual maintenance Community Referred Laboratory – site visits Equipment return FPSC briefing invitation	3DHB Maori Health – proposed changes New 3DHB appointments Preventing SSI's - webinar Viewing radiation treatments on MAP Philippines typhoon Social media access Power outage in Pilmuir House

Weekly staff eLink (Hutt Valley emailed/printable newsletter) well received, planning rollout of Wairarapa version in December, in conjunction with the Hospital Manager.

Staff forums

FPSC briefings to affected and impacted staff on both sites

Intranet stories 24 October – 25 November 2013

Wairarapa	**Hutt Valley**
New 3DHB appointments Christmas and new year hospital hours Antibiotics awareness week Health Passport launch 2DHB Theatre business manager appointed DHB Antenatal Classes underway White ribbon day CRISP update 3DHB Maori Health proposal Too busy for quality? Christmas is coming – CE advisory on staff functions Reducing SSI webinar Colombo Road entrance closing 3DHB Corporate Services Change document Staff Christmas BBQ lunch Seven ways to lead by example Enable New Zealand general manager appointed Farewell to Jan McEwan, 47 years nursing Tips for success and happiness General Surgery update Consultation process – 3DHB Maori Health Acute Services staff introduced to new equipment 9 qualities of truly confident people Roasting up a new brew	New 3DHB appointments Grand Round: Vulnerable Children's Initiatives 'Santa's sleigh' Christmas Charity toy run Alcohol based handwash changes White ribbon day 2DHB Theatre business manager appointed Z charity event for Hutt Hospital Philippines fundraising update Antibiotics awareness week 'Pimp my trolley' 2013 Young Achiever award Christmas and new year hospital hours Movie fundraise Painting to be auctioned PDRP showcase Team pic of the week (x4) Hutt Hospital monthly balanced scorecard Breastfeeding room now available International Stop Pressure Injury day No major problems during substation shut-down $700 from first Philippines bakesale Fundraising for the Philippines begins Social media policy Reducing SSI webinar Grand Round: Hutt Hospital Foundation 3DHB Movember update Minister welcomes 377 graduate doctors (MIN) Heretaunga evacuation workshop Scooter awareness campaign a hit with kids 3DHB Corporate Services Change document Proposed disestablishment of RPH Maori role Regional hospital chaplains gather for training day ICAFS smash their waiting list after 6week blitz Have you washed your hands

	Christmas is coming – CE advisory on staff functions Parkinsons awareness week 3DHB Maori Health proposal Presentation on emerging privacy issues Hand Hygiene campaign Viral Hepitatis workshop Care Capacity Demand Management

5 Other Communications projects

Wairarapa	**Hutt Valley**
Community Open Forums x 4 Palliative Care – Kahukura/Hospitrce Wairarapa partnership Shared intranet/workspaces 3DHB style-guide Over and Above – positive story bank for next 8 weeks Simon Prior clinical scholarship material produced. Ongoing patient information brochures Produced flipchart for Allied Health referrals, placed in all the wards.	Care Capacity Demand Management (CCDM) intranet pages and posters EQ comms Screening matters article on Breast Cancer Awareness Month Student assignment query: the effects that rising drugs such as 2C-I and 25-I are having on users Allied Health Values Scorecard Communications for operation Blackout at Hutt Hospital Radiology project Efficiency Plan communications Safe Hutt Valley (mulit-agency) Coroners cases

Appendix Five – Official Information Act Requests

<table>
<tr><th>OIA</th><th>Requestor</th><th>Date</th><th>Request/Response</th><th>Status</th></tr>
<tr>
<td>OIA 698</td>
<td>Kurt McLauchlan Office of Leader of the Opposition</td>
<td>10/10/13</td>
<td>

The amount of money that has been spent for each of the last five years on initiatives designed to save money or to reprioritise spending.
The total forecasted benefits for each of the last five years from initiatives designed to save money or reprioritise spending.

Wairarapa District Health Board (WDHB) response:
Over the past five years Wairarapa DHB has had savings initiatives forecast to save around $14.6m. These initiatives are mostly targeted at working smarter especially around patient care pathways. By improving the patient journey through services we reduce waste in the system. As this is core business for a DHB we do not separately track the costs of implementing such initiatives. This means we are unable to provide the information on the first part of your question as it does not exist, and accordingly this aspect of your request is declined pursuant to Section 18(e) of the Official Information Act. In reaching this decision I have considered whether consulting with you would assist you to make the request in a form that would remove the reason for the refusal.
As to the second part of your request, the tables below provide the forecast benefits of saving and reprioritisation initiatives over the last five years.
2009-2010 WDHB
<table>
<tr><th>Item</th><th>Forecast saving ($000)</th></tr>
<tr><td>Clinical Services Revenue initiatives</td><td>844</td></tr>
<tr><td>Other Revenue initiatives</td><td>214</td></tr>
<tr><td>Service and Workforce reviews</td><td>349</td></tr>
<tr><td>Procurement Savings Initiatives</td><td>145</td></tr>
<tr><td>Sundry Expenditure Initiatives</td><td>3,100</td></tr>
<tr><td>2009-2010 Total forecast savings</td><td>4,652</td></tr>
</table>
</td>
<td>Completed 11/11/2013</td>
</tr>
</table>

Appendix Five – Official Information Act Requests

2010-2011 WDHB

Item	Forecast saving ($000)
Achieve Financial Security	1,150
Improved hospital productivity and quality	940
Enhance Regional cooperation	240
2010-2011 Total forecast savings	**2,330**

2011-2012 WDHB

Item	Forecast saving ($000)
Mental Health Regional Initiative	110
Ambulance Contract	150
Shared Services – HBL 1	175
Radiology – diagnostic and imaging management	62
Periop additional revenue and clinical supplies management	277
Nursing Directorate Educator	5
Building & Property Compliance Savings	56
Outsourced Contracts	19
Funder – Performance Improvement Action Target	600
HBL Treasury Management	100
General	120
2011-2012 Total Forecast Savings	**1,674**

Appendix Five – Official Information Act Requests

2012-2013 WDHB

Item	Forecast saving ($000)
National Pharmacy/Close Control	400
HBL National Procurement Savings	250
HBL Facilities Management Savings	250
Repatriation of non-complex electives	300
Electives work performed for other DHBs	175
Radiology Service MRI savings	40
Radiology part user charges	225
Management Savings	160
Treasury Banking	120
PHO Governance Arrangements	83
Manager Vacancy	90
Reduce TAT spend	50
Maternity Revenue Primary Care	150
CRISP Opex timing change	165
2012-2013 Total Forecast Savings	**2,458**

2013-2014 WDHB

Item	Forecast saving ($000)
Health Benefits initiatives	383
Regional Shared Service Initiatives	400
Provider- 2012/13 Procurement savings	117
3DHB Plan – ELT amalgamation	500
Blood Product Savings	300

