Hutt Valley District Health Board

District Annual Plan

2006/07

Minister of Health's letter of approval

Office of Hon Pete Hodgson
MP for Dunedin North
Minister of Health
Minister for Land Information

31 AUG 2006

4 SEP 2006

Mr Peter Glensor
Chair
Hutt Valley DHB
Private Bag 31-907
LOWER HUTT

Dear Mr Glensor

Hutt Valley District Health Board: 2006/07 District Annual Plan

This letter is to advise you that I have signed Hutt Valley District Health Board's (HVDHB's) 2006/07 District Annual Plan (DAP) for the three years 2006/07-2008/09 and the Board has my support for the implementation of this plan.

I wish to express my appreciation to the Board, management and staff for all the effort that has gone into producing the plan and the efforts made to manage your services within the funding available.

Risks

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

Electives

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

I am disappointed that the timeframe you have proposed for compliance with all Elective Service Performance Indicators (ESPI) in all services is later than 30 September 2006. The consequences of non-compliance by 30 September 2006 were outlined in the Acting Director-General of Health's letter of 8 June 2006 to your Chief Executive. The plan that the Ministry has reluctantly accepted must be strictly adhered to. I will regard any slippage as a Board performance issue.

Parliament Buildings, Wellington, New Zealand. Telephone: (04) 470 6558; Facsimile: (04) 496 8449

Mental Health

I note that you have received additional blueprint funding for 2006/07 above what was originally proposed and via the DAP process have outlined the proposed use of this funding. It is important that the planned use of this funding occurs and in the timeframes outlined in the DAP so service growth can be progressed and funding applied to more and better mental health services for your population

Getting ahead of the curve – The Chronic Disease Burden

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

Capital

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

Service Configurations

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

This letter should be attached to the copy of the signed plan held by the Board and a facsimile of the letter should be attached to all copies of the Plan made available to the public or any other third party.

Yours sincerely

Hon Pete Hodgson
MINISTER OF HEALTH

Mihi

Ti Hei Mauriora
He honore he kororia ki te Atua
He maungarongo ki te whenua
He whakaaro pai ki te tangata

E mihi ana tenei ki a Te Atiawa otira ki nga iwi o te motu e noho mai nei i roto i te rohe o Awakairangi ara Te Upoko o te Ika.
Tenei te karanga, te wero, te whakapa atu i a tatou katoa kia horapa, kia whakakotahi o tatou kaha i te whakatikatika o tatou mauiui. He aha ai, he oranga mo te tangata.
Kei i a te Poari Hauora o Awakairangi te mana tiaki putea Me ki e rua nga whainga o te Poari.
Ko te whainga tuatahi ko te tohaina o te putea ki nga wahi e tika ana.
Tuarua ki a waihangatia katoa nga ratonga he painga mo te iwi.
No reira e raurangatira ma kei roto i a tatou ringaringa te korero.
No reira haere whakamua, pumau ra ki te kaupapa o te Hauora.
Tena koutou katoa.

Greetings

All honour and glory to our maker.
Let there be peace and tranquility on earth.
Goodwill to mankind.

The Hutt Valley District Health Board respects Te Atiawa and acknowledges the community of the Hutt Valley.
This is the cry, the challenge to all concerned to collectively unite our efforts in addressing and improving the health needs of the community.
The Hutt Valley District Health Board's District Strategic Plan has specific responsibilities in providing equitable funding in the continual delivery of core services. The ultimate goal of the Hutt Valley District Health Board is the wellness of the community.
Therefore the community collectively needs to grasp with both hands the initiative to be involved and committed.
So let's move forward.
Tena koutou katoa.

Vision, Mission, Values

Whanau Ora ki te Awakairangi

Vision	Healthy People, Healthy Families, Healthy Communities Whanau Ora ki te Awakairangi
Mission	Working together for health and wellbeing
Values	'Can do' – leading, innovating and acting courageously Working together with passion, energy and commitment Trust through openness, honesty, respect and integrity Striving for excellence

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1. Statement from Chair and Chief Executive

We are pleased to present our District Annual Plan (DAP) for the 2006/2007 year.

Hutt Valley District Health Board has a strong reputation for the responsible way in which we undertake our business. For the last three years we have returned a small surplus while at the same time expanding and developing both hospital and community-based services.

Fiscal responsibility is at the heart of the organisation's activities. The Board and senior management team believe strongly that we can only continue to implement the government's priorities and meet the community's expectations, if we continue to be financially sound.

It is pleasing, therefore, to submit a breakeven budget for 2006/2007 and the following two years.

Achieving this budget will not be without its challenges. There are a number of factors outside of our control, most particularly the impact of national industrial settlements for major groups. Historically, national agreements have been at higher levels than those allowed for in DHB budgets and health workforce expectations are high.

So there are major risks to overcome, but Hutt Valley DHB is, nevertheless, committed to meeting our budget.

We are equally committed to improving the Hutt Valley community's health. This is the first annual plan to be produced under Hutt Valley DHB's District Strategic Plan 2006-2011. As such it is a key document in ensuring that we maintain progress along the path to achieving the goals, objectives and priorities set out in that plan. It also sets out to address national priorities.

In the coming year we will, in particular, be focusing on reducing disparities, furthering primary care, increasing integration and further developing our secondary services.

With regards to hospital-based care, there are significant challenges in ensuring that we maintain both acute and elective surgery within the constraints of our capacity to provide those services. Hutt Valley DHB has made some great progress in these areas and is putting even greater emphasis on this in the coming year.

Equally, we are committed to further developing community-based care and in supporting the national primary care strategy.

At the heart of our organisation is the relationship we have with our community. Hutt Valley DHB went to unprecedented lengths to include our community in the development of our strategic plan and this document is, therefore, the first step in meeting the commitments we made as a result of that consultation process.

1.2 Signatories

Peter Glensor **Chair Hutt Valley DHB**	**Hon. Pete Hodgson** **Minister of Health**

1.3 Executive Summary

This District Annual Plan for 2006/07 is the first plan to reflect the key goals and strategies of our District Strategic Plan 2006-2011. The priorities and objectives in this plan are guided by our statutory objectives as a DHB, national health sector priorities and strategic frameworks (including Ministerial priority areas) and our District Strategic Plan.

Our key priorities for 2006/07 are:

- Improving health equity
- Primary health care accountability and gains
- Prevention and management of chronic diseases, including Healthy Eating Healthy Action implementation
- Sustainability in older people services
- Pandemic planning
- Managing within budget, including generating revenue, working to contract volumes in the provider arm and reducing Inter District Flow (IDF) outflows by providing more services locally.
- Working regionally and nationally to prioritise the services in which we invest.
- Workforce development, including DHB-wide planning, Magnet accreditation and working nationally to control employment costs.

We are committed to reducing inequalities in health, through changes in the ways that existing services are delivered (such as diabetes services) and the development of new and innovative programmes (such as Healthy Lifestyles Pasifika and the housing retrofit projects). We recognise our responsibilities to Maori and the principles of the Treaty of Waitangi. We have established a Maori health service development group and are implementing new services for kaumatua and children with respiratory conditions.

We will continue to work with our primary health care providers on tangible projects aimed at preventing chronic diseases and assisting people to manage their conditions more effectively. We will emphasise implementation of the Healthy Eating Healthy Action strategy in primary health and public health services. We have built a shared understanding with our PHOs on the importance of transparency around fees, which has enabled us to put comprehensive fees information on our website. We expect to maintain this in 2006/07.

In 2006/07, we will continue our focus on seeking financially sustainable approaches to improving services for older people.. This will require innovation and collaboration with a wide range of organisations, to establish restorative programmes and greater support for people to age in their homes for as long as possible (referred to in this document as ‘ageing in place’).

We are also aware that difficulties for patients with multiple and complex needs can arise from poor coordination across services and between providers, and we will address these through a number of inter-service initiatives.

We will continue our preparations for the possibility of a major pandemic, alongside our usual emergency response planning. Considerable work is required to ensure that all of our local plans (for hospital, primary care, and community providers) are coordinated and that they align with national and regional plans.

Along with the rest of the New Zealand health sector, Hutt Valley DHB is experiencing workforce issues, particularly increasing shortages of skilled health professionals. Increasing demand for services, combined with fewer workers, means

that we will need to continuously look at different ways of doing things, what health workers do and how we use them. In 2006/07, we will implement the first stages of our strategic workforce development plan, with a special focus on achieving recognition as a Magnet Hospital. This programme emphasises the role of nurses in the delivery of services and has been shown in the United States to improve both the standard of patient care and the recruitment and retention of staff.

This year will be particularly challenging financially as a result of increasing costs, particularly due to the impact and flow-on of national wage settlements, and increased costs for older people's services, referred services and high-cost treatments. Hutt Valley DHB will continue to take a financially responsible approach, exploring opportunities to generate more revenue and, at the same time, managing our expenditure to ensure that we contain costs as much as possible. We will work closely with our local clinicians (in both the hospital and primary health care) to manage the risks arising from demand driven expenditure, particularly for pharmaceuticals, laboratory tests, and high-cost treatments.

We will undertake a number of service reviews during 2006/07 to ensure that we improve access to services and reduce inequalities for our people while achieving our budgeted financial position. We will work at regional and national levels to manage financial and service risks which could undermine services to our population. We will continue to support and participate in the Service Planning and New Health Intervention Assessment (SPNIA) process.

Improvements are needed in facilities at Hutt Hospital to ensure that appropriate services can continue to be provided as close as possible to the Hutt Valley community. Hutt Valley DHB is in the process of planning capital development on the Hutt Hospital campus which will include a larger intensive care unit, an expanded emergency department (including the construction of an acute assessment unit) and upgrades to the mental health inpatient unit. Importantly, there are not enough operating theatres to meet the current demand for acute and elective procedures, let alone the predicted increase in demand from the ageing population, so the capital planning includes providing more operating theatres.

All of the above development is being progressed as part of an Integrated Campus Plan, currently being prepared. The plan will be based on a Clinical Services Plan which takes into account the need to work with other DHBs in the region. These plans will enable Hutt Valley DHB to provide appropriate services to the local population while being involved in a rational approach to regional service improvement. Throughout our planning and implementation, we are developing robust business cases, and ensuring strong financial accountability.

Hutt Valley DHB has a well proven record of focus on ensuring financial viability. Our ethos has been, and remains, that we can only maintain and improve services to the people of the Hutt Valley if we are financially prudent and responsible. Therefore, the capital and service developments mooted in this District Annual Plan should be seen in the light of the DHB's financial responsibility.

We are fully aware that there are significant pressures on DHBs at this time. Nevertheless we are confident that this is, indeed, a prudent and thought-through plan, which throughout its sections, outlines the potential risks and also outlines the strategies and mitigations we have identified in order to overcome those risks.

2. Introduction

Hutt Valley District Health Board (Hutt Valley DHB) is responsible for improving the health of Hutt Valley residents within available financial resources. We provide health services through Hutt Hospital and many DHB community services, but just as importantly, Hutt Valley DHB plans and funds most health and disability support services in the Hutt Valley. The Ministry of Health is responsible for planning and funding public health, disability services for young people and some other national services.

2.1 General

DHBs were established and function under the New Zealand Public Health and Disability Act 2000, which includes DHB objectives and functions. Other legislation and requirements that DHBs must comply with include among others the Public Finance Act 1989, the Health and Disability Services (Safety) Act 2001, Human Rights legislation and the Ministry of Health's Operational Policy Framework.

Our District Strategic Plan[1] sets out our DHB's goals and the strategies we will follow to achieve our goals. Every year we complete a District Annual Plan, which reflects the District Strategic Plan. The District Annual Plan covers the level of services that will be funded, the services that are to be provided and the key strategic initiatives that are to be advanced over the year. Key milestone events, performance targets and financial plans are also included within the annual plan.

2.2 Responsibilities to Maori

Hutt Valley DHB is committed to reducing health inequalities and improving health outcomes for Māori in accordance with our statutory responsibilities to Māori under the NZPHD Act 2000, and is guided by the Government's health strategies and policies and our Maori Health Strategic Plan, Whanau Ora ki te Awakairangi. [2]

2.3 Treaty of Waitangi

We recognise and respect the principles of the Treaty of Waitangi, including partnership, participation and protection. We are committed to satisfying our responsibilities to the principles of Treaty of Waitangi within the framework of New Zealand Public Health and Disability Act 2000.

Partnership

We are committed to a framework that enables Māori to engage and contribute to decisions at the highest strategic level based on mutual understanding and cooperation.

Participation

We recognise our role as a joint partner in identifying priority areas for Māori health within the Hutt Valley District. Māori are involved in overall strategic, operational, planning and consultation processes.

Protection

We are committed to a bi-cultural approach in our delivery of health and disability services and the utilisation of tikanga Māori. We will work with Māori to ensure the protection of Māori cultural concepts, values, practices and other taonga.

We are committed to enabling greater Māori participation at all levels of the health and disability sector. We have identified a number of ways in which to enable Māori to contribute to decision-making and to participate in the delivery of health and disability services

In 2003/04 Te Awakairangi Hauora was established as the local Maori partnership board with Hutt Valley DHB. A 3-tiered proposal was accepted in 2004 by the DHB 2004 detailing the consolidation of the group in line with community linkages, a road map for out years and regular meetings were scheduled for the Boards and management teams to meet. Te Awakairangi Hauora is currently preparing the process for increased community participation in membership by re-linking with the original sponsorship group. We are in discussions, at a governance level, with the orginal sponsors from the Maori community to develop a consensus on an appointment process so Te Awakairangi Hauora has maximum legitimacy within the Hutt Valley Maori community.

The Hutt Valley has two Maori members, Dr Catherine Love (Te Atiawa, Taranaki, Ngati Ruanui, Nga Ruahinerangi, Ngati Tama) and Dr Chris Cunningham (Ngati Raukawa and Toa Rangatira). The Board has also appointed Maori members to the three of the Board sub committees (Community and Public Health Advisory Committee, Hospital Advisory Committee and Disability Advisory Committee).

Following consultation on our Maori Health Strategic Plan and a further engagement process with local Maori communities, we have recently established a Maori Health Service Development group. The overall purpose of the group is to work with the Chief Operating Officer, the Director Planning, Funding and Public Health and their staff on the development of services that will better meet the needs of Maori. Through dialogue, the group will guide service funding, service design, service delivery and consultation processes, covering the range of services provided by the DHB and those funded by the DHB and provided by other organisations. The group may advise on issues raised by the DHB, or it may provide advice in relation to issues raised by group members. The intention is that DHB issues should come to the group at an early stage. Advice may include suggestions on service specifications or service location or any other aspects of service design and delivery and prioritisation.

3. Our Objectives and Priorities

The performance objectives outlined below reflect Hutt Valley DHB's priorities, the New Zealand Health Strategy[3], New Zealand Disability Strategy[4], the Minister of Health's 'priorities', and are relevant to the needs of our community and priorities of the Board. In addition, these objectives were developed through a Health Needs Assessment and prioritisation process during our District Strategic Planning.

3.1 Objectives of DHB

Hutt Valley DHB's statutory objectives are:

- To improve, promote, and protect the health of people and communities.
- To improve integration of health services, especially primary and secondary health services.
- To promote effective care or support for those in need of personal health services or disability support services.
- To promote the inclusion and participation in society and independence of people with disabilities.
- To reduce health inequalities by improving health outcomes for Māori and other population groups.
- To reduce, with a view to eliminating, health outcome inequalities between various population groups within New Zealand, by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.
- To exhibit a sense of social responsibility by having regard to the interests of people to whom it provides, or for whom it arranges the provision of services.
- To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services.
- To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations.
- To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations.
- To be a good employer.

3.2 Local Goals and Strategies

During district strategic planning in 2005, and using our vision, mission and values as our guide, we formulated key goals. Goals are what we want to achieve while strategies are ways we achieve our goals. These are -

1. Improved health equity
2. Healthier communities
3. A focus on prevention, early treatment and easy access
4. Effective, efficient and high quality services
5. Seamless integration
6. An inclusive district

We see these six goals as the foundation for our activities in the coming five years. They take into account our obligations under the New Zealand Health and Disability Act 2000. We have emphasised reducing disparities where they exist in the community and ensuring members of the community stay healthy for as long as possible.

In order to achieve these goals we have selected eight strategies. These, in turn, will be used to develop actions over the course of the next five years. Our annual planning process will be our means for developing those actions. The strategies are.-

1. Developing primary health care

2. Working with other agencies
3. Re-designing services and consolidating gains
4. Taking a whole person, whanau and lifespan approach
5. Working in harmony with Maori
6. Sharing information and measuring progress
7. Developing the workforce
8. Improving our hospital

We believe that by employing the eight strategies outlined we will deliver on the goals we have set ourselves. In addition to these key goals and strategies, we had already produced plans to meet the specific needs of Maori, Pacific peoples and the elderly – the Hutt Valley Maori Health Strategic Plan – Whanau Ora ki te Awakairangi[2]; the Pacific Health Action Plan[5]; the Older Persons Health Plan[6]. These plans will continue to set the agenda for the development of services to those groups. We have referred to those documents throughout this plan.

3.3 Health Sector Priorities

The New Zealand Health Strategy[3] (NZHS) and the New Zealand Disability Strategy[4] (NZDS) provide the framework for the overall direction of the health and disability sector. These strategies take a population approach to identify the priority areas where interventions can contribute to the goals of healthy and independent New Zealanders. Sitting alongside each other, these strategies guide the development and implementation of more detailed service, health issue and population-group-specific strategies, and action plans.

The NZHS emphasises improving population health outcomes and reducing disparities in health between all New Zealanders, including Māori and Pacific peoples, and identifies seven fundamental principles that should be reflected across the health and disability sector. It highlights the priorities the Government considers to be most important. Those priorities reflect diseases such as diabetes and cancer as well as factors that influence health such as smoking and nutrition.

The NZDS is an intersectoral strategy relevant across the whole public sector and identifies 15 objectives underpinned by detailed actions to advance New Zealand towards being a more inclusive society by eliminating the barriers to people with disabilities to participating in and contributing to society.

Although the NZHS and the NZDS provide an overarching framework for action in the health and disability sector, they do not identify how specific priority objectives or services will be addressed, and other population, service and disease based strategies sit under these two strategies to provide more detailed guidance for the health and disability sector. These strategies include:

- He Korowai Oranga: Māori Health Strategy[7].
- The Primary Health Care Strategy[8].
- The Health of Older People Strategy[9].
- Improving Quality (IQ): A systems approach for the New Zealand health and disability sector[10].
- The New Zealand Cancer Control Strategy[11].
- Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau: A strategic framework[12].
- The Child Health Strategy[13].
- The Mental Health Strategy[14].
- The Pacific Health and Disability Action Plan[15].

During 2006/07 progress is expected to be made in all these strategies with an emphasis on quality and safety and on reducing inequalities. Other implementation priorities for 2006/07 are:

- Developing health infrastructure.
- Completing the Meningococcal Vaccine Strategy and achieving improved overall immunisation rates.
- Improving elective services including orthopaedics and cataracts.
- Collaborating across agencies to progress programmes to reduce tobacco, alcohol and other drug abuse, and minimise family violence, child abuse and neglect.

We will support the strategic frameworks developed for the health and disability sector over the last six years with an emphasis on strengthening good relationships and collaboration between the Ministry, DHBs, service providers, other government agencies and our communities.

The Minister of Health has identified a number of priority areas requiring concerted action in 2006/07. These include:

- An integrated continuum of prevention and intervention services for chronic diseases, including progress in the implementation of the Healthy Eating Healthy Action (HEHA) strategic framework, the Cancer Control Strategy and the Tobacco Control Strategy.
- Child and Youth services, including hearing tests for neonates, increased wellchild checks for preschoolers, child and adolescent mental health services, improved oral health services and free primary care services for under six years olds.
- Continuing the implementation of the Primary Health Care Strategy to achieve reduced costs for more people and to shift towards a population approach to primary health care, including a prevention and early detection focus for PHOs and the broadening of the range of health professionals involved in the continuum of care.
- Older peoples services to support people at home for longer and developing the continuum of care model to support people moving between their homes, residential care, assessment treatment and rehabilitation services, and primary services.
- Information and workforce infrastructure, including progressing the Health Information Strategy New Zealand (HIS-NZ)[16] and workforce strategies.
- Cost effectiveness, where opportunities must be found in an ongoing, deliberate and systematic way.

3.4 Our Priorities for 2006/07

The following are Hutt Valley DHB's key priorities for 2006/07.

- Improving health equity (including Maori, Pacific and other high need populations)
- Primary health care accountability and gains
- Prevention and management of chronic diseases, including Healthy Eating Healthy Action implementation
- Sustainability in older people services
- Pandemic planning
- Managing within budget, including generating revenue, working to contract volumes in the provider arm and reducing Inter District Flow (IDF) outflows by providing more services locally.
- Working regionally and nationally to prioritise the services in which we invest.
- Workforce development, including DHB-wide planning, Magnet accreditation and working nationally to control employment costs.

4. Issues and Risks

The following sections summarise the key issues and risks facing Hutt Valley DHB during 2006/07 and mitigations to manage these. Also outlined are areas of service review or change during the period.

4.1 Issues

Our population is changing over time – we'll have fewer children and more older people and more Maori and Pacific people. Our Older Persons Service Plan, Pacific Health Action Plan and Hutt Valley's Maori Health Strategic Plan – Whanau ora ki te Awakairangi - already recognise this and set out strategies to address those needs.

While management of people with chronic conditions in primary and community settings is expanding, admissions to hospital continue to be relatively high, putting pressure on staff and budgets. In 2006/07, we will continue to work with primary care and other community providers to expand and improve care of people with chronic conditions, through programmes such as Care Plus, and the continuum of care initiatives for cardiovascular, diabetes and respiratory illness. We will also support increased preventative efforts around the key risk factors for these diseases (e.g. smoking, nutrition and diet, physical activity, alcohol misuse) to reduce the incidence in the population.

Smoking and alcohol misuse will continue as major causes of disease and injuries and increasing levels of obesity will result in more diabetes and heart conditions, all of which is likely to further increase demand for services. Our strategies under the goals for 'healthier communities' and 'prevention, early intervention and easy access' address these.

Some people and groups within our population face major barriers to good health – insufficient income, poor housing, lack of affordable transport, etc. People also face barriers to getting health services. These barriers include the cost of some services, poor transport links to services and the hours services are open. This is the prime reason for the strong emphasis on 'working with other agencies' and on taking a 'whole person, whanau and lifespan approach' in this plan.

Our own capability as an organisation will be an issue.

- Our Clinical Board is addressing major clinical policy issues and will extend its activities over time.
- Research and teaching activities are growing and we need to nurture them.
- We wish to maintain the good relations between clinical staff and managers which are a real feature of Hutt Valley DHB.
- Hutt Hospital does not have enough operating theatres and improvements are needed in the intensive care unit, emergency department, acute assessment unit and in the mental health inpatient unit.
- Our nurses make up the largest group in our workforce. We need to ensure they have strong leaders and good support. The Magnet quality programme is a key initiative in supporting, attracting and retaining our nurses.

The Government's health funding is based on population. We are already funded for our fair share so we won't be getting large increases of funding based on our population. That makes it even more important that we get value for money from the services that we fund and provide. Our financial planning takes this into account (see Section Seven) and we have recognised areas where we need to make changes under our goal 'effective, efficient and high quality services'.

We need to be prepared for major emergencies such as a worldwide outbreak of an infectious disease (called a pandemic) and civil defence emergencies like an earthquake or a flood. The way the Hutt Valley, and the greater Wellington region could easily be cut off needs to be taken into account in our preparations. We are upgrading our major incident policies and processes and we are participating in the pandemic preparation being led by the Ministry of Health, because we realise how important these issues are. Agencies we are working with include local and regional health providers and emergency services. The processes developed will be evaluated through local, regional and national emergency exercises.

4.2 Key Risks and Mitigations

The key risks for the DHB and the Hutt Valley population fall into three key areas: financial management; service effectiveness; and infrastructure (workforce, facilities and information). These three are often inter-related, with a failure in one leading to negative consequences in another. Specific risk areas are identified below, and mitigation strategies are outlined.

Financial Management

This year will be a very challenging year as a result of increasing costs, particularly as a result of the impact of national wage settlements and increase in both demand for services for older people and the prices predicted in 2006/07. Hutt Valley DHB does not receive significant additional funding as a result of population based funding, so we will need to look to additional revenue opportunities as well as continuing to contain costs.

Recent wage settlements for health professionals (particularly nurses, junior doctors and senior doctors) have substantially increased remuneration and other benefits. With wages a major component of DHB costs, the overall impact of these wage increases is significantly higher than the price increase passed on to DHBs in the 2006/07 funding package. The gap between wage increases and DHB price increases will create a significant challenge for us, and we will need to use what influence we have to attempt to restrict future salary increases to an affordable level.

While DHBs have received specific funding for the New Zealand Nursing Organisation (NZNO) and expect to receive funding for the Public Service Association (PSA) wage settlements in 2005/06, it is not yet clear if the funding is sufficient for the actual impact in the DHB provider arm. Providers in the primary care sector and the aged care sector have also identified that they risk losing nursing staff to DHB positions, given the higher pay rates that DHB nurses are receiving. In both sectors, loss of experienced nurses will undermine the Primary Health Care Strategy and the Health of Older People Strategy. The DHB will not be able to assist these providers financially, as the “pay jolt” funding is tagged for DHB nurses only.

Services for older people are a major financial risk for the Hutt Valley DHB, as the funding received is unlikely to cover the increases in volumes and prices expected in 2006/07. The older population is growing steadily (those aged 75 years and over will grow by 2.5% between 2005/06 and 2006/07). Residential care providers are signalling that they have historically been under-funded and that they are facing increasing cost pressures (particularly if they wish to retain experienced nursing staff, given the higher pay rates nurses are receiving in the DHB sector).

Also, DHBs experience a higher impact of a percentage rise in the price paid for residential care services, because of the current subsidy structure which caps client contributions. (For example, a 1% percentage increase paid to aged residential care providers will actually result in a 1.7% increase in DHB expenditure on these

services.) In the longer term, we aim to reduce the financial risk and to improve the services available to older people by developing a wider range of flexible options for restorative, rehabilitation, support and care services to enable “Ageing in Place”. In the short-term, our ability to reduce this financial risk is limited, and this needs to be recognised by central agencies.

The financial effects of the recent changes in the Income and Asset Testing (IAT) policy for older people are still being identified. We are developing models to enable us to understand the impact of the 2005/06 changes, and to predict the impact of the changes that will occur in 2006/07 and out years. We expect that the Ministry of Health will ensure that DHBs are reimbursed for actual expenditure resulting from IAT.

At a regional level, we are working to clarify and correct mental health data underpinning the allocation of Inter-District Flow (IDF) purchase units. We expect this work to be completed early in the 2006/07 year. The findings of this work may result in a significant change in IDF allocations for mental health. We will work with our regional colleagues to define transition paths to reduce the immediate impact on specific DHBs.

Within personal health services, there are several financial risks arising from services where demand drives expenditure. Along with other DHBs, we address the risks in pharmaceutical expenditure by working with PHARMAC on supply-side strategies to both contain costs and to promote good clinical practice. We intend to increase our efforts to work locally with primary health care practitioners to improve the cost effectiveness of their prescribing.

We will in 2006/07 implement a new primary health laboratory service contract following an extensive service development and tendering process. Access to laboratory tests will be restricted to patients referred by approved referrers and it is expected that the new contract will cap demand and result in a lower price.

The increasing demand for high-cost treatments and drugs (often labelled as “new technologies”) also poses a financial risk to the DHB. Pressures are clearly evident in many tertiary services, including cardiology, renal services and cancer services. For example, the incidence of cancers is increasing; costs are increasing at a rate much greater than DHB funding; there is increased use of Pharmaceutical Cancer Treatment (PCT) drugs, enhanced requirements to meet standards for radiotherapy use, and plans for introduction of brachytherapy.

Where tertiary services in the central region are not sufficient for our population (because of financial pressures, or loss of key workforce) Hutt Valley DHB then faces additional costs to reimburse patients and their families for out-of-region travel and accommodation costs if this is necessary.

The key strategy for reducing the financial risk of high-cost treatments and drugs is to improve decision making on both new investments (e.g. the introduction of new technologies) and disinvestment (e.g. reducing or stopping some interventions or services). While the Service Planning and New Health Intervention Assessment (SPNIA) framework for collaborative decision-making has been developed at a national level, considerable work is needed across the health sector to apply it well. Resources for analytical and secretariat support need to be identified nationally as DHBs do not have the capacity to undertake this work within existing resources. Hutt Valley DHB will continue to participate in SPNIA processes, where possible. We will

also continue to work with central region DHBs to obtain a comprehensive view of regional services and agree a process for shared decision-making.

Service Effectiveness
Hutt Valley DHB is keen to proceed with the proposed new model for community-based dental care for children and adolescents, once the funding and other requirements have been confirmed. In the meantime, we will continue to work with schools to address facility issues in the existing school dental clinics. A newer financial risk is developing within dental services for adolescents, as contracts implemented in 2005/06 are resulting in increased uptake by young people. This is a good service outcome but does pose a financial risk to the DHB.

Some difficulties arise from different funding streams, where services are funded by both the DHB (say, personal health services) and by the Ministry of Health (say, disability services for people under 65 years). These risks would be greatly reduced by a concerted effort by the Ministry and DHBs to clarify and agree on how to handle these "boundary" issues.

Other difficulties for patients with multiple and complex needs arise from poor coordination across services and between providers. In 2006/07, we will address these through inter-service initiatives, including developing a system for coordination of services for older people co-location of DHB community nurses with primary health care providers, and a review of psychogeriatric and mental health services for older people.

Many of our providers are experiencing an increase in the number of patients with multiple and complex needs. These providers (and the patients themselves) are reporting considerable difficulties in getting flexible and integrated responses. The risks here include unnecessary deterioration in the patient's condition, critical incidents and the associated negative publicity, and widespread inefficiencies (as providers, families and patients waste time trying to navigate an unwieldy system).

Infrastructure: Workforce
Along with the rest of the New Zealand health sector, Hutt Valley DHB is facing increasing shortages of skilled health professionals. More and more of our workforce are getting closer to retirement and there are fewer younger people to replace them. As well, there is increasing international competition for trained health professionals.

While there are specific vacancies within the DHB provider arm, the Hutt Valley also has a lower number of Full-Time-Equivalent general practitioners per head of population than the national average. The DHB has prepared a strategic workforce development plan[17] and specific actions are identified in this 2006/07 document for implementation.

Higher demand, combined with fewer workers, means that we will not always be able to provide services in the same way we do now. We will need to look at different ways of doing things, what health workers do and how we use them (e.g. increasing use of nurse-led clinics). This is being addressed through our strategies to redesign services and the strategic workforce development plan.

Infrastructure: Facilities
Improvements are needed in facilities at Hutt Hospital to ensure that appropriate services can continue to be provided as close as possible to the Hutt Valley community. Hutt Valley DHB is in the process of planning capital development on the Hutt Hospital campus which will include a larger intensive care unit, an expanded

emergency department (including the construction of an acute assessment unit) and upgrades to the mental health inpatient unit. Importantly, there are not enough operating theatres to meet the current demand for acute and elective procedures, let alone the predicted increase in demand from the ageing population, so the capital planning includes providing more operating theatres.

All of the above development is being progressed as part of an Integrated Campus Plan, currently being prepared. The plan will be based on a Clinical Services Plan which takes into account the need to work with other DHBs in the region. These plans will enable Hutt Valley DHB to provide appropriate services to the local population while being involved in a rational approach to regional service improvement. Throughout our planning and implementation, we are developing robust business cases, and ensuring strong financial accountability.

While plans are being developed for improvements and expansions, these will take time to proceed through regional and national capital approval processes, tendering and building. Hutt Valley DHB will therefore be at risk of not meeting elective targets in the short to medium term. Mitigation strategies are being developed in an Interim Capacity Plan, including use of theatre capacity at other sites and demand management at a local level.

Infrastructure: Information
It is expected that the 12 Action Zones of the New Zealand Health Information Strategy (HIS-NZ) will be implemented throughout the NZ health sector. In the absence of independent funding for HIS-NZ projects, we are identifying local and regional priorities in the Hutt Valley DHB Information Systems Strategic Plan (ISSP), and addressing them as resources become available. Hutt Valley DHB is planning for the development of an Electronic Medical Records (EMR) referral system. We are interested in being a national pilot site for this project.

4.3 Service Reviews and Changes

We propose to undertake a number of service reviews during 2006/07. A selection of services will be reviewed during the planning period to ensure the DHB reaches its budgeted financial position for 2006/07 and to advance issues of improving access to services and reducing inequalities for our populations.

Local reviews and changes planned are:

- Review Diabetes outreach services.
- Review Community respiratory services.
- Deliver elective gynaecology at Hutt Hospital (rather than Boulcott Hospital).
- Review community pharmaceutical prescribing.
- Cease payment for community laboratory services performed for private hospital and private specialists.
- Implement the national School Dental Review service recommendations, if fully funded by the Ministry of Health.
- Implement the regional five year mental health and addiction service plan.
- Develop and implement a plan for psychogeriatric and mental health services for older people.
- Review Maori and Pacific alcohol and addiction services.
- Review the Hutt Valley Older Persons service plan.
- Develop an integrated continuum of care for services for older people.

These reviews and plans may lead to service reconfigurations, the extent of which is unknown at this stage. It is noted that any reconfigurations will be preceded by consultation with the appropriate groups.

