

Wairarapa District Health Board **Statement of Intent**

2010/11-2012/13

FINAL: 1 September, 2010

The financials in this Statement of Intent have been updated to reflect additional electives revenue and are now consistent with the approved 2010/2011 District Annual Plan.



Wairarapa DHB

Wairarapa District Health Board

Te Poari Hauora a-rohe o Wairarapa

Wairarapa DHB's vision is:

Well Wairarapa –Better health for all
Wairarapa ora – Hauora pai mo te katoa

Our mission is:

To improve, promote, and protect the health status of the people of the Wairarapa, and the independent living of those with disabilities, by supporting and encouraging healthy choices.

Wairarapa DHB Treaty of Waitangi Statement

The Wairarapa DHB recognises and respects the Treaty of Waitangi, and the principles of partnership, participation and protection, in the context of the New Zealand Public Health and Disability Act 2000.

The Wairarapa DHB will continue to work with the Te Oranga o te Iwi Kainga to ensure Maori participation at all levels of service planning, and service delivery for the protection and improvement of the health status of Maori.

Wairarapa DHB Board Values:

The values that underpin all of our work are:

- **Respect - Whakamana Tangata**
According respect, courtesy and support to all
- **Integrity – Mana Tu**
Being inclusive, open, honest and ethical
- **Self Determination - Rangatiratanga**
Determining and taking responsibility for ones actions
- **Co-operation - Whakawhanaungatanga**
Working collaboratively with other individuals and organisations
- **Excellence – Taumatatanga**
Striving for the highest standards in all that we do

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1. EXECUTIVE SUMMARY

This Statement of Intent (SOI) outlines to Parliament and the general public the performance intentions for Wairarapa District Health Board (DHB) for the next three years as we work to improve, promote, and protect the health status of the people of the Wairarapa in pursuit of our vision of a "Well Wairarapa".

The SOI reflects our continued commitment to deliver on the Government's priorities within a tight fiscal environment. The way forward will require a range of efficiency and effectiveness initiatives, including how we better integrate primary and secondary health care services in the Wairarapa. It will also involve working with other DHBs in the Central region to more efficiently and effectively deliver services to our population.

Wairarapa DHB recognises that 2010/11 will be year which will present many challenges as we strive to live within our means. We are committed to meeting these challenges, and our efforts will be underpinned by our DHB values of respect, integrity, self determination, co-operation and excellence.



Bob Francis
Chair

Date: 28-6-2010



Jarine Vollebregt
Deputy Chair

Date: 22/6/10

2. OPERATING ENVIRONMENT

This section describes the DHB's strategic context, its current operating environment which influences our ability and capacity to meet a range of competing demands and priorities¹, and the DHB's population environment and health profile.

2.1 Strategic Context

This Statement of Intent (SOI) outlines to Parliament and the general public the performance intentions for Wairarapa District Health Board (DHB) during 2000/11 and contains non-financial and financial forecast information for 2011/12 and 2012/13². It provides an overview of the services we will fund and deliver along with the performance targets we have set ourselves for the period ahead.

This SOI has been developed in accordance with Government expectations, local priorities, legislative compliance and public sector accountability³.

The SOI reflects our continued commitment to deliver on the Government's six health targets, its continued focus on health services that deliver better, sooner, more convenient health care, improved hospital productivity, safety and quality and strengthened clinical leadership and clinical networks, including clinical networks between primary and secondary care.

Meeting these Government's priorities needs to occur within a tight fiscal environment and will require various efficiency and effectiveness initiatives. It will also include how we will transform health care delivery in the Wairarapa by better integrating primary and secondary health care services in line with the Wairarapa Integrated Family Health Network and our Clinical Services Action Plan for the Wairarapa.

Recognising that funding is tight, our spending on health services will have a focus on those with poorer health outcomes. We will give special consideration to the needs of Maori given that health outcomes for Maori are typically poorer than other population groups within our district. Our approach will also recognise the most effective ways of improving the health status of those with poorer health status – for instance, through an emphasis on whanau ora services.

Wairarapa DHB will work closely with other DHBs in the Central region to plan and fund services in the most efficient way. This will include exploring joint procurement opportunities and shared service functions.

2.2 Wairarapa District

In population terms, Wairarapa DHB is the second smallest of the twenty-one DHBs, with a population of nearly 40,000. Whilst it has a small population base, this population is spread over a large geographic area.

¹ The DHB is required under Section 141(1)(a) of the Crown Entities Act to provide key background about the DHB and its operating environment.

² DHBs were created on 1 January 2001 under the New Zealand Public Health and Disability Act 2000 (NZPHD Act) and are categorised as Crown Entities under the Crown Entities Act 2004. As such, all 21 DHBs are required to produce a SOI to meet the requirements of both these Acts – the NZPHD Act (sections 39 (8) and 42) and the Crown Entities Act 2004 (section 139 (1)).

³ The SOI, as a public accountability document, is used at the end of the year by auditors working on behalf of the Office of the Auditor-General to compare our planned performance with the actual performance described in our DHB's Annual Report.

Its cover extends from the Rimutaka Hill and Ocean Beach in the south to Mount Bruce in the north, a total of 5,936 square kilometres. The Wairarapa district includes three Territorial Local Authorities: Masterton; Carterton and South Wairarapa.

The area is characterised by urban clusters surrounded by sparsely populated rural areas. About half of the population lives in urban centres compared with the national average of 83% for all DHBs.

Masterton, the largest of these urban clusters, is located in the heart of the Wairarapa and has a population of 18,000. Masterton, separated geographically from the rest of the Wellington region by the Rimutaka Ranges, is about an hour and a half drive from both Wellington and Palmerston North.

Carterton, located south of Masterton, has a population of just over 7,000.

South Wairarapa, with a total population of nearly 9,000, includes the towns of Featherston, Greytown and Martinborough. Approximately 30 percent of the properties in South Wairarapa are owned by absentee owners.

Rangitane O Wairarapa and Ngati Kahungunu Ki Wairarapa have manawhenua status within the district⁴.

Further detail about our population and the district's health profile is provided below.

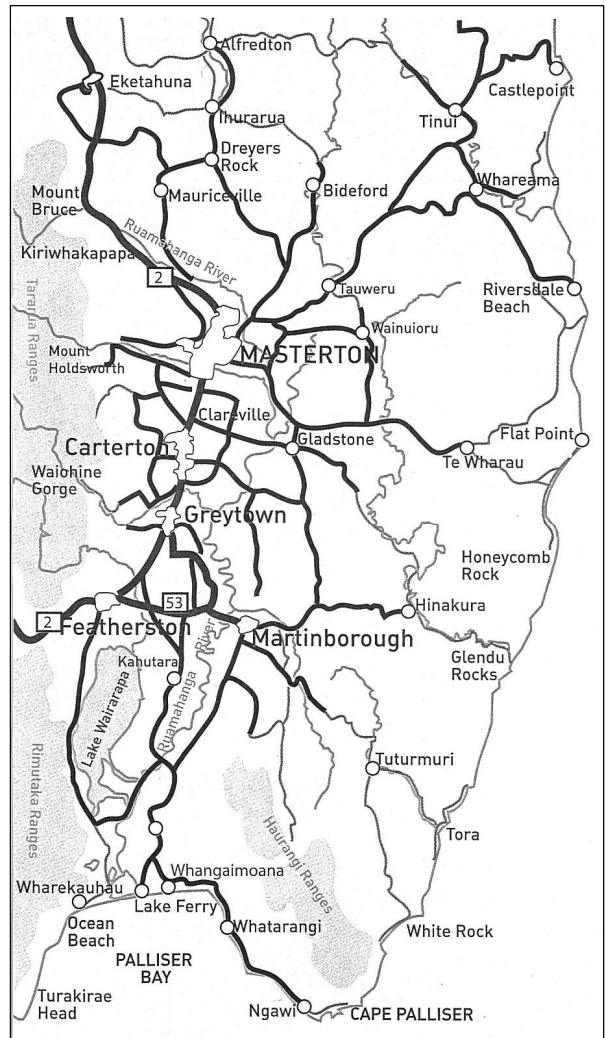
2.2.1 Population Profile

The Wairarapa population is static and aging. At the 2006 census the Wairarapa DHB is estimated to have a total population of 38,610 making it the second smallest DHB. The Wairarapa population is projected to decrease by 4% between 2006 and 2026, compared to New Zealand which is projected to increase by 15% for the same period.

Maori make up 14% of the total population, have a younger age profile and are projected to form an increasing proportion of the population. Pacific people make up 2% of the population.

Key demographic features of Wairarapa population include:

- Declining population overall (projected to decline 4% in next ten years)
- Increasing Maori population (projected to increase 20% in next ten years).
- Older and rapidly aging population (over 55 population projected to grow 14.6% in the next 10 years)
- Very small Pacific population.



⁴ Manawhenua status means that the Iwi is recognised as having tribal authority within the district.

The population mix is predicted to change over the next few years, with increasing percentages of older people and increasing numbers of Maori. These are the groups that have the greatest needs for health and disability services.

2.2.2 Health Profile

The 2008 Wairarapa Health Needs Assessment Report indicates the following key issues for the Wairarapa population:

- Aging population and older people
- Socio economic status
- Long term chronic conditions
- Lifestyle factors
- Maori health
- Children and young people
- Suicide & self harm.

Aging Population

By 2026 the population aged 55 years and over is projected to increase by 14.6%. Wairarapa has 4% more people aged 65 years and over than the national average. Because older people are high users of health and disability support services the rapid growth in the number and proportion of older people will increase pressure on health services and funding in the coming years.

Socio-economic status

Socio-economic status variables such as income, education and employment are major indicators of health. Deprivation levels have changed in Wairarapa over the last 10 years. There are 57% more people in the least deprived group and 10% fewer people in the most deprived group. However a large number of Wairarapa people live in deciles 7 and 8 (decile 10 is the most deprived) where there is a greater proportion than the NZ average. This means reducing financial and social barriers to accessing health services must remain a high priority for Wairarapa.

Long-term (chronic) conditions

Heart disease, diabetes, renal failure and kidney disease, respiratory disease and cancer were the top five causes of admissions to hospital of Wairarapa people from 2000–2006. Many of these conditions are preventable through lifestyle choices such as being smoke-free, physical activity and healthy eating. Reducing the rate and impact of long-term conditions is a key priority for Wairarapa DHB.

Heart disease

Diseases of the circulatory system (primarily heart disease) is the leading cause of death in the Wairarapa. The annual number of deaths due to heart disease is forecast to rise due to our ageing population.

Diabetes

Significant improvements have been made in case detection and diabetes management, with the completion of an increasing number of annual diabetes checks. However, our death rate for all types of diabetes has increased more than the New Zealand rate and Wairarapa's hospitalisation rates for Maori due to all types of diabetes have increased.

Cancer

Cancer remains the second highest cause of death in the Wairarapa. The annual number of cancer deaths is forecast to rise because of population growth and an ageing population.

Lifestyle factors affecting health

Lifestyle factors such as increasing physical activity and nutrition and reducing tobacco smoking, alcohol intake and obesity are choices people can make to prevent long term conditions (such as heart disease, diabetes and cancer) and improve their health and well being. Statistics for Wairarapa include:

- Smoking: a high percentage of Wairarapa Maori women smoke (47.4%)
- Nutrition: more males than females do not have adequate fruit & vegetable intake. More Maori than non-Maori do not have adequate fruit & vegetable intake.
- Obesity: obesity levels for both males & females are worse in the Wairarapa than New Zealand as a whole, with Maori being more obese than non-Maori.
- Drug & Alcohol: Wairarapa has a higher prevalence of hazardous drinking than the New Zealand average.
- Physical Activity: Wairarapa people have similar levels of physical activity to the rest of New Zealand.

Maori Health

Maori health is worse, with poorer outcomes, than other ethnic groups across almost all indicators. However differences are reducing for childhood immunisation, breastfeeding, oral health and death rates due to chronic ischaemic heart disease and stroke.

- Wairarapa Maori males have shorter life expectancy than the NZ average for Maori males.
- The leading causes of death for Wairarapa Maori are diseases of the circulatory system (35%) and cancers (30%).
- Levels of obesity of both males and females are higher in Wairarapa than NZ as a whole.

Children and Young People

Injuries are the leading cause of acute hospital admissions and death for children in the Wairarapa. Car accidents were the leading cause amongst young people, although assaults and suicide attempts also made a significant contribution.

- Immunisation coverage rates are higher amongst European children than Maori children, although Maori coverage rates are higher than the NZ Maori average.
- Admission rates for serious bacterial infections are lower than the NZ average, although rates are higher for Maori children.
- Hospital admissions for asthma and respiratory infections in children in the Wairarapa have steadily declined and are now lower than the NZ rate.
- Children and young people have twice the rate of admission to hospital for diabetes and epilepsy than New Zealand as a whole.

Suicide & self-harm

Between 2000 and 2006 Wairarapa had the highest suicide rates of all District Health Board areas. However this is heavily influenced by a high number of suicides (13) in 2003 compared to an average of 5.6 in 2004, 2005 and 2006.

Hospital admissions for self-harm of Wairarapa young people aged 15-24 years are consistently higher than the national average.

2.3 DHB Operating Environment

Nationally, Wairarapa DHB is one of the highest performing DHBs in terms of a range of non-financial performance indicators:

- high levels of patient satisfaction

- productivity of Wairarapa hospital has increased significantly over the past five years
- elective surgical procedures are provided at a much higher rate than the national average
- community services activity (e.g. wound care, IV therapy in the home, palliative and oncology services) has also increased
- increased ratio of older people being supported at home compared to those supported in residential care.

However, Wairarapa DHB's current funding and provision of services is unsustainable. During 2008/09 the DHB has moved from financial breakeven to deficit as growth in outputs and costs has outstripped growth in funding. Government has made it clear that DHB deficits will not be supported and that in 2010/11 and beyond Vote: Health will grow much more slowly.

There is growing recognition around the world that expenditure on healthcare cannot continue to grow as it has over recent years. In New Zealand the latest Treasury forecasts indicate the Government will be able to afford only very minimal growth in health funding for the next decade. Health services also face increasing workforce constraints. Forecasts indicate the health workforce cannot grow fast enough to meet the projected demands for services in the future.

We must move quickly to reorganise how we work so as to regain financial breakeven, manage within workforce constraints, and continue to improve health outcomes, whilst addressing changing demands and increasing needs of an aging population.

At the same time there is increasing focus nationally and internationally on the quality and safety of health services, with recent legislation requiring certification, credentialing and audit, and reports of the Health and Disability Commissioner placing increasing demands and expectations on the provision of care. Added to this are the statutory requirements on DHBs to improve health outcomes and reduce inequalities.

Against this background, the DHB worked very closely in 2009/10 with clinicians in the hospital and in the community to build a vision for a sustainable future for health service delivery in the Wairarapa. This close collaboration with clinicians and health service providers has resulted in the development of our Wairarapa Clinical Services Action Plan (CSAP) and the establishment of a Joint Clinical Forum which will help support its implementation.

The CSAP outlines how we can best use our resources to meet our community's increasing demand for clinical services. It details actions the DHB and health service providers working within the district can take to create a set of services that are clinically and financially sustainable and that provide safe quality care.