Appendix Five – Official Information Act Requests

			3DHB Plan - Improving utilisation of theatres across sub-region: 500 3DHB Plan - Value for Money Funder Arm initiatives: 922 Insurance savings: 126 Revenue opportunities: 250 **2013-2014 Total forecast savings: 3,498**	
OIA 699	Annette King MP	21/10/13	How many women waiting for breast reconstruction surgery have been removed from the surgery waiting list and referred back to their GP for the years 2011/12 and 2012/13? Response: Hutt Valley District Health Board (DHB) have had no patients removed from the waiting list whilst waiting for breast reconstruction at Hutt Hospital during 2011/12 and 2012/13. Please note: Breast reconstruction surgery is not undertaken at Wairarapa and Capital & Coast DHBs, patients are sent to Hutt Valley DHB.	Completed 12/11/2013
OIA 700	Annette King MP	21/10/13	What lymphoedema care is provided to women who have undergone mastectomy by the DHBs? Please provide details of the range of care provided. Response: Neither Wairarapa DHB nor Hutt Valley DHB offer such treatment, any local patients would be referred to Capital & Coast DHB for treatment.	Completed 12/11/2013
OIA 701	Annette King MP	21/10/13	All correspondence sent or received by the DHB which relates to my Official Information Act request dated 18 September (W686) for 'correspondence received since January 2013 on the impact of the increase in Prescription charges to $5' to 4 October. All correspondence sent or received by the DHB between 18 September 2013 and 4 October includes my name. I am responding on behalf of the Wairarapa, Hutt Valley and Capital & Coast District Health Boards to your request under the Official Information Act 1982 for: *All correspondence sent or received by the District Health Board which relates to my Official Information Act request dated 18 September 2013 for 'correspondence received since January 2013 on the impact of the increase in prescription charges to $5' to 4 October 2013.* *All correspondence sent or received by the District Health Board between 18 September 2013 and 4 October*	Completed 19/11/2013

Appendix Five – Official Information Act Requests

			2013 includes my name. We have searched through our files to the best of our ability and there are a number of emails that fall within the bounds of your request. We have withheld some emails and documents on the basis of legal privilege as per the Act: *9. Other reasons for withholding official information* *(2) Subject to sections 6, 7, 10, and 18, this section applies if, and only if, the withholding of the information is necessary to -* *(h) maintain legal professional privilege;* Please note that under Section 28, you may ask an Ombudsman to investigate and review our decision to withhold this information.	
OIA 702	Victor Boyd Citizens Commission on Human Rights	22/10/13	This is a request made under the Official Information Act, for copies of any and all reports by the Office of the Ombudsman's Inspectors over the past five years. These reports relate to inspections in places of detention as part of their role under the Optional Protocol to the Convention Against Torture (OPCAT). Response: Wairarapa District Health Board does not provide an in-patient mental health service, therefore would not hold anyone under the Mental Health Act. Hence, Wairarapa District Health Board has not undergone any inspection during the past five years, and has not received any reports.	Completed 14/11/2013
OIA 703	Karaitiana Taiuru Maori Internet Society	23/11/13	1. *What public Internet domain names does your organisation have registered at the third level with their associated second level domain (i.e. name.govt.nz)? This includes all .govt.nz and non .govt.nz domain names.* Wairarapa and Hutt Valley DHBs have the following .org.nz domain names: www.wairarapa.dhb.org.nz www.huttvalleydhb.org.nz www.huttmaternity.org.nz www.wairarapamaternity.org.nz (about to be launched) www.rph.org.nz (Regional Public Health) www.healthyjobs.co.nz (recruitment portal, Hutt Valley DHB) www.wairarapadhb.currentjobs.co.nz (recruitment portal, Wairarapa DHB)	Completed 19/11/2013

Appendix Five – Official Information Act Requests

			2. *Does the current .govt moderation policy give your organisation the flexibility required to use te reo Māori, or is this not relevant to your organisation?* Neither DHBs have any .govt websites. 3. *Why do you/don't you use your bilingual name (if applicable) as a domain name for your organisation?* We do not use the bilingual name as a domain name for either DHB. For Wairarapa DHB, the bilingual name Te Poari Hauora a-rohe o Wairarapa forms part of the DHB logo and is therefore used on all letterheads, signage and official publications. For Hutt Valley DHB, there is no bilingual name attached to the DHB, but in consultation with local iwi, the name Te Awakairangi was given when the DHB assisted the four local Primary Health Organisations to form a single organisation.	
OIA 704	Michelle Duff Dom Post	24/11/13	This is an Official Information Act request into exactly how many roles at your DHB are being disestablished and relocated as a result of the national Finance, Procurement and Supply Chain programme announced by Health Benefits Limited on October 10. I would like to know how many roles are being disestablished and relocated, how many staff will be effected, how many roles there were at your DHB before and how many there will be afterwards.	Transferred to HBL 25/10/2013
OIA 705	Annette King MP	29/10/13	1. *What is the District Health Boards (DHB) discharge from hospital policy/procedure for older people who have been admitted to hospital, please provide details*. On the ward there is a discharge planning process which is individualised to the patients functional needs and community context. There is a discharge planner who co-ordinates discharges. Discharges can be: a. Home, no need for support/ follow-up eg young patient with pneumonia b. Home with short term help for house-hold management/ district nurse eg dressings/ new catheter c. Home with existing care package d. Transfer to AT&R for further assessments, rehabilitation and complex discharge planning e. To our Health Recovery programme f. Directly into long term care g. To palliative service h. Other: died/transferred to another DHB 2. *What policy/procedure does the DHB have for older New Zealanders being treated at Emergency Department (ED) in relation to the time of night they are sent home?*	Completed 25/11/2013