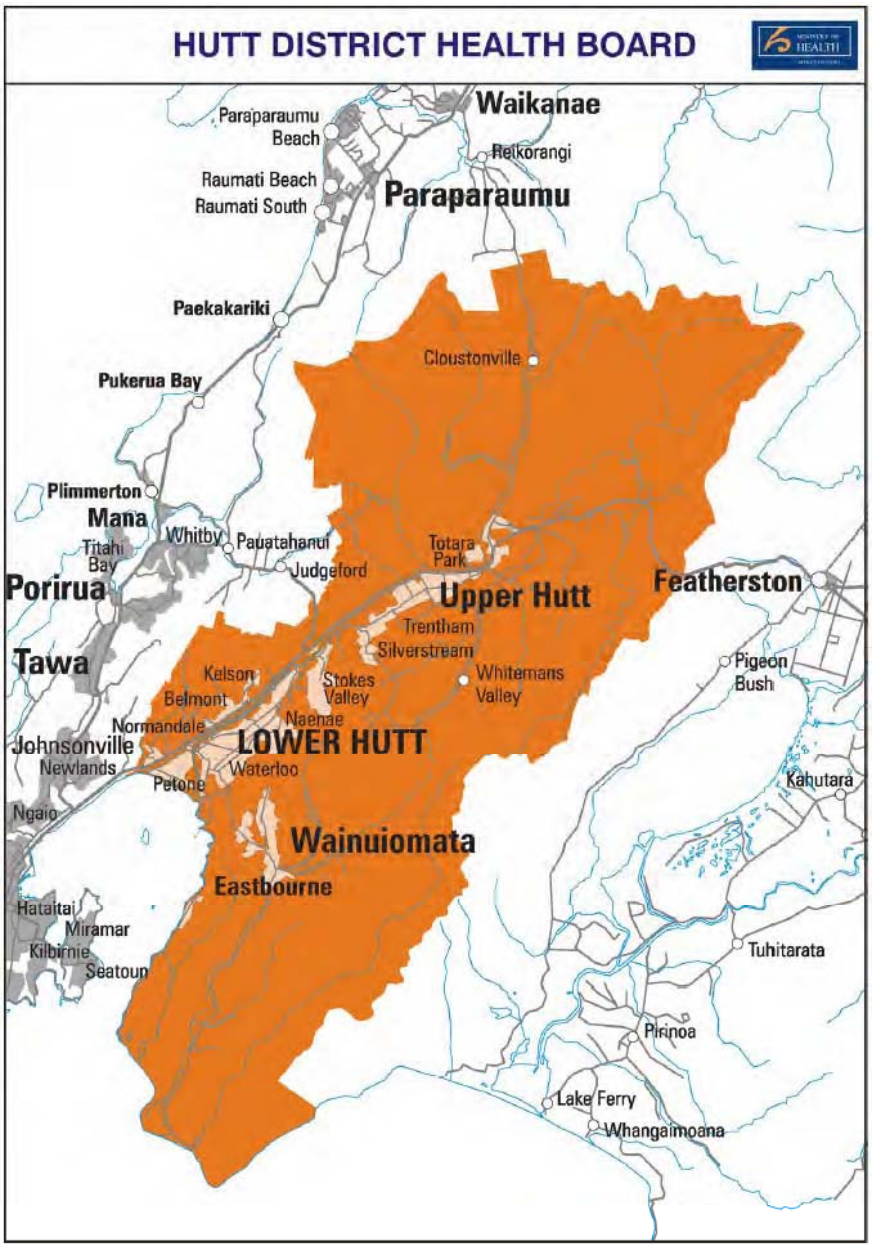
In addition to the local reviews, we will also review a number of regional services or areas which may have an impact on other DHBs. These include:

- Review our Information Systems Strategic Plan, including consideration of local and regional approaches to sharing of clinical and service information.
- Review tertiary sexual health services.
- Implement CEOs' decision for a national haemophilia risk pool.
- Develop the Integrated Campus Plan, business cases and an interim plan to enhance local capacity for delivery of medical and surgical services.
- Assess cardiology, general surgery, gynaecology, orthopaedics, respiratory and , ear, nose and throat services to identify ways of increasing local access and/or delivery.
- Increase delivery of oncology outpatient services at Hutt Hospital by the end of 2006/07. If there is insufficient progress, move towards the development of an oncology service at Hutt Hospital in 2007/08.
- Explore the viability of delivering neurology and renal medicine (haemodialysis and CAPD) outpatient services at Hutt Hospital. If there is insufficient progress, move towards the development of services at Hutt Hospital in 2007/08.
- Increase delivery of dental inpatient and daycases by Hutt Valley DHB.
- Work with other central region DHBs, and Capital and Coast in particular, to improve access to and increase local delivery of urology services for the residents of Hutt Valley.
- Review effectiveness and utilisation of regional mental health services (including Regional Specialty Services and forensic services).
- Review delivery of technical and other services by the central region shared services agency, Technical Advisory Services (TAS), in conjunction with other central region DHBs.

It has been indicated that some additional child and youth services are planned for implementation in 2006/07 (e.g. hearing tests for neonates, increased wellchild checks for preschoolers, child and adolescent mental health services, improved oral health services and free primary care services for under six years olds). If Hutt Valley DHB is expected to incur additional costs as a result, we are assuming that these will be fully funded.

5. Our People

This section provides background on the environment in which Hutt Valley DHB operates. It outlines geographical location, analysis of the environment, population profile and illustrates the DHB's objectives in relation to health priorities for the Hutt Valley district.



5.1 Population and Demographic Information

Hutt Valley DHB covers the areas controlled by our two local councils, Hutt City and Upper Hutt City. Our neighbouring DHBs are Capital and Coast, Wairarapa and Mid Central DHBs. The Hutt Valley is at risk of flooding from the Hutt River. The Hutt Valley is also at risk of major earthquakes because of major seismic fault lines that run through and near it. It should be noted that the following population information is based on data projected from the 2001 Census as data from the 2006 Census is not expected to be available until November 2006.

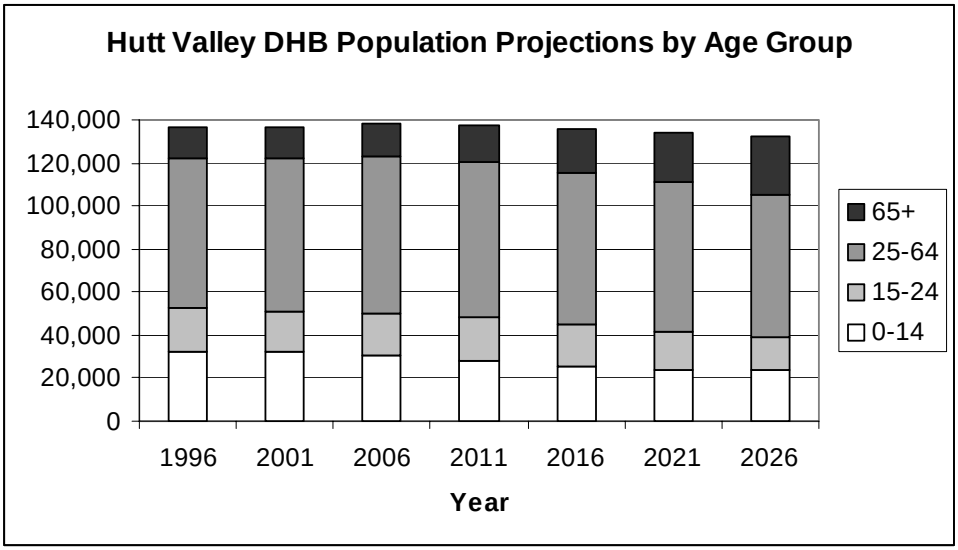
Today around 139,000 people live in the Hutt Valley – 100,000 in Hutt City and 39,000 in Upper Hutt City. 17% of the people who live here are Maori and 8% are Pacific peoples. Fewer Maori and Pacific people (as a percentage of the population) live in Upper Hutt than Hutt City. More of the Maori and Pacific people who live here are younger than other ethnic groups - half of the Maori and Pacific people here are aged under 25. We also have significant Asian and refugee populations.

The total Hutt Valley population has seen only slight growth since 1996 and is projected to peak around 2006. However, both Hutt Maori and Pacific populations are projected to increase at around 1 percent per annum over the next 20 years and make up an increasing proportion of the Hutt Valley population. The total projected population drop is driven by other ethnicities which are projected to slowly decrease over time. It is expected that the number of people living here will fall a little to 132,000 in twenty years time. We will also have more older people and fewer young people living here in the future.

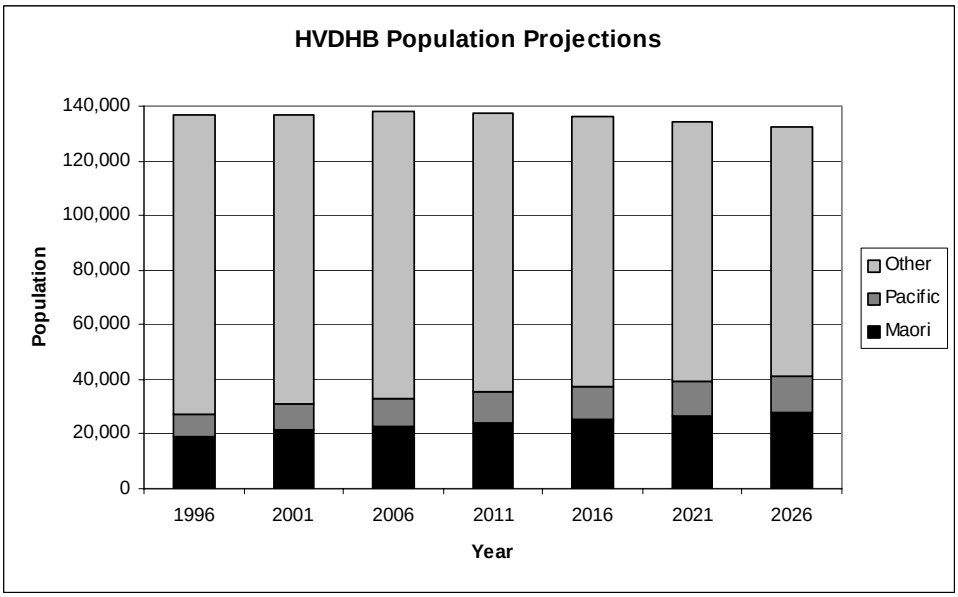
Hutt Valley Projected Population 2006 by Age and Ethncity

	# Maori	# Pacific	# Other	# Total	% Maori	% Pacific	% Other
Children 0-14 Years	8,260	3,340	19,710	31,320	26%	11%	63%
Youth 15-24 Years	4,030	1,890	13,230	19,130	21%	10%	69%
Adults 25-34 Years	3,520	1,680	12,070	17,280	20%	10%	70%
Adults 35-44 Years	3,220	1,480	17,360	22,070	15%	7%	79%
Adults 45-54 Years	2,260	1,060	15,970	19,280	12%	5%	83%
Adults 55-64 Years	1,110	700	12,170	13,980	8%	5%	87%
Older Persons 65-74 Years	460	290	7,820	8,580	5%	3%	91%
Older Persons 75-84 Years	90	80	5,310	5,490	2%	1%	97%
Older Persons 85+ Years	10	10	1,780	1,810	1%	1%	98%
All Ages	23,000	10,500	105,400	138,900	17%	8%	76%

Source: Statistics New Zealand



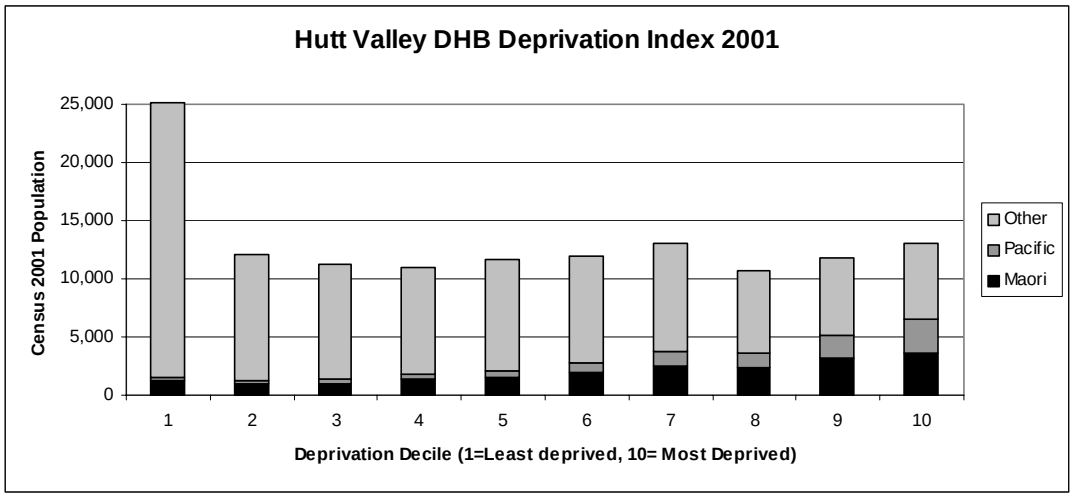
By 2026, the percentages of Maori and Pacific people is expected to increase to around 21% and 10% respectively of the total Hutt population.



Deprivation

While the Hutt Valley community is less deprived than New Zealand as a whole, some groups in our community are more deprived than others. One third of Maori in the Hutt Valley fall into the two lowest decile groups, and nearly half of Pacific people living in the Hutt Valley fall into these two lowest groups. One half of those in the lowest two decile groups are neither Maori nor Pacific.

Parts of our district with high deprivation include Taita, Naenae, Pomare, Moera, Timberlea, and parts of Stokes Valley, Wainuiomata, Petone, Waiwhetu and central Upper Hutt.



Hospitalisations

14,000 Hutt Valley adults and 5,000 Hutt Valley children need to stay in hospital every year. Some have more than one visit meaning there are 20,000 adult and 6,000 child stays. Two thirds of these stays are at our local Hutt Hospital, with a quarter at Wellington hospital. Older people visit hospital the most - a quarter of all people aged over 75 need to stay in hospital each year. Figures show Maori and Pacific people are 10-20% more likely to need to stay in hospital, particularly for infectious diseases and diabetes. More people need to go to hospital each year. Reasons include increasing amounts of chronic disease as the population ages as well as the development of new treatments.

Age Group	Leading Causes of Hospitalisation
Children 0-14 years	Respiratory diseases, Injury and poisoning, Perinatal conditions
Youth 15-24 years	Pregnancy and childbirth, Injury and poisoning (road traffic accidents and suicide)
Adults 25-44 years	Pregnancy and childbirth, Injury and poisoning (road traffic accidents and suicide)
Adults 45-64 years	Circulatory diseases, Cancers, Respiratory diseases
Older People 65-84 years	Circulatory diseases, Cancers, Digestive diseases
Older People 85+ years	Circulatory diseases, Falls, Respiratory diseases

Deaths

Around 1,000 Hutt Valley people die every year. Three-quarters of those that die are over 65, and more than half are over 75 years old. Fewer young people die now than in the past. Of the Hutt Valley people that die, 80% die of chronic diseases. More men than women die in each age group. This difference is particularly marked in the 15-44 age group as many more men die as a result of accidents.

A woman born today will live an average of 81 years in New Zealand, while a man will live on average 76 years. A Maori woman born today can expect to live on average 73 years, while a Maori man can expect to live 69 years. Proportionately more Maori die in the 45-64 age group from chronic diseases when compared with the total New Zealand population.

Hutt Valley death rates for specific causes are similar to those nationally. The lead causes of death are set out in the table below.

Age Group	Leading Causes of Death
Children 0-14 years	Perinatal conditions, Birth defects, Injury and poisoning
Youth 15-24 years	Injury and poisoning (road traffic accidents and suicide)
Adults 25-44 years	Injury and poisoning (road traffic accidents and suicide), Cancers (breast), Circulatory diseases
Adults 45-64 years	Cancers (lung, breast, colon), Circulatory disease, Respiratory diseases
Older People 65-84 years	Circulatory diseases, Cancers (lung, breast, prostate, colon), Respiratory diseases, Diabetes
Older People 85+ years	Circulatory diseases, Respiratory diseases

5.2 Key Health Issues

In 2004/05 the health needs of the six central region DHBs (Capital and Coast, Wairarapa, Hawkes Bay, Wanganui, Mid-Central and Hutt Valley) were assessed. That assessment included a lot of data on what sort of people made up our populations, what factors were affecting their health and what health services they used the most. If you would like more information from that assessment, you can refer to our website (www.huttvalleydhb.org.nz).

In the Hutt Valley some groups of people have poorer health and often have poorer access to health services than other groups – these differences are known as health disparities. These groups include Maori, Pacific, refugees and those living in the poorest areas of the Valley. They also include groups who can become socially isolated, such as people with disabilities or with mental health issues. They have shorter lives (on average) and higher rates of chronic diseases - and they develop those diseases earlier in their lives than other groups. As well, when they get those diseases, the treatment they receive from the health system tends to be more variable than for other groups. Their health is often affected by factors outside the direct control of the health system, such as access to transport, or inadequate or inappropriate housing.

In general the key health issues for the Hutt Valley are the same as for the population of New Zealand. There are a variety of ways to compare the leading health conditions in New Zealand. The ranking of the top causes of premature death and disability depends on the specific method used, but the following causes consistently appear for both men and women and for all ethnicities:

- Cardiovascular disease (heart disease and strokes)
- Diabetes
- Cancer
- Depression
- Chronic Obstructive Respiratory Disease
- Asthma
- Suicide and self harm

We can help to improve health by working to prevent ill health, so that people don't need hospital care; and by ensuring when they do get unwell, they get services in the community so they don't require hospital care. The Ministry of Health has studied why people under the age of 75 end up in hospital beds[18]. The study showed that

30% of those hospital stays could be potentially avoided. Leading causes of death in the Hutt Valley are similar to the rest of New Zealand, with cardiovascular disease and cancer accounting for nearly three quarters of deaths. Injuries account for around 6% of deaths and these are mostly amongst people in the 15-24 and 25-44 age groups. Diabetes is a major contributor to cardiovascular and other deaths. In the late 1990s studies showed that 70% of the people who died under the age of 75, could have lived longer if diseases such as cardiovascular disease and cancer, as well as injuries, were avoided or treated earlier[5].

5.3 Maori Health

We are committed to the Hutt Valley Maori Health Strategic Plan[2], Whanau Ora ki te Awakairangi, and to He Korowai Oranga[6], the national Maori health strategy. We acknowledge the special relationship between Maori and the Crown reflecting the Treaty of Waitangi and the principles of partnership, protection and participation. Maori in the Hutt Valley have, on average, worse health than the wider Hutt Valley community. We developed in partnership with the Te Awakairangi Hauora Board and the Maori community here in the Hutt Valley, the Maori Health Strategic Plan, designed to improve the health of the Maori community.

The current Hutt Valley Maori population is around 23,000 people, or 17 percent of the Hutt Valley population. The proportion of Maori in the Hutt Valley is slightly higher than the national average of 15 percent. By 2021 the Hutt Valley Maori population is projected to grow to around 26,800, or around 20 percent of the total Hutt Valley population.

The gender and age distribution of Hutt Valley Maori is similar to that for Maori nationally, younger than the total population with over half aged under 25 years. Of the total Hutt Valley population under 25 years, nearly a quarter are Maori. Most of the future projected growth in the Hutt Valley Maori population is in the older age groups.

The tangata whenua (local Iwi) within Te Awakairangi (the Hutt Valley) are Te Atiawa. The mana whenua organisation for the Hutt Valley district is Te Runanganui o Taranaki Whanui ki te Upoko o te Ika a Maui Inc. In the 2001 Census, nearly 22,000 Hutt Valley residents indicated having Maori descent, however of these around 2,300 but did not self-identify as Maori. Nearly 16,800 specified belonging to one or more Iwi while around 3,900 didn't know their Iwi.

Suburbs with high proportions of Maori (20 percent and over) include Wainuiomata, Gracefield, Moera, Waiwhetu North, Taita, Naenae, Trentham South, Maidstone, Maoribank, Upper Hutt Central, Esplanade (Petone), Holborn and Delaney (Stokes Valley West).

Cardiovascular disease (mainly ischaemic heart disease and stroke) account for around 40 percent of Hutt Valley Maori deaths, while cancers account for just over 20 percent. Diabetes is a major contributor to cardiovascular and other mortality. While suicides and injury accidents account for around 7 and 5 percent of Hutt Valley DHB Maori deaths respectively, these are concentrated in the 15-44 year age group. After age-standardising for differences in population structure, Hutt Valley Maori have a total death rate of 1.6 times that of other ethnic groups (excluding Pacific Peoples). Relative death rates are even higher for Sudden Infant Death Syndrome, diabetes, endocrine, circulatory & respiratory diseases and lung cancer.

Pregnancy and childbirth account for nearly a fifth of Hutt Valley Maori hospital admissions. Hutt Valley Maori hospitalisations vary by age group with just over a

third in children. In comparison to the population numbers by age group, admission rates are highest in the young (<1 years) and the old (55+).

5.4 Pacific Health

Hutt Valley is one of seven District Health Boards (DHBs) with specific responsibility for addressing Pacific Health inequalities given its relatively high Pacific population. Our Pacific Health Action Plan represents Hutt Valley DHB's on-going commitment to improving the health of Pacific community in the Valley. The Action Plan will guide development and help inform decision-making around Pacific People Health in the Hutt Valley over the period 2004-2007

Approximately 10,500 Pacific people are resident in the Hutt Valley with a projected 11% increase over the next 5 years. The Pacific population in the Hutt Valley is generally younger than the rest of the population and experience higher levels of deprivation than both Maori and non-Maori in the Hutt Valley. 60% of the Pacific population in Hutt Valley is Samoan, with the next biggest island groupings being Cook Island Maori and Tokelauan.

Pacific people experience significantly poorer health than non-Pacific. In particular, they experience high rates of chronic diseases such as diabetes and heart disease – diseases that are mainly avoidable through good preventative strategies such as exercise and diet. Pacific people also experience the highest rates of ambulatory sensitive hospitalisations in the Hutt Valley. Pacific adults have high admission rate for congestive heart failure and coverage rates for breast cancer is lower for Pacific than non-Pacific women.

Pacific children suffer higher rates of vaccine-preventable infectious diseases (e.g. measles), asthma and injuries and also have higher rates of other infectious diseases and their complications (e.g. meningococcal disease, rheumatic fever, respiratory infections, glue ear and skin infections).

Health issues for Pacific youth are no different from those that affect other age groups or non-Pacific. These include: mental health issues such as depression and suicide, drug and alcohol, personal health issues such as sexual and reproductive health, and accidental injuries. The importance and the complexity of Pacific values and cultures, the differences between New Zealand born and Island born are all key elements that put pressure on Pacific youth to adapt to both Pacific and NZ based-culture. Because of the cultural diversity of Pacific communities and a multiplicity of languages, protocols, beliefs and traditions the importance of culture must be recognised as a determinant of health.

The major causes of death for Pacific people in the Hutt Valley are ischaemic heart disease and diabetes, followed by breast cancer, lung cancer, stroke, suicide and motor vehicle crashes. Pacific people are more likely to die before 65 years of age than non-Pacific.

The Vision For The Future Of Pacific Health In The Hutt Valley, being implemented through the DHB's Pacific Health Action Plan, is:

- Optimising wellness for children, youth and family health.
- Promoting healthy lifestyles and illness prevention.
- Targeted support for Pacific patients and their families accessing mainstream services.
- Development of quality services targeting Pacific peoples both through Pacific and mainstream providers.

- Improving mainstream capacity and capability to work with Pacific communities and their families.
- Strengthen existing foundations both at a community and provider level.
- Pacific input into service planning and needs assessment.

5.5 Disability Profile

Information available from Census data indicates that an estimated 23,000 Hutt Valley residents with some form of disability and around 15,000 of those people are younger than 65 years. National disability surveys do not generally provide information at a District Health Board level. Because their disabilities differ, people's needs vary widely, as do the needs of their families, carers and whanau. Most disabled people (95%) live in the community with only 13% of older disabled people in residential care and fewer than 1% of disabled people under the age of 65 are in residential care.

6. Nature and Scope of Activities

The activities of the DHB fall into three categories:

- Governance
- Planning and Funding
- Provision of Services.

6.1 DHB Governance

The Board consists of eleven members and is the governance body responsible for operation of the Hutt Valley DHB under the NZPHD Act 2000. Seven of the members are elected as part of the triennial local body election process (last held in October 2004) and four are appointed by the Minister of Health by notice in the Gazette.

The Board has all the powers necessary for the governance of the DHB and has a delegation policy, approved by the Minister of Health, to delegate decisions on management matters to the Chief Executive. It has the following sub committees comprised of Board members and community representatives, the first three of which are Statutory Committees under sections 34 – 36 of the NZPHD Act 2000. In accordance with schedule 4 of the NZPHD Act 2000, public notice of the date, time and venue of meetings of the Board and committees must be provided.

We've set up a number of advisory committees to the Board:

- Community and Public Health Advisory Committee: This committee provides advice and recommendations to the Board on the health needs of Hutt Valley people and advises the Board on priorities for the use of the available health funding.

- Disability Support Advisory Committee: This committee provides advice and recommendations to the Board on the disability support needs of Hutt Valley people. It also provides advice and recommendations to the Board on priorities for the use of the available disability funding.

- Hospital Advisory Committee: This committee monitors the performance of the hospital and other services run directly by the DHB. It also makes recommendations on priorities for hospital funding.

- Finance and Audit Committee: This committee monitors the DHB's financial performance. It is required to provide sound advice to the Board on the financial affairs of the DHB. It also oversees all DHB audits and information systems.

All the meetings of our committees, except the Finance and Audit Committee, are open to our community to attend. The public are excluded from some items if a good reason exists – for example if the Board is receiving an update on commercial negotiations.

To ensure the cohesiveness of the governance function, the Chair and Deputy Chair of the Board meet regularly with the chairs of the various Committees. In general, all meetings where the Board or any of its Statutory Committees make decisions are open to the public to attend, as observers. Certain discussions may be held without public presence as outlined within the NZPHD Act. All DHB Board and Statutory Committee meetings are held monthly.

Details of Board and Committee meetings are publicly available on the DHB website, www.huttvalleydhb.org.nz. Hutt Valley DHB's organisational structure can be found in appendix 1.

Also, Hutt Valley DHB jointly funds the Central Region Technical Advisory Service (TAS) to provide support to the Central Region DHBs. The purpose of TAS is to support the effective functioning of District Health Boards so they can meet the objectives of the New Zealand Health Strategy and the New Zealand Public Health and Disability Act 2000. TAS operates as an expert advisory service that combines information management and analytical capabilities with health service experience and project management skills to provide quality health service advice to DHBs. A core range of support services have been established around the following areas:

- Information management and applied analysis.
- External audit and quality improvement of contracted providers.
- Regional mental health work.
- Service evaluation and development.

6.2 DHB Planning and Funding

Planning and Funding core activities are:

- Determining the health and disability needs of the community
- Operationalising national health and disability strategies in relation to local need
- Funding health and disability services in the District
- Involving the community through consultation and participation
- Identifying service gaps and developing services accordingly
- Undertaking service contracting and monitoring and evaluation of service delivery, including audits.

The Planning and Funding area of Hutt Valley DHB is also responsible for arranging access to specialist services that are not delivered in the district. Government policies and priorities guide the planning and funding of health and disability services. Funding is also carried out within national policies, such as the Nationwide Service Framework. This framework sets out the criteria for access. The Planning and Funding area is responsible for planning and funding the following services:

- Primary care.
- Hospital and specialist services.
- Mental health services.
- Support services for older people (including residential services).
- Māori health.
- Pacific health.

In funding these services, Hutt Valley DHB strives to maintain and improve the health of the resident population of the Hutt Valley district; within the constraints of the funding allocated. Hutt Valley DHB receives funding from the Government for the majority of personal health, mental health, Māori health and older persons services for Hutt Valley residents as per the Service Coverage Schedule. Funding for public health and under-65s' disability support services remains with the Ministry of Health.

Hutt Valley DHB has designed the organisation to maintain a clear separation between management of planning and funding activities and management of hospital service provision activities. This is to avoid any real or perceived conflict of interest with respect to being seen to be unfairly favouring our hospital service provider in funding decisions.

6.2.1 Decision-Making Framework

We cannot fund all the new services people would like us to fund. We need to decide what new services we should provide. We have developed a framework to help us decide what should get priority. The key principles of this framework are:

- Effectiveness
- Equity
- Acceptability
- Consistency with the New Zealand Health Strategy & New Zealand Disability Strategy
- Value for Money
- Maori development in health

Hutt Valley DHB has developed a methodology to apply these principles and to score service proposals and rank them in priority order. The ranking thus derived is an

input to the Board decision-making process. More information on our decision making principles and the prioritisation scoring tool can be found in Appendix 9.

6.3 DHB Objectives

The following sections provide an overview and specific annual objectives for the services to be funded and/or provided by Hutt Valley DHB during 2006/07.

6.3.1 Reducing Inequalities

What does the DSP say and other key directives?
Reducing health disparities is a focus of the New Zealand Health Strategy and improved health equity is a key goal of Hutt Valley DHB.

What progress was made in 2005/06?
All funding proposals are assessed against equity criteria, including the Health Equity Assessment Tool[19], and service reviews included an equity focus, utilising the Reducing Inequalities Intervention Framework[20]. Education of staff in the area of inequalities continues through presentations given within the DHB's Cultural Training and Leadership Training programmes. Inequalities analysis was included both within the Health Needs Assessment (see section 5.2) that was undertaken as part of District Strategic Planning and as part of the District Annual Planning process.

What is planned for 2006/07?
Ongoing use of equity tools in planning, funding and service development and staff education in inequalities will be continued. Inequalities analysis will be focused on the key priority areas identified within this plan.

Annual Objective 1: All planning, funding and service review activities consider current inequalities and include remedial actions in future activities	
Measures and Targets (see Appendix 7) RIH-01 Progress toward further incorporating health inequalities concepts and actions into overall policy, planning, funding and service provision.	
Approach 1.1: Application of equity assessment tools in the review and development of services and in annual service planning, focussing on key priority areas.	
Milestones 1.1: • Inequalities analysis for 2007/08 business planning – Q2. • Use of Reducing Inequalities Intervention Framework and Health Equity Assessment Tool in service planning and development – ongoing.	
Position Responsible 1.1: Director Planning, Funding and Public Health	
Risks 1.1	**Mitigations 1.1**
Limited analytical resource	Focus analysis on key priority areas
Approach 1.2: Continue education of DHB staff in the area of inequalities.	
Milestones 1.2: • Inequalities presentation continuing within the DHB's cultural training programme. • Inequalities presentation continuing within the DHB's leadership training programme.	
Position Responsible 1.2: Population Health Outcomes Manager	
Risks 1.2	**Mitigations 1.2**
Only limited numbers of staff can attend the programmes each year.	Explore the potential for other one-off presentations to ensure wide coverage of staff.

6.3.2 Primary Health Care

There are six PHOs in the Hutt Valley, which together include 31 medical centres located within the district. Together, their enrolled populations represent about 96% of the DHB's total population.

	Established	Practices	Population
Piki te Ora ki Te Awakairangi	Oct-02	3	12,809
Mid Valley Access PHO	Apr-04	3	20,739
Valley PHO	Apr-04	21	62,607
Ropata Community PHO	Oct-04	1	16,480
Tamaiti Whangai PHO	Jul-04	2	4,711
Family Care PHO	Jul-05	1	14,703
Total		31	132,049

The DHB is working closely with these PHOs to identify how together, we can make further progress in implementing the Primary Health Care Strategy. This includes exploring what scope there is for further improvements in access to services, disease prevention and co-ordination of services. It may also involve other providers becoming more closely involved with PHOs in the future. In particular, we are looking for increased efforts to reduce the incidence and impact of chronic conditions.

What does the DSP say and other key directives?
Developing primary health care is one of the DSP's eight key strategies for the next five years. By developing primary health care and building on the gains made in implementing the Primary Care Strategy, we will contribute to our DSP's six key goals.

What progress was made in 2005/06?
In 2005/06, we:

- Worked with all PHOs and primary care providers on how after hours care could best be provided in the Hutt Valley
- Supported the development of a valley-wide primary health support agency, Kowhai Health Trust, which is now providing PHO management services to three PHOs in the Hutt Valley
- Worked with PHOs, the DHB provider arm and Kowhai Health Trust to introduce a warfarin management programme which assists general practitioners manage these patients in the community
- Supported primary mental health service development in the Hutt Valley
- Supported one PHO enter the PHO Performance Indicator Framework
- Reviewed and agreed PHO Business Plans in accordance with their different annual cycles
- Continued to work closely with all PHOs. The DHB continues to host and facilitate a PHO Forum which provides an opportunity for parties to share ideas, discuss spending priorities and new service developments.
- Commenced evaluation of the low income oral health service pilot which Piki te Ora ki Te Awakairangi is funded to deliver
- PHOs established and increased their levels of Care Plus service delivery.

What is planned for 2006/07?
We will work with PHOs to ensure better access to general practitioners for most Hutt Valley people continues and that this includes after hours services. We will build on programmes that improve access and promote good health amongst the communities PHOs serve. These will include preventative efforts encouraging people to eat healthier food, exercise more, stop smoking and reduce alcohol misuse so that people are less likely to get serious long-term diseases, as well as increased participation in screening programmes aimed at detecting diseases (including cancer) at an early stage so they can be treated earlier. We will work with health providers in the community to ensure people know the benefits of immunisation.

A key focus will be the management of people with chronic conditions and how we can assist PHOs manage these people in primary and community settings, including how we provide education to patients so they can manage better with a chronic illness. This will involve the DHB continuing to encourage and support PHOs as they increase their levels of Care Plus service delivery.

Annual Objective 2: Further improve access to primary health care services, with a particular focus on the health of high need groups and the management of people with chronic conditions.

Measures and Targets (see Appendix 7)
SER-01 Accessible and appropriate services in PHOs (also a Board DSP Indicator)
SER-02 Care Plus Enrolled Population (also under Chronic Diseases)
SER-04 Low or reduced cost access to first level primary care services
Primary Care Utilisation (National Core Measure)

Approach 2.1: Work with all six PHOs and Kowhai Health Trust to continue developing access to primary health care services including:

- CarePlus services.
- Primary mental health services.
- After hours services.
- Identify and implement activities that will improve the health of high needs groups in the Hutt Valley and which promote healthy choices so that the health of our community can be improved.

Milestones 2.1:

- Encourage PHOs to increase Care Plus uptake levels in each quarter.
- By Q2, assess how current efforts to better co-ordinate cardiac and respiratory services between community-based providers and the hospital services are working, and establish what changes may be necessary to improve service integration from a patient perspective.
- Throughout 2006/07, continue to support primary mental health service development by MidValley Access PHO and Piki te Ora ki Te Awakairangi PHO.
- Work with PHOs to ensure ongoing provision of after-hours cover in the Hutt Valley throughout 2006/07.
- Throughout 2006/07, monitor the fees set by PHO general practices to ensure they support low cost/reduced cost access.

Position Responsible 2.1: Senior Portfolio Manager, Planning and Funding.

Risks 2.1	**Mitigations 2.1**
PHOs fail to increase Care Plus uptake levels.	Withhold PHO Care Plus funding until necessary uptake levels are achieved.
Difficulty reaching agreement between community-based providers and the	Engage early with service providers and involve them in any change processes.

Provider Arm on how cardiac and respiratory services can be better co-ordinated and who should be responsible for delivering different parts of the patient continuum of care.	Assist the parties to understand each other's area of responsibility and how, by working together, they might improve cardiac and respiratory services from both a patient and provider perspective.
PHO fee structures are not consistent with low cost/reduced cost access.	If discussions with PHOs do not achieve a review of fees, activate the Fees Review Committee process specified in the PHO contract.
Approach 2.2: Increased emphasis on preventative efforts by PHOs, with a focus on Healthy Eating Healthy Action and cancer prevention strategies.	
Milestones 2.2: • Throughout 2006/07, Regional Public Health supports each PHO to develop a health promotion leader capacity and assists with the provision of appropriate health promotion training for PHO governance, management and staff.	
Position Responsible 2.2: Senior Portfolio Manager, Planning and Funding	
Risks 2.2	**Mitigations 2.2**
PHOs are unable or unwilling to develop a stronger health promotion role.	Work closely with PHOs to assist them better understand the importance of health promotion activities and encourage them to explore opportunities to collaborate with each other and with Regional Public Health.

Annual Objective 3: Assist primary health care to increase the general practitioner and primary health nursing numbers in the Hutt Valley.
Measures and Targets (see Appendix 7) Primary Care Workforce (Board DSP Indicator).
Approach 3.1: Work with PHOs, GP and nurse leaders within the Hutt Valley and Kowhai Health Trust to address the challenge of an ageing workforce and an increasing shortage of skilled health professionals within primary health care through implementing specific strategies detailed in the DHB's Strategic Workforce Development Plan 2005-2011 and the implementation of specific recommendations from the Primary Health Care Nursing Project
Milestones 3.1: • By Q2, subject to Provider Arm capability, rotate junior doctors through general practice and continue the career pathway through the GP registrar programme. • By Q1, determine whether we can continue to financially support the new graduate programme for primary health care nurses. • From Q1, provide access to the DHB's Healthy Job web pages for primary and community providers to advertise vacancies. • By Q2, determine whether we can assist with the establishment of a nursing leadership position with the primary care environment, subject to funding availability. • By Q2, establish a casual pool for practice nurses to work in primary health care settings throughout the Hutt Valley, subject to support from primary care and funding availability.
Position Responsible 3.1: Senior Portfolio Manager, Planning and Funding.
Risks 3.1 | **Mitigations 3.1**

Workforce strategies do not ease the immediate pressure on the primary health care workforce.	Actively engage with primary health care providers to ensure that workforce strategies which the DHB is pursuing have their support and are likely to have a positive impact on the primary care workforce.

