Hutt Valley District Health Board

District Annual Plan

2007/08

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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.

Hutt Valley DHB Vision, Mission and 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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Office of Hon Pete Hodgson
MP for Dunedin North
Minister of Health

10 JUL 2007

- 9 JUL 2007

Mr Peter Glensor
Chair
Hutt Valley District Health Board
Private Bag 31907
LOWER HUTT

Dear Mr Glensor

Hutt District Health Board: 2007/08 District Annual Plan

I am pleased to advise that I have signed Hutt District Health Board's (HVDHB) 2007/08 District Annual Plan (DAP) for three years, and that the Board has my full support for implementing this plan.

This year your Board and management have put tremendous effort into successfully managing what was a challenging 2006/07 plan. I can see from your 2007/08 plan that you intend to continue this effort. I am really appreciative of this.

Service Change and Reconfiguration
May I remind you that my approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

Health Targets
The introduction of the new Health Targets was designed to provide an increased focus on my continuing priorities. They provide the sector with a solid platform for measurable progress in the coming year. I am delighted with the emphasis that your Board plans to give to these priorities. I look forward to receiving updates from you as the year progresses.

Reducing Burden of Chronic Disease
Although variable across DHBs, many DAPs this year are showing an increasing commitment to health promotion and illness prevention strategies. Healthy Eating Healthy Eating (HEHA) initiatives are developing well and the progress the sector plans on oral health and tobacco control is very pleasing. Keep up the good work on establishing the cancer control regional networks. I am particularly pleased that you are focussing on identifying and addressing inequalities for people who need cancer

treatment. The work you are doing on cancer services is so important because it impacts on the lives of so many New Zealanders.

Primary Care
This year I will be looking for the progress you have signalled in primary care. Primary Health Organisations (PHOs) are not new anymore. You should be expecting a solid contribution from them towards both your promotion and prevention strategies (especially for children and youth), and in their management and support of patients with chronic disease.

I look forward to an update regarding your initiatives that increase the involvement of primary care in the management and treatment of diabetes.

Primary care also has a tremendous contribution to make to the management of elective services although you have strong primary care linkages, I would encourage you to consider the appointment of a General Practitioner (GP) liaison so that we can achieve real improvement in the interface between primary and secondary services. Consider reviewing your processes within both primary and secondary care where gains can still be made.

Electives
Meeting Elective Services Patient Flow Indicators (ESPI) remain an area of high priority. I do realise the challenges inherent in the management of elective services but will reiterate my message to you from last year. People have a 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. Could you as a Board, please ensure that you have mechanisms (such as "buffers" and robust internal reporting systems) in place to ensure that your ESPI compliance is maintained and that your commitment to additional volumes is achieved.

Achievement of increased elective volumes could be a tangible demonstration of productivity gains and a contribution to value for money strategies. Please frequently review your productivity levels as the year progresses.

Health of Older People
Your plan to advance the implementation of the Health of Older People strategy shows a strong commitment to this age group in your community. I am very pleased to see the work you plan on developing community based services and on supporting workforce enhancements.

Mental Health
I note that again you have taken up the opportunity of Blueprint funding. I am keen to see that you have in place mental health services, using this funding as early as possible in the new year.

As a nation we need to make more progress in building and broadening services to support people with mental health or addiction illnesses. This year I am expecting to see real improvements in services for children and young people.

Financial and Risk Management
I hardly need to remind you of the need to continue to manage your services within your allocated funding. I note the risks outlined in your DAP and the mitigation strategies you have identified have my support. I expect robust financial performance and that you continue to keep the Ministry of Health (the Ministry) informed of emerging risks.

Capital
My approval of your 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 dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

Monitoring Intervention Framework
I am pleased to note that HVDHB has maintained the status of standard monitoring on the Monitoring and Intervention Framework (MIF). This is a reflection of your ongoing positive performance and is rewarded by the benefit of receiving early payment of your funding. I am confident that you will be working to retain your MIF status throughout 2007/08.

Inequalities
Lastly, but most importantly, there remains within our community population groups whose health and well being is significantly lagging behind the majority. I ask that you continue to focus on reducing inequalities.

In conclusion I know that as you enter this new year you and your Board will have in the front of your minds improving service quality, meeting fiscal imperatives and managing industrial challenges. All of this in the context of impending Board elections. It is a tremendous contribution that you are making to the lives of New Zealanders. Thank you. Best wishes with the implementation of your 2007/08 DAP.

Could I ask that a copy of this letter is attached to the copy of your signed DAP held by the Board and to all copies of the DAP made available to the public.

Yours sincerely

Hon. Pete Hodgson
MINISTER OF HEALTH

1. Statement from Chair and Chief Executive

We are pleased to present Hutt Valley District Health Board's District Annual Plan (DAP) for the 2007/2008 year.

This is perhaps the most significant and challenging year Hutt Valley DHB has faced since it was established in 2001. The following executive summary clearly sets out the key areas of focus and challenge for the year.

In short, Hutt Valley DHB will be focussing on meeting elective surgery targets, the essential expansion of Hutt hospital, while at the same time maintaining the continued development of community-based services and services for the elderly and dealing with the impact in the DHB's status under population-based funding.

These are significant challenges but ones to which we are fully committed.

In the 2006/2007 financial year Hutt Valley DHB took an innovative approach to meeting elective services performance indicators (ESPIs). The DHB maintained its commitment to people to whom it had given certainty of treatment and this affected Hutt Hospital's ability to meet the September deadline for ESPI compliance. However, compliance was reached in December 2006 and in a way which was sustainable for the future.

However, in order to become compliant Hutt Valley DHB has needed to use private hospital facilities in which to undertake publicly-funded surgery. While excess private capacity in the Wellington region has made this feasible, this is not seen as a permanent or long-term solution.

The expansion of Hutt Hospital's operating theatre block and Emergency Department is driven by the need to meet the government's targets for elective surgery and meet the DHB's obligations to the Hutt Valley community, as well as to deal with structural issues in the Emergency Department, in order to cope with both current and future demand. A number of the hospital's core functional services are in flood-prone or earthquake-risk areas and need to be relocated.

It is fundamental for the future availability of good hospital care to the people of the Hutt Valley that we complete the approval process for building of the hospital expansions in the 2006/2007 financial year and commence on detailed planning. We will also be focusing on ensuring we can develop the appropriate workforce to meet future requirements.

At the same time we will continue initiatives designed to strengthen the primary sector, develop services for both our older and younger people and we will look for more inter-sectoral co-operation in order to continue to reduce disparities.

We are doing all of this while dealing with a financial situation which is not ideal. Hutt Valley DHB, through no fault of its own, has gone from being an under-funded board using the population based funding formula, to being an over-funded DHB. This is because while our population is relatively static, other parts of the country are growing at a faster rate. The net result is that in the 2007/2008 year Hutt Valley DHB will receive $5 million in transitional funding and will not in future receive extra population growth funding.

Hutt Valley DHB has a strong record of financial management. Indeed at the beginning of the 20067/2007 financial year we tendered a break-even budget to the

Ministry of Health at a time when we were facing already considerable financial issues. At the time of writing the DHB is on track to meet that budget and we face these new challenges in the same way.

In the coming year we will focus on revenue generation, value-for-money and cost containment strategies. This will be difficult, but it is a challenge the DHB feels confident in meeting.

We have, in Hutt Valley DHB, a strong sense of our duty to our community and, in our workforce, genuine links to and care for that community. This DHB has proven its ability to work with its providers and community to come up with solutions which take account of everyone's needs and we will continue on that path during the period of this annual plan.

This annual plan is very much in line with the DHB's current District Strategic Plan, which was developed with great community input. It is the second annual plan under the current strategic document and we are pleased that it continues the progress envisaged in that document.

1.1 Signatories

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

1.2 Executive Summary

The District Annual plan for 2007/08 is the second 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 2007/08 are:

- Continuation of responsible financial performance.
- Enhanced elective services, including meeting elective service performance indicators; additional elective services funding and delivery; and development of patient focussed booking options.
- Improved primary health care delivery and capability.
- Increased value for money in community pharmaceutical and pharmacy expenditure.
- Approval of the Emergency Department/Theatre Project.
- Enhanced organisational culture and workforce development, building on the Magnet programme and engagement with schools.
- Information projects that support service delivery.
- Intersectoral collaboration, including the areas of Healthy Eating Healthy Action – Oranga Kai Oranga Pumau and work with the Ministry of Social Development.
- Innovation in services for older people, through improved needs assessment and service coordination, packages of care and implementation of psycho-geriatric review.
- Innovation in services for children and youth, including oral health and review of child and youth mental health services.

For the first time, Hutt Valley DHB will be classed as an over-funded board from 2007/08 as a result of population changes in New Zealand. Transition funding of $5 million in 2007/08 will soften the impact but there will be no extra population growth funding to purchase new or additional services. We will therefore increase our focus on revenue generation, value-for-money and cost containment strategies.

This is a significant financial risk for the DHB and the emphasis on sound financial management, a feature of our DHB in the past, will again be to the fore.

While management of people with chronic conditions in primary and community settings is expanding, admissions to hospital continue to grow, putting pressure on staff and budgets. In 2007/08, 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 of chronic diseases 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 'improved health equity', 'working with other agencies' and on taking a 'whole person, whanau and lifespan approach' in this plan.

We will place particular significance this year on progressing the development of new operating theatres and emergency department facilities at Hutt Hospital. These facilities are critical for the future of health services in the Hutt Valley and in order to be able to provide the community with adequate hospital services.

It should be noted that there are a number of financial pressures outside the DHB's control. With wages a major component of DHB costs, the overall impact of these wage increases is significantly higher than the funding increase passed on to DHBs in the 2007/08 funding package. The gap between wage increases and DHB funding increases will create a significant challenge for us.

Services for older people are a financial risk for the Hutt Valley DHB, with an increasing aging population but with no new demographic funding. Hence any increase in volumes in 2007/08 will need to be found within existing overall funding.

Therefore, 2007/08 provides the Hutt Valley DHB with the greatest challenge since the inception of DHBs. In spite of this, it also offers the organisation the opportunity to imbed gains already made in the first year of the Strategic Plan period and make progress towards the five-year goals laid out in that plan.

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 Māori

In order to recognise and respect the principles of the Treaty of Waitangi, the New Zealand Public Health and Disability Act 2000, Part 1, section 4 identifies that DHBs must work to improve health outcomes for Māori through the provision of mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

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

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 Māori partnership board with Hutt Valley DHB. 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 original sponsors from the Māori community to develop a consensus on an appointment process so Te Awakairangi Hauora has maximum legitimacy within the Hutt Valley Māori community.

The Hutt Valley DHB has two Māori 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 Māori 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 Māori Health Strategic Plan and a further engagement process with local Māori communities, we have established a Māori 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 Māori. Through dialogue, the group guides 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.

3. Our Objectives and Priorities

The sections 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 reflect the needs of our community. 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, through good employer and non-discrimination policies (e.g good and safe working conditions, equal employment opportunities, and anti-bullying).

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. 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. 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 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 Māori.
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 Māori, Pacific peoples and the elderly – the Hutt Valley Māori 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.

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 2007/08 progress is expected to be made in all these strategies with an emphasis on quality and safety and on reducing inequalities.

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 2007/08. These include:

- Chronic disease, through implementing Healthy Eating Healthy Action – Oranga Kai Oranga Pumau[12] and the New Zealand Cancer Control Strategy[11].
- Child and Youth Services, through the introduction of hearing tests for neonates, increased well child checks for preschoolers, work towards free primary care services for under six year olds, increased access to specialist mental health and addiction services, immunisation and antenatal HIV screening.

- Primary care, through progressing the Primary Health Care Strategy.
- The health of older people, through implementing the Health of Older People (HOP) Strategy[9] by 2010.
- Infrastructure, through significantly progressing the Health Information Strategy (HISNZ)[16].
- Value for Money, through demonstrating the pursuit of efficiency, productivity and innovation (particularly in the area of diabetes), and progressing the Future Workforce Initiative.

Other ongoing government priorities include:
- Progressing the New Zealand Disability Strategy, He Korowai Oranga and Whakatātaka.
- Reducing inequalities.
- Quality and safety.
- Improving elective services, including orthopaedics and cataract initiatives.
- Improving mental health.
- Re-establishment of child and adolescent oral health services.
- Collaborating across agencies to minimise family violence.

3.4 Our Priorities for 2007/08

The following are Hutt Valley DHB's key priorities for 2007/08:
- Continuation of responsible financial performance.
- Enhanced elective services, including meeting elective service performance indicators; additional elective services funding and delivery; and development of patient focussed booking options.
- Improved primary health care delivery and capability.
- Increased value for money in community pharmaceutical and pharmacy expenditure.
- Approval of the Emergency Department/Theatre Project.
- Enhanced organisational culture and workforce development, building on the Magnet programme and engagement with schools.
- Information projects that support service delivery.
- Intersectoral collaboration, including the areas of Healthy Eating Healthy Action – Oranga Kai Oranga Pumau and work with the Ministry of Social Development.
- Innovation in services for older people, through improved needs assessment and service coordination, packages of care and implementation of psycho-geriatric review.
- Innovation in services for children and youth, including oral health and review of child and youth mental health services.

4. Issues and Risks

The following sections summarise the key issues and risks facing Hutt Valley DHB during 2007/08 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 Māori and Pacific people. Our Older Persons Service Plan, Pacific Health Action Plan and Hutt Valley's Māori 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 2007/08, 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 at a level slightly above our population share so our population-based funding is not likely to increase in real terms over the next few years. That makes it even more important that we generate revenue from other sources and 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 of '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 Upper Hutt and Lower Hutt, 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

Hutt Valley DHB will be classed as an over-funded board from 2007/08 as a result of population changes in NZ. Transition funding of $5m in 2007/08 will soften the impact but there will be no demographic funding to purchase new or additional services. We will therefore increase our focus on revenue generation, value-for-money and cost containment strategies.

