planning, provide greater evidence of changes to health outcomes, enable better targeting of funding, and inform decisions regarding clinical service delivery." At this stage, TDH has met all requirements to support the National Pricing Project.

Action Zone 10: Primary Care Information

The focus is on improving clinical governance and population health through the effective use of primary health information. This includes the standards, data capture and information exchange mechanisms required for the sector to derive real value from distributed primary care information. Currently, the systems capability and collaboration needed to support Action Zone 10 varies considerably across primary care services in New Zealand.

In addition to the progress on action zones as noted above, TDH response to this action zone at the local level has been to promote the uptake and usage by local GP's of an electronic PMS system. This has reached the stage where all Tairawhiti GPs are using the MedTech 32 system. Subsequent to this, we have opened discussions via our GPIT liaison group in respect of next steps, which may include a single instance of the MedTech 32 system shared by all practises, with concurrent agreement on how the system is used, and the implementation of standards. TDH is progressing this discussion within the GPIT Liaison Group and more recently has commenced the same discussion with Pinnacle Group who provides management services to the majority of the Tairawhiti GP practises.

Action Zone 11: National System Access

National System Access is to be delivered through a cohesive set of policies, processes, and information technology initiatives that will enable improved access to National Systems. In practice, this is one of the least developed Action Zones and at this stage, TDH awaits further clarification.

Action Zone 12: Anchoring Framework

This action zone is to develop and implement a framework for the identification, prioritisation, coordination and governance of key enablers for information sharing and interoperability within the Health and Disability sector, including (but not limited to) standardised architectural and data models, business processes, information technologies and usage principles and policies. However, like action zone 11, this needs further work before TDH can engage.

6.4.2 Information Technology

Technical Infrastructure

Work has continued this year, building on previous years work with respect to technical infrastructure and providing a secure and robust environment. This work will be ongoing given the ever changing nature of technology and the threats to information that arise from it. Planning focus has increased from purely security driven goals towards increasing availability through redundancy. Under this heading, a number of activities have been carried out:

- Redundant firewall/routeing installed on the internal network.
- Increased use of virtualisation (multiple servers hosted on a single hardware platform).

- Reconfiguration of various aspects of the network infrastructure to allow for growth and increased security for various aspects of the TDH operation.
- Commencement of a wireless trial to allow tablet computers for clinicians at the bedside. There is still a good deal of work to complete on this project before an evaluation can be conducted.
- Updating servers from Windows Server 2003 to Windows server 2008 has commenced and will continue over the coming year.
- Completed edge network switch upgrade to consistent platform.
- Implementation of Philips support network for improved Radiology support.

Software Management

TDH continues to utilise the Microsoft G2006 licensing Agreement, which has had material impact upon our Microsoft licensing costs. Microsoft instigated an audit in February, for which the DHB supplied information.

Front Line Support

The workload for first level desktop support remains consistent, and well below that of a few years ago. Improvements to build procedures and software distribution continue to improve the end user experience and further improvements are planned.

Asset Management

A capital replacement plan has been instigated based on the work carried out in the previous year and it includes desktop computers, and server's network components. This year 80 workstations were replaced and two servers.

6.4.3 Clinical Records

Archiving

With a growth in the number of Clinical Records, there has been increasing pressure on storage space. This year saw the development of both a secondary files room, and the Clinical Records Archive facility. The archive facility has had to be provisioned throughout the year with the implementation of mobile shelving units to increase storage space and address health and safety concerns, and additionally with a number of attributes to meet security standards for storing Clinical information.

6.4.4 Clinical Coding

Upgrades to the Coding software and system have been implemented through the year and the coding function is progressing well with the only material concern relating to the delay in receiving the fully completed documentation following the discharge of the patient. TDH continues to meet the NZHIS standard for timely discharge processing.

A third staff member completed a national Coding Qualification (Coders being a very scarce and valuable resource), and commenced coding in August 2007. This provides TDH with three qualified Coders.

7.0 PROVIDING SERVICES

7.1 MATERNAL CHILD AND YOUTH HEALTH SERVICES

The Maternal, Child and Youth Health Group, is managed from the Morris Adair Building. The service employs 144 staff members, who make up 104.61 full time equivalent positions. Currently there are 100.75 FTE employed and 3.86 FTE vacancies.

7.1.1 Maternal Health

The Maternity Unit consists of 5 birthing suites and 10 inpatient beds. It caters for approximately 750 births per year.

The main quality highlights for maternity services over the past year include:

- Maintenance of Baby Friendly Hospital Initiative Accreditation.
- Ongoing Recruitment of new midwives.
- Initiation of a move to having at least two midwives per shift.
- Purchase of new remote monitoring equipment for mothers in labour.
- The opening of a garden for use by mothers and Whanau.
- Implementation of an HIV screening option for mothers.

The main issues facing Maternity Services currently include:

- Demanding educational requirements to maintain registration.
- Retention of the midwifery workforce.

7.1.2 Child Health

“Planet Sunshine” (the Children’s Ward) is a 16 bed Paediatric unit, which accommodates medical and surgical inpatients and also provides for Paediatric outpatient clinics. There is 1 House Officer and 3.2 FTE Paediatricians (including a community Paediatrician) who also oversee the Level 2, six-bed Neonatal Unit. Planet Sunshine is also the base for the Paediatric outreach nursing service, which cares for children in the community who would otherwise require hospital treatment.

The Child Development Service provides an ongoing assessment and therapy service for children up to school leaving age that have neurological and developmental disabilities. This service is provided largely in the community.

The main quality highlights for the year were:

- Strengthening of the branding of our Children’s Ward “Planet Sunshine”.
- Improving the décor and reflecting the bicultural nature of our client group.
- A move toward integration with former Public Health Unit child-focused services.
- Fundraising efforts to assist with minor capital projects.
- Development of a specialist oncology room.
- Strengthening of the Paediatric outreach service.

The main issues facing Child Health Services currently include:

- Maintaining safe staffing levels while living within a challenging budget.
- Retention of senior nursing staff.
- A need to reduce the numbers of Ambulatory sensitive admissions.

- Maintaining a friendly and accessible environment while ensuring patient safety.
- Managing demand for Child Developmental Services.
- Recruitment of a further Paediatrician.

7.1.3 Adolescent Health

The Child and Adolescent Mental Health Service or CAHMS is a multi-disciplinary team working to provide assessment, counselling and support services for young adults and their families. They currently contract the services of visiting Child Psychiatrists, but are looking to recruit a permanent Child Psychiatrist for this district.

The main quality highlights for the year were:

- Recruitment of new staffing positions in accordance with the Williment Report.
- Extension of physical facilities for staff.
- Implementation of new referral systems for clients.
- Recruitment of 2 extra visiting Child Psychiatrists for the service.

The main issues facing Child and Adolescent Mental Health Services currently include:

- Insufficient arrangements for offering acute and ongoing respite care to clients.
- Need to improve information systems.
- The need to strengthen our ability to deal with eating disorder cases

7.1.4 Community Services

In October 2007, several services from the former Public Health Unit were transferred to Maternal Child and Youth.

Well Child, incorporating Public Health Nurses, Hearing and Vision testers, and Immunisation services. This service provides a variety of primary health services to children and youth within our community.

The School Dental Service provides on site services to the children of our district through a combination of static and mobile clinics. This service has been the subject of a recent major review and the “Oral Health Business Case” will be rolled out progressively over the next few months.

The Cervical Screening Service provides Database administration, promotion for, and actual cervical screening services.

The Sexual Health Clinic is located in Bright Street and provides a range of sexual health services including diagnosis and treatment of STDs, education, contraception and counselling related to the termination of pregnancy.

The main quality highlights for the year were:

- Smooth integration to the new management structure.
- Relocation of Cervical Screening Services to Women’s Health Clinical Area.

The main issues facing Community Services currently include:

- Need to improve information systems.
- Need for more integration of well child services with the Paediatric Outreach team.

7.1.5 Clerical Support Services

Clerical support services are provided to support all MCY departments, plus the Diabetes Educator, Dietetics and the Obstetricians and Gynaecologists.

The main quality highlights for the year were:

- Far greater multi-tasking within the service
- Establishment of centralised clerical budgeting
- Establishment of a train pool of casual staff

The main issues facing Clerical Support Services currently include:

- Control of office-related expenditure
- Maintaining a skilled and trained workforce
- Implementation of the new Patient Management System (iPMS)

7.2 ADULT SERVICES

A full and comprehensive service review was undertaken of the Adult Group in October 2007. This followed an organisational review undertaken by the Chief Executive, which aligned the Community and Older Persons Service with the Adult Group. The service was renamed Adult Integrated Services and individual departments were realigned and a clinical leadership framework was introduced. The new structure is now fully implemented with all key leadership positions in place.

Adult Integrated Services comprises four key areas, which encapsulate the adult patient journey at Gisborne Hospital to access services from entry to exit to community based services. These include Ambulatory Services, Inpatient Services, Perioperative Services and integrated services, which includes all Allied Health staff and community based care. Implementation of a new clinical leadership structure will drive the achievement of our overall goal for the Adult Integrated Services team. This goal is to apply lean thinking principles to optimize the patient journey and utilisation of resources, reduce clinical incidents and errors, improve communication with patients and whanau, and achieve the objectives of our District Annual Plan.

7.2.1 Ambulatory Services

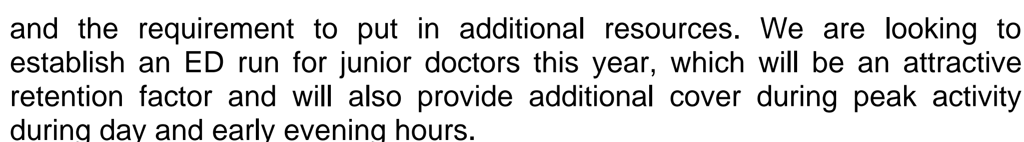
Outpatients

The Outpatient Department plays a lead role in the Elective Services Patient Indicators (ESPIs) programme and is running more effectively under the new management structure. Currently we are working on a master schedule and production plan for all outpatient activity for the coming year and this will be monitored by steering groups in relevant specialties.

Following preparation for the National Cervical Screening audit, we are now undertaking all Lletz procedures in the outpatient setting. Roles and responsibilities have been defined and the gynapp database is being utilised effectively, which populates nationally collected data to the NCSU. Most of the recommendations of the audit have been implemented.

Emergency Department

It is now nearly two years since the medical staff in ED came back under the TDH organisational structure. This transition has gone very well. This past year has seen a marked increase of 1600 presentations to the department



and the requirement to put in additional resources. We are looking to establish an ED run for junior doctors this year, which will be an attractive retention factor and will also provide additional cover during peak activity during day and early evening hours.

7.2.2 Inpatient Services

Following the Adult Services review, all inpatient facilities have been integrated under a clinical management framework.

Inpatient activity has been fairly constant over the past year without the usual slow down over the summer months. Current key areas of focus for us was the preparation for the certification and accreditation progress visit in July and the result of this audit was excellent with 1 recommendation for the Adult Group. There has been significant improvement in ICU over the past six months with a strong recruitment drive alongside an education program to expedite an increase in knowledge and skill mix in that clinical area. The surgical ward lost some staff to ICU but we are gradually rebuilding this unit. This coming year there will be some considerable focus on discharge planning processes and coordination.