Annual Objective 4: Monitor PHOs to ensure that they are making a positive difference in the communities they serve.	
Measures and Targets (see Appendix 7) SER-03 PHOs participating in Performance Management Programme. SER-05 The proportion of laboratory and pharmaceutical transactions with a valid National Health Index (NHI).	
Approach 4.1: Use a variety of information to monitor PHO activity.	
Milestones 4.1: • From Q1, report quarterly to our Board on PHO performance, using the information from the PHO Performance Management Programme as a basis for these reports. • From Q1, use information from the MoH on CarePlus to keep our Board informed of uptake and actions which might increase uptake, by individual PHOs .	
Position Responsible 4.1: Senior Portfolio Manager, Planning and Funding.	
Risks 4.1	**Mitigations 4.1**
PHOs object to the PHO Performance Management Programme being used as a basis for reporting to our Board.	Discuss the reports on PHO performance that we submit to our Board with PHOs, and include their suggestions for improvement where appropriate.
PHOs continue to have difficulty increasing Care Plus uptake.	Using the MoH funded evaluation of Care Plus, convene discussions with PHOs from Q1 to discuss and share ideas about how delivery of Care Plus programmes by our six PHOs could be enhanced.

6.3.3 Hospital and Specialist Services

Hutt Valley DHB's Provider Arm provides a range of secondary and tertiary services to the people within the Hutt valley and central region districts. Inpatient and outpatient services are provided from Hutt hospital.

For more detail of the provider arm volume schedule, see Appendix 6.

Key contracted service outputs
The table below provides the key contracted service outputs as agreed between Planning & Funding team of the DHB for the year. This includes only those services purchased by the DHB as a funder, and provided by the DHB's Provider Arm. It is important that the DHB provides the number of operations that they are contracted to provide.

Contracted ouput/service	Measure/Unit	2005/06 Volumes	2006/07 Volumes	Variance %
Medical in-patient	Caseweights	6,954	6,875	-1%
Surgical in-patient	Caseweights	9,345	9,381	0%
Medical out-patient	Attendances/Procedures	27,701	28,208	2%
Surgical out-patient	Attendances/Procedures	39,901	40,952	3%
Mental health	FTE/Bed days	10,980	10,978	0%
Emergency department	Attendances	35,343	35,612	1%
Maternity	Attendances/Procedures	5,542	5,652	2%
Disability Support Services	FTE/Bed days	12,234	13,727	12%
Personal/Community Health		158,510	161,484	2%
Total		**306,509**	**312,869**	**2%**

What does the DSP say and other key directives?
There are three key strategic goals that apply to hospital and specialist services:
- Effective, Efficient and High Quality Services.
- Seamless Integration.
- Prevention, Early Treatment and Easy Access.

Redesigning services and consolidating gains is a key strategy that focuses on the need to address acute demand problems and to identify process improvements to look at ways in which the DHB can improve what it does.

Healthy Eating Healthy Action (HEHA) activity and primary health care management of chronic diseases (diabetes, cardiovascular, and respiratory) are mostly delivered in community settings but are expected to impact on hospital activity in the medium to long term.

What progress was made in 2005/06?
Specific activities to reduce acute demand included a focus on managing challenging behaviour and difficult residents through policy development, staff training, and establishing a telephone consultancy service to enable management of such people in the community setting, rather than referring them to the hospital.

Hospital in the home has been developed to allow earlier discharge and care of patients at home. There has been a focus on development of the after-hours primary

care service, the success of which has a direct impact on the emergency department. The sections on chronic diseases and elective services also report on progress made.

What is planned for 2006/07?
The DHB will continue to focus on reducing the pressure of the acute inpatient demand through process improvement, innovation and improving links with primary care. Better management of chronic disease in primary care will have an impact (see the Chronic Diseases and Primary Care sections).

Clinical and non-clinical support services, such as social work, community nursing and home support, have emerged as particular areas needing attention to allow earlier discharge in a number of services. The Interim Capacity Plan will help us to identify system and process improvements in the management of acute patients to allow earlier discharge.

Annual Objective 5: Improve the management of acute inpatient demand.

Measures and Targets (see Appendix 7)
HKO-03 Improving Mainstream Effectiveness (also under Quality and Maori)
Total Cost Weights/Relevant FTEs (National Core Measure)
Hospital Performance (Board DSP Indicator)
Hospital Benchmarking Information

Approach 5.1: Focus on process improvement initiatives to facilitate the timeliness of assessment, treatment and discharge of patients.

Milestones 5.1:
- Extend the delerium and dementia specialist nurse role from the provider arm to residential care facilities to improve care for residents from Q1.
- Pilot of "one point of entry" service for older people completed by Q1 with evaluation by Q2.
- Coordinate with implementation of electronic referrals (see section on Information Services)
- An agreed work programme for psychogeriatric and mental health for older people services completed by Q3 (see section on Older People).
- Nurse led initiatives (ED "sift and sort" nurse; Medical outreach nurse; Medical discharge nurse) are scoped and established from within existing establishment to support patient flow into and out of secondary services by Q4.

Position Responsible 5.1: Manager Acute and Chronic Care.

Risks 5.1	**Mitigations 5.1**
Electronic referral process not completed.	Continue to work with Information Services to develop an appropriate referral system.
Clinicians are reluctant to share decision-making with nurse clinicians/specialists.	Ongoing education and awareness of impact of nurse led initiatives.

Approach 5.2: Focus on developing and maintaining collaborative and supportive relationships among secondary services and between secondary and primary care to facilitate seamless patient care.

Milestones 5.2:

- Following data gathering and planning in 2005/06, pilot measures to improve the responsiveness of community health and support services in Q1 and evaluate in Q3.
- Mental health/ ED self harm collaboration project is developed by Q2.
- Links with primary care and secondary care specialists to support medical and nursing and allied health activity in the community are established by Q3.
- Links with hospice to improve care of end stage heart failure/cardiac patients will be developed by Q3.

Position Responsible 5.2: Group Manager Medical and Surgical Services	
Risks 5.2	**Mitigations 5.2**
Insufficient capacity to maintain and enhance relationships.	Ensure this is a priority for management and clinical staff.

6.3.4 Chronic Diseases

What does the DSP say and other key directives?
Our DSP identifies healthier communities and a focus on prevention, early treatment and easy access as two key goals.

We know we can do more to prevent people in our community getting sick, so our first focus will be on providing health services that prevent people getting chronic diseases. We also know that if people are sick, the earlier they receive treatment, the more likely they are to get better, stay better, and for longer. Our second focus will be to encourage early access to health services such as general practitioners (GPs) and screening programmes. Our third focus will be to ensure that once people know they are sick, they are given care as soon as possible.

What progress was made in 2005/06?
We have made considerable progress on services for people with diabetes including:

- PHO GP practice registers capturing accurate data to identify and record people who have been identified with a diagnosis of diabetes.
- Systems in place to collect the number of annual reviews completed; retinal screening data that is assessed with a rapid patient referral to ophthalmology services if required, and clinical outcomes are recorded.
- The diabetes specialist outreach service (DSOS) is supporting primary care practices on delivering best practice diabetes management.
- Primary care practices are participating in staff training programmes about diabetes.
- Trained PN and private podiatrists are approved to deliver services free to targeted patients.
- The central region DHBs are in the final stages of investigating the introduction of the new MoH diabetes database. This will be operational through a central IT server.

In addition,

- Primary care nurses have been trained in respiratory management and patient education sessions are provided free to at-risk patients.

What is planned for 2006/07?
We will have a greater focus on prevention to reduce causes of chronic disease such as smoking, obesity and alcohol misuse. We will continue to work with primary care providers to enhance their capacity to identify people at risk of chronic disease, to intervene in the early stages, and to improve management of the conditions (see sections on Primary Health Care, Intersectoral Collaboration, Public Health, and Maori Health).

Annual Objective 6: Decrease the incidence and impact of diabetes, cardiovascular and respiratory disease.
Measures and Targets (see Appendix 7) SER-02 Care Plus Enrolled Population (also under Primary Care) POP-01 Diabetes (also a Board DSP Indicator) Diabetes Management HBA1c (National Core Measure) POP-02 Cardiovascular Disease POP-03 Stroke
Approach 6.1: Review achievements through the diabetes specialist outreach service (DSOS), to improve Maori and Pacific uptake of diabetes review and other support programmes.

Milestones 6.1:

- Consultation with Maori and Pacific communities about their satisfaction of the strategies that are in place to increase service reach completed by Q2.
- Internal review of DSOS first 12 months of service completed by Q4.

Risks 6.3	**Mitigations 6.3**
General Practice have not addressed access barriers of high needs patients.	DSOS maintains communication with General Practice to understand and find solutions to address barrier issues.

Approach 6.2: Participate in implementation of a regional information system to capture diabetes annual review data direct from PHOs (central region).

Milestones 6.2:

- Host DHB for diabetes server agreed Q1.
- Systems are in place and database operational Q2.

Position Responsible 6.2: Portfolio Manager Planning & Funding

Risks 6.2	**Mitigations 6.2**
Ministry of Health software programme not ready in time; current provider ceases as a provider from end Q2.	Establish if real-time milestones will be achieved to meet timeframes by Q1. Risk strategy developed to hold batch data at PHO level until server ready. Involve PHO from outset in planning.

Approach 6.3: Improve the primary and secondary interface for cardiovascular patients, with a particular focus on meeting the needs of Maori and Pacific people.

Milestones 6.3:

- Establish links programme between primary care and secondary care MDT specialists (e.g. GP/consultant; practice nurse and specialist nurse clinics) by Q3.
- Primary care nurse specialists attend appropriate hospital training programmes, secondary nurse forums and participate in joint specialist nurse clinics by Q3.
- A medical outreach nurse role to facilitate discharge and link patient with appropriate primary services and supports (including Maori and Pacific providers) is scoped by Q4.
- The development of a dedicated stroke area and MDT team within the medical ward is scoped by Q3.
- Cardiovascular initiatives link with intersectoral support services (e.g. Work and Income, Ministry of Social Development and local authorities) and reflect Healthy Eating, Healthy Action and tobacco control objectives.

Position Responsible 6.3: Manager Acute and Chronic Care

Risks 6.3	**Mitigations 6.3**
Secondary clinical staff lack confidence to discharge patients to primary care	Continue to build relationships between primary and secondary providers
I. S does not support the development of appropriate primary care information on the Intranet	Continue to work with I.S to develop appropriate GP/PHO/Primary care nurse information on the Intranet.
Workforce resources and capabilities not available to support ongoing primary and secondary developments	Link with Workforce development strategies to identify and focus on primary care areas

Approach 6.4: Review the effectiveness of the community based respiratory service.	
Milestones 6.4: • Evaluate community spirometry respiratory service Q2.	
Position Responsible 6.4: Portfolio Manager Planning & Funding	
Risks 6.4	**Mitigations 6.4**
The evaluation is not seen as a priority.	Early communication between Planning & Funding and Senior Management.
Approach 6.5: Audit presentations to ED with diagnosis of asthma in past 12 months.	
Milestones 6.5: • Complete Emergency Department 2005/06 presentations audit in Q1 • Develop and then trial an improved process of follow up for those who present to the Emergency Department with asthma Q3.	
Position Responsible 6.5: Manager Acute and Chronic Care	
Risks 6.5	**Mitigations 6.5**
Capacity to manage in the timeframe set.	Audit included in Business plan and identified as a priority.

6.3.5 Elective Services

The Hutt Valley DHB is committed to meeting the government's expectations around elective services, particularly in the three key policy areas of:

- Patient Flow Management.
  The DHB has made a commitment to achieve and maintain compliance with all Elective Services Patient Flow Indicators (ESPIs) and will agree a recovery plan with the Ministry by June 2006 to deliver ESPI compliance.
- Level of Service (volumes, case weighted discharges, standardised intervention rates/standardised discharge ratios).
  The DHB will ensure delivery of services in line with the agreed Provider Arm Volume Schedule. We will deliver on our commitments in respect of the Orthopaedic and Cataract initiatives. We will review our intervention rates for key elective procedures to ensure we are delivering an appropriate level of service for our population
- Order of Service (Prioritisation).
  The DHB is committed to ensuring that patients are prioritised for access to services on a consistent basis, and that patients then receive access according to the priority assigned.

What does the DSP say and other key directives?

The key goal of prevention, early treatment and easy access recognises that if people are sick, the earlier they receive treatment, the more likely they are to get better, stay better, and for longer. Hutt Valley people should also get the best hospital services that are possible from within available resources. Key strategies include continually evaluating the effectiveness of services and making a major investment in Hutt Hospital's facilities.

What progress was made in 2005/06?

- Appointment of an elective services manager to enable a stronger focus on management of the booking system and implementation of the CQI and ESPI recovery plans.
- Business cases in preparation for new theatres, day procedure facilities and beds as part of the Integrated Campus Plan (ICP) to increase surgical capacity.
- Maintained elective volumes at planned rates.
- Implemented the CQI and ESPI recovery plans.
- Implemented innovations including nurse led clinics in orthopaedics and general surgery.
- Development of an Interim Capacity Plan to manage capacity until ICP redevelopment is commissioned.

What is planned for 2006/07?

In the medium to longer term, increased access to elective services is dependent on expanding hospital capacity. In the short to medium term we will use other opportunities (outlined in the Interim Capacity Plan) to manage output as a transition to a hospital with greater capacity.

Annual Objective 7: Maintain elective volumes and compliance with Elective Services Patient Flow Indicators [ESPIs].

Measures and Targets (see Appendix 7)
SER-06 Continuous Quality Improvement – Elective Services
Percentage Eligible Elective Day Case Surgery (National Core Measure)
Key Procedure Standardised discharge ratio
Total Hip and Knee Standardised discharge ratio
Cataract Standardised discharge ratio

Approach 7.1: Implementation of Interim Capacity Plan, which:

- Develops options for the sustainable delivery of elective surgical services by the Hutt Valley DHB over the period 2006/07 through 2008/09, including bringing back elective gynaecology from Boulcott Hospital.
- Makes recommendations on improvement to processes and information and reporting tools and systems.

Milestones 7.1:

- Implement recommendations from the Interim Capacity Project Q1.

Position Responsible 7.1: Group Manager Medical and Surgical Services

Risks 7.1	**Mitigations 7.1**
Acute demand crowds out electives.	Continue acute demand initiatives.
Cost of recommendations unaffordable.	Review priorities.
Unavailability of additional theatre capacity.	Review priorities.
Staff availability.	Refer to section on workforce plan.

Approach 7.2: Monitor ESPI performance, take proactive action to maintain compliance and improve systems for prioritisation consistency.

Milestones 7.2:

- Compliance with Indicators for three consecutive months (Q1-4).
- Review compliance and systems and make recommendations to Board as necessary (Q1,2,3,4).

Position Responsible 7.2: Elective Services Patient Care Manager

Risks 7.2	**Mitigations 7.2**
Shift to web based IBA waiting list system resulting in data errors.	Fully investigate change implications. Appropriate training for booking staff and others involved in entering data into the system.
Capacity constraints.	Management to contract and adjustment of treatment thresholds as appropriate. Implementation of Interim Capacity Plan.
Clinician non-compliance with prioritisation processes.	Discuss issues with Clinical Heads of Department on a regular basis. Provide ongoing feed back to clinicians.

Approach 7.3: Delivery of Orthopaedic Initiative Hip and Knee joint volumes.

- Develop and agree on Hip and Knee Joint Production Plan for 06/07.
- Develop plan to continue to meet Elective Services Patient Flow Indicator targets while delivering additional volume.
- Development of specialist nurse patient care co-ordinator role.

Milestones 7.3:

- Orthopaedic Production Plan agreed with CHOD orthopaedics.
- Appointment of patient care co-ordinator from Q1.
- Production target achieved Q4.
- ESPI compliance Q1-4.

Position Responsible 7.3: Elective Services Patient Care Manager

Risks 7.3	**Mitigations 7.3**
Acute demand crowds out electives.	Maintain acute demand initiatives.
Theatre capacity constraints.	Realistic production plan. Interim capacity plan project.
Impact of foot and ankle sub speciality on ESPI compliance.	Development of major and minor procedure scoring tool. Adjust score range for Active Review.

Approach 7.4: Delivery of Cataract Initiative cataract volumes.

- Contract volumes to Capital and Coast DHB.
- Monitor ESPI compliance.
- Optimise outpatient clinic delivery in the Hutt.

Milestones 7.4:

- Agree on Production Plan with Capital and Coast DHB.
- Develop plan to continue to meet Elective Services Patient Flow Indicator targets while delivering additional volume.
- Review of pilot project for optometrists to do FSAs (see Productivity and Value for Money section)

Position Responsible 7.4: Elective Services Patient Care Manager

Risks 7.4	**Mitigations 7.4**
Inability to influence Capital and Coast DHB volume delivery.	Ongoing monitoring and liaison.
Lack of information about ESPI compliance for Hutt domicile patients.	Work with Capital and Coast to produce Hutt domicile report showing ESPI 3 and ESPI 5 numbers.

6.3.6 Maternity, Child and Youth Health

What does the DSP say and other key directives?
Developing child and youth health care is a priority that fits within all of the DSP's eight key strategies for the next five years. In 2006/07, our efforts will build on the objectives of the Child Health Strategy and the National Youth Development Strategy Aotearoa and consolidate the gains made in implementing the New Zealand Health Strategy.

What progress was made in 2005/06?
In 2005/06 the progress we made to improve child and youth health culminated in:

- The DHB Family Violence Scoping Project Report (June 2005) recommendations and action plan were approved, and funding was identified.
- The nurse led eczema clinic was developed.
- The virtual child and youth team commenced, with the employment of a adolescent physician.
- Networking and positive relationships have been maintained with VIBE (the Hutt Valley youth health service) and other key provider stakeholders.
- A new recruitment drive is underway following delays in appointing the community paediatric role due to shortages of suitably trained clinicians.
- Redesign of the obstetric department with all obstetricians now employed by the DHB. The stable management structure will be further consolidated with the agreed development of a new Maternity Advisor position.
- The Baby Friendly Hospital Initiative (BFHI) accreditation survey was completed in Q2 and breastfeeding rates continued above 80%. Final Accreditation is expected to be complete by the end of quarter 4 in 2005/06 with the resolution of outstanding issues from the survey.
- Building on the gains made with BFHI, a successful HEHA submission for additional Ministry of Health funding that will allow the set up of a community led breastfeeding support service. The programme is a joint initiative, with the DHB working with three Hutt Valley PHOs and other key providers.
- A successful model of antenatal classes for teenage mothers has been developed. This joint initiative supports the teenage mother and her peer supporters. The programme has been developed in partnership with the Hutt Valley Youth Health Service.
- The child skin infection project now ensures consistent information and clinical practice guidelines are promulgated across the region.
- Successful implementation of the National Immunisation Register (NIR), with birth cohort children enrolled from October 2005.
- Successful implementation of the MeNZB vaccination programme with good coverage rates achieved.

May 2006 National Immunisation Register

Hutt Valley DHB NIR Volumes	3 May 2006
MeNZB (Primary Care**)	38,532
MeNZB (SBVS*)	184,098
Total	222,630
Concurrent childhood immunisations given	11,548

*SBVS includes Hutt Valley DHB and Capital & Coast DHB school children vaccinated.

April 2006 MeNZB Coverage Reports

DHB	As of Wk	6 wks - 4yrs			5 - 17 yrs			18 - 19 yrs		
		Dose 1	Dose 2	Dose 3	Dose 1	Dose 2	Dose 3	Dose 1	Dose 2	Dose 3
Wairarapa	49	83.5%	79.6%	74.0%	87.9%	8691%	85.6%	73.2%	69.8%	65.6%

CCDHB	50	85.5%	80.5%	72.2%	89.5%	88.0%	85.2%	61.7%	55.7%	48.4%
HVDHB	**51**	**87.3%**	**82.4%**	**74.8%**	**92.4%**	**90.7%**	**88.2%**	**72.4%**	**65.6%**	**57.3%**
MidCentral	53	86.4%	81.2%	73.4%	88.4%	87.0%	85.0%	57.1%	53.1%	48.3%
Whanganui	55	84.0%	78.2%	68.6%	91.2%	89.4%	86.3%	79.7%	71.6%	61.2%
Hawkes Bay	57	83.1%	76.3%	67.7%	90.5%	88.7%	86.6%	70.8%	64.1%	58.2%
CMDHB	92	96.6%	90.3%	80.6%	102.1	100.2%	96.3%	81.7%	76.8%	70.0%
New Zealand		86.7%	81.1%	73.1%	89.7%	87.9%	85.0%	59.8%	55.1%	49.7%

What is planned for 2006/07?

We will work towards giving children the best start in life, by improving services to high-needs mothers before birth, increasing support for breastfeeding and continuing efforts to improve immunisation coverage. We will be working with providers to improve the knowledge on the benefits of immunisation. We will use NIR information to address any gaps in primary care immunisation trends in conjunction with the immunisation facilitation service who will work with individual GP practices on increasing target rates. NIR information will also assist GPs to refer more quickly to outreach immunisation services and will allow targeting of the birth cohort onwards.. We will cooperate with new Ministry of Health programmes to increase well child checks for preschoolers and hearing tests for neonates, once the funding and responsibilities are defined.

It is proposed to maximise the use of the NIR by reviewing the NIR processes for all NIR users, including the Outreach Immunisation Service (OIS). This will include the business and IT processes and a review of the outreach referral process. Identifying and following up newborn babies with no GP, monitoring decline rates and Opt Off rates and the accuracy of data received from the maternity system is included in the work for the year ahead. Hopefully the MOH will improve the accuracy and reliability of the reports for the childhood immunisation coverage rates so that these can be used by the NIR Coordinators, the Immunisation Coordinator and providers to improve coverage rates.

We will reduce children's exposure to unhealthy situations through several key intiatives. A smoking cessation project will identify parents and caregivers who are interested in becoming smoke-free and refer them to a smoking cessation service. We will implement a DHB family violence programme which addresses the Children's Commisioner's recommendations on Child Safety in Hospitals, and includes regular interface with Child, Youth and Family Services, Police and other organisations. We will expand Health Eating, Healthy Action activities with a strong emphasis on school and early childhood settings (see Intersectoral Collaboration and Public Health sections)

We will improve services for children and adolescents in the areas of mental health and oral health services (see Mental Health and Oral Health sections). We will continue to support youth development in the Hutt Valley, working closely with VIBE (the Hutt Valley youth service) and the Steering Group for the Youth Transition Service (see Intersectoral Collaboration and Public Health sections).

Annual Objective 8: Improve health care services to support families to provide a healthy start to our children and young people.

Measures and Targets (see Appendix 7)
POP-12 Immunisation (also a Board DSP Indicator)
POP-13 Ambulatory Sensitive Admissions (also under Older People and a National Core Measure)
Increase community partial breastfeeding rates at three months after birth.
Reduce caesarean section rate to under 25%

Approach 8.1: Continue to redesign the antenatal education programmes to target high needs groups.

Milestones 8.1:
- Culturally appropriate antenatal programmes are in place by Q4.

Position Responsible 8.1: Maternity & Child Service Manager

Risks 8.1	**Mitigations 8.1**
Women do not attend the culturally appropriate classes that are offered.	Involve the community and women in the development of the most appropriate classes.

Approach 8.2: Increase community breastfeeding rates by consolidation of the primary care breastfeeding support programme.

Milestones 8.2:
- Each participating PHO will have identified active community volunteers providing breast feeding support to mothers by Q2.

Position Responsible 8.2: Portfolio Manager Planning & Funding

Risks 8.2	**Mitigations 8.2**
PHOs do not able the workforce capacity to maintain a community approach	Regular monitoring and engagement of PHOs to support early risk management strategies.

Approach 8.3: Reduce caesarean section rates through the development of sound clinical audit indicators with the multidisciplinary team and key participating providers.

Milestones 8.3:
- Audit indicators developed by Q1
- Benchmark data disseminated to primary care by Q2
- All key stakeholders participating by Q3.

Position Responsible 8.3 Maternity & Child Service Manager

Risks 8.3	**Mitigations 8.3**
Different sectors of the maternity workforce may resist participation in audit.	All sectors involved from the outset in the development and management of indicators.

Approach 8.4: Target 95% of two year olds fully immunised by continued local General Practice audit and the dissemination of benchmark information.

Milestones 8.4:
- 65% of practices achieve 95% of two year olds fully immunised by Q4.

Position Responsible 8.4 Maternity & Child Service Manager

Risks 8.4	**Mitigations 8.4**

Ministry of Health withdraws funding for the Outreach Immunisation Service (OIS).	Discuss funding options with Ministry of Health if the national evaluation suggest poor outcomes from other DHBs.
Unexpected communicable disease that changes priorities for primary care workforce.	DHB disaster planning continues to include primary care participation.

6.3.7 Oral Health

What does the DSP say and other key directives?
Developing child and youth health care is a priority that fits within all of the DSP's eight key strategies for the next five years. We will focus on four of our DSP's six key goals:

- Improved Health Equity
- Healthier Communities
- A focus on Prevention, Early Treatment and Easy Access
- Effective, Efficient and High Quality Services.

The Minister of Health's vision for child and adolescent oral health services is:

- A community based dental service with strong links to schools, Maori oral health providers and primary care providers
- A seamless 01-18 year old structure, with the ability to extend to whanau/adults
- Delivery through a mix of fixed and mobile facilities, suitable for modern dentistry
- A focus on prevention and very early intervention, and
- An appropriate and skilled workforce.

What progress was made in 2005/06?

- Implementation of risk assessment criteria to identify and treat those at greatest risk of oral disease was completed.
- Established a low-income oral health service pilot for adults enrolled in Piki Te Ora ki te Awakairangi PHO delivered through the Whai Oranga health centre in Wainuiomata.
- A weekend clinic for School Dental Service enrolled children was successfully run at Hutt Hospital Dental Unit between October and December 2005.
- Dental therapy scholarships offered to 2 students to commence study in 2006. All five existing dental therapy scholarship students successfully completed their first year of training and will advance to Year 2 in 2006.
- The clinical career pathway has been implemented for dental therapists as part of the Collective Employment Contract, together with registration as part of the Health Practitioners Competency Act (introduced in September 2004).
- Increased service profile in the community through the *Word of Mouth* newsletter to schools and a number of communications with schools and other community stakeholders as part of community engagement for the School Dental Service review.
- The DHB Community Dental Service website became operational improving the service's capability and communications.
- Continued central region coordination initiatives, including:
    - Participating in a national adolescent oral health 0800 advertising campaign and delivery of central region specific promotion resources.
    - Appointment of a joint district co-ordinator for Hawkes Bay completing capacity for the Central Region Coordination Service.
    - Review and improve transfer process for Year 8 children to adolescent dental services within the central region.

What is planned for 2006/07?
Hutt Valley DHB is keen to implement the new model for community-based dental care for children and adolescents, once the project, capital and operational funding and other requirements have been clarified. We will look at establishing the model at one or two sites in the first stage, so that we can apply what we learn in the full roll-out. In the meantime, we will continue to work with schools to address facility issues in the existing school dental clinics.

Considerable progress has been made in addressing workforce shortages in the school dental health service, but efforts will need to continue to expand the service's capacity to effectively deliver on the new model for child and adolescent dental care.

The School Dental Service and the Oral Health Promotion Team will collaborate to strengthen local and regional linkages with primary care providers, community organisations and early childhood centres to improve uptake of services by preschoolers. We will continue regional and local initiatives to increase enrolment of adolescents with dental services.

We will complete the evaluation of the low-income oral health service pilot for adults enrolled in Piki Te Ora ki te Awakairangi PHO delivered through the Whai Oranga health centre in Wainuiomata. Continuation of the service will be dependent on the results of the evaluation and the funding required.

<table>
<tr><td colspan="2">Annual Objective 9: Improve oral health status for children and adolescents</td></tr>
<tr><td colspan="2">Measures and Targets (see Appendix 7)
POP-05 Oral Health - Percentage caries free at age five
POP-06 Oral Health – Mean DMFT score at Year 8 (also a Board DSP Indicator)
Submit an analysis of the caries progression in a sample of the children currently on recalls over 12 month, by Q4.</td></tr>
<tr><td colspan="2">Approach 9.1: Maintain coverage and provide regular dental care for children under the care of the school dental service (SDS) by maintaining an appropriate level of dental therapist staffing.</td></tr>
<tr><td colspan="2">Milestones 9.1:
• Achieve an SDS target of 37.16 FTE dental therapists by Q3.
• Develop a CDS Workforce Development Plan, including a recruitment and retention package, by Q1.</td></tr>
<tr><td colspan="2">Position Responsible 9.1: Dental Service Manager</td></tr>
<tr><td>Risks 9.1</td><td>Mitigations 9.1</td></tr>
<tr><td>Ongoing dental therapist vacancies.</td><td>Implement workforce development plan.</td></tr>
<tr><td>High percentage of child overdue for care.</td><td>Identify alternate service delivery options; communicate with affected schools early; identify potential alternate providers.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Approach 9.2: Establish a project to implement the new model of community-based dental care for children and adolescents on one or two sites</td></tr>
<tr><td colspan="2">Milestones 9.2:
• Negotiations with the Ministry of Health to define project, operational and capital funding and other requirements for the new model in Q1
• Project established in Q2
• Project plan, including comprehensive communications plan, developed in Q3</td></tr>
<tr><td colspan="2">Position Responsible 9.2: Dental Service Manager</td></tr>
<tr><td>Risks 9.2</td><td>Mitigations 9.2</td></tr>
<tr><td>Insufficient project, operational and capital funding available to successfully implement the new model</td><td>Communications and negotiations with Ministry of Health.</td></tr>
</table>

Insufficient capacity at two DHBs to support project management	Ensure sufficient project funding, expertise and sponsorship in place
Delays in implementing the new model result in increased expenditure to address facility issues in existing clinics.	Ongoing negotiation with schools and the Ministry of Education to improve the standard of school dental clinics, including consolidation of clinics in fewer sites.
Approach 9.3: Reduce disparities in oral health by improving enrolment rates for preschoolers.	
Milestones 9.3: • SDS Preschool Enrolment Project team established Q2. • 50% of the areas preschool children are registered by Q4.	
Position Responsible 9.3: School Health Team Leader	
Risks 9.3	**Mitigations 9.3**
Early childhood centres unwilling to participate.	Early engagement of the early childhood centres and the Ministry of Education in the consultation phase.
Approach 9.4: Evaluate the low-income oral health service pilot for adults enrolled in Piki Te Ora ki te Awakairangi PHO delivered through the Whai Oranga health centre in Wainuiomata.	
Milestones 9.4: • Completion of the Wainuiomata pilot evaluation Q1. • Decision on ongoing funding for 2007/08 year and beyond made by Q2.	
Position Responsible 9.4: Portfolio Manager Planning and Funding	
Risks 9.4	**Mitigations 9.4**
Skill set to review not available in the timeframe.	Early planning and engagement of the review team.
Funding not available to continue service on ongoing basis	Assess proposal against national service coverage requirements, DHB prioritisation criteria, and other competing services

6.3.8 Cancer and Palliative Care

What does the DSP say and other key directives?
The Hutt Valley DHB DSP goals of reducing health disparities, seamless integration and a focus on prevention, early treatment and easy access are relevant to this objective. The strategies of developing primary care, working with other agencies and working in harmony with Maori are a key focus of this objective in 2006/07. We know that Maori and Pacific people access cancer services later than others and the evidence tell us that health outcomes are worse for these groups.

We are working to implement the NZ Palliative Care strategy. While there is a high degree of public awareness of the work of the hospice in the Hutt Valley, there are some groups that have lower levels of access to these services. Patients diagnosed with cancer are the predominant group accessing palliative care services, but there are increasing number of people with other chronic conditions that are benefiting from palliative care, such as those with motor neurone disease. The hospice provides a mainstream palliative care service, and access to the service by Maori has traditionally been low in comparison to the population of the Hutt Valley.

What progress was made in 2005/06?
- Continued preventive work to reduce the risk of cancer from smoking and poor nutrition
- Health promotion for breast and cervical screening has been directed at developing links with PHOs and the primary health care sector.
- Specific initiatives to target the Maori and Pacific Island eligible population.Work has progressed towards full implementation of the age extension for breast screening.
- Successful application to the Ministry of Health for funding to analyse the experiences of cancer patients (especially Maori, Pacific, children and adolescents) on “The Patient Journey – Te Huarahi o Nga Tangata Katoa”. This will be the foundation for the development of a local Cancer Action Plan linked to a regional cancer control strategy.
- Te Omanga Hospice established the Maori education and liaison service and the number of Maori using these services has increased.
- End of life support provides support to those in the final stages of life enabling people to remain at home by providing brief respite (up to 24 hours) for carers. In 2005 this service was combined with the Cancer Society nursing support service, which was devolved from Capital and Coast. The pilot will be evaluated by December 2006.

What is planned for 2006/07?
We will continue to deliver health promotion and disease preventive programmes to reduce the risk of cancer from smoking and poor nutrition (see Public Health section).

From the analysis of “The Patient Journey – Te Huarahi o Nga Tangata Katoa”, we will better understand the gaps and flaws in existing services for people with cancer. We will work within available funding to implement the Cancer Action Plan to improve local service delivery and coordination among primary health care, NGOs and other providers. We will also collaborate with the cancer services of other DHBs to improve the service quality experienced by Hutt Valley residents, particularly for those patients who are more at risk of not receiving appropriate services.

Regional Screening Services deliver breast and cervical cancer screening services to women in the Capital and Coast, Hutt Valley and Wairarapa DHB areas. In 2006/07,

work will continue on reducing disparities by improving health promotion services, closer collaboration with service providers and improved use of information technology. We will complete the expansion of our screening facilities and offer a more co-ordinated service so that we can screen the larger number of women who are now eligible for breast screening.

A specialist palliative care nurse (providing education, liaison and support about palliative care to other health providers) was introduced in 2002, resulting in a reduction in admissions from residential facilities of people in the final stages of life of 15% in the first year. We will augment current workforce development, and enable a wider range of providers to access this service. There will be a particular focus on working more closely with hospital staff.

Annual Objective 10: Improve access to and quality of cancer services for Hutt Valley residents with particular emphasis on identified high need communities.

Measures and Targets (see Appendix 7)
POP-16 Radiation oncology and chemotherapy waiting times
Breast and Cervical Screening Coverage rates by ethnicity (Board DSP Indicator)
Hospital palliative care liaison service established

Approach 10.1: Implement key recommendations of the Hutt Valley Cancer Action Plan.

Milestones 10.1:

- The Cancer Action Plan includes specific targets to ensure that disparities for Maori accessing cancer services are addressed.
- Key recommendations from the Hutt Valley DHB Cancer Action Plan are agreed by Q1.
- One key recommendation from the Hutt Valley DHB Cancer Action Plan has been implemented by Q4.
- A Regional Cancer Plan that identifies and addresses the needs of Hutt Valley residents is completed by Q2.

Position Responsible 10.1: Portfolio Manager Planning and Funding

Risks 10.1	**Mitigations 10.1**
Cancer Action Plan delayed.	Monitor and assist with analysis and preparation of plan.
Preparation of Regional Cancer Plan delayed by factors at treating DHBs	Maintain strong collaborative relationships with those preparing the plan

Approach 10.2: Complete the expansion of our screening facilities to ensure sufficient capacity to handle the increased age range of women eligible for the breast screening programme.

Milestones 10.2:

- Building work at Hutt Hospital site completed by Q1

Position Responsible 10.2: Regional Screening Service Manager

Risks 10.2	**Mitigations 10.2**
Delays in building work	Ensure meeting of timeframes and completion of project management milestones

Approach 10.3: Increase screening rates for breast and cervical cancer with particular emphasis on identified high need communities, through enhanced health promotion strategies and closer relationships with PHOs and independent service providers.