The CSAP identifies a Triple Aim - which puts the patient at the centre of all endeavours and says patient needs will be served best when we simultaneously provide the services which make the most difference to health overall, in ways which provide the best possible experience for the patient, and provide them at the lowest cost

2.4 Summary of DHB Operating Environment

The key internal and external environmental factors impacting on our work are summarized in the table below:

Aspect of the operating environmental scan (external and internal factors)	Potential Impact on DHB
Economy and State budget	
1. Tight fiscal environment	Expenditure on health cannot continue to grow as before
Social environment	
1. Tight labour market	Ability to attract and retain qualified staff
2. Increasing consumer expectations for health services	Inability to satisfy burgeoning demand, and need to prioritise access to services, and consider range of services being made available. Encourage people to take greater responsibility for actions that minimise their risk of adverse health outcomes and greater emphasis on self management.
3. Increased focus on quality and safety of services	Meeting safety and quality requirements imposes additional costs on the organisation
Health status	
1. Heart disease leading cause of death	Increased primary care and hospital costs – improve disease management by primary and hospital services
2. Diabetes hospitalisation and death rates are high	Increased primary care and hospital costs improve disease management by primary and hospital services
3. High cancer morbidity and mortality	Increased primary care and hospital costs – early intervention, improved screening and early detection (e.g. breast and cervical screening)
4. Higher than average obesity levels	Increased risks of developing long term condition and associated cost to the health system – need to target health promotion and early intervention efforts
5. Higher prevalence of hazardous drinking	Targeted health promotion and early intervention efforts
6. Maori health status generally poorer than pakeha	Need to improve access to and appropriateness of services
7. High suicide rates	Target health promotion and early intervention efforts
Demographics	
1. Small population, rural, large geographic area	Transport and access to services
2. Declining total population	Decreasing relative share of population based funding
3. Increasing Maori population	Maori have higher health needs
4. High percentage of elderly which is increasing	Elderly have higher health needs
Issues with providers of health services	
1. High patient satisfaction	Public expects good performance to continue
2. High hospital productivity	Less opportunities to further increase productivity
3. Higher rates of elective surgery	Meets Minister's expectations, builds public support, but at a cost
4. Large proportion of elderly supported at home	Helps reduce costs, but many now eligible for residential care services (with associated increased costs)
Effect of the physical and structural environment	
1. Physical – bed and theatre capacity throughout the Central region	Rationalise to ensure best use of existing and new theatre facilities and ward capacity
2. Structural – multiple providers (including multiple DHBs, PHOs and providers in the region)	Some consolidation and rationalisation of providers is likely
3. Many of the hospital services received by Wairarapa people are delivered outside the district	Imposes considerable costs on Wairarapa DHB (these inter district flows projected to account for \$20M or 18.5% of our expenditure in 2010/11.)

Issues emerging from current arrangements	
1. Changing views about how services should be planned and delivered (e.g. closer collaboration with other providers, with other DHBs including regional and national service planning)	Rationalise capacity and delivery within the Central region through the following: <ul style="list-style-type: none"> • Central region DHBs' Regional Services Action Plan • Wairarapa Clinical Services Action Plan
2. Need to make productivity improvements in planning and management areas through joint procurement and shared service functions	Consolidation of management activity at a sub-regional, local, regional and national level
3. Expectations for greater clinical input into decision-making	Need for strengthened clinical leadership and clinical engagement: <ul style="list-style-type: none"> • Clinical Forum • Clinicians leading development of clinical pathways • Develop regional service plans with clinician involvement
4. Access to services based on need	Increasingly, make service funding decisions and decisions about access to services based on need, and principle of addressing inequalities in health: <ul style="list-style-type: none"> • Work directly with at risk populations and organisations and/or structures which may represent these populations (e.g. runanga) to support at risk populations to pursue lifestyle choices that minimise the risk of adverse health outcomes (e.g. iwi health plans) • adopt a whanau ora approach to address poorer health status of Maori • set regional thresholds for access to elective services which are based on need • set regional referral criteria to elective services

2.5 Implementing our Performance Improvement Actions

Acknowledging this operating environment the DHB has identified four performance improvement actions (PIAs) which will assist the DHB to achieve its Triple Aim of improving the patient experience, improving the health of the whole population and reducing and controlling costs. These PIAs are all aligned and supported by specific actions contained within our CSAP.

In 2010/11, the DHB will focus its efforts on progressing four key PIAs which span activity within the four DHB output classes as well as our relationship with DHBs in the Central region. These four PIAs are detailed in the table below.

Objectives	Savings Impact
<p>1. Address Inequalities ensuring all of our spending decisions consider those with the poorest health status, where possible focus spending on those with the greatest need, including the frail elderly, those with long term conditions, and population groups with the poorer health outcomes, including Maori.</p>	\$0.0m
<p>2. Achieve Financial Security by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings.</p>	\$.95m
<p>3. Improve productivity and quality with a focus on hospital wards, theatre utilisation, increasing day surgery, and emergency departments.</p>	\$.70m
<p>4. Enhance regional cooperation through clinical regional service plans and through greater regionalisation of shared services and back-office functions.</p>	\$.70m

3. WHAT WE DO

The DHB receives funding from the Government to enable it to fund and provide health and disability services to the people that live in the Wairarapa.

3.1 DHB Performance Objectives

Wairarapa DHB is responsible for working within its allocated resources to “improve, promote, and protect” the health of the population within the district and to promote the independence of people with disabilities (as set out in section 23 of the NZPHD Act). This requires Wairarapa DHB to consider all needs and services including prevention, early intervention, treatment and support services, and how these services can be provided to best meet the needs of the population.

To deliver against this responsibility, Wairarapa DHB, in consultation with key stakeholders and our community, plans and funds how it can best allocate the population based funding it receives from the Government.

The DHB uses the funding it receives from the Government to fund and provide health and disability services that can be grouped into four different output classes:

- Public health services
- Primary and community health services
- Hospital services
- Support services.

It is these four output classes that are used in our Statement of Forecast Service Performance (SFSP) to describe the services we intend to fund and provide to our population in 2010/11.

The scale and scope of services we fund across each of these four output classes is influenced by the outcomes and priorities that the Government and the DHB want to achieve, as well as the Government’s service coverage requirements and our assessment of the health needs within our community. Whilst many of the services we fund are provided locally, many of the more specialist services are delivered by health providers outside the Wairarapa.

Section Four provides further detail about the key outcomes the DHB is seeking to achieve and its priority areas that influence what services we fund, and their scale and scope. Section Five details the measures we will use to assess our performance to achieve the desired outcomes in each of the four output classes.

3.2 The Scope of Our Work

Of the services that the DHB funds each year, about half of these services are provided directly by the DHB’s Provider Arm. The other half of the services funded by the DHB are delivered by organisations other than Wairarapa Hospital, including hospitals located in other districts. In summary, Wairarapa DHB:

- **Plans** the strategic direction for health and disability services in Wairarapa, in consultation with our stakeholders and our community and in collaboration with other DHBs, regional and national stakeholders and other health and disability service providers (e.g. development of our District Strategic Plan for 2005-2015, our 2009/10

Clinical Services Action Plan and our 2010/11 District Annual Plan⁵ and planning work with DHBs in the Central region on the Regional Clinical Services Plan⁶);

- **Funds** health and disability service providers to deliver services to the people of Wairarapa (e.g. service contracts for primary health services, well child services, oral health services, Maori health services, community pharmacy services, community laboratory services, community diagnostic imaging services, aged residential care services, home based support services, palliative care and hospice services, and hospital services delivered by DHBs other than Wairarapa DHB - Capital and Coast, Hutt Valley, MidCentral and Auckland DHBs are all funded by Wairarapa DHB to provide services to Wairarapa's population)
- **Provides** health and disability services (e.g. emergency services; specialist medical and surgical services which include services delivered in inpatient, outpatient and community settings; maternity services; paediatric services; mental health services, diagnostic services including laboratory and radiology services; pharmacy services; allied health services; ambulance services; community nursing and rehabilitation services).
- **Promotes** community and public health and well-being through health promotion, health education and population health programmes (e.g. healthy lifestyle programmes, tobacco control and smoking cessation programmes, suicide prevention, targeted programmes in high need communities).

This activity is overseen by the DHB's governance structure. The Board consists of eleven members and has overall responsibility for the operation of Wairarapa DHB. Seven of the members are elected as part of the three-yearly local body election process. The Board has established a Maori partnership committee, three statutory advisory committees and an audit and risk committee which are described further in Appendix One.

The DHB's Clinical Board and the newly formed Joint Clinical Forum provide clinical leadership and direction for the DHB.

3.3 DHB Ownership Interest

In 2010/11, Wairarapa DHB expects to receive \$107.8M from the Government to spend on health and disability services for its population, as well as investment in the DHB's workforce, infrastructure and future planning activity. This money will be allocated in accordance with the table below:

Of the \$107.8M the DHB expects to receive in 2010/11, \$48.7M will be spent on services provided by Wairarapa DHB. The balance of \$59.1M will be spent on services delivered by other providers.

Of the \$48.7M the DHB will spend on services it provides this will include the following:

- 24-hour accident and emergency, and ambulance services
- general medicine
- general surgery/urology and orthopaedic surgery
- laboratory, imaging and pharmacy
- rehabilitation
- mental health services
- women's and children's health services
- Community nursing

⁵ These plans can be viewed on our website www.wairarapa.dhb.org.nz

⁶ Regional Clinical Services Plan (2008) Central Region's Technical Advisory Services Ltd (on behalf of Central District Health Boards) FINAL DRAFT www.rcsp.org.nz

- Public Health.

Wairarapa Hospital faces the continuing challenge of increasing demand, increasing costs of new technologies and treatments, providing services within the available funding, compliance with legislation, and recruiting and maintaining the workforce it requires.

Crown Funding Envelope Allocation (GST exclusive)

Expenditure category	2009/10	2010/11	2011/12	2012/13
	\$	\$	\$	\$
DHB provider and governance total	47,033,563	48,730,599	49,412,827	50,055,194
Demand driven primary care items	11,949,847	12,127,389	12,297,122	12,456,984
Net Services purchased from other DHBs (Net IDFs)	17,503,421	20,063,472	20,344,361	20,608,837
DSS –residential aged care	10,146,528	10,929,574	11,082,588	11,226,662
DSS – aged care – non residential	2,805,078	2,891,647	2,932,130	2,970,248
Medlab Central	3,371,380	3,456,220	3,542,070	3,542,070
Wairarapa PHO	6,919,402	7,095,059	7,194,390	7,287,917
Other personal health NGOs	1,437,700	1,121,824	1,137,530	1,152,318
Maori Health NGOs	593,404	574,914	582,962	590,541
Mental Health NGOs (includes Maori providers)	3,899,892	3,716,371	3,768,401	3,817,390
Contingency for risks	300,000	0	0	0
Funder Arm efficiencies to be allocated	0	(700,000)	(633,381)	(505,161)
Total Allocated	105,960,215	110,007,070	111,661,000	113,203,000
Total Funding	105,002,669	107,818,546	110,511,000	113,203,000
Surplus/(Deficit)	(957,546)	(2,188,524)	(1,150,000)	0

4. OUTCOMES AND PRIORITIES

4.1 Key Outcomes and Priorities for our DHB

Wairarapa DHB will deliver better health and disability services for the communities now and into the future. Wairarapa DHB's District Strategic Plan (DSP) for 2005-2015 sets out seven priority outcomes for improving health and reducing inequalities in Wairarapa:

- Improving the health of Maori
- Improving the health of people in low socio-economic groups
- Improving the health of older people
- Improving the health of children and youth
- Reducing the incidence and impact of chronic disease
- Reducing the incidence and impact of mental illness and addictions
- Reducing the incidence and impact of cancer.

These local priorities and outcomes were chosen by Wairarapa DHB through its health needs assessment and public consultation processes in development of its DSP. The DSP for 2005-2015 will soon be updated.

The revised DSP will be informed by our Clinical Services Action Plan (CSAP) which was developed in 2009/10 through a major collaborative exercise with our community, other health and disability organisations and key stakeholders. CSAP identifies the changes necessary to put Wairarapa DHB back onto a financially sustainable pathway, manage increasing workforce constraints, and improve patient experiences and health outcomes.

The CSAP has the Triple Aim of:

- Improving the patient experience
- Improving the health of the whole population
- Reducing and controlling costs.

This plan has helped inform the performance objectives we have established for the DHB as part of our 2010/11 District Annual Plan (DAP). Not all of the activities and actions within the CSAP have been incorporated into our SOI. However, where the activities have direct relevance to the four Outputs, these activities are included in our Statement of Forecast Service Performance.

4.2 Why these outcomes are important to the DHB

By improving the patient experience and by improving the health of the whole population, we will be contributing to the seven priority outcomes that we are seeking to achieve in our current DSP. The third aim of reducing and controlling costs recognises that the DHB needs to be financially sustainable if it is to succeed.

Improving the health of Maori

Maori have much worse health status than non-Maori, across nearly all indicators. Disparities in health outcomes are greater between Maori and non-Maori than between any other population groups.

The improvement of health outcomes for Maori is a strategic priority for Wairarapa DHB. Maori participation in the provision and development of health services in Wairarapa will continue to be underpinned at the governance level by the relationship between the Board and Te Iwi Kainga.

Improving the health of people in low socio-economic groups

People who live in relatively deprived areas are twice as likely to die early from avoidable diseases. They are also much more likely to be admitted to hospital for diabetes, asthma and other chronic conditions, compared with the rest of the population. They face greater barriers to accessing health services (e.g. transport and patient charges pose greater difficulties than for less deprived population groups). About 12% of the total Wairarapa population lives in the most deprived areas (Deciles 9 and 10).

Improving the health of older people

As people get older their health needs usually increase, their health needs are more complex and their impact more severe and prolonged. Compared with other DHBs, Wairarapa has a greater proportion of older people and its population is also aging faster – the proportion of people in Wairarapa who are over 65 years will grow from 17% in 2006 to 23% in 2016, and to over 30% in 2026. The greatest projected increase is in the numbers of people aged 75 years and above – these ‘old’ older people are the biggest users of health and disability services.

Wairarapa DHB is progressively implementing its local Health of Older People plan which sets out how Wairarapa DHB will develop more integrated health and disability services that are responsive to older people's varied and changing needs. The proportion of people receiving disability support who are being supported at home continues to increase steadily, reflecting the DHB's focus on enabling older people to remain safely at home.

Wairarapa DHB is enhancing community based services through an increased range of service options to enable individual needs to be met so that older people can remain living in their own homes. Service options to support people living at home are coordinated through FOCUS (Needs assessment Service Coordinator agency NASC) and in future will be accessed through a single point of entry for home based nursing and support services (including NASC services). These actions will strengthen the provision of integrated health and disability services for older people, including enabling more older people to remain safely at home.

Improving the Health of Children and Young People

Children and young people have their own age specific health issues. These early years of life also set the pattern for health in later life as both risk and protective factors are established for many diseases that affect adult health.

- While generally improving, health statistics for children and youth in Wairarapa are below national averages in some key areas
- Wairarapa youth show high levels of risk behaviours – sexual activity, binge drinking, exposure to drugs, unsafe driving
- Children and young people are more likely than adults to live in areas of high deprivation
- Wairarapa children and young people have high rates of hospitalisation
- High use of sexual health services indicates high level of sexual activity among Wairarapa youth.

Reducing the incidence and impact of Chronic Conditions

Chronic (or long term) conditions cover a very wide range of physical and mental conditions including: asthma, diabetes, arthritis, depression, heart disease, stroke, and cancer. Reducing the incidence and impact of long term conditions is a key outcome for the DHB, which can be assisted through effective public health interventions and effective primary and community service delivery:

- Long term conditions account for 80% of all deaths and 70% of health services expenditure
- The numbers of people with long term conditions are rising dramatically worldwide
- Long term diseases are the main cause of the gap in life expectancy between Maori and non-Maori
- Maori are three times more likely to have diabetes and five times more likely to die from it than non Maori
- People live with a long term condition for a long time – this affects all aspects of life for them and their family/whanau
- Chronic conditions have common risk factors – inactivity, unhealthy diets, obesity, stress, depression, smoking and alcohol mis-use.