7.2.3 Perioperative Services

The key challenge for the Perioperative service is the recruitment of experienced and/or trainable theatre staff to fill current vacancies, which impact on our ability to deliver expected volume. There is current attention to the percentage of Day of Surgery and Day case admissions as there appeared to be a deterioration of this indicator. Preliminary analysis is indicating a drop off in Day case surgery, which skews the overall data for these patient subsets. We will determine if recent innovative projects, which have shifted some day case volume to an outpatient setting, is the cause of this shift in day case volume e.g. Lletz procedures and cystoscopies. There is pressure on theatre's physical facilities to meet both our acute and elective volume particularly in light of the additional elective work that we have committed to.

7.2.4 Integrated Services

Integrated Services is comprised of District Nursing, Physiotherapy, Occupational Therapy, Social Work, Dietetics, Orthotics, Speech Language Therapy, and Clinical Nurse Specialists for Renal, Cardiac Rehab, Respiratory, Chronic Heart Failure, Diabetes, Wound Care, and Continence. Realignment of these services within the Adult Group has forced shorter lines of communication between entry and inpatient service providers with their allied health colleagues and improved interaction and coordination of these services, which are integral to transitioning patient care from hospital to home.

Throughput remains reasonably constant through these services. The outpatient waiting list for physiotherapy has been significantly reduced with the recruitment of a physiotherapist. The accreditation audit for this group against SNZ HB 8171.1:2005 occurred on 31 March and most standards were met with an action plan for those that were not met.

There has been a marked increase in time units utilised with patients in the District Nursing service. Time units are an indicator of complexity measured

by the amount of time spent with the patient. A 'complexity' audit was undertaken by the District Nursing Service comparing March 2008 with the findings of the same audit undertaken in October 2007 when time units were noted to increase. There is evidence that patients being discharged are more complex and require greater support with personal and clinical cares in the home environment. This has required additional resources but on a casual basis.

	2007	**2008**
Age	58%> 65 years	70%> 65 years
Living alone	64%> 75 years alone	71%>75years alone
Co-morbidity	72% with co-morbidity	89% with co-morbidity
Other MDT input	65%	75%
Stability	12% deemed unstable	68% deemed unstable

The new position of Oncology Social Worker has been filled 0.5FTE and is working closely with the Oncology Clinical Nurse Specialist. The Paediatric Social Worker remains within this service group to maintain professional alliance with the Social Work team at this stage, and this position will be reviewed at the end of the financial year. The Paediatric Outreach Service is now fully functional, and the Social Worker has been involved in promotion of this service. The team has worked hard at building relationships with organisations such as Life Unlimited in improving access for patients under 65 to funding for home support services, and with the NASC team internally for the over 65yr group. There have been challenges with the ACC/NASC interface for patients with pre-existing conditions, and this coordination role takes Social Workers away from core business.

The Occupational Therapy team has had chronic staffing issues this year, resulting in the community waiting list increasing at one point to 15 months. The team will be fully staffed again by September, and arrangements have been made for an overlap of staffing to allow the waiting list to be brought down to less than 6 months. The resignation of both the Occupational Therapist and Physiotherapist from the Wheelchair and Seating service has highlighted the clinical risk of providing a specialist service, and all Occupational Therapists are now receiving a basic wheelchair and seating training, with two therapists training to a more complex level of seating skills. This succession planning should prevent this from occurring again in the future.

7.2.5 Issues:

Workforce

Workforce recruitment and retention remains a constant project but is being managed well. Locums continue to form part of our medical workforce and enable us to have appropriate on call rosters. Currently we are not carrying any vacancies for medical staff positions, which is encouraging as we face a year with considerable targets to be achieved. Nursing recruitment has been problematic in specialty areas and currently we are exploring way to strengthen our theatre team. Recruitment to the Allied Health teams has been difficult this past year and there are still vacant positions.

Elective Service Patient Indicators

Maintenance of Elective Services Patient Indicators (ESPIs) remains a key work stream and it is important to gain and maintain compliance at service

level for each specialty as the there is a financial downstream effect if this is not achieved. There is a steering group in place, which meets on a regular basis to implement and monitor recovery plans.

We did not meet our elective surgical throughput targets for the 2007/08 year. We under-delivered by seven joint replacements under the Orthopaedic Initiative and did not complete all the additional elective surgery. We were also behind in general surgical case weight delivery. We are implementing production plans to improve the phasing of the elective work.

Renal Services

Demands on the renal service are exceeding earlier forecast volumes by a considerable margin. In December 2007, there were 23 patients in the district currently receiving Continuous Ambulatory Peritoneal Dialysis (CAPD). At the end of March 2008, 29 patients were receiving CAPD, which demonstrates a 26 percent increase in demand for the first quarter. The research undertaken for the Renal Services Plan for Midland in 2004 predicted we would have 26 patients by 2010. Our visiting renal specialist is seeing patients currently who have significantly diminished renal function and predicts we could have between 35 – 40 patients on CAPD by the end of 2008. This will impact significantly on our ability to fund these services and is a source of pressure to embark on the planning and funding of a renal satellite dialysis centre.

Cardiac / Pulmonary Rehabilitation

Initial meetings have taken place to explore the possibility of having our cardiac and pulmonary rehabilitation programmes delivered in a community based setting utilising the equipment and skills of the YMCA and Sport Gisborne. This project is being driven by the Clinical Nurse Specialists who currently undertake these programs in a hospital based setting. There is a desire to utilise a different model of care delivery which is more far reaching and focussed on life style changes that are permanent than the current “patient” focused model. This is a very exciting and innovative project and demonstrates the collective skills of clinicians working with trained health and fitness specialists based in the community.

7.3 MENTAL HEALTH

Mental Health and Addiction Services (MH&AS) provider arm services provide the following Adult and Older Adult Secondary Specialist Care Services.

Te Whare Awhiora/Ward 11 – acute psychiatric inpatient unit – eight beds and three seclusion rooms. The beds are for adolescents, adult and older adults.

Community Mental Health Services with the following teams:

- Psychiatric Assessment Triage Team (PATT)
- Mobile Intensive Treatment Team (MITT)
- Key workers team (K/W)
- Therapy/counselling team
- Older Adult Team (OAT)
- Maternal Mental Health
- Friendship House (FH) daily activities programme.

Cultural Assessment Team are situated in community and Kaiawhina and Kaitakawaenga work across all MH&AS

Awhina House – Addictions assessment, care and treatment. Methadone Programme consists of doctor, nurse, clinical psychologist, and counsellors.

Child and Adolescent Mental Health Services (CAMHS) sit with Maternal Child and Youth (MC&Y) services in Tairawhiti. Adult MH&AS maintains a synergistic relationship with CAMHS. We provide psychiatric assessment triage and on-call psychiatrist after hours, weekends, and public holidays. CAMHS team access inpatient beds for youth, and adult psychiatrist input during business hours.

Adult & Older Adult MH&AS Review Recommendations

A review of Adult and Older Adult MH&AS has been completed and the Funder/Planner Arm is waiting for submissions and feedback from sector and community stakeholder(s). It is anticipated there are significant changes ahead for the secondary specialist TDH MH&AS who hold the majority of clinical service provision agreements which relates to managing very high risks associated with the following responsibilities with financial implications;

Service Provision – capacity, capability, competency, sustainability including access and responsiveness.

Service Practice - legislation requirements; Mental Health Act, Health Practitioners Competency Assurance Act (HPCAA), Privacy Act, Health Sharing Information Code, Smoke Free Act, Health and Disability Code of Rights, Clinical responsibility, Responsible Clinician and Duly Authorised Officers as per the MH Act.

Quality and National Information Collection, reporting and auditing systems requirement and obligations – Quality Health NZ Accreditation Standards, Use of Seclusion, Electroconvulsive Therapy use, Non financial reporting to MoH, Financial reporting to MoH, Local Quality Plan Key Performance Indicators (KPI) and Business Plan KPI's, Implementation of National Quality Information Systems KPI's, Consumer Surveys, local, regional and national Workforce Development, recruitment and retention and local Information Sharing Plan.

National Forensic Implementation Framework

The Capital Coast DHB (CCDHB) Forensic team have distributed their Central Regional Forensic five-year plan for review. The recent national review of the 2001 Implementation Forensic MH plan does not provide a financial or operational strategy to assist general Adult MH&AS providers and Child and Youth MH&AS providers to have opportunities to build extra capacity and capability for forensic clients. This concern will be expressed in the feedback report. We wish to seek an assertive consultative and collaborative approach with CCDHB forensic services and their staff to ensure transitional and integrative planning with whanau/families is paramount when transitioning people with mental illness and high needs to Tairawhiti.

Local MH&AS network Tairawhiti Local Advisory Group – Mental Health (TLAG)

The Local MH&AS sector comprises of all at the current agreement holders and interested stakeholders, who together form TLAG which provides an oversight/monitoring role to the improvement of Mental Health Services in the district.

Quality

It is anticipated that the National Mental Health Standards (NMHS) will be integrated into Quality Health NZ Accreditation Standards in 2008. TDH MH&AS staff will continue to monitor, review and report clinical and cultural practices against the NMHS until notified by MoH of the situation with NMHS. In addition, MH&AS staff participate assertively in reviewing and reporting their ongoing performance against TDH approved accreditation standards according to the Quality Health NZ (QHNZ) framework.

MH&AS have established robust quality systems and processes. Quality is owned by staff and quality has moved to a bottom up process. We have several forums, which include clerical and non-clerical, and Mentally, Healthy Workplace champion forums. The recent accreditation certification audit team has signed off the action plan as being completed. It is anticipated that we will develop a plan to reduce the use of tobacco products in the acute inpatient unit and seclusion area of Te Whare Awhiora in response to the certification audit recommendation in June 2008. The plan will also include working in collaboration with service users and smoking cessation support workers in the community to reduce the use of tobacco products and increase abstinence.

The Quality Audit Review Group (QARG) is made up with representatives from the local MH&AS sector including Maori and Pacific representatives. This group has a governance role, which focuses on monitoring outcomes, providing strategic direction for service improvement and continues quality improvement activities and trends. This group meets quarterly.

Recruitment and Retention

Recruitment and Retention has and is always challenging especially in the recruitment of Adult Consultant Psychiatrists and Clinical Psychologists. Fortunately, we have our FTE requirement of clinical psychologists, other allied Health Professionals, and nurses. We are assertively recruiting for 2 FTE Adult consultant Psychiatrists. The use of locum psychiatrist to cover leave and roster on call requirements will continue in the mean time.

7.4 CLINICAL SUPPORT SERVICES

7.4.1 Audiology

Audiology continued to provide support to the Ear Nose and Throat Specialists and also worked closely with other groups such as the Advisor on deaf children and ear nurse specialists.

Tairawhiti was selected to be one of the three lead DHB's for the implementation of newborn hearing screening

The demand for hearing tests and fitting of hearing aids continued to increase and we are in the process of recruiting a second audiologist.

7.4.2 Pharmacy

The department continued to be fully staffed with the return of the Chief Pharmacist after an absence of two years.

The upgrade of the sterile unit was postponed previously but the plans have been revisited with the intention to complete this initiative in the next financial year.

The Pharmacy Department is investigating new information systems, as the current system will become unsupported within the next year. The intention is to align themselves with other Pharmacies within the region.