Milestones 10.3:

- Relationships established with PHOs by Q2.
- Pacific Peoples health promotion strategies reviewed and strengthened by Q3.
- Develop relationships with Hutt Valley Maori health providers by Q4

Position Responsible 10.3: Regional Screening Service Manager

Risks 10.3	**Mitigations 10.3**
Difficulties faced in addressing cultural taboos around breast and cervical screening.	Early engagement with Hutt Valley DHB advisors and identified key people within community.

Approach 10.4: Augment current education and liaison services in palliative care to maximise integration and linkages with health services, particularly hospital services.

Milestones 10.4:

- Hospital liaison service in palliative care established by Q2

Risks 10.4	**Mitigations 10.4**
Lack of recognition of role of palliative care approach by health professionals whose role is assist people to recover.	Clear communication about the role of palliative care to key stakeholders.

6.3.9 Mental Health

Hutt Valley DHB provides mental health and addiction services on the basis of the national mental health plan, Te Tāhuhu – Improving Mental Health 2005-2015[7]. Te Tāhuhu builds on previous mental health strategies and establishes the current outcomes for mental health and addiction services. Specifically it also broadens the range of services for people who are severely affected by mental illness.

We will be implementing Te Tahuhu locally by establishing the current baseline for local and regional mental health addiction services against the Te Tahuhu framework. We will also be implementing our five-year mental health and addiction service plan and working collaboratively with the other Central Region DHBs to implement the regional strategic plan for 2006 /09 and the regional service plan for 2006/07.

We will continue to develop mental health and addiction services that are high quality, accessible, appropriate, capable, effective responsive, sustainable, recovery and whanau ora oriented.

We continue to participate actively in regional planning and delivery of mental health services. Two regional positions are located with and managed by Hutt Valley DHB Planning and Funding Division: the Regional Mental Health and Addiction Services Contracts Manager for regional NGO providers; and the Regional Alcohol and Other Drugs Coordinator.

What does the DSP say and other key directives?

Under the DSP goal of effective, efficient and high quality services, our service priority in mental health is to fully implement the Mental Health Blueprint to redesign services and consolidate gains. The DSP goal of focusing on prevention, early intervention and easy access will be advanced through reviewing and improving the way we deliver mental health services for older people in our community.

We will work with other agencies to promote positive mental health and to reduce suicides and suicide attempts. We will reduce health disparities by developing our mental workforce, continuing to offer mental health and Maori mental health scholarships.

What progress was made in 2005/06?

- The completion of the five year mental health and addiction service plan was achieved through active participation from key stakeholders, in particular the Local Leadership and Advisory Group (LLAG). The service plan includes the priorities areas of child, adolescent and family; older people; Maori; and Pacific people.
- A Pacific mental health NGO service has been established and is meeting regularly with the Hutt Valley DHB community mental health team.
- Primary mental health pilot initiatives have been established with two PHOs in the Hutt Valley basin. The target population are the people that registered with the PHOs who have mild to moderate mental illness.
- The Hutt Valley DHB community mental health team has been contracted to deliver psychological therapies (outreach clinics) in Access PHOs. The target population for this service are those with high and complex needs. Evaluation has been delayed and will now be undertaken in 2006/07.
- Utilisation of the youth residential services has improved over the last 6 months through collaboration and up-skilling of staff.

- A 0.5 FTE Maori mental health consumer advisor position was funded in the DHB provider arm for two year (expires June 2006).
- Out of hours telephone support (Warmline) was set up with an NGO provider.
- A local mental health and addiction service directory (web based and hard copy) has been established.
- Mental health and addiction workforce scholarships, which aim to increase the capacity and capability of the local mental health and addiction workforce, were developed and launched.
- Mana Tupuranga Maori mental health scholarships are in their second year. This initiative aims to promote and build Maori local capacity in mental health services.
- Valley Transitionz, the first successful transition employment service in New Zealand, has been established and has achieved positive outcomes in its initial year.

What is planned for 2006/07?

The key priority for the DHB is to implement the five-year mental health and addiction service plan 2006 - 2011. This will continue the recovery and whanau ora approach undertaken during the service planning process, and build on the stakeholder participation, in particular that of mental health and addiction service users and the Local Leadership and Advisory Group. We will establish the current service baseline for mental health and addiction services against the Te Tahahu framework, and implement Te Puawaitanga (the national Maori mental health strategic framework) locally.

Hutt Valley DHB will continue to resource and develop the mental health and addiction workforce along with establishing a small (2.5 FTE) service development team who will work directly with the providers (individually and collectively) to assist primarily with implementing the five year mental health and addiction plan, local provider infrastructure, organisational developments and training. This latter initiative will be funded through the 2006/07 Blueprint funding.

We will fund new services using the MOH allocated 2006/07 Blueprint funding (see table below)

Purchase Units	Service Description	Blueprint Allocation 2006/07 (excl GST)	Indicative Timeframes
MHCR20 & MHCRS30	Additional funding to fully implement the Alcohol and Other Drug Intensive Treatment Review	145,000	Quarter 2
MHCS19	Māori Child Adolescent and Family (Clinical 0.4FTE)	65,000	Quarter 2
MHCS20	Māori Child Adolescent and Family (Non - Clinical 1 FTE)	85,000	Quarter 2
MHCS18	Packages of Care for Older people (0.25 FTE)	13,000	Quarter 3
MHWD01	Implement five year service plan (2 FTE)	200,000	Quarter 4
MHCS06A	Primary Mental Health Promotion and Prevention Initiative (1 FTE)	90,000	Quarter 2

MHWD01	Consumer Advocacy Service (1 FTE)	76,000	Quarter 2
MHCR09.2	Pacific Community Alcohol and Drug Service (1.5 FTE)	104,000	Quarter 3
Hutt Valley DHB TOTAL		778,000	

We will work with key stakeholders, the DHB provider arm mental health and addiction services and other agencies to implement new services and improve existing services for older people and for children and adolescents (see also the section on the health of older people and maternity, child and youth health). We will expand collaboration within DHB services, across the mental health and addiction sector and with other agencies. We will seek greater consumer input and improve quality of services with the appointment of a Family Advisor.

Annual Objective 11: Advance the development of mental health and addiction services for Hutt residents.

Measures and Targets (see Appendix 7)
POP-08a Mental Health Access and People seen only once
POP-08b Repeat acute mental health admissions
QUA-01b Results for people with enduring severe mental illness
Mental Health Services Utilisation (National Core Measure and Board DSP Indicator)

Approach 11.1: Implement the five-year mental health and addiction service plan 2006 - 2011.

Milestones 11.1:

- Two projects from the five-year mental health and addiction service plan scoped and implemented by Q4.
- Establish the current service baseline for mental health and addiction services against the Te Tahahu framework by Q2
- Establish the leadership/governance and operational teams and resources to implement the five year mental health and addiction service plan by Q1

Position Responsible 11.1: Portfolio Manager

Risks 11.1	**Mitigations 11.1**
Insufficient capacity to carry out the work from the five-year service plan, including adequate funds and managing the stakeholders' expectations.	Ensure that realistic goals and timeframes are set and that adequate resources are available to implement the plan and to bring in additional resources if required. Be prepared to renegotiate the scope of the project.
Quality of the information collected from a wide range of stakeholders may not be adequate to enable good planning.	Involve key stakeholders early in the design, development of the questioner. Provide training workshops and additional support if required
Difficulty in establishing operational team	Start recruitment process early including "shoulder tapping people"
Difficulty in establishing the leadership / governance group:	Encourage and support people in existing networks to be involved e.g. the LLAG representatives

Approach 11.2: Implement Te Puawaitanga / national Maori mental health strategic framework in Hutt Valley mental health and addiction providers (DHB & NGOs providers)

Milestones 11.2:

- Implement at least two initiatives supporting Te Puawaitanga implementation with the Hutt Valley mental health and addiction providers by Q4
- Work with the other five Central Region DHBs to develop a monitoring and reporting framework by Q3
-

Position Responsible 11.2: Portfolio Manager

Risks 11.2	**Mitigations 11.2**
Anticipating the complexity and volume of work from the Te Puawaitanga plan including adequate funds and managing the stakeholders' expectations.	Ensure that realistic goals and timeframes are set and that adequate resources are available to implement the plan and to bring in additional resources if required. Be prepared to renegotiate the scope of the project.

Approach 11.3 Improve access to local and regional mental health services

Milestones 11.3:

- Strategy agreed to ensure improved access to and accountability from Regional Specialist Services by Q2. This may include reconfiguration and reallocation of resources for regional speciality services.
- Continue to review the effectiveness and utilisation of forensic services, with a potential reconfiguration and reallocation of resources.
- See regional AOD initiative.

Position Responsible 11.3: Portfolio Manager & Mental Health Service Manager

Risks 11.3	**Mitigations 11.3**
Information to progress is not readily available	Work with key stakeholders

Approach 11.4: Improve child, adolescent and family mental health and addiction services

Milestones 11.4:

- Identify access and service improvements for child and adolescent mental health services by Q3.
- Develop a proposal for a Kaupapa Maori Child Adolescent and Family service by Q2.
- Establish the Kaupapa Maori Child Adolescent and Family service by Q4.

Position Responsible 11.4: Mental Health Service Manager

Risks 11.4	**Mitigations 11.4**
Recruitment of new specialist position to the Kaupapa Maori Child Adolescent and Family service.	Develop a recruitment, retention and training plan for the new services positions.

Approach 11.5: Increase integration of service delivery and collaboration among mental health and addiction services

Milestones 11.5:

- Psycho-geriatric and mental health for older people service review completed Q2. (see service for older people)
- Improve collaboration between mental health services and other health services, particularly the Emergency Department and older peoples services, with a working group in place by Q3
- Increase capacity in Pacific Community Support Services by Q3

Position Responsible 11.5: Mental Health Service Manager & Portfolio Manager

Risks 11.5	**Mitigations 11.5**
Lack of resources and managing the sectors expectations	Be clear to stakeholders about the parameters, limitations and consider other sources of funding

Approach 11.6: Improve level of consumer and family input and quality of service delivery

Milestones 11.6:

- Establish a Family Advisor position by Q2.
- Establish a consumer advocacy position by Q2
- Undertake annual consumer and family/whanau satisfaction survey by Q3

Position Responsible 11.6: Mental Health Service Manager

Risks 11.6	**Mitigations 11.6**
Capacity to under take the survey	Consider making additional resources available if required

Approach 11.7: Enhance mental health workforce capacity and capability

Milestones 11.7:

- Continue to offer mental health and Maori mental health scholarships (subject to availability of resources) by Q3.
- Consider being one of two pilot sites for Central Region for the "Essentially Peoples' Regional Training and development programme, and implement by Q4 (subject to availability of funding).

Position Responsible 11.7: Portfolio Manager

Risks 11.7	**Mitigations 11.7**
Insufficient capacity within the services to allow staff time off to participate in the training	In the communication plan stress the requirements and benefits of the training and consider other incentives for providers such back-fill funding and training on-site.

Approach 11.8: Develop a primary mental health promotion programme as a two year pilot.

Milestones11.8:

- Service scoped for a primary mental health promotion programme by Q2.

Position Responsible 11.8: Portfolio Manager

Risks 11.8	**Mitigations 11.8**
Potential for this initiative to become isolated from the established primary mental health pilots and public health initiatives.	Active involvement of current primary mental health pilots and public health initiatives in the planning and implementation.

Central Region Mental Health and Addiction Services
The following are a summary of key elements taken from the Central Region Mental Health and Addiction Strategic Plan 2006/09.

Summary of achievements for 2005/06 and work programme for 2006/07
Central Region DHBs have guided service planning and resource allocation over 2005/06. The key achievement for this period has been the reconfiguration of the Central Region mental health and addiction network. Progress made against the other ten priority goals and the regional work programme set by the network are summarised in the Central Region mental health and addiction strategic plan 2006/09.

Description of the Central Regional Mental Health & Addiction Network (CRMHAN)
Following a review in 2004, there was a revision of the structure of the network. The revised structure aims to enhance local and regional accountabilities and relationship. This will be achieved by:

- DHB Mental Health Portfolio Managers working collaboratively to lead develop and administer the network.
- Individual Portfolio Managers taking lead relationship management roles with the different existing regional stakeholder groupings, such as service users, Māori, Pacific, families, NGO, PHO and DHB Providers.
- Portfolio Managers take regional issues back to their Local Advisory Groups (LAG's), and facilitate raising local issues to a regional level.
- Intra-network relationships are encouraged.

Central Region DHBs will work towards developing the following characteristics:

- Efficient and effective utilisation of resources.
- Commitment to the implementation of national strategies that describe the general service environment and consumer expectations.
- Demonstrate the cost benefits of participating in a regional network.
- Recognise existing regional and local network structures, interest/industry groups, and established leadership.

Regional Collaboration Initiatives
In the Central Region, several regional initiatives have been undertaken. The six Central Region DHBs have funded each jointly and each has contributed significantly to enhancing the mental health and addiction service capacity and capability, locally and regionally.

There are two positions that are located and managed by Hutt Valley DHB, Planning and Funding Division

1. the Regional Mental Health and Addiction Services Contracts Manager for Regional Non-Government Organisations Providers and
2. the Regional Alcohol and Other Drugs Coordinator.

Their work programme is set and monitored by the central region DHB mental health portfolio managers.

Annual Objective 12: Advance regional mental health and addiction collaboration initiatives
Measures and Targets (see Appendix 7) Regional reporting

Approach 12.1: Continue to implement the recommendations of the AOD Intensive Treatment Review (TAS 2004).

Milestones 12.1:

- Implementation of phase two of the regional AOD residential coordination data information system by Q3 (subject to regional funding approval).
- Implement a Youth AOD sub-regional service that is available to Hutt Valley, Capital & Coast and Wairarapa DHB population (within identified resources).
    - Establish contract by Q2.
    - Establish a combined local, regional and national monitoring and advisory steering group Q2.
    - Establish new AOD residential and day/evening programme services by Q3.

Position Responsible 12.1: Regional Alcohol and Other Drugs Coordinator; Portfolio Manager Mental Health

Risks 12.1	**Mitigations 12.1**
Reconfiguration of the current payment mechanism may become problematic and unwieldy	Involve key stakeholders in the outset of the project in particular the Portfolio Managers and AOD residential providers
Sustainable funding must be available to implement the Youth AOD sub regional service	The monitoring and advisory steering group (that includes MOH) is critical to the success of this service.
Service demand may be higher than anticipated and there is potential for high staff turn over	Continue to work with key stakeholders to reduce unknown factors as much as possible.

6.3.10 People with Disabilities

The services provided for people with disabilities are designed considering the New Zealand Disability Strategy. Hutt Valley DHB's vision is to have a fully inclusive community, where people with disabilities can live in a society that values them and continually enhances their full participation.

The working definition for disability used by Hutt Valley DHB originated from the World Health Organisation's framework for health and disability and is supported by Disabled Peoples' International. It defines disability as:

"The outcome of the interaction between a person with an impairment and the environmental and attitudinal barriers he/she may face"

What does the DSP say and other key directives?

The New Zealand Disability Strategy is a national strategy for addressing issues disabled people face. Hutt Valley DHB is committed to playing its part in implementing that plan. The District Strategic Plan states that we will ensure we take into account the needs of disabled people, and we'll listen to what different groups in our community have to say before designing services.

What progress was made in 2005/06?

In 2005/2006 there was increased participation of people with disabilities in Hutt Valley DHB activities.

- We held a workshop with a specific focus on disability as part of our District Strategic Plan process.
- Our Disability Support Advisory Committee (DSAC) appointed additional members who have personal experience of disability. DSAC meetings are now conducted with the assistance of NZ Sign Language interpreters.
- We invited disabled people who had previously used our regional breast screening services to a meeting to comment on our services and to contribute to the planning of our new site
- We have made significant progress towards setting up a Hutt Valley Disability Advisory Group in conjunction with Upper Hutt City Council and Hutt City Council. The group will provide advice on issues that concern disabled people in the Hutt Valley.
- The draft Implementation Work Plan for the New Zealand Disability Strategy will be finalised, following the current consultation process.
- We have trialled the process of identifying accessibility barriers, both physical and non-physical, in our provider arm services.
- We have prepared draft accessibility guidelines, which will be finalised when the stakeholder consultation process is completed.

What is planned for 2006/07?

The focus for 06/07 is to embed disability perspectives in Hutt Valley DHB processes and activities. The DSAC work plan outlines the Committee's priorities for the year.

Requirements of disabled people are considered alongside others so, for example, NZ Sign Language is included in our "Interpreting Service" policy. We will continue to collect information about access to services and barriers, including information from disabled people. Our accessibility guidelines provide a framework for us to utilise the information.

Annual Objective 13: Implement the Hutt Valley DHB work plan for the New Zealand Disability Strategy.

Measures and Targets (see Appendix 7)
% of DHB staff with disability recorded

Approach 13.1: Develop and utilise the Hutt Valley Disability Advisory Group to help ensure our services take into account the needs of disabled people.

Milestones 13.1:
- Terms of Reference are finalised and agreed by Q1.
- Advisory group is an effective intersectoral resource accessed by operational staff by Q3.

Position Responsible 13.1: Disability Advisor

Risks 13.1	**Mitigations 13.1**
Disabled people feel that their perspective is not adequately represented by the group.	Transparent processes and continuing close liaison with Disabled Persons Assembly Inc. (DPA) and other representative groups.

Approach 13.2: Implement the process of identifying and removing accessibility barriers in Hutt Valley DHB activities.

Milestones 13.2:
- Questions on disability and access included in patient satisfaction surveys from Q1.
- Guidelines to improve accessibility for people with disabilities developed by Q1.
- Guidelines used in the development and implementation of the Integrated Campus Plan and sub-projects by Q4.

Position Responsible 13.2: Disability Advisor

Risks 13.2	**Mitigations 13.2**
Removing identified barriers may involve considerable cost and additional projects.	Work with disability communities to prioritise projects in line with available resources.

Approach 13.3: Investigate options for collecting, storing and retrieving patient information on disabilities as part of Electronic Medical Record project.

Milestones 13.3:
- Report to DSAC on options by Q1.

Position Responsible 13.3: Disability Advisor

Risks 13.3	**Mitigations 13.3**
Community concern about the use of the information.	Provide clear information about the purpose of collection, and the proposed uses of the information.

6.3.11 Health of Older People

Hutt Valley DHB is progressively implementing the Health of Older People Strategy. Implementing the strategy by 2010 will require Hutt Valley DHB to systematically review and refocus services to better meet the needs of older people now and in the future. The local Health of Older People plan[4] sets out how we will develop more integrated health and disability services that are responsive to older people's varied and changing needs.

What does the DSP say and other key directives?

The DHB is continuing to strengthen and integrate health and disability services for older people. The key goals in our DSP that are relevant are seamless integration and effective, efficient and high quality services.

"Seamless integration" is consistent with the aim of the Health of Older People Strategy to develop an integrated continuum of care that is responsive to the diverse and changing needs of older people and optimises their health and well being.

A commitment to developing effective, efficient and high quality services will require an evaluation of existing services and contracting frameworks. Reviews of how we do things from a strategic perspective will help address service gaps, re-design service delivery and contract frameworks and develop new roles.

What progress was made in 2005/06?

Hutt Valley DHB has implemented the following new initiatives in 2005/06:

- Piloting of the InterRAI Minimum Dataset for Home Care assessment and care planning tool.
- Commenced facility based restorative respite pilot.
- Developed a packages of care pilot with home based support providers.
- Established a research based falls prevention programme in partnership with ACC.
- Set up a Pacific for Pacific elders day care programme.
- Established a community based supported independent living programme pilot.
- Provided additional funding to home based support service (HBSS) providers to train support workers.
- Implemented a policy and support service to manage challenging behaviour of residents in aged care facilities.
- Developed a Health of Older People Management Policy to assist with the direction for ongoing service development for older people.
- Key stakeholder engagement on care coordination service has led to redefinition of the scope of the service

What is planned for 2006/07?

Progress will continue on implementing ageing in place initiatives and delaying entry to long-term residential care. This will be achieved through improving coordination and process interfaces with community groups, primary and secondary care, the home based support sector and aged residential care. Reviewing the coordination of services for older people and developing a central care coordination system will help identify system and process improvements for older people as they transition across a continuum of services.

The DHB plans to achieve an integrated continuum of care:

- Co-ordination and information sharing between planning and funding and service providers.

- Designing services and models of care that are patient centred and meet the support needs of older people within available funding.
- Assisting providers to fill key workforce and skill shortages in services for older people.
- Promoting services which help older people return to as independent a life as possible after they have had an illness or injury.
- Improving the coordination of services for older people.
- Establishing inter-sectoral partnerships to ensure older people have better access to appropriate and affordable accommodation. E.g. Multiple agency project on housing for older people (see Intersectoral Collaboration section) .

We will continue the development of initiatives to enable us to monitor and manage aged care services within available funding. This includes modelling of service demand and costs for aged care.

<table>
<tr><td colspan="2">Annual Objective 14: Continue to develop services to establish an integrated continuum of care and support ageing in place initiatives.</td></tr>
<tr><td colspan="2">Measures and Targets (see Appendix 7)
POP-13 Ambulatory Sensitive Admissions (also under Maternity, Child and Youth and a National Core Measure)
POP-14 Relationship between Assessed Level of Need and Entry to Residential Care</td></tr>
<tr><td colspan="2">Approach 14.1: Review current coordination services for older people, identify service gaps and duplication and develop a central care coordination system using a restorative approach to facilitate effective service utilisation and service efficiencies.</td></tr>
<tr><td colspan="2">Milestones 14.1:
• Modelling of current systems including referral patterns and patient flows that are service specific Q1
• Implement one point of entry service subject to available funding Q1
• Evaluation of one point of entry service Q2
• Central Care Coordination system specifications developed by Q3</td></tr>
<tr><td colspan="2">Position Responsible 14.1: Older Persons Portfolio Manager</td></tr>
<tr><td>Risks 14.1</td><td>Mitigations 14.1</td></tr>
<tr><td>Workforce capacity and capability may be limited.</td><td>Early engagement of key stakeholders in the development stages of the project. Link with workforce development strategies to identify and focus on aged care development.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Approach 14.2: Monitor and analyse the progress of packages of care service (where home based support providers use a restorative approach to promote effective service utilisation and timely client centred services).</td></tr>
<tr><td colspan="2">Milestones 14.2:
• Initial analysis completed by Q1.
• Monitoring and reporting continues Q2, Q3 & Q4
Note: Evaluation will occur in 07/08</td></tr>
<tr><td colspan="2">Position Responsible 14.2: Portfolio Manager Planning and Funding</td></tr>
<tr><td>Risks 14.2</td><td>Mitigations 14.2</td></tr>
<tr><td>Workforce capacity and capability may</td><td>Early engagement of key stakeholders in</td></tr>
</table>

be limited.	the development stages of the project. Link with workforce development strategies to identify and focus on aged care development
HBSS providers object to the reporting and monitoring measures used as a basis for reporting to our Board.	Discuss the reports with providers and include suggestions for improvement where appropriate.
Approach 14.3: Review of psycho-geriatric services and mental health services for older people. The review will inform the development of responsive inpatient and community based services to support older people requiring psychogeriatric and/or mental health services. The review is primarily patient-centered.	
Milestones 14.3: • Psycho-geriatric and mental health for older people service review completed Q2. • An agreed work programme for psycho-geriatric and mental health for older people service completed Q3.	
Position Responsible 14.3: Older Persons Portfolio Manager	
Risks 14.3	**Mitigations 14.3**
Difficulty in engaging an appropriately skilled external review team within the planned time frame.	Ensuring early planning to ensure timeframes are able to be met.
There is difficulty reaching agreement between stakeholders on how psycho-geriatric and mental health services for older people can be better co-ordinated and who should be responsible for which parts of the patient continuum of care.	Assist the parties to understand each other's area of responsibility and how, by working together, might improve psycho-geriatric and mental health services from both a patient and provider perspective.
Workforce availability does not improve the immediate pressure on service and access issues.	Engage with key stakeholders to ensure that workforce strategies support agreed recommendations and initiatives.
Approach 14.4: Review of the DHB's Health of Older Persons plan.	
Milestones 14.4: • Terms of reference of review agreed Q3. • Project plan for older persons service plan completed Q4..	
Position Responsible 14.4: Older Persons Portfolio Manager	
Risks 14.4	**Mitigations 14.4**
Difficulty in engaging with an appropriately skilled team within the planned time frame.	Ensure early planning to enable timeframes to be met.
Community representatives engaged to participate in the review do not consider they are having sufficient involvement in setting service priorities for improving patient access to service.	Seek agreement to the terms of reference that the plan is the basis of strategic direction for health of older peoples services.

Approach 14.5: Ensure the work force requirements in the aged care and home based support services (HBSS) are considered in the implementation of the Hutt Valley DHB Workforce Development Plan.

Milestones 14.5:

- Establish an aged care representative as a key role on the DHB's strategic workforce development steering group to support service development in the aged care sector in partnership with other providers and key agencies Q1
- Assist aged care and HBSS sector to implement effective recruitment practices by Q4
- Promote aged care as a positive career choice within DHB wide workforce strategies by Q4

Position Responsible 14.5: Older Persons Portfolio Manager

Risks 14.5	**Mitigations 14.5**
Funding not available.	Engage senior management in negotiations.
Workforce resource and capability not available.	Link with workforce development strategies to identify and build skill in aged care.

Approach 14.6

Develop model for monitoring and projecting aged care service requirements and costs.

Milestones 14.6:

- Model developed by Q2
- Implemented by Q3

Position Responsible 14.6: Senior Portfolio Manager, Mental Health and Older Persons

Risks 14.6	**Mitigations 14.6**
Relevant data not robust or available.	Be prepared to vary model to suit data available and make estimation where data is not available. These estimations will be detailed in assumptions.
Model may differ from regional or national developments	Keep informed of regional and national developments.

6.3.12 Maori Health

Whakatātaka[8] sets out to achieve change at the systems level within DHBs. All DHB activities are directed at improving Māori health rather than efforts being concentrated on ad hoc programmes and initiatives. It seeks to build on the strengths and assets within whānau and Māori communities. There are four pathways for action:

Te Ara Whakahaere: Pathway Ahead – Implementing Whakatātaka

- Te Ara Tuatahi: Pathway 1 – Developing whānau, hapu, iwi and Māori communities
- Te Ara Tuarua: Pathway 2 – Increasing Māori participation throughout the health and disability sector
- Te Ara Tuatoru: Pathway 3 – Creating effective health and disability services
- Te Ara Tuawhā: Pathway 4 – Working across sectors.

The pathways for action in Whakatātaka 2002-2005 continue and are integral to Hutt Valley DHB. Four priority areas have been identified: by the Ministry of Health for Whakataka two, these are primary health care, benchmarking and building quality data, developing whānau ora based models and increasing Māori participation – workforce development and governance. A number of Hutt Valley DHB priorities are aligned to these areas and we are expected to build on them over the next two to three years .

What does the DSP say and other key directives?

Our District Strategic Plan supports the ongoing implementation of our Maori Health Strategic Plan and identifies a range of conditions where significant health disparities exist between Maori and other residents. These include smoking, heart disease, cancer (lung, breast, cervical), diabetes, high blood pressure and respiratory disease (pneumonia, influenza and asthma). Both plans were developed in consultation with our Maori communities.

The District Strategic Plan identifies the following three key priorities for the Board in relation to Maori health:

- Developing a partnership with local Maori.
- Implementing service plan strategies to reduce inequalities.
- Expanding Maori capacity through provider and workforce development.

What progress was made in 2005/06?

Progress was made in the following areas in the implementation of our Maori Health Strategic Plan.

- The Maori Health Service Development group has been established. The group functions at the operational level of the DHB, working with the DHB planning and funding and the DHB provider operations, to ensure robust processes are used when considering priorities for Maori health gain.
- A draft Maori Health Workforce plan has been completed.
- Workforce development funding to support student work/holiday has been invested in the Maori Health Unit.
- An event showcasing Maori health providers and best practice approaches was held.
- A draft Maori Provider capability and capacity plan has been drafted.
- A number of one off funding projects have been completed (the Maori Health Unit position of Whanau Ora Facilitator has been reviewed; theToi Ora ki te Awakairangi speakers day was part-sponsored; and a workforce development initiative with Dr Te Rangimarie Rose Pere was initiated this year).

- One-off funding of $27,000 was invested in cancer and HEHA projects targeting Maori.
- Ongoing funding of $50,000 was invested in a respiratory support service for Maori children.
- Ongoing funding of $75,000 was allocated for a new kaumatua service.
- $30,000 funding was approved to support improved Maori responsiveness at hospice services.
- $60,000 funding for diabetes outreach services to Maori has been allocated.

What is planned for 2006/07?
The implementation of Whanau Ora ki te Awakairangi (our Maori Health Strategic Plan) began in July 2005. Progress for implementation has included working closely with the community at early stages to ensure the Maori Health Service Development group was properly established. The work for this year will focus on linking this group into DHB services so that DHB staff become accustomed to working alongside this group.

In 2006/07 we expect to prioritise and commit the remainder of funding allocated to the implementation of the Mäori health strategic plan. At this stage it is expected to target the management of chronic disease with a particular focus on diabetes and cancer. We will implement a small number of workforce development programmes that target sustainability and retention in the workforce. These are priority programmes outlined in the Maori Health Strategic Plan and the draft Maori health workforce plan.

Annual Objective 15: Implementation of the Mäori Health Strategic Plan - Whanau Ora Ki Te Awakairangi.

Measures and Targets (see Appendix 7)
HKO-01 Participation
HKO-02 Workforce (also under Workforce)
HKO-03 Improving Mainstream Effectiveness (also under Quality and Hospital)
HKO-04 Funding

Approach 15.1: Investment in Maori health of 3% on base funding for the 2006-07 year.

In 2003-04 the DHB outlined a future funding track increase of 5% for the next three years on the baseline of all “for Maori by Maori” funding. We have found that the capacity of Maori providers to deliver new services has not been adequately recognised in previous years, and we have adjusted the proposed funding track to a more realistic level for the 2006-07 year.

Milestones 15.1:
- Confirmation of new funding Q1.
- Service priorities agreed by Maori health service development group Q1.
- Implementation approach agreed Q2.
- Implementation Q3 and Q4.

Position Responsible 15.1: Maori Health Portfolio Manager

Risks 15.1	**Mitigations 15.1**
Funding not secured.	Ensure early indication to Ministry of Health
Funding not able to be spent.	Ensure funding papers for one-off spend are prepared and signed off in timely fashion.

Approach 15.2: Participation and consolidation of the Maori Health Service Development Group at the operational level, with increased capacity of the group.

- Build capacity of the group and support development of functional relationships at the operational level between the group and key personnel of the planning and funding unit and the DHB provider.

Key activities through 2006-07 are the following:

- Provide input into utilisation of the balance of funding allocated to the Maori health strategic plan and new funding streams
- Provide input into DHB annual planning

Milestones 15.2:

- Service priorities recommendations for funding for 2006-07 agreed Q1.
- Process for input into the District Annual Plan agreed Q1.
- Priority funding for 2007/08 agreed Q3.
- Work-plan for 2007/08 prepared Q4.

Position Responsible 15.2: Maori Health Portfolio Manager

Risks 15.2	**Mitigations 15.2**
Group not able to decide funding prioritisation.	Provide development sessions related to funding and planning early in the year.

Approach 15.3: Consolidate and expand the following service development initiatives.

- Consolidate the new children's respiratory support service and kaumatua services.
- Facilitate and support Maori Provider development in response to the cancer patient pathway (for Maori) and integrate the findings with the continuum of care developments (for diabetes and cardiovascular disease) as appropriate.
-

Milestones 15.3:

- Children's respiratory support service and kaumatua services are achieving expected capacity by Quarter 3.
- The continuum of care for disease management for Maori is agreed by Q3 for implementation in 2007/08.

Position Responsible 15.3: Maori Health Portfolio Manager

Risks 15.3	**Mitigations 15.3**
Continuum of care work incomplete or delayed.	Monitor progress of cancer control strategy; if early signal of delays, adjust planning cycle in accordance with delay.

Approach 15.4: Improve mainstream effectiveness.

- Continue Maori responsiveness training run by Raukura Wänanga for all staff both in the DHB provider services and the wider community services.
- Continue patient satisfaction surveys (Maori focus).
- Initiate a programme supporting the reduction of inequalities by collation of core data to assist the DHB provider to link service access and delivery to improved outcomes.

Milestones 15.4:

- 2 training sessions completed per quarter.
- 2 patient surveys completed per annum.
- Identify key services in DHB provider where increased access will play a significant role in improving outcomes for Maori Health by Q1.
- Develop strategies to improve access for Maori in these services as part of 2007/08 annual planning process – Q3.

Position Responsible 15.4: Maori Health Advisor

Risks 15.4	**Mitigations 15.4**
Services unable unwilling to provide data.	Early engagement with core services to encourage participation in collation and reporting.

Approach 15.5: Develop the Maori workforce. The following programmes were identified as high priority in the Maori Health Strategic plan and draft Maori health workforce plan. They are expected to augment the DHB wider workforce planning initiatives.

- Implement approach for Cadetships and consolidate Scholarship programmes.
- Develop Maori health workforce initiatives including Cadetship, Year 2 Toi Ora ki te Awakairangi and scholarships.
- We expect a number of one off initiatives will be funded. These will be focused on:
- Initiating a cadets programme.
- Extending the scholarships programme currently focused on Mental health development to include a more generic development program.
- Extending the Te Wheke programme initiated in 2004-05.

Milestones 15.5:

- Process for enrolment onto cadets programme agreed Quarter 2.
- Selection for Cadetship and scholarships Quarter 3.

Position Responsible 15.5: Maori Health Advisor and Maori Health Portfolio Manager

Risks 15.5	**Mitigations 15.5**
Programme development is delayed in start up	Communicate delays to key stakeholders, adjust timetables as required.

6.3.13 Pacific Health

The national Pacific Health and Disability Action Plan sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples. It is directed at the health and disability service sectors and Pacific communities, and aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders.

Priority Areas:

- Pacific child and youth health
- Promoting pacific healthy lifestyles and well-being
- Pacific primary health care and preventive services
- Pacific provider development and workforce development
- Promote participation of disabled pacific peoples
- Pacific health and disability information and research.

What does the DSP say and other key directives?

Developing Pacific health care is a priority that fits within all of the DSP's eight key strategies for the next five years. We will focus on three of our DSP's six key goals:

- Improved health equity
- Healthier communities
- A focus on prevention, early treatment and easy access

Focusing on three key goals for the 0607 year we will continue to implement Ili Ole Ola (the Hutt Valley DHB Pacific Health Action Plan). Ili Ole Ola identifies seven key goals, and the objectives and actions required to meet those goals.

What progress was made in 2005/06?

- The MeNZB campaign for Hutt Pacific children and young people, led by the Pacific Health Service Hutt (PHS). It was a successful collaboration between the MeNZB team, our other Pacific Providers, Pacific community leaders and GPs across the Hutt Valley and wider Wellington region. Follow up vaccinations continue where necessary.
- Pacific Health Service Hutt received Pacific Plan funding to develop as a Well child provider for Pacific children 0 – 5 years.
- Established an intersectoral project with the Ministry of Social Development (MSD) and local NGO Lavea'I Trust to offer free health screening programmes to parents and children attending Strategy for Kids, Infomation for Parents (SKIP) programmes in the Hutt Valley DHB area.
- PHS continue to deliver Healthy Lifestyle exercise programmes through PHO funding at five community sites with an estimated 4,500 participants that address diabetes, heart disease nutrition, physical activity. An evaluation was completed in December 2005. The programme has been selected as one of 21 finalists in the New Zealand Health Innovation Awards.
- Mental health support services for Pacific island clients have been established by Mid Valley and Piki te Ora PHOs, employing Pacific workers to deliver the service.
- The Pacific Unit Cadet Programme increased the number of Pacific undergraduates in health from one to four and continues to further develop the program
- Pacific representatives continue roles on DHB Advisory Committees and on PHO boards.
- The Pacific Unit is developing a resource to assist staff at mainstream to better understand Pacific clients.