Reducing the incidence and mental illness and addictions

Mental illness (including alcohol and drug addiction) is widespread and will affect 1 in 5 people at some point in their lives. Also seen as a long term condition:

- Mental illness and addiction is rising worldwide, and is a major cause of disability
- Mental illness is estimated to cause about 25% of all disability and will account for 15% of the total global burden of illness by 2020
- Mental illness is very strongly associated with low socio-economic status - unemployment, poor housing, less education, and low income
- Increasing drug abuse, including 'P' is a significant and growing complication in mental illness.
- Wairarapa appears to have more drug and alcohol related problems than many other areas
- Maori suffer more from mental illness than do non Maori
- Access to mental health services in Wairarapa still falls short of what is required to meet national targets.

Reducing the incidence and impact of cancer

Cancer covers a very large number of different diseases many of which are increasing as the population ages. While success rates for cancer treatments are improving, the numbers dying from cancer are still increasing as growing numbers of people are affected by cancer.

- Cancer is a leading cause of hospitalisation and death – the second highest cause of death in Wairarapa
- Cancer among Wairarapa Maori is increasing faster than in Maori elsewhere
- Lung, bowel and breast cancers cause the most cancer deaths in Wairarapa
- Cancer survival rates are increasing
- The incidence of cancer is increasing
- More screening, and early treatment can reduce the numbers of people who are affected by cancer for a long time.

4.3 How we aim to meet the Government Priorities

As well as being informed by our local strategic priorities (as set out in our District Strategic Plan⁷ and our Clinical Services Action Plan), our planning, priorities, activities and performance objectives are also informed by, and aligned with, the Minister of Health's expectations and priorities for 2010/11, the six national Health Targets, and by national health and disability strategies⁸.

The Minister of Health wants the public health system to deliver *better, sooner more convenient healthcare* for all New Zealanders. The Minister has identified he would like to see a strong focus on the availability and quality of hospital services.

The expectations of the Minister (as detailed in his 2010/11 Letter of Expectations) are for all DHBs to:

- Improve services and reduce waiting times
 - Increase elective surgical volumes year on year
 - Improve emergency department waiting times
 - Improve cancer waiting times
- Take the next steps in the Primary Health Care Strategy
- Enhance, encourage and involve Clinical leadership
- Develop and enhance Regional co-operation
- Create a more unified health system
- Reduce and control costs.

The six national Health Targets are included within the performance measures within our Statement of Service Performance and are also clearly identified in the DHB's 2010/11 District Annual Plan. These targets include:

- Shorter stays in Emergency Departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunization
- Better help for smokers to quit
- Better diabetes and cardiovascular services.

4.4 Key Mechanisms for Intervention

Wairarapa DHB will seek to achieve both its local outcomes and priorities and the Government priorities by continuing to plan how services can be best delivered, in consultation with our community and in collaboration with other DHBs, as well as other key stakeholders. It will then fund providers to deliver services on behalf of its population, including some services which it will provide directly to its population, and it will promote community health and well-being through health promotion, health education and population health programmes. Section 3.2 provides further detail about how we intervene as both a funder and provider of services to "improve, promote, and protect" the health of the population within the district.

4.5 How we measure our progress – DHB intervention logic

To achieve our Triple Aim of improving the patient experience, improving the health of the whole population and reducing and controlling costs, which in turn, will contribute to the

⁷ Wairarapa DHB will be completing a full review of its DSP in 2010/11 which may result in significant changes in the strategic priorities noted above.

⁸ Available from the Ministry of Health website, www.moh.govt.nz

seven priority outcomes we have identified in our DSP to improve health and reduce inequalities in the Wairarapa, three types of actions are needed:

- Improvements in service delivery
- Realise opportunities to maximise revenue
- Reshape services to increase value for money.

These actions need to span the whole health delivery system, they need to take into account how well our different providers are integrated with one another, and they need to consider the different needs of our local population to ensure people receive the best and most appropriate care for their specific needs.

Our Clinical Services Action Plan considers that Wairarapa people will be served best by a single integrated system of local services, encompassing all service provider organisations across Wairarapa, with clear access pathways to more specialised services in other DHBs, supported by regional clinical networks. Better integration has the potential to improve patients' experience of care, improve health outcomes and lower costs.

- *System Integration:* Effective linkages between all provider services and organisations across the whole continuum of care. It also involves working with them to encourage and support co-ordinated service delivery within the single networked system. To help support this systems integration, we have established the Wairarapa Joint Clinical Forum which includes clinicians involved in delivering services across the four output classes. We are also working closely with other DHBs in the Central region, and in particular, Hutt Valley DHB and Capital & Coast DHB.
- *Patient level integration:* This involves ensuring individuals and families/whanau receive the best and most appropriate care for their specific needs. This requires a focus on the needs of individuals and whanau whilst ensuring that the patient's journey through the health system is timely and seamless between providers.

Our model of care is for one integrated, patient centric, co-ordinated system of health services working to common goals, pathways and protocols across the continuum; in which:

- Individual team, agency and professional roles and linkages are clearly identified and understood by both staff and patients and their whanau;
- Patients know their "medical home" and that this "home" will ensure their health care needs are well communicated and met seamlessly.

This patient centred model of care needs to recognise that people's needs vary and change over time.

Within the Wairarapa, a large proportion of our population is healthy. We need to fund services that help more people to stay well (i.e. Output Class One: Public Health Services). We will know if these services are meeting the needs of our community if our health education, promotion and prevention activities are keeping more people well in the community.

There are those within our population at greater risk of developing long term conditions. By funding screening, early detection and intervention activities (i.e. Output Class One: Public Health Services and Output Class Two: Primary and Community Services), we can help more people to be seen and treated early.

For those people within our population who have developed a long term condition (e.g. diabetes, heart disease, respiratory disease, cancer or a mental health illness) we need to

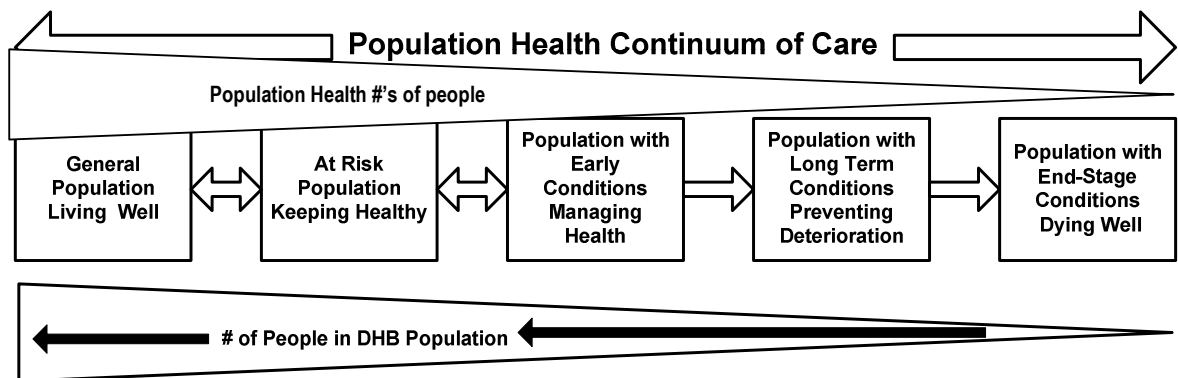
fund services that enable people to be better managed within the community (i.e. Output Class Two: Primary and Community Services), thereby avoiding unnecessary hospital admissions. To support Primary and Community Services maintain people within the community, general practice needs good access to diagnostics and responsive secondary specialist advice (i.e. Output Class Three: Hospital Services).

A smaller proportion of our population requires access to more complex care. We need to ensure this care, which is often hospital level care (i.e. Output Class Three: Hospital Services), is well integrated with services that are available in the community. This care may also involve providing restorative support services (i.e. Output Class Four: Support Services) so people can return to their normal lifestyle and avoid further complications.

For some people, ongoing care and support is required (i.e. Output Class Four: Support Services). This includes providing support to those who are dying.

Whilst a small proportion of our population require more intensive services (i.e. Output Class Three: Hospital Services and Output Class Four: Support Services), the relative cost of treatment for people receiving these services is high. The drivers for change (i.e. clinical and financial sustainability) and the preferred model of care (i.e. helping more people to stay well in the community) indicate reorientation of health care delivery over time away from hospital and specialist level care to primary and community level care, and ultimately from primary and community level care to self care by informing, educating and empowering people through illness prevention and health promotion (i.e. Output Class One: Public Health Services and Output Class Two: Primary and Community Services).

Wairarapa DHB is pursuing an intervention logic that shifts costs toward the 'prevention' end of the, 'population health continuum of care' because these interventions are cheaper, support our goal of a 'Well Wairarapa' and cover more of the total population. This is illustrated in the drawing below.



Our intention is to maximise the proportion of the population that is “living well” – in terms of the triangle at the bottom of the drawing, this means shifting more of the population’s health upstream. This is done through maintaining current health status, slowing deterioration in health status, and preventing worsening of health status over time. This involves a mix of prevention approaches that includes keeping the well healthy, keeping those at risk of or with an early condition from deteriorating and keeping people with long-term conditions from worsening health and improving their quality of life (while reducing the time they may spend disabled).

In our CSAP, we have articulated this need to reorientate services by identifying actions and activities in the following six areas:

- Focus on individuals and whanau

- Redesign and co-ordinate the patient journey
- Develop primary care services
- Reorganise and develop the healthcare workforce
- Public health interventions
- Control costs and maximise revenue.

We have included some of the activities from these six areas in our Statement of Forecast Service Performance.

The following table illustrates the Wairarapa DHB outcomes framework.

Wairarapa DHB Outcomes Framework

In order for Wairarapa DHB to realise its vision of "Well Wairarapa – Better Health for All", it must purchase a range of outputs aggregated into four output classes (i.e. Public Health Services, Primary and Community Services, Hospital Services and Support Services).

Outcomes	Well Wairarapa – Better Health for All			
	<p>Improve the health of the whole population, improve the patient experience and reduce and control costs (i.e. the Wairarapa Clinical Services Action Plan's Triple Aim) By focusing on our Triple Aim and creating a more integrated health system, we will contribute to our District Strategic Plan's seven priority outcomes for improving health and reducing inequalities in Wairarapa -: Improving the health of Maori; improving the health of people in low socio-economic groups; improving the health of older people; improving the health of children and youth; reducing the incidence and impact of chronic disease; reducing the incidence and impact of mental illness and addictions; reducing the incidence and impact of cancer.</p>			
Impacts	<p>Achieve the Wairarapa Clinical Services Action Plan's Triple Aim by having an impact on six key components of the health system: individuals and whanau; the patient journey; primary care services; the healthcare workforce; public health interventions; and costs and revenues.</p> <p style="text-align: center;">This focus will help us create a more integrated health system, characterised by connected providers and integrated services that are patient centred.</p> <p>A more integrated health system will be supported by providers having clearer roles and responsibilities, establishment of district-wide patient pathways, primary care established as the "medical home", improved communications, joint clinical forums and governance and regional clinical leadership and decision making.</p>			
	Government Priorities: Better, Sooner, More Convenient Care Minister's Expectations, Health Targets			
Output classes	Public Health Services (\$2.095M)	Primary & Community Services (\$39.442M)	Hospital Services (\$65.128M)	Support Services (\$18.216M)
Outputs	Health promotion and education services Statutory and regulatory services Population based screening Immunisation, well child and school health services	Primary health care services Oral health services Primary and community care programmes Community pharmaceuticals Community referred tests/diagnostic services	Mental health services Electives services Acute services Maternity services Assessment, treatment and rehabilitation services	Support services assessment and coordination Palliative care Rehabilitation and transition services Aged residential care services Home based support services Services to support family care givers
Key measures (quantity)	Number of people participating in smoking cessation programmes Number of breastfed infants Number of before school checks Number of people screened Number of children and elderly vaccinated	Proportion of population enrolled Number of oral health enrolments and examinations of pre-school and school children and adolescents Number of people enrolled in programmes (e.g. diabetes annual reviews, CVD risk assessments, Care Plus)	Number of unique clients receiving mental health services Number of elective discharges Number of ED & triage attendances Number of acute bed days Number of maternity deliveries Number of ATR patients Number of blood stream infections	Number of patients supported for palliation % people >65yrs receiving funded support who are living at home % of clients under 65 years receiving long term services to support them to live at home who are Maori % of people over 65 years accessing support needs assessment who are Maori Number of people admitted to hospital from residential care who have a decubitus ulcer Waiting time for routine >65 support needs assessments % of patients in the palliative service who die in the place of their choosing
Key priorities/activities	Implement Clinical Services Plan Keeping Well Strategy Implementation Healthy Lifestyles Go 4 Your Life Immunisation programme Before School Check Programme	Implement Clinical Services Plan Create one virtual Integrated Family Health model for the Wairarapa Implement Oral Health Business Case Pilot community pharmaceuticals initiatives (i.e. synchronisation and budget holding) Progress clinical pathway development Develop primary health pathway for frail older people	Implement Clinical Services Plan Implement the Regional Elective Surgery Plan Progress clinical pathway development for key procedures within the district and across the region Develop integrated service models across community and hospital services	Implement Clinical Services Plan Wairarapa Elder Local Links plan implementation Progress implementation of InterRAI Develop home based support framework

5. OUTPUT CLASSES AND STATEMENT OF FORECAST SERVICE PERFORMANCE

5.1 Output Classes

This section outlines the four output classes that Wairarapa DHB is using to describe the services it either directly provides or funds for delivery to the local population. These four output classes include: public health services, primary and community services, hospital services, and support services.

For each of these four output classes, our SOI provides measures and forecast standards of output delivery performance. This provides the basis for the DHB to then evaluate and assess what services and products it has delivered in 2010/11. Actual delivery against these forecast performance levels for each output class will be reported and audited at the end of the 2010/11 financial year.

5.2 Formation of an output-focused Statement of Forecast Service Performance

The Statement of Service Performance (SFSP) identifies how the DHB's planned activities in each of the four output classes will contribute to our key outcomes and priorities discussed in Section 4.

For each output class, we have selected key priorities and described how our planned activities will contribute to the outcomes and priorities. We have also detailed how we will measure how these activities have contributed to performance against our key outcomes and priorities.

When we report on our performance for the year against our SFSP, we will use these measures to evaluate and assess the services and products Wairarapa DHB has funded and delivered on behalf of its population in 2010/11.

The measures indicated in this section are not a complete list of all the ways by which the DHB monitors and reviews its performance. However, our SFSP includes the six national health targets where appropriate within each of the four output classes together with many of the Indicators of DHB Performance, which are also contained within our 2010/11 DAP, and which the Ministry of Health uses to assess our performance.

5.3 Output Class One: Public Health Services

Public health services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population.

Public health services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Public health services include:

- health promotion to ensure that illness is prevented and unequal outcomes are reduced
- statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases
- individual health protection services such as immunisation and screening services.

Public health services involve many organisations across the region including the Ministry of Health, principally as a funder of public health services, and also a regulator and planner, Regional Public Health (RPH), as a provider of services, DHBs, in both funding and provision, Primary Health Organisations (PHOs) and other community service providers.

Twelve public health units (PHUs) provide more than half the country's public health services. Wairarapa DHB offers a range of public health services, half of which are delivered on behalf of RPH, by Wairarapa DHB Public Health Unit.