7.4.3 Radiology

The Department was able to recruit two locums to support the residing Radiologist. Additional Radiologist sessions were purchased from a private radiology group mainly to provide interventional coverage. In addition, two external radiologists continued to provide on call coverage as well as reporting for CT, MR and ultrasound when required.

A contract was signed to upgrade I Site to Enterprise, which will provide almost the full functionality of a PACS (Picture Archiving Computerised System.) This upgrade will facilitate the roll out of reporting to several other external radiologists. A contract was also signed to obtain computerised radiology. Once installed all radiology modules will the be available electronically

7.4.4 Laboratory

TLab, a joint venture between Tairawhiti District Health and Medlab Central, has been providing laboratory services for the district since 1 September 2007.

8.0 STATEMENT OF SERVICE PERFORMANCE

TDH has clear targets of performance that are time framed and linked to its DSP, the New Zealand Health Strategy, and/or TDH's own key issues for 2007 08.

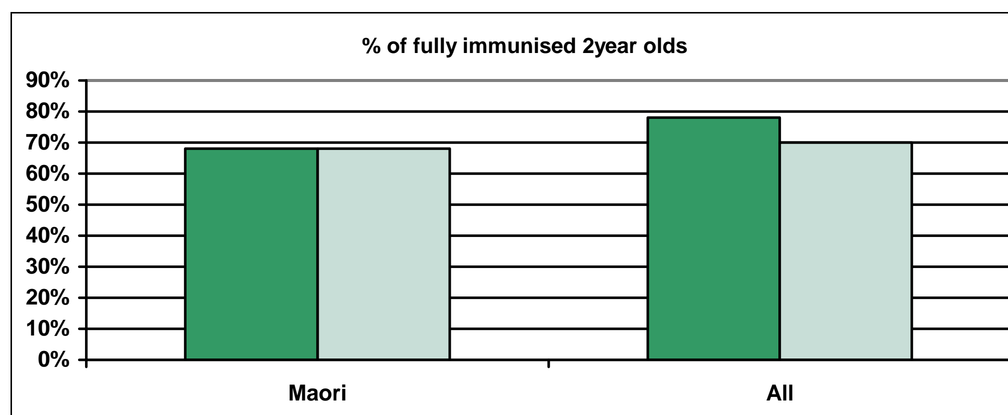
8.1 HEALTH TARGETS

The following targets provide the measures that reflect the Minister's Health Targets for 2007/08 and also sets the TDH expected achievements in respect of each target.

IMPROVING IMMUNISATION COVERAGE

National Indicator:

That 95% of two year olds are fully immunised with at least a 4 to 6% point increase on the 2005 National Immunisation Coverage Survey Baseline



2006/07		TDH Target	2007/08
N/A	Maori	68%	68%
N/A	All	78%	70%

Comment:

Partially achieved.

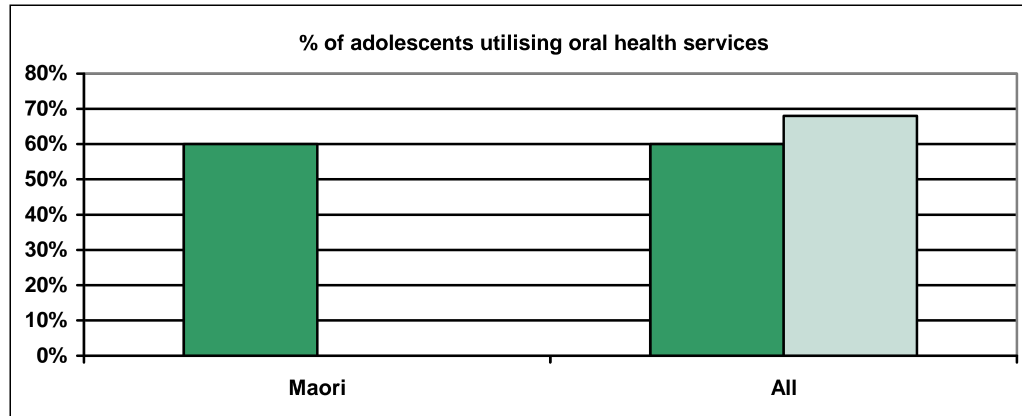
The targets were set high intentionally in order to provide an incentive to work hard to achieve them.

Part of the reason for non-achievement lies with data quality issues, as PHO Performance Monitoring data from GP patient management systems is higher than the National Immunisation Register data for Tairawhiti. A tool has been developed to reconcile these differences and is in the process of being applied to GP Practice Registers. TDH anticipates an improvement in reported coverage in 2009.

IMPROVING ORAL HEALTH

National Indicator:

Progress towards 85% adolescent oral health utilisation



2006/07		TDH Target	2007/08
N/A	Maori	60%	N/A
N/A	All	60%	68%

Comment:

Partially achieved.

The major reconfiguration of the district's community oral health services, commencing in 2008/09 and going through to 2011, will enable easier access to services, making them more appropriate to the needs of the child and adolescent services users in particular. This will enable the DHB to ensure that the national target of 85% utilisation is achieved.

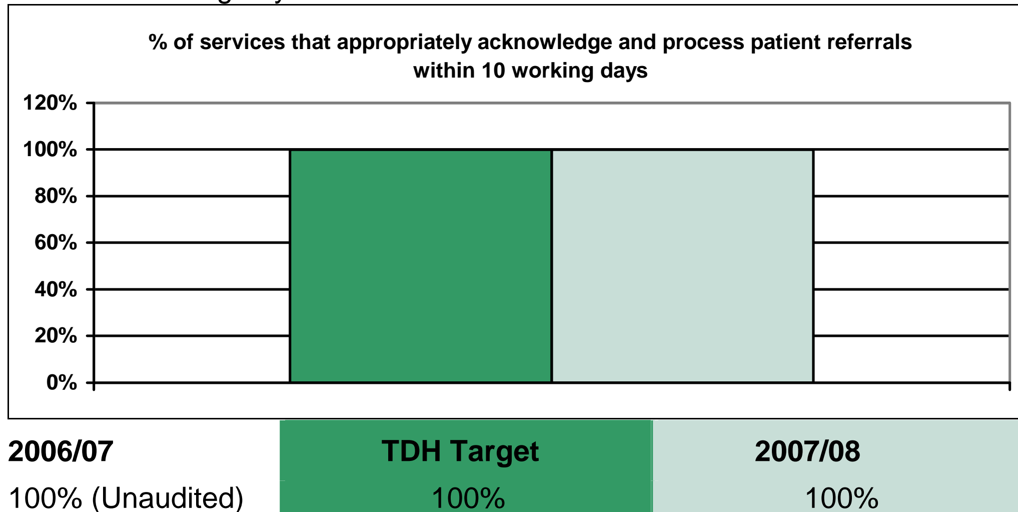
IMPROVING ELECTIVE SERVICES

National Indicator:

Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs)

ESPI 1:

DHB services that appropriately acknowledge and process all patient referrals within 10 working days



2006/07	TDH Target	2007/08
100% (Unaudited)	100%	100%

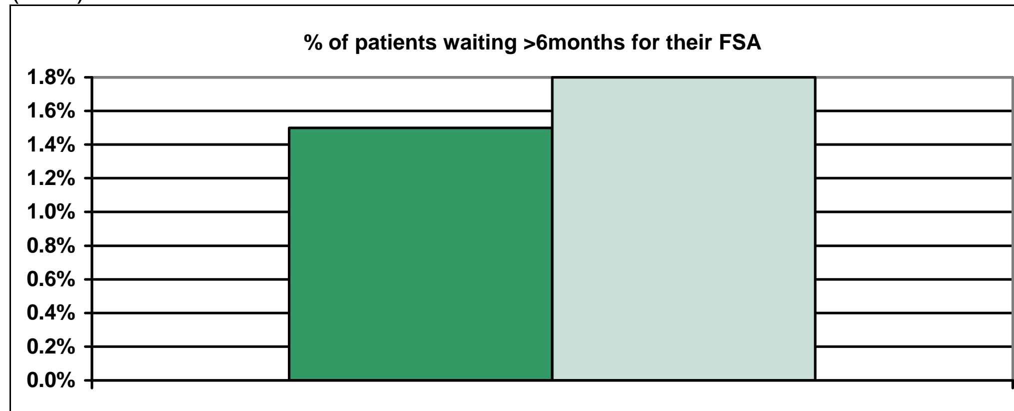
Comment:

Achieved.

Robust guidelines coupled with ongoing review have ensured this pleasing result. We are continually reviewing associated processes to ensure that they best meet the needs of the community and organisation. We are continuing to make enhancements to our referral management processes to facilitate quicker turn around times in the prioritisation of referrals by our team of visiting specialists.

ESPI 2:

Patients waiting longer than six months for their first specialist assessment (FSA)



2006/07	TDH Target	2007/08
1.4% (Unaudited)	<1.5%	1.8%

Comment:

Not achieved.

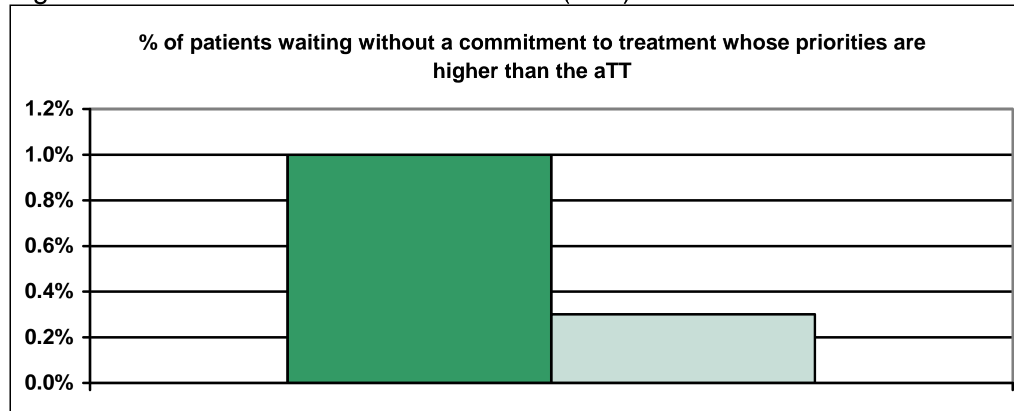
The impact of industrial action, which necessitated reductions in planned clinics coupled with clinician leave and revised clinician workloads, has had a negative impact. Additional locum support was sourced and additional clinics held to address backlogs.

Further work at individual service level is being undertaken e.g. the Otorhinolaryngology service has revised its referral management processes, with criteria now set and material developed by the service supplied to referrers in the event that service is declined. Additional resources have been applied to this speciality also, to address the backlog of referrals awaiting an FSA.

A working party has been formed to monitor referral inflows and outflows and devise both short-term and long-term strategies for continued ESPI 2 compliance. Work is being progressed in regards to the formulation of master clinic schedules and clinic configurations to ensure that these align with contractual volumes and ESPI compliance.

ESPI 3:

Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)



2006/07	TDH Target	2007/08
0% (Unaudited)	<1.0%	0.3%

Comment:

Achieved.

All patients with scores above the aTT are given a commitment to receive treatment.

ESPI 4:

Clarity of treatment status – no patients are on residual waiting lists.