- Hutt Valley DHB Pacific Advisor continues a regular radio broadcast providing updates and health promotion topics to Pacific communities in the region
- Established the Hutt Valley DHB Pacific Provider Managers' Group comprising of managers of contracted providers that interface at the DHB planning and funding operations level
- Established the Hutt Valley DHB Pacific Provider Network that interfaces with the Hutt Valley DHB Pacific Advisor, Hutt Valley DHB Pacific Provider Managers' Group, Regional Pubic Health Pacific Programme Advisor and Pacific Portfolio Manager

What is planned for 2006/07?
Hutt Valley DHB will continue to implement Ili Ole Ola (our Pacific Health Action Plan) for the third year. The focus for Pacific this year will be on consolidating gains made by Pacific provider and workforce development, collaborative opportunities to strengthen efficiency of Pacific service delivery and succession planning for 2007/08 and thereafter.

Hutt Valley DHB will continue to support young Pacific people studying in areas of health and develop collaborative opportunities, work experience and mentoring within the DHB provider arm and Pacific provider networks.

Pacific Provider Development Fund (PPDF)
Hutt Valley DHB will support collaborative Pacific health provider and community initiatives under the new category of innovative development initiatives which allows the DHB flexibility to extend this funding stream to Pacific non-health providers to support the development of Pacific networks across sectors to address determinants of health.

Annual Objective 16: To improve the health status of Pacific peoples in the Hutt Valley.
Measures and Targets (see Appendix 7) PAC-01 Progress towards the implementation of priority areas identified in the Pacific Health and Disability Action Plan. PAC-02 Engagement and participation of Pacific peoples in DHB decision making and the development of strategies and plans which include goals for Pacific Health gain.
Approach 16.1: Continue to implement Ili Ole Ola (the Hutt Valley DHB Pacific Health and Action Plan) and progress planning for later years.
Milestones 16.1: • Develop a Pacific project focussing on skin disease Q2 • Develop a Pacific men's health programme Q2 • Develop a Pacific Plan working group to progress planning for 07/08 and later years by Q2 • Develop a service plan for the Pacific Unit Q3 • Continue scholarships and monitor Pacific student's achievements, as resources allow • Implement the Pacific workforce plan • Explore the potential of new health innovation programmes based in community settings, planned with input from community leaders eg. church based screenings
Position Responsible 16.1: Pacific Health Advisor: Pacific Health Portfolio Manager

Risks 16.1	**Mitigations 16.1**
Lack of buy-in from the Pacific community.	Early engagement and consultation with stakeholders.

Approach 16.2: Support the allocation of the Pacific Provider Development Fund (PPDF).	
Milestones 16.2: • The Hutt Valley DHB Pacific Provider Development Fund Strategic Plan developed Q1. • Continue PPDF initiatives Q1	
Position Responsible 16.2 Pacific Health Portfolio Manager	
Risks 16.2	**Mitigations 16.2**
Lack of applications from Pacific providers for the Pacific Provider Development Fund	Regular and early engagement and consultation with Pacific providers
Lack of sustainable funding paths for successful PPDF pilot projects.	Evaluation of pilots will be integral to enable early advice for future planning of funding streams.

6.3.14 DHB and Intersectoral Collaboration

What does the DSP say and other key directives?
The intersectoral collaboration outlined in this section will assist in achieving several of the goals in the District Strategic Plan, including the goals of improved health equity and healthier communities. Collaboration with other DHBs and key health agencies will assist us to achieve effective, efficient and high quality services. Collaboration is a direct demonstration of the key DSP strategy, working with other agencies.

What progress was made in 2005/06?
Strategic Partnerships with Territorial Local Authorities
In August 2005 Hutt Valley District Health Board entered into a Memorandum of Understanding with the Greater Wellington Regional Council (GWRC), the Hutt City Council (HCC) and the Upper Hutt City Council (UHCC). Three priorities have been agreed between the parties and officers of the organisations meet regular to progress these priority areas which are:

- Deprived areas
- Youth and children
- Physical activities.

We are also working with the local authorities and transport providers to improve access and suitability of transport services for Hutt Valley people, including people with disabilities. We are keen to see better integration of public transport services within the Hutt Valley to enhance access to Hutt Hospital. We are advocating for better route planning and greater integration of transport services so that Hutt Valley people can more easily reach services at Wellington and Kenepuru hospitals.

Hutt Housing Steering Group
The Hutt Housing Steering Group is an intersectoral initiative to support housing projects and aid in advocacy, co-ordination and development of funding lines. The group's membership has expanded and now includes: Hutt Mana Charitable Trust, Piki Te Ora, Mid-Valley, Valley PHO, Wellington School of Medicine, Dept of Internal Affairs, Upper Hutt City Council, Hutt City Council, Energy Efficiency Conservation Authority (EECA), Housing New Zealand, Energy Smart and the Ministry of Social Development. The focus for the group has been information sharing, collaboration and the development of housing projects (see below).

Upper Hutt Healthy Homes Project
This project (co-funded by Hutt Mana Charitable Trust, EECA and Hutt Valley DHB) is to provide retrofitting measures to 75 low-income, Maori and Pacific households of which 50 will be in Upper Hutt . The project will be launched in February 2006.

Healthy Housing Index
This collaborative project was a pilot involving the Wellington School of Medicine, DHBs, BRANZ, Housing NZ, and Councils. It had a focus on improving the housing conditions and health outcomes for low-income families. Following its completion, funding has been provided by Hutt Valley DHB and other agencies to take remedial action on some of the housing properties assessed during the pilot.

Other Housing funding initiatives
Funding of $50,000 has supported the Kokiri marae retrofitting project. 168 referrals have been made to the project, with 104 homes within the Hutt Valley and Wainuiomata areas retrofitted since the project began in February 2005. We are

currently finalising an agreement with Otago University for $100,000 that will be used to install heating into homes identified as part of a separate Health and Heating project.

Naenae Rejuvenation Project
This is an interagency project with Hutt Valley DHB, Hutt City Council and Housing New Zealand to address a range of issues in the Naenae area. The group has completed a needs assessment, consultation report and a stock take of existing initiatives in Naenae. The two key areas identified for further development are a dedicated community facility and youth participation in services/activities for young people in Naenae. Action plans are being developed and will be implemented in 2006. Regional Public Health will support the youth participation stream with other stakeholders.

Pomare Access Project
The Pomare Access project was derived from community consultation and engagement with the local health provider, Hutt Union and Community Health Service (HUCHS). It was launched in November 2004. Its primary focus was the development of a one-stop shop that would allow increased opportunity for the Pomare community to work more closely together with HUCHS. HNZC has recently informed HUCHS that an appropriate building has been vacated and is ready for development. A redesign of the building is expected to occur before occupancy. The District Health Board indicated its support for this work.

Youth Transition Service
Upper Hutt City Council and Hutt City Council have been managing the recent tender of the Youth Transition Service (YTS) for the Hutt Valley, funded by the Ministry of Social Development (MSD). Hutt Valley DHB personnel have been selected to be members of the strategic steering group to support this work.

Health Promoting Schools Grants Programme
Hutt Valley DHB recently approved a grant programme designed to encourage school participation in health promoting activities. This programme targets schools in decile 1-3 in the Hutt Valley area only. 12 schools were invited to participate with an expectation that eight would eventually join; ten schools have been confirmed. Participating schools will be provided with a small grant to cover start-up activities. It is expected that these schools will then go on to become Health Promoting Schools (HPS) joining other schools currently participating in the HPS programme. HPS is funded through the Public Health Directorate of the Ministry of Health.

Physical activities
Hutt Valley DHB has purchased a franchise for the 10,000 Steps programme and is currently working to implement it with other interested parties in the Hutt Valley. A project manager has been employed to run the process, under the guidance of a DHB steering group. Upper Hutt City Council , Hutt City Council and Hutt Valley DHB are initiating a programme focused on safe environments for walking and cycling. Work in this area is still in the early stages.

Memorandum of Understanding with Ministry of Social Development (MSD)
A memorandum of understanding between MSD and Hutt Valley DHB has been agreed and signed. The following areas are our key priority focus areas.

- The joint establishment and facilitation of a Health and Income Working Group (HIWG). The HIWG brings together individuals from community and health-related organisations for the purpose of identifying potential solutions to particular health and income related issues.

- Supporting opportunities for sickness and invalid clients into employment with the support of targeted healthcare.

Also, Hutt Valley DHB and MSD have brought together a range of local and central agencies with the aim of increasing intersectoral support for Welltrust (a provider of youth alcohol and other drug services to the wider Wellington region).

Regional and national collaboration
In 2005/06, Hutt Valley DHB maintained its participation in regional collaborative efforts, working closely with the other central region DHBs (Capital and Coast, Wairarapa, Wanganui, MidCentral, Hawkes Bay) and their shared services agency, Technical Advisory Services (TAS). One aspect of the work programme was core technical work, assisting with analysis and monitoring of referred services (such as community phamaceuticals and community laboratory services) and aged residential care services. A second major focus was regional planning and contracting for mental health services (see Mental Health section).

As a group of DHBs, we have increased our focus on regional service development, progressing the recommendations of the review of plastics and burns services and initiating a review of cardiology services. The region is facing some key decisions on the future scope, size and delivery methods of tertiary services over the next few years. In preparation for this, the planning and funding general managers are meeting with senior provider arm managers to agree on prioritisation processes and financial management strategies.

What is planned for 2006/07?
We will continue our intersectoral focus on the three key areas of deprived areas; children and youth; and physical activity. We will continue to work closely with our local councils, especially for initiatives in specific communities and around physical activity (see also the Public Health section).

We will work towards improved health and wellbeing for children through implementation of a family violence action plan (see the Child Health section) and by enhanced efforts with schools. We will support youth through participation in the steering group for the Youth Transition service and other projects.

We will continue to develop joint activities with the Ministry of Social Development (MSD), with initial efforts providing targeted health care to assist sickness and invalid clients into employment. We also want to establish formal relationships with Child Youth and Family Service (CYFS), Police and the Accident Compensation Commission (ACC).

Annual Objective 17: Working intersectorally to improve coordination and collaboration across agencies to support the following three priority areas for Hutt Valley DHB:
- Children and Youth.
- Deprived areas.
- Physical activity.

Measures and Targets (see Appendix 7)
Six monthly update and progress report to DHB Board

Approach 17.1: Improving coordination and collaboration across agencies to support children and to reduce family violence by:

- Employing a family violence co-ordinator to implement the family violence action plan developed in 2005/06.
- Engaging with senior officials of CYFS, ACC, Education, Police and MSD to progress a Memorandum of Understanding focused on improving joint response for children in risky situations.
- Initiating discussions with key agencies to develop culturally appropriate parenting programmes to children in high needs communities.

Milestones 17.1:

- Family violence co-ordinator employed Q1.
- Memorandum of Understanding with CYFS and Police developed for signing Q3.
- Target an agreed approach to integrated contracting for parenting programme in the NGO sector Q4.

Position Responsible 17.1: Intersectoral Relations Manager

Risks 17.1	**Mitigations 17.1**
Delayed employment of FTE.	Early alert to reduce impact of delay.
Process of engagement with key agencies slow at progressing.	Ensure adequate resource is allocated to keep momentum and focus.
Government agencies are not ready to work with Hutt Valley.	Signal early to prepare for change with CYFS, MSD, Ministry of Education and the target NGO early.

Approach 17.2: Improving coordination and collaboration across agencies to support youth by:

- Working with key officials in local schools to progress the following local programs:
  - Encourage further enrolment in health promoting schools.
  - Supporting increased activity through walking and cycling programmes development in collaboration with city councils.
- Supporting the Youth Transition Service to reach capacity and capability over the next 12 to 18 months.

Milestones 17.2:

- Initiate relationships with primary and secondary school principals to enhance participation in Healthy Eating Healthy Action programmes - Q1.
- Work with RPH, council and schools to progress walking and cycling programmes - Q3
- Consolidate schools arrangement formally by Q4
- DHB membership on youth transition steering group regularly reports to Board.

Position Responsible 17.2: Intersectoral Relations Manager

Risks 17.2	**Mitigations 17.2**
Schools do not see value in interacting with DHB.	Ensure approach is supported by key stakeholders in schools.
Agencies are not prepared to implement programmes due to conflicting timetables.	Early warning of delays and adjust timetables to address.

Approach 17.3: Improving coordination and collaboration across agencies to improve support in deprived communities by:

- Initiating a work plan with the Ministry of Social Development to address health and income issues including specific initiatives providing targeted health care to assist sickness and invalid clients into employment (PATHS).
- Continuing to work with Hutt Housing Steering Group on housing and health projects.
- Continuing engagement with Hutt City Council with the Naenae rejuvenation programme, with a particular focus for youth access.
- Monitoring progress of the Pomare access program.

Milestones 17.3:

- PATHS programme initiated in Hutt Valley Q3.
- Housing programmes providing regular consolidated reports.

Position Responsible 17.3: Intersectoral Relations Manager

Risks 17.3	**Mitigations 17.3**
Delays in initiating work plan with MSD.	Early alert timetables adjusted.

Approach 17.4: Improving coordination and collaboration across agencies to support physical activity·by:

- Initiating discussion with TLA intersectoral group that looks at the range of walking, cycling opportunities and agree to develop one project for 2006/07, e.g. extending the current Hikoi program.
- Work alongside councils to promote activities led by their agencies, e.g. the bridge to bridge walks.

Milestones 17.4:

- Intersectoral TLA group agree project Q2.

Position Responsible 17.4: Intersectoral Relations Manager

Risks 17.4	**Mitigations 17.4**
Lack of resource.	Alert early and delay if necessary.

In 2006/07, we will continue our regional collaboration, working closely with the other central region DHBs (Capital and Coast, Wairarapa, Wanganui, MidCentral, Hawkes Bay) and the shared services agency, Technical Advisory Services (TAS). We will continue with the core technical work, covering analysis and monitoring of referred services and aged residential care services. We will continue with regional planning and contracting for mental health services, focussing on implementation of the regional strategic and service plans for mental health.

As a group, we will maintain our focus on regional service development, progressing the recommendations of the review of plastics and burns services and completing the review of cardiology services. We will apply the agreed prioritisation processes and financial management strategies to ensure sustainability in cardiology, cancer and renal services.

At a national level, we will continue to participate in national activities coordinated by District Health Boards New Zealand (DHBNZ). Key activities will include preparation and negotiation of national contracts, as well as the ongoing relationships with PHARMAC and Ministry of Health programmes.

Annual Objective 18: Working collaboratively with other DHBs and health agencies to ensure sustainability and efficiency in service delivery.

Measures and Targets (see Appendix 7)
Six monthly update and progress report to DHB Board

Approach 18.1: Continue participation in national activities through DHBNZ and the Ministry of Health

Milestones 18.1:

- Participation in programme development and delivery in primary health care as required.
- Participation in national contracting processes (aged residential care, dental, primary care, pharmacy) as required.
- Participation in setting the parameters for PHARMAC activities, as required.

Position Responsible 18.1: Director, Planning, Funding and Public Health

Risks 18.1	**Mitigations 18.1**
Insufficient time for consideration of negotiation positions	Push for early preparation by those responsible
Lack of strategic focus and insufficient information available for proper decision making	Push for relevant and skilled people to participate

Approach 18.2: Collaboration by central region DHBs for improved service delivery and greater efficiency.

Milestones 18.2:

- Complete regional service plan for mental health by Q2.
- Initiate implementation of regional service plan for mental health by Q4.
- Continue to progress development of regional approaches with plastics and burns service.
- Complete review of cardiology services by Q3.
- Assess what is needed to ensure sustainability in cardiology, cancer and renal services by Q2.
- Assist the delivery DHB(s) to apply the agreed prioritisation processes and financial management strategies to ensure sustainability in cardiology, cancer and renal services.
- Implement the regional diabetes database by Q3.

Position Responsible 18.2: Regional General Managers, Planning and Funding

Risks 18.2	**Mitigations 18.2**
Insufficient capacity in DHBs to progress regional projects	Prioritise regional work in work plans

Approach 18.3: Review the approaches and work programme of the shared services agency (TAS) to ensure relevance and efficiency of services delivered.

Milestones 18.3:

- Review undertaken by Q2.
- Work programme revised and new framework agreed for 2007/08 by Q3.

Position Responsible 18.3: Regional General Managers, Planning and Funding

Risks 18.3	**Mitigations 18.3**
Conflicting priorities mean that TAS	Ensure that Chief Executive Officers and

cannot accommodate new directions	General Managers have agreed on the purpose and processes of the TAS review before starting

6.3.15 Public Health

What does the DSP say and other key directives?
The District Strategic Plan identifies the following goals to achieve healthier communities:

- Promote healthy choices in the community, workplaces and schools.
- Work with other organisations and sectors to influence the wider determinants of health so that the health of the community can be improved.

What progress was made in 2005/06?

- Hutt Valley DHB became licensed to deliver the 10,000 steps @ Work Programme. The programme was delivered for Hutt Valley DHB staff for a second time with record numbers of participants.
- Completed a mapping exercise of Healthy Eating Healthy Action Initiatives in the Hutt Valley.
- Links established between Physical Activity Networks and Nutrition Networks
- Worked together with local councils, Sport and Recreation New Zealand (SPARC) and others on the Hutt Valley Active Community Management Group
- Hutt Valley DHB mapping exercise of current programmes and activities to ensure these are in-line with the Healthy Eating Healthy Action Implementation Plan completed.
- Changes made to the Hutt Valley DHB cafeteria menu and presentation.
- Evaluation of Healthy Lifestyles Pasifika.
- Naenae Breakfast Co-op launched at Rata Street School.
- Worked with Valley PHO to support the ten local Kohanga Reo by providing “Ka Nukunuku Ka Nekeneke”, sports equipment and physical activity training.
- Feasibility report for Hutt Valley DHB Smokefree Hospital project completed and recommendations approved.
- Sponsored and supported Koraunui Marae with their plan to be Tuturu Auahi Kore (smoke free).
- Sponsored and supported Pa Wars – a regional sports event held in the Hutt. The event was both Auahi Kore (smoke free) and alcohol free.
- Needs analysis compiled of all intermediate and secondary schools to identify barriers to implementing smokefree projects and activities in schools.
- Smokefree schools email address and email newsletter initiated. These will be used to disseminate tobacco related information to school staff.
- Alcohol Controlled Purchase Operation across 69 on and off-licensed premises in the Hutt Valley.
- Night inspections conducted of eight licensed premises to check compliance.
- Worked with four schools in the Hutt Valley in regard to safe Afterball events.
- A summit in October 2005 of refugees, government agencies and non-governmental organisations produced six issues groups (housing, healthy lifestyle, knowledge and skills, safety and security, economic wellbeing, and community capacity building) who have been developing a Refugees Health and Wellbeing Action Plan. A draft is intended to be made available for consultation by the end of March 2006.
- Intersectoral work continues with the Skin Infections project, including the Ministry of Education to improve hand hygiene in schools, Work and Income with training and other DHBs and Public Health Units to launch a skin infection website. An evaluation of this project is also being conducted.
- Provided two Health Impact Assessment (HIA) workshops for local Government senior policy analysts and planners. The aim was to ensure that Territorial Local Authority decision-making and policy development processes included consideration of the potential health impact for communities.

What is planned for 2006/07?
In addition to the objective areas below, a continued focus for Regional Public Health will be delivering Ministry of Health funded public health services to the greater Wellington region in the areas of health protection, health promotion, social environments and school health.

Annual Objective 19: Contribute to a range of population health programmes that promote healthy lifestyles, including Healthy Eating Healthy Action strategies and cancer prevention programmes.

Measures and Targets (see Appendix 7)
Physical Activity (Board DSP Indicator)

Approach 19.1:

- Implement Healthy Eating Healthy Action strategies in the Hutt Valley, including
    - working intersectorally linking between local and regional providers,
    - supporting PHOs,
    - working in early childhood centres and school settings,
    - increasing participation in the Hikoi programme and
    - continuing to support workplace activities including 10,000 Steps and Walk challenge
    - capacity building with Maori and Pacific providers and workforce.
- Work with Work and Income, Housing NZ and foodbanks to address issues of food poverty.
- Continue working in the area of public transport to promote expanded accessible public transport and to encourage active modes of transport.
- Continue tobacco control work, including
    - implementation and enforcement of the SmokeFree Environments Act 1990,
    - Hutt Valley SmokeFree DHB Policy and a Systems First Approach for a Smokefree hospital, with the first step being a smoking cessation pilot in the children's health service
    - wider SmokeFree promotion, including the provision of information and support to community organisations, marae, schools, clubs.

Milestones 19.1:

- Healthy Eating Healthy Action Network Terms of Reference developed by end of Q2.
- Evaluation of Hikoi 2007 indicates increased participation rates by Q4.
- Capacity building opportunity for community providers held by Q3.
- Undertake a research project to enhance work to promote Healthy Eating and Healthy Action by end of Q4.
- Link with the Hutt Valley DHB School Grants scheme to implement a range of health promotion strategies in schools, if resources allow.
- Hutt Valley DHB Smokefree Hospital pilot projects completed and evaluated by end Q3.
- Rollout of Hutt Valley DHB Smokefree policy across the wider DHB to commence in Q4.
- Support community organisations with events associated with World Smokefree day in Q4.
- Smokefree Schools email newsletter distributed six weekly during school terms.
- Health Impact Assessment of the strategic options for regional transport funding is completed (in conjunction with the Greater Wellington Regional Council.

Position Responsible 19.1: Team Leader Health Promotion

Risks 19.1	**Mitigations 19.1**
Lack of buy-in from key stakeholders.	Proactive engagement with key stakeholders to achieve common goals.

Approach 19.2

- Reduce alcohol related harm among young people through the Youth Access to Alcohol Project (YATA) and Alcohol Controlled Purchase Operations.
- On-going collaboration with Police and District Licensing Agencies to address alcohol related harm associated with problem premises.

Milestones 19.2:

- Combined Enforcement Group meetings held with managers of problem premises to resolve issues.
- Night inspections of problem premises to check compliance with the Sale of Liquor Act.
- Support schools requesting assistance with Afterball parties in Q2.
- Use information on Hutt youth culture, views and perceptions obtained through the YATA Photovoice project and through text messaging-based consultation methods to increase the effectiveness of our work with young people.

Position Responsible 19.2: Team Leader Health Promotion

Risks 19.2	**Mitigations 19.2**
Lack of buy-in from key stakeholders.	Proactive engagement with key stakeholders to achieve common goals.

Annual Objective 20: Work intersectorally with key agencies to improve health outcomes and address the determinants of health.

Measures and Targets (see Appendix 7)
Physical Activity (Board DSP Indicator)

Approach 20.1: Support specific intersectoral projects aimed at improving health outcomes and addressing the determinants of health in the Hutt Valley.

Milestones 20.1:

- Continue to work with the Hutt Housing Steering Group on housing and health projects.
- Finalisation of the intersectoral Refugee Health and Wellbeing Action Plan Q1, and implementation from Q2.
- Reduce hospitalisation due to serious skin infections by implementing a project to assist families to access appropriate entitlements through WINZ, ACC and PHOs.
- Work alongside schools in the Hutt Valley to promote healthy environments (including hand hygiene practices and first aid knowledge) that reduce the risk of serious skin infections.

Position Responsible 20.1: Intersectoral Relations Manager and Team Leader Social Environments team.

Risks 20.1	**Mitigations 20.1**
Disparate views between different agencies.	Develop memorandum of agreement to ensure joint work programmes and outcomes.
Impact of other priorities may delay development and roll-out of intersectoral project plans.	Develop agreed work plans that ensure that responsibility for key project milestones is shared amongst all project partners.

Approach 20.2: Support Territorial Local Authority workforce development in Health Impact Assessment to ensure that consideration is given to the impact on health of decisions made.

Milestones 20.2:

- Workforce development workshops undertaken.

Position Responsible 20.2: Team Leader Social Environments team.

Risks 20.2	**Mitigations 20.2**
Workforce development in Health Impact Assessment is not considered to be a priority by Hutt City Council and Upper Hutt City Council staff.	Active promotion of the benefits of Health Impact Assessment to improve outcomes for high need communities.

6.3.16 Emergency Planning

What does the DSP say and other key directives?
The DSP acknowledges that we need to be prepared for major emergencies such as a pandemic and civil defence emergencies like an earthquake or a flood. We are upgrading our major incident policies and processes and we are participating in the pandemic preparation being led by the Ministry of Health. The processes developed will be evaluated through local, regional and national emergency exercises. We are working with local and regional health providers and emergency services, as well as Civil Defence Emergency Management (CDEM).

What progress was made in 2005/06?
Pandemic planning has taken priority in the 2005/06 year, highlighting issues of internal resources required to develop and implement required plans, the significant impact a pandemic would have on the Hutt Valley community, and the ability of our health services to cope. Specific achievements are:

- Development of a draft Pandemic Plan for the primary and secondary sector.
- Improvements to the hospital's operational Co-ordinated Incident Management System (CIMS) structure, including revised resources, action cards, external training provided and an exercise completed.
- Ongoing collaboration externally with emergency services and local authorities and the primary care sector has resulted in a number of initiatives that have strengthened the Hutt Valley's overall emergency preparedness.
- Participation in Operation Spandex and Exercise Phoenix IV assisted Hutt Valley DHB to identify strengths and weaknesses with our emergency preparedness.
- Hutt Valley DHB participated in the development of the Central Region Health Coordination Plan which was issued in July 2005.

What is planned for 2006/07?
We will actively work with others in the region to deal with any pandemic, major disease outbreak, or other health emergency. Contingency planning for a pandemic remains a priority.

We will continue to collaborative closely with external agencies in finalising the Pandemic Plan. We will provide support to the primary care sector to develop their emergency preparedness plans and facilitate participation in emergency exercises. We will educate staff regarding emergency preparedness, including personal/family and workplace responsibilities.

Annual Objective 21: Ensure Hutt Valley DHB has emergency management plans in place that meet national and regional requirements to enable it to respond to emergency situations.
Measures and Targets (see Appendix 7) Mandatory requirements
Approach 21.1: • Collaborate closely with external agencies in developing the pandemic and other emergency plans. • Provide support to the primary care sector to develop their emergency preparedness plans and facilitate participation in emergency exercises. • Educate staff regarding emergency preparedness, including personal/family and workplace responsibilities.

Milestones 21.1:

- Revised emergency plan for Hutt Valley DHB that addresses all areas of emergency management (including the Pandemic Plan) by Q4.
- Revised emergency preparedness plans for all Hutt Valley DHB services by Q4.
- Revised emergency preparedness plans for the primary care sector by Q4.
- Exercises of the above plans to test preparedness - ongoing.
- Programme for staff education in place by Q4.

Position Responsible 21.1: Emergency Management Coordinator	
Hutt Valley DHB unprepared for emergency situation	Ensure plans are developed, and tested through exercises.
Staff are unprepared for emergency situation	Focus on staff education, training and support

6.3.17 Magnet

Hutt Valley DHB is progressing towards achievement of Magnet Recognition by January 2007. This programme adopts a set of key governance, leadership and management principles that result in safe, quality focused health care. Organisations that reflect these principles are able to attract, motivate and retain well-qualified and committed nursing staff. Magnet Recognition is a key element of Hutt Valley DHB's workforce development, as it supports and is aligned with the goals of our workforce plan.

What does the DSP say and other key directives?
Nurses make up the largest group in Hutt Valley DHB's workforce. We need to ensure they have strong leaders and good support. The Magnet Recognition Programme is a key initiative in supporting, attracting and retaining nurses.

What progress was made in 2005/06?

- Following key appointments that included the Director of Nursing, Associate Director of Nursing and Magnet Project Leader during 2005, Hutt Valley DHB has deferred the application process for Magnet Recognition to 2006.
- The re-building of a Magnet Project Team with closer links to the existing quality and safety framework has ensured that Magnet and other quality initiatives are well aligned and afforded the knowledge and skills of appropriate personnel.
- Re-engagement of key clinical staff has seen a renewed interest in the Magnet Programme. This is culminating in the collation of the required documentation and subsequent site visit by American Nurses Credentialing Centre (ANCC).
- An Expo was held in December 2005 providing an excellent opportunity for services to show case their innovations and examples of best practice. The response was exceptionally positive, including a visit by the Minister of Health. A DVD has been produced for use in future recruitment and orientation initiatives, as well as providing evidence to ANCC of Hutt Valley DHB's positive culture of collaborative practice.

What is planned for 2006/07?
Following submission of the Magnet documentation to ANCC, preparations will commence for the site visit in late 2006. It is anticipated that Magnet Recognition will be awarded by January 2007. Following successful recognition, ongoing monitoring of compliance with the Magnet programme will occur.

<table>
<tr><td colspan="2">Annual Objective 22: Achievement of Magnet Recognition by ANCC.</td></tr>
<tr><td colspan="2">Measures and Targets (see Appendix 7)
To achieve Magnet Recognition by January 2007.</td></tr>
<tr><td colspan="2">Approach 22.1 The Magnet Project Plan provides the framework for successful achievement of Magnet Recognition.</td></tr>
<tr><td colspan="2">Milestones 22.1:
• Document submission by July 2006.
• Site visit in Q2.
• Magnet Recognition achieved in Q3.</td></tr>
<tr><td colspan="2">Position Responsible 22.1: Director of Nursing</td></tr>
<tr><td>Risks 22.1</td><td>Mitigations 22.1</td></tr>
</table>

Change in nursing leadership could delay programme	Retention of key nursing leadership positions
Documentation requirements not met	Planned approach ensuring timeframes met and high quality of information submitted
Site visit does not result in Magnet Recognition	Organisation is fully committed to achievement of Magnet Recognition
Approach 22.2: Development of a plan to ensure ongoing compliance with the Magnet Programme through continuous quality improvement.	
Milestones 22.2: • Plan developed outlining the Magnet monitoring programme by Q3 • Resources allocated to monitoring programme by Q4 • Monitoring programme commenced 2007/08	
Position Responsible 22.2: Director of Nursing	
Risks 22.2	**Mitigations 22.2**
Loss of momentum following achievement of Magnet Recognition	Monitoring programme ensures ongoing organisational commitment

6.3.18 Quality and Safety

What does the DSP say and other key directives?
Effective, Efficient and High Quality Services is one of our key goals. The Quality Plan for Hutt Valley DHB reflects the Improving Quality[10] (IQ) document from the Ministry of Health. This document outlines the quality dimensions of access and equity, safety, effectiveness and efficiency, while recognising the importance of a systems approach to quality improvement across all levels of the system. Quality and safety initiatives within Hutt Valley Hutt ValleyDHB reflect this framework and provide a mechanism for staff at all levels to participate in a culture of quality improvement.

What progress was made in 2005/06?
The Clinical Board meets monthly providing an increased focus on clinical leadership with quality and risk management activities. Work continues on a framework for how the DHB considers the approval and funding of new health interventions. Clinical research, informed consent and clinical alert policy/process have been reviewed.

A surveillance visit from Quality Health New Zealand (QHNZ) confirmed that good progress is being made with recommended quality improvements from the June 2004 audit against the Health & Disability Sector Standards (HDSS) and QHNZ Accreditation Standards.

A quarterly Quality Report summarises activity including quality and patient safety initiatives, complaints, event reporting, ACC treatment injury and patient satisfaction.

The re-establishment of the Magnet Project Team now includes the Quality Manager, ensuring closer links with the quality programme and alignment with existing accreditation frameworks.

What is planned for 2006/07?
The Clinical Board will review its terms of reference relating to the inclusion of the primary care sector in its membership. This will provide opportunities for information sharing and enhanced clinical advice across primary and secondary services.

Re-certification against the HDSS is due in July 2006 – this will be combined with a survey against the QHNZ Accreditation Standards to realign both processes into one site visit.

Implementation of a web-based event reporting system will enhance ability of front-line staff to report quality issues and improve management of the reporting and trend analysis vital in lessening reoccurrence.

Annual Objective 23: To support staff to deliver high quality care within a quality improvement framework: through positive, visible and professional clinical leadership and through a culture of safe reporting and consumer participation.
Measures and Targets (see Appendix 7) QUA-01a Quality Systems HKO-03 Improving Mainstream Effectiveness

Approach 23.1:
The Quality/Risk Unit will provide coordination and support to all services for the achievement of accreditation/certification, Magnet Recognition Programme, Clinical Board and re-credentialing activities.

Milestones 23.1:
- Completion of accreditation/certification documentation, successful survey (July 2006).
- Completion of Magnet documentation and achievement of Magnet status (October 2006).
- Clinical Board monthly meetings and sub-committee activities coordinated (Ongoing).
- Re-credentialing programme in place (Ongoing).

Position Responsible 23.1: Quality Manager

Risks 23.1	**Mitigations 23.1**
Accreditation/certification/Magnet status not achieved.	Planned approach ensuring timeframes met and high quality of information submitted.

Approach 23.2:
- Ensure consumers and their representatives are given every opportunity to express their views and have input into the planning and delivery of services.
- Ensure staff are encouraged to report and learn from system failures.

Milestones 23.2:
- Patient satisfaction survey results are analysed and results fed back for focus on improvement (quarterly).
- The outcome of complaints, coronial, Accident Compensation Corporation, Health and Disability Commissioner and Privacy events are analysed and utilised for improvement opportunities (ongoing).
- The event reporting process is streamlined, trends are identified and organisational projects undertaken to target patient safety issues by Q4.

Position Responsible 23.2: Quality Manager

Risks 23.2	**Mitigations 23.2**
Satisfaction levels drop and complaints increase.	Focus on quality improvement opportunities.
Workplace culture does not support open disclosure and safe reporting of events.	Foster culture of safe reporting, focus on learning and improvements.

6.3.19 Information Services

What does the DSP say and other key directives?
Sharing Information and Measuring Progress is one of eight key strategies in the DSP. This strategy encompasses using and improving access to information about health and health services, measuring the effectiveness of different initiatives on patient outcomes, and allowing relevant and timely patient information to be shared by clinical staff involved in a patient's care.

The 12 Action Zones of New Zealand Health Information Strategy (HIS-NZ) are included in the Hutt Valley DHB Information Systems Strategic Plan (ISSP), and are wrapped around regional and local priorities where possible in the absence of independent funding for HIS-NZ projects. Hutt Valley DHB is planning for the development of an Electronic Medical Records (EMR) referral system. We are interested in being a national pilot site for this project.

What progress was made in 2005/06?
There is continuing progress on collecting consistent information and sharing it with DHB stakeholders. The Clinical Information Systems within the hospital environment are reasonably mature, and there is a steady stream of innovation which improves the processing of and access to patient information across both primary and secondary sectors.

Two initiatives were successfully implemented in Primary Care Information Technology based on key components of the Primary Care IT Plan.

- Valley-wide on-line network linking GPs, PHOs, the MSO (Kowhai Health) and the DHB together – 80% of GPs have joined this network
- Publication and compliance with minimum standards for IT infrastructure at GP practices – over 90% compliance has been achieved.

The design of electronic referrals has been agreed with ground-breaking work done around standards and the software development/integration approach.

Another initiative which delivers services in the community is the new school dental system. The EXact Dental system is currently live at Whai Oranga and actively used by 20 school dental teams on location using laptops networked via Telecom's 3G cellphone network. Deployment of the system to the remaining 20 school dental teams and the hospital dental unit will continue in 2006.