In recent years, wage settlements for health professionals 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 2007/08 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.

Services for older people are a financial risk for the Hutt Valley DHB, with an increasing aging population but with no new demographic funding. Hence any increase in volumes in 2007/08 will need to be found within existing overall funding.

We are working to reduce the financial risk and to improve the services available to older people by developing an augmented NASC service and a wider range of flexible options for restorative, rehabilitation, support and care services to enable "Ageing in Place". In the short-term, though, our ability to reduce this financial risk is limited.

Within personal health services, there are several financial risks arising from demand driven services. In 2006/07, we implemented a new primary health laboratory service contract following an extensive service development and tendering process. The new contract resulted in a lower fixed price, which has capped our financial exposure. Laboratory tests for patients of private specialists have largely been excluded, addressing an historical anomaly.

The 2007/08 PHO capitation roll-out for the 25-44 year old age group poses financial risk to Hutt Valley DHB as we have a high enrolment rate of our population into PHOs. We are concerned that no wash-up from the Ministry will be paid if costs exceed the nationally modelled amount in 2007/08, even if the DHB incurs real costs at a higher level.

With the devolution of primary maternity services to DHBs there is a risk that insufficient transition funding will be available to fully prepare and plan for managing these services.

Along with other DHBs, we continue to address the risks in pharmaceutical expenditure by working with PHARMAC on 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 and pharmacists to improve the cost effectiveness of their prescribing and dispensing.

The wash up of Inter-district Flow (IDF) Case-weighted Discharges (CWD) means that where volumes increase there is a financial risk. Hutt Valley DHB will be closely monitoring IDF CWD and looking at ways of reducing this risk. Conversely there is also a risk of losing IDF CWD revenue if the provider arm does not provide treatment for other DHB's populations to the budgeted level.

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 cancer drugs; enhanced requirements to meet standards for radiotherapy use are increasing pressure for an additional linear accelerator in the region, and brachytherapy is being introduced in Wellington. Increased cancer services and the re-establishment of electrophysiology services in Wellington will increase costs for Hutt Valley DHB.

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, and we are preparing a business case jointly with Capital and Coast DHB. We will only be able to fully implement the new model if local communities support the changes required and if sufficient funding is made available. 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). While these risks have been reduced by the establishment of the Interim Funding Pool, further work is required to effectively implement the new arrangements.

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).

Difficulties for patients with multiple and complex needs arise from poor coordination across services and between providers. In 2007/08 we will address these through inter-service initiatives, including the augmented NASC service and implementation of the plan for psycho-geriatric and mental health services for older people.

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 and Lead Maternity Carers (LMCs) 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 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 are trying different ways of doing things, exploring what health workers do and how we use them (e.g. increasing use of nurse-led clinics). We are using new strategies to redesign services and enhance our workforce development, building on the impetus of the Magnet programme.

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 and an expanded emergency department (including the construction of an acute assessment 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. This is part of our Emergency Department/Theatre project.

All of the above development is being progressed as part of an Integrated Campus Plan, 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 have developed robust business cases, which are now proceeding through regional and national processes.

Infrastructure: Information
Information demands continue to feature prominently for both effective service delivery and funding decisions. There are steadily increasing demands on Information Services because of both the increased reliance people have on systems and electronic information, and because of the demand for new services and functionality.

The main focus areas for Information Services in 2007/08 will be on improving information systems to meet the requirements of additional elective services workload, and on supporting Radiology Services for improved clinical workflow and diagnostic tools using a Picture Archiving Communication System (PACS). There will also be on-going improvements in the electronic medical record system which includes the use of electronic referrals from GPs.

4.3 Service Reviews and Changes

We propose to undertake a number of service reviews and service changes during 2007/08. A selection of services will be reviewed during the planning period to ensure the DHB reaches its budgeted financial position for 2007/08 and to advance issues of improving access to services and reducing inequalities for our populations.

Local reviews and changes planned are:

- Develop ultrasound scanning for rheumatology patients, to avoid multiple appointments.
- Review regional specialty service utilisation and availability for Hutt residents and implement recommendations with local delivery of service.
- Review Diabetes Outreach Services.
- Implement an augmented Needs Assessment and Service Coordination (NASC) service.
- Review community pharmaceutical prescribing and dispensing.
- Implement the local five year mental health and addiction service plan.
- Implement the plan for psycho-geriatric and mental health services for older people.
- Review Māori and Pacific alcohol and addiction services.
- Implement the new model of community-based dental care for children and adolescents, dependent on sufficient funding from the Ministry of Health.

These reviews and plans may lead to service reconfigurations, the extent of which is unknown at this stage. It is noted that any significant 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:

- Gain approval for and commence the Emergency Department/Theatre project.
- Exploring the provision of Computerised Tomography Angiography at Hutt Hospital.
- Review effectiveness and utilisation of regional mental health services (including Regional Specialty Services and forensic services).

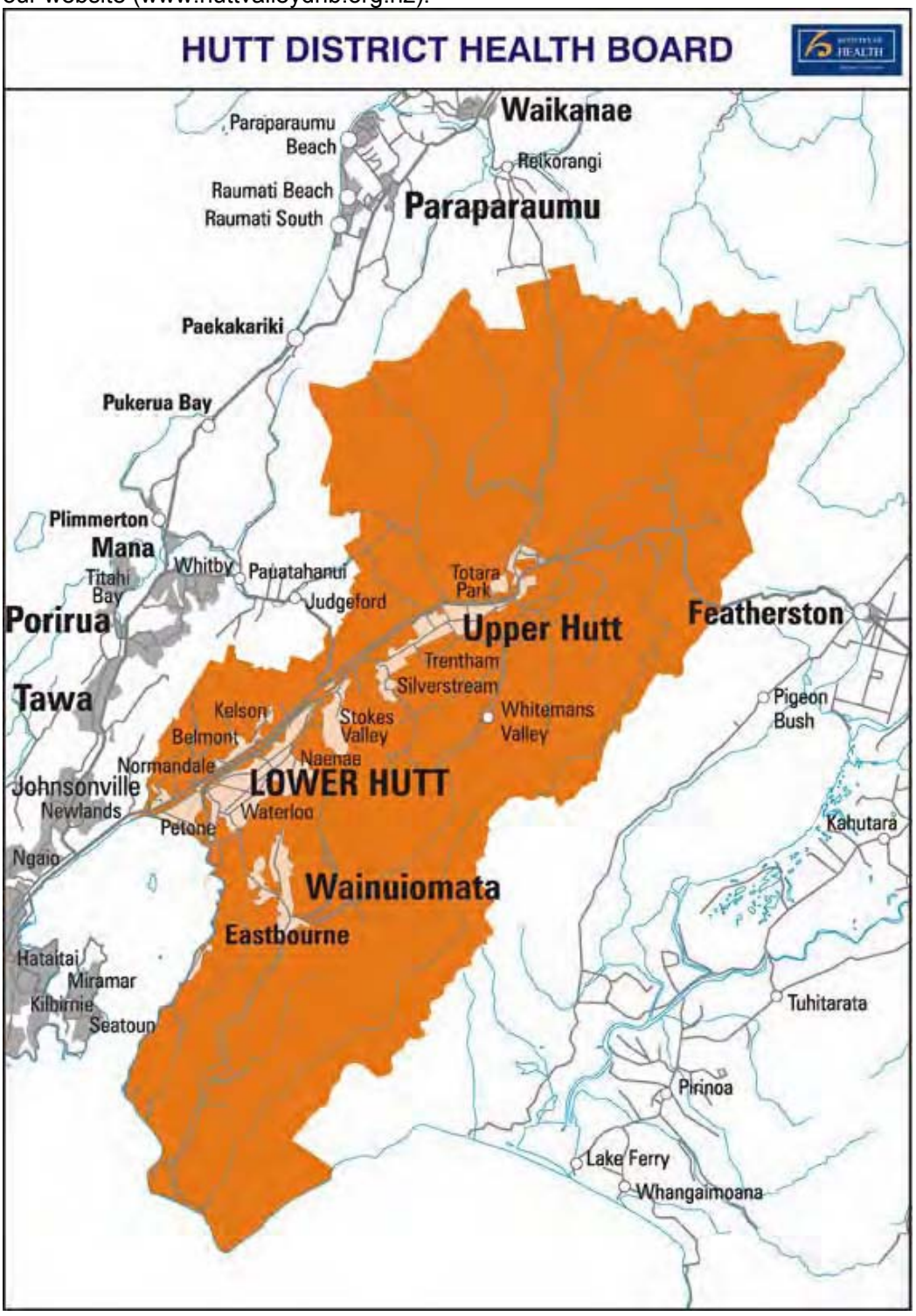
- Review access and utilisation of regional methadone, early intervention, personal psychotherapy and dual diagnosis services.
- Review our Information Systems Strategic Plan, including consideration of local and regional approaches to sharing of clinical and service information.
- Review the approaches and work programme of the shared services agency (TAS) to ensure relevance and efficiency of services delivered, in conjunction with other central region DHBs.
- Increase delivery of oncology outpatient services at Hutt Hospital. If there is insufficient progress, move towards the development of an oncology service at Hutt Hospital in 2008/09.
- Review Central region provision of renal dialysis and 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 2008/09.
- Work with other central region DHBs, and Capital and Coast DHB in particular, to improve access to and increase local delivery of urology services for the residents of Hutt Valley.
- Implement the regional five year mental health and addiction service plan.

We will follow the requirements of the Operational Policy Framework in relation to all service changes signalled.

It has been indicated by central government that some additional child and youth services are planned for implementation in 2007/08 (e.g. hearing tests for neonates, increased wellchild checks for preschoolers, child and adolescent mental 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 and health status information. More detail can be found within our District Strategic Plan[1] and additional information from our Health Needs Assessment can be found on our website (www.huttvalleydhb.org.nz).



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.

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 Māori and 8% are Pacific peoples. Fewer Māori and Pacific people (as a percentage of the population) live in Upper Hutt than Hutt City. More of the Māori and Pacific people who live here are younger than other ethnic groups - half of the Māori 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 2011. However, both Hutt Māori 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 137,000 in twenty years time. We will also have more older people and fewer young people living here in the future. By 2026, the percentages of Māori and Pacific peoples is expected to increase to around 21% and 10% respectively of the total Hutt population.

Hutt Valley Projected population 2007 by age and ethnicity

	# Māori	# Pacific	# Other	# Total	% Māori	% Pacific	% Other
Children 0-14 years	8,320	3,360	19,040	30,710	27%	11%	62%
Youth 15-24 years	4,090	1,910	13,380	19,380	21%	10%	69%
Adults 25-64 years	10,270	5,010	57,260	72,540	14%	7%	79%
Older People 65+	620	410	15,030	16,050	4%	3%	93%
Total	23,300	10,690	104,710	138,680	17%	8%	75%

Source: Statistics New Zealand

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 Māori, 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 Māori Health

We are committed to the Hutt Valley Māori Health Strategic Plan[2], Whanau Ora ki te Awakairangi, and to He Korowai Oranga[6], the national Māori health strategy. The current Hutt Valley Māori population is around 23,300 people, or 17 percent of the Hutt Valley population. The proportion of Māori in the Hutt Valley is slightly higher than the national average of 15 percent. By 2021 the Hutt Valley Māori population is projected to grow to around 28,400, or around 20 percent of the total Hutt Valley population.

Māori in the Hutt Valley have, on average, worse health than the wider Hutt Valley community. Cardiovascular disease (mainly ischaemic heart disease and stroke) account for around 40 percent of Hutt Valley Māori 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 Māori deaths respectively, these are concentrated in the 15-44 year age group. After age-standardising for differences in population structure, Hutt Valley Māori 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 Māori hospital admissions. Hutt Valley Māori 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+).

We developed our Māori Health Strategic Plan, Whanau Ora kit e Awakairangi, in partnership with the Te Awakairangi Hauora Board and the Māori community here in the Hutt Valley. The vision of Whanau Ora ki te Awakairangi is that Māori who live in Te Awakairangi are healthy, vibrant, contributors to the community (Te Ao Māori and New Zealand society) who can access support easily when needed.

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 is guiding development and informing decision-making around Pacific People Health in the Hutt Valley.

Approximately 10,700 Pacific people are resident in the Hutt Valley with a projected 28% increase over the next 20 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 Māori and non-Māori in the Hutt Valley. Around 60% of the Pacific population in Hutt Valley is Samoan, with the next biggest island groupings being Cook Island Māori 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 (hospital admissions that could be avoided by community based services) 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 youth. 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-cultures. 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 27,000 Hutt Valley residents with some form of disability and around 16,000 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 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 four 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, including people aged 65 years and older. 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.
- Māori and Pacific 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 Provision of Services

Hutt Hospital is a secondary level hospital, which provides some regional tertiary services such as rheumatology, plastics, burns and maxillofacial. In addition, Hutt Hospital provides emergency department, general medical, cardiology, orthopaedic, general surgical, paediatric, obstetrics & gynaecology, rehabilitation, mental health, and some primary maternity and community services.

6.4 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 2007/08.

6.4.1 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 2006/07?

Regional Public Health (RPH) works across three DHBs (Capital and Coast, Hutt Valley and Wairarapa) to initiate and support a wide range of programmes. Some of these are joint activities while others are specific to certain DHBs.

- We are helping to lead developments of the Hutt Housing Steering Group with Housing New Zealand Corporation. The group have developed an older person's healthy housing pilot which is providing retrofitting, minor house maintenance and health and social assessments to 100 low income elderly across the Valley.
- The Naenae Work and Income Pilot for serious skin infections has been evaluated and planning is underway expand the programme to other areas, including Wainuiomata. Health promotion capacity has been increased through work with Hutt Valley PHOs in the development of 'promoting healthy skin' actvities.
- A Health Impact Assessment on the Draft Regional Land Transport Strategy was completed. This provided a base for submissions by DHBs to advocate that more funding should be allocated to public transport, walking and cycling.
- We have helped lead the Living Well action area of the Wellington Regional Refugee Health and Wellbeing Action Plan and are part of the working group overseeing the whole project. Regional Public Health and the Wellington Community Interpreting Service are providing training for health professionals to improve communication with refugees.
- The Public Health Regional Steering Group are overseeing the development of a revised strategic plan for public health services in the greater Wellington region.