Wairarapa Public Health has programmes that include:

- District Immunisation Facilitation
- Health promotion: Injury Prevention, Older People, Mental Health, Oral Health, Pacific and Maori, Smokefree, Children & Young People
- Environment safety: drinking water, air quality, emergency management, bio-security, looking after hazardous substances
- Food and water safety
- Infectious disease prevention, control and management
- School Based Services: health promoting schools advisor, public health nurses, and vision and hearing technicians
- Health Impact Assessments.

The following discussion details what Wairarapa DHB wants to achieve through public health service delivery.

5.3.1 What outcomes are needed?

- Improve the health of the whole population
- Improve the health of Maori
- Improve the health of people in lower socio economic groups
- Reduce the incidence of preventable disease (including the incidence of long term conditions such as cardiovascular and respiratory disease, diabetes and cancer).

5.3.2 What activities will contribute to these outcomes?

- Improved targeting of health promotion to high need and high risk groups
- Improved nutrition (e.g. increased fruit and vegetable consumption, breastfeeding) and increased physical activity
- Reduced smoking rates and increased cessation
- Increased access to primary care early intervention for those with identifiable risk factors
- Increased immunisation rates, with a focus on Maori immunisation rates and vaccinating the elderly against influenza
- Older persons health information, education and promotion.

5.3.4 How will we work to achieve these outcomes?

- Implement the Wairarapa Clinical Services Plan
- *Keeping Well* Strategy implementation, and imbed its priorities into public health planning and contracting
- Continue to progress the DHB's *Healthy Lifestyles* and *Go 4 Your Life* programmes

- Focus on the inequalities that exist in the incidence and impact of long term conditions (through an early detection, prevention and promotion focus on high-need groups with poorer health status indicators) and target programmes in high need communities
- Advocate on health issues as a participant in the Masterton East project being led by Masterton District Council
- Further develop tobacco control and smoking cessation programmes
- Clarify and streamline health promotion actions between the PHO, Public Health Unit and NGOs.

5.3.5 How will we measure what impact we are having?

MoH Indicator Code	Outputs	Measures	Baseline 2008/09	Targets		
				2010/11	2011/12	2012/13
HT5	Health Promotion Services: Smoking Cessation	90% of hospitalised smokers are provided with advice to help to quit	<u>87% Q3 09/10</u>	90%	95%	95%
		80% of patients attending primary care will be provided with advice to help to quit	New	80%	90%	95%
	Health Target					
SI7	Health Promotion Services: HEHA	% of women full and exclusively breastfeeding All	<u>6 weeks</u> 68%	74%	75%	76%
			<u>3 months</u> 55%	57%	60%	65%
			<u>6 months</u> 26%	27%	30%	35%
			<u>6 weeks</u> 64%	74%	75%	76%
			<u>3 months</u> 39%	57%	60%	64%
			<u>6 months</u> 23%	27%	30%	32%
		Maori				
	Population Screening Services: Cancer	Percentage of high needs woman aged 45 - 69 who have had mammograms in the last two years.	61.18%	63.18%	65.18%	67.18%
	Population Screening Services: Cancer	Percentage of woman aged 20-69 who have had a cervical smear over the previous three years (high needs).	67.92%	69.42%	71.92%	74.42%
HT4	Health Protection: Immunisation Services	Progress towards the national target of 95% of 2 yr olds fully immunised (Maori)	86%	91%	95%	95%
	Health Target					
HT4	Health Protection: Immunisation Services	Progress towards the national target of 95% of 2 yr olds fully immunised (Total)	85%	90%	95%	95%
	Health Target					

5.3.6 Cost of Service

The following table shows the cost of service for the Public Health Service Output Class.

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Workforce costs	1,188	1,228	1,135	1,151	1,166
Treatment related costs	255	198	127	129	131
External providers	1,063	991	679	689	698
Inter district flows	0	0	0	0	0
Depreciation & amortisation	1	1	1	1	1
Total Operating Expenditure	2,507	2,418	1,942	1,970	1,996
Allocation of corporate costs	203	204	153	155	157
Total Cost of Service	2,710	2,622	2,095	2,125	2,153
Revenue	2,710	2,622	2,095	2,125	2,153
Net Result of Service	0	0	0	0	0

5.4 Output Class Two: Primary and Community Services

Primary and community services comprise services that are delivered by a range of health and allied health professionals in various private, not-for-profit and Government settings. They include general practice, community and Maori health services, pharmacy services, child and adolescent oral health services.

These services are more generalist, usually accessible from multiple health providers and from different locations within the Wairarapa.

A strong primary health care system is central to improving New Zealanders' overall health, and to reducing health inequalities between different groups. New Zealand is experiencing a growing prevalence of long-term conditions including diabetes and cardiovascular and respiratory disease. Some groups of New Zealanders suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. Long-term conditions require an increased focus across the primary/secondary interface to ensure that they are recognised early and managed effectively.

Wairarapa DHB supports accessible, affordable and appropriate primary health care services and a primary care approach, consistent with the Government's Primary Health Care Strategy. Wairarapa has one PHO encompassing all primary medical practices across the whole district with 97% of the district population enrolled in the PHO. There are seven general practices, with at least one practice located in each town. The practices each provide comprehensive first line medical and nursing services and collaborate to provide after hours service jointly. Other PHO services include: Care Plus; primary mental health care; services to improve access, and health promotion.

The following discussion details what Wairarapa DHB wants to achieve through primary and community service delivery.

5.4.1 What outcomes are needed?

- Improve the health of Maori
- Improve the health of people in lower socio economic groups
- Reduce the incidence and impact of long term conditions, including mental illness (and better support people to self manage conditions and to be better managed in the community)
- Reduce unplanned readmissions among older people
- Improve the patient experience
- Improve child and youth oral health
- Reduce and control costs.

5.4.2 What activities will contribute to these outcomes?

- Increase the access of people in lower socio economic groups to primary care services (e.g. increase primary care consultations for Maori and focus on whanau ora)
- Increase access to Well Child Services and B4 School Checks
- Improve disease management for those with a diagnosed long term condition (e.g. improve diabetes detection and the number of diabetes annual reviews)
- Increase the rates of Maori accessing mental health services
- Reduce waiting times for alcohol and drug services
- Increased utilisation of oral health services by children and young people
- Complete local and national processes to build and procure dental facilities
- Increase training of hospital and primary care practitioners in the identification of oral health need, diabetes and cardiovascular disease management
- Contain growth on community pharmaceuticals.

5.4.3 How will we work to achieve these outcomes?

- Implement the Clinical Services Plan
- Work with Wairarapa PHO to ensure greater focus is placed on high needs groups
- Implement the Tihei Wairarapa primary care business case including:
 - Establish general practices as the “medical home” for each patient
 - Support practices to develop guided carer roles in primary care
 - Develop primary health care teams including providers external to the PHO
 - Establish guided care, MDT management processes for patients with complex and/or long term conditions, including a review of the Care Plus programme.
- Re-orient services to support self care and independence from medical services
 - Increase linkages and referrals between primary / secondary care and NGO and voluntary / community services.
- Create one virtual Integrated Family Health network for Wairarapa incorporating primary and secondary services
 - Develop GP and nurse specialists working across practices
 - Develop referral pathways between practices and between practices and other primary care providers (e.g. Maori providers and pharmacists)
 - Develop clinical pathways for people with long term conditions (e.g. diabetes, CVD, Respiratory disease).
- Implement the guided model of care and long term conditions model to identify people at high risk of developing long term conditions such as diabetes,

cardiovascular disease, cancer or a respiratory condition, and their subsequent management (e.g. Care Plus)

- Continue to implement the DHB's Child & Youth Health Strategy
- Increase collaboration between child health providers and intersectoral agencies working with children from high needs groups
- Extend the pharmaceutical synchronisation pilot to all pharmacies in the Wairarapa district
- Trial bulk funding with community pharmacy
- Support the Clinical Forum.

5.4.4 How will we measure what impact we are having?

MoH Indicator Code	Outputs	Measures	Baseline2009	Targets		
				2010/11	2011/12	2012/13
HT6	PHO (Other Services): CVD risk assessment Health Target	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years (Maori)	73%	75%	76%	77%
HT6	PHO (Other Services): CVD risk assessment Health Target	Increased percent of the eligible adult population have had their CVD risk assessed in the last five years (Other)	80%	82%	83%	84%
HT6	PHO (Other Services): Diabetic Annual Reviews (DAR) Health Target	Proportion estimated to have diabetes accessing free annual checks (Maori)	73%	73%	73%	73%
HT6	PHO (Other Services): Diabetic Annual Reviews (DAR) Health Target	Proportion estimated to have diabetes accessing free annual checks (Other)	77%	77%	77%	77%
HT6	PHO (Other Services): Diabetes management Health Target	Proportion on the diabetes register who have good diabetes management (HbA1C + or < 8%) (Maori)	67%	72%	74%	76%
HT6	PHO (Other Services): Diabetes management Health Target	Proportion on the diabetes register who have good diabetes management (HbA1C + or < 8%) (Other)	78%	80%	81%	82%
			Baseline 2008/09			
PP11	Oral Health Services	Children caries free at 5 years of age (fluoridated)	54%	63%	64%	65%
PP12	Oral Health Services	Adolescent oral health utilisation rates	76%	79%	80%	80%

Note: The DHB has made significant improvements on 2008/09 baseline data noted above for HT6 and in all instances is currently performing within 5 percent of 2010/11 targets.

5.4.5 Cost of Service

The following table shows the cost of service for the Primary and Community Service Output Class.

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Workforce costs	4,924	4,122	4,134	4,042	3,944
Treatment related costs	1,064	1,116	968	985	998
External providers	27,039	28,149	27,456	27,957	28,433
Inter district flows	1,688	1,920	1,934	1,982	2,034
Depreciation & amortisation	105	144	153	155	157
Total Operating Expenditure	34,820	35,451	34,645	35,121	35,566
Allocation of corporate costs	2,816	2,991	4,797	4,793	4,782
Total Cost of Service	37,636	38,442	39,442	39,914	40,348
Revenue	37,636	38,442	39,442	39,914	40,348
Net Result of Service	0	0	0	0	0

5.5 Output Class Three: Hospital Services

Hospital services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are generally complex and provided by health care professionals that work closely together. They include:

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

Wairarapa Hospital is the major provider of health services in the Wairarapa, providing a range of emergency, inpatient and ambulatory services. As the hospital is relatively small, and serves a small population, a number of secondary and tertiary services are purchased from other DHBs, notably Capital Coast, MidCentral and Hutt Valley DHBs.

The services that are currently provided by Wairarapa Hospital include:

- 24-hour accident and emergency, and ambulance services
- general medicine
- general surgery/urology and orthopaedic surgery
- laboratory, imaging and pharmacy
- rehabilitation services
- mental health services
- women's and children's health services.

To remain a clinically and financially sustainable provider, it must ensure that it continues to improve its operating efficiency and effectiveness and attract and retain appropriate numbers of suitably qualified staff. Wairarapa DHB faces a growing

challenge to fund and provide increasing access to the required range of safe, high quality services at levels that will deliver the best value for money within its fiscal envelope.

In 2010/11 and outyears, growth in Wairarapa DHB's funding envelope will be less than in previous years, while demand for services and operating costs are rising faster. Managing in this environment requires Wairarapa DHB to make the best possible prioritisation and allocative decisions and to focus on cost reduction, and cost containment.

Each year Wairarapa Hospital agrees a Service Level Agreement (SLA) with Wairarapa DHB. As part of this SLA the hospital agrees to provide certain 'outputs' which include provision of elective services. Elective services (booked surgery) are for patients who do not require immediate hospital treatment. The DHB is committed to meeting the government's expectations around elective services, particularly the key principles underlying the electives system:

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

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

Patient Flow Management - complying with required standards on Elective Services Patient Flow Indicators (ESPIS)

Level of Service - ensuring that the hospital(s) provide the amount of elective operations, procedures and assessments agreed to in the DAP.

Order of Service - making sure that patients are assessed and prioritised for surgery on a consistent basis.

The following discussion details what Wairarapa DHB wants to achieve through hospital service delivery.

5.5.1 What outcomes are needed?

- Improve the patient experience, including improving their level of comfort and function
- Reduce the incidence and impact of long term conditions, including mental illness (and reduce the number of hospital attendances and admissions that are potentially avoidable)
- Reduce and control costs
- The patients condition is not exacerbated through poor quality service delivery.

5.5.2 What activities will contribute to these outcomes?

- Effective patient management through hospital services
- Improved management of acute demand
- Reduce avoidable hospitalisations (e.g. ambulatory sensitive admissions)
- Improving Day of Surgery and Day Case rates
- Reduce cancer waiting times
- Achieving hospital volumes within funding parameters

- Effective discharge planning
- Reduced wastage in hospital resources
- Further improvements in hospital service productivity (e.g. theater use)
- Effective quality and safety protocols and practices.

5.5.3 How will we work to achieve these outcomes?

- Continue to implement the Central region DHBs' Regional Clinical Services Plan
- Implement the Wairarapa Clinical Services Plan
- Optimise the patient journey and develop clinical care pathways for key procedures within the district and across the region
 - Develop district-wide care pathways and guidelines, and reduce service duplication for common conditions.
 - Build system-wide integration across all providers
 - Streamline patient pathways, e.g. for pre-operative assessment
 - Improve admission to discharge planning
 - Increase the patient focus groups; facilitate patient input into process redesign
 - Redesign outpatient services to reduce clinics and support virtual GP consults.
- Develop integrated service models across community and hospital services in the Wairarapa to:
 - improve the management of people with long term conditions
 - improve the flow of other patients from primary care through the hospital and back to primary care
 - support virtual GP consults with hospital specialists.
- Collaborate effectively with other DHBs, including shared staffing
 - Participate in regional clinical networks
 - Develop shared staffing of clinicians with CCDHB, HVDHB and MCDHB.
- Deliver the 2010/11 Quality and Safety Plan
- Work with primary care to reduce avoidable hospitalisations and better manage emergency department attendances
- Monitor and benchmark performance against key quality indicators
- Engage patients in the Cardiac Rehabilitation Programme
- Work with the Central Cancer Network to improve services for cancer patients across the region
- Use the Wairarapa Cancer Control Action Group to progress regional and local projects to improve services for cancer patients
- Support clinicians on Wairarapa DHB's senior leadership team to be active participants in all decision making
- Develop partnerships between clinicians and management at all levels of the organisation with shared decision making, responsibility and accountability
- Support Wairarapa DHB's Clinical Board and the advice and recommendations they give to the DHB Board on the quality and safety of services delivered by the Hospital

- Devolve decisions and accountability to the most appropriate clinical units or teams (which may include clinics, wards or departments) across the DHB
- Ensure strong clinical leadership and governance of the Wairarapa Clinical Services Action Plan
- Create effective integrated IT/IS systems
 - Implement Wairarapa DHB's IT initiatives
- Undertake the Vulnerable Services Projects in Radiology, Women's Services and Older Adults with other Central region DHBs as part of the Regional Clinical Services Plan.