2006/07	TDH Target	2007/08
0% (Unaudited)	0%	0%

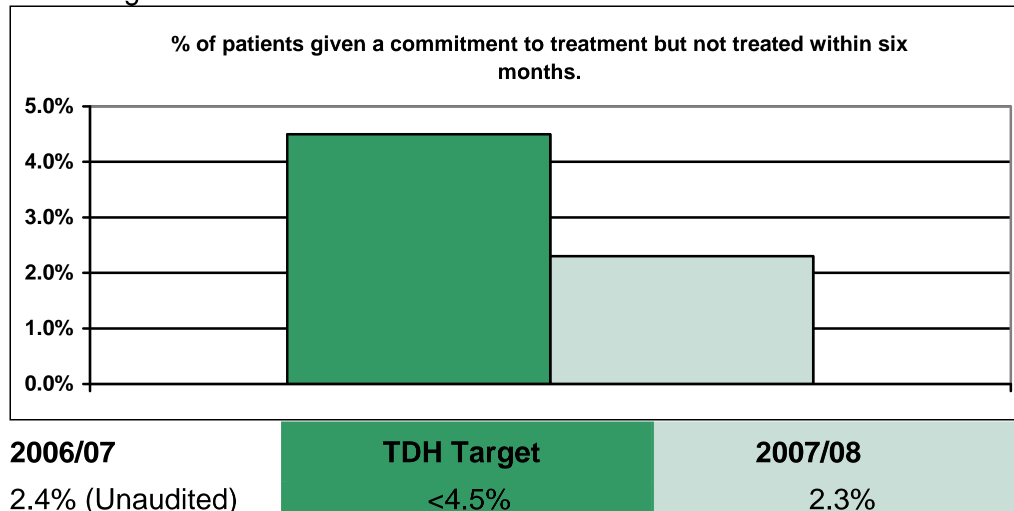
Comment:

Achieved.

Following a specialist assessment, all patients are informed of whether they will or not receive treatment. A 'residual' treatment list does not exist at Tairawhiti DHB.

ESPI 5:

Patients given a commitment to treatment but not treated within six months.



2006/07	TDH Target	2007/08
2.4% (Unaudited)	<4.5%	2.3%

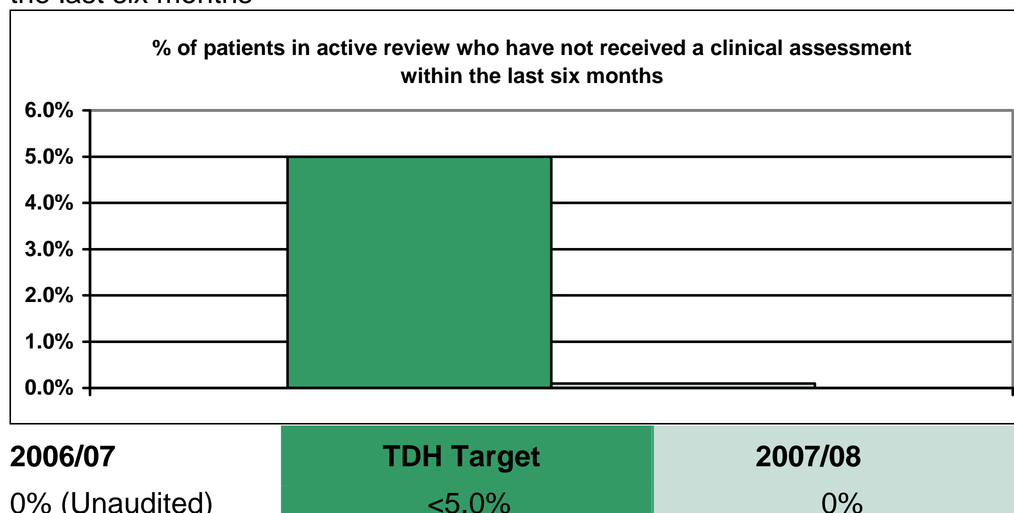
Comment:

Achieved.

It is particularly pleasing to note that compliance has been achieved for this target. To assist with ongoing compliance, close monitoring of treatment list inflows and outflows is occurring. This will enable the implementation of remedial plans if required to maintain continued ESPI 5 compliance. if any deficit is foreseen

ESPI 6:

Patients in active review who have not received a clinical assessment within the last six months



2006/07	TDH Target	2007/08
0% (Unaudited)	<5.0%	0%

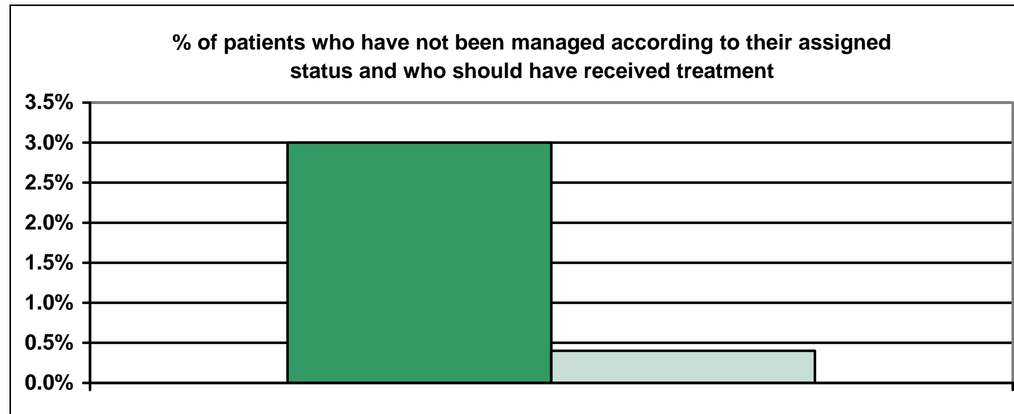
Comment:

Achieved.

Tairawhiti DHB does not utilise active review as a care pathway.

ESPI 7:

Patients who have not been managed according to their assigned status and who should have received treatment



2006/07	TDH Target	2007/08
1.7% (Unaudited)	<3.0%	0.4%

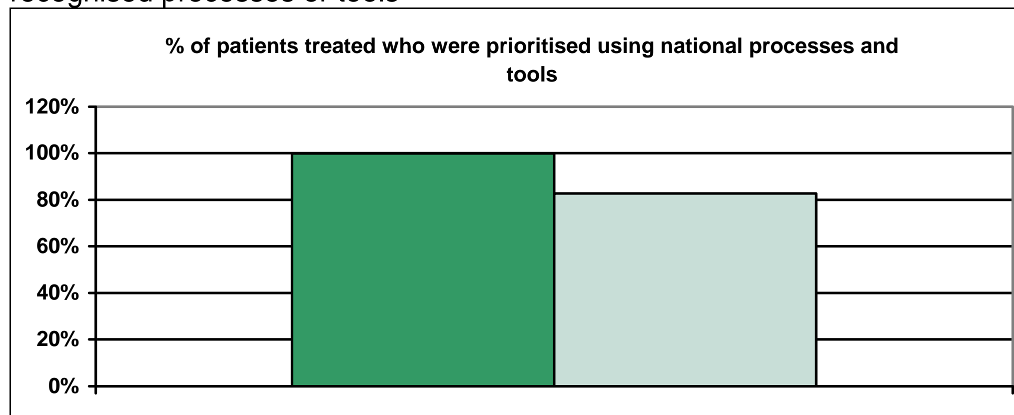
Comment:

Achieved.

Ongoing review and maintenance of treatment lists is proving to be an effective tool in ensuring that patients waiting outside the timeframes are readily identified and remedial plans to address deficits are put in place as soon as possible in a bid to maintain continued ESPI 7 compliance.

ESPI 8:

The proportion of patients treated who were prioritised using nationally recognised processes or tools



2006/07	TDH Target	2007/08
100% (Unaudited)	100%	82.75%

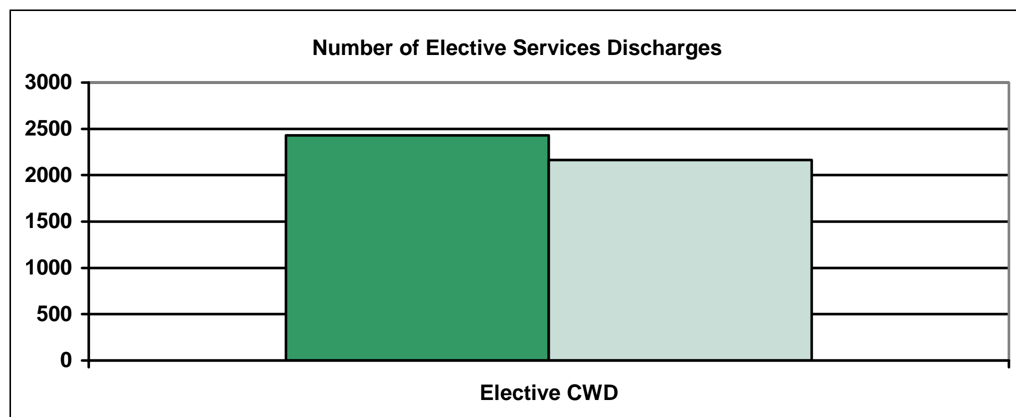
Comment:

Not achieved (Dispensation granted)

A substantial work program, which has necessitated the development and implementation of local General Surgery and Urology tools (at the request of the MoH), is reflected in the result. A dispensation for the period for non-compliance has been granted by the MoH to enable TDH to treat those listed under the old tool codes, whilst new processes are embedded into practice.

National Indicator:

Each DHB will set an agreed increase in the number of elective service discharges, and will provide the level of service agreed.



2006/07		TDH Target	2007/08
2088.43 (Unaudited)	Elective CWD	2429.83	2163

Comment:

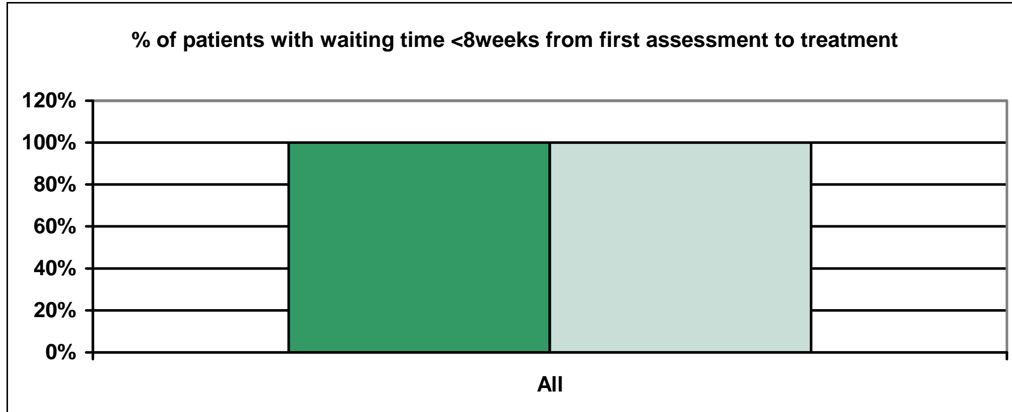
Not achieved.

The target has not been achieved with a resultant deficit of 267 CWDs. Clinician vacancies coupled with industrial action and unplanned clinician leave have contributed to the disappointing year end deficit.