Nutrition and Physical Activity

- Following the success of a pilot garden programme in four Pacific early childhood centres in Wellington South, the project has been extended to three centres in Naenae - one kohanga reo, a Tokelaun language nest and a mixed language nest.
- We continue to support PHOs and schools to develop and run their own health promotion initiatives. We have worked alongside Valley PHO to implement the 'Hikoi.com Challenge'.
- The Rata Street School Breakfast Co-op is continuing to have strong sales and a short-term impact evaluation should be completed by June 2007.
- We worked with the Wellington Regional Recreation Initiatives Group on the development of the Wellington Urban Regional Physical Activity Strategy draft strategy (now renamed 'AT the Heart"). Our involvement has ensured that the wider determinants of health, barriers to access and participation by vulnerable groups and the Healthy Eating Healthy Action strategy have been incorporated.

Tobacco Control

- Smokefree promotion through the DHB, PHOs, schools, Pa Wars and World Smokefree day and Smokefree regulatory activity.
- The Smokefree DHB pilot project commenced in November in the Coronary Care Unit and Special Care Baby Units.
- Other smokefree policy successes include working with Marae from the Whanganui-A-Tara Rohe to become Tuturu Auahi Kore (Smokefree). Koraunui Marae in Stokes Valley celebrated one year celebration of being Tuturu Auahi-kore. Orongomai Marae has continued with its Tuturu Auahi Kore message and work continues towards Te Kakano o Te Aroha Marae attaining Tuturu Auahi Kore status.

Alcohol and other drugs

- Processing of new license licensing applications have all been within the timeframe set out in the Sale of Liquor Act and we supported the Police and the DLA to take three premises to the Liquor Licensing Authority (LLA).
- We worked with the Wellington Racing Club at the Trentham racecourse prior to the Wellington Cup Day to help in the preparation of a Host Responsibility Policy especially for Cup Day in response to problems at last year's meet. We also assisted St Bernard's and Taita Colleges to organise an alcohol-free after-ball partys.
- We contributed to Youth Access to Alcohol projects, controlled purchase operations and the Hutt Liquor Liaison Group.

What is planned for 2007/08?

A revised strategic plan for public health services in the greater Wellington region will be completed and implementation begun.

RPH will work with key agencies through specific projects to improve health outcomes and address the determinants of health. This will include contributions to a range of population health programmes that promote healthy lifestyles, including Healthy Eating Healthy Action – Oranga Kai Oranga Pumau strategies and cancer prevention programmes. This work will have an intersectoral focus and there are significant linkages with the next section on Intersectoral Collaboration.

We will work with the Ministry of Health to develop a tobacco control plan for the region. It is envisaged that this plan will:

- Identify priority groups.
- Outline current tobacco control activities.
- Consider current expenditure on tobacco control activities.
- Identify local initiatives to support the national promotion of smokefree homes and cars, reduce initiation among young people, and strengthen and enhance access to smoking cessation services.

RPH will also continue to provide health promotion and regulatory functions in the areas of tobacco control and alcohol misuse.

Annual Objective 1: Contribute to a range of population health programmes that promote healthy lifestyles, including Healthy Eating Healthy Action – Oranga Kai Oranga Pumau strategies and cancer prevention programmes.
Measures and Targets (see Appendix 7) Improve nutrition, increase physical activity and reduce obesity, Reduce the harm caused by tobacco, Physical Activity.

Approach 1.1: Implement Healthy Eating Healthy Action – Oranga Kai Oranga Pumau strategies in the Hutt Valley, including:

- Working intersectorally with relevant agencies and services including Kohanga Reo and Pacific Early Childhood Education Centres, schools, Kura and Marae.
- Supporting Primary Health Organisations.
- Support workplace activities such as 'Walk the Hutt'.
- Capacity building with Māori and Pacific providers and workforce.
- Work on strategies to increase the use of active modes of transport.

Milestones 1.1:

- Assessment of workplace health programme framework.
- Collaborate with National Heart Foundation on implementation of Ministry of Education's Food & Nutrition Guidelines for Early Childhood Education Centres and schools.
- Healthy Eating Healthy Action coordinator, Regional Public Health, Māori Health Service Development Group, Pacific Advisory Group, Pacific Provider Managers Forum, Māori and Pacific communities work together to develop and implement local activities.

Position Responsible 1.1: Team Leader Health Promotion.

Risks 1.1	**Mitigations 1.1**
Lack of buy-in from key stakeholders.	Establishing and strengthening sustainable partnerships.
Fluctuations in work force capacity.	Effective recruitment & retention of work force.

Approach 1.2: Reduce alcohol related harm among young people through the Youth Access to Alcohol Project (YATA) and Alcohol Controlled Purchase Operations and on-going collaboration with Police and District Licensing Agencies to address alcohol related harm associated with problem premises.

Milestones 1.2:

- Maintain Combined Enforcement Group meetings held with managers of problem premises to resolve issues.
- Complete inspections of problem premises to check compliance with the Sale of Liquor Act.
- Support schools requesting assistance with after-ball parties.
- Explore specific interventions that focus on a target audience of Māori and/or Pacific, including looking at linking with other Public Health teams to develop such a project.

Position Responsible 1.2: Team Leader Health Promotion.

Risks 1.2	**Mitigations 1.2**
Lack of buy-in from key stakeholders.	Proactive engagement with key stakeholders to achieve common goals and proactive support from the DHB to work with key stakeholders to achieve common goals.

Approach 1.3: Continue Tobacco control work, including:

- Implementation and enforcement of the Smoke Free Environments Act 1990.
- Continue Smokefree DHB/Systems first project.
- Maintain wider health promotion with local community organisations, marae, schools, clubs and PHOs.

Milestones 1.3:

- Develop and begin a retailer compliance project for the Hutt Valley under the Smokefree Environments Act 1990.
- Complete the Smokefree DHBs pilots in the Coronary Care and Special Care Baby Units and use results to develop wider implementation.
- Increase tobacco control through enhanced community and agency relationships supporting specific initiatives e.g. World Smokefree Day, Pa Wars, Te Ra.
- Maintain Auahi Kore support for local marae and referrals for local Aukati Kai Paipa services.
- Explore the feasibility of working with PHOs on developing tobacco control programmes for their enrolled health services.

Position Responsible 1.3: Team Leader Health Promotion.

Risks 1.3	**Mitigations 1.3**
Lack of buy in from key stakeholders.	Proactive engagement with key stakeholders to achieve common goals. Proactive support from the DHB to work with key stakeholders to achieve common goals.

6.4.2 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 is a direct demonstration of the key DSP strategy, working with other agencies.

What progress was made in 2006/07?

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). Progress has been made in addressing each of the three agreed priorities:

Children and youth

Hutt Valley DHB personnel serve on the strategic steering group of the Youth Transition Service (YTS) for the Hutt Valley, funded by the Ministry of Social Development (MSD) with the contract managed by Upper Hutt City Council and Hutt City Council.

Hutt Valley DHB has continued 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. In addition to the ten schools supported in 2006, a further seven will be eligible to receive small grants to cover start-up activities in 2007.

We have also employed a family violence prevention coordinator, who will be working with multiple agencies, community organisations and DHB staff throughout the valley to develop practical strategies for reducing family violence, especially the impact on children.

Physical activity

The MoU partners have identified synergies in their efforts to promote walking and cycling strategies, travel planning for schools and workplaces, and the Healthy Eating Healthy Action – Oranga Kai Oranga Pumau programme. We have employed a Healthy Eating Healthy Action – Oranga Kai Oranga Pumau (HEHA) Programme Manager who will co-ordinate the development of a local HEHA plan in collaboration. The DHB and RPH assisted in the development of the Upper Hutt Active Recreation Programme (UHARP) launched in February 2007. RPH also facilitate the Physical Activity and Nutrition Network Group.

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 advocating for better route planning and greater integration of transport services so that Hutt Valley people can more easily reach services at Hutt, Wellington and Kenepuru hospitals.

Deprived areas

Hutt Valley DHB is supporting the rollout of the Pomare access project, including the establishment of a new building to house health and related services which is expected to be in place by the end of 2006/07. DHB staff continue to support the Naenae rejuvenation programme focus on youth.

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 Valley DHB, Regional Public Health, Hutt Mana Charitable Trust, Piki Te Ora PHO, Mid-Valley PHO, 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 Accident Compensation Corporation, Te Puni Kokiri, Pacific Health Service Hutt Valley, Tu Kotahi Māori Asthma Trust and the Ministry of Social Development. The focus for the group has been information sharing, collaboration and the development of several housing projects over the past few years.

Progress on housing projects included the Kokiri Marae Retrofitting project, the Upper Hutt Healthy Homes Project, the Otago University Health and Heating project and a Healthy Homes Healthy People pilot targeted to older people.

Working with the Ministry of Social Development (MSD)
In 2006/07, we have explored opportunities to assist sickness and invalid clients into employment with the support of targeted healthcare. Work is now underway to establish a PATHS (Providing Access to Health Solutions) programme in the Hutt Valley.

Healthy Eating Healthy Action - Oranga Kai Oranga Pumau
A Hutt Valley DHB Ministry Approved Plan (MAP) for Healthy Eating Healthy Action – Oranga Kai Oranga Pumau (HEHA) is being developed for implementation in 2007/08. The MAP is an intersectoral process planning tool to assist in identifying how the DHB will go about planning and developing its own HEHA Strategy. Progress to date has involved engaging with a number of key stakeholders within the DHB, public health, inter-agency groups, education sector, councils, health and community based provider services, PHOs and the wider community sector. A stocktake of all HEHA related activities is underway which will support the ongoing work around identifying what is currently in place and what gaps exist within services, workforce and resources.

Two key stakeholder groups are being established to support the 2007/08 priorities of the MAP for HVDHB. These groups are the HEHA Intersectoral Steering Group and the Education Sub-Group. The Steering group will provide for the planning, prioritising, funding and monitoring of HEHA, with representation expected to include the Ministry of Education, School Support Services Management, DHB Provider Services, HVDHB Advisory Roles, Hutt and Upper Hutt City Councils, the Māori Health Service Development Group, Regional Public Health, Regional Sports Trusts, PHO and NGO groups. The Education Sub-group will focus specifically on the needs of the education sector with similar agency/stakeholder representation on it but involving specific personnel working within education environments.

What is planned for 2007/08?
We will implement our Healthy Eating Healthy Action-Oranga Kai Oranga Pumau plan and enhance efforts with schools and early childhood centres, including the language and culturally specific needs of Te Kohanga Reo, Pacific Language Nests, Kura Kaupapa Māori and Whare Kura. The priorities within the 2007/08 year for HEHA is to focus on;

- Establishing relationships.
- Stocktake and needs analysis.
- The establishment of supportive processes for the implementation of HEHA.

We will engage with our communities in 2007/08, focusing on those sectors of the community identified as priority groups i.e. Māori, Pacific and areas of the community with low income status, as well as groups with specific needs, such as people with disabilities, mental health consumers and refugee/new migrant communities.

The stocktake and needs analysis will be an ongoing part of HEHA implementation to assist in identifying gaps, needs and issues. It will allow monitoring of HEHA initiatives currently in place as well as looking at areas for future development. Breastfeeding, schools, early childhood centres, workforce capability and capacity, and Māori and Pacific needs have been identified as key priorities. Other areas for development in 2007/08 include:

- Lower socio-economic groups, children, young persons and their whanau.
- Environments.
- Primary and secondary health care settings.

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 intend to work with Hutt City Council, Upper Hutt City Council, SPARC and Wellington region Sports Trusts to be part of a "no exceptions" recreational district.

Our work towards reducing family violence will have an initial focus on families with children. A Family Violence prevention co-ordinator has been employed. The aim is to work with the DHB community and the Provider Arm to improve awareness and increase intersectoral collaboration.

We will support youth through participation in the steering group for the Youth Transition service and other projects.

We will expand our efforts to reduce ill health through improved housing. If the evaluation shows the Healthy Homes Healthy People pilot to be successful, the project will be rolled out to more low-income households in 2007/08, subject to available funding. In addition, Housing New Zealand Corporation has indicated that the Hutt Valley, specifically Naenae and Taita, are being considered as the next site for its Healthy Housing Programme. This programme is a joint initiative between the Corporation and District Health Boards that focuses on reducing the risk of diseases associated with overcrowding such as respiratory diseases, cellulitis, meningococcal disease, rheumatic fever and tuberculosis. It aims to generally improve housing conditions within HNZC properties in a defined area. If approved, several hundred Hutt Valley households are expected to be included in the programme, which would run over a three year period.

We will continue to develop joint activities with the Ministry of Social Development (MSD). The first major initiative will be implementation of a PATHS programme operating in the Hutt Valley from early in 2007/08 to assist MSD clients into employment.

Annual Objective 2: 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)
Improve nutrition, increase physical activity and reduce obesity, Reduce the harm caused by tobacco, Physical Activity, Planning and Implementing Family Violence Intervention.

Approach 2.1: Improving coordination and collaboration across agencies to support children by:

- Working with other agencies and community organisations to reduce family violence, with a focus on improving our joint response for children in risky situations.
- Continue to work with key stakeholders (e.g. PHOs, Work and Income, low decile schools) to promote healthy skin, improve access to preventatives and medications, and reduce medical care required for skin infections.
- Working with key officials in local schools to progress:
  - Further enrolment in health promoting schools.
  - Implementation of the Healthy Eating Healthy Action – Oranga Kai Oranga Pumau programme.
- See also Child and Youth section, Oral Health section, and Healthy Eating Healthy Action – Oranga Kai Oranga Pumau work with children and youth in Public Health and Māori Health sections.