5.5.4 How will we measure what impact we are having?

MoH Indicator Code	Outputs	Measures	Baseline 2008/09	Targets		
				2010/11	2011/12	2012/13
HT1	ED attendances Health Target	95% of patients (or better) will be admitted, discharged or transferred from the Emergency Department within 6 hours.	98%	95%	95%	95%
HT2	Elective CWDs Health Target	Electives discharges	1,809	1,841	1,841	1,841
HT3	Cancer treatment services Health Target	% of patients who receive radiation oncology treatment within 6 weeks by the end of July 2010 (and within 4 weeks by December 2010) of the first specialist assessment	87%	100%	100%	100%
OS3	Length of Stay	Elective and Arranged Inpatient Length of Stay	4.10	3.92	3.79	3.64
OS4	Medical CWDs ⁹	Acute Inpatient Length of Stay	3.55	3.55	3.55	3.55
OS6	Elective CWDs	Percentage of people receiving elective operations whose operation is performed as a day case	60%	62%	63%	65%
OS6	Elective CWDs	ESPI compliant for all specialties	87%	100%	100%	100%
OS7	Surgical CWDs	Percentage of people admitted for surgery whose surgery is performed on the day of admission (DOSA)	98%	98%	98%	98%
OS8	Acute CWDs	The proportion of inpatients admitted that had previously been admitted in the past 30 days and were readmitted to the same specialty.	10.8%	</=10.3%	</=9.9%	</=9.4%
SI1	Hospitalisation	Rates of ambulatory sensitive hospitalisations for Maori (0-74 yrs)	165	125	<125	<125
SI1	Hospitalisation	Rates of ambulatory sensitive hospitalisations for other (0-74 yrs)	144	134	<134	<134

⁹ Wairarapa DHB is already a top performing DHB in terms acute inpatient length of stay.

MoH Indicator Code	Outputs	Measures	Baseline 2008/09	Targets		
				2010/11	2011/12	2012/13
	Ambulance Response Times	Priority 1 Ambulance response time from receipt of call to arrival at a Masterton location	8 minutes	<= 8 minutes	<= 8 minutes	<= 8 minutes
	ED Triage Wait times	100% of patients are seen within ED triage waiting times Triage1 - 3	100%	100%	100%	100%
	Blood Stream Infections (BSI)	Hospital Acquired BSI's per 1000 bed days	To be determined	<3.5	<3.0	<2.5

5.5.5 Cost of Service

The following table shows the cost of service for the Hospital Services Output Class.

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Workforce costs	25,880	27,175	27,350	28,134	27,998
Treatment related costs	14,523	13,322	12,681	13,560	13,338
External providers	451	763	767	775	777
Inter district flows	17,943	19,577	18,869	21,129	21,360
Depreciation & amortisation	1,716	1,490	1,631	1,654	1,675
Total Operating Expenditure	60,513	62,327	61,298	65,252	65,148
Allocation of corporate costs	4,903	5,282	4,396	1,601	2,800
Total Cost of Service	65,416	67,609	65,694	66,853	67,948
Revenue	61,308	63,409	63,505	65,703	67,948
Net Result of Service	(4,108)	(4,200)	(2,189)	(1,150)	0

5.6 Output Class Four: Support Services

Support services are delivered following a needs assessment and service co-ordination process. These support services include palliative care services, home-based support services and residential care services. These services support people with a disability, people with a long term condition, older people, as well as people at the end stage of life (palliative care services).

Older People Services

As people age, their health needs usually increase. These needs are likely to be complex with longer and more severe impact, and they are more likely to suffer from chronic conditions.

Generally, older people prefer to receive these services in their own homes where this is possible, rather than entering residential care. Research shows people supported in their own homes have better health outcomes than those admitted to residential care. During 2010/11, Wairarapa DHB will continue to expand service options to enable more people to remain safely in their own homes if they wish. This

approach is already being reflected in the growing proportion of people receiving disability support who are being supported at home.

Wairarapa DHB is enhancing community based services through an increased range of service options to enable individual needs to be met so that older people can remain living in their own homes. Service options to support people living at home are coordinated through a single point of entry for home based nursing and support services (including NASC services). These actions strengthen the provision of integrated health and disability services for older people, including enabling more older people to remain safely at home.

Palliative Care Services

From 1 September 2008, palliative care services for people of the Wairarapa have been provided by a new partnership between Wairarapa DHB, Wairarapa Community PHO and Te Omanga Hospice. Arohanui Hospice provides advice and support to the partnership, including input into education and training sessions and participation in the Palliative Care Management and Advisory Group (PCMAG). In October 2009 the Cancer Society and Hospice Wairarapa Community Trust also joined the membership of the PCMAG.

Under the service a consistent palliative care approach is being developed and implemented for Wairarapa DHB's population. Palliative care is being delivered across the primary, community and secondary health services, so that the palliative needs of all patients are assessed and their care and support provided in a coordinated way as an integral part of the primary and secondary health services. The district wide generalist palliative care approach is underpinned and overseen by specialist palliative education, advice and services as required to meet more complex needs.

Wairarapa DHB's aim is to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. The following discussion details what Wairarapa DHB wants to achieve through support service delivery.

5.6.1 What outcomes are needed?

- Improve the health and independence of older people (e.g. enable older people to remain in safe and well in their own homes)
- Reduce the incidence and impact of long term conditions, including mental illness
- Palliative patients receive satisfactory levels of comfort and support.

5.6.2 What activities will contribute to these outcomes?

- Appropriate levels of support provided to frail older people living in their own homes, and continue to provide flexible packages of care for people with high and complex needs
- Improved assessment of client needs, to ensure older people consistently receive appropriate levels of care at the right time
- Continuing to ensure guaranteed access to respite care for family carers
- Access to timely primary and preventative care for older people
- Making palliative care services available to those who need them.

5.6.3 How will we work to achieve these outcomes?

- Implement the Clinical Services Action Plan
- Continue to implement the Ministry's Health of Older People Strategy, the principles of which have been incorporated into the Wairarapa Elder Local Links (W.E.L.L.) plan¹⁰
 - review and refocus services to better meet the needs of the older people in the community.
- Develop a more comprehensive continuum of care for older people whose needs span major diagnoses
- Continue to progress implementation of InterRAI Home Based Assessment Tool
- Continue to implement recommendations from the Rehabilitation Service Review
- Implement the outcomes of the Palliative Care Services Review
- Increase capacity and capability of aged residential care (ARC) services to manage their own patients
 - Provide advisory nurse support to ARC facilities
 - Provide training for registered and enrolled nurses in ARC facilities
 - Implement GP support and proactively manage residents health in ARC facilities.

5.6.4 How will we measure what impact we are having?

Outputs	Measures	Baseline 2008/09	Targets		
			2010/11	2011/12	2012/13
Access to support services for Maori	The percentage of people over 65 years accessing support needs assessment who are Maori	3%	4%	4%	4%
Access to support for younger disabled Maori	The percentage of clients under 65 years receiving long term services to support them to live at home who are Maori	18%	20%	22%	24%
Quality of care as measured by skin condition	The number of people admitted to hospital from residential care who have a decubitus ulcer	8	5	<5	<5
Palliative Care Services	Number of patients who have received integrated Palliative Care Service	New service	230	240	250
Timeliness of Support needs assessment	Waiting time for routine >65 support needs assessments	4 weeks	3 weeks	2 weeks	2weeks
Quality and patient centered care based on meeting patients wishes.	Percentage of patients in the palliative service who die in the place of their choosing	To be determined	75%	85%	90%
Aging in place	% people >65yrs receiving funded support who are living at home	62.4%	63%	64%	65%

¹⁰Wairarapa Elder Local Links (W.E.L.L.) – Health of Older People Plan, Wairarapa DHB 2004

5.6.5 Cost of Service

The following table shows the cost of service for the Support Service Output Class.

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Workforce costs	815	980	996	1,010	1,023
Treatment related costs	574	540	580	588	596
External providers	12,665	13,084	14,044	14,242	14,426
Inter district flows	1,043	1,188	1,252	1,284	1,317
Depreciation & amortisation	1	1	1	1	1
Total Operating Expenditure	15,098	15,793	16,873	17,125	17,363
Allocation of corporate costs	1,221	1,333	1,343	1,322	1,299
Total Cost of Service	16,319	17,126	18,216	18,447	18,662
Revenue	16,319	17,126	18,216	18,447	18,662
Net Result of Service	0	0	0	0	0

6. ORGANISATIONAL CAPABILITY

This section is about key organisational needs and initiatives the DHB will undertake to support organisational performance (e.g. investment in information services and workforce development including strengthened clinical leadership and engagement).

This section also identifies various change management initiatives, including changes to the way in which the DHB funds and provides services (e.g. regional collaboration including the possibility of joint procurement opportunities and shared service functions).

6.1 Human Resources

Workforce development and organisational health are concepts that are pivotal to the success of the DHB. The foundation of a skilled workforce coupled with a culture of ongoing learning supports the DHB to achieve better, sooner, more convenient health care. By focusing on leadership, the provision of relevant development opportunities and the support of a innovative working environment, the DHB aims to develop a reputation as a preferred employer of health workers.

As a 'good employer' we have a number of policies that promote an organisational environment that is equitable and fair, including:

- fair and transparent recruitment processes that aim to meet current and future workforce needs
- a zero-tolerance of all forms of harassment and bullying
- equitable training and development opportunities for all employees
- the management and disclosure of adverse events to ensure a safe quality working environment.

The DHB is committed to developing a workforce profile that shows commitment to promoting leadership opportunities, attracting skilled and diverse staff and developing a culture where our workforce is engaged.

6.2 National and Regional Collaboration, and cross-sector Collaboration

Wairarapa DHB works collaboratively across the sector and with other health and social service providers. In 2010/11, the DHB will further strengthen its collaborative efforts as it seeks to reduce and control costs and improve the patient experience.

The DHB is committed to sharing resources with regional DHBs and providers as well as collaboration with the Ministry of Health, DHBNZ¹¹, NGOs¹² and other service providers in order to achieve its goals.

National

Wairarapa DHB has an open and strong working relationship with the Ministry of Health. The DHB is also an active participant in a number of national work programmes, coordinated through DHBNZ, to develop consistent approaches to the implementation of national health policies and strategies. It is expected some of this national work will contribute to improved quality and efficiency of the DHB (e.g. DHBNZ national procurement activities and the Health Workforce Information Project).

¹¹ DHBNZ (District Health Boards New Zealand) has the overall purpose of assisting DHBs in meeting their objectives and accountabilities to the Crown.

¹² NGOs (Non-Governmental Organisations) for more information on NGOs go to <http://www.moh.govt.nz/ngo>

Wairarapa DHB also funds various national providers, including other DHBs, to deliver services on behalf of its population, many of which form part of the Hospital Services Output Class (e.g. neurosurgery and plastic surgery). The DHB will continue to explore the optimal arrangements for securing this specialised capacity from national service providers in the most cost efficient and effective manner.

Regional

Wairarapa DHB works closely with the Central region DHBs¹³ on a wide range of issues. This regional collaboration is assisted by the Central Region's Technical Advisory Services Limited (TAS) which provides the Central region's DHBs with shared support services such as health information and service planning, to support local DHB decision-making. This support includes co-ordinating the development of the Regional Clinical Services Plan (RCSP) and an associated implementation plan on behalf of the region.

The RCSP sets out a vision and framework for the region's health services to the year 2020. This vision involves a regionally co-ordinated system of health service planning and delivery, thus creating lasting improvements in the sustainability, quality and accessibility of clinical services. Underpinning this vision are two aims:

- improved clinical outcomes
- patients and their families / whānau have an enhanced experience of the Central region health service

These aims are balanced with the need for an affordable health service that is able to demonstrate value for money and to live within available resources.

To support implementation of the RCSP, regional clinical networks have been established for cancer, cardiac, mental health, plastic surgery, and renal. In future there will be increased linkages through clinical networks with common predefined disease pathways to support consistent management of patients across the region. There will be an increasing need for DHBs to share the clinical workforce to ensure clinical viability across all hospitals and specialist services.

Central region DHBs are also committed to a range of projects that will increase productivity such as implementing the Regional Elective Surgery Plan, progressing clinical pathway development for key procedures across the region and undertaking the Strengthening Hospitals Projects in Radiology, Women's Services and Older Adults.

In describing the need for change, the RCSP identified a number of services that it regarded as being vulnerable, initially assessed on the basis of medical workforce shortages and then across a broader criteria. The result was a summary action plan, "Strengthening Hospital Services: Regional Action Plan" and which, when added to existing regional projects has agreed the following priority areas by way of a regional work programme for 2010/11:

- Clinical services – Cancer, Cardiac, Mental Health, Older Adults (AT&R and Specialist Rehabilitation for under 65 years), Plastics, Radiology, Renal, and Women's Services (Maternity, Gynaecology, Gynae Oncology Surgery and Maternal Foetal Medicine)

¹³ Central Region DHBs include Capital and Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa, and Whanganui DHBs.

- IT and Communication
- Long Term Conditions (chronic conditions management)
- Regional Electives Surgery Plan
- Regional Credentialling of Medical Clinicians
- Transport and Accommodation

The work programme has necessitated the development of a regional governance and decision making framework to best support regional activity, including the establishment of:

- a regional committee including DHB Chairs and CEOs and an independent chair
- a Clinical Leadership Group representative of DHB clinicians
- a steering group that is multi-representative
- links with a newly created Mana Whenua Board, comprising representatives from individual DHB Iwi Relationship Boards.

It will also ensure standardised prioritisation tools and processes are used to inform access to regional services and review access to elective services to ensure equity with other DHBs. This may result in reductions in some procedures that are performed regionally (and locally) given that Wairarapa is providing higher intervention levels for its population than the national average.

Sub Regional Activity

Wairarapa DHB currently funds various regional providers, including other DHBs, to deliver services on behalf of its population, many of which form part of the Hospital Services Output Class (e.g. complex ear, nose and throat surgery, complex ophthalmology services, cardiothoracic surgery). The DHB will continue to explore the optimal arrangements for securing this specialised hospital capacity from other DHBs particularly with neighbouring DHBs (Hutt Valley and Capital & Coast).

The three DHBs have recently signed a statement of commitment which commits the organisations to developing a clinically led programme of work over the next 1-2 years. At a joint planning day with Hutt Valley DHB, it was agreed that the first areas of focus are:-

Services provided for Wairarapa by other District Health Boards:

- Regional Cancer Centre - MidCentral and CCDHB
- Tertiary services for treatment of cardiovascular disease - mostly CCDHB
- Renal dialysis services - CCDHB
- Specialist mental health and forensic services - CCDHB
- Outsourced acute mental health services - HVDHB and MCDHB
- Specialist child and neonatal services - CCDHB and ADHB
- Termination of Pregnancy Services in second trimester - CCDHB
- Psychogeriatric Services by various districts
- Retinal Screening Services - Compass Health.

- General Surgery / Anaesthetics - looking at opportunities for joint clinical work with the Hutt Valley DHB and a shared workforce
- Paediatrics-exploring opportunities for joint clinical work and a shared workforce
- Mental Health-participating in work already underway with Capital & Coast and Hutt Valley DHBs with a particular emphasis on regional acute Psychiatry cover
- Radiology-as part of the strengthening hospital's project, working with Hutt Valley DHB and other Central Region DHBs on initiatives to generally improve clinical sustainability

- Emergency Department-exploring how a sub regional arrangement might work with Capital & Coast and Hutt Valley DHBs
- Public Health Services-participating in work being under taken by the Ministry of Health and Regional Public Health on the future funding of Public Health Services.

Clinical Leaders from the three DHBs also recently agreed to participate in regional service planning for ENT and Health of Older People and supported the Mental Health and Paediatric work noted above.

Corporate Service / Back Office Functions

As well as a focus on sustainable hospital services, Wairarapa DHB will be working with Hutt and Capital and Coast DHBs on opportunities for corporate convergence initiatives in a number of areas including:-

- Payroll
- Human Resources
- Planning and Funding and
- Financial transaction services.

It is anticipated that this work will lead to a greater level of corporate convergence between these DHBs and that there will be significant developments around shared support services both regionally and nationally in the next 12-24 months.

This convergence work may also includes the opportunity to have a joint DAP/DSP process across Wairarapa, Hutt Valley and Capital and Coast DHBs in 2011/12.