What is planned for 2006/07?
Of the 12 Action Zones, our priority will be progressing the following three:

- Electronic Referrals – this will enable better communication and management of referrals between primary and secondary care.
- National Non-Admitted Patients Collection (NNPAC) – this is a requirement of the Ministry and DHBs and is needed for better analysis of the use of outpatient based health services run by DHBs.
- National/Regional Network – this willenable enhanced collaboration between DHBs through consolidation of resources, convergence of systems, and centres of expertise. Specific applications such as the regional diabetes server or the Hutt Valley/Capital and Coast laboratory repository will be able to be set up once but delivered anywhere within the region. A proposal for a high speed cost effective Central Region Network is being prepared and will be reviewed by the Regional Capex Committee and HISAC's Infrastructure sub-committee.

During 2006/07 we will also review our Information Systems Strategic Plan (ISSP).

Annual Objective 24: Electronic Referrals (HIS-NZ Action 8).	
Measures and Targets (see Appendix 7) Percentage of primary care referrals and hospital discharges done electronically for different services (Board DSP Indicator).	
Approach 24.1: Implement electronic referral management for GPs referring patients to secondary provider services.	
Milestones 24.1: • Start pilot of Electronic Referrals from GPs – Q1. • 50% of Hutt GP Practices using Electronic Referrals – Q3.	
Position Responsible 24.1: Chief Information Officer	
Risks 24.1	**Mitigations 24.1**
New system development involving three vendors working together.	Clear demarcation and accountabilities through Hutt Valley DHB project management.
New business processes required for both GPs and the hospital support services.	Obtain Executive and GP Leaders support; GP representatives on implementation team.
Needs standards for data and code sets.	HISO standard in progress.

Annual Objective 25: National Non-admitted Patients A Collection (NNPAC) (HIS-NZ Action 9).	
Measures and Targets (see Appendix 7) Extract of Outpatients and ED visits to Ministry of Health according to specifications by 1 July 2007.	
Approach 25.1: Implement NNPAC data collection and data extract to Ministry according to agreed specifications.	
Milestones 25.1: • NNPAC data collection in place – Q1. • NNPAC data extract in place - Q4.	
Position Responsible 25.1: Chief Information Officer	
Risks 25.1	**Mitigations 25.1**
Accuracy and timeliness of data.	Preparation and training of end users.
MoH timeframes for data collection are unrealistic	Negotiate with MoH for more time
Consistent data definitions.	Agreed data standards and definitions (nationally) – ensure systems aligned with need to collect correct data.

6.3.20 Workforce Development

What does the DSP say and other key directives?
Our District Strategic Plan identifies Developing the Workforce as one of eight key strategies. We aim to build a skilled workforce that meets our communities needs in the face of national and international shortages of healthcare professionals.

Regionally, the six DHBs in the central region have produced a Human Resources plan that facilitates collaboration around a number of workforce and service delivery issues, such as nursing recruitment, employee relations, and learning and development initiatives. This will support both local and national directions.

The national framework for the delivery of workforce directions is the implementation of key activities outlined initially in the DHB/DHBNZ Workforce Action Plan (WAP) and the recommendations of the Health Workforce Advisory Committee (HWAC) that informed last year's planning. This has now evolved and updated to a document which DHB Chief Executives have endorsed – Future Workforce - that now guides all DHBs in their workforce development activities.

What progress was made in 2005/06?
Organisational Development
The focus has been the completion and implementation of "Healthy Jobs - Healthy Communities", our Strategic Workforce Development Plan 2005-2011. The plan contains eight goals with associated strategies:
Goal 1: Positive workplace cultures
Goal 2: Inspiring Leaders
Goal 3: Attracting and recruiting the workforce we need
Goal 4: Retaining a skilled workforce of the right people with the right skills
Goal 5: Developing Maori Health Workforce
Goal 6: Developing Pacific Health Workforce
Goal 7: Regional Workforce Collaboration
Goal 8: National Workforce Collaboration

A new innovation to help guide our implementation of "Healthy Jobs - Healthy Communities" is the organisation of a workforce reference group made up of DHB health practitioners from our provider arm and primary and community providers. This group is unique in its role, designed to 'think-tank' planning priorities and workforce solutions.

Employee Relations
The majority (in excess of 90%) of our staff are now covered by national or regional Collective Employment Agreements. Whilst the relationship between manager and employee is key, we recognise that our relationships with employee representatives are also very important. Accordingly, we continue to build and encourage collaboration and mutual understanding with unions through bipartite meetings.

Health & Safety
We continue to be accredited at secondary level in the Accident Compensation Corporation Partnership Programme, which demonstrates continuous improvement in work-safe management practices, claims management, and rehabilitation of injured employees. This accreditation will be maintained by demonstrating continued improvement in all aspects of Health and Safety management and Occupational Health practices.

Due to our success last year with the 10,000 Steps walking programme, we have secured the franchise for the Wellington region. In conjunction with Regional Public Health we have just completed the 2nd rollout of the programme to our staff, as well as commencing discussions with external organisations who wish to pick up this healthy staff initiative.

What is planned for 2006/07?
We plan to implement the year one priority directions identified in our 'Healthy Jobs - Healthy Communities" strategic plan which developed a DHB-wide workforce development plan in response to the on-going issues Hutt valley, like all New Zealand's DHBs, has in attracting and retaining skilled health workers. 'DHB-wide' means we have considered workforce issues across primary and community healthy providers and hospital services and have developed strategies that will support workforce development across all types of health services in the Hutt Valley.

Annual Objective 26: Implement Strategic Workforce Development priorities.

Measures and Targets (see Appendix 7)
HKO-02 Maori Workforce Development (also under Maori)
INV-02 Workforce
Workplace Injury Rate (National Core Measure)

Approach 26.1: *Positive Workplace Culture* - Continuation of strategies that make Hutt Valley DHB a healthy and great place to work.

Milestones 26.1:
- Meet project plan milestones Q1, Q2, Q3, Q4.
- Obtain baseline data for national DHB healthy workplace indicators currently under development – Q1.
- Participation in Department of Labour employer work-life balance project Q1-4.
- Participation in pay and employment equity projects Q1-4.
- Maintain bipartite relationships with unions and associations that are productive and effective – ongoing.

Position Responsible 26.1: General Manager, Human Resources:
Goal Sponsors as per the Strategic Workforce Development Plan 2005-2011.

Risks 26.1	**Mitigations 26.1**
Lack of buy-in from staff and key stakeholders.	Be open in our communication about what is going on and encourage participation from across the wider DHB.
Commitment of resources and significant volume of input required on projects.	Be realistic about project priorities and milestones, including resourcing, timeframes and funding.

Approach 26.2: *Recruitment and Retention* – Focus on key vacancies and retention issues in hospital services and primary care as well as introduction of easy to use recruitment processes for community health providers.

Milestones 26.2:
- Meet project plan milestones Q1, Q2, Q3, Q4.
- Develop a DHB-wide marketing strategy – Q1-4.
- Provide access to Hutt Valley DHB Healthy Job web pages for primary and community providers to advertise vacancies – Q2.

Position Responsible 26.2: General Manager, Human Resources:
Goal Sponsors as per the Strategic Workforce Development Plan 2005-2011.

Risks 26.2	**Mitigations 26.2**
Commitment of resources and significant volume of input required on projects.	Be realistic about project priorities and milestones, including resourcing, timeframes and funding.

Approach 26.3: *Inspiring Leaders* – Establish a co-ordinated and proactive approach to developing great people managers.

Milestones 26.3:

- Meet project plan milestones Q1, Q2, Q3, Q4.
- Develop DHB-wide leadership capability training and programmes –Q1-4.
- Provide induction, orientation and mentoring/coaching for all appointed service line managers – Q3.
- Develop succession planning frameworks – Q4

Position Responsible 26.3: General Manager, Human Resources and Goal Sponsors as per the Strategic Workforce Development Plan 2005-2011.

Risks 26.3	**Mitigations 26.3**
Commitment of resources and significant volume of input required on projects.	Be realistic about project priorities and milestones, including resourcing, timeframes and funding.

Approach 26.4: *DHB wide Health Education Unit* – Scope the establishment of a co-ordinated practice unit across the wider DHB, with a focus on the streamlined delivery of current and future clinical, practice and leadership/management education and development needs.

Milestones 26.4:

- Meet project plan milestones Q1, Q2, Q3, Q4.
- Identify the skill mix required across disciplines and teams and reflect this in DHB-wide access to education, and training – Q4.

Position Responsible 26.4: General Manager, Human Resources and Goal Sponsors as per the Strategic Workforce Development Plan 2005-2011.

Risks 26.4	**Mitigations 26.4**
Commitment of resources and significant volume of input required on projects.	Be realistic about project priorities and milestones, including resourcing, timeframes and funding.

6.3.21 Capability, Capital and Campus Planning

What does the DSP say and other key directives?
The Hutt Valley DHB District Strategic Plan identifies organisational capability as a key issue over the next five years (p16). In particular the DSP outlines the following specific areas on which we intend to focus:

- Clinical policy issues.
- Research and teaching.
- Clinical staff and management relationship.
- Nursing leadership and support, Magnet.
- Facilities (operating theatres, intensive care unit, emergency department, acute assessment unit, mental health inpatient unit).

The DSP includes three strategies that are targeted at improving our capability:

- Strategy 3: Redesigning services and consolidating gains.
- Strategy 7: Developing the Workforce.
- Strategy 8: Improving our Hospital.

What progress was made in 2005/06?
Significant progress has been made in the 2005/2006 financial year:

- Our Clinical Board continues to refine terms of reference and focus on specific policy issues.
- Our internal Leadership Course has been accredited and is being run in conjunction with Weltec.
- We are pursuing opportunities for further joint venture initiatives in the research sector.
- Management and senior clinicians have worked closely on a number of strategic issues during the year (DSP, Campus Plan, specific service issues).
- We appointed a new Director of Nursing and have progressed the Magnet programme to the point where we will apply for accreditation in June/July 2006.

We successfully completed a greatly improved Asset Management Plan (AMP) in October 2005. The AMP is now supported by integrated financial information provided by the BEIMS system that was implemented during the year.

We made significant progress towards implementing the Integrated Campus Plan, as follows:

- We purchased and installed a new Computed Topography (CT) scanner.
- We designed and built a new Breast Screening facility (due for completion in Q1 2005/06).
- We progressed work on improvements to our Intensive Care facilities.
- We completed design work for a new Magnetic Resonance Imaging (MRI)/CT facility.

As a result of the planning work completed on our Integrated Campus Project, we have identified that the majority of the facility improvements we will need are physically located together and will need to be addressed as an integrated development, rather than as a coordinated group of smaller projects. The facility development is then a larger project that will require more detailed planning and approvals. By the end of the 2005/06 financial year we will have completed the following planning:

- Demand modelling for 20 years.
- Clinical consultation on base demand and facility projections.

- MoH demand modelling comparison.
- Campus Master Plan.
- Infrastructure Review.
- Clinical Service Plan (including Regional Services considerations).
- Initial concept designs.
- Initial project cost estimates.
- Detailed timeline for development of business cases and approvals.

What is planned for 2006/07?
We anticipate that during the 2006/07 financial year we will complete the following:
- Operationalise new MRI/CT services through the purchase of a new MRI scanner and the building of the new facility.
- Explore options for a new Picture Archiving Communication System (PACS) system.
- Complete the Breast Screening facility and relocate services from current locations.
- Progress development of the theatre for Caesarean procedures.
- Complete business cases for Integrated Campus Plan and progress approvals at local, regional and national levels.
- Implement recommendations of interim capacity plan.
- Business case for Mental Health Te Whare Ahuru facility.
- Investigate parking and traffic management on campus, including removal of 618 High Street.

Annual Objective 27: Develop and implement the Integrated Campus Plan and interim capacity plan.	
Measures and Targets (see Appendix 7) Business plans complete for campus redevelopment. MRI purchased, installed successfully and new facility meets user requirements. Achievement of timelines within budget and to the satisfaction of users and service staff.	
Approach 27.1: Complete business cases for Integrated Campus Plan, and progress approvals at local, regional and national levels. Implement an interim capacity plan.	
Milestones 27.1: • Preliminary planning completed by June 2006. • Business cases prepared and presented to Board by December 2006.	
Position Responsible 27.1: Chief Operating Officer.	
Risks 27.1	**Mitigations 27.1**
Timeline delay impacts on radiology.	Ongoing contract management.
Project cost escalation.	Contract and user group management.
Successful co-location of services.	User group consultation.
Approach 27.2: Complete the new MRI / CT facility and explore options for a Picture Archiving Communication System (PACS) implementation.	

Milestones 27.2

- Final designs and budget for Board update/approval by May 2006.
- Tender for construction let by July 2006.
- Construction/installation will commence once the current space is vacated by the Breast Screening service, and will be complete by December 2006.
- PACS options assessed by June 2007.

Position Responsible 27.2: Chief Operating Officer.

Risks 27.2	**Mitigations 27.2**
Board Approval.	Updated design and financials.
Delay in commissioning.	Preliminary planning.
Functionality.	User group consultation.

Approach 27.3: Complete Breast Screening Facility.

Milestones 27.3:

- August completion of construction and fit-out.
- September complete relocation of services.

Position Responsible 27.3: Chief Operating Officer.

Risks 27.3	**Mitigations 27.3**
Timeline delay impacts on radiology.	Ongoing contract management.
Project cost escalation.	Contract and user group management.
Successful co-location of services.	User group consultation.

Approach 27.4: Develop new Caesarean Theatre.

Milestones 27.4:

- Business case to Board by June 2006.
- Construction/installation complete by December 2006.

Position Responsible 27.4: Chief Operating Officer.

Risks 27.4	**Mitigations 27.4**
Board Approval.	Business case.
Functionality.	User group consultation.

Approach 27.5: Upgrade of Mental Health Te Whare Ahuru (inpatient) facility.

Milestones 27.5:

- Peer review by June 2006.
- Concept agreed by December 2006.
- Business case developed in conjunction with ICP programme by Q4.

Position Responsible 5.1: Chief Executive Officer.

Risks 5.1	**Mitigations 5.1**
Financial feasibility.	Business case.
Board agreement.	Business case.
Functionality not at best practice level.	Peer review process.

6.3.22 Productivity and Value for Money

What does the DSP say and other key directives?

Having effective, efficient, and high quality health services is one of our key goals. We will achieve this through strategies of developing primary care and continually evaluating the effectiveness of services to innovate and redesign services to improve service delivery.

What progress was made in 2005/06?
A major review of the provision of laboratory services in the Hutt Valley and Capital and Coast DHBs was undertaken to reduce the cost of lab services. We have undertaken a review of our vehicle fleet and are moving to a tender process which we expect to reduce costs. Changed arrangements for catering and cafeteria services have been applied across the organisation.

What is planned for 2006/07?
Innovations and changes are embedded in a number of the sections of this DAP. A few of the highlights are included here including activity about managing demand driven expenditure.

Hutt Hospital's constrained operating theatre and bed capacity places severe limits on the growth in additional surgery. These are currently running at capacity and are among the most productive in New Zealand. We are developing an Interim Capacity Plan to manage this pressure until a long term solution through the hospital redevelopment is in place. This interim plan includes a pilot use of private sector theatre facilities among other things. Other efficiency initiatives include our community laboratory review, regional planning and campus planning (see section 7.4)

The high wage and salary settlements, through national MECAs, have embedded cost growth into the future that is unlikely to be matched by increases in output using current measures. We will continue to work with the Ministry of Health and other DHBs to restrain wage and salary costs and to improve the measurement of community and hospital services output.

Annual Objective 28: Manage demand-driven expenditure for referred services.	
Measures and Targets (see Appendix 7)	
Approach 28.1: Manage demand-driven expenditure for laboratory services by implementing new laboratory contract to reduce financial risk from volume growth.	
Milestones 28.1: • New laboratory contract finalised by Q1. • New laboratory provider operating from Q2.	
Position Responsible 28.1: Portfolio Manager Planning and Funding.	
Risks 28.1	**Mitigations 28.1**
Litigation by unsuccessful applicants	Probity plan and probity auditor in place
Resistance to proposed withdrawal of funding for testing for private specialists	Consultation with stakeholders

Approach 28.2: Manage demand-driven expenditure for community pharmaceuticals through pharmacy facilitation with both community and hospital specialist prescribers, focussing on the quality of prescribing and the use of appropriate incentives.

Milestones 28.2:

- Referred Services Advisory Group Meetings to set priorities (Q1 & Q3)
- Review operation and resourcing of pharmacy facilitation by PHOs by Q1.
- Undertake priorities set by RSAG (Q1-4)

Position Responsible 28.2: Portfolio Manager Planning and Funding.

Risks 28.2	**Mitigations 28.2**
Limited levers and incentives for improved pharmacy facilitation	Present objective evidence to PHOs and consider financial incentives from within existing funding

Annual Objective 29: Reduce waiting times and costs for GP referred hospital services.

Approach 29.1: Use community optometrists to do first specialist assessments to reduce waiting times and costs for ophthalmology care.

Milestones 29.1:

- Complete pilot by Q1.
- Evaluation of pilot (by the Ministry of Health) completed by Q2.
- Reduced ophthalmology assessments from Q3 (subject to outcome of the evaluation).

Position Responsible 29.1: Portfolio Manager Planning and Funding.

Risks 29.13	**Mitigations 29.1**
Ophthalmologists uncooperative	Facilitation by senior medical staff
Insufficient capacity by optometrists	Consider one-off after-hours clinics

Annual Objective 30: Improved hospital productivity

Measures and Targets (see Appendix 7)

Approach 30.1: Improve throughput by improved management of acute demand and implementation of the recommendations from the review of psycho-geriatric services (refer sections on Hospital and Specialist Services and Older People)

Milestones 30.1:

- Refer section on Hospital and Specialist Services
- Refer to the section Hospital and Specialist Services and the section on Older People.

Position Responsible 30.1: Group Manager Medical and Surgical Services.

Risks 30.1	**Mitigations 30.1**
Increased acute demand.	Ongoing monitoring of acute demand and identification of key drivers.

7. Managing Financial Resources

Our DAP for 2005/2006 effectively planned for a break-even result. Our projections for the 2006/2007 2007/08 and 2008/09 years indicate break-even results.

We have a number of activities in progress that are intended to ensure we manage our financial performance as much as possible within funding provided. However it will be difficult for us to achieve our DAP result for 2006/2007.

The main financial pressures we face are common across the health sector. They include:

- employment cost increases and in particular those resulting from national settlements at higher levels than our funding increases provide
- community pharmaceutical costs increasing due to population demand
- demand for aged care services increasing due to the aging population
- increasing cost pressure from our aged care and home support service providers due to their wage costs
- pressure on increasing Interdistrict Outflows (IDFs) in particular to higher cost tertiary services
- cost impact of additional capital charge and depreciation resulting from a significant revaluation of our land and buildings

Our revenue projection for 2006/2007 DAP is based on additional funding as advised in the latest funding advice.

We have applied base revenue increases of 3.4% for 2007/2008 and 3.1% for 2008/2009 as suggested in the funding advice.

We have a number of initiatives in progress that will commence during 2006/2007 and will have an impact on our planned results for 2007/2008 and 2008/2009 planning periods. In particular we are looking at minimising IDF inflow and outflow risks through regional coordination of services, increasing non-vote health revenue potential, improving our contracting approach to minimise demand driven expenditure and utilising off-campus surgical facilities to provide additional capacity. As a result of these initiatives we are projecting break-even results for 2007/2008 and for 2008/2009.

Hutt Valley DHB recognises the requirements of the Operational Policy Framework (OPF) regarding “ring-fenced” monies. Hutt Valley DHB will ensure that any surplus or deficit arising from ring-fenced monies will be managed in accordance with the OPF requirements.

7.1 Budgeted Financial Statements

The following table shows the statement of financial performance for Hutt Valley DHB for the planning period. The full set of financial statements are included in Appendix 4 of this plan.

Consolidated Statement of Prospective Financial Performance	2004/05 $'000 Actual	2005/06 $'000 Forecast	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan
Revenue	277,904	295,703	315,316	326,007	336,093
Less Operating Expenditure					
DHB Provider Expenditure	(122,318)	(127,818)	(139,276)	(143,985)	(149,054)
External provider expenditure	(138,252)	(151,781)	(157,588)	(163,341)	(168,100)
Governance & Funding Administration	(2,797)	(2,879)	(2,743)	(2,818)	(2,904)
Taxation	0	0	0	0	0
Total Operating Expenditure	(263,367)	(282,478)	(299,607)	(310,144)	(320,058)
Surplus/ (Deficit) before Interest, Depreciation, and Capital Charge	14,537	13,225	15,709	15,863	16,035
Gain / Loss on sale of assets	(50)	0	0	0	0
Interest	(1,214)	(1,188)	(1,184)	(1,178)	(1,178)
Depreciation	(6,444)	(7,156)	(8,518)	(8,685)	(8,857)
Capital Charge	(6,777)	(4,881)	(6,007)	(6,000)	(6,000)
NET SURPLUS / DEFICIT	52	-	0	0	-

Consolidated Statement of Prospective Movements in Equity	2004/05 $'000 Actual	2005/06 $'000 Forecast	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan
Crown Equity at start of period	61,458	59,130	74,759	74,759	74,759
Repayment of Crown Equity	0	0	0	0	0
Surplus/ (Deficit) for the period	52	-	0	0	-
Distributions to the Crown	0	0	0	0	0
Revaluation Reserve	(2,380)	15,629	0	0	0
Crown Equity at the end of the period	**59,130**	**74,759**	**74,759**	**74,759**	**74,759**

Consolidated Statement of Prospective Financial Position	2004/05 $'000 Actual	2005/06 $'000 Forecast	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan
CROWN EQUITY	59,130	74,759	74,759	74,759	74,759
CURRENT ASSETS					
Bank balances, deposits, cash	9,841	1,171	3,747	8,885	9,115
Receivables	13,364	16,130	15,787	16,284	16,360
Properties intended for resale	0	-	-	-	-
Inventory	902	972	972	972	972
CURRENT LIABILITIES					
Payables and accruals	28,131	47,739	55,832	62,177	62,736
NET WORKING CAPITAL	(4,024)	(29,466)	(35,326)	(36,036)	(36,289)
NON CURRENT ASSETS					
Fixed Assets	96,671	124,325	130,185	130,895	131,148
Investments					
NON CURRENT LIABILITIES					
Borrowings and Provisions	33,517	20,100	20,100	20,100	20,100
NET ASSETS	59,130	74,759	74,759	74,759	74,759

Consolidated Statement of Prospective Cash Flows	2004/05 $'000 Actual	2005/06 $'000 Forecast	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan
OPERATING CASHFLOWS					
Cash inflows from operating activities	274,327	293,045	314,265	326,115	336,660
Cash outflows from operating activities	(268,111)	(297,793)	(297,310)	(311,423)	(327,024)
INVESTING CASHFLOWS					
Cash inflows from investing activities	58	0	0	0	0
Cash outflows from investing activities	(5,846)	(3,922)	(14,378)	(9,554)	(9,406)
FINANCING CASHFLOWS					
Cash inflows from financing activities	0	0 -			
Cash outflows from financing activities	-	0	0	0	0
Net increase / (decrease) in cash held	428	(8,670)	2,577	5,138	230
Add opening cash balance	9,413	9,841	1,171	3,747	8,885
CLOSING CASH BALANCE	9,841	1,171	3,748	8,885	9,115
Made up from:					
Balance sheet bank and cash	9,841	1,171	3,747	8,885	9,115

DHB Provider Statement of Prospective Financial Performance	2004/05 $'000 Actual	2005/06 $'000 Forecast	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan
Revenue	134,968	139,807	153,008	157,277	162,146
Expenses	(136,800)	(127,818)	(139,208)	(143,984)	(149,054)
Surplus / Deficit prior to eliminations Interest / Depreciation and Capital Charge	(1,832)	11,989	13,800	13,293	13,092
Less Revenue Eliminations	(103,368)	(115,212)	(126,182)	(129,572)	(133,581)
SURPLUS / DEFICIT(before Interest, Depreciation and Capital Charge)	(105,200)	(103,223)	(112,382)	(116,279)	(120,489)

DHB Governance Statement of Prospective Financial Performance	2004/05 $'000 Actual	2005/06 $'000 Forecast	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan
Revenue	3,236	2,930	2,743	2,818	2,904
Expenses	(2,800)	2,879	2,743	2,818	2,904
SURPLUS / DEFICIT(before Interest, Depreciation and Capital Charge)	436	51	-	-	-

DHB Funds Statement of Prospective Financial Performance	2004/05 $'000 Actual	2005/06 $'000 Forecast	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan
Revenue	243,068	268,178	285,747	295,484	304,624
Expenses	(241,620)	(266,992)	(283,770)	(292,913)	(301,681)
Surplus / Deficit prior to eliminations, Interest / Depreciation and Capital Charge	1,448	1,186	1,977	2,571	2,943
Expense eliminations	103,368	115,212	126,182	129,572	133,581
SURPLUS / DEFICIT(before Interest, Depreciation and Capital Charge)	104,816	116,398	128,159	132,143	136,524

Consolidated Statement of Prospective Financial Performance	2004/05 $'000 Actual	2005/06 $'000 Forecast	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan
COMMITMENTS					
Capital Commitments	5,964	-	-	-	-
Operating Lease Commitments	2,058	400	-	-	-
Other commitments	0	-	-	-	-
CONTINGENT LIABILITIES	8,022	400	0	0	0

7.1.1 Summary of 2006/07 Operating Budget

Our operating forecast for 2006/2007 is a break-even position.

7.1.2 Funding Advice

A funding advice was received in December 2005 that included additional funding for 2006/2007. The additional funding consists of a 2.93% cost increase (called Future Funding Track - FFT), and an increase for demographic changes in our population. The funding advice also provided new base funding for Inter-district Flows (IDFs) and a continuation of pay-jolt funding for the NZNO settlement.

7.1.3 Funder Financials

We have reviewed our financial projections for the Funder Arm of the DHB in line with the details provided in the latest funding advice mentioned above.

A new price/volume schedule has been agreed with the Provider Arm to reflect new national pricing guidelines and required contract volumes.

We have estimated the likely costs for demand driven community services such as pharmaceuticals, laboratory tests and aged care services.

We have reviewed our projections for external service provider contracts including an estimate for price increases within our FFT funding.

We have identified those new initiatives suggested for 2006/2007 and have prioritised those for which funding is not immediately available.

As a result of these reviews we have projected a summary surplus for the Funder Arm of $1,978,000 for 2006/2007.

7.1.4 Provider Financials

The financial projection for the Provider Arm includes a number of significant assumptions that are detailed in the next section (section 7.2).

Base funding for the Provider Arm is agreed through the Memorandum of Agreement (MOA) with the Funder Arm. Volumes are determined by the Funder Arm after consideration of services available and the demands of the Hutt Valley population. Prices are determined by a national pricing programme.

The agreed price/volume schedules for each of the Provider Arm services reflects a realistic volume taking into account national intervention rates for those services. Our planning carefully aligns resources in each of the services with the contracted volumes and includes service improvements and efficiencies where possible.

The greatest financial pressure in the Provider Arm is in relation to staff costs. Most of our staff are covered by national employment agreements over which we have little control. Recent agreements have been settled at rates higher than our funding provides. In addition those agreements have included requirements for us to employ additional staff in a number of areas and to pay penal rates that also increase our projected costs.
In line with other DHBs we have made some important assumptions concerning staff costs for 2006/2007 that are detailed in the following section.

We are estimating a DAP deficit for the Provider Arm of $1,978,000 for 2006/2007. This compares to a budget deficit for 2005/2006 of $1,236,000.

7.2 Assumptions

The following sections list the key assumptions we have included in the annual plan for 2006/2007. Appendix 11 contains our Statement of Accounting Policies.

7.2.1 Provider

- Base revenue has been allocated to the Provider Arm based on contract volumes required and national prices.
- Pay jolt funding in relation to the NZNO settlement has been passed to the Provider Arm.
- We have limited our projection for staff costs to provide for increases only up to the level for which we are funded. We are assuming national contract negotiations can be settled within this limit.
- We have assumed a general increase in other costs of 3%.
- We plan to make use of external surgical facilities to provide temporary capacity.
- Our interest income is based on funding being received one month in advance from the Ministry of Health.
- Capital expenditure projects within the planning period will be funded from operating cash.
- We have assumed IDF inflows are as per the funding advice
- Corporate service costs have been allocated according to standard accounting drivers that are proxies for the likely use of corporate services.

7.2.2 Funder

- Costs incurred as a result of the ARC price increase and the Income and Asset Testing rules are assumed to be fully funded.
- We have assumed that a new contract for community laboratory services will be negotiated and will provide some net cost savings in 2006/2007.
- Price increases for external service providers will not exceed FFT funding.

- Cost increases for services provided by Pharmac will be within FFT funding.
- Community demand driven costs can be managed within current FFT expectations.

7.2.3 Risks

There are some significant risks associated with the assumptions we have made in our DAP budget. The most important are:

- Revaluation of Assets - previous cost increases resulting from asset revaluation have been funded by the Ministry of Health. We have provided for additional costs of $1.622M which we expect to result from a revaluation in June 2006. Offsetting these costs we have included additional Ministry funding of 1.358M and we have also provided for a number of cost reductions.
- Employment Costs – if any employment award settlements exceed our funding expectations, resulting additional costs will produce an increased deficit
- Revenue in Advance – we have assumed that the Ministry of Health will continue to pay us our funding monthly in advance. Should this not be the case we risk a significant loss of interest income that will increase our deficit.
- Inter-District Flows – actual volumes of services delivered by us for other DHBs, or delivered to our population by other DHBs are very difficult to predict or manage. There is a significant risk that these volumes may vary and that the resulting cost impact could be unfavourable.
- Demand Driven Costs – we have a limited ability to manage demand for a number of our services. Any significant variation in that demand will result in increased costs that could increase our deficit.

7.2.4 Outyears 2007/08 to 2008/09

We have assumed base revenue increases of 3.4% and 3.1% for the 2007/2008 and 2008/2009 years respectively. After providing for increased costs and for the impact of our improvement initiatives, we estimate break-even results in 2007/2008 and in 2008/2009.

7.3 Capital Expenditure

The following table outlines our capital expenditure plans for the three year planning period.

Hutt Valley District Health Board
Capital Expenditure
For the year ended 30 June

	2006/07 $000's	2007/08 $000's	2008/09 $000's
Property	5,126	5,718	6,544
Computer Equipment	7,721	2,114	1,073
Clinical Equipment	1,504	1,500	1,526
Other Office Equipment	27	222	263
Total Capital Expenditure	**14,378**	**9,554**	**9,406**

We are currently working on a campus development plan in conjunction with clinical service planning and asset management planning which will identify additional facilities required to meet projected service needs over the next five to fifteen years.

Our capital expenditure estimates for the planning period include an allowance for some of the preliminary work associated with that process.

Our intention is to self-fund any capital development as far as our resources will allow.
We have not identified any significant assets that are surplus to long-term health service delivery needs.

7.4 Efficiency Initiatives

The following initiatives are in progress and will impact on our results for the 2006/2007 planning period:

Community Laboratory Review – a new contract for provision of this service is currently being tendered. The intention is to also remove funding for private hospital and specialist testing as a result of this review. We anticipate some net savings in 2006/2007 with a full year impact in 2007/2008 and outyears.

Interim Capacity Planning – we are actively reviewing the provision of services throughout the provider arm in particular with reference to capacity and resource requirements. We are planning to access additional external surgical facilities to enable us to meet our surgical demand.

Regional Planning – we are actively involved in working with the central region DHBs to identify opportunities for service coordination.

Campus Planning – we are currently completing a campus master plan and a clinical service plan. These will be used in conjunction with our asset management plan to produce an integrated campus plan to identify our future facility requirements. These plans will help ensure we can deliver services as efficiently as possible.

7.5 Disposal of Land / Assets

We currently have no plans to dispose of any land. When disposing of land, Hutt Valley DHB will abide by the appropriate statutes and be guided by appropriate business principles. Hutt Valley DHB will not dispose of any land without first consulting with the Minister of Health. We will also comply with the relevant protection mechanism that addresses the Crown's obligations under the treaty of Waitangi and any process relating to the Crown's good governance obligations in relation to Maori sites of significance.

7.6 Asset Valuation

Under Crown accounting policies we are required to revalue our Land and Buildings whenever there is a material movement in carrying value. We estimate that we will be required to revalue our assets with effect from 1 July 2006 and that this could result in an increase in value of around $17M. This increase will result in an increase in capital charge and an increase in depreciation based on the new carrying values. We have estimated these cost increases at $1.622M in 2006/2007

7.7 Business Cases

At the time of writing this Plan we have no business cases that require the approval of either the Ministry of Health or Treasury.

7.8 Debt and Equity

The key banking covenant ratios and the budgeted ratios are shown in the table below. It can be seen that the budgeted ratios are well within the covenant ratios as

required by the Crown Financing Agency (CFA) and there is scope for additional debt to fund major projects if required. The CFA is the key lender to Hutt Valley DHB with current loans of $19M at a fixed rate of 6.25% to December 2007. In addition, Hutt Valley DHB has a working capital facility with BNZ of $6M for use as required.

Hutt Valley District Health Board
Covenant Ratios
As at 30 June

	2005/06 $000's	2006/07 $000's	2007/08 $000's	2008/09 $000's
CFA Ratio Calculations				
Debt to Debt + Equity	20.3%	20.3%	20.3%	20.3%
(Long term debt + Short term debt + Bank overdraft) / ((Long term debt + Short term debt + Bank overdraft) + Total Equity)				
CFA target	**<60%**	**<60%**	**<60%**	**<60%**
Interest Times Coverage	11.13	13.27	13.47	13.61
(Net Surplus + Interest Expense + Capital Charge Expense + Depreciation) / (Interest Expense)				
CFA target	**>2.5**	**>2.5**	**>2.5**	**>2.5**

8. Measuring Performance: Output Objectives, Measures and Targets

Our Chief Executive Officer is accountable to our Board for the successful accomplishment of the annual plan intentions, including meeting all of the key milestones and performance targets. Our Board monitors the actions of management on a monthly basis. This occurs through the monthly Board meeting and Board committee meetings. Our Board requires management to provide specific monthly performance reports so the Board can assess whether we'll achieve the plan, as well as specific reports on any key issues that arise during the course of the year. We use an organisation-wide risk management system to identify and address any key risks. We also issue a public annual report that describes whether we did what we said we'd do in the Annual Plan.

We have selected the following key indicators for our community to judge our progress against the goals and priorities we have set out in this plan. While we monitor and report to the Ministry of Health on a large set of Indicators, the following indicators have been selected to be included in our upcoming annual plans (in which we'll be setting annual targets), Statements of Intent and Annual Reports.

The following table lists presents our key indictors within the Ministry of Health's Performance Assessment and Management framework.