Milestones 2.1:

- Hutt Valley DHB participating in formal agreement (MoU) and work programme to address family violence, in conjunction with CYFS, Police, and other agencies.
- Families able to access needed items for preventing skin infections.
- Low decile schools implement policy and practices which promote healthy skin.
- Annual meetings with primary school principals to enhance collaboration and participation.

Position Responsible 2.1: Intersectoral Relations Manager and Service Manager Regional Public Health.

Risks 2.1	**Mitigations 2.1**
Schools do not see value in interacting with DHB.	Ensure approach is supported by key stakeholders in schools.
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 on family violence.	Signal early to prepare for change with CYFS, Police, MSD, Ministry of Education and community organisations.

Approach 2.2: Improving coordination and collaboration across agencies to support youth by:

- Supporting the Youth Transition Service to increase its capacity and capability over the next 12 months.
- Establishing a Youth Health Reference Group to advise on planning, development and funding of services for youth.
- Working with key officials in local schools to progress:
  - Further enrolment in health promoting schools.
  - Implementation of the Healthy Eating Healthy Action – Oranga Kai Oranga Pumau programme.
- See also Child and Youth section, Oral Health section, and Healthy Eating Healthy Action – Oranga Kai Oranga Pumau work with children and youth in Public Health and Māori Health sections.

Milestones 2.2:

- DHB membership on youth transition steering group regularly reports to Board.
- Revised Youth Health plan prepared with strong youth engagement.
- Annual meetings with secondary school principals to enhance collaboration and participation.

Position Responsible 2.2: Intersectoral Relations Manager and Service Manager Regional Public Health.

Risks 2.2	**Mitigations 2.2**
Schools do not see value in interacting with DHB.	Ensure approach is supported by key stakeholders in schools.
Methods of engaging with young people are ineffective.	Use multiple methods, and community networks to reach young people.

Approach 2.3: 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, e.g. PATHS.
- Continuing to work with Hutt Housing Steering Group on housing and health projects.
- Work with councils to ensure their long term community outcomes address the determinants of health including using Health Impact Assessment in the early stages of policy development.
- Monitoring progress of the Pomare access and Naenae rejuvenation programmes.
- Implementing the Wellington Regional Refugee Health and Wellbeing Action Plan and the six action areas of community capacity building, living well, economic wellbeing, safety and security, knowledge and skills, and housing.
- Participate in national initiatives to improve the health of prisoners, acknowledging resource constraints.

Milestones 2.3:

- Hutt Valley DHB participating in PATHS programme.
- Housing programmes providing regular consolidated reports on retrofitting and other initiatives.
- Implementation of the Refugee Health and Wellbeing Action Plan and 6 action areas.
- Scope future opportunity for working more closely with key stakeholders (including corrections, health services in prisons, community social and clinical support agencies) to enable the successful reintegration of prisoners in our area.
- Build effective working relationships with communities, key planners and policy makers in local government.
- Participate in Hutt Valley intersectoral Pacific steering group lead by Hutt City Council.

Position Responsible 2.3: Intersectoral Relations Manager and Service Manager Regional Public Health.

Risks 2.3	**Mitigations 2.3**
Lack of resource.	Alert early and delay if necessary.
Housing New Zealand Corporation do not receive approval to establish Healthy Housing Programme.	Review local retrofitting activities.

Approach 2.4: Improving coordination and collaboration across agencies to support physical activity by:

- Work alongside councils to promote activities led by their agencies, e.g. Upper Hutt Active Recreation Programme (UHARP), the bridge to bridge walks.
- Work with RPH, councils and schools to progress walking and cycling programmes.
- See also Healthy Eating Healthy Action – Oranga Kai Oranga Pumau work with children and youth in Public Health and Māori Health sections.

Milestones 2.4:

- Healthy Eating Healthy Action – Oranga Kai Oranga Pumau programme is strongly linked to the Upper Hutt Active Recreation Programme (UHARP).

Position Responsible 2.4: Intersectoral Relations Manager and Service Manager Regional Public Health.

Risks 2.4	**Mitigations 2.4**
Lack of resource.	Alert early and delay if necessary.

6.4.3 DHB Collaboration

What does the DSP say and other key directives?
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 2006/07?
Regional and national collaboration
In 2006/07, 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, completing a review of cardiology services and addressing immediate issues in electrophysiology services. Planning and Funding General Managers and Chief Operating Officers are meeting regularly to consider the scope, size and delivery methods of secondary and tertiary services over the next few years.

What is planned for 2007/08?
In 2007/08, we will continue our regional collaboration, working closely with the other central region DHBs 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 implementation of the reviews of plastics and burns services and of cardiology services. We will continue work on strategies to ensure sustainability in cardiology, cancer and renal services within the financial parameters of the six District Health Boards.

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.

See also section 6.4.20 Information Services for collaborative regional initiatives in the areas of laboratory results, RIS/PACS and dental services.

Annual Objective 3: Working collaboratively with other DHBs and health agencies to ensure sustainability and efficiency in service delivery.
Measures and Targets Six monthly update and progress report to DHB Board.

Approach 3.1: Continue participation in national activities through DHBNZ and the Ministry of Health.

Milestones 3.1:

- 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 3.1: Director, Planning, Funding and Public Health.

Risks 3.1	**Mitigations 3.1**
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 3.2: Collaboration by central region DHBs for improved service delivery and greater efficiency.

Milestones 3.2:

- Implement first year of regional service plan for mental health.
- Implement the agreed regional approach for the plastics, burns and maxillofacial service.
- Implement the agreed regional approach for cardiology services.
- Implement the Regional Cancer Network in line with the NZ Cancer Control strategy.
- Undertake a regional review of renal services.
- Undertake agreed regional procurement initiatives.
- Participate in other agreed regional projects.

Position Responsible 3.2: Regional General Managers, Planning and Funding.

Risks 3.2	**Mitigations 3.2**
Insufficient capacity in DHBs to progress regional projects.	Prioritise regional work in work plans.

Approach 3.3: Review the approaches and work programme of the shared services agency (TAS) to ensure relevance and efficiency of services delivered.

Milestones 3.3:

- Review undertaken.
- Work programme revised and new framework agreed for 2008/09.
- Health needs assessment prepared for regional DHBs.
- Regional quality and audit programme maintained.

Position Responsible 3.3: Regional General Managers, Planning and Funding.

Risks 3.3	**Mitigations 3.3**
Conflicting priorities mean that TAS cannot accommodate new directions.	Ensure that Chief Executive Officers and General Managers have agreed on the purpose and processes of the TAS review before starting.

6.4.4 Primary Health Care

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 2006/07?

- We worked with PHOs to increase Care Plus uptake levels and to build the sustainability of their Care Plus programmes.
- We supported two PHOs with their primary mental health service pilots.
- We worked with PHOs to ensure after hours arrangements that were put in place during 2005/06 continued.
- DHB management, hospital clinicians and various primary care representatives met to look at cardiovascular disease and how primary and secondary care might better co-ordinate their identification and management of people with cardiovascular disease.
- We supported the PHOs and the valley-wide primary health support agency, Kowhai Health Trust (KHT), to begin exploring what cardiovascular and diabetes risk assessment tool is preferred by all parties, with a view to a common tool being adopted within the Hutt Valley.
- A working group has been established involving DHB management, KHT, hospital respiratory services and Tu Kotahi Māori Asthma Trust which began exploring opportunities for better collaboration in relation to the management of people with asthma.
- By 1 January 2007, all six PHO had entered the PHO Performance Management Programme.
- We reviewed and agreed PHO Business Plans in accordance with their different business cycles.
- We continued to host a PHO Forum which provides an opportunity for people to share ideas, discuss spending priorities and new service developments.
- We supported one of our access PHOs, Piki te Ora ki te Awakairangi, to gain access to the additional "very low cost access funding" from 1 October 2006.
- We supported four applications for additional nurse capacity from primary care providers as part of the 2007 Primary Graduate Nursing Programme which the DHB partly funds.

In December 2006, Hutt Valley DHB hosted a workshop with all PHOs and Hutt Hospital based providers to discuss what they considered the priorities for primary health care should be in 2007/08. This workshop gave PHOs the opportunity to influence our planning, and as a result four key directions were identified for primary care which all PHOs supported and which feature in this DAP:

- Health promotion.
- Chronic disease management.
- Workforce development.
- Information systems.

PHOs then had the opportunity to comment on the draft primary care section of our DAP, and as a result, various amendments were made to better align it with PHO activity. As a result of this workshop, PHOs undertook to align activities they might describe in their yet-to-be developed 2007/08 Business Plans with the direction outlined in this document. We have yet to receive and review PHO Business Plans for 2007/08.

What is planned for 2007/08?
The DHB will continue to work closely with the six PHOs in the Hutt Valley (i.e. Piki te Ora ki Te Awakairangi, Mid Valley Access PHO, Valley PHO, Ropata Community PHO, Tamaiti Whangai PHO, and Family Care PHO) to progress implementation of the Primary Health Care Strategy. This includes exploring what scope there is for further collaboration in the following areas:

- Health promotion.
- Chronic disease management.
- Workforce development.
- Information systems.

We will continue to work with PHOs to align and co-ordinate our respective business planning processes and service development activities that form part of these plans. The DHB will also continue to monitor PHOs to ensure they are making a positive difference to the communities they serve, and that they are demonstrating value for money. This will include monitoring information from the PHO Performance Monitoring Programme, PHO Care Plus uptake levels, and monitoring PHO fee levels. Where proposed fee increases are above reasonable levels, the DHB will refer these to the regional fees review committee process.

Hutt Valley DHB currently does not have the funding to incentivise PHOs and/or practices to make primary health care for under sixes free. Without the incentive of additional funding for under sixes, we do not have sufficient leverage to encourage practices to make care for under sixes free. Should additional funding become available for this purpose, we will actively encourage primary health care to make services for under sixes free.

The trust deeds of each PHO specify the number of community representatives, Māori and Pacific representatives required on each PHO at a governance level. Several of the PHOs have also formed services committees. These are responsible for considering how Services to Improve Access funding and Health Promotion funding might be allocated on behalf of the PHO's enrolled population. As well as including community, Māori and Pacific representatives from the PHO Boards, the service committees can also include other community representatives as part of the decision making process.

In 2007/08 we will explore the level of interest amongst PHOs for larger primary health care fora, involving representatives from Hutt Valley DHB, as well as from PHO Boards, PHO management, provider members, and PHO services committees as an opportunity for improved information sharing and relationship building on issues such as workforce, health disparities and chronic care.

We will also be hosting fono and hui in 2007/08 to enhance understanding between community and health sector leaders. For instance, the bi-annual Pasifika Health Forum which Hutt Valley DHB hosts will bring together Pacific providers, Pacific PHO representatives, Pacific advisory groups, and hospital based teams focusing on Pacific health to explore opportunities for contributing positively to Pacific Health.

Annual Objective 4: We will progress implementation of the Primary Health Care Strategy by focusing on the following areas: health promotion; chronic disease management; workforce development; and information systems.

Measures and Targets (see Appendix 7)
Reducing ambulatory sensitive (avoidable) admissions, Primary Health, Workforce, POP-09, SER-01, SER-02, SER-03, SER-07, District After-Hours Strategic Plan, Primary Care.

Approach 4.1: RPH will explore a common approach to health promotion activities with all six PHOs, in areas such as:

- Healthy Eating Healthy Action – Oranga Kai Oranga Pumau (HEHA).
- Other activity directed at preventing the development of chronic conditions.
- Working closely with schools and children to get across the HEHA messages.

In determining where to focus our collective efforts, consideration will be given to those groups at greatest risk of ill health (e.g. Māori, Pacific and people living in more deprived areas).

Milestones 4.1:

- Establish regular meetings between RPH and the PHOs to discuss proposed health promotion activities.
- Where there are opportunities to collaborate on health promotion activities, PHOs realign how they allocate Health Promotion funding as part of their respective business planning exercises.

Position Responsible 4.1: Service Manager Regional Public Health, Senior Portfolio Manager Planning and Funding and PHO Managers.

Risks 4.1	**Mitigations 4.1**
Some PHOs do not want to participate in collective health promotion activity.	PHOs have the autonomy to determine how they allocate their health promotion spending that best meets the needs of their enrolled populations. However, through the regular meetings between PHOs and RPH, there is potential for a common approach to develop.
It takes time for PHOs to reconfigure health promotion spending to support a common approach.	PHOs reallocate health promotion spending, as they are able and as they consider appropriate.

Approach 4.2: Continue working together to improve the management of people with chronic conditions within primary and secondary care, with a focus on those in high need (e.g. Māori, Pacific and people living in more deprived areas).

Milestones 4.2:

- PHOs reach agreement on their preferred cardiovascular and diabetes risk assessment tool(s) and start to adopt the preferred risk assessment tool(s) for early identification and management of cardiovascular and diabetes patients.
- Encourage PHOs to give priority to Health Promotion and Services to Improve Access initiatives that contribute to the management of people with chronic conditions and to increase Care Plus uptake levels.
- The DHB Provider Arm (in particular cardiology, diabetes, respiratory and cancer services), PHOs and primary care providers work more closely together to improve service integration for patients, including:
  - When patients enter and exit the care of Provider Arm services.
  - The DHB and community-based providers will work together to support discharge of chronic care patients back into the community (e.g. outreach services, community nursing and home support).
  - Jointly exploring how Provider Arm services might be able to support PHOs manage their Care Plus clients (e.g. a shared visit involving clinicians from both primary and secondary care).
  - What education the DHB and Primary Care may be able to offer each other to increase their capacity to manage people with chronic conditions in the community.
  - Investigating whether it is possible to expand general practice access to Concerto so that they can review the treatment their enrolled patients have received whilst in hospital.
- Support and improve integration and access between secondary and primary mental health services with the development of a primary mental health liaison position.

Position Responsible 4.2: Portfolio Managers Planning and Funding, Service Manager Acute and Chronic Care, PHOs Managers, Kowhai Health Trust CEO, Chief Information Officer.