Cross-Sector

Over recent years, Wairarapa DHB has built sound collaborative relationships with local government and key community groups. There is widespread community ownership of Wairarapa DHB's vision and goals and growing understanding of the societal determinants of health – that health is everybody's business. This will develop further through a strongly consultative approach to development of new strategies and initiatives, with hui and open community meetings held to debate significant issues and new developments.

Wairarapa DHB has strong relationships with the three territorial local authorities, and the regional council, and contributes to some joint planning processes with them. Examples of this include the Long Term Community Council Plans (LTCCPs) and the Regional Land Transport Strategy.

Wairarapa DHB works with Work and Income, the Ministry of Social Development, Accident Compensation Corporation (ACC), Te Puni Kokiri and the education sector to identify and use opportunities for shared approaches to common problems. This is particularly important in progressing implementation of 'whole of government' strategies such as the National Suicide Prevention Strategy, and the New Zealand Disability Strategy.

Wairarapa DHB leads several intersectoral groups including:

- Suicide Prevention Steering Group (under the Suicide Prevention Coordinator Pilot Project)
- Healthy Lifestyles Oversight Group (Led by the Healthy Eating Health Action (HEHA) Coordinator)

The DHB is also an active participant in a many other inter-sectoral groups and projects, including:

- Violence Free Wairarapa
- Strengthening Families
- Healthy Homes
- Regional Intersectoral Forum (convened by Te Puni Kokiri)
- Government Agencies Networking Group (convened by the Masterton District Council).

Service Advisory Groups

In addition to this, Wairarapa DHB has a number of processes in place to enable engagement with the community and special interest groups. A number of groups meet regularly with Wairarapa DHB staff. These include:

- Cancer control advisory group
- Mental health local advisory group
- Local diabetes team
- Child Health Advisory Group
- Palliative care Community Reference Group
- FOCUS stakeholders group, and
- Health of the Older Person advisory group.

6.3 Workforce Development and Organisational Health

Workforce Development

Wairarapa DHB is committed to developing and maintaining a sustainable health workforce that is aligned with local and national strategic objectives.

Workforce development and the organisational health and culture are central to continuing the ability to provide high quality, effective services. Wairarapa DHB aims to be an employer of choice offering employees flexibility, opportunities for innovation, skill development and leadership, and an exemplar 'good employer'.

As a 'good employer', Wairarapa DHB will continue to grow a positive organisational culture, ensuring the fair and proper treatment of employees in all aspects of their employment. This will be achieved by continually reviewing and renewing human resource policies and procedures, and focusing on a strategy of providing a work environment where employees are able to develop new skills and have opportunities to work in professionally challenging and rewarding roles.

Wairarapa DHB believes that it will benefit from a diverse workforce and is committed to recognising and valuing different skills, talents, experiences and perspectives of employees.

Wairarapa DHB recognises the importance of leadership to support the workforce. It will continue to provide ongoing education for managers and aspiring managers through its 'Professional Managers' seminar programme. Employees will be provided with regular monthly seminars related to leadership in order that their leadership skills can be developed to the highest level.

Fostering Clinical Leadership

The DHB supports the *In Good Hands* task force report. This report identified the New Zealand healthcare system in regards to clinical governance based on the following six principles:

1. Quality and safety will be the goal of every clinical and administrative initiative
2. The most effective use of resources occurs when clinical leadership is embedded at every level of the system
3. Clinical decisions at the closest point of contact will be encouraged
4. Clinical review of administrative decisions will be enabled
5. Clinical governance will build on successful initiatives
6. Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.

Wairarapa DHB is committed to continuing to support and grow clinical leadership by supporting clinical governance of the patient journey across primary and secondary services. Our success in strengthening clinical leadership and clinician involvement in decision making will underpin our rate of progress in our PIAs.

Identifying more efficient and effective ways to deliver services at a regional, sub-regional and local level; controlling the growth of hospital labour costs; maintaining and where possible, improving hospital productivity; and achieving better integration of local primary and secondary services all require support, active involvement and leadership by clinicians.

The DHB will continue to ensure local clinicians take a lead role in the establishment of regional clinical networks, local and regional clinical pathways, and optimal clinical arrangements for securing specialised hospital capacity with neighbouring DHBs. This strengthened clinical leadership will be assisted through the activity of the Clinical Forum, the Clinical Board and involvement of clinicians in the development of collaborative service models (e.g. general surgery, women's health, anaesthetics, paediatrics, mental health, radiology, emergency services, public health) at a sub-regional and regional level. Both the Clinical Board and the Clinical Forum have a broad focus on health service delivery for the Wairarapa. Clinicians are also represented on the DHBs Information Systems Action Committee (ISAC) and the Capital Committee playing an important role in determining the resource allocation of IT and capital initiatives across the DHB.

6.4 Building Capability

Wairarapa DHB is committed to continuous development of its capability and capacity through workforce development, provider relationships, service development and re-configuration, improving quality and safety, information systems and management, and increasing participation by Maori.

Governance capability

Wairarapa DHB has a well functioning Board whose members bring a wide range of skills and experience to their governance roles. Governance capability is maintained and developed through training and workshop opportunities. Governance capability is further enhanced through its relationship with Te Iwi Kainga.

Planning and Funding capability

Wairarapa DHB's planning and funding team is a small, well functioning group with expertise in a number of areas and strong relationships with other DHBs and the Central region shared service agency. Where specific capability or capacity is not available within the team it is outsourced from another agency or individual with the appropriate expertise. In 2010/11, the DHB will explore the benefits that might derive from converging this function with neighbouring DHBs (i.e. Hutt Valley and Capital and Coast) as part of the DHB's focus on reducing expenditure on support and corporate functions.

Provider Arm capability

Wairarapa DHB's provider capability has been enhanced significantly through the development of the new Wairarapa hospital. The facility is supporting the delivery of high quality hospital services and assisting with our recruitment and retention efforts. However, the maintenance of a full complement of suitably qualified clinical staff to meet the requirements of Wairarapa DHB is an ongoing challenge. This will need a concerted recruitment effort regionally, nationally and internationally, as the available workforce is very limited.

To maximise the use of scarce clinical resources, the DHB is working with Central region DHBs as part of the implementation of the Regional Clinical Services Plan, involving the most efficient and effective way to fund and deliver services across the region. We are also focusing on opportunities to better integrate clinical services with neighbouring DHBs, in particular Hutt Valley and Capital and Coast. This is likely to result in new opportunities to share clinical staff across DHBs.

Provider Arm staff are also actively involved in discussions about new models of care and changes to quality, safety and clinical governance. As the focus of service provision continues to shift more to home and community based care, through policies such as 'aging in place' and the emphasis on better sooner more convenient services as demonstrated in our business case *Tihei Wairarapa*, there is greater need for widening skills bases and development in primary health services and community organisations (NGOs and Maori providers). The inclusion therefore of these groups together with Provider Arm clinicians in the development of the CSAP, on the Clinical Forum, in the development of the primary care business case, and in Wairarapa DHB's workforce development initiatives will be crucial to ensuring service users have access to high quality, recovery focused and culturally safe services.

Over the next year, Wairarapa DHB's Provider Arm will continue to improve quality and value of service delivery, with specific focus on hospital related actions detailed in the CSAP which are carried through into the 2010/11 DAP, including:

- actively managing staff and recruitment costs
- exploring alternative service delivery models
- continuously improving primary-secondary service links in every specialty.

6.5 Information Services

Although one of the smallest DHBs in terms of budget and staff numbers, Wairarapa DHB has a relatively complex information environment to support the needs of the organisation. Development of information technology is within the context of Wairarapa DHB's Information Systems Strategic Plan (ISSP) which may be found on Wairarapa DHB's website: www.wairarapa.dhb.org.nz. The DHB has an Information Systems Action Committee (ISAC) which prioritises major IS projects and provides Governance.

Wairarapa DHB operates and maintains local and area wide networks across seven sites in the district, which service about 400 devices (Personal Computers, Thin Client terminals and printers). The network infrastructure also includes routers and firewalls that interconnect, route and secure authorised network traffic between Wairarapa DHB's networks and others. During the past year there has been considerable progress as evidenced in implementation of new IS-IT services. These are outlined in the 2010/11 DAP.

Major projects that are planned for 2010/11 include:

- The DHB will implement the Titanium Oral Health system into its school dental service. Planning for this started last year. This system is already running separately at several DHBs in the region and it is likely we will leverage one of those systems rather than install our own. This will save on implementation cost and speed implementation.
- The Concerto electronic medical record used in the hospital will be made accessible to primary care and community based providers. It will be integrated with MedTech so that primary care information from all patients in the district can be viewed within Concerto. This will effectively create the first iteration of a "shared care record" in the Wairarapa. The quality and capacity of the networks between primary care and the DHB ICT networks may need to be upgraded to efficiently support this.
- The eReferrals solution which was introduced into the district in 2009/10 will be upgraded providing new referral forms based on the developing national standards coming out of the Auckland Region project as well as supporting new referral management pathways within the Hospital and community.
- The management and care of patients through hospital acute services will be improved through enhancements to the systems which will see an improved flow of information electronically from the community and primary care, into the emergency department and back again.
- An initiative to provide clinicians and pharmacists with a patients medication list will be undertaken. This initiative will aim to provide a patient centric view within Concerto of medications that have been prescribed or dispensed for that patient. This will integrate information from the hospital and GP systems as well as local pharmacies. This initiative will be an invaluable tool for aiding more efficient and safer medications management. This project will be supported through the EOI Business case process.
- Continuing IS infrastructure improvements.

At this stage, there are no plans to progress initiatives around the financial system replacement, or the human resource system until such time as the plans of the neighbouring DHBs are finalised and national initiatives are confirmed.

The Central region has identified the following information projects as a shared priority for 2010/11:

- Shared PACS image repository - that will enable immediate access to all diagnostic images in the region by any clinician and support radiologists from any DHB (or private provider) to report any other DHBs studies.
- Video conferencing interconnection – will make video conferencing technology more accessible to improve both corporate and clinical communications between DHBs, reducing travel and meeting costs.
- Single sign-on.

6.6 Quality and Safety

The DHB is using a 'Just Culture' philosophy to underpin all of its quality, safety and risk systems. This is demonstrated through:

- taking a fair and balanced approach to incident reporting
- learning from mistakes and protecting people's honest mistakes from being seen as culpable but at the same time holding people and the organisation accountable for patient safety by basing disciplinary action on behavioral choices.

To this end a shift in mindset around quality, safety, risk reporting and management is required throughout the DHB to raise the profile of quality and for staff to feel safe with the processes in place. Some of the actions supporting this are:

- Trial of the introduction of joint appointee quality leader roles into the clinical areas to lead by example, monitor and improve the quality of care provided. Dependent on the success of this project over the next 12 months in the secondary setting, consideration will be given to facilitating the role out of the quality leader roles supporting primary care and aged care facilities.
- Greater visibility and profile of the quality, safety and risk team.
- Embedding quality and risk management processes into everyday DHB practice

Quality Improvements

To respond to the rapidly changing parameters of health care, the DHB needs to be able to change and foster innovation, quality improvements and clinical leadership. Through the DHB restructure, we are aiming to work smarter, not harder, and this is reliant on a willing and engaged workforce.

To support and encourage its workforce, the DHB has commenced the reintroduction of the quality and innovation awards at a local level, with the aim of dovetailing these into the National Quality Awards offering the staff public recognition for the achievements made across the DHB and resulting in an improvement to the patient's quality of health care.

The CSAP's Triple Aim and its six key areas for improvement form the basis of the DHB's quality and risk strategic plan. This involves improving the health of the whole population and the patient experience through:

- Improved inter-professional communication and collaboration
- Clarifying and improving coordination and integration across providers and services based on the patient, not the provider
 - Clarifying roles and responsibilities for the coordination of services for the individual patient
 - Develop clear accountabilities for patients under the care of multiple agencies and healthcare professionals.
- Improving systems and organisational support, particularly in regard to duty of care and medico-legal risk
- Continuing to develop the clinical governance of the DHB.

These strategic quality improvements support the six system components identified in the CSAP which are required to achieve the Triple Aim. They will be mirrored throughout the organisation in all levels of quality improvement.

Wairarapa DHB's Clinical Board oversees and reviews clinical quality systems, safety and clinical practices within the provider arm, using a clinical governance framework.

The following table provides a sample of some of the quality measures that are used by the DHB's Provider Arm to assess its performance in this area.

MoH Indicator Code	Measures	Baseline 2008/09	Targets		
			2010/11	2011/12	2012/13
	The number of inpatient falls	119	<115	<87	<58
	The number of medication errors	55	<50	<35	<25
	Hospital acquired pressure ulcers	9	<9	<7	<4
	The number of surgical site infections	6.5%	6%	4%	2%
OS12	Patient satisfaction mean of "Good" and "Very Good" (Q17)	92.02%	92.5%	=/> 92.5%	=/> 92.5%

The DHB is committed to the continuing support and participation in the five identified National Quality Improvement Committee (QIC) projects¹⁴ to manage the risk of maintaining patient safety and clinical quality. This will allow benchmarking with other DHBs and shared learning.

Wairarapa DHB's Quality Strategy is available on Wairarapa DHB website: www.wairarapa.dhb.org.nz

6.6 Subsidiaries

Wairarapa DHB, with other central region DHBs, has joint ownership of TAS. TAS provides analytical and planning support services to the central region DHBs. TAS is funded by the DHBs on an annual budget basis to provide services. Currently TAS has 24 FTE and an annual budget of \$2.87 million.

Wairarapa DHB also has a wholly owned subsidiary company – Biomedical Services New Zealand Limited (Biomed) which has its own board of directors and reports on a regular basis to Wairarapa DHB as their owner. Biomed provides testing and servicing of patient related equipment to a number of DHBs throughout New Zealand.

6.7 Reporting Requirements

Wairarapa DHB provides regular reporting to the Minister and Ministry of Health as outlined below. In accordance with s 141 (1) (g) Crown Entities Act 2004 we will consult with the Minister via the Ministry of Health on any significant developments not covered in this plan.

Reporting	Frequency
Information Requests	Ad Hoc
Financial Reporting	Monthly
National Data Collections	Monthly
Risk Reporting	Quarterly
Health Target reporting	Quarterly
Crown Funding Agreement non-financial reporting	Quarterly
Indicators of DHB Performance	Quarterly
Annual Report & audited statements	Annually
District Strategic Plan (DSP)	3 yearly

¹⁴ The five QIC projects include safe medication management, management of healthcare incidents, optimising the patient's journey, infection prevention and control, and national mortality review systems.

7. FINANCIAL PERFORMANCE

This section outlines the DHB's projected financial position for financial year 2010/11 and the two out-years beyond this: 2011/12 and 2012/13. It also summarises the key financial challenges and the action plans for dealing with these challenges and provides projected financial statements for Wairarapa DHB.

7.1 Financial Outlook

Wairarapa DHB continues its commitment to manage expenditure within the provided funding. However, we are projecting deficits through to 2009/10, 2010/11 and 2011/12. These deficits recognise the continuing increases in the costs of providing services provided by other DHBs for the Wairarapa population (i.e. the inter-district flows) as well as additional cost pressures across Wairarapa DHB at greater rates than provided for in the Funding Envelope.