Appendix Five – Official Information Act Requests

<table>
<tr><td></td><td></td><td></td><td>There is no formal policy and the action taken is on a case by case basis. From ED it is at the discretion of staff who would take into consideration the patients social circumstances, eg lives alone, time of night, whether the family are able to take them home to their place, patients wishes etc.</td><td></td></tr>
<tr><td>OIA 706</td><td>Lynne Sijbrant Healthcare Holdings Ltd</td><td>30/10/13</td><td>1. The number of people presenting to the DHB Emergency Department per month during the periods: 1 Jan to 30 Jun 2011, 1Jan to 30 June 2012, and 1 Jan to 30 Jun 2013.
2. The number of admissions subsequently made to hospital following presentation to ED for each of the 3 half years.
3. Any related information in respect of these figures in Q1 and Q2 (for example, any reports or analysis on these figures</td><td>In Progress</td></tr>
<tr><td>OIA 707</td><td>Karen Brown Radio New Zealand</td><td>01/11/13</td><td>Elective and non-urgent surgery over the last 5 years for both Wairarapa and Hutt Valley District Health Boards (DHB).
1. What overall funding has the district health board made available for all elective, or non-urgent surgery over each of the past five years, since 2008?
We cannot supply funding, but we can identify actual caseweights for elective and acute surgery, which can then translate to a dollar value, derived from the caseweight price - source of actuals is NMDS and/or Caseload Monitoring Report.
Caseweight Price for Wairarapa and Hutt Valley
<table>
<tr><th></th><th>2008/09</th><th>2009/10</th><th>2010/11</th><th>2011/12</th><th>2012/13</th></tr>
<tr><td></td><td>3,985.32</td><td>4,315.48</td><td>4,410.38</td><td>4,567.49</td><td>4,614.36</td></tr>
</table>
2. What proportion of that funding has been spent on total hip and total knee replacement operations in each of the past five years?
<table>
<tr><th></th><th>2008/09</th><th>2009/10</th><th>2010/11</th><th>2011/12</th><th>2012/13</th></tr>
<tr><td>Wairarapa</td><td>17%</td><td>15%</td><td>17%</td><td>17%</td><td>19%</td></tr>
<tr><td>Hutt Valley</td><td>17%</td><td>13%</td><td>15%</td><td>16%</td><td>17%</td></tr>
</table>
3. How many total hip and total knee replacement operations has the DHB carried out (on-site and through out-sourcing) in the past five years?
<table>
<tr><th></th><th>2008/09</th><th>2009/10</th><th>2010/11</th><th>2011/12</th><th>2012/13</th></tr>
<tr><td>Wairarapa</td><td>140</td><td>108</td><td>124</td><td>118</td><td>136</td></tr>
<tr><td>Hutt Valley</td><td>296</td><td>229</td><td>259</td><td>272</td><td>318</td></tr>
</table>
4. How many patients met the clinical threshold for total hip and total knee replacement operations at the DHB</td><td>Completed 25/11/2013</td></tr>
</table>

Appendix Five – Official Information Act Requests

			but did not get placed on a waiting list for surgery in each of the past five years? We do not have any information which would help us to identify whether this has occurred at all. 5. *What effect has the ending of the Orthopaedic Joint Replacement Initiative had on the number of total hip and total knee replacement operations at the DHB generally?* We are unable to provide any information, additional to the data submitted in question 3. 6. *What effect will the reduction in waiting time from six months to four months by December 2014 have on patients who have been assessed as meeting clinical requirements for a hip or knee replacement operation, in the DHB's view?* There will be no effect on patients as we reduce the weight times from five to four months by December 2014. Once a commitment has been made to a patient that they have been accepted for a First Specialist Appointment (FSA) or treatment, and therefore placed on a list, the patient has been given 'Certainty' and this must be honoured by the DHB.	
OIA 708	Jessie Barwick Office of Darien Fenton MP Labour	11/11/13	Does the DHB contract for different lengths of time for home-based support visits depending on the outcome of the clients Comprehensive Clinical Assessment, if so, what are the different categories and length of time for visits? Des the DHB contract for different lengths of time for home-based support visits depending on the nature of the support package being provided, what are the packages offered and the length of times contracted for visits? I also request a copy of the DHB's guidelines, protocols or procedures for home-based support visits.	In progress
OIA 709	Marty Sharpe Hawkes Bay reporter/Dom Post	14/11/13	**1**, I would like to know how many patients arrived at your ED in the year to date and last year who were ineligible for publicly funded health and disability services. **2**, How many fell into each of the Triage Codes (1-5) **3**, If fees differ from the following please provide details: Triage Code 1, $311.65 (incl. GST), Triage Code 2, $459.71 (incl. GST), Triage Code 3, $315.98 (incl GST), Triage Code 4, $326.58, Triage Code 5, $245.41 (incl. GST). **4**, How many invoices were sent to recover these charges? **5**, How many of these were paid? **6**, What was the total sum collected? **7**, How many were unpaid? **8**, What was the total sum of unpaid invoices, including collection costs? **9**, How many, if any, of these debts were written off?	Withdrawn 21/11/2013

Appendix Five – Official Information Act Requests

			10, What was the total sum written off?	
OIA 710	Annette King MP	14/11/13	How many of the following procedures have been carried out in DHB hospitals 2009/10, 2010/11, 2011/12, 2012/13? Hernia, Varicose Veins, Tube Ligations, Vasectomies, Cataracts	In Progress
OIA 711	Annette King MP	18/11/13	What, if any, weaning programmes does the DHB provide for tube fed children? How many tube fed children does the DHB have in the DHB region currently receiving DHB services? What is the estimated cost for tube fed services?	In progress
OIA 712	Tom Hunt Dom Post	20/11/13	Could you supply details of all serious and reportable events related to your DHB morgues in the past three years.	In Progress
OIA 713	Michelle Duff	22/11/13	OIA request for all audits into services at CCDHB, Hutt and Wairarapa DHB in the past year.	In Progress
OIA 714	Stacey Kirk Dom Post	22/11/13	I'd like to submit a request for information relating to children hospitalised for drug and/or alcohol overdoses. What I'm wanting to know is: Total number of patients and drug-related admissions to hospital since 2011. How many of those were alcohol related? How many were drug related? In a spreadsheet format, could I please request a breakdown identifying: - The number of children and young adults (aged 0-18) that have been hospitalised for drug and/or alcohol overdoses since 2011. - The age of each child - Length of stay in hospital - The circumstances under which they were hospitalised (i.e. what kind of poisoning) Have any of these patients died since 2011? If so, what was the age of the patient, what month and year was their death? Was the death/s drug or alcohol related? If possible, could I please have some details of the youngest patient brought in - i.e. how did the child present? Who was the child brought in by? What kinds of substances were identified? And in what wards was the child cared for before he or she was discharged? Have there been any diagnoses of addiction to drug or alcohol in patients 18 and under since 2011? Could I please have all reports and recommendations written by, or given to the DHB about the abuse or treatment of alcohol and drug issues since 2011. (Crossing all age brackets - not just pertaining to children and young adults)	In Progress

Appendix Five – Official Information Act Requests

			Many thanks in advance for this. I note that under the Official Information Act, you have up to 20 working days to respond. I estimate the deadline to be Friday December 20.	
OIA 715	Annette King MP	25/11/13	What is the current threshold at which a patient receives hip, knee and cataract surgery and how does this compare each month since June 2012?	23/12/2013

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

Wairarapa District Health Board

FINANCIAL REPORT

OCTOBER 2013

Report Number D0000

1. ORIGIN OF THE REPORT

This report is a regular report and standing agenda item providing an update on the latest financial result and other relevant financial matters to the Board of Wairarapa District Health Board (WDHB).