Risks 4.2	**Mitigations 4.2**
PHOs adopt different cardiovascular and diabetes risk assessment tools.	Whilst a common risk assessment tool would ensure a consistent approach across PHOs cardiovascular and diabetes screening and intervention programmes, this is considered of secondary importance to ensuring that each PHO has a risk assessment tool that it is willing to use.
PHOs and the Provider Arm have different views on how chronic care services can be better co-ordinated.	The parties work together to understand their respective areas of responsibility and expertise in the chronic care patient journey.
PHOs fail to increase Care Plus uptake levels.	The DHB and PHOs work together to explore opportunities for increasing Care Plus uptake.

Approach 4.3: Assist primary care to develop its workforce through a number of measures.

Milestones 4.3:

- Work with primary care and the Provider Arm to establish the most appropriate mechanisms for GP and nursing liaison.
- Research the likely future supply of General Practitioners and Practice Nurses in the Hutt Valley jointly with primary care.

Position Responsible 4.3: Senior Portfolio Manager, Planning and Funding.

Risks 4.3	Mitigations 4.3
These various workforce strategies either do not ease the pressure on the primary health care workforce or are not supported by primary care.	Actively engage with primary health care providers to ensure that workforce strategies that the DHB is pursuing have their support and are likely to have a positive impact on the primary care workforce. The DHB will invite PHOs to be represented on the DHB's Workforce Steering Group.

Approach 4.4: Encourage information system developments that enable relevant patient information to be shared between clinical staff in primary and secondary care in a timely way to support good decision making, efficient service delivery and effective patient outcomes. See also Information Services section.	
Milestones 4.4 • Continue to support electronic referral management for GPs referring patients to secondary care services. • Investigate the possibility of general practice having access to Concerto. • Ensure general practices receive timely delivery of outpatient letters and advice about changes in waiting list/referral status.	
Position Responsible 4.4: Chief Information Officer.	
Risks 4.4	**Mitigations 4.4**
New business processes required by general practice and hospital support services.	Early involvement by GPs with a key interest in information technology who can pilot, and potentially champion, new developments.

6.4.5 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	2006/07 Volumes	2007/08 Volumes	Variance %
Medical in-patient	Caseweights	6,923	7,037	2%
Surgical in-patient	Caseweights	9,533	9,699	2%
Medical out-patient	Attendances/Procedures	28,245	28,939	2%
Surgical out-patient	Attendances/Procedures	36,295	41,100	13%
Mental health	FTE/Bed days	13,010	13,010	0%
Emergency department	Attendances	36,092	37,116	3%
Maternity	Attendances/Procedures	5,710	5,694	0%
Disability Support Services	FTE/Bed days	13,126	14,853	13%
Personal/Community Health		160,444	164,568	3%
Total		**309,377**	**322,017**	**4%**

We will submit our plan for phase two (funding for 2007/08) of the additional elective service funding by May 2007. This plan will include additional case-weighted volumes and outpatient attendances to the above table.

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 remains a key strategy for this year. We need to continue to focus on addressing acute demand problems and to identify process improvements.

What progress was made in 2006/07?

- Further development of the electronic referral system.
- The delirium/dementia nurse has been working between the hospital and the community to support these patients.
- Nursing initiatives have been piloted and planed to continue include; Emergency Department 'sift and sort' pilot and the Critical Care Outreach Nurse and community health 'community discharge liaison nurse).
- The Emergency Department/mental health self-harm collaboration has been progressing well and changes are already noted in the system and by patients.

What is planned for 2007/08?

- Keep people well in the community by supporting them after discharge and providing early intervention for those otherwise likely to need hospital care.
- Critical Care Outreach Nurse role to support deteriorating patients after-hours, to develop the EWS (early warning score) to identify critically ill and deteriorating patients, to support 1:1 clinical education for junior staff (medical and nursing).
- Development of a patient flow initiative to address continuity of care, medical length of stay and to enable timely and supported discharge.
- Community discharge liaison nurse role to support frail medical patient discharge.
- See also Elective Services section for the development of Patient Focused Booking (PFB) for outpatient appointments in three specialities.
- See also the Mental Health service section for implementation of the psycho-geriatric review.

Annual Objective 5: Improve the management of acute inpatient demand.
Measures and Targets (see Appendix 7) Hospital Performance, HKO-03, Hospital Benchmarking Information reporting.

Approach 5.1: Patient flow initiatives to address the acute medical patient length of stay, within existing resources.	
Milestones 5.1: • The business plan for increased Intensive Care Unit bed capacity (including acute dialysis) is completed. • Community discharge liaison nurse supports early discharge of non-acute medical patients. • Investigate the provision of Computerised Tomography Angiography at Hutt Hospital. • The development of a dedicated stroke area and multidisciplinary team within the medical ward is implemented. • Initiatives identified by the Medical ward focus group are progressed, initially by developing a project plan. • Patient flow workgroup identifies initiatives that continue to address patient flow issues during the 2007/08 period and initiatives implemented as resources and funding allow.	
Position Responsible 5.1: Service Manager, Acute and Chronic Care.	
Risks 5.1	**Mitigations 5.1**
Lack of clinical staff buy-in to the need to change.	Involve clinical staff in all developments and planning.
Project timeframes slip due to pressure of acute demand.	Schedule regular project meetings to maintain momentum

Approach 5.2: Improve the elective/acute patient management process to ensure we have the capacity to manage the demands.
Milestones 5.2: • Improve and develop systems for elective patient journeys from first specialist assessment through surgery and discharge. • Pilot Patient Focused Booking (PFB) in three specialities. • Explore more dedicated acute theatre time to manage acute surgery in a timely manner. • Improve the management of the acute/elective patient balance, including criteria for access to theatre. • Develop ultrasound scanning for rheumatology patients, to avoid multiple appointments.

Position Responsible 5.2: Service Manager, Acute and Chronic Care and Service Manager, Elective Care.	
Risks 5.2	**Mitigations 5.2**
Resistance to change.	Communication with and involvement of staff.
Project timeframes slip due to pressure of acute demand.	Schedule regular project meetings to maintain momentum.

Approach 5.3: Improve supported care in the community	
Milestones 5.3: • Community discharge liaison nurse supports early discharge of non-acute medical patients. • Provide effective and efficient allied health services to the community by establishing specialist allied health led clinics. • Further development of the Specialist Rehabilitation community team with an emphasis on early intervention and supported discharge from hospital by establishing geriatrician supported GP liaison groups and rest home liaison.	
Position Responsible 5.3: Service Manager, Acute and Chronic Care and Service Manager - Rehabilitation, Older Persons and Allied Health.	
Risks 5.3	**Mitigations 5.3**
Staff Flexibility / Resistance to Change.	Communication with and involvement of staff.
Project timeframes slip due to pressure of acute demand.	Schedule regular project meetings to maintain momentum.

6.4.6 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 2006/07?

- The Diabetes Specialist Outreach Service (DSOS) continues to support primary care practices in delivering best practice diabetes management.
- Youth specific clinics established in partnership with the Hutt Valley Youth Health Service (VIBE) NGO and a family counsellor employed.
- Pacific specific service has increased Pacific people access to diabetes service and utilises church based care delivery and Pacific radio.
- Primary care practices are participating in staff training programmes about diabetes – all practices have a nominated practice nurse (PN) who has identified diabetes management skill set.
- Diabetes Outreach Service (DOS) established through Kokiri provider based on their very successful model of Outreach Immunisation Service.
- Consultation with Māori and Pacific communities about their satisfaction of the strategies that are in place to increase their access to diabetes services completed.
- PHOs agreed on diabetes Get Checked data to be collated through a central IT server for the Hutt Valley DHB through Kowhai Health Trust management agency.
- Primary care nurses have been trained in respiratory management and patient education sessions are provided free to at-risk patients.
- Arising from the Emergency Department 2005/06 asthma presentations audit, successful implementation of an improved process pathway.
- Funded new service through Tu Kotahi Māori Asthma Society to provide respiratory support services for Māori tamariki and rangatahi aged 0 to 14 years following hospitalisation.

What is planned for 2007/08?

- We will continue to work to decrease the incidence and impact of diabetes, cardiovascular and respiratory disease to:
  - Improve the primary and secondary interface for diabetes patients.
  - Improve the primary and secondary interface for cardiovascular patients.
  - Deliver respiratory services closer to the community.
- Implement aspects of the regional cardiology review, within available resources.
- Improve value for money in the delivery of renal dialysis services.
- Continue our focus on prevention to reduce causes of chronic disease such as smoking, obesity and alcohol misuse (see also Public Health section).
- Continue to implement Healthy Eating Healthy Action – Oranga Kai Oranga Pumau (see also Primary Health Care and Public Health sections).

- 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 their chronic conditions (see also Primary Health Care section).
- Continue to implement the New Zealand Cancer Control Strategy (see also Cancer and Palliative Care section).

Annual Objective 6: Decrease the incidence and impact of diabetes, cardiovascular and respiratory disease.
Measures and Targets (see Appendix 7) Improving diabetes services, Diabetes, POP-01, POP-02, POP-03, Diabetes Self Evaluation.

Approach 6.1: Improve the primary and secondary interface for diabetes patients, with a particular focus on meeting the needs of Māori and Pacific people to: • Increase the primary care focus of the Provider Arm diabetes service and support the development of the primary care diabetes clinics. • Review achievements through the Kokiri Diabetes Outreach Service (DOS), to improve Māori and Pacific uptake of diabetes review and other support programmes. • Develop a partnership developed between the Māori Disease State Management (DSM) nurses involving the Provider Arm diabetes service and a local provider to manage diabetes within the community.
Milestones 6.1: • Review of the Kokiri Outreach Diabetes Service completed. • Partnership developed between the Provider Arm diabetes service and local provider. • Continue to use diabetes Get Checked data to monitor uptake and patient management.
Position Responsible 6.1: Service Manager Acute and Chronic Care, Portfolio Manager Planning & Funding.

Risks 6.1	**Mitigations 6.1**
Secondary clinical staff lack confidence to discharge patients to primary care.	Continue to build relationships between primary and secondary providers.
Capacity of primary care to manage numbers of patients with diabetes.	Work closely with primary care to better understand their resource constraints.
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.
Review of DOS delayed by other pressures.	Early agreement on scope of review and those involved.
Difficult to achieve agreement on development of a partnership model.	Early engagement with all stakeholders.

Approach 6.2: Improve the primary and secondary interface for cardiovascular patients, with a particular focus on meeting the needs of Māori and Pacific people.
Milestones 6.2: • Review the rehabilitation/heart failure programme structure and integration with primary care. • Increase collaboration between cardiology services and primary care. • The DHB and primary care work together to identify a preferred cardiovascular risk assessment tool that could be used by general practices in the Hutt Valley.
Position Responsible 6.2: Service Manager Acute and Chronic Care, Portfolio Manager Planning & Funding.

Risks 6.2	Mitigations 6.2
Insufficient buy-in from primary and secondary care to work more closely together.	Early engagement between primary and secondary care in model development.
Capacity of primary care to manage numbers of patients with cardiovascular disease.	Work closely with primary care to understand resource constraints.
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 6.3: Deliver respiratory services closer to the community.

Milestones 6.3:

- Review respiratory admissions, current service delivery and the impact of preventative measures such as Healthy Housing.
- Improve liaison between PHO outreach and practice nurses and the hospital respiratory team, including opportunities for supported follow-up education post admission.
- Review the respiratory education provided to practice nurses.
- Explore opportunities for developing a Respiratory Specialist Outreach Service to support primary care practices including the possibility of locating respiratory services in Pomare on an outreach basis.
- Explore opportunities for targeting improved spirometry services for people with respiratory disease, targeting those over 35 who are smokers.
- Subject to capacity, explore the possibility of developing a hospital at home service for chronic obstructive pulmonary disease (COPD) patients. This service would be designed to address the length of stay of COPD patients in hospital and provide supportive early discharge for those patients.

Position Responsible 6.3:
Service Manager Acute and Chronic Care, Portfolio Manager Planning & Funding.

Risks 6.3	Mitigations 6.3
Lack of buy-in from at-risk and key stakeholders.	Early consultation to develop service model. Explore whether the outreach model used by DSOS could fit with outreach respiratory services.

Approach 6.4: Implement aspects of the regional cardiology review.

Milestones 6.4:

- Investigate and, if appropriate, commence Computerised Tomography Angiography, a new Hutt Valley DHB provided service that will increase capacity for the region.

Position Responsible 6.4
Service Manager Acute and Chronic Care.

Risks 6.4	Mitigations 6.4
Lack of buy-in from at-risk and key stakeholders.	Early consultation to develop service model.

Approach 6.5: Improve value for money in the delivery of renal dialysis services.

Milestones 6.5:

- Participate in national discussions on access criteria for any service rationing of renal dialysis services.
- Regional service configuration agreed with scope of capital, workforce and funding implications.

Position Responsible 6.5: Service Manager Acute and Chronic Care, Portfolio Manager Planning & Funding.	
Risks 6.5	**Mitigations 6.5**
Analysis not completed for agreement decision of service model.	Maintain participation in service planning group.

6.4.7 Elective Services

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 2006/07?

- Significant progress was made in working towards the Government's electives objectives.
- Compliance with all Elective Services Patient Flow Indicators at a summary level was achieved in December 2006. Compliance at a speciality level has been achieved in all but two specialities and a plan is in place to achieve compliance with these by June 2007.
- To keep faith and the confidence of the local community, the commitment to everyone promised an outpatient appointment of surgery has been kept. The elective surgery catch-up included providing surgery to patients who had already been given certainty of treatment.
- We contracted offsite theatre capacity to do more elective surgery as a transition to having additional capacity on campus.
- We have developed strategies to access additional elective surgery funding.

The DHB is finalising its proposal for additional elective funding for presentation to the Ministry by the end of May 2007.

What is planned for 2007/08?