The financial results for the parent DHB are summarised as follows:

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Revenue	117,973	121,599	123,258	126,062	128,860
Operating Expenditure					
Workforce costs	36,466	36,672	36,999	37,519	38,005
Treatment related costs	19,543	18,044	17,679	17,928	18,163
External providers	40,843	43,386	42,352	42,948	43,502
Inter district flows	20,674	23,132	24,056	24,395	24,711
Total Operating Expenditure	117,526	121,234	121,086	122,790	124,381
Result before Interest, Depreciation & Capital Charge	447	365	2,172	3,272	4,479
Interest, Depreciation & Capital Charge					
Interest expense	1,958	1,880	1,800	1,825	1,849
Depreciation & amortisation	1,912	2,123	2,081	2,110	2,137
Capital charge	685	562	480	487	493
Total Interest, Depreciation & Capital Charge	4,555	4,565	4,361	4,422	4,479
Net Operating Results	(4,108)	(4,200)	(2,189)	(1,150)	0

Key financial challenges

Wairarapa DHB is facing significant financial challenges ahead and the financial projections assumes that these challenges will be managed by the DHB with a reduced deficit in 2010/11 to that forecast for 2009/10. The key financial challenges affecting the DHB include:

- The downturn in the New Zealand and world-wide economy will continue to have a significant effect on the DHB. The immediate impact has been on the Crown's ability to continue the level of funding increases received in the last few years there is also reliable evidence that an economic downturn creates an increase in demand across all areas of the health service. For example, the income of the population has a high impact on the determinants of health and as such a downturn in the economy is likely to result in increased demand.
- The DHB competes in the national and international market for clinical staff and workforce shortage is currently being experienced in some specialised clinical areas. Wairarapa DHB is a small player on both the national and

international markets and our ability to recruit and retain qualified clinical staff is hampered by our size. Hence the sustainability of a viable clinical workforce is a critical factor in the regional and sub-regional discussions as highlighted elsewhere in this SOI.

- The population of the Wairarapa is ageing at an increasing rate. Studies have shown that a significant percentage of the health dollar spent on an individual is incurred in the last two years of that individual's life. As the population ages there is an increasing demand placed on not just the hospital to provide services but also there is increasing demand on the aged residential care and supported at home areas of the sector.
- The continued rising costs of healthcare have contributed to increases in the pricing regime for services paid for by Wairarapa DHB, but provided by our neighbouring DHBs (i.e. the inter-district flows or IDFs). This higher price, in conjunction with additional capacity in these neighbouring DHBs, has resulted in an increased percentage of the new funding provided to Wairarapa DHB being applied to the total IDF spend.

Action plan for dealing with financial challenges

The DHB will progress the following four PIAs in an effort to reduce and control costs in 2010/11:

1. **Address Inequalities** ensuring all of our spending decisions consider those with the poorest health status, where possible focus spending on those with the greatest need, including the frail elderly, those with long term conditions, and population groups with the poorer health outcomes, including Maori.
2. **Achieve Financial Security** by ensuring delivery on Minister agreed financial forecasts within available funding, through active cost management and achieving planned productivity savings.
3. **Improve productivity and quality** with a focus on hospital wards, theatre utilisation, increasing day surgery, and emergency departments.
4. **Enhance regional cooperation** through clinical regional service plans and through greater regionalisation of shared services and back-office functions.

We expect these PIAs to impact positively on our financial and service performance in 2010/11 and enable the DHB to deliver on both Government and local priorities.

Out-years scenario

The DHB expects funding increases for out-years to be around 2.4% (planning advice from the Ministry of Health suggested funding increases should be at the same nominal value as the DHB received for 2010/11). The DHB has also assumed that it will contain expenditure increases to be, on average, below the rate of funding increase received.

We will continue implementing the strategies and actions developed to meet our financial challenges and achieve financial sustainability. We assume that our strategy and action plans will enable the DHB to further reduce its deficit in 2011/12 and reach break-even in 2012/13.

Financial assumptions and risks

Included in the financial forecast are the following key assumptions:

- The DHB's funding allocations will increase as per funding advice from the Ministry of Health and early payment is retained;
- The rate for capital charge will remain at 8%;
- No industrial action will occur over the coming year;
- No revaluation of land and buildings will be required in 2010/11 or the two out-years;
- Employee cost increases are based on terms agreed in current wage agreements. Expired wage agreements are assumed to be settled on affordable and sustainable terms. Efficiencies will be generated under the partnership programmes and tripartite agreements;
- Staff vacancies (existing and as they occur in future) will be reassessed to ensure the positions are still required, affordable and alternatives explored before vacancies are filled. Improved employee management can be achieved with emphasis in areas such as sick leave, discretionary leave, staff training and staff recruitment/turnover;
- The cost of any new initiatives or programmes and the financial impact associated with any new legislative, regulatory or compliance policies, required by Government, will be fully funded through specific additional funding allocations to the DHB. Any financial impact associated with changes to DSS boundaries between age related and non age related services and any contracts or services devolved will be cost neutral;
- External providers will operate within the available funding received after allowance made for committed and uncontrollable funding commitments;
- Price increases agreed collaboratively by DHBs for national contracts and any regional collaborative initiatives will be affordable and sustainable;
- Any increase in treatment related expenditure and supplies is maintained at affordable and sustainable levels and the introduction of new drugs or technology will be funded by efficiencies within the service;
- We are able to align our service and access criteria with that of other DHBs;
- The DHB can establish joint primary/secondary pathways to reduce hospital and specialist service demand and overall service costs;
- All other expenses increases including volume growth will be managed within uncommitted funds available or deferred;
- At the time of writing it is assumed that the hospital site sale will be completed in FY2010/11; and
- That the DHB will be an active participant in the development of an Integrated Family Health Network.

The overriding risk to achieving the financial performance relates to the key assumptions above not holding true and the risks around wage increase expectations for the health sector, both internal staff and external providers, following the national employment collective settlements. Other risks include the inability to implement identified service reconfiguration or service reduction, according to planned timeframes and the inability to achieve efficiencies and address cost overruns internally.

7.2 Asset Planning and Sustainable Investment

Asset management planning

Wairarapa DHB is committed to asset management planning with a view to a more strategic approach to asset maintenance, replacement and investment.

A revised Asset Management Plan (AMP) is to be developed in the first half of the 2010/11 financial year. The revision of the AMP includes a detailed review of the asset management practices and will provide a robust platform on which to base

capital investment decisions in the future. The AMP reflects the joint approach taken by all DHBs and current best practice.

Capital expenditure

The DHB has significant capital expenditure committed in the 2010/11 financial year that flows on from increased capital expenditure budgets in previous years.

Based on the DHB's fiscal position, we estimate that we will be able to fund a total of \$1.0 million of capital expenditure in 2010/11 which is a significant reduction in the planned amount of capital expenditure from the 2009/10 financial year. This decrease is necessary to ensure an improved liquidity position is achieved and to support the projected deficit. As capital expenditure funding will be tight, we plan to be disciplined and focus on the DHB's key priorities in determining our capital expenditure spending. Where possible, we will seek to collaborate with other DHBs to avoid duplication. This collaboration could arise through national or regional decisions made by the Shared Services Establishment Board.

Business cases

Wairarapa DHB has submitted a business case for the development of the Community Health facility. This facility will accommodate the oral health, community nursing, public health and Focus services as well as provide flexible clinic space. At the time of writing this business case was on hold pending discussions around the development of an Integrated Family Health Network, as per the Tihei Wairarapa business case. The capital cost and associated financing has not been incorporated within the financial statements presented herein.

As noted elsewhere within this Plan, Wairarapa DHB is in discussions with Capital & Coast DHB and Hutt Valley DHB regarding a range of clinical and non-clinical cooperation opportunities. It is likely that one or more business cases will be required to progress any initiatives, particularly information system initiatives. At the time of writing it is not known what the value of any investment is nor whether any additional capital funding will be required. In the financial statements presented, it has been assumed that any funding will be met from baseline capital budgets.

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

Asset valuation

Wairarapa DHB revaluated its property and building assets at 30 June 2007 in line with generally accepted accounting practice requirements and NZIFRS.

There is increasing likelihood that there will be a need for an asset revaluation to be carried out on the building and property assets during the future financial years. At the current point in time no allowance has been made for any change in the asset valuation. However, this will depend on whether the valuation has a material impact on the financial statements. If a revaluation does occur then there will be additional depreciation and capital charge costs which are unlikely to be reimbursed on a yearly basis.

Disposal of land and other assets

Wairarapa DHB actively reviews assets to ensure that it has no surplus assets. No significant assets are scheduled for disposal during the plan period as a result of being declared surplus.

The approval of the Minister of Health is required prior to the DHB disposing of land. The disposal process is a protective mechanism governed by various legislative and policy requirements.

It is noted that the Wairarapa DHB is progressing the sale of the old Masterton Hospital campus and this is expected to be complete and funds realised during the 2010/11 year.

7.3 Debt & Equity

Core debt

The DHB has a long-term debt facility of \$25.75 million with the Crown Health Financing Agency (CHFA). The DHB's total term debt held with the Crown Health Financing Agency (CHFA) is expected to be \$25.25 million as at June 2010 and reduces by \$0.25 million in each of the three financial years covered by this SOI. There are no covenant ratios applicable to this debt facility.

Other debt facilities

The DHB has a range of finance leases covering the replacement of the Ambulance fleet and partial funding for the implementation of the RIS/PACS system. These leases are at very competitive interest rates (ranging from 1% to 4% per annum) and are provided by the Wairarapa Community Health Trust. This reflects a long standing arrangement where the Trust has provided the funding for the regular replacement of all the ambulance fleet.

The DHB has received approval from the Ministers of Health and Finance for the extension of the Selina Sutherland private hospital wing. The cost of this extension is \$0.7 million and is financed through a ten-year loan facility with Selina Sutherland Hospital Ltd. The repayment terms provide for the repayment of principal and interest over the term of the facility.

The DHB maintains a working capital facility of \$6.0 million with the ANZ Bank. The ANZ Bank also provides the transactional banking facilities for the DHB. All banking covenants with the ANZ Bank are complied with.

7.4 Miscellaneous Financial Provisions

Activities for which compensation is sought

No compensation is sought for activities sought by the Crown in accordance with Section 41(D) of the Public Finance Act.

Acquisition of Shares

Before Wairarapa DHB or any associate or subsidiary subscribes for, purchases, or otherwise acquires shares in any company or other organisation, the Board will consult the responsible Minister/s and obtain their approval.

7.5 Prospective Financial Statements

Accounting Policies

The accounting policies adopted are consistent with those in the prior year for a full statement of accounting policies refer to Appendix 2.

Financial statements

The projected financial statements are shown in Appendix 3. The projected financial statements include a cost of service financial statement for each of the four output classes of Wairarapa DHB.

The actual results achieved for the period covered by the financial projections are likely to vary from the information presented, and the variations may be material. The financial projections comply with section 142(1) of the Crown Entities Act 2004 and the information may not be appropriate for any other purpose.

8. APPENDICIES

APPENDIX ONE

BOARD COMMITTEES

Statutory Advisory Committees

There are three sub committees to the Board made up of Board members, DHB staff, and community representatives. These statutory committees are required under the NZPHD Act:

- *Hospital Advisory Committee (HAC)* - monitors the financial and operational performance of the hospital and assesses strategic issues relating to the provision of hospital services.
- *Community and Public Health Advisory Committee (CPHAC)* - provides the Board with advice on the health and disability needs of the region's population and issues that have a significant affect on the population's health.
- *Disability Support Advisory Committee (DSAC)* - informs the Board about the needs of people with disabilities in the region and prioritises the use of the funds provided for those with a disability.

Te Oranga o Te Iwi Kainga

Wairarapa DHB has established a Maori partnership committee, Te Oranga o Te Iwi Kainga. The DHB has a relationship agreement with Te Oranga o Te Iwi Kainga (representing the two Iwi) in which the partners agree to work together to improve Maori health outcomes.

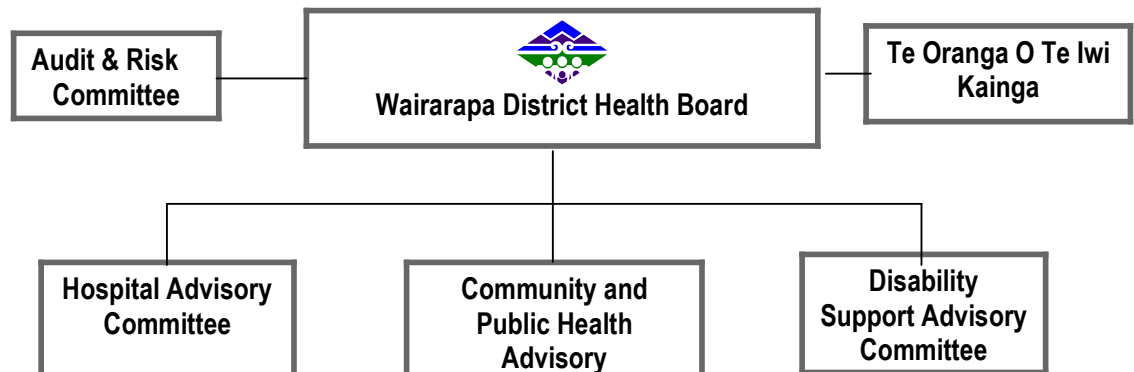
Audit and Risk Committee

This committee monitors and reports risk, and advises the Board on its responsibilities in relation to integrity of financial reporting, risk management, and regulatory conformance.

Meeting Frequency and Attendance

These committees meet regularly throughout the year. They are supported by the Board and Committee Secretaries, and members of the senior leadership team, as appropriate. The public are welcome to observe the meetings of the board and statutory committees. Details of the meetings (such as agendas, minutes, membership of the committee, people who attended a meeting) are publicly available on www.wairarapa.dhb.org.nz. Table 1 illustrates Wairarapa DHB's Governance structure.

Table 1: Governance and Organisational Structure



STATEMENT OF ACCOUNTING POLICIES**Reporting entity**

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

Wairarapa DHB is a public benefit entity, as defined under NZIAS 1. The consolidated financial statements of Wairarapa DHB for the year ended 30 June comprise Wairarapa DHB and its subsidiary Biomedical Services New Zealand Limited and joint venture the Central Region Technical Advisory Service Limited (TAS) which is one sixth owned.

Wairarapa DHB's activities involve delivering health and disability services and mental health services in a variety of ways to the community.

The financial statements were authorised for issue by the Board on 30 October 2008.

Statement of compliance

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

Basis of preparation

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

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

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

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

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by Wairarapa DHB. Control exists when Wairarapa DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Joint ventures

Joint ventures are those entities over whose activities Wairarapa DHB has joint control, established by contractual agreement. The consolidated financial statements include Wairarapa DHB's interest in joint ventures, using the equity method, from the date that joint control commences until the date that joint control ceases.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates and jointly controlled entities are eliminated to the extent of Wairarapa DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Budget figures

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

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Revenue relating to service contracts

Wairarapa DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Wairarapa DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Goods sold and services rendered

Revenue from goods sold is recognised when Wairarapa DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Wairarapa DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Wairarapa DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Wairarapa DHB.

Rental income

Rental income from investment property is recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Expenses

Operating lease payments

Payments made under operating leases are recognised in the statement of financial performance in the periods in which they are incurred.

Finance lease payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Net financing costs

Net financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, interest received and receivable on funds invested calculated using the effective interest rate method, dividend income and gains and losses on hedging instruments that are recognised in the statement of financial performance.

The interest expense component of finance lease payments is recognised in the statement of financial performance using the effective interest rate method.

Dividend income is recognised in the statement of financial performance when the shareholder's right to receive payment is established.

Non-current assets held for sale

Immediately before the classification of assets as held for sale, the measurement of the assets (and all assets and liabilities in a disposal group) is brought up-to-date in accordance with applicable NZIFRSs. Then, on initial classification as held for sale, a non-current asset and/or a disposal group is recognised at the lower of its carrying amount and its fair value less costs to sell.