2. RECOMMENDATIONS

That the Board:

1. **RECEIVES** the Wairarapa DHB financial report for the month ended 31 October 2013.

3. COMMENTARY

3.1 Overview

The summary statement of financial performance is shown on page 5. This shows that the DHB has posted a deficit of ($1,261k) for the four months ended 31 October 2013 which is $151k favourable to the planned result YTD.

3.2 Financial Commentary

3.2.1 Revenue

Revenue is favourable to plan by $313k for the four months ended 31 October 2013 which can mostly be attributed to ACC Acute Rehabilitation Contract Revenue ($76k favourable), ACC Claims for Staff absences ($51k favourable), and MOH Subcontracts ($73k favourable).

3.2.2 Workforce expenses

Workforce expenses were $282k favourable to budget for the four months.

- Medical workforce costs are ($24k) adverse to budget across employed and contracted medical staff. We continue to have two RMO's who cannot work nights due to MECA restrictions and locums were required to cover this and other gaps.
- Nursing costs are favourable to budget by $101k for the four months to the end of October.

3.2.3 Outsourced services

Outsourced services were ($9k) adverse to plan for the four months. This was primarily due to the higher than planned MRI expenses.

3.2.4 Clinical supplies

Clinical supplies were ($239k) adverse to plan for the four months. Key areas contributing to the adverse variance are:

- A $141k accrual for estimated costs of repairs to CSSD equipment due to fire damage. There is a possibility that some of these costs can be recovered, this is yet to be confirmed.
- Patient transport and accommodation is ($45k) adverse to budget. These costs reflect the subsidised travel for patients and a family member where services are provided, generally out of the Wairarapa. This is demand driven and is paid under the National Travel & Assistance Policy issued by the MoH.
- Air ambulance costs are ($45k) adverse to budget. This cost is also demand driven.

3.2.5 Non-clinical supplies

Non-clinical supply costs were favourable to plan by $67k for the four months with this variance spread across a number of cost lines including utilities (coal and electricity) and computer lease costs.

3.2.6 Funder

The Funder YTD variance is $31k favourable.

IDF expenses are ($647k) adverse to plan as at the end of the first quarter. This has been offset by prior year accruals and other favourable variances. The IDF expense reflects the washup with Capital and Coast DHB for inpatients to the end of October. The two DHBs are currently in discussion as to how IDF balances in excess of the agreed budgets between them will be treated during the year.

The following graph shows the trend for total community pharmaceutical spend over the last 16 months. It shows that pharmaceutical costs have largely levelled out since the introduction of the new contract in July 2012.

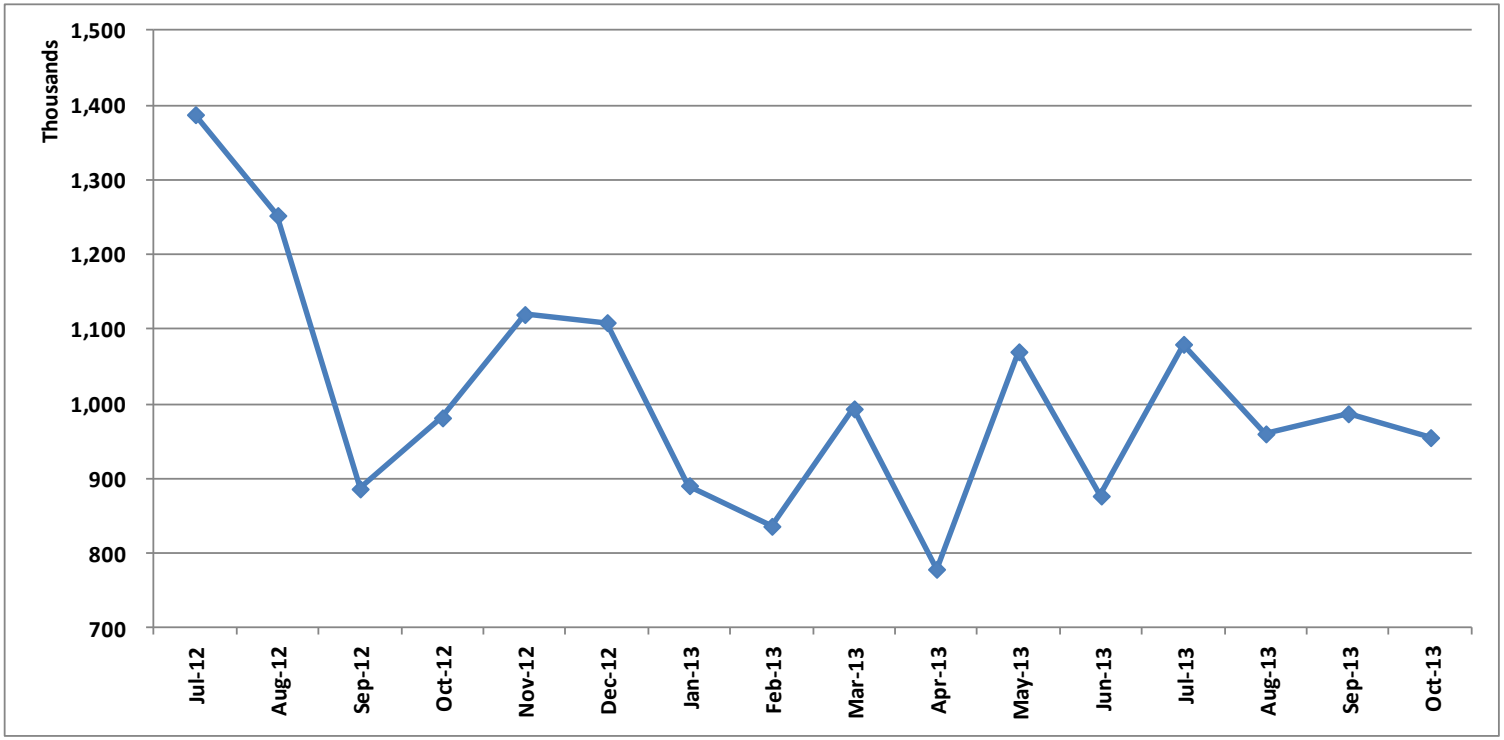


Figure1: Total Community Pharmaceutical Expenditure July 2012 to October 2013

3.2.7 Interest, Depreciation & Capital Charge

Interest, Depreciation & Capital Charge costs were adverse to plan by ($62k) for the four months. The variance mainly relates to a required increase in the capital charge provision stemming from the 30 June 2013 property revaluation. At this stage, the extra $264k annual provision required will be booked at $24k per month over eleven months to June 2014.