Performance Assessment and Management framework area	**National Core Measures**	**Board Key Measures**
Effectiveness	Ambulatory-Sensitive Hospitalisations Chronic Disease Management: Diabetes Management	Diabetes
Equity and Access	Mental Health Services Utilisation	Workforce Oral Health Screening Mental Health Services Primary Health
Intersectoral Focus	Risk Reduction Obesity	Physical Activity
Quality	Work-related Injury or Illness Rate	Immunisation Information
Efficiency and Value-for-Money	Percentage Eligible Elective Day Case Procedures	Hospital Performance

8.1 National Core Measures

8.1.1 Secondary Mental Health Services Utilisation

Mental Health Services Utilisation: Number of Consumers as Percentage of Population

Objective	Impacts, outcomes or objectives	Timeframes
Improving the health status of people with severe mental illness so that people with experience of mental illness and addiction have the same opportunities as everyone else to fully participate in society and in everyday life of their communities and whānau. They experience recovery focused mental health services that provide choice, promote independence and are effective, efficient, responsive and timely.	Improve access to local and regional mental health services.	Over 2006/07-2008/09.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports

Te Tahuhu: Improving Mental Health 2005-2015	Equity and Access	The percentage of the population annually accessing secondary mental health services. Numerator: (Data source: Ministry of Health) The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months*) for: • Child and youth aged 0-19, specified for each of the three categories: Māori, other, and in total. • Adults aged 20-64, specified for each of the three categories: Māori, other, and in total. • Older people aged 65+, specified for each of the three categories: Māori, other, and in total. Denominator: (Data Source: Ministry of Health) Projected population of DHB region by age and ethnicity.	Baseline data 2005 Age Total Maori non-Maori 0.19 1.65% 1.64% 1.65% 20.64 2.82% 3.65% 2.68% 65+ 1.19% 0.77% 1.21%	Targets 2006/07 Age Total Maori non-Maori 0.20 1.8% 1.8% 1.8% 20.65 2.9% 3.7% 2.8% 65+ 1.2% 0.8% 1.2% Targets 2007/08 Age Total Maori non-Maori 0.21 1.9% 1.9% 1.9% 20.66 3.0% 3.8% 2.9% 65+ 1.3% 0.9% 1.3% Targets 2008/09 Age Total Maori non-Maori 0.22 2.0% 2.0% 2.0% 20.67 3.1% 3.9% 3.0% 65+ 1.4% 1.0% 1.4%

8.1.2 Day Case Procedures

Percentage Eligible Elective Day Case Procedures

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
Cost effectiveness so that the best possible improvement in New Zealander's health status and quality of life is achieved within the resources available. Elective procedures undertaken on a day case basis cost less than the same procedures undertaken on an inpatient basis and are associated with reduced risk to the patient.	Increased use of same day procedures where clinically appropriate.	Over 2006/07-2008/09.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
Minister's letter of expectations2006/07	Efficiency and Value-for-Money	Percentage of elective procedures done as daycases. The Hospital Benchmark Information (HBI) is: Numerator: number of elective procedures (from eligible list) performed as daycases. Denominator: total number of elective procedures (from eligible list) performed (as daycase or inpatient).	The 2004/05 average for all DHBs was 71%. Hutt Valley DHB's average quarterly figure for 2004/05 was 73%. In the first quarter of 2005/06 Hutt Valley DHB's figure was nearly 79%.	Hutt Valley DHB Targets 2006/07 74% 2007/08 75% 2008/09 76%

8.1.3 Ambulatory-Sensitive Hospitalisations

Rates of hospitalisation potential amenable to primary health care intervention

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
People will be part of local primary health services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Ambulatory sensitive hospitalisations are an indicator of access to and effectiveness of primary health care. These hospitalisations result from conditions eg, cellulitis, asthma, common infections, that are potentially preventable by appropriate primary care. The measure looks at children and older people.	Further improve access to primary health care services, with a particular focus on the health of high need groups and the management of people with chronic conditions.	Over 2006/07-2008/09.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports

Primary Health Care Strategy and Health of Older People Strategy	Effectiveness	Rate of Ambulatory Sensitive Hospitalisations (ASH), i.e. hospitalisations that were potentially avoidable through primary health care intervention. Numerator: (Data source: National Minimum Data Set) The total number of hospital discharges considered being ambulatory sensitive, as they result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable. Age bands: Children <5, 5 to 14, 15 to 24, Older People 65 to 74. Total population, and Māori/Pacific peoples/other. Denominator: (Data Source: Census) Current Census populations, using medium projection as at the end of the reporting period.Hutt Valley DHB Actuals Oct04-Sept05 Total Maori Pacific Other Children 0-4 113 116 165 103 Children 5-14 28 29 45 25 Children 15-24 16 19 16 15 Adults 65-74 70 136 148 64 Hutt Valley DHB Actuals Apr04-Mar05 Total Maori Pacific Other Children 0-4 107 108 141 101 Children 5-14 27 27 43 24 Children 15-24 17 22 16 16 Adults 65-74 76 132 188 69	Hutt Valley DHB Targets 2006/07 Total Maori Pacific Other Children 0-4 100 100 140 100 Children 5-14 25 25 40 25 Children 15-24 15 18 15 14 Adults 65-74 69 130 140 63 2007/08 Total Maori Pacific Other Children 0-4 95 95 120 95 Children 5-14 23 23 35 22 Children 15-24 15 17 14 14 Adults 65-74 68 120 130 62 2008/09 Total Maori Pacific Other Children 0-4 90 90 115 90 Children 5-14 21 21 31 20 Children 15-24 14 16 14 14 Adults 65-74 67 115 120 61

8.1.4 Diabetes Management (HBA1c)

Percentage of diabetics receiving diabetes 'Get Checked' annual reviews with an HbA1c level less than or equal to 8%

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
Reduced incidence of chronic conditions. Chronic disease (cancer, Diabetes Mellitus, cardiovascular disease) comprises the major health burden for New Zealand now and into the foreseeable future. Diabetes Mellitus is a major and increasing cause of disability and premature death; it is also a good indicator of the responsiveness of a health service for people in need.	Decrease the incidence and impact of diabetes through the Diabetes Specialist Outreach Service (DSOS) to improve Maori and Pacific uptake of diabetes reviews and other support programmes.	Review of DSOS completed by end of 2006/07.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
New Zealand Health Strategy	Effectiveness	Percentage of 'Get Checked' reviews where the diabetic person has managed levels of HBA1c in their blood. Numerator: The number of people with type I or II diabetes mellitus on a diabetes register that had an HbA1c (blood test) equal to or less than 8% and had their annual check during the reporting period. Denominator: Number of people with type I or type II diabetes mellitus on diabetes register whose date of annual check was during the reporting period.	2001-04 Average for NZ 70% Hutt Valley DHB Actuals 2005 Total Maori Pacific Other 74% 58% 50% 80% 2004 Total Maori Pacific Other 72% 58% 49% 78% 2003 Total Maori Pacific Other 72% 58% 47% 77%	Hutt Valley DHB Targets 2006 Total Maori Pacific Other 75% 60% 52% 81% 2007 Total Maori Pacific Other 76% 62% 54% 82% 2008 Total Maori Pacific Other 77% 64% 56% 83%

8.1.5 DHB Staff Work-related Injury or Illness

Rate of time lost to DHB staff work-related illness or injury

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
An objective of each DHB is to be a good employer this includes providing good and safe working conditions. This indicator provides an indication of the Provider Arms' efforts to minimise the occurrence of workplace injuries or illnesses through managing occupational hazards and risks to the health and safety of employees.	Reduced work-related injury and illness.	Over 2006/07-2008/09.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
NZ Public Health and Disability Act P3 s23 (k)	Quality	Rate of time lost to DHB staff work-related illness or injury. Numerator: all occurrences of work-related injury or illness resulting in time lost from work during the quarter. Denominator: the total number of hours worked by all employees during the quarter. Numerator/Denominator*1, 000, 000	2004/05 average for all DHB Provider Arms was 8.5. Hutt Valley DHB's average quarterly figure for 2004/05 was 5.4. In the first quarter of 2005/06 Hutt Valley DHB's figure was 14.1	Hutt Valley DHB Targets 2006/07 5.4 2007/08 5.4 2008/09 5.4

8.1.6 Chronic Disease: Risk Reduction: Obesity

Percentage of schools participating in Health Promoting Schools programme.

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
Reduced incidence of chronic conditions. Chronic disease (cancer, diabetes mellitus, cardiovascular disease) comprises the major health burden for New Zealand now and into the foreseeable future. Risk reductions includes providing an environment communities are supported to eat well, live physically active lives, and attain and maintain a healthy body weight. Prevention of obesity is a crucial component in the prevention of diabetes.	Implement Healthy Eating Healthy Action strategies in the Hutt Valley and link with the Hutt Valley DHB School Grants scheme to implement a range of health promotion strategies in schools, if resources allow.	Over 2006/07-2008/09.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
Healthy Eating, Healthy Action Strategy	Intersectoral Focus	The number of health promoting schools as a percentage of the total number of schools within the DHB (as part of the Healthy Eating Healthy Action strategy).	In 2005/06 Hutt Valley DHB had 10 schools participating in Health Promoting Schools programmes out of around 77 schools within the Hutt Valley, or around 13%.	Target to have 12 schools participating in Health Promoting Schools programmes by June 2007 and additional schools in each outyear, dependent on funding.

8.2 Board District Strategic Plan Indicators

8.2.1 Immunisation Coverage

Percentage of children fully immunised by age two

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
To improve child health. Improving immunisation coverage is key to improving child health by preventing diseases in individual children and the population.	Increase the percentage of two year olds fully immunised by continued local General Practice audit and the dissemination of benchmark information.	One audit every six months.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
New Zealand Health Strategy, Primary Health Care Strategy, He Korowai Oranga	Quality	Percentage of children fully immunised by age two. Numerator: Children who have had the identified vaccines. Denominator: Children whose second birthday falls in the reporting period.	Information available from immunisation audits indicates that around 92% of Hutt valley children are fully immunised by age two. Awaiting National Immunisation register data for complete baseline data, including ethnic breakdowns.	Hutt Valley DHB Target 2006/07 93% Hutt Valley DHB Target 2007/08 94%Hutt Valley DHB Target 2008/09 95%

8.2.2 Oral Health

Average decayed, missing and filled teeth at year 8 of school

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
To reduce the average decayed/missing/filled teeth score for children at year 8.	Want to see reductions in average Decayed, Missing and Filled Teeth scores through targeting high needs children and schools.	Over 2006/07-2010/11.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
Child Health Strategy	Equity and Access	Average number of decayed/missing/filled teeth in year 8 children seen by the School Dental Service (SDS) Numerator: (Data source: DHB via SDS and other oral health providers) The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries) or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS. Denominator: (Data Source: DHB via SDS and other oral health providers) The total number of children who have been examined in the Year eight group, in the year to which the reporting relates.	Hutt Valley DHB Actuals 2005 Total Maori Pacific Other 1.0 1.7 1.8 0.7 2004 Total Maori Pacific Other 0.9 1.3 1.2 0.8	Hutt Valley DHB Targets Total Maori Pacific Other 2006 0.9 1.6 1.7 0.7 2007 0.8 1.5 1.6 0.7 2008 0.8 1.4 1.5 0.7

8.2.3 Primary Health

Ratio of age standardised consultations for high need populations compared with others

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
Progress is made towards improving access to appropriate primary health care services.	The DHB will share and discuss baseline data with the six Primary Health Organisations (PHOs) in the Hutt Valley on a quarterly basis. It is anticipated that those PHOs which are not performing as well will be able to learn from PHOs that are achieving appropriate levels of access to primary care services.	Quarterly reviews.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
Primary Care Strategy	Equity and Access	Ratio of age-standardised General Practitioner (GP) consultations for high need patients (patients of Māori or, Pacific ethnicity and non-Maori/Pacific patients living in areas with a New Zealand Deprivation Index score of 9 or 10, NZDep 9 & 10) compared to age-standardised GP consultations for non-high need (non-Maori/Pacific patients living in areas with a New Zealand Deprivation Index score of 1-8.).	Baseline data at January 2006 indicates a ratio of 0.99.	The DHB's target is for high need people to have on average, more GP consultations than other enrolees (i.e. a utilisation ratio of greater than 1) for all years.

8.2.4 Diabetes

Uptake of diabetes annual reviews, management of HBA1c levels and uptake of retinal screening

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
To reduce the incidence and impact of diabetes. Diabetes Mellitus is a major and increasing cause of disability and premature death; it is also a good indicator of the responsiveness of a health service for people in need.	Decrease the incidence and impact of diabetes through the Diabetes Specialist Outreach Service (DSOS) to improve Maori and Pacific uptake of diabetes reviews and other support programmes.	Review of DSOS completed by end of 2006/07.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports

New Zealand Health Strategy	Effectiveness	Uptake of annual diabetes checks, bi-annual retinal screening and diabetes management (HBA1c blood levels) of diabetics receiving annual checks.1) Annual Diabetes Checks Numerator: (Data source: DHB) The number of unique individuals with type I or type II diabetes mellitus on a diabetes register, whose date of their free annual check is during the reporting period. Denominator: (Data Source: the Ministry) The expected number of unique individuals to have type I or type II diabetes mellitus, as at the end of the reporting period.2) Bi-annual Retinal Screening Numerator: (Data source: DHB) The number of people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last two years, and the date of the free annual check is during the reporting period. Denominator: (Data Source: DHB) The number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period.3) Diabetes Management Numerator: The number of people with type I or II diabetes mellitus on a diabetes register that had an HbA1c (blood test) equal to or less than 8% and had their annual check during the reporting period. Denominator: Number of people	Hutt Valley DHB Targets 2006 1) Total Maori Pacific Other 70% 45% 80% 77% 2) Total Maori Pacific Other 80% 80% 80% 80% 3) Total Maori Pacific Other 75% 60% 52% 81% Hutt Valley DHB Targets 2007 1) Total Maori Pacific Other 71% 47% 81% 78% 2) Total Maori Pacific Other 81% 81% 81% 81% 3) Total Maori Pacific Other 76% 62% 54% 82% Hutt Valley DHB Targets 2008 1) Total Maori Pacific Other 72% 49% 82% 79% 2) Total Maori Pacific Other 82% 82% 82% 82% 3) Total Maori Pacific Other 77% 64% 56% 83%

8.2.5 Screening

Breast and cervical screening programme coverage rates

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
To increase the coverage of breast and cervical screening programmes.	Want increased rates for breast and cervical screening with particular emphasis on identified high need communities, through enhanced health promotion activities and closer relationships with PHOs and independent service providers. We will complete the expansion of our screening facilities to ensure sufficient capacity to handle the increased age range of women eligible for the breast screening programme.	Over 2006/07-2010/11.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
Cancer Control Strategy	Equity and Access	Breast and cervical screening coverage rates for different age groups and by ethnicity. Numerator: (Data source: DHB) Number of Hutt valley women screened during reporting period. Denominator: (Data Source: Ministry of Health) Projected female population of DHB region by age group during reporting period.	Breast Screening Wellington Region coverage rates May 2005. 50-64 Years 68% 45-49 Years 3% 65-69 Years 49% Breast Screen Central coverage rates June 2005 Maori 46% Pacific 35% Cervical Screening Wellington region coverage rates 20-69 Years 75% Cervical Screening Hutt Valley coverage rates 20-69 Years Total 63% Other 68%	We want to see increasing coverage rates for eligible populations. The BreastScreen Aotearoa target is 70% coverage for all years. The Wellington Region Cervical Screening target is 78% coverage for all years. Hutt Valley DHB supports BreastScreen Aotearoa and Wellington Region Cervical Screening targets.

8.2.6 Mental Health Services

Percentage of population accessing secondary mental health services (note same as Core National Measure 8.1.1 above)

Objective	Impacts, outcomes or objectives	Timeframes
Improving the health status of people with severe mental illness so that people with experience of mental illness and addiction have the same opportunities as everyone else to fully participate in society and in everyday life of their communities and whānau. They experience recovery focused mental health services that provide choice, promote independence and are effective, efficient, responsive and timely.	Improve access to local and regional mental health services.	Over 2006/07-2010/11.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports

Te Tahuhu: Improving Mental Health 2005-2015	Equity and Access	The percentage of the population annually accessing secondary mental health services. Numerator: (Data source: Ministry of Health via NZHIS) The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months*) for: • Child and youth aged 0-19, specified for each of the three categories: Māori, other, and in total. • Adults aged 20-64, specified for each of the three categories: Māori, other, and in total. • Older people aged 65+, specified for each of the three categories: Māori, other, and in total. Denominator: (Data Source: Ministry of Health) Projected population of DHB region by age and ethnicity.	Baseline data 2005 Age Total Maori non-Maori 0.23 1.65% 1.64% 1.65% 20.68 2.82% 3.65% 2.68% 65+ 1.19% 0.77% 1.21%	Targets 2006/07 Age Total Maori non-Maori 0.24 1.8% 1.8% 1.8% 20.69 2.9% 3.7% 2.8% 65+ 1.2% 0.8% 1.2% Targets 2007/08 Age Total Maori non-Maori 0.25 1.9% 1.9% 1.9% 20.70 3.0% 3.8% 2.9% 65+ 1.3% 0.9% 1.3% Targets 2008/09 Age Total Maori non-Maori 0.26 2.0% 2.0% 2.0% 20.71 3.1% 3.9% 3.0% 65+ 1.4% 1.0% 1.4%

8.2.7 Information

Percentage of primary care referrals and hospital discharges done electronically

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
Electronic Referrals is one of the 12 Action Zones from the New Zealand Health Information Strategy (HIS-NZ). We want to increase the electronic sharing of information between primary care providers and the hospital.	Implement electronic referral management for General Practitioners (GPs) referring patients to secondary provider services and increased electronic discharges back to GPs.	Over 2006/07-2010/11.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
Health Information Strategy	Quality	Percentage of primary care referrals and hospital discharges done electronically for different services. Numerator: (Data source: DHB) Number of electronic hospital discharges/primary care referrals during the reporting period, by service. Denominator: (Data Source: DHB) Total number of hospital discharges/primary care referrals during reporting period, by service.	Hutt Valley DHB Actuals August 2005 Service Discharges Referrals Dental 67% 0% Specialist Rehab 97% 0% Mental Health 84% 0% Gynaecology 98% 0% Rheumatology 100% 0% Ear Nose & Throat 93% 0% Orthopaedics 91% 0% Cardiology 97% 0% General Surgery 98% 0% Obstetrics 99% 0% Paediatric Medicine 99% 0% Plastics Burns 95% 0% General Medicine 99% 0%	Want to see increasing percentages of primary care referrals and hospital discharges done electronically. Target for electronic discharges for 2006/07 is >95% for all services, 2007/08 >96% and 2008/09 >97%. Target for start of e-referrals by August 2007.

8.2.8 Workforce

Ratio of primary care practitioners to the population

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
Increase primary care coverage for the population to improve access to our population.	The DHB will work with PHOs, GP leaders and primary care nurses in the Hutt Valley to explore opportunities for attracting and retaining more GPs and primary care nurses. Many of these opportunities are already indicated in the Workforce Strategy that has been developed in consultation with primary care. This strategy includes developing a DHB-wide marketing strategy, promoting primary care as a positive career choice and developing a DHB-wide Health Education Unit to co-ordinate workforce training and development.	Over 2006/07-2010/11.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
Primary Care Strategy	Equity and Access	Ratio of Full-Time Equivalent (FTE) General Practitioners and Practice Nurses to the population. Numerator: (Data source: DHB) General Practitioner and Practice Nurse FTEs working within the Hutt Valley. Denominator: (Data Source: Ministry of Health) Projected population of DHB region	As at August 2005 there were 108 General Practitioners working approximately the equivalent of 75 FTEs (including regular locums but excluding registrars) and one nurse practitioner waiting accreditation. This equates to around one practitioner to 1,850 residents.	Want to see practitioner coverage for the population to be increased or at least maintained at current levels. Target of one practitioner to less than 1,850 residents for all years.

8.2.9 Physical Activity

Percentage of population using active modes of transport for short trips

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
Increase the level of physical activity within the population.	Continue working in the area of public transport to promote expanded accessible public transport and to encourage active modes of transport.	Over 2006/07-2010/11.

Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
Healthy Eating Healthy Action Strategy	Intersectoral Focus	Proportion of population using active modes of transport (walking or cycling) for trips shorter than two kilometres. Source: Greater Wellington Regional Council annual transport surveys.	In the 2004 annual transport survey for the Greater Wellington Regional Council 19% of trips shorter than 2km were made by active modes.	Want to see an increase in walking and cycling for short trips. The Greater Wellington Regional Council (GRWC) currently has a target of a 70% increase in walking and cycling for short trips, i.e. 32% of trips shorter than 2km made by active modes. This target is under review as part of consultation on the GRWC's Long Term Council Community Plan. Hutt Valley DHB supports GWRC targets.

8.2.10 Hospital Performance

Percentage day case discharges of total admissions

Government or Local Policy outcome or objective & rationale for inclusion in this SOI	Impacts, outcomes or objectives	Timeframes
Reduce average length of stay where clinically appropriate.	Reduce costs through the reduction of overnight stays and hence improve efficiency.	Over 2006/07-2010/11.

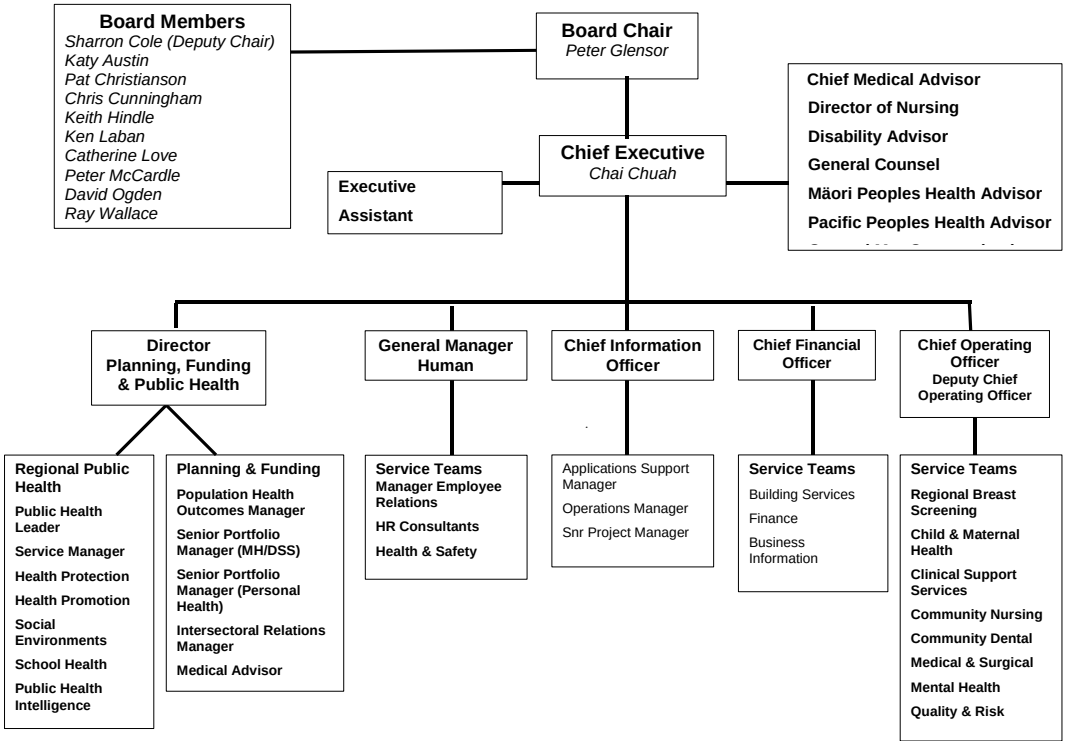
Relevant Strategy	Output Class	Performance Measure/Standard Definition	Baseline Data & Previous targets (if relevant)	2006/07 & 2008/09 performance targets to be reported against in Annual Reports
New Zealand Health Strategy	Efficiency and Value-for-Money	Proportion of day case discharges. Numerator: (Data source: DHB) Total day case discharges in reporting period. Denominator: (Data Source: DHB) Total discharges in reporting period.	During 2004/05 the proportion of day case discharges from Hutt hospital was 36%.	Want to see increasing proportions of day cases. Hutt Valley DHB Targets 2006/07 37% 2007/08 38% 2008/09 39%

References

1. Hutt Valley DHB. Towards a Healthier Hutt Valley: Hutt Valley District Health Board's Five Year Strategic Plan from July 2006. Lower Hutt: Hutt Valley DHB, 2006.
2. Hutt Valley DHB. Whanau Ora ki te Awakairangi: Maori Health Strategic Plan. Lower Hutt: Hutt Valley DHB, 2005.
3. Ministry of Health. New Zealand Health Strategy. Wellington: Ministry of Health, 2000.
4. Ministry of Health. New Zealand Disability Strategy. Wellington: Ministry of Health, 2001.
5. Hutt Valley DHB. Pacific Health Action Plan. Lower Hutt: Hutt Valley DHB, 2004.
6. Hutt Valley DHB. Older Persons Service Plan. Lower Hutt: Hutt Valley DHB, 2004.
7. Ministry of Health. He Korowai Oranga – Maori Health Strategy. Wellington: Ministry of Health, 2002.
8. Ministry of Health. The Primary Health Care Strategy. Wellington: Ministry of Health, 2001.
9. Ministry of Health. Health of Older People Strategy: Health Sector Action to 2010 to Support Positive Ageing. Wellington: Ministry of Health, 2002.
10. Ministry of Health. Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector. Wellington: Miistry of Health , 2003.
11. Ministry of Health and the New Zealand Cancer Control Trust. The New Zealand Cancer Control Strategy. Wellington: Ministry of Health, 2003.
12. Ministry of Health. Healthy Eating – Healthy Action. Oranga Kai – Oranga Pumau: A Strategic framework. Wellington: Ministry of Health, 2003.
13. Ministry of Health. Child Health Strategy. Wellington: Ministry of Health, 1998.
14. Ministry of Health. Te Tāhuhu: Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan. Wellington: Ministry of Health, 2005.
15. Ministry of Health. The Pacific Health and Disability Action Plan. Wellington: Ministry of Health, 2002.
16. Ministry of Health. Health Information Strategy for New Zealand (HIS-NZ). Wellington: Ministry of Health, 2005.
17. Hutt Valley DHB. Healthy Jobs – Healthy Communities: Hutt Valley DHB Strategic Workforce Development Plan 2005-2011. Lower Hutt: Hutt Valley DHB, 2005.
18. Ministry of Health. Our Health, Our Future: Hauora Pakari, Kaiora Roa: The Health of New Zealanders. Wellington: Ministry of Health, 1999.
19. Ministry of Health. A Health Equity Asessment (Equity Lens) for Tackling Inequalities in Health. Wellington: Ministry of Health, 2004.
20. Ministry of Health. Reducing Inequalities in Health. Wellington: Ministry of Health, 2002.

Appendices

Appendix 1 - Organisation Structure



Appendix 2 - DAP Financial Template

[Provided electronically to Ministry of Health Data Team. Too big to paste in]

Appendix 3 - Mental Health Plan Template

[Provided electronically to Ministry of Health Data Team. Too big to paste in]

Appendix 4 - Forecast Financial Statements

DHB Provider
Forecast Statement of Financial Performance
For the year ended 30 June

	2005/06 $000's	2006/07 $000's	2007/08 $000's	2008/09 $000's
Revenue				
Revenue	138,874	152,915	157,181	162,048
Interest Revenue	933	93	96	98
Total Revenue	**139,807**	**153,008**	**157,277**	**162,146**
Expenditure				
Operating Expenditure	(128,264)	(139,706)	(144,428)	(149,512)
Depreciation	(7,156)	(8,518)	(8,685)	(8,857)
Interest	(1,188)	(1,184)	(1,178)	(1,178)
Capital Charge	(4,881)	(6,007)	(6,000)	(6,000)
Internal Allocations	446	430	443	458
Total Expenditure	**(141,043)**	**(154,985)**	**(159,848)**	**(165,089)**
Net Surplus/(Deficit)	**(1,236)**	**(1,977)**	**(2,571)**	**(2,943)**
Gain/(Loss) on Sale of Assets	-	-	-	-
Net Surplus/(Deficit)	**(1,236)**	**(1,977)**	**(2,571)**	**(2,943)**

DHB Governance & Administration
Forecast Statement of Financial Performance
For the year ended 30 June

	2005/06 $000's	2006/07 $000's	2007/08 $000's	2008/09 $000's
Revenue				
Revenue	1,979	2,093	2,148	2,214
Interest Revenue	951	650	670	690
Total Revenue	**2,930**	**2,743**	**2,818**	**2,904**
Expenditure				
Operating Expenditure	(2,433)	(2,315)	(2,375)	(2,446)
Depreciation	-	-	-	-
Internal Allocations	(446)	(428)	(443)	(458)
Total Expenditure	**(2,879)**	**(2,743)**	**(2,818)**	**(2,904)**
Net Surplus/(Deficit)	**51**	**-**	**-**	**-**

DHB Fund
Forecast Statement of Financial Performance
For the year ended 30 June

	2005/06 $000's	2006/07 $000's	2007/08 $000's	2008/09 $000's
Revenue				
Revenue	268,178	285,747	295,484	304,624
Total Revenue	**268,178**	**285,747**	**295,484**	**304,624**
Expenditure				
Provider Expenditure	(266,992)	(283,770)	(292,913)	(301,681)
Total Expenditure	**(266,992)**	**(283,770)**	**(292,913)**	**(301,681)**
Net Surplus/(Deficit)	**1,186**	**1,977**	**2,571**	**2,943**

Hutt Valley District Health Board
Forecast Statement of Financial Performance
For the year ended 30 June

	2005/06 $000's	2006/07 $000's	2007/08 $000's	2008/09 $000's
Revenue				
Revenue	293,819	314,573	325,241	335,305
Interest Revenue	1,884	743	766	788
Total Revenue	**295,703**	**315,316**	**326,007**	**336,093**
Expenditure				
Provider Expenditure	(151,781)	(157,589)	(163,341)	(168,100)
Operating Expenditure	(130,697)	(142,018)	(146,803)	(151,958)
Depreciation	(7,156)	(8,518)	(8,685)	(8,857)
Interest	(1,188)	(1,184)	(1,178)	(1,178)
Capital Charge	(4,881)	(6,007)	(6,000)	(6,000)
Total Expenditure	**(295,703)**	**(315,316)**	**(326,007)**	**(336,093)**
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**
Gain/(Loss) on Sale of Assets	-	-	-	-
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**

Hutt Valley District Health Board
Forecast Statement of Movements in Equity
For the year ended 30 June

	2005/06 $000's	2006/07 $000's	2007/08 $000's	2008/09 $000's
Opening Equity	28,127	28,127	28,127	28,127
Opening Retained earnings	(657)	(657)	(657)	(657)
Revaluation reserve	47,289	47,289	47,289	47,289
Net Surplus/(Deficit) for the Period	-	-	-	-
Net Surplus/(Deficit)	**74,759**	**74,759**	**74,759**	**74,759**

Hutt Valley District Health Board
Forecast Statement of Financial Position
As at 30 June

	2005/06 $000's	2006/07 $000's	2007/08 $000's	2008/09 $000's
Public Equity				
Equity	28,127	28,127	28,127	28,127
Revaluation Reserve	47,289	47,289	47,289	47,289
Retained Earnings	(657)	(657)	(657)	(657)
Total Equity	**74,759**	**74,759**	**74,759**	**74,759**
Represented by:				
Current Assets				
Bank in Funds	1,171	3,747	8,885	9,115
Receivables	15,585	15,242	15,740	15,816
Other Current Assets	1,517	1,517	1,517	1,517
Total Current Assets	**18,273**	**20,506**	**26,142**	**26,448**
Current Liabilities				
Bank Overdraft	-	-	-	-
Payables & Provisions	(47,739)	(55,832)	(62,178)	(62,736)
Short Term Borrowings	-	-	-	-
Total Current Liabilities	**(47,739)**	**(55,832)**	**(62,178)**	**(62,736)**
Net Working Capital	**(29,466)**	**(35,326)**	**(36,036)**	**(36,289)**
Non Current Assets				
Property, Plant & Equipment	124,325	130,185	130,895	131,148
Trust Funds	750	750	750	750
Total Non Current Assets	**125,075**	**130,935**	**131,645**	**131,898**
Non Current Liabilities				
Borrowings & Provisions	(20,100)	(20,100)	(20,100)	(20,100)
Trust Funds	(750)	(750)	(750)	(750)
Total Non Current Liabilities	**(20,850)**	**(20,850)**	**(20,850)**	**(20,850)**
Net Assets	**74,759**	**74,759**	**74,759**	**74,759**

Hutt Valley District Health Board
Forecast Statement of Cash Flows
For the year ended 30 June

	2005/06	2006/07	2007/08	2008/09
Operating Cash Flows				
Cash Receipts	291,161	313,523	325,349	335,872
Interest Received	1,884	743	766	788
Payments to Providers	(196,646)	(184,314)	(194,097)	(206,356)
Payments to Employees & Suppliers	(96,266)	(107,059)	(111,326)	(114,669)
Capital Charge Paid	(4,881)	(5,938)	(6,000)	(6,000)
Net Operating Cash Flows	**(4,748)**	**16,955**	**14,692**	**9,635**
Investing Cash Flows				
Cash Received from Sale of Fixed Assets	-	-	-	-
Cash Paid for Purchase of Fixed Assets	(3,922)	(14,378)	(9,554)	(9,406)
Net Investing Cash Flows	**(3,922)**	**(14,378)**	**(9,554)**	**(9,406)**
Financing Cash Flows				
Additional Loans Drawn	-	-		
Loans Repaid	-	-	-	-
Net Financing Cash Flows	**-**	**-**	**-**	**-**
Net Cash Flows	**(8,670)**	**2,577**	**5,138**	**229**
Opening Cash Balance	9,841	1,171	3,747	8,885
Closing Cash Balance	**1,171**	**3,748**	**8,885**	**9,114**
Represented by:				
Bank in Funds	1,171	3,747	8,885	9,115
Bank Overdraft	-	-	-	-
Total Cash on Hand	**1,171**	**3,747**	**8,885**	**9,115**

Appendix 5 - Revenue Reconciliation

2006/07 DAP Revenue Reconciliation Version 8.1

DHB FUNDS AND DHB PROVIDER

TOTAL FUNDS AND PROVIDER REVENUE LINES MUST AGREE TO THE DAP FINANCIAL TEMPLATE
GST EXCLUSIVE

Add Lines as Necessary

DHB FUNDS	Service Area Code	Account Code	2006/07 Plan
PBF Vote Health			
Mental Health Ringfence	20	1004	-30,279
Funding Package (excluding Mental Health Ringfence)	20	1005	-216,476
PBF Adjustments	20	1085	
MOH - Funding Subcontracts	20	1086	-315
MOH Devolved Funding	20	1002	(247,070)
IDF inflows - Mental Health services	20	991	-3,552
IDF inflows - all other (excluding Mental Health)	20	992	-34,837
Inter-District Flows	20	1552	(38,389)
TOTAL DHB FUNDER REVENUE FROM MOH			(285,459)
FUNDING ENVELOPE ADVISED BY MOH			**-283,769**
VARIANCE			(1,690)
FULL BREAKDOWN OF VARIANCE: *(Add lines as necessary)*			
IDF discrepancy to MOH calculation			**18**
Nicotine Replacement Therapy			**60**
Pacific Provider Development Fund			**155**
Cancer Plan Implementation			**100**
Additional Funding for 2006 Revaluation			**1,357**
EXPLAINED			1,690
UNEXPLAINED			(0)

DHB PROVIDER	Service Area Code	Account Code	2006/07 Plan
MOH Non-Devolved Contracts (Provider arm side contracts)			
Personal Health	10	1102	6,459
Mental Health	10	1202	
Public Health	10	1302	6,979
Disability Support Services (Under 65s)	10	1402	1,353
Maori Health	10	1502	
Clinical Training Agency	10	1550	2,453
Total MOH Non-Devolved Contracts	10	1101	17,244
Contract information by Service Area			
Personal Health			
NSU Breast			4,003
NSU Cervical			1,078
Maternity Fees			180
Community Labs,Pharms, Radiology			330
Orthopaedic Joint Initiative			703
Cataract			165
	10	1102	6,459
		Unexplained	-
Mental Health			
	10	1202	-
		Unexplained	-
Public Health			6,539
Fruit In schools			133
National Immunisation Register			100
PI Well child			82
Shellfish Biotoxn			24
INH Services			55
National Oral Health			46
	10	1302	6,979
		Unexplained	-
Disability Support Services (Under 65s)			1,353
	10	1402	1,353
		Unexplained	-
Maori Health			
	10	1502	-
		Unexplained	-
Clinical Training Agency			2,453
	10	1550	2,453
		Unexplained	-

Appendix 6 - Provider Arm Volume Schedule

[Provided electronically to Ministry of Health Data Team. Too big to paste in]

Appendix 7 - Indicators of DHB Performance

The following section lists our Indicators of DHB Performance which we report on a quarterly basis to the Ministry of Health.