We will maintain compliance with the Elective Patient Flow Indicators (ESPI) so patients with the highest priority continue to be assessed and treated within the required timeframes. We will meet the targets for additional orthopaedic and cataract surgery and will use the additional elective surgery funding for priorities agreed with the Ministry of Health.

A programme of to improve the patient experience is planned to start in 2007/08. Elements of this programme include Patient Focussed Booking, increasing daycase surgery and a review of assessment processes.

We will be supplying additional elective volumes based on agreement with the Ministry of Health once the additional elective funding proposal for 2007/08 is completed in May 2007 and then accepted by the Ministry. We will be delivering 121 joints against the orthopaedic initiative. We will be managing our capacity by streamlining our internal theatre functions, reducing oversupply in plastics by managing to contracted and agreed additional elective volumes for our local population, and by utilising a private provider for ENT, orthopaedics, general surgery and dental volumes.

We have a policy to be honest, fair and timely in managing elective services. We plan to do this in all specialties with the following four programmes.

1. Patient focus- enhancement of elective services from a patients perspective, focusing on honesty and timeliness.

2. Timeliness in the delivery of elective services. Treatment of patients in a timeframe consistent with best clinical practice and current resources. This means we only accept people for appointments and treatment when we can see and treat them within a six month period. For those patients whose conditions do not meet our documented acceptance criteria we tell them honestly and in writing. We use a registered scoring tool to place people in the certainty of treatment, active review and for GP care category.

3. Efficient use of DHB resources in the provision of elective service - improvement of systems to ensure that resources are used in the most efficient manner.

4. Access - equity of access to elective services. This includes ensuring that the Hutt population has access to secondary elective services close to where they live and that regional services provided at Hutt Hospital are accessible to both Hutt and feeder DHB populations.

The following tables detail expected volumes for each service with the base and additional numbers for both CWD and the estimated numbers of discharges (additional volumes at a service level are still being negotiated with the Ministry of Health).

Service	Elective CWDs			Estimated Elective Discharges		
	Base	Additional	Total	Base	Additional	Total
Cardiology	223	39	262	140	20	160
Cardiothoracic	390	46	436	59	7	66
Dental	141	90	231	236	150	386
Ear, Nose and Throat	313	27	340	565	50	615
General Surgery	1,016	69	1,085	729	50	779
Gynaecology	462	40	502	543	50	593
Neurosurgery	82	2	84	45	1	46
Ophthalmology	334	6	340	546	9	555
Orthopaedics	1,261	71	1,332	521	55	576
Paediatric Surgery	74	2	76	94	2	96
Plastics and Burns	557	31	588	768	70	838
Urology	198	30	228	156	24	180
Vascular	211	110	221	93	50	143
Total	5,262	565	5,827	4,495	538	5,033

Orthopaedic and Cataract Initiatives

	Base	Additional	Total Procedures
Major Joint Procedures	174	121	295
Cataract Procedures	284	76	360

The DHB will receive surplus funding under both initiatives in 2007/08.

Annual Objective 7: Maintain ESPI compliance and increase elective surgery through efficiency of booking processes and improved surgical capacity.
Measures and Targets (see Appendix 7) Improving elective services, SER-04, Elective Services Patient Flow Indicators.

Approach 7.1: Build on work from 2006/07, maintain central focus on management of capacity and target initiatives to improve efficiency and capacity.

Milestones 7.1:

- Maintain current processes for ensuring consistent application of referral criteria including:
  (i) Documentation of referral criteria and triage process and communication of these to referrers.
  (ii) Monitoring of trends in referral numbers and priorities at service manager meetings.
  (iii)Six monthly review of referral criteria by clinicians led by Clinical Head of Department
  (iv) Audit of application of criteria where indicated.
  (v) regular review of clinic specifications.
  The Patient Focused Booking initiative that the DHB plans to implement in this finaincial year will use an electronic system to pick patients for clinic appointments ensuring that those patients waiting the longest are invited to phone for an appointment first.

- Maintain current processes for ensuring consistent application of CPAC tool and booking for surgery based on priority score including:
  (i) Monitoring of ESPI performance.
  (ii) Discussion at Service Team meetings and with total clinical team if necessary.
  (iii) Regular review of CPAC by clinical staff.
  (iv) Documentation of booking process and training of booking staff.
  (v) Regular review of individual surgeons list by Booking Administration Manager.

Position Responsible 7.1: Service Manager, Elective Care.

Risks 7.1	**Mitigations 7.1**
Unpredictable down time in theatre sessions, e.g. industrial action.	Allow buffer in capacity management as far as practical.
Loss of clinician buy in.	Continue clinician involvement at all levels of decision making.

Approach 7.2:
Pilot Patient Focused Booking (PFB) in three specialities, one medical, one surgical and one community, evaluating the pilots and extending it where it is appropriate.

Milestones 7.2:

- Pilot of PFB in three specialities.
- Evaluation of pilots.

Position Responsible 7.2: Service Manager, Elective Care.

Risks 7.2:	**Mitigations 7.2**:
Insufficient time to train staff in new approach.	Carefully identify resourcing needs in implementation plan.
Medical, nursing and administrative staff not supportive of approach.	Involvement of staff in planning from beginning.
Insufficient resourcing.	Use additional Ministry funding.

Approach 7.3: Maximise the effective use of day-case surgery by benchmarking existing day case practice against Australasian and European best practice, identifying procedures where there is opportunity to increase the percentage of day cases, select five procedures where most impact can be made and work to develop and implement a plan to improve day case ratio per procedure.

Milestones 7.3:

- Bench marking completed.
- Identification of five key procedures.
- Development of plan to implement agreed best practise day case percentage.
- Implementation.

Position Responsible 7.3: Service Managers.	
Risks 7.3	**Mitigations 7.3**
Clinician support.	Involvement of clinicians in all stages.
Availability of Day Procedures Unit beds.	Identify pattern of use and strategies for increasing capacity (e.g. longer opening hours, overnight opening).

Approach 7.4: Use additional elective funding to increase elective volumes.	
Milestones 7.4: • Identify services where additional volumes can be provided. • Identify and secure infrastructure requirements to ensure sustainable increases in elective volumes. • Approval by the Ministry of the plan for the additional funding. • Implement as per the plan.	
Position Responsible 7.4: Service Manager, Elective Care and Service Managers.	
Risks 7.4	**Mitigations 7.4**
Workforce availability.	Involvement of clinicians in all stages and secure commitment at plan stage.
Theatre & clinic availability.	Secure commitment at plan stage.
Availability of business information and IT support	Secure commitment at plan stage.
Plan not approved by Ministry.	Maintain close communication with Ministry.

6.4.8 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 2006/07?
Children's Health Service attended a smoke free "train the trainers" course and teaching sessions, then commenced a family smoke free pilot programme within Special Care Baby Unit (SCBU), to identify and support families to implement and maintain a smoke free environment.

Successful Accreditation as a Baby Friendly Hospital (BFHI). New model introduced for delivering gynaecology and obstetric services. New Clinical Head of Obstetrics and Gynaecology commenced and other permanent SMO staff employed to work in O & G. The service continues to improve birthing outcomes for women in our community.

The MoH supported a HEHA project to increase breastfeeding to a minimum of 3 months duration and this has commenced. The project targets high needs mothers/families. Following extensive community consultation and engagement the model was agreed and a Project Manager appointed. Progress milestones: Governance group established; completion of train the trainer course; MOU signed with participating PHOs; community programmes scheduled.

All very high needs schools (decile 1-3) are supported by a DHB grant to implement the Health Promoting Schools Project. Two events to mark the progress have been held. The first event was a demonstration of the schools' progress of their projects and the second event a showcase and celebration of the schools' success.

We will complete Memorandums of Understanding with Child, Youth and Family Services, Police and other appropriate organisations that address family violence co-ordination and Child Safety in Hospitals.

Planning and Funding have employed a Family Violence prevention co-ordinator. The aim is to work with the DHB community and the Provider Arm to improve awareness and increase intersectoral collaboration. A regular family violence prevention training programme for midwives and lead maternity carers has been set up.

We consulted on and established an immunisation unit that includes the Immunisation Facilitation role and the NIR team based within the Regional Public Health Communicable Diseases Team. This team provides a one-stop-shop immunisation support unit for the Hutt Valley and is currently working on projects that will maximise NIR efficiencies.

Hutt Valley General Practices achieved 94% immunisation coverage of children fully immunised at age two with 67% of practices achieving >95%.

What is planned for 2007/08?
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 use NIR information to address any gaps in primary care immunisation trends in conjunction with the outreach immunisation service to maintain and increase our target rates. Utilising NIR data we will work with well child providers, Lead Maternity Carers, midwives and other clinicians to improve handover processes that result in early baby GP enrolment. NIR data confirms provider feedback that there are delays in accurate and timely referral information, which we will address.

We will cooperate with new Ministry of Health programmes to increase well child checks for preschoolers, hearing tests for neonates, and the introduction of antenatal HIV screening, once the funding and responsibilities are defined. Hutt Valley, Capital & Coast and Wairarapa DHBs have agreed to take a regional approach to antenatal HIV screening and are working to formalise arrangements, including provider education, laboratory testing and information systems to meet programme standards.

We will reduce children's exposure to unhealthy situations through several key initiatives. A smoking cessation project will identify parents and caregivers of hospitalised children who are interested in becoming smoke-free and refer them to a smoking cessation service.

A family Violence prevention co-ordinator has been employed. The aim is to work with the DHB community and the Provider Arm to improve awareness and increase intersectoral collaboration and to assist the DHB to address recommendations from previous audits and reviews. We will implement a DHB family violence programme and include regular interface with Child, Youth and Family Services, Police and other organisations (see also Intersectoral Collaboration section).

We will expand Healthy Eating Healthy Action – Oranga Kai Oranga Pumau activities with a strong emphasis on school and early childhood settings (see also Intersectoral Collaboration and Public Health sections). We will improve and better integrate services for children and adolescents in the areas of mental health and oral health services (see also Mental Health and Oral 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) Improving immunisation coverage, Reducing ambulatory sensitive (avoidable) admissions, Immunisation, POP-08, POP-09.

Approach 8.1: Increase service integration to improve child and family service efficiency health gain.	
Milestones 8.1: • Revise and update the 2001 Hutt Valley DHB Child and Family Plan to expand the inter-agency approach to service delivery. • Establishing a Youth Health Reference Group to advise on planning, development and funding of services for youth.	
Position Responsible 8.1: Portfolio Manager Planning and Funding.	
Risks 8.1	**Mitigations 8.1**
Intersectoral agencies and government departments contribution is not fully represented.	High level agreement sought and all key stakeholder interests consulted.

Approach 8.2: Support increased access to families to ensure healthy start for children, redesign access criteria to support attendance to antenatal classes for high need families and increase immunization coverage and improve best practice.	
Milestones 8.2: • Antenatal education classes access criteria is redesigned to increase support for high needs mothers/ families. • RPH Service delivery framework further developed to increase efficiency for the National Immunisation Register (NIR), communicable disease management and promulgate best practice. • Reduce caesarean section rates through the development of sound clinical audit indicators.	
Position Responsible 8.2: Service Manager, Child and Women's Services, Service Manager Regional Public Health, Health Protection and School Health.	
Risks 8.2	**Mitigations 8.2**
Ownership of target communities not gained.	Early engagement with the sector and target communities.
Need for change not endorsed by staff.	Early consultation with staff.

Approach 8.3: Introduce additional screening services, subject to sufficient funding and clarity over roles.	
Milestones 8.3: • Additional hearing screening for neonates introduced. • HIV antenatal screening introduced.	
Position Responsible 8.3: Maternity & Child Service Manager.	
Risks 8.3	**Mitigations 8.3**
Ministry of Health does not provide sufficient funding for viability of the programmes.	Discuss funding options with Ministry of Health (including the National Screening Unit).

Approach 8.4: Support increased access for young people to youth friendly health services.	
Milestones 8.4: • Partnership development between youth health stakeholders to develop a Youth Health Reference Group. • Develop a Youth Plan.	
Position Responsible 8.4: Service Manager Regional Public Health, Portfolio Manager.	
Risks 8.4	**Mitigations 8.4**
Lack of buy in from youth health stakeholders.	Early engagement with youth health stakeholders.

6.4.9 Oral Health

What does the DSP say and other key directives?

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.

We will focus on five of the Ministries seven key action areas:

- Re-orientate child and adolescent oral health services.
- Reduce inequalities in oral health outcomes and access to oral health services.
- Promote oral health.
- Build links with primary care.
- Build the oral health workforce.

What progress was made in 2006/07?

School Dental Service

- Established a joint Oral Health Service Provision for Children and Adolescents (OHSPCA) Project between Capital and Coast and Hutt Valley DHBs.
- By June 2007, have submitted OHSPCA business case to implement the new model of community-based dental care for children and adolescents.
- Offered four scholarships for students to undertake dental therapy training at the University of Otago and AUT, and employed four new graduate dental therapy students.
- Developed a Pre-school Enrolment project and developed a prevention programme for the practice nurses linking into the immunisation program.

Hospital Dental Unit

- Improved access for First Specialist Assessments.
- Additional theatre sessions were undertaken in a pilot utilising theatres at Southern Cross Hospital reducing GA waiting lists.
- Implemented an Electronic Appointment Book.
- Increased focus on oral health and prevention for special needs clients.
- Introduction of Specialist Paediatric Dental service to address increased demand.

Whai Oranga o te Iwi Oranga Niho (low income adult oral health service pilot)

- Completed evaluation of the Whai Oranga o te Iwi Oranga Niho oral health service pilot for low income adults, an initiative between Piki Te Ora PHO, Whai Oranga health centre in collaboration with the Hutt Valley DHB Community Dental Service. Continuation of the service will be dependent on the outcome of the evaluation.

What is planned for 2007/08?