Impairment losses on initial classification as held for sale are included in the statement of financial performance, even when the asset was previously revalued. The same applies to gains and losses on subsequent remeasurement.

Business combinations involving entities under common control

A business combination involving entities or businesses under common control is a business combination in which all of the combining entities or businesses are

ultimately controlled by the same party or parties both before and after the business combination, and that control is not transitory.

Wairarapa DHB applies the book value measurement method to all common control transactions.

Income tax

Wairarapa DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Foreign currency

Foreign currency transactions

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

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings
- medical equipment
- information technology
- motor vehicles
- other plant and equipment
- work in progress.

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance. Additions to property, plant and equipment between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, Plant and Equipment Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Wairarapa Health Limited (a hospital and health service company) vested in Wairarapa DHB on 1 January 2001. Accordingly, assets were transferred to Wairarapa DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the health board has recognised the cost (or in the case of land and buildings – the valuation) and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sales price and the carrying amount of the asset.

Properties Intended for Sale

Properties intended for sale are valued at the lower of cost or net realisable value.

Leased assets

Leases where Wairarapa DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

The property held under finance leases and leased out under operating lease is classified as investment property and stated at fair value. Property held under operating leases that would otherwise meet the definition of investment property may be classified as investment property on a property-by-property basis.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Wairarapa DHB. All other costs are recognised in the statement of financial performance as an expense as incurred.

Depreciation

Depreciation is charged to the statement of financial performance using the straight line method. Land is not depreciated.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

<u>Class of Asset</u>	<u>Estimated Life</u>
Freehold buildings	2 to 50 years
Medical equipment	2.5 to 15 years
Information technology	2.5 to 15 years
Motor vehicles	5 to 12.5 years
Other plant and equipment	2.5 to 15 years

The residual value of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Intangible assets comprise computer software products acquired by Wairarapa DHB and are stated at cost less accumulated amortisation and impairment losses.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

<u>Type of asset</u>	<u>Estimated life</u>
Software	2 to 5 years

Impairment

The carrying amounts of Wairarapa DHB's assets, inventories and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance sheet date and was estimated at the date of transition.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

For non-cash generating assets that are not part of a cash generating unit value in use is based on depreciated replacement cost (DRC). For cash generating assets value in use is determined by estimating future cash flows from the use and ultimate disposal of the asset and discounting these to their present value using a pre-tax discount rate that reflects current market rates and the risks specific to the asset.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Investments

Investments, including those in subsidiary and associated companies, are stated at the lower of cost and net realisable value. Any decreases are recognised in the Statement of Financial Performance.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Inventories

Inventories are stated at the lower of cost and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cost is based on weighted average cost.

Inventories held for distribution

Inventories held for distribution are stated at the lower of cost and current replacement cost.

Cash and cash equivalents

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

Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of financial performance as incurred.

Defined benefit plan

Wairarapa DHB's net obligation in respect of defined benefit pension plans is calculated separately for each plan by estimating the amount of future benefit that employees have earned in return for their service in the current and prior periods; that benefit is discounted to determine its present value, and the fair value of any plan assets is deducted. The discount rate is the yield at the balance sheet date on New Zealand government bonds that have maturity dates approximating to the terms of Wairarapa DHB's obligations. The calculation is performed by a qualified actuary using the projected unit credit method.

When the benefits of a plan are improved, the portion of the increased benefit relating to past service by employees is recognised as an expense in the statement of financial performance on a straight-line basis over the average period until the benefits become vested. To the extent that the benefits vest immediately, the expense is recognised immediately in the statement of financial performance.

All actuarial gains and losses as at 1 July 2006, the date of transition to NZIFRSs, were recognised. Likewise, all actuarial gains and losses that arise subsequent to the transition date in calculating Wairarapa DHB's obligation in respect of a plan are recognised in the statement of financial performance.

Long service leave, sabbatical leave and retirement gratuities

Wairarapa DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

Annual leave, conference leave, sick leave and medical education leave

Annual leave, sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount Wairarapa DHB expects to pay. Wairarapa DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Provisions

A provision is recognised when Wairarapa DHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring

A provision for restructuring is recognised when Wairarapa DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Trade & other payables

Trade and other payables are stated at amortised cost using the effective interest rate.

Cost of Service Statements

The cost of service statements, as reported in the statement of objectives and service performance, report the net cost of services for the outputs of Wairarapa DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost Allocation

Wairarapa DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to major board activities. Indirect costs are charged to major board activities based on cost drivers and related activity/usage information.

Criteria for Direct and Indirect Costs

Direct costs are those costs directly attributable to a specific Wairarapa DHB activity.

Indirect costs are those costs which cannot be identified in an economically feasible manner with a specific Wairarapa DHB activity.

Cost Drivers for Allocation of Indirect Costs

The cost of internal services not directly charged to board activities is allocated as overheads using appropriate cost drivers such as direct cost ratios, actual usage, staff numbers and floor area.

APPENDIX THREE

PROJECTED FINANCIAL STATEMENTS

A. Projected Statement of Comprehensive Income

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Revenue	117,973	121,599	123,258	126,062	128,860
Operating Expenditure					
Workforce costs	36,466	36,672	36,999	37,519	38,005
Treatment related costs	19,543	18,044	17,679	17,928	18,163
External providers	40,843	43,386	42,352	42,948	43,502
Inter district flows	20,674	23,132	24,056	24,395	24,711
Total Operating Expenditure	117,526	121,234	121,086	122,790	124,381
Result before Interest, Depreciation & Capital Charge	447	365	2,172	3,272	4,479
Interest, Depreciation & Capital Charge					
Interest expense	1,958	1,880	1,800	1,825	1,849
Depreciation & amortisation	1,912	2,123	2,081	2,110	2,137
Capital charge	685	562	480	487	493
Total Interest, Depreciation & Capital Charge	4,555	4,565	4,361	4,422	4,479
Net Operating Results	(4,108)	(4,200)	(2,189)	(1,150)	0
Other comprehensive income					
Gain / (loss) on property revaluations	0	0	0	0	0
Total other comprehensive income	0	0	0	0	0
Total comprehensive income	(4,108)	(4,200)	(2,189)	(1,150)	0
Total comprehensive income attributable to:					
Wairarapa District Health Board	(4,108)	(4,200)	(2,189)	(1,150)	0
Non-controlling interest	0	0	0	0	0

B. Projected Statement of Financial Position

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Assets					
Property, Plant & Equipment	42,269	42,662	40,194	38,975	37,732
Intangible Assets	516	784	1,296	2,055	2,811
Investments	103	103	103	103	103
Trust Fund Investments	61	52	52	52	52
Total Non-Current Assets	42,949	43,601	41,645	41,185	40,698
Cash & Cash Equivalents	(1,260)	(1,698)	77	1,577	2,114
Inventories	698	697	700	700	700
Trade & Other Receivables	3,998	4,064	3,962	3,963	3,964
Assets Classified as Held for Sale	2,300	2,300	0	0	0
Total Current Assets	5,736	5,363	4,739	6,240	6,778
Total Assets	48,685	48,964	46,384	47,425	47,476
Equity					
Crown Equity	18,854	23,283	25,480	26,627	26,624
Revaluation Reserve	1,479	1,479	1,479	1,479	1,479
Retained Earnings	(15,247)	(19,447)	(21,636)	(22,786)	(22,786)
Total Equity	5,086	5,315	5,323	5,320	5,317
Liabilities					
Interest-Bearing Loans & Liabilities	20,208	20,600	20,925	20,850	21,275
Employee Benefits	520	486	486	486	486
Trust Funds	61	150	60	60	60
Total Non-Current Liabilities	20,789	21,236	21,471	21,396	21,821
Interest-Bearing Loans & Liabilities	5,557	5,307	5,057	4,807	4,057
Payables & Accruals	10,671	11,144	8,461	9,820	10,189
Employee Benefits	6,582	5,962	6,072	6,082	6,092
Total Current Liabilities	22,810	22,413	19,590	20,709	20,338
Total Liabilities	43,599	43,649	41,061	42,105	42,159
Total Equity & Liabilities	48,685	48,964	46,384	47,425	47,476

C. Projected Statement of Movements in Equity

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Balance at 1 July	8,606	5,086	5,315	5,323	5,320
Total comprehensive income previously reported	(4,108)	(4,200)	(2,189)	(1,150)	0
Effect on retained earnings of restatement	0	0	0	0	0
Total comprehensive income as restated	(4,108)	(4,200)	(2,189)	(1,150)	0
Equity injection from the Crown	591	4,432	2,200	1,150	0
Repayment of equity to the Crown	(3)	(3)	(3)	(3)	(3)
Movements in equity for the year	588	4,429	2,197	1,147	(3)
Balance at 30 June	5,086	5,315	5,323	5,320	5,317
Total comprehensive income attributable to:					
Wairarapa District Health Board	(4,108)	(4,200)	(2,189)	(1,150)	0
Non-controlling interest	0	0	0	0	0
Total comprehensive income	(4,108)	(4,200)	(2,189)	(1,150)	0

D. Projected Statement of Cash Flows

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Cash Flows From Operating Activities					
Operating Receipts	117,202	121,599	123,258	126,062	128,860
Interest Received	360	100	111	180	180
Payments to Supplies & Employees	(116,254)	(121,239)	(122,625)	(122,327)	(124,932)
Capital Charge Paid	(811)	(562)	(480)	(487)	(493)
Interest Paid	(1,958)	(1,850)	(1,440)	(1,200)	(1,200)
Taxes paid (net)	66	0	0	0	0
Total Cash Flows From Operating Activities	(1,395)	(1,952)	(1,176)	2,228	2,415
Cash Flows From Investing Activities					
Proceeds From Sale of Property, Plant & Equipment	0	0	2,300	0	0
Dividends received	17	50	25	25	25
Acquisition of Property, Plant & Equipment	(1,834)	(2,874)	(600)	(650)	(650)
Acquisition of Intangible Assets	(378)	(93)	(750)	(1,000)	(1,000)
Total Cash Flows From Investing Activities	(2,195)	(2,917)	975	(1,625)	(1,625)
Cash Flows From Financing Activities					
Loans Drawn Down	120	350	152	120	120
Equity Injected	590	4,435	2,200	1,150	0
Repayment of Loans	(358)	(351)	(373)	(370)	(370)
Repayment of Equity	(3)	(3)	(3)	(3)	(3)
Decrease in Investments & Restricted Funds Movement	7	0	0	0	0
Total Cash Flows From Financing Activities	356	4,431	1,976	897	(253)
Net Increase in Cash Held	(3,234)	(438)	1,775	1,500	537
Cash & Cash Equivalents at Beginning of the Year	1,974	(1,260)	(1,698)	77	1,577
Cash & Cash Equivalents at End of the Year	(1,260)	(1,698)	77	1,577	2,114

E. Projected Cost of Service Statements

Output Class Summary

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Hospital Services	65,416	67,609	65,694	66,853	67,948
Primary & Community Health Services	37,636	38,442	39,442	39,787	40,097
Public Health Services	2,710	2,622	2,095	2,125	2,153
Support Services	16,319	17,126	18,216	18,447	18,662
Total Operating Expenditure	122,081	125,799	125,447	127,212	128,860
Revenue					
Hospital Services	61,308	63,409	63,505	65,703	67,948
Primary & Community Health Services	37,636	38,442	39,442	39,787	40,097
Public Health Services	2,710	2,622	2,095	2,125	2,153
Support Services	16,319	17,126	18,216	18,447	18,662
Total Revenue	117,973	121,599	123,258	126,062	128,860
Net Operating Results	(4,108)	(4,200)	(2,189)	(1,150)	0

The following four tables show the costs of service for the four output classes.

I. Public Health Services

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Workforce costs	1,188	1,228	1,135	1,151	1,166
Treatment related costs	255	198	127	129	131
External providers	1,063	991	679	689	698
Inter district flows	0	0	0	0	0
Depreciation & amortisation	1	1	1	1	1
Total Operating Expenditure	2,507	2,418	1,942	1,970	1,996
Allocation of corporate costs	203	204	153	155	157
Total Cost of Service	2,710	2,622	2,095	2,125	2,153
Revenue	2,710	2,622	2,095	2,125	2,153
Net Result of Service	0	0	0	0	0

II. Primary & Community Health Services

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Workforce costs	4,924	4,122	4,134	4,042	3,944
Treatment related costs	1,064	1,116	968	985	998
External providers	27,039	28,149	27,456	27,957	28,433
Inter district flows	1,688	1,920	1,934	1,982	2,034
Depreciation & amortisation	105	144	153	155	157
Total Operating Expenditure	34,820	35,451	34,645	35,121	35,566
Allocation of corporate costs	2,816	2,991	4,797	4,793	4,782
Total Cost of Service	37,636	38,442	39,442	39,914	40,348
Revenue	37,636	38,442	39,442	39,914	40,348
Net Result of Service	0	0	0	0	0

III. Hospital Services

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Workforce costs	25,880	27,175	27,350	28,134	27,998
Treatment related costs	14,523	13,322	12,681	13,560	13,338
External providers	451	763	767	775	777
Inter district flows	17,943	19,577	18,869	21,129	21,360
Depreciation & amortisation	1,716	1,490	1,631	1,654	1,675
Total Operating Expenditure	60,513	62,327	61,298	65,252	65,148
Allocation of corporate costs	4,903	5,282	4,396	1,601	2,800
Total Cost of Service	65,416	67,609	65,694	66,853	67,948
Revenue	61,308	63,409	63,505	65,703	67,948
Net Result of Service	(4,108)	(4,200)	(2,189)	(1,150)	0

IV. Support Services

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Operating Expenditure					
Workforce costs	815	980	996	1,010	1,023
Treatment related costs	574	540	580	588	596
External providers	12,665	13,084	14,044	14,242	14,426
Inter district flows	1,043	1,188	1,252	1,284	1,317
Depreciation & amortisation	1	1	1	1	1
Total Operating Expenditure	15,098	15,793	16,873	17,125	17,363
Allocation of corporate costs	1,221	1,333	1,343	1,322	1,299
Total Cost of Service	16,319	17,126	18,216	18,447	18,662
Revenue	16,319	17,126	18,216	18,447	18,662
Net Result of Service	0	0	0	0	0

F. Funding Arm Financial Summary

The following table shows the summary financial performance for the three funding arms of the Wairarapa DHB as disclosed in previous DAPs.

	2008/09 Actual \$000	2009/10 Forecast \$000	2010/11 Projection \$000	2011/12 Projection \$000	2012/13 Projection \$000
Revenue					
Funds	111,314	114,446	115,789	118,487	121,185
Governance & Funding Administration	2,067	3,207	3,438	3,486	3,534
Provider	54,976	55,010	55,600	56,385	57,112
Internal Eliminations	(50,384)	(51,064)	(51,569)	(52,296)	(52,971)
Total Revenue	117,973	121,599	123,258	126,062	128,860
Operating Expenditure					
Funds	112,066	117,946	117,978	119,638	121,185
Governance & Funding Administration	2,195	3,206	3,438	3,486	3,534
Provider	58,204	55,711	55,600	56,384	57,112
Internal Eliminations	(50,384)	(51,064)	(51,569)	(52,296)	(52,971)
Total Operating Expenditure	122,081	125,799	125,447	127,212	128,860
Net Operating Results					
Funds	(752)	(3,500)	(2,189)	(1,151)	0
Governance & Funding Administration	(128)	1	0	0	0
Provider	(3,228)	(701)	0	1	0
Internal Eliminations	0	0	0	0	0
Total Net Operating Results	(4,108)	(4,200)	(2,189)	(1,150)	0