REDUCING CANCER WAITING TIMES

National Indicator:

All patients wait less than 8 weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D)



2006/07		TDH Target	2007/08
Not reported	All	100%	100%

Comment:

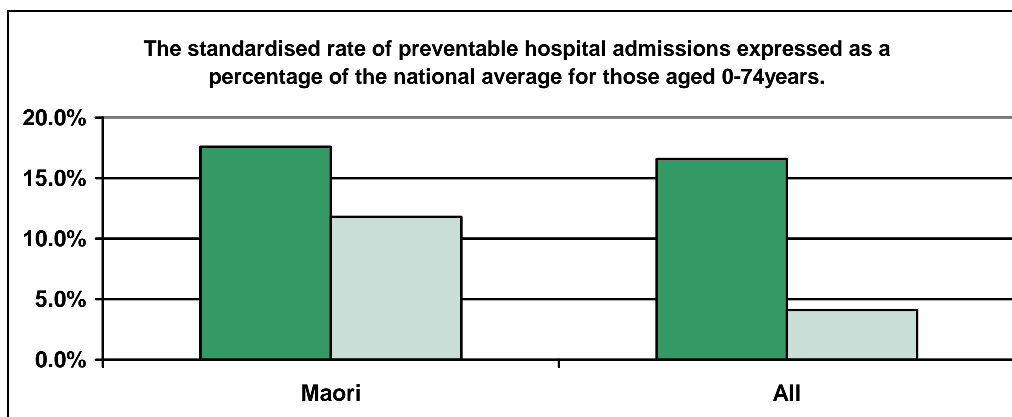
Achieved.

MidCentral DHB provides these services to TDH and its population and they have been able to meet the target.

REDUCING AMBULATORY SENSITIVE (AVOIDABLE) ADMISSIONS

National Indicator:

There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0-74 across all population groups (Targets are expressed as a figure above or below the national level (100).)



2006/07		TDH Target	2007/08
Not Reported	Maori	17.6%	11.8%
Not Reported	All	16.6%	4.1%

Comment:

Achieved.

In the child health area, a number of initiatives are underway to continue reducing Ambulatory sensitive admissions. These include:

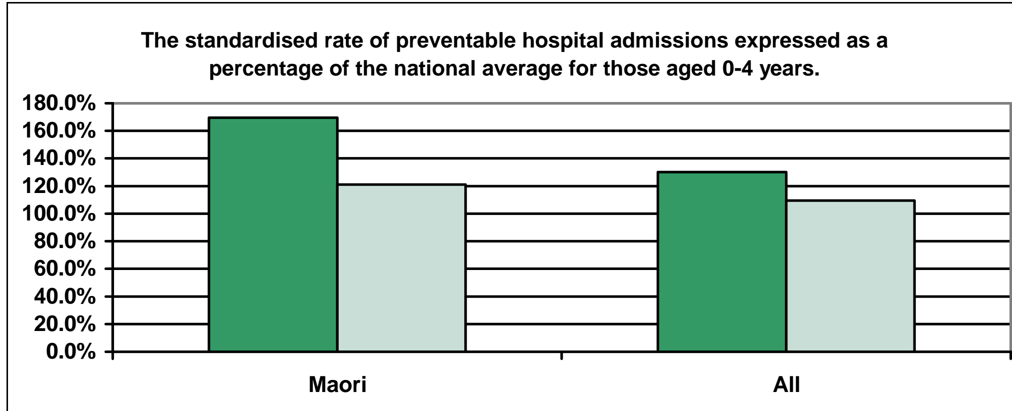
- Appointment of a second Paediatric Outreach Nurse
- A formal research project into local causes of skin infection
- Establishment of an extra .5 community paediatric position (yet to be filled).
- Initiation of a hand washing educational campaign in schools using UV cream and torches.
- Continuing dialogue with local GPs.

In older peoples health we are focusing on the following:

- Improving access to primary and community health services by ensuring low cost services for those with greatest health need.
- Ensuring provider development is targeted to the providers working with those with greatest health needs.
- Continuing to work with rural communities to improve access to services.
- Continuing to utilise a funding prioritisation system that incorporates an assessment of health equity so that all funding decisions seek to reduce, not increase, health inequalities.
- Supporting providers demonstrating leadership and innovation in reducing access barriers and delivering services.
- Developing and supporting a highly qualified and competent Maori health workforce.
- Advocating for action to improve the determinants of health: employment, housing, education etc.
- Utilising the Tairawhiti Health Needs Assessment (HNA) to further

identify where health inequalities exist.
- Developing cultural competency for all non-Maori workforces to assist with improving access

Quarter 4 data reflects DHB achievement against target for 'Maori' in the 0-74 age groups. In relation to those classified as 'other' Tairawhiti DHB has also successfully achieved a pleasing result within the 0-74 age groups.

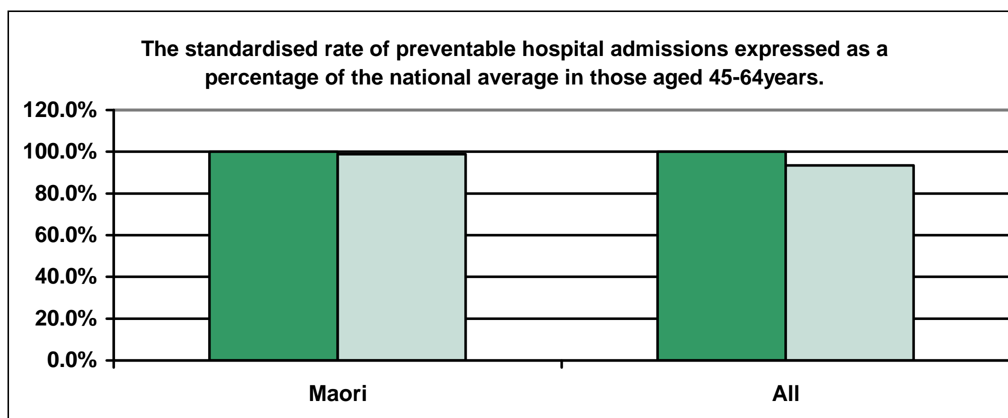


2006/07		TDH Target	2007/08
Not Reported	Maori	69.6%	21.1%
Not Reported	All	30.2%	9.6%

Comment:

Achieved.

As a result of consistent effort in all sectors of the community there has been a dramatic reduction in ASH rates for the districts 0-4 year olds with a number of initiatives to be rolled out in 2008/09 we expect to see a reduction in the factors which have contributed to the districts previously high rates.



2006/07		TDH Target	2007/08
Not Reported	Maori	<100%	98.9%
Not Reported	All	<100%	93.5%

Comment:

Achieved.

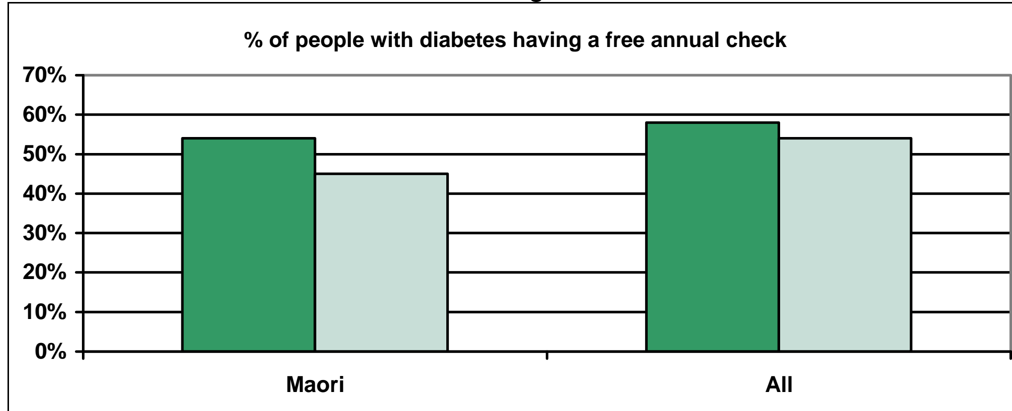
It is pleasing to note that both targets have been achieved. The recent appointment of a GP Liaison position is proving to be pivotal in enhancing communication and acting as a conduit between the primary and secondary care sectors.

IMPROVING DIABETES SERVICES

National Indicator:

There will be an increase in the percentage of people in all population groups:

- estimated to have diabetes accessing free annual checks



2006/07		TDH Target	2007/08
Not Reported	Maori	54%	45%
Not Reported	All	58%	54%

Comment:

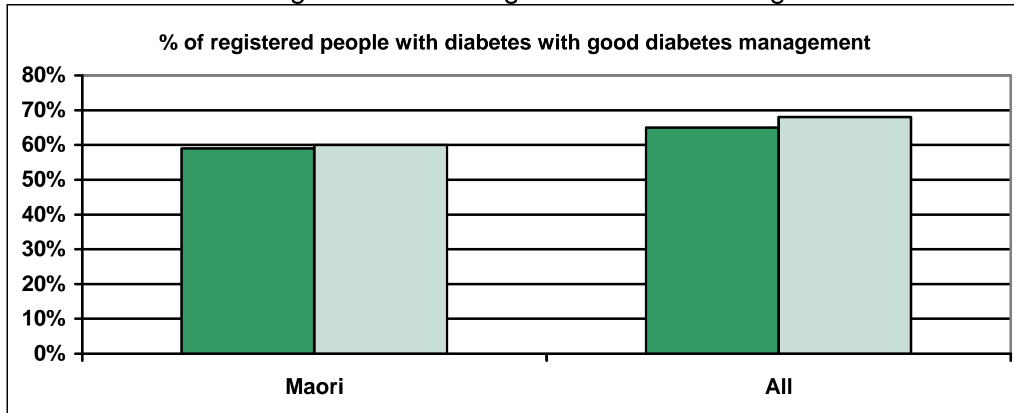
Not achieved.

TDH undertook a review of Diabetes services in 2007/08, with some key recommendations for improving the care of people with diabetes. TDH is now in the process of implementing these recommendations, including the establishment of a Specialist Diabetes Centre, which would, amongst other things like managing complex clients, support the primary care workforce to better manage their clients with diabetes. Furthermore, Turanganui PHO has been rolling out their chronic care framework – HealthRight – in the last 12 months over 3 of their 6 practices. Health Right has a strong focus in improving the care and outcomes for people with diabetes through specialist nursing services, lifestyle coaches, nutrition advice, self-management techniques, and strong links to the green prescriptions programme. Ngati Porou Hauora has just begun working on their chronic care framework, which will also see an emphasis on diabetes.

National Indicator:

There will be an increase in the percentage of people in all population groups:

- on the diabetes register who have good diabetes management



2006/07		**TDH Target**	**2007/08**
Not Reported	Maori	59%	60%
Not Reported	All	65%	68%

Comment:

Achieved.