3.3 Ministerial Cap on Management & Administration Staff

WDHB remains within the cap set by the Minister for management and administration staff. A further reduction in the number will occur with the transfer of 1.0FTE to the CRISP programme. As reported in April 2013, the payroll transfer to CCDHB of the Strategic Development team (now part of SIDU) took effect 1 April and this is reflected in the reduced Actual and Budget (from 1 July) FTE numbers reported below.

It is noted that the definition applied to an FTE with the cap differs to that applied to normal FTE reporting and also includes any subsidiaries of a DHB. The definition applied is that one employed FTE is based on one person who works a 40 hour week, a person working more than 40 hours a week is counted as one FTE.

The following table shows the current levels:

Management/Administration Cap

Full Time Equivalent (FTE) Staff Numbers

for the period ended October 2013

	Year to Date		
	Actual	**Budget**	**Variance**
Employed FTE	101.3	117.0	15.7
Vacant FTE	6.0	0.0	(6.0)
Contractor FTE	4.0	3.0	(1.0)
Subsidiary FTE	4.0	4.0	0.0
Total FTEs	**115.3**	**124.0**	**8.7**

4. FINANCIAL STATEMENTS

The detailed financial statements are included on the following pages.

Wairarapa District Health Board

Statement of Financial Performance

For the Period to October 2013

	Month			Year To Date			Annual
	Actual $000	Budget $000	Budget Var $000	Actual $000	Budget $000	Budget Var $000	Budget $000
Revenue	**11,336**	**11,036**	**301**	**45,412**	**45,099**	**313**	**135,063**
Expenditure							
Medical	901	953	53	3,805	3,781	(24)	10,672
Nursing	1,349	1,364	16	5,498	5,599	101	16,226
Allied Health	439	478	39	1,867	1,943	76	5,489
Support	63	64	1	252	265	14	743
Management/Admin	562	593	30	2,286	2,401	115	6,682
Workforce Expenses	**3,314**	**3,453**	**139**	**13,709**	**13,990**	**282**	**39,812**
Outsourced Services	379	380	0	1,548	1,539	(9)	4,605
Clinical Supplies	896	732	(164)	3,027	2,788	(239)	8,251
Non-Clinical Supplies	722	686	(35)	2,778	2,846	67	8,129
Funder Provider Payments	3,501	3,661	160	15,028	15,473	445	45,843
IDF Expenses	2,474	2,185	(289)	9,389	8,742	(647)	26,226
Total Expenditure	**11,286**	**11,097**	**(189)**	**45,479**	**45,379**	**(101)**	**132,865**
EBIDCC	**51**	**(61)**	**112**	**(67)**	**(280)**	**213**	**2,198**
Interest, Depreciation & Capital Charge	305	284	(21)	1,194	1,132	(62)	3,398
Net Surplus / (Deficit)	**(254)**	**(345)**	**91**	**(1,261)**	**(1,412)**	**151**	**(1,200)**

Wairarapa District Health Board

Statement of Financial Performance by Arm

For the Period to October 2013

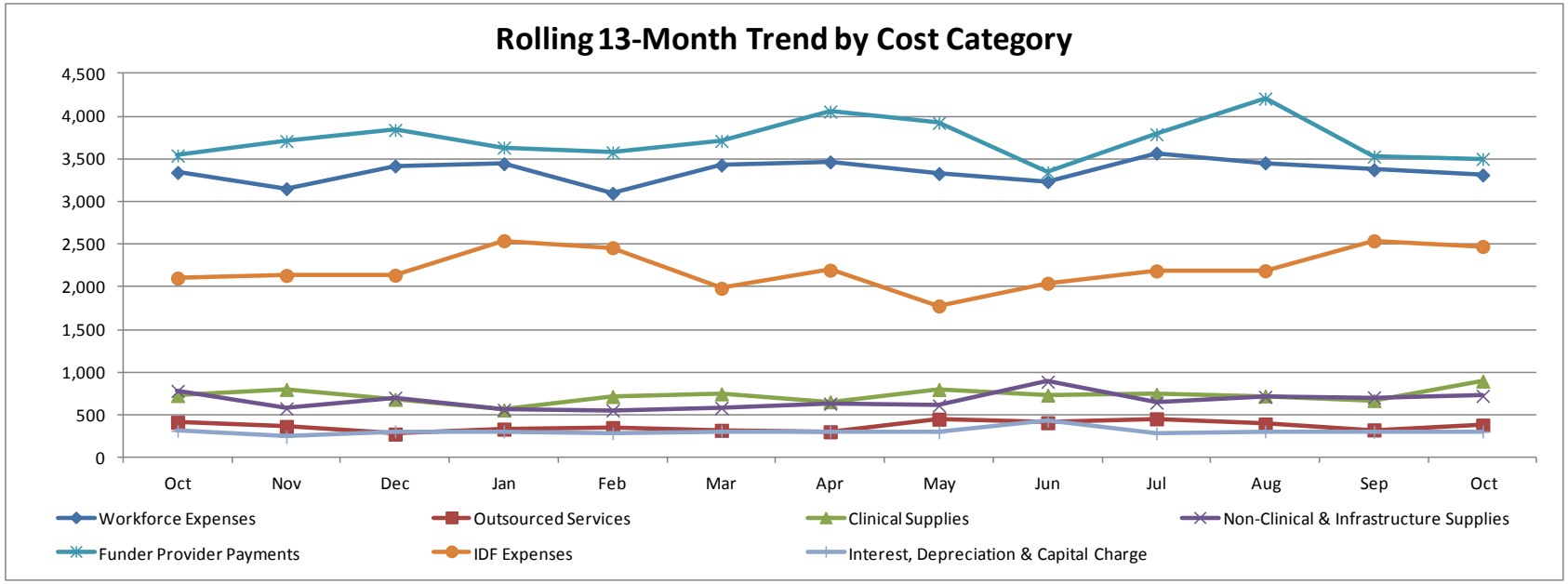
	Month			Year To Date			Annual
	Actual $000	Budget $000	Budget Var $000	Actual $000	Budget $000	Budget Var $000	Budget $000
Funder							
Revenue	10,672	10,505	167	43,056	42,849	207	127,970
Expenditure	10,606	10,486	(120)	42,952	42,775	(177)	127,749
Net Contribution	**66**	**18**	**48**	**104**	**74**	**31**	**221**
Provider							
Revenue	5,092	4,954	137	20,066	19,927	139	60,176
Expenditure	5,391	5,288	(103)	21,381	21,334	(47)	61,598
Net Contribution	**(300)**	**(333)**	**34**	**(1,315)**	**(1,407)**	**92**	**(1,422)**
Governance							
Revenue	212	217	(4)	850	883	(33)	2,597
Expenditure	233	247	14	896	960	64	2,597
Net Contribution	**(21)**	**(31)**	**10**	**(46)**	**(76)**	**31**	**()**
Net Surplus / (Deficit)	**(254)**	**(346)**	**92**	**(1,257)**	**(1,410)**	**153**	**(1,200)**