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
HKO-01 Effectiveness	Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain.	Six monthly (Q2, Q4)	Measure 1: Percentage of PHOs with Māori Health Plans (MHP) that have been agreed to by the DHB. Numerator = Total number of agreed PHO MHPs, Denominator = Total number of established PHOs Measure 2: Percentage of District Health Board members that have undertaken Treaty of Waitangi training. Numerator = Total number of District Health Board members who have undertaken Treaty of Waitangi training, Denominator = Total number of District Health Board members. Measure 3: Report achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Māori health relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties. Provide a copy of the MoU. Measure 4: Report on how (mechanisms and frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring and evaluation (include a section on PHOs). Measure 5: Report on how MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs) or for newly established PHOs, a report on progress in the development of MHPs (include a list of the names of these PHOs). Measure 6: Describe when Treaty of Waitangi training (including any facilitated by the Ministry) has, or will, take place for Board members.
HKO-02 Equity and Access	Development of Māori health workforce and Māori health	Six monthly (Q2, Q4)	Measure 1: Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Māori out of the total numbers of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs in the DHB respectively.

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
	providers.		Measure 2: Provide a copy of the DHB Māori Health Workforce Plan (or agreed regional Māori Workforce Plan), or the timeframe to complete the Plan. Measure 3: Report on achievements based on key deliverables in the DHB (or Regional) Māori Workforce Plan, or if the Plan is being developed, describe at least two key DHB Māori health workforce initiatives that the DHB has achieved.
HKO-03 Quality	Improving mainstream effectiveness.	Six monthly (Q2, Q4)	DHBs to report providing the following information for the DHB's provider arm: Measure 1: Provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving access to effective services for Māori. Measure 2: Report on an example(s) of actions taken to address issues identified in the reviews.
HKO-04 Equity and Access	DHBs will set targets to increase funding for Māori Health and disability initiatives.	Six monthly (Q2, Q4)	Measure 1: DHB to report actual expenditure on Māori Health Providers by GL code. Measure 2: DHBs to report actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit (PU). Measure 3: DHBs to report total actual expenditure for Iwi/Māori-led PHOs. Measure 4: DHBs to report actual expenditure for mainstream PHO services targeted at improving Māori health. Measure 5: DHBs to report total actual expenditure on DHB Māori Workforce or Provider Māori Workforce Development initiatives, which are not funded through the Māori Provider Development Scheme. Measure 6: Where information is available, DHBs to report a comparison between

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
			expenditure for above measures for 2005/06 (in addition to mandatory reporting against 2006/07 expenditure). Targets: Additional 2006/07 Maori health expenditure 3% plus Future Funding Track (FFT) Additional 2007/08 Maori health expenditure 5% plus FFT Additional 2008/09 Maori health expenditure 5% plus FFT
PAC-01 Equity and Access,	Progress towards the implementation of priority areas identified in the Pacific Health and Disability Action Plan.	Six monthly (Q2, Q4)	Report responding to the following key points: 1. Pacific child and youth health • What initiatives have been implemented and progressed to improve and protect the health of Pacific children (0-14 years)? • What initiatives have been implemented or progressed to improve the health of Pacific youth (15-25 years)? 2. Promoting Pacific healthy lifestyles and wellbeing • What initiatives have been implemented or progressed to encourage and support healthy lifestyles? 3. Pacific primary health care and preventative services • What initiatives have been implemented or progressed to ensure that there are locally available Pacific primary health providers that effectively meet the needs of their local Pacific communities? 4a. The Pacific Health and Disability Workforce Development Plan • What initiatives have been implemented or progressed to develop a competent and qualified Pacific health and disability workforce that will meet the needs of Pacific peoples? 4b. Pacific Provider Development • What initiatives have been implemented or progressed to develop and support Pacific health providers capacity and capability to effectively deliver health services? 5. Promote participation of disabled Pacific peoples • What initiatives have been implemented or progressed to deliver disability support and health services that will enable disabled Pacific peoples to participate fully in their

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
			communities? 6. Pacific health and disability information and research • What initiatives have been implemented or progressed to inform policy, planning and service development?
PAC-02 Effectiveness	Engagement and participation of Pacific peoples in DHB decision-making and the development of strategies and plans that include goals for Pacific health gain.	Six monthly (Q2, Q4)	Report describing how Pacific peoples are engaged and participate in DHB decision-making and the development of strategies and plans which include goals for Pacific health gain. Include the following points: • Demonstrate that Pacific peoples are engaged and participate in DHB decision-making on equity, accessibility and resource allocation at a governance and management level in the DHB organisation. • Giive the number, purpose and outcomes of any community participation activities that have been conducted during the reporting period.
POP-01 Equity and Access, Intersectoral Focus	Diabetes.	Annually (Q3)	Reduced development of contributory risk factors - Obesity. The number of health promoting schools as a percentage of the total number of schools within the DHB (as part of the Healthy Eating Healthy Action strategy). In 2005/06 Hutt Valley DHB had 10 schools participating in Health Promoting Schools programmes out of around 77 schools within the Hutt Valley, or around 13%. Target to have 12 schools participating in Health Promoting Schools programmes by June 2007. Reduced development of contributory risk factors – Smoking. Numerator: (Data source: DHBs via PHO Performance Monitoring)The number of enrolled persons >14 years with smoking status on record. Denominator: (Data source: DHBs via PHO Performance Monitoring)The total number of enrolled persons >14 years. Awaiting baseline data to set targets. Increased early recognition and response to individuals with chronic conditions - CVD Risk recognition. Numerator: (Data source: DHB via PHO monitoring framework) The number of

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
			people in each target group who have had their five-year absolute CVD risk recorded in the last five years. Denominator: (Data Source: DHB via PHO monitoring framework) The number of people in each respective target group. • Māori/Pacific & Indian subcontinent men >35 years of age • Māori/Pacific & Indian subcontinent women >45 years of age • European & other men >45 years of age • European & other women >55 years of age. Indian subcontinent should be defined as level 2 codes 43 Indian and 44 Other Asian as per the ethnicity data protocols for the Health and Disability Sector. Awaiting baseline data to set targets. Slowed rate of progression, reduced incidence of avoidable complications - Diabetes follow-up. Numerator: (Data source: DHB) The number of unique individuals with type I or type II diabetes mellitus on a diabetes register, whose date of their free annual check is during the reporting period. Denominator: (Data Source: the Ministry) The expected number of unique individuals to have type I or type II diabetes mellitus, as at the end of the reporting period. Targets: Total – 70%, Maori – 45%, Pacific – 80%, Other – 77% Slowed rate of progression, reduced incidence of avoidable complications - CVD follow-up – Statins. Numerator: (Data source: DHBs via PHO Performance Monitoring) The number persons where CVD risk >= 15% where statins have been prescribed in the past year. Denominator: (Data source: DHBs via PHO Performance Monitoring) The total number of persons where CVD risk >= 15 %. Awaiting baseline data to set targets. Increased co-ordination across providers, processes and community resources - Diabetic retinopathy screening. Numerator: (Data source: DHB) The number of people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last two years, and the date of the free annual check is

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
			during the reporting period. Denominator: (Data Source: DHB) The number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period. Targets: Total – 80%, Maori – 80%, Pacific – 80%, Other – 80% % Strengthened self-management capability of individuals, family and whanau - Diabetes Management. Numerator: (Data source: DHB) The number of people with type I or type II diabetes mellitus on a diabetes register that had an HBA1c of equal to or less than 8% and at their free annual check during the reporting period. Denominator: (Data Source: DHB) The number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period. Targets: Total – 75%, Maori – 60%, Pacific – 52%, Other – 81%
POP-02 Equity and Access, Intersectoral Focus	Cardiovascular disease.	Annually (Q3)	Increased co-ordination across providers, processes and community resources - Cardiac Rehabilitation Programme. Numerator: (Data source: DHB) The number of people who have suffered a CVD event who attend a cardiac rehabilitation outpatient programme as defined below. Denominator: (Data Source: DHB) The number of people who have suffered a CVD event who were admitted and discharged from hospital. A CVD event is defined as patients with coronary heart disease, specifically those following an acute coronary syndrome (acute Myocardial infarction/unstable angina) and following coronary artery bypass surgery and angioplasty. (2002 NZGG cardiac rehabilitation guidelines) [ICD 10 – 120-125]. All cardiac patients from the medical unit and CCU are referred to cardiac rehab team. All M.I's and Acute coronary syndrome, heart surgery, angioplast/stents will receive a home visit and be invited to attend outpatient cardiac rehab group - a 9 week exercise, education and relaxation course. This follows the NZGG guidelines. The cardiac rehab outpatient clinic is an expanding clinic which is nurse-led for pre/ post heart surgery, pre/post PCI and stents, complex case management, weight management, lipid management, and blood pressure management. The NZGG cardiac rehab and cardiovascular risk management

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
			guidelines are the guiding tools for the clinics. The DHB also has nurse-led heart failure services which are a combination of home visits and outpatient clinics. The proportion of people who attended a cardiac rehabilitation programme in 2005 was 66% for non-Maori and 72% for Maori. Targets for 2006/07: 68% non-Maori and 74% for Maori.
POP-03 Equity and Access, Intersectoral Focus	Stroke.	Annually (Q3)	Increased co-ordination across providers, processes and community resources - Organised Stroke Services. Numerator: (Data source: DHB) The number of people who have suffered a stroke event who have been admitted to organised stroke services and remain there for their entire hospital stay. Denominator: (Data Source: DHB) The number of people who have suffered a stroke event. Stroke event is defined as 'a clinical syndrome typified by rapidly developing signs of focal or global disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than of vascular origin'. (Stroke Guidelines Nov 2003) [ICD 10 – 161, 163, 164]. Hutt Valley DHB does not yet have a stroke unit but will prioritise the establishment of a stroke unit along side other priorities to improve outcomes for patients.
POP-05 Equity and Access	Oral health - percentage of children caries free at age five years.	Annually (Q3)	Numerator: (Data source: DHB via School Dental Service (SDS) and other oral health providers) The total number of caries free children at the first examination after the child has turned five years, but before their sixth birthday, examined by the DHB School Dental Service. Denominator: (Data Source: DHB via SDS and other oral health providers) The total number of children who have been examined in the age five group, in the year to which the reporting relates. This data should be collected at unit level, on first examination after the child has turned five years of age, but before their sixth birthday. The data must be broken down by: • Ethnic group (Māori, Pacific, Other) • Fluoridation status (of the school area the child attends). Targets: Total – 55%, Maori – 40%, Pacific – 33%, Other – 65%.

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
POP-06 Equity and Access	Oral health - mean DMFT score at year eight.	Annually (Q3)	Numerator: (Data source: DHB via SDS and other oral health providers) The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries) or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS. Denominator: ((Data Source: DHB via SDS and other oral health providers) The total number of children who have been examined in the Year eight group, in the year to which the reporting relates. Data on Decayed, Missing (due to caries) and Filled teeth should be collected at unit level. Describe any interpretation issues or technical issues and indicate whether DHBs generate data or if it will be generated by the Ministry and forwarded to DHBs. The data must be broken down by: • Ethnic group (Māori, Pacific, other). • Fluoridation status (of the school area the child attends). • Mean components of the DMF index (ie. D-teeth, M-teeth, F-teeth). Targets: Total – 0.9, Maori – 1.6, Pacific – 1.7, Other – 0.7.

<table>
<tr><th>Measure and Output Class</th><th>Description</th><th>Frequency</th><th>Deliverables and Targets 2006/07</th></tr>
<tr><td>POP-08 (a) Equity and Access</td><td>Improving the health status of people with severe mental illness.</td><td>Quarterly</td><td>Numerator: (Data source: Ministry of Health) The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for:
• Child and youth aged 0-19, specified for each of the three categories: Māori, other, and in total.
• Adults aged 20-64, specified for each of the three categories: Māori, other, and in total.
• Older people aged 65+, specified for each of the three categories: Māori, other, and in total.
Denominator: (Data Source: Ministry of Health) Projected population of DHB region by age and ethnicity.
<table>
<tr><td>Targets</td><td>Total</td><td>Maori</td><td>Other</td></tr>
<tr><td>Children & Youth 0-19</td><td>1.8%</td><td>1.8%</td><td>1.8%</td></tr>
<tr><td>Adults aged 20-64</td><td>2.9%</td><td>3.7%</td><td>2.8%</td></tr>
<tr><td>Older People aged 65+</td><td>1.2%</td><td>0.8%</td><td>1.2%</td></tr>
</table>
</td></tr>
<tr><td>POP-08 (b) Equity and Access</td><td>Reducing repeat acute mental health admissions.</td><td>Six monthly (Q2, Q4)</td><td>Rolling annual DHB repeat admission rate (3 or more times).
Target: To have no more than 52 clients admitted acutely 3 or more times annually.</td></tr>
<tr><td>POP-12 Effectiveness</td><td>Progress towards the national target of 95% of two year olds fully immunised.</td><td>Quarterly</td><td>A) DHB NIR Enrolled Populations
Percent of eligible newborns born and enrolled on the NIR in reporting period:
1. Numerator: number of newborns born and enrolled during reporting period. Denominator: number of children born during reporting period*.
2. Numerator: number of newborns born and enrolled during reporting period of each ethnicity. Denominator: number of children born during reporting period of each ethnicity.
3. Numerator: number of newborns born and enrolled during reporting period of each level of deprivation. Denominator: number of children born during reporting period of each level of deprivation.
4. Numerator: number of children on the NIR less than two years of age with an ‘Opt-Off’ status as at the report date. Denominator: number of children less than two years of age on</td></tr>
</table>

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
			2. Numerator: number of children on the NIR of each ethnicity up to date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period. Denominator: Number of children on the NIR of each ethnicity who turned a specified age (6, 12, 18, 24 months) during the reporting period. 3. Numerator: number of children on the NIR of each level of deprivation up to date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period. Denominator: Number of children on the NIR of each level of deprivation who turned a specified age (6, 12, 18, 24 months) during the reporting period. 4. Numerator: number of children on the NIR up-to-date with MMR immunisation on the day they turned 18 months during the reporting period. Denominator: number of children on the NIR who turned 18 months during the reporting period. Targets for two year olds fully immunised: 2006/07 93%, 2007/08 94%, 2008/09 95%

<table>
<tr><th>Measure and Output Class</th><th>Description</th><th>Frequency</th><th>Deliverables and Targets 2006/07</th></tr>
<tr><td>POP-13
Equity and Access</td><td>Ambulatory sensitive admissions - children and older people - discharge rate per 1000 population.</td><td>Six monthly (Q2, Q4)</td><td>Numerator: (Data source: NMDS) The total number of hospital discharges considered being ambulatory sensitive, as they result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable. Age bands: Children <5, 5 to 14, 15 to 24, Older People 65 to 74. Total population, and Māori/Pacific peoples/other.
Denominator: (Data Source: Census 2001) Current Census populations, projected to 2006/07 using medium projection as at the end of the reporting period.
Targets: Where the DHB region and ethnic rate is significantly greater than the total NZ (all ethnicity) national rate (99% confidence interval) the DHB will provide information on the current and planned initiatives likely to influence future outcomes specifically for the effected population group(s).
<table>
<tr><th>Target rates/1000</th><th>Total</th><th>Maori</th><th>Pacific</th><th>Other</th></tr>
<tr><td>Children 0-4</td><td>100</td><td>100</td><td>140</td><td>100</td></tr>
<tr><td>Children 5-14</td><td>25</td><td>25</td><td>40</td><td>25</td></tr>
<tr><td>Children 15-24</td><td>15</td><td>18</td><td>15</td><td>14</td></tr>
<tr><td>Adults 65-74</td><td>69</td><td>130</td><td>140</td><td>63</td></tr>
</table>
</td></tr>
<tr><td>POP-14
Equity and Access</td><td>Radiation oncology and chemotherapy treatment waiting times.</td><td>Part 1 Monthly, Part 2 Quarterly</td><td>Part 1: Monthly templates that measure the interval between the patient's referral from a medical practitioner to the oncology department, and the beginning of radiation/chemotherapy treatment, are supplied on time and complete from each DHB (or from cancer center for contributing DHBs as agreed). (Including provision of information by DHB of domicile.)</td></tr>
</table>

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
			Waited 8-12 weeks 0% Waited >12 weeks 0%
QUA-01 (a) Quality Systems	Quality systems.	Annually (Q3)	The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting a high level summary (list) of key quality improvement and clinical audit initiatives and results, focusing on those that are effective and/or ineffective against the Goals in Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector.
QUA-01 (b) Quality Systems	Results for People with enduring severe mental illness.	Annually (Q2)	Provide a report on: 1. The number of adults (20 – 64 years) with enduring serious mental illness (two years or more in treatment*, since the first contact with any mental health service. (* in treatment = at least one provider arm contact every three months for two years or more.) 2. The number (and percentage) of long-term clients with up-to-date crisis prevention plans (NMHSS criteria 16.4) and describe how this is assured? 3. The number (and percentage) of long-term clients in full time work (> 30 hours). 4. The number (and percentage) of long-term clients with no paid work. 5. The number (and percentage) of long-term clients undertaking some form of education e.g. University, Polytechnic.
RIH-01 Equity and Access	Progress toward further incorporating health inequalities concepts and actions into overall policy, planning, funding and service provision.	Measure 1 Q1, Measure 2: Q3.	Measure 1: Key areas of inequalities that are identified within its Health Needs Assessment. Measure 2: Actions/steps taken to address the identified inequalities using an appropriate equity tool (eg, the Reducing Inequalities Intervention Framework, the Health Equity Assessment Tool (HEAT), etc).

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
RIS-01 Equity and Access	Service Coverage.	Quarterly	Report progress achieved during the quarter towards resolution of gaps in service coverage identified in the DAP and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: • Analysis of explanatory indicators • Media reporting • Risk reporting • Formal audit outcomes • Complaints mechanisms • Sector intelligence.
SER-01 Equity and Access	Accessible and appropriate services in Primary Health Organisations.	Quarterly	Numerator: (Data source: Ministry of Health via HealthPAC) The age-standardised rate of General Practitioner consultations per high need person. Denominator: (Data source: Ministry of Health via HealthPAC) The age-standardised rate of General Practitioner consultations per non-high need person. Baseline data at January 2006 indicates a ratio of 0.99. Our target is for a ratio >1.
SER-02 Effectiveness	Care Plus Enrolled Population.	Quarterly	Numerator: (Data source: Ministry of Health via HealthPAC) The number of each PHO's Care Plus enrolled population. Denominator: (Data source: Ministry of Health via HealthPAC) Each PHO's expected Care Plus enrolled population. The national goal is that a PHO would have achieved 70% of its expected Care Plus population enrolled in Care Plus by July 2007. Baseline data at December 2005 indicates a 17% enrolment rate in Care Plus overall with variable PHO rates due to differing starting dates. Our target is for an average 70% enrolment across all our PHOs by June 2007.
SER-03 Effectiveness	Primary Health Organisations participating in the PHO	Six monthly (Q2, Q4)	Numerator: (Data source: Ministry of Health via HealthPAC) The number of the PHOs participating in the PHO Performance Management Programme. Denominator: (Data source: Ministry of Health via HealthPAC) The total number of PHOs that have been operational for more than one quarter.

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
	Performance Management Programme.		The national goal is that 90% of PHOs are participating in the PHO Performance Management Programme by the end of June 2007. Baseline data at February 2006 indicates that one of our six PHOs is currently participating in the PHO Performance Management Programme. Our target is to have all six of our PHOs participating by June 2007.
SER-04 Equity and Access	Low or reduced cost access to first level primary care services.	Quarterly	Numerator: (Data source: DHBs quarterly fee reporting) The number of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients. Demonstration is achieved by compliance with the government policy for access and interim PHOs across all groups, where the subsidies apply and where this is approved by the DHB and the Ministry. Denominator: (Data source: DHBs quarterly fee reporting) The number of PHO practices in a DHB region. Our target is to have all six of our PHOs demonstrating that increased subsidies have been translated into low or reduced cost access for eligible patients.
SER-05 Efficiency and Value for money	The proportion of laboratory and pharmaceutical transactions with a valid NHI.	Quarterly	Numerator: (Data source: Ministry of Health via HealthPac) Pharmaceuticals: the number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted. Laboratory tests: The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted. Denominator: (Data source: Ministry of Health via HealthPac) Pharmaceuticals: the total number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district. Laboratory:The total number of tests carried out by community laboratories in the DHB district. Percent NHI for Pharmaceuticals: Currently 88%. Target 92% Percent NHI for Laboratory Tests: Currently 89%. Target 92%
SER-06 Quality	Continuous Quality	Six monthly (Q2, Q4)	Standardised Discharge Ratios (SDRs) for 11 elective procedures as published on the Ministry website each quarter (excluding hip and knee replacements and cataracts covered

Measure and Output Class	Description	Frequency	Deliverables and Targets 2006/07
	Improvement – Elective Services.		by separate initiatives). Report demonstrating: • For any SDR that is more than 5% below the national average of one, ie, a rate of less than 0.95, what analysis the DHB has done to review the appropriateness of its rate. • The reason that the DHB considers the rate to be appropriate for its population, or an action plan as to how it will address its relative under-delivery of that procedure.

Appendix 8 - Consolidated List of Service Coverage Exceptions

The Operational Policy Framework established by the Ministry of Health, which sets out the quasi-regulatory rules that all DHBs must comply with, includes an extensive service coverage specification.

The service coverage specification describes the type of services and levels of access to services that the Ministry of Health requires DHBs to provide. Over the last few years, Hutt Valley DHB has developed a much greater understanding of the contracts it inherited in 2001/02 and any gaps between actual service provision and the content of the service coverage specifications.

Hutt Valley DHB expects to meet Government service coverage expectations with the following exceptions and caveats:

- A low income dental relief of pain service has never been funded in the Hutt Valley, though there is partial access to this service via the Hutt Hospital dental outpatients and a low-income dental pilot.
- The Hutt Valley is not funded at Blueprint levels and does not achieve the 3% intervention rate target for mental health. We will, however, ensure that the DHB will continue to provide service coverage to the level of Blueprint funding available.
- Community radiology is available free of charge only for CSC cardholders.
- Hutt Valley DHB is not able to see all primary school age children every 12 months for an oral health examination. We have instituted a 12-month recall for high need individuals, and up to 24 month recalls for low need individuals.
- Hutt Valley DHB has little influence over the provision of most tertiary services provided by other DHBs and has difficulty determining access levels. Hutt DHB will however, develop a resolution plan with Capital and Coast DHB that will formalise a mechanism for discussion and escalation regarding issues of tertiary service coverage.
- Diabetes carer relief for children not funded by the Ministry in the central region.
- Provision of complete data for Phase 1A of the National Non-Admitted Patient Activity Collection (NNPAC) will not be possible until an upgrade of our Patient Management System is completed late in 2006.

Although Hutt Valley DHB expects to comply with national service specification framework requirements, compliance may be limited where knowledge of requirements is incomplete or where staff shortages occur. In particular, Hutt Valley DHB does not currently meet all quality requirements for specialist medical staffing and triage times.

Hutt Valley DHB is responsible for funding the following services in 2006/07:

- Local Maori Health services.
- Local Pacific Peoples Health services.
- Local personal health services.
- Local mental health services.
- Local older person disability support services.
- Some regional and national personal and mental health services.

Hutt Valley DHB does not have responsibility for funding a range of other services, currently funded by the Ministry of Health. These include:

- Workforce development and clinical training.
- Public Health.
- Maternity.
- Maori and Pacific Provider development.

- National contracts, including Wellchild..
- Disability Support Services (under-65s).

Measures
RIS-01 Service Coverage

Appendix 9 - Decision Making Principles and Prioritisation Tool

Decision Making Principles
The principles of the Hutt Valley DHB Decision-Making Framework are listed below.

Effectiveness
Hutt Valley DHB will consider the available information on the effectiveness of the service or intervention under consideration. Effectiveness will include the extent to which health and disability services produce desired health outcomes, such as reductions in pain, the maintenance of daily living activities, and extending life. The implication of this principle is that Hutt Valley DHB will not normally fund services where there is weak or no evidence of effectiveness. Interventions such as workforce development or quality initiatives will generally be considered as attempts Hutt Valley DHB District Annual Plan 2005/06 93 20/12/2005 to improve the effectiveness of services. This principle may be seen to disadvantage new or emerging interventions for which limited evidence exists. Effectiveness will be quantified where possible.

Equity
Hutt Valley DHB will seek equity of outcome to reduce disparities in health status where possible for groups with lower levels of health, including (but not limited to) the Maori population, the Pacific population and groups of low socio-economic status. The implication of this principle is that all other things being equal, Hutt Valley DHB would fund a service aimed at improving health outcomes for Maori or Pacific or other groups with lower average health status before funding a similar service targeting the general population. For instance, a smoking cessation initiative might be targeted at Maori until their outcomes are equivalent to the general population, if there were insufficient funds to service the whole population. As part of its equity considerations, Hutt Valley DHB is committed to using the Reducing Inequalities Intervention Framework and the Health Equity Assessment Tool (HEAT) when refocusing mainstream funding and planning to address health inequalities.

Acceptability
The expectations and values of Hutt Valley residents will be considered in Hutt Valley DHB's decision making processes. The implication of this principle is that some services where the evidence for effectiveness is weak, but which are highly valued by the community, may continue to be funded. In light of the Maori Health principle, the values of the Maori community would need to be given particular consideration.

Consistency with the New Zealand Health Strategy & New Zealand Disability Strategy
Hutt Valley DHB will give priority to initiatives that are consistent with the NZHS and NZDS health gain and service priority areas, and with our strategic plan.

Value for Money
Hutt Valley DHB will consider the total economic costs of services, including flow-on effects in both the health and other social sectors, to ensure available funding is used to achieve the maximum possible gain in health and independence status. Total economic cost includes cost to the user. The implication of considering all economic costs is that some interventions that appear high cost (e.g. kidney transplants) may actually be low cost when the downstream costs of the alternatives (e.g. ongoing dialysis) are considered. Considering intersectoral costs and benefits has the general impact of promoting services or interventions that may relieve costs on other social service agencies. For instance, surgery that allows someone to return to work may save the payment of a benefit. Total economic costs will often be very difficult to

calculate accurately, but potential cost impacts can at least be considered. Costs may be considered in light of the number of people benefiting from the intervention. Combining cost and effectiveness information will, where good information exists, allow the calculation of cost effectiveness, or cost utility ratios, to allow for the comparison of different service options.

Maori and Pacific Development in Health
In making funding decisions, Hutt Valley DHB acknowledges the requirement to encourage Maori and Pacific participation in providing and using services. Maori and Pacific health issues will be considered when applying all of the other decision making principles. One implication of this principle is that those proposing service initiatives will need to identify as specifically as possible the impact on Maori or Pacific. This may include estimating prevalence and access issues, discussing effectiveness, etc. The principle means that Hutt Valley DHB will give priority to services targeting, or provided by, Maori and Pacific, all other things being equal.

Prioritisation Tool
Hutt Valley DHB has developed a methodology to apply these principles and to score service proposals and rank them in priority order. The ranking thus derived is an input to the Board decision making process. The following is the scoring template.

Proposal Name:

Score	Maori Health Criteria
1	No targeting for Maori, mainstream service
2	Little targeting to Maori (e.g. targeted to low income), mainstream service
3	Mainstream service targeted to Maori
4	Maori service
5	Fully by Maori for Maori service

15% Weighting

Score	5
Weighted score	15

Score	Effectiveness Criteria
1	No expert evidence
2	Conflicting evidence but recommended by Service Planning Groups
3	Some evidence or expert consensus
4	Good international evidence or well designed controlled trials
5	Good New Zealand evidence or randomised control trials

25% Weighting

Score	5
Weighted score	25

Score	Equity Criteria
1	Untargeted service
2	Untargeted service but with relatively high proportions of those with the poorest health and highest need
3	Some targeting to those with the poorest health and highest need
4	Generally targeted to those with the poorest health and highest need
5	Targeted specifically to those with the poorest health and highest need

25% Weighting

Score	5
Weighted score	25

Total Score	100

Value-for-Money dimensions

Score	Cost per Person Criteria
1	>$10,000 per person
2	$1,000-$10,000 per person
3	$100-$999 per person
4	$10-$99 per person
5	$0-$9 per person

15% Weighting

Score	5
Weighted score	15

Score	Cost Savings Criteria
1	Little or no cost offsets ($0-$9 per person)
2	Small cost offsets ($10-$99 per person)
3	Medium cost offsets ($100-$999 per person)
4	Large offsets ($1,000 - $10,000 per person)
5	Very Large cost offsets (> $10,000 per person)

5% Weighting

Score	5
Weighted score	5

Score	Effectiveness per Person Criteria
1	Little, if any, direct gain
2	Some benefits, small reduction in disability or small increase in quality of life
3	Medium benefits, moderate reduction in disability and/or some increase in quality of life or life expectancy
4	Large benefits, good reduction in disability and/or increase in quality of life or life expectancy
5	Huge benefits, adding many years of quality life

10% Weighting

Score	5
Weighted score	10

Score	Timing of Benefits Criteria
1	10+ years
2	6-9 Years
3	3-5 years
4	2 years
5	Within 1 year

5% Weighting

Score	5
Weighted score	5

Fill in only green shaded cells

Appendix 10 - Statement of Intent

Appendix 11 - Statement of Accounting Policies

Reporting Entity
Hutt Valley District Health Board was established on 1 January 2001 following the enactment of the New Zealand Public Health and Disability Act 2000. Under the New Zealand Public Health and Disability Act 2000 the assets and liabilities of Hutt Valley Health Corporation Limited were vested in Hutt Valley District Health Board. The Board's operations combine the functions of the predecessor entity and some of the functions previously performed by the Health Funding Authority.

General Accounting Policies
Hutt Valley District Health Board is a crown entity in terms of the Public Finance Amendment Act 2004 and the New Zealand Public Health and Disability Act 2000. These financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Public Finance Amendment Act 2004.

Particular Accounting Policies
The following particular accounting policies, which materially affect the measurement of results and financial position, are applied:

Leases
Finance leases
Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset are transferred to Hutt Valley District Health Board, are classified as finance leases. Where assets are acquired by finance leases, the lower of the present value of the minimum lease payments and fair value is recognised as an asset at the beginning of the lease term and depreciated on the same basis as equivalent fixed assets. A corresponding liability is also established and each lease payment is allocated between the liability and interest expense.

Operating leases
Operating lease payments, where lessors effectively retain substantially all the risks and benefits of ownership of the leased items, are charged as expenses in the periods in which they are incurred.

Investments
Investments are stated at the lower of cost and net realisable value.

Goods and Services Tax
All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables, which are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Employee Entitlements
Provision is made for annual leave, long service leave, retirement gratuities, parental leave and senior medical officers' allowances for conference leave and reimbursement of expenses. Annual leave and parental leave are calculated on an actual entitlement basis at current rates of pay. Conference leave and expenses reimbursement allowances are calculated on an actual entitlement basis per the senior medical officers' employment contract. Other provisions are calculated on an actuarial basis utilising current rates of pay.

Accounts Receivable
Accounts receivable is stated at expected realisable value after providing for doubtful and uncollectable debts.

Inventories
Inventories are stated at the lower of cost, determined on a weighted average basis, and net realisable value. This valuation includes allowances for slow moving inventories.
Obsolete inventories are written off.

Fixed Assets
Fixed assets were vested in Hutt Valley District Health Board from Hutt Valley Health Corporation Limited on 1 January 2001. These assets were recorded at the initial cost incurred by Hutt Valley Health Corporation Limited. Fixed assets, other than land and buildings, acquired by the Board subsequent to its establishment, are recorded at cost less accumulated depreciation. Cost includes all appropriate costs of acquisition and installation including materials, labour, direct overheads and transport costs. Land and buildings, including site improvements, are revalued every five years to their fair value as determined by an independent registered valuer to their highest and best use. Additions between valuations are recorded at cost. The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

Depreciation of Fixed Assets
Depreciation is provided on a straight-line basis on all tangible fixed assets other than freehold land, at rates, which will write off the cost of the assets, less their estimated residual value, over their useful lives.
The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Asset Class	*Useful Life*	*Associated Depreciation Rates*
Building structure	15 – 65 years	1.5% - 6.7%
Building fitout and services	3 – 40 years	2.5% - 33.3%
Plant and equipment	1 – 15 years	6.7% - 100%
Motor vehicles	5-10 years	10% - 20%
Computer equipment	1 – 5 years	20% - 100%
Leased assets	6.5 – 8 years	12.5% - 15.4%

Gains and losses on disposal of fixed assets are taken into account in determining the net operating surplus for the period.
Capital work in progress is not depreciated. The total cost of a project is transferred to a fixed asset category on its completion and is then depreciated.

Properties Intended for Sale
Properties intended for sale are valued at the lower of cost and net realisable value and are classified as a current asset where the intention is for the property to be sold within the next financial year.

Taxation
Hutt Valley DHB is a public authority 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.

Trust and Bequest Funds
Donations and bequests received are treated as revenue on receipt in the statement of financial performance, except where the restrictive conditions are such that the Board has a liability to the donor.

Cost of Services Statements
The cost of services statements report the net cost of services provided by each significant activity. The net cost is the significant activity's cost of providing the service, less revenue collected by the activity.

Cost Allocation
The net cost of service for each significant activity has been arrived at using the cost allocation system outlined below.

Cost allocation policy
Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs
Direct costs are those costs directly attributable to an output class. Indirect costs are those costs which cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs
The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as full time equivalent staff numbers, staff head count numbers and floor space used.

Statement of Cash Flows
Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the Board invests as part of its day-to-day cash management, net of bank loan facilities.

Operating activities include all transactions and other events that are not investing or financing activities.

Investing activities are those activities relating to the acquisition and disposal of non-current assets.

Financing activities comprise the change in equity and debt capital structure of the Board.

Financial Instruments
Hutt Valley District Health Board is risk averse and seeks to minimise exposure arising from its treasury activity. The Board is not authorised by its treasury management policy to enter into any transaction that is speculative in nature. Financial instruments reflected in the statement of financial position include cash and bank balances, receivables, trade creditors and borrowings. These instruments are, generally, carried at their estimated fair value. For example, receivables are carried

net of the estimated doubtful receivables. The particular recognition methods adopted are disclosed in the individual policy statements associated with each item.

Changes in Accounting Policies
There have been no changes in accounting policies adopted and all policies have been applied on a basis consistent with the previous period.

Implementation of International Financial Accounting Standards
The financial reporting standard about preparing prospective financial statements (FRS-42) says that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statement at the end of that financial year. The (prospective) forecast financial statements in the SOI have been prepared in accordance with NZ GAAP. However, from 1 July 2007 a new set of accounting standards will be used on New Zealand called the New Zealand Equivalents to International Financial Reporting Standards (NZIFRS). This means that the financial statements at the end of the financial years 2007/08 and 2008/09 will be prepared in accordance with the new NZIFRS but the prospective (forecast) statements in this document are prepared using the previous standards (NZ GAAP). The prospective statements for 2007/08 and 2008/09 in this SOI do not comply with FRS-42 because the full impact of the NZIFRS has not yet been determined.