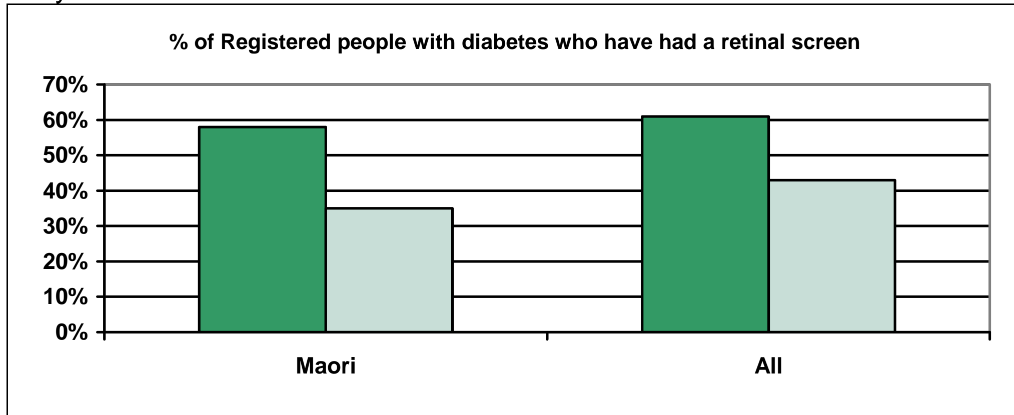
Although TDH achieved this target at a population level, it is disappointing that this achievement came at the expense of increasing inequalities in the ability of Maori people with diabetes to manage the disease.

For actions taken, refer to the comment on the indicator for “free annual checks”.

National Indicator:

There will be an increase in the percentage of people in all population groups:

- on the diabetes, register who have had retinal screening in the past two years.



2006/07		TDH Target	2007/08
Not Reported	Maori	58%	35%
Not Reported	All	61%	43%

Comment:

Not achieved.

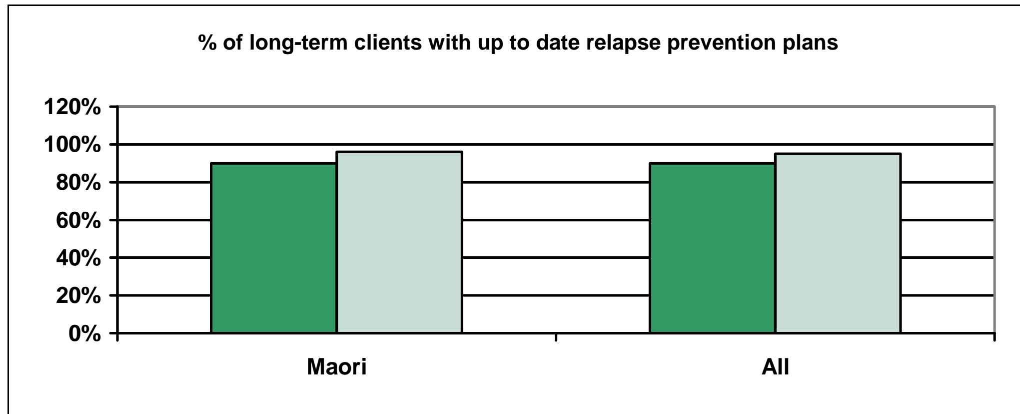
The retinal screening of those who have received a diabetes annual review within the last two years has fallen below 50% for the first time since the programme initiation in 2001. The gap in screening coverage between Maori and Non Maori has increased in one year from 6% in 2006 to 8% in 2007.

For actions taken, refer to the comment on the indicator for “free annual checks”.

IMPROVING MENTAL HEALTH SERVICES

National Indicator:

100% of long term clients have up to date relapse prevention plans (NMHSS criteria 16.4)



2006/07		TDH Target	2007/08
Not Reported	Maori	90%	96%
Not Reported	All	90%	95%

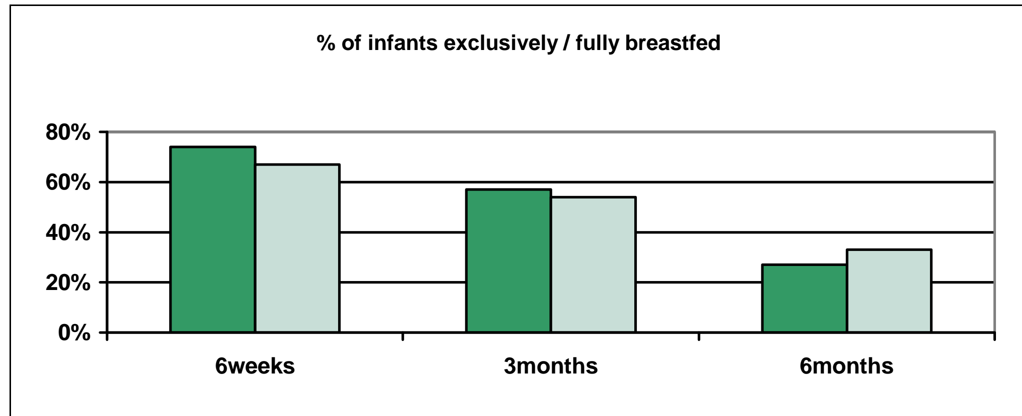
Comment:

Achieved.

IMPROVE NUTRITION

National Indicator:

Proportion (percent) of infants exclusively and fully breastfed



2006/07		TDH Target	2007/08
65% (Unaudited)	6weeks	74%	67%
Not Reported	3months	57%	54%
12% (Unaudited)	6months	27%	33%

Comment:

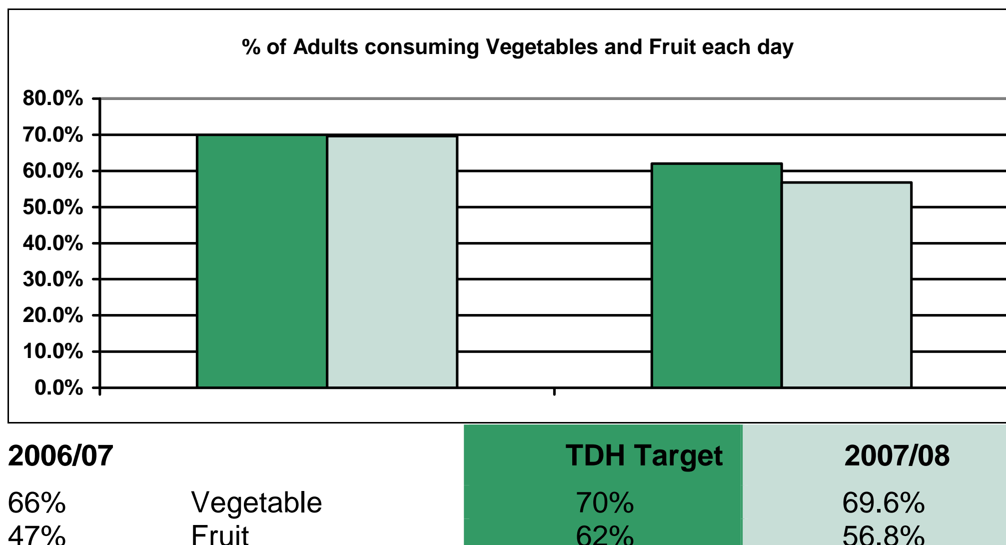
Not achieved.

6 Weeks and 3 Month targets are not being met despite a significant effort going into the Baby Friendly Hospital Initiative at Gisborne Hospital. This is disappointing and promotional work continues.

INCREASE PHYSICAL ACTIVITY AND REDUCE OBESITY

National Indicator:

Proportion (percent) of adults (15+) years consuming at least three servings of vegetables per day and proportion (percent) of adults (15+) years consuming at least two servings of fruit per day



2006/07		TDH Target	2007/08
66%	Vegetable	70%	69.6%
47%	Fruit	62%	56.8%

Comment:

Not achieved.

The relevance of the data is questionable given that Tairawhiti itself was not specifically measured. The data has come from "Portrait of Health" and Tairawhiti has been grouped in with Northland, Hawkes Bay, Lakes, and Whanganui districts for analytical purposes. Tairawhiti ethnicity data is derived via a synthetic prediction methodology, which takes into account data for both the total DHB population level and the national level for any specific subgroup.

Leaving aside the questionable accuracy of the data, significant activity continues to occur through TDH's Population Health team who are responsible for implementing TDH's Healthy Eating Healthy Action (HEHA) implementation plan. Over the past 12 months, the plan has focussed on implementing strategies towards mobilising Maori communities (funding of Maori community projects) and evaluation and integration of breastfeeding strategies with findings and methods that will best engage our priority groups. A number of workforce strategies have also been implemented as part of the Maori Obesity Fund, including funding a number of providers to attend nutrition training outside of the District.

The Nutrition Fund has also been a key focus of activity with a number of successful applicants receiving funding to support nutrition activities in schools (water quality, community and school gardens etc), and the Fruit in Schools programme has been rolled out in Tairawhiti with strong buy-in from the schools and communities in which these have been implemented in.

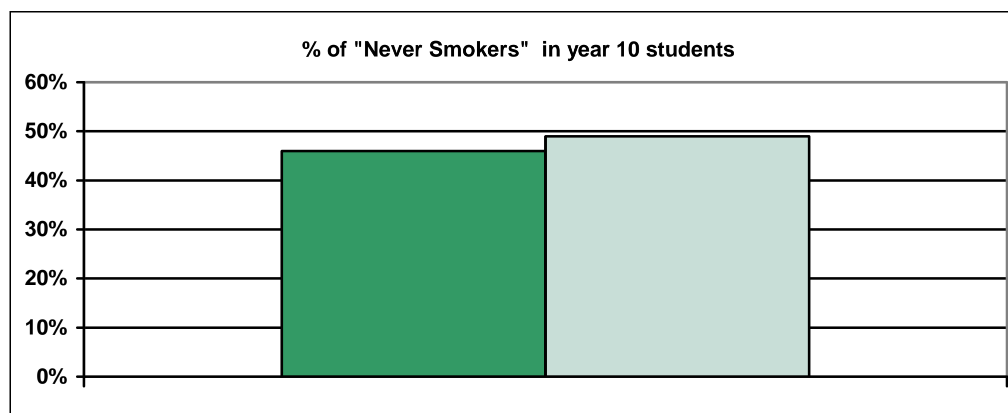
TDH also jointly funded with the MoH and the PHO a HEHA initiative in pre-schools "E Tipu Rea", which has seen a number of preschools and Kohanga Reo in the district, adopt healthy nutrition policies, and implemented the

active Mokopuna programme. Other funded programmes, including Ngati Porou Hauora's Ngati and Healthy, as well as Turanganui PHO's Active Whanau Health Initiative (AWHI), are also supporting the HEHA plan. The Green Scripts programme also continues to be heavily supported through its integration with TPHO's chronic care framework HealthRight.

REDUCE THE HARM CAUSED BY TOBACCO

National Indicator:

To increase the proportion of "never smokers" among Year 10 students by at least 2% (absolute increase) over 2007/2008.