Wairarapa District Health Board

Revenue Analysis

For the Period to October 2013

	Month			Year To Date			Annual
	Actual $000	Budget $000	Budget Var $000	Actual $000	Budget $000	Budget Var $000	Budget $000
Vote Health & PBF	9,781	9,769	12	39,924	39,904	19	119,136
Other MOH	555	515	41	2,125	2,059	66	6,177
Health Workforce New Zealand	39	30	9	175	120	55	361
Inter District Flows	291	291	0	1,165	1,163	2	3,489
Other DHBs	70	55	16	221	222	()	667
ACC	203	166	37	792	665	127	1,994
Patient/Consumer	7	8	(1)	41	39	1	118
Training Fees & Subsidies	0	0	0	0	0	0	0
Other	390	203	188	969	927	43	3,121
Internal Revenue	()	()	0	()	()	0	()
Total Revenue	**11,336**	**11,036**	**301**	**45,412**	**45,099**	**313**	**135,063**

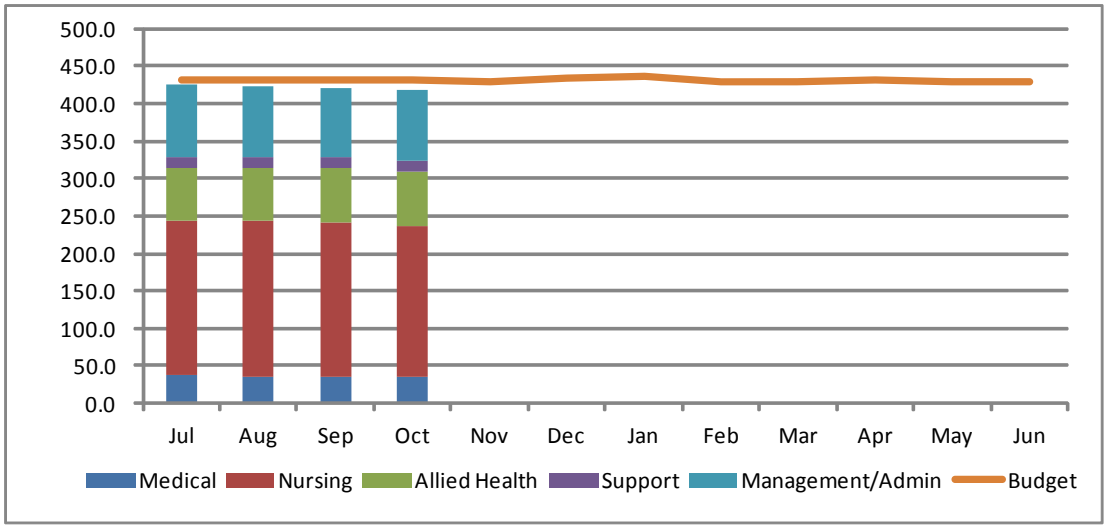

Rolling 13-Month Trend by Cost Category
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Workforce Expenses
Outsourced Services
Clinical Supplies
Non-Clinical & Infrastructure Supplies
Funder Provider Payments
IDF Expenses
Interest, Depreciation & Capital Charge

Wairarapa District Health Board

Full Time Equivalent (FTE) Staff Numbers

for the period ended October 2013

	Month			Year to Date			Annual
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
Medical	34.3	43.5	9.2	35.6	43.0	7.4	43.4
Nursing	203.0	201.1	(1.9)	205.4	201.1	(4.3)	201.2
Allied Health	72.3	78.1	5.8	72.2	78.5	6.4	78.2
Support	14.6	13.2	(1.4)	14.4	13.3	(1.1)	13.1
Management/Admin	92.7	94.8	2.1	93.6	95.1	1.5	95.1
Total FTEs	**417.0**	**430.7**	**13.8**	**421.1**	**431.1**	**9.9**	**431.0**



Wairarapa District Health Board

Statement of Financial Position

for the period ended October 2013

	Actual $000	Budget $000	Variance $000
Property, Plant & Equipment	44,343	42,946	1,397
Investments	2,768	999	1,769
Trust funds	258	200	58
Non-Current Assets	**47,369**	**44,145**	**3,224**
Cash & HBL sweep	0	0	0
Debtors & prepayments	3,892	5,110	-1,218
Inventories	772	725	47
Properties intended for sale	0	0	0
Curent Assets	**4,664**	**5,835**	**-1,171**
TOTAL ASSETS	**52,033**	**49,980**	**2,053**

	Actual $000	Budget $000	Variance $000
Crown equity	39,043	34,204	4,839
Revaluation reserve	5,558	2,155	3,403
Retained earnings	-35,007	-29,465	-5,542
Crown Equity	**9,594**	**6,894**	**2,700**
Interest-bearing loans	21,739	14,889	-6,850
Employee entitlements	551	620	69
Trust funds	258	210	-48
Non-Current Liabilities	**22,548**	**15,719**	**6,829**
Cash & HBL sweep overdraft	686	1,796	1,110
Creditors & accruals	9,800	8,763	-1,037
Employee entitlements	4,845	6,071	1,226
Interest-bearing loans	4,560	10,737	6,177
Current Liabilities	**19,891**	**27,367**	**-7,476**
TOTAL EQUITY & LIABILITIES	**52,033**	**49,980**	**2,053**

5. CASHFLOW FORECAST

The cash flow forecast on the following page highlights the cash forecast through to 30 June 2014. It is based on cash flow expectations as at 12 November 2013. The forecast shows the DHB continues to operate with a tight cash position.

Wairarapa District Health Board
Forecast Statement of Cash Flows
For period October 13 - June 14