Subject to approval of the joint OHSPCA project business case, we will begin to implement a 'hub and spoke' model for oral health services for 0 to 18 year olds. This will comprise community fixed-site clinics with mobile examination outreach services. It will build linkages with private dentists contracted under the national Combined Dental Agreement, primary care organisations and oral health promoters and work to address oral workforce recruitment and retention issues. Opportunities for increased value for money will be explored through shared procurement with other DHBs, e.g. mobile clinics.

We will implement the recommendations arising out of the evaluation of the low income adult oral health service pilot.

Annual Objective 9: Improve oral health status for children and adolescents.
Measures and Targets (see Appendix 7) Improving oral health, Oral Health, POP-04, POP-05, POP-11, Oral Health, Oral Health Progress Report.

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 according to the OHSPCA Workforce Plan.	
Milestones 9.1: • Achieve an SDS target of 36 FTE dental therapists.	
Position Responsible 9.1: Dental Service Manager.	
Risks 9.1	**Mitigations 9.1**
Ongoing dental therapist vacancies.	Implement OHSPCA Workforce Plan.
High percentage of children overdue for care.	Identify alternate service delivery options; communicate with affected schools early; identify potential alternate providers.

Approach 9.2: Continue with the OHSPCA Project to implement the new model of community-based dental care for children and adolescents with a particular focus on high needs populations.	
Milestones 9.2: • Obtain Ministry approval of the OHSPCA Project business case. • Appropriate consultation for the zone and clinic site locations for the new model of community-based dental care for children and adolescents. • Appoint Project Manager to oversee the development of a new service delivery model of community-based dental care for children and adolescents, building of new facilities and the transition of staff to these new facilities.	
Position Responsible 9.2: Dental Service Manager and Oral Health Project Manager.	
Risks 9.2	**Mitigations 9.2**
Insufficient project, operational and capital funding available to successfully implement the new model.	Communications and negotiations with Ministry of Health.
Delay in project timelines.	Early planning and ongoing communication with the Project Steering Group.
Insufficient engagement with project stakeholders.	Early planning and ongoing communication through a timely Communication and Engagement Plan.

Approach 9.3: Seek to improve adolescent enrolment rates as part of the new oral health service model for 0-18 year olds.

Milestones 9.3:

- Explore with members of the OHSPCA's Reference Group how we can best increase adolescent enrolment rates, including:
  - Whether there are other private dentists interested in being part of CDA.
  - What opportunities there are for adolescents to receive dental care within the new community-based oral health facilities that will be built.
- Explore how the current Adolescent Regional Co-Ordination Service can help to increase adolescent enrolment rates given the establishment of new community-based oral health facilities.

Position Responsible 9.3: Dental Service Manager and Oral Health Project Manager.

Risks 9.3	**Mitigations 9.3**
Difficulty encouraging private dentist involvement in the new model for oral health services.	Early engagement through the Oral Health Reference Group with private dentists nominated by NZDA.
Community Dental Service unable to assume role in treating adolescents due to staffing constraints and/or opposition from private dentists.	Early engagement through the Oral Health Reference Group with the Community Dental Service.

6.4.10 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 Māori are a key focus of this objective in 2007/08. We know that Māori and Pacific people access cancer services later than others and the evidence tell us that health outcomes are worse for these groups.

We have made significant progress in implementing the NZ Palliative Care Strategy, with the implementation of a hospital palliative care team being the last major action to complete. 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 while access to the service by Māori has traditionally been low in comparison to the population of the Hutt Valley, the recent introduction of the Māori liaison service has seen a significant increase in the number of Māori accessing palliative care services.

What progress was made in 2006/07?

- Completion of "The Patient Journey – Te Huarahi o Nga Tangata Katoa" document; an analysis of the experiences of cancer patients (especially Māori, Pacific, children and adolescents) and presentation at the Ministry of Health 2006 Symposium.
- Development of a local Cancer Action Plan linked to a regional cancer control strategy.
- Opening of the new Breast Screening Centre by the Hon Pete Hodgson Minister of Health.
- Replacement database introduced that is compatible with the national screening unit (NSU) ensuring consistency in data collection and reporting.
- PHO pilot project underway that enables primary care practice to target their patients for breast and cervical screening.
- Specific initiatives to target the Māori and Pacific Island eligible breast screening population. Work has also progressed with full implementation of the age extension for breast screening.
- Continued preventive work to reduce the risk of cancer from smoking and poor nutrition.
- Introduction of a palliative care education and liaison nurse in the hospital as the first stage in developing a hospital palliative care team. This role began in 2006/07 and will provide education, liaison and support about palliative care to other health professionals.

What is planned for 2007/08?

We will continue to deliver health promotion and disease preventive programmes to reduce the risk of cancer from smoking and poor nutrition (see also Public Health section).

We will address the findings of "The Patient Journey – Te Huarahi o Nga Tangata Katoa" to identify and address inequalities in access to early diagnosis and treatment for Māori, Pacific and low income groups.

We will implement the Hutt Valley DHB Cancer Action Plan, based on the above findings, to improve local service delivery and coordination among primary health care, NGOs and other providers, subject to available funding and service change discussions. This includes involvement in the regional cancer network (currently being established with workstreams on Promotion & Screening, Diagnosis & Treatment, Support & Rehabilitation, Palliative Care and Research & Surveillance), workforce development, using multi-disciplinary teams across cancer pathways and the enhancement of palliative care support and rehabilitation services. This will include a focus on high-need populations to address areas of inequality through the engagement of a local service improvement facilitator as a change agent.

We will also collaborate with the cancer services of other DHBs (through the regional network) 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 2007/08, work will continue with PHOs on reducing disparities by improving access to screening services. Using the PHO pilot project model, non-participating women will be actively recruited for breast and cervical screening by their PHO general practice.

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) Reducing cancer waiting times, Screening, POP-10, Cancer Control Implementation Plan.

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 Māori accessing cancer services are addressed. • Key recommendations from the Hutt Valley DHB Cancer Action Plan are agreed. • One key recommendation from the Hutt Valley DHB Cancer Action Plan implemented. • Continued implementation of the palliative care strategy.	
Position Responsible 10.1: Portfolio Manager Planning and Funding.	
Risks 10.1	**Mitigations 10.1**
Regional agreement is not reached on the introduction of the Regional Cancer Network.	Maintain strong collaborative relationships with the participating DHBs.

Approach 10.2: Increase screening rates for breast and cervical cancer with particular emphasis on identified high need communities, through enhanced health promotion strategies, closer relationships with PHOs and independent service providers and enhanced booking processes.	
Milestones 10.2: • Implement health promotion strategies to Pacific people. • Develop relationships with Hutt Valley Māori health providers.	
Position Responsible 10.2: Regional Screening Service Manager.	
Risks 10.2	**Mitigations 10.2**
Difficulties faced in addressing cultural	Early engagement with Hutt Valley DHB

taboos around breast and cervical screening.	advisors and identified key people within community.

6.4.11 Mental Health

We will continue to implement Te Tahuhu and the action plan Te Kokiri. This is being progressed through the regional mental health plan and our five year mental health plan *Make it Happen (Whakamahingia).* Our aim for mental health services in the next five years is:

- Improved information.
- Better relationships.
- Structure and systems which are useful and innovative.
- Environments that enhance whanau ora and enable recovery.

What progress was made locally in 2006/07?

- Consumer lead engagement in the development of our five year mental health plan 'Make it Happen (Whakamahingia)'. The strong focus on consumer engagement has delayed progression of some blueprint spending, but will prove beneficial for mental health consumers in the long term.
- Alcohol and other drug (AOD) residential services have been established with an NGO provider.
- Alcohol and other drug day and evening programmes established with NGO provider.
- The review of psycho-geriatric and mental health for older people has been completed with implementation occurring in 2007/08.
- Additional Pacific AOD support services have been delayed due to limited local Pacific capacity and capability, so 2006/07 Blueprint funding will be used to develop local Pacific providers.
- A local community consumer advocacy position has been established.
- This is the third year of the Māori mental health scholarships, and we successfully allocated 30 scholarships for the 2007 calendar year.
- A self-harm / suicide collaboration project has enhanced access for clients through the Emergency Department (ED) by strengthening the relationship between the mental health services and ED.
- Additional family advisor and Māori consumer advisor positions were implemented.
- Additional Kaupapa Māori tamariki, rangatahi and whanau services were established.
- Additional funding for a primary mental health clinical position for child and youth services.

What is planned for 2007/08?

Our key priority is the implementation of 'Make it Happen'. Initial stages are to establish an implementation steering group to lead the implementation process.

We will also implement the recommendations from the psycho-geriatric and mental health of older people review with blueprint funding.

'Blueprint' Funding

Hutt Valley DHB will provide the following services with 'Blueprint' Funding:

Purchase Units	Service Description	Blueprint Allocation 2007/08 (excl GST	Blueprint Allocation 2008/09 (excl GST)	Coverage
MHCS18	Psycho-geriatric and mental health of older people's	$300,000	$300,000	Local

	services review recommendation implementation including service and workforce development			
MHCR11	Forensic step-down residential beds – Yr 1. Establish 5beds for the Wellington Region. Yr.2. Establish 2nd 5 bed unit in another part of the Central Region	$275,000	$275,000	Regional
MHCS09C	Eating Disorder Services – Specialist Centre of Excellence for EDS services	$150,000	$100,000	Regional
MHCS09C	Eating Disorder Services – increase access by increasing capacity in the central region	$350,000	Nil	Regional
MHWD01	Workforce development regional sustainability plan that includes initial 1FTE building to 2FTE plus a training budget	$120,000	$250,000	Regional
MHWD01	NGO development – Fund NGOs to release staff to attend training	Nil	$100,000	Regional
MHRE04	CAHMS – foster family development – Region wide initiative	Nil	$120,000	Regional

Annual Objective 11a: Advance the development of mental health and addiction services for Hutt Valley / Te Awakairangi population.
Measures and Targets (see Appendix 7) Mental Health Services, Improving mental health services, POP-07, QUA-02, Mental Health Audit Activity.

Approach 11.1: Implement the 'Make it Happen' / five-year mental health and addiction framework / action plan 2007 - 2012.	
Milestones 11.1: • Two projects from the five-year mental health and addiction service plan scoped and implemented. • Establish the current service baseline for mental health and addiction services against the Te Tahahu framework.	
Position Responsible 11.1: Mental Health Portfolio Manager.	
Risks 11.1	**Mitigations 11.1**
Access to mental health baseline information in both NGO and DHB services may not be readily available.	Involve the service providers early in the process and ensure that the data collection and process is simple.

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

Milestones 11.2:

- Implement Te Puawaitanga with the Hutt Valley mental health and addiction providers, subject to available funding.
- Implement monitoring and reporting framework locally, based on regional work.

Position Responsible 11.2: Mental Health Portfolio Manager.

Risks 11.2	**Mitigations 11.2**
Capacity within planning & funding to implement the initiatives.	Effective planning and ensure resources are available.

Approach 11.3: Implement the recommendations of the review of psycho-geriatric and mental health for older people services.

Milestones 11.3:

- Implementation plan agreed.
- Change management principles agreed.
- Implementation oversight group established to support change management processes.

Position Responsible 11.3 Mental Health Portfolio Manager & Older Persons Portfolio Manager, Chief Operating Officer.

Risks 11.3	**Mitigations 11.3**
Resistance to change.	Early engagement of key stakeholders in the early stages of implementation.
Workforce capability.	Ensure implementation plan is linked with training and workforce development strategies with a focus on developing appropriate skills for staff working with older people in mental health services and conversely with aged care services.

Approach 11.4: Progress the implementation of PRIMHED.

Milestones 11.4:

- Local components of PRIMHED implementation complete.

Position Responsible 11.4: Mental Health Service Manager.

Risks 11.4	**Mitigations 11.4**
Funding may not be sufficient to complete all parts of PRIMHED.	Keep Ministry of Health informed of progress and costs of implementation.

Approach 11.5: Review service utilisation and availability for Hutt residents of regional speciality services.

Milestones 11.5:

- Review completed regarding access and utilisation of regional methadone, early intervention, psychological therapies and dual diagnosis services.
- Implement recommendations with local delivery of service where appropriate.

Position Responsible 11.5, Mental Health Portfolio Manager.

Risks 11.5	**Mitigations 11.5**
Resistance to change from current provider.	Early engagement of key stakeholders.
Capacity and capability to deliver service locally.	Implement review recommendations as capacity and capability permits.

Approach 11.6: Review access to specialist Mental Health and Addiction services for child and youth.

Milestones11.6:

- Review mental health services for children, youth and their whanau, which will include local and regional DHB and NGO services, in conjunction with Child, Family and Youth plans (see also Maternity, Child and Youth Health section).
- Investigate current access rates and issues.
- Increase NGO and regional specialist provider reporting to MHINC.

Position Responsible 11.6: Mental Health Portfolio Manager, Planning & Funding.

Risks 11.6	**Mitigations 11.6**
Different sectors may resist participation.	All sectors involved in the project and in the management of implementing recommendations and guidelines.

Central Region Mental Health and Addiction Services

What progress was made in 2006/07?

- The review implementation of five regional specialty services at Capital & Coast DHB is complete. Local liaison positions, memorandums of understandings and reporting have been put in place within the entire central region DHBs.
- Te Puawaitanga Māori mental health baseline information has been collected collated, analysed and reports are complete. Implementation will be locally led, and the monitoring and reporting framework is currently being progressed.
- Ten of the twelve recommendations of the regional alcohol and other drugs intensive review have been completed. Of the final two recommendations, one has been partially completed, and the other will be completed by 30 June 2007.
- Two youth multi-systemic therapy alcohol and other drugs services have been established with MidCentral and Hutt Valley as the lead DHBs.
- The revised Central Region mental health and addiction network is now fully functioning with the development of the Central Region mental health and addiction service plan a key initiative that the six DHB Mental Health Portfolio Managers worked on together.
- The regional eating disorder service has successfully transferred to Hutt Valley DHB following the withdrawal from the contract by the Eating Disorders Service NGO. Although the service has been renamed the Central Region Eating Disorder Service (CREDS) it still employs all but one of the original staff and operates from the same base.
- A system to track contract and IDF movement within the Central Region has been implemented and is currently being monitored.