2006/07	TDH Target	2007/08
44% (Unaudited)	46%	49%

Comment:

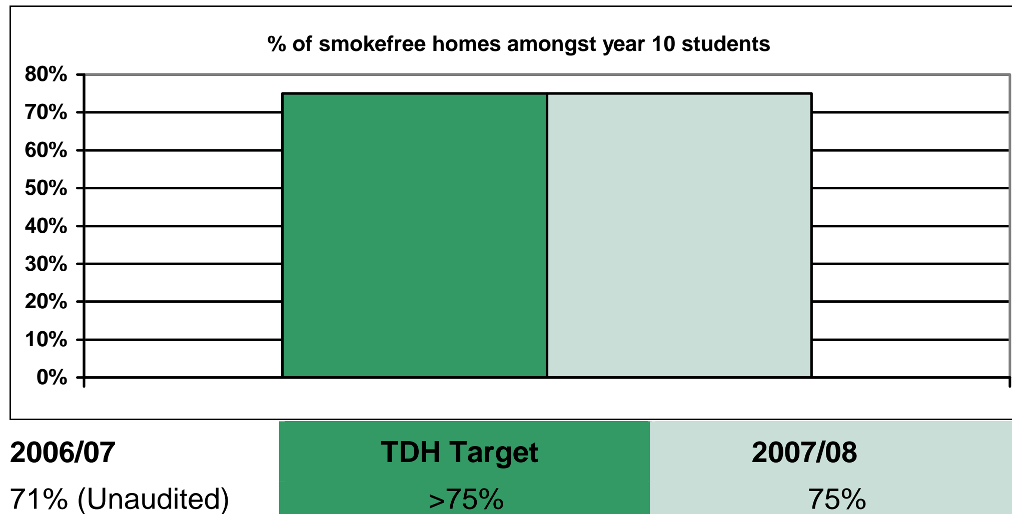
Achieved.

Never smokers increased from 44% of those surveyed in 2006 to 49% in 2007, a 5% increase. Tobacco consumption rates amongst young people have declined in almost all DHBs and it is pleasing to see that Tairawhiti has similarly shown a downward decline in this. Although a number of small scale efforts have occurred in Tairawhiti as a result of local action in 2007/08, the bulk of the decline needs to be attributed to national public health efforts, including social marketing campaigns, which have consistently reinforced the negative health benefits of tobacco consumption.

Given that a reduction in tobacco consumption is a key area for Tairawhiti, TDH developed a Tobacco Control plan in partnership with the Ministry of Health and the Health Sponsorship Council in late 2007. This plan identifies a range of initiatives that will be implemented over the next 3 years with a clear focus on impacting on Maori smoking rates in particular. TDH was successful in receiving additional funding from the Ministry of Health to support the roll-out of this plan. Key components of the plan are around mobilising primary and secondary care to improve their smoking cessation pathways, ABC training for primary care providers, improving the range and quality of current cessation services in the district, community action through key Maori events (kapa haka festivals etc), as well as the implementation of a healthy workplace strategy that encourages key public and private sector agencies to become smoke free.

National Indicator:

To increase the proportion of homes, which contain one or more smokers and one or more children that have a smoke free policy to over 75% in 2007/2008.



2006/07	TDH Target	2007/08
71% (Unaudited)	>75%	75%

Comment:

Achieved.

75% of those surveyed stated that their home is smoke free. This is an increase of 4% over 2006

The same survey also reported a 3% decrease in the number of year 10 students that smoked daily and a 4% decrease in those that said they have parents that smoke.

As noted above, legalisation changes regarding smoking and public spaces, as well as intensive social marketing campaigns regarding 'second hand' smoke, appear to have had a significant impact on this measure.

8.2 TDH KEY MEASURES

The following targets are TDH's "key measures" as defined in the Crown Entities Act and they relate back to the Health Gain Priorities for TDH as outlined in the District Strategic Plan.

SECONDARY MENTAL HEALTH SERVICES UTILISATION

Objective:

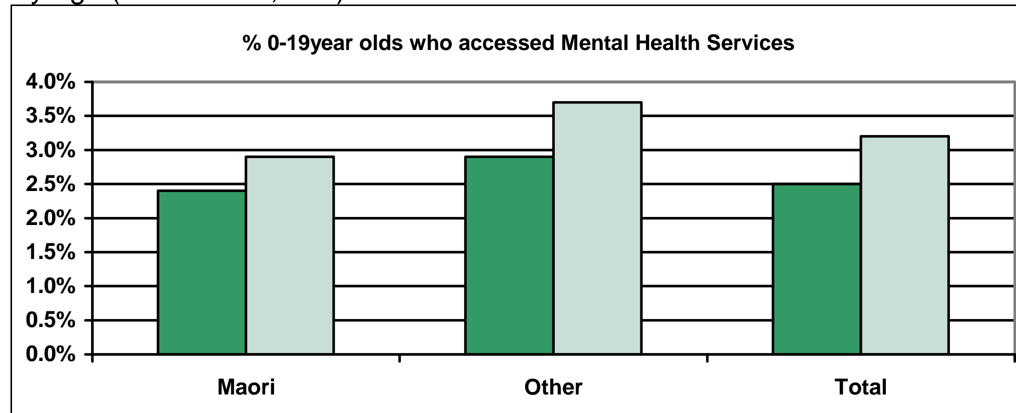
People with mental illness or addiction recover through improved access to services

Measure/Standard Definition:

Numerator: Number of people domiciled in region who are seen by mental health services.

Denominator: Projected population of DHB.

By ethnicity
By age (0-19: 20-64; 65+)

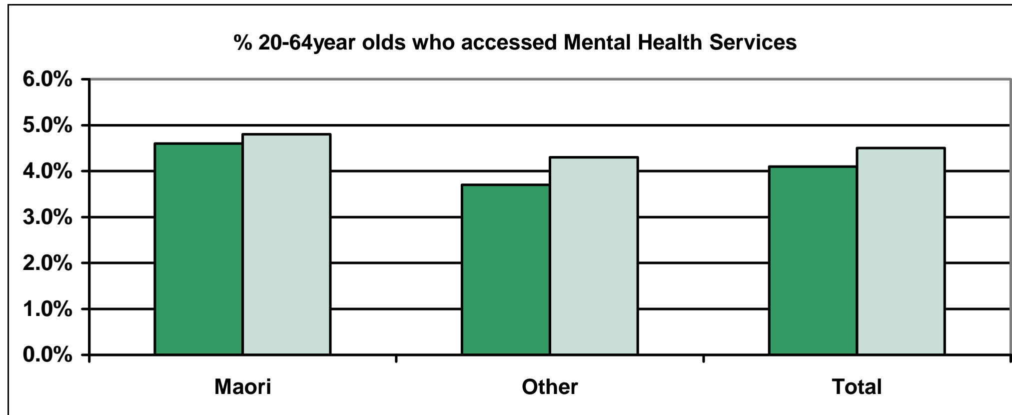


2006/07		TDH Target	2007/08
2.5% (Unaudited)	Maori	2.4%	2.9%
3.8% (Unaudited)	Other	2.9%	3.7%
2.7% (Unaudited)	Total	2.5%	3.2%

Comment:

Achieved.

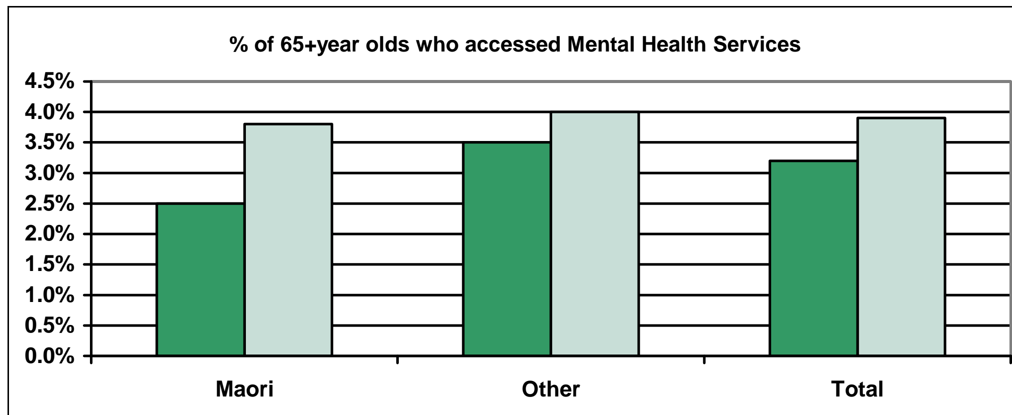
Capacity and resources have increased this year due to the implementation of the 2006/07 Child Adolescent Mental Health Services (CAMHS) review recommendations.



2006/07		TDH Target	2007/08
4.5% (Unaudited)	Maori	4.6%	4.8%
4.2% (Unaudited)	Other	3.7%	4.3%
4.3% (Unaudited)	Total	4.1%	4.5%

Comment:

Achieved.



2006/07		TDH Target	2007/08
1.9% (Unaudited)	Maori	2.5%	3.8%
3.5% (Unaudited)	Other	3.5%	4.0%
3.1% (Unaudited)	Total	3.2%	3.9%

Comment:

Achieved.

Despite achieving positive results, this service requires extra capacity and resources to be able to meet anticipated increased demand in the future. In addition PHO and aged care providers will require shared care approaches with Adult Integrated medical and community teams and secondary specialist older adult MH&AS team to meet the increasing demand.

AMBULATORY SENSITIVE HOSPITALISATIONS

Outcome:

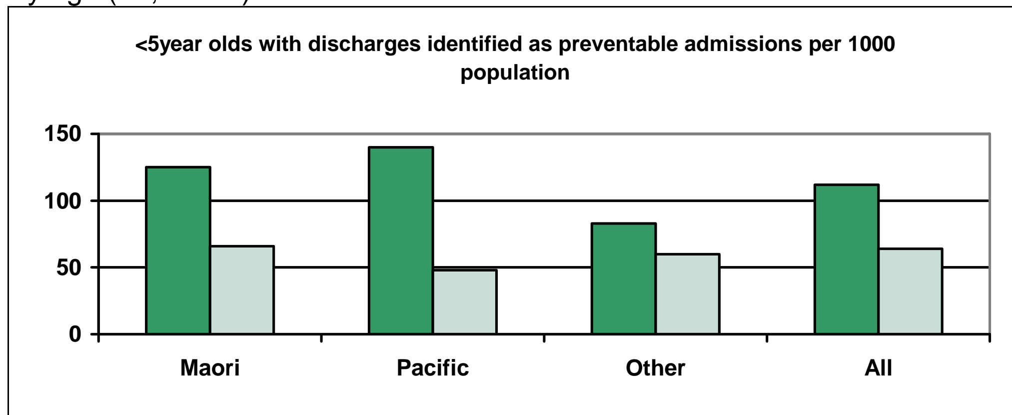
Children and older people are healthier as measured by lower rate of hospital admissions

Measure/Standard Definition:

Numerator: Total number of hospital discharges (as identified by relevant ICD10 codes – the types of admissions that could be prevented).

Denominator: Current census populations using medium projection.

By ethnicity
By age (<5; 65-74)



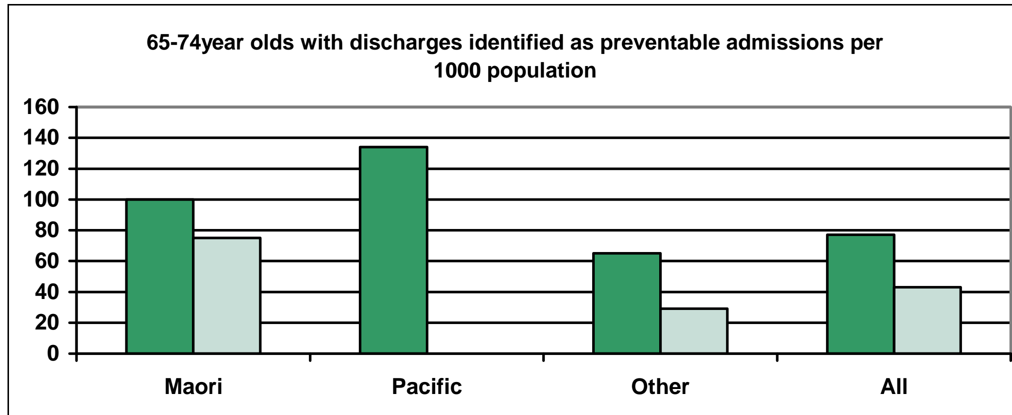
2006/07		TDH Target	2007/08
117 (Unaudited)	Maori	125	66
104 (Unaudited)	Pacific	140	48
89 (Unaudited)	Other	83	60
108 (Unaudited)	All	112	64

Comment:

Achieved.