	Nov-13 Forecast $000	Dec-13 Forecast $000	Jan-14 Forecast $000	Feb-14 Forecast $000	Mar-14 Forecast $000	Apr-14 Forecast $000	May-14 Forecast $000	Jun-14 Forecast $000
Operating Cash Flows								
Operating receipts	13,046	12,510	12,605	13,055	12,630	12,530	13,030	12,580
Operating payments	-13,304	-11,546	-13,510	-12,794	-12,671	-12,983	-13,194	-12,207
Capital charge paid	0	-729	0	272	0	0	0	-100
Total operating cash flows	**-259**	**236**	**-905**	**533**	**-41**	**-453**	**-164**	**273**
Investing Cash Flows								
Interest Receipts	8	8	8	8	8	8	8	8
Sale of assets	0	0	0	0	0	0	0	0
Purchase of Fixed Assets	-50	-50	-146	-317	-146	-201	-166	-217
Increase in Investments & Restricted & Trust Fund Assets	0	0	0	0	0	0	0	0
CRISP investment	0	-233	0	0	0	0	0	-233
FPSC investment	0	-55	0	-55	0	-55	0	-54
Total investing cash flows	**-42**	**-330**	**-138**	**-364**	**-138**	**-248**	**-158**	**-496**
Financing Cash Flows								
Capital Injections	0	0	0	0	0	0	0	0
Equity repaid	0	0	0	0	0	0	0	-3
Loans drawn	0	0	125	125	125	126	0	0
Debt repaid	-4	-4	-4	-4	-8	-8	-8	-8
Net interest expense (Loans)	0	-120	0	0	0	-550	0	-116
Total financing cash flows	**-4**	**-124**	**121**	**121**	**117**	**-432**	**-8**	**-127**
Net Cash Flows	**-305**	**-218**	**-922**	**290**	**-62**	**-1,133**	**-330**	**-349**
Opening cash balance	-682	-986	-1,204	-2,126	-1,836	-1,898	-3,031	-3,361
Closing cash balance	**-986**	**-1,204**	**-2,126**	**-1,836**	**-1,898**	**-3,031**	**-3,361**	**-3,710**

Prepared by: Financial Controller

6. TREASURY MANAGEMENT

6.1 Key Financial Ratios

The following table shows the four key financial ratios used to assess the financial performance by the National Health Board Business Unit (NHB) within the Ministry of Health.

Wairarapa District Health Board

Key Financial Ratios

for the period ended October 2013

	Year to Date		
	Actual	Budget	Variance
Net Surplus / (Deficit) $000	-1,261	-1,411	150
Working Capital Ratio	0.23	0.31	-0.08
Interest Coverage	-0.77	-1.13	0.36
Gearing	74%	83%	9%

6.2 Borrowing Schedule

The following table shows the borrowing facilities currently available to the DHB and the amounts drawn against each facility.

Wairarapa District Health Board

Borrowing Schedule

for the period ended October 2013

	Facility Limit $000	Maturity Date	Amount $000	Interest Rate
Working Capital				
HBL Sweep arrangement	5,000		686	3.97% Floating
Selina Sutherland	700	08-Dec-20	**549**	7.00% Fixed margin plus OCR
Term Borrowing (National Health Board Business Unit)				
Core	25,750			
		15-Dec-18	3,000	3.08% Fixed
		15-Dec-19	3,000	3.20% Fixed
		15-Apr-14	4,500	2.59% Fixed
		15-Apr-15	4,500	6.67% Fixed
		15-Apr-16	5,000	5.18% Fixed
		15-Apr-17	1,250	2.93% Fixed
		15-Dec-17	4,500	4.85% Fixed
			25,750	
Total Borrowing	**31,450**		**26,985**	

7. CAPITAL EXPENDITURE

The following table shows the Capital Expenditure Actual versus Budget to 31st October 2013.

Wairarapa DHB - Capex Budget Actual vs Budget spend year to date						
As at 31st October 2013						
	Spent to 31/10/2013 $000	Budget FY13/14 $000	Unspent to 31/10/2013 $000		Budget FY14/15 $000	Budget FY15/16 $000
CRISP (TAS Investment)	-	465	465		853	28
FPSC	40	219	179		322	-
	40	**684**	**644**		**1,175**	**28**
Baseline Capital - made up of:						
Buildings (incl Facilities Workshop)	56	450	394			
Clinical (incl ePrescription)	75	116	41		125	600
IT	-	-	-		-	600
Intangible (incl CRISP)	68	200	132		150	222
Other (Contingency)	5	50	45		50	50
	204	**816**	**612**		**325**	**1,472**
Total CAPEX:	**244**	**1,500**	**1,256**		**1,500**	**1,500**
Capex carried over from 2011/12, then 2012/13						
	Spent to 31/10/2013 $000	11/12 Budget $000	Spent to 30/06/13 $000		Unspent as at 30/06/13 $000	Unspent as at 31/10/13 $000
Oral Health BroadBand Project	5	63	6		57	52

PUBLIC

Wairarapa DHB – Wairarapa District Health Board – Te Poari Hauora a-rohe o Wairarapa / HUTT VALLEY DHB	**BOARD INFORMATION PAPER** **Date: 25 November 2013**

Author	Helen Pocknall, Executive Director of Nursing and Midwifery
Endorsed By	Graham Dyer, Chief Executive
Subject	**Workforce Sustainability – New Graduate Nurse Employment** **The case for increasing New Graduate Nursing numbers across Hutt Valley and Wairarapa DHBs for 2014 and out years**

RECOMMENDATION

It is recommended that the Boards

a. **NOTE** the case for increasing new graduate nursing numbers across Wairarapa and Hutt Valley DHBs

b. **NOTE** this paper

c. **NOTE** that the EDoNM will work with the Office of the Chief Nurse and Health Workforce NZ to share this initiative with other DHBs, in particular Capital and Coast DHB

d. **NOTE** modelling will be undertaken at a national level for primary health care and aged and residential care providers

1 BACKGROUND

Historically, the number of new graduate nurses employed by Wairarapa and Hutt Valley District Health Boards (DHBs) year on year has been variable, with decision-making driven primarily by vacant full time equivalents within individual wards/units – a position mirrored in a number of colleague DHBs.

As a result, a growing number of new graduate nurses find themselves without employment; and this mismatch between supply and demand has long been a source of concern for Nurse Leaders nationally.

In addition the modelling that has been undertaken by the Nursing Council of New Zealand (BERL Report, 2013) and Health Workforce NZ shows NZ faces a significant nursing shortage as early as 2020 if we do not find appropriate solutions. Enhanced recruitment of new graduate nurses is one way of ensuring supply will meet future demand.

In the last year Hutt DHB had agreed in principle to accept 22 graduates per annum. Wairarapa has taken from three to seven per year. Unfortunately this number remains variable and affected by vacancies at the time. Charge Nurse Managers recruit to their current (known) vacancies even though the turnover in nursing is 14% at Hutt and 11.5% at Wairarapa. This has resulted in a shortfall of 11 FTEs (i.e. Hutt has only offered positions to 11 new graduates). Wairarapa has only offered three positions for 2014[1].

The goal to recruitment of new graduates should be based on:
- Creating a continuous and predictable 'pipeline' of new talent;
- Assists in ensuring medium term nursing sustainability;

[1] The costings have yet to be completed for Wairarapa

PUBLIC

- Demonstrates our professional commitment to these nurses; and
- Reduces overall nurse workforce costs.

The benefits to the organisation include:

- In Year One, the cost of a new grad is 80% of the current staff
- By replacing nursing vacancies with the 22 new grads every year, the total savings will be $314,776 in year one and accumulative yearly.