What is planned for 2007/2008

Implementing the Central Region mental health and addiction service plan will be the primary focus for the Central Region DHBs. In addition, Hutt Valley DHB will lead the review and service development of the regional eating disorder services and the evaluation of youth multi-systemic therapy alcohol and other drugs services on behalf of the Central region DHBs.

Annual Objective 11b: Advance regional mental health and addiction collaboration initiatives.

Measures and Targets (see Appendix 7)
Regional Mental Health Strategic Plan.

Approach 11.7: Regional mental health and addiction service capacity and capability development.

Milestones 11.7:

- Assess the service and workforce requirements of NGO regional mental health and addiction services, including a review of NGO contracts that include workforce issues, and develop an action plan.

Position Responsible 11.7: Regional Contract Manager.

Risks 11.7	**Mitigations 11.7**
Resistance to changes particularly where current contracts operate.	Engage change management strategies.

Approach 11.8: Review regional eating disorder services.

Milestones 11.8:

- Service review completed, including reviewing the age criteria to address the younger age groups requiring these services.
- Increase access to eating disorder service by increasing capacity through 2007/09 Blueprint regional funds.
- Increase regional capability by developing a centre of excellence for eating disorders services through 2007/08 Blueprint funding.

Position Responsible 11.8: Regional Contract Manager.

Risks 11.8	**Mitigations 11.8**
Resistance to changes particularly where current contracts operate.	Develop a strategy that is fully supported by the Regional DHB Portfolio Managers and work directly with any potentially effected organisations.
The availability of eating disorder expertise.	Active robust RFP process.

Approach 11.9: Multi-systemic therapy alcohol and other drugs services evaluation 2007/09.

Milestones 11.9:

- Evaluators appointed.
- Evaluation project plan agreed.
- First year interim report presented to Hutt Valley/MidCentral DHBs and the Central Region DHB Mental Health Portfolio Managers.

Position Responsible 11.9: Regional Contract Manager.

Risks 11.9	**Mitigations 11.9**
Availability of evaluators to undertake the evaluation over two years.	Active robust RFP process.

6.4.12 People with Disabilities

Services 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 the Strategy. 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 2006/07?
In 2006/2007 there was increased participation of people with disabilities in Hutt Valley DHB activities.

- Along with Upper Hutt City Council and Hutt City Council, we formed a Hutt Valley Disability Advisory Group. The group advises those involved in Planning, Funding, Managing and Delivering services in the three organisations.
- We included questions on disability in our patient satisfaction surveys.
- We have finalised our New Zealand Disability Strategy Implementation Plan.
- We developed accessibility guidelines to protect and improve accessibility for people with disabilities.
- We are collecting patient information on disabilities as part of the Electronic Medical Record project.
- We have included disability considerations in our building processes, for example to improve signage in our new breast screening facilities.

What is planned for 2007/08?
The focus for 2007/08 is to progress the inclusion of disability perspectives in Hutt Valley DHB processes and activities. The DSAC work plan outlines the Committee's priorities for the year.

We will ensure that the requirements of disabled people are considered alongside others. For example our patient satisfaction surveys allow us to identify any areas where people with disabilities evaluate our services differently from those without a disability. 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.

We intend to work with Hutt City Council, Upper Hutt City Council, SPARC and Wellington region Sports Trusts to be part of a "no exceptions" recreational district.

In response to the New Zealand Sign Language Act 2006, we will trial New Zealand Sign Language videos on our website. The project plan was developed by members of the Deaf community, who were recommended by the Deaf Association.

Annual Objective 12: Implement the Hutt Valley DHB NZ Disability Strategy Implementation Plan.
Measures and Targets Six monthly update and progress report to DHB Board.

Approach 12.1: Standardise the way we record disability information.	
Milestones 12.1: • Update staff EEO form to include Statistics NZ disability categories. • Record disability information on outpatient first contact information form. • Record disability information on the admission form.	
Position Responsible 12.1: Disability Advisor.	
Risks 12.1	**Mitigations 12.1**
Community concern about the use of the information.	Provide clear information about the purpose of collection, and the proposed uses of the information.

Approach 12.2: Identify and remove accessibility barriers in Hutt Valley DHB activities.	
Milestones 12.2: • Signpost accessible routes to main reception areas. • Ensure that disability issues are included in transport and parking work being done for Hutt Hospital. • Patient satisfaction survey results are analysed and recommendations made to DSAC and HAC. • Pilot New Zealand Sign Language videos on our website.	
Position Responsible 12.2: Disability Advisor.	
Risks 12.2	**Mitigations 12.2**
Removing identified barriers may involve considerable cost and additional projects.	Work with disability communities to prioritise projects in line with available resources.

6.4.13 Health of Older People

What does the DSP say and other key directives?

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 sets out how we will develop more integrated health and disability services that are responsive to the varied and changing health and social needs of older people's.

What progress was made in 2006/07?

- Review of service coordination for community referred services for older people.
- Commenced a staged approach to implement centralised service coordination and improved integration of services with ageing in place initiatives.
- Review of psycho-geriatric and mental health services for older people completed.
- Workforce requirements of the aged care and home based support sector integrated with the implementation of the DHB's workforce development plan.
- Model developed for the monitoring and projection of utilisation of health of older peoples services.
- Framework developed to support the implementation of restorative home based support services.
- Successful implementation of the fair travel policy with providers of home based support services.
- Management of the interim funding pool in partnership with disability support services (DSD).

What is planned for 2007/08?

Progress will continue on implementing ageing in place initiatives and slowing down entry to long-term residential care. This will be achieved through improving coordination and process interfaces with an augmented NASC and ageing in place initiatives.

We will implement the recommendations of the review of psycho geriatric services with mental services for older people (see also Mental Health section).

We will complete the review of the older persons service plan.

The DHB plans to develop the following areas to achieve an integrated continuum of care by:

- Improving access to a wider range of health and social services.
- Extending the range of services delivered in the community.
- Continuing to develop an integrated service continuum across primary care, community services and secondary services.
- Build capability across the workforce and continuum.
- Continuing to improve service interfaces across Hutt Valley DHB services.
- Designing services and models of care that are patient centred and meet the support needs of older people within available funding.
- 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 also Intersectoral Collaboration section).
- Research the likely future supply of General Practitioners and Practice Nurses in the Hutt Valley jointly with primary care (see also Primary Health Care section).

Annual Objective 13: Continue to develop services to establish an integrated continuum of care and support ageing in place initiatives.
Measures and Targets (see Appendix 7) Reducing ambulatory sensitive (avoidable) admissions, POP-09, Health of Older People.

Approach 13.1: Implement a staged approach to centralised service coordination with an augmented needs assessment and service coordination service.	
Milestones 13.1: • Implement an augmented Needs Assessment and Service Coordination (NASC) service to augment aging in place initiatives.	
Position Responsible 13.1: Older Persons Portfolio Manager.	
Risks 13.1	**Mitigations 13.1**
Workforce capacity and capability may be limited.	Early engagement of key stakeholders in the development stages of the project. Link with workforce development strategies to identify and focus on implementing a restorative approach to service delivery.
Service transition may be problematic.	Early engagement of key stakeholders in the development stages of the project to incorporate communication strategies.

Approach 13.2: Early community based intervention service for older people diagnosed with dementia.	
Milestones 13.2: • A responsive community based service for early intervention of people with dementia implemented.	
Position Responsible 13.2 Older Persons Portfolio Manager.	
Risks 13.2	**Mitigations 13.2**
Relevant data not robust or available.	Adapt model and data sources if required.
Service outputs may differ from regional or national developments.	Keep informed of regional and national developments.

Approach 13.3: Implement restorative home based support services with the augmented NASC and home based support providers.	
Milestones 13.3: • Advisory oversight group established to support co-ordinated community based service implementation, review and monitoring. • Service implemented.	
Position Responsible 13.3 Older Persons Portfolio Manager.	
Risks 13.3	**Mitigations 13.3**
Workforce capacity and capability may be limited.	Early engagement of key stakeholders in the development stages of the project. Link with workforce development strategies to identify and focus on development for key roles.
Integration of service with secondary care services may not be accepted.	Early engagement of key stakeholders in the development stages of the project. Ensure liaison roles are supported appropriately.

Approach 13.4: Reconfigure restorative respite service for older people.	
Milestones 13.4: • Restorative respite service reconfigured and implemented. • Monitor and analyse client outcomes.	
Position Responsible 13.4 Older Persons Portfolio Manager.	
Risks 13.4	**Mitigations 13.4**
Workforce capacity and capability may be limited.	Early engagement of key stakeholders in the development stages of the service. Link with training and workforce development strategies to identify and focus on implementing a restorative approach to service delivery.
Problematic service transition.	Early engagement of key stakeholders in the development stages of the project to incorporate communication strategies. Ensure staff are supported appropriately.

Approach 13.5: Implement post pilot options for the interRAI MDS-HC assessment tool.	
Milestones 13.5: • Successfully transition to new software. • Implement training programme to support system requirements. • Monitor and analyse client outcomes in the community. • Ensure expanded NASC is using interRAI to assess for community support services.	
Position Responsible 13.5 Older Persons Portfolio Manager.	
Risks 13.5	**Mitigations 13.5**
Technical problems with software or messaging devices.	Ensure staff receive appropriate training and adequate support from information support.

6.4.14 Māori Health

Whakatātaka Tuarua 2006-2011[19], the second Māori Health Action Plan, sets objectives for Māori health over the next five years and builds on from Whakatātaka - The Māori Health Action Plan which was implemented in 2002 and 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 2006-20011 continue and are integral to Hutt Valley DHB. Four priority areas have been identified: by the Ministry of Health for Whakataka two of 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 Māori Health Strategic Plan and identifies a range of conditions where significant health disparities exist between Māori 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 Māori communities.

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

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

What progress was made in 2006/07?

We have established a Māori Health Service Development Group. The overall purpose of the group is to work with the DHB on the development of services that will better meet the needs of Māori and to 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.

We completed the Whanau Ora Facilitation review to reduce unnecessary admissions and re-admissions for Māori to Hutt Valley DHB arising from inappropriate discharge planning and follow up procedures.

Whanau accommodation has been upgraded to ensure the comfort and peace of mind of whanau who are supporting a family member in the Inpatient service and are from out of the District.

Māori patient satisfaction surveys have integrated Magnet based questions and results from inpatient, outpatient and breast screening satisfaction surveys indicate high overall satisfaction.

Te Whare Ahuru (Inpatient Services)/ Te Oranga Hinengaro have developed a quality improvement project that is providing Kaupapa Māori mental health care across the Acute/ community continuum.

Promotional presentations are being provided at Te Raukura Wananga training days, the new Grad Nursing Orientations, monthly staff orientation days and the Health assistant staff days. It has also been expanded to include the community NGO sector to ensure good referral processes, follow ups and relationships are maintained and continue to grow.

The DHB is one of a number of agencies involved with a Pilot programme being run in Wainuiomata. Although this programme does not target Māori specifically it is managed through a Māori provider and some specific Māori funds are allocated through the provider. The main recipients of the programme in this high need area are predominantly Māori and Pacific Whanau.

A draft Māori health workforce action plan has been completed. The plan incorporates key actions from both the Māori Health Strategic Plan and Hutt Valley DHB strategic workforce plan. A project to scope the development of a cadetship programme for Māori youth has commenced.

A developing partnership with Te Runanganui o Taranaki Whanui and the Hutt Valley DHB Diabetes team will see Hutt Valley DHB providing advice on recruitment, assessment, clinical training and orientation of the nurses recruited into the role.

Development of a Māori provider capacity and capability plan has commenced. A new Kaumatua support service has been established and contracted to a local Māori Provider. The service aims to reduce isolation, provide information, and improve access to brief and early interventions.

What is planned for 2007/08?

- Development and implementation of the Māori Health Service Development Group work plan.
- Increasing funding for Māori health.
- Service development initiatives, focusing on cancer and chronic diseases.
- Improving mainstream effectiveness.
- Developing the Māori workforce.

Annual Objective 14: Implementation of the Māori Health Strategic Plan - Whanau Ora Ki Te Awakairangi.
Measures and Targets (see Appendix 7) HKO-01, HKO-02, HKO-03, HKO-04.

Approach 14.1: Investment in Māori health of 5% on base funding for the 2007/08 year. The DHB is outlining a future funding track increase of 5% for the next three years on the baseline of all “for Māori by Māori” funding.

Milestones 14.1:

- Advice given about funding priorities by Māori health service development group (see also Mental Health section).
- Implementation undertaken.

Position Responsible 14.1: Māori Health Portfolio Manager.

Risks 14.1	**Mitigations 14.1**
Funding not secured.	Ensure early indication to Ministry of Health.
Funding not able to be spent.	Ensure funding papers for expenditure are prepared and signed off in timely fashion.

Approach 14.2: Participation and consolidation of the Māori 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.

Milestones 14.2:

- Workplan for 2007/08 implemented.
- Input into the 2008/09 District Annual Plan agreed.
- Input into utilisation of funding allocated to the Māori Health Strategic Plan and new funding streams for 2008/09 agreed.
- Input into revised Hutt Valley DHB Child Health and Youth Health service plans.
- Workplan for 2008/09 prepared.

Position Responsible 14.2: Māori Health Advisor and Māori Health Portfolio Manager.

Risks 14.2	**Mitigations 14.2**
Group membership not well informed on service delivery options.	Provide information sessions early in the year to enable active participation in service planning.

Approach 14.3: Facilitate service development initiatives and improvements for Māori, with a focus on cancer and chronic disease prevention and management at primary and secondary levels.

Milestones 14.3:

- Facilitate and support provider development in response to the cancer patient pathway for Māori (see also cancer sections).
- Review effectiveness of the continuum of care developments (for diabetes and cardiovascular disease) as appropriate (see also chronic disease section).
- Assist DHB staff with review of PHO Māori health plans.