The targets for this indicator were achieved. A lot of work is happening to improve results in this area. This work includes:

- A hand-washing campaign in schools
- Research into true reasons for cellulitus rates
- Work with GPs about appropriate referrals
- Appointment of a second Paediatric Outreach Nurse



2006/07		TDH Target	2007/08
137 (Unaudited)	Maori	100	75
0 (Unaudited)	Pacific	134	N/A
74 (Unaudited)	Other	65	29
93 (Unaudited)	All	77	43

Comment:

Partially achieved.

Although all targets have been achieved, substantial work is continuing as we are very aware of the high rate of inequalities in our District and in particular how these inequalities, fuelled by the highest rates of deprivation in the country, impact on our health services and health outcomes.

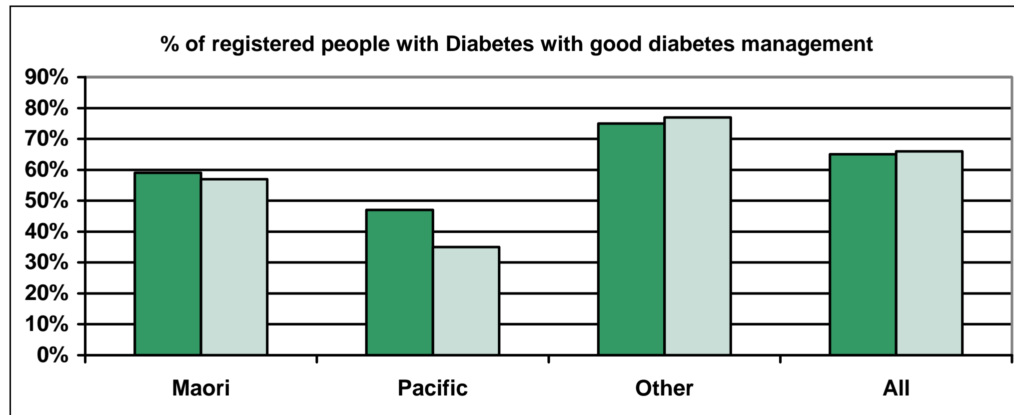
CHRONIC DISEASE MANAGEMENT: DIABETES MELLITUS

Outcome:

People with diabetes are healthier

Measure/Standard Definition:

The percentage of people with diabetes on the diabetes register who have good diabetes management



2006/07		TDH Target	2007/08
56%	Maori	59%	57%
33%	Pacific	47%	35%
76%	Other	75%	77%
63%	All	65%	66%

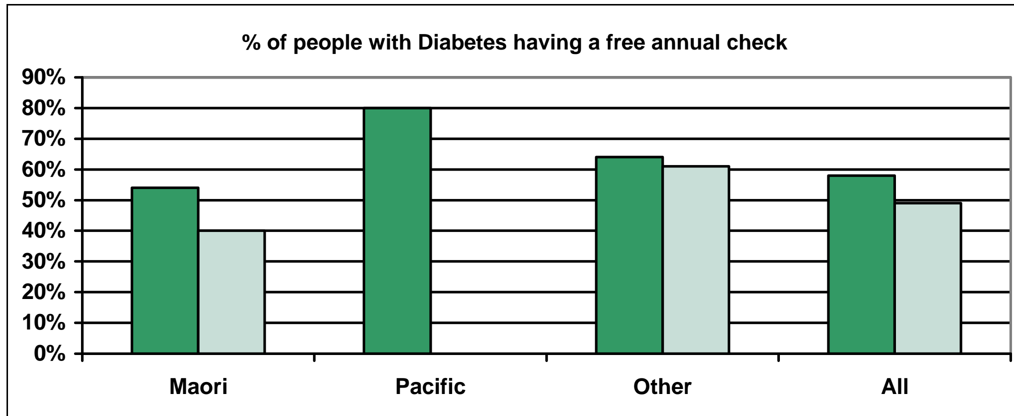
Comment:

Not achieved.

Refer to previous section re diabetes

Measure/Standard Definition:

The percentage of people with diabetes having a free annual check (ensuring people with diabetes have access to good advice on diabetes management)



2006/07		TDH Target	2007/08
Not Reported	Maori	54%	40%
Not Reported	Pacific	80%	-
Not Reported	Other	64%	61%
Not Reported	All	58%	49%

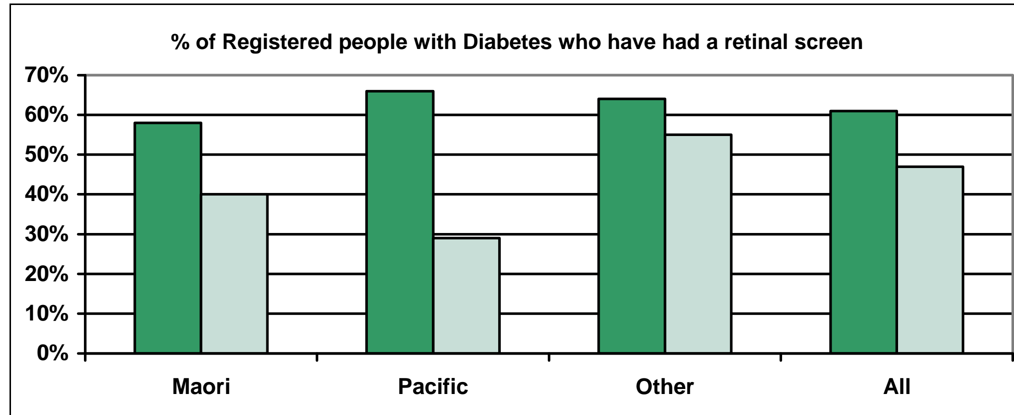
Comment:

Not achieved.

Refer to previous section re diabetes

Measure/Standard Definition:

The percentage of people with diabetes on a diabetes register who have had retinal screening or seen an ophthalmologist in the last two years (checking eyes to make sure they are not being affected by diabetes)



2006/07		TDH Target	2007/08
Not Reported	Maori	58%	40%
Not Reported	Pacific	66%	29%
Not Reported	Other	64%	55%
Not Reported	All	61%	47%

Comment:

Not achieved.

Refer to previous section re diabetes

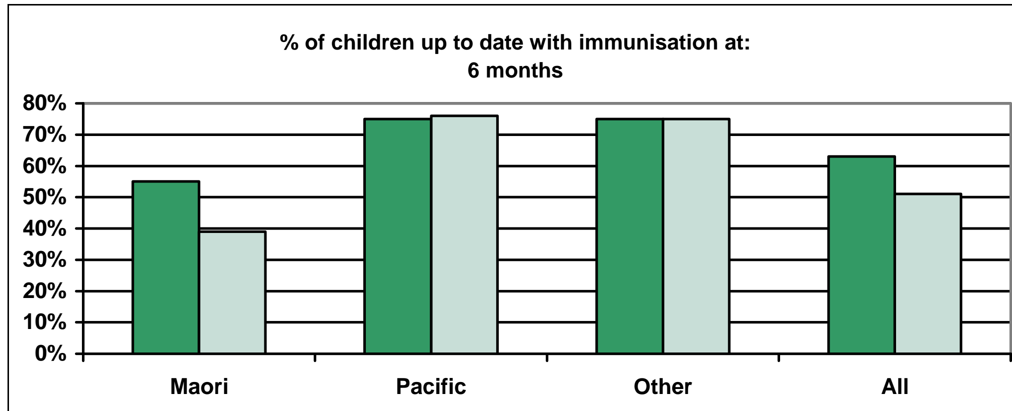
IMMUNISATION COVERAGE

Outcome:

Vaccine preventable diseases in childhood are eliminated

Measure/Standard Definition:

Progress towards the national target of 95% of two year olds fully immunised



2006/07		TDH Target	2007/08
49% (Unaudited)	Maori	55%	39%
75% (Unaudited)	Pacific	75%	76%
73% (Unaudited)	Other	75%	75%
57% (Unaudited)	All	63%	51%

Comment:

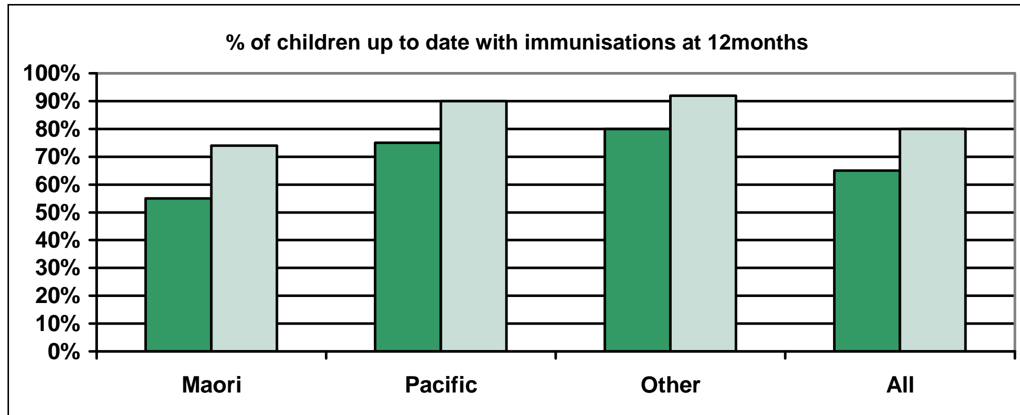
Not achieved.

Assessment is made from a data extract taken from the National Immunisation Register for the 12-month period ending 31 March 2008.

This data indicates that the target has been achieved for Pacific and Other, but not for Maori or the whole cohort. Work is needed to promote the benefits of immunisation to caregivers of Maori babies.

As the inequalities in this age group are significant, immunisation efforts are specifically focusing on Maori.

Improvements in reconciling GP practice data with National Immunisation Register data are underway and should result in improvements in coverage levels in the next 3 – 6 months. A District Immunisation Plan is under development and is scheduled for completion in November.



2006/07		TDH Target	2007/08
49% (Unaudited)	Maori	55%	74%
73% (Unaudited)	Pacific	75%	90%
77% (Unaudited)	Other	80%	92%
59% (Unaudited)	All	65%	80%

Comment:

Achieved.

Assessment is made on data that has been taken from a data extract from the National Immunisation Register for the 12-month period ending 31 March 2008.

This data shows that the target was met for all ethnic categories for this indicator. Improvement is considered to be a combination of more health promotion activity, use of the NIR and outreach and better data quality.

The results show definite progress in the immunisation coverage for children at 12months of age. Specific data at the 2 year-old age was not collected.