2 COSTS AND BENEFITS

The cost of nurses' wages range from $47,057 (new grad) to $63,528 (Step 5). Currently the average cost at Hutt is $62,054[2]. With loading of 19% for leave and training cover, the cost per nurse is $61,036 for new graduates and $75,344 for current staff.

Health Workforce NZ pays the DHBs $7,200 for each new graduate in their first year of practice. Payment is conditional on the new graduate being enrolled in, and completing the Nursing Council of New Zealand approved Nurse Entry to Practice Programme (NEtP)

There are a number of costs associated with each new graduate employed in the first year, including supernumerary (learning) time, study requirements and support and HWNZ reporting and compliance costs.

3 THE PROPOSAL

Wairarapa and Hutt will be increasing their nursing new graduate numbers for 2014 and accordingly for the out years based on financial modelling and the need to better ensure nursing workforce sustainability. The additional nurses will be distributed based on service need and skill mix.

3.1 In Scope:

Hutt DHB:
Medical and Community Directorate: ED, medical wards, MAPU, Medical Day Stay, district nursing,
Surgical Directorate: theatres, PACU, Surgical Day unit, wards, outpatients, children's ward, SCBU, Maternity
Regional Public Health
WairarapaDHB:
Medical surgical ward, Rehab ward, Acute services, Children's ward, peri-operative, District Nursing, Public Health Nursing

3.2 Out of Scope:

Mental Health Directorate
Primary Health Care including Aged and Residential Care
Allocation and Casual Pools

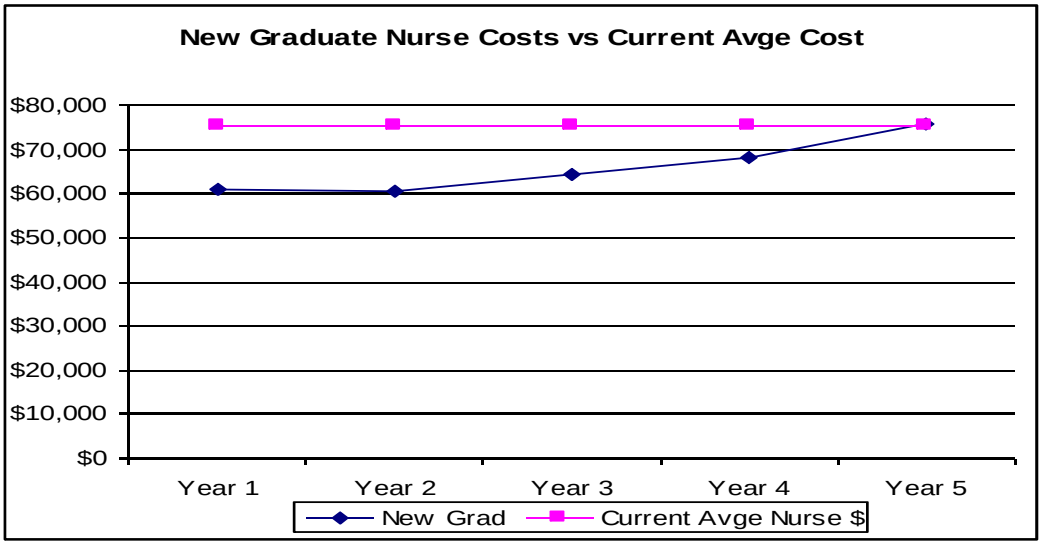
Benefits Of note:

1. The total cost of $61,036 for a new grad is based on a basic salary of $47,057, 19% loading for leave cover, $7,200 per FTE from HWNZ, PDU costs, orientation and preceptorship days
2. The savings per nurse in Year One is $14,308. This translates to $314,782 for 22 FTEs
3. The savings will be accumulative if the organisation commits to 22 new graduates every year. So in Year One, savings is $314,782, Year Two = $638,746, Year Three = $879,563 and so on. The savings become less apparent by Year Five

[2] Wairarapa's costs have not yet been completed but are anticipated to be the same if not higher.

PUBLIC

4. As new graduates only cost 80% of current staff, the organisation can 'carry' the risk of overstaffing by up to 12 weeks. It is unlikely this will occur given the amount of annual leave accrued by the current staff and the high turnover of nurses (14%)
5. No adjustments have been made to potential changes in the nursing MECA



4 RISKS AND MITIGATIONS

Risks	Score	Mitigations
Employment of new graduates places the cost centres above their budgeted 13/14 FTEs	H	Unlikely as the current turnover is 14% Use 'surplus' FTE to further manage each cost centre's accrued annual leave balance Monthly reporting and tracking of actual FTEs and forward planed rostered leave Hold vacancies and use either casuals or allocation staff (via the Op Centre) as an interim
Delays in approval to recruit to the 22 new graduates for February 2014	H	This will adversely affect our ability to recruit to the increase in new graduates and opportunities to reduce costs in nursing costs
New graduate to exiting FTE ratio may 'tip' the cost centre skill-mix	M	Balance new graduate nurse numbers against non – NG FTEs to minimise risk
Burden for existing workforce managing orientation and student numbers	L	Continue to use PDU resources to support the team Ensure rostering of preceptors promotes continuity

PUBLIC

5 ACTONS

The executive leadership team has approved:

- The employment of a minimum of 22 FTEs of new nursing graduates every year for Hutt Valley
- The employment of a minimum of 5 FTE of new nursing graduates every year for Wairarapa
- The cost of potential over-recruitment will be offset by lower costs of new graduates and using 'surplus' FTEs to further manage each cost centre's accrued annual leave balance
- Initial savings of $314,776 in Year One and accumulative savings in subsequent years by recruiting to 22 new graduates every year.
- Savings at Wairarapa will be proportional to numbers of graduates taken
- That there is an agreed plan in place in each Directorate to manage the skill-mix
- An emphasis be put on employment of Maori and Pacific new graduates

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**DECISION PAPER**
	Date: December 2013

Author	Bob Francis
Subject	**Resolution to Exclude the Public**

RECOMMENDATION

It is recommended that the Public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table.

The grounds for the resolution is the Committee, relying on Clause 32(a) of Schedule 3 of the Act believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists under the Official Information Act 1982 (OIA), in particular:

Agenda Item	Reason	Reference
Chief Executive Report	Paper contains information and advice that is likely to prejudice or disadvantage commercial activities	Sections 9(2)(i)
2014 Board and Committee Dates	Opportunity to discuss availability including personal commitments	Section 9(2)(a)
Regional ePharmacy	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Common Operating Environment Business Case	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Laboratory Services, Expressions of Interest	Paper contains information and advice that is likely to prejudice or disadvantage commercial activities	Sections 9(2)(i)
CRISP	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Health Informatics	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Committee Report Backs	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Annual Planning 2014/15	Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(j)
Quality Accounts	Opportunity to discuss and approval before they can be released to public	Section (2) (i) (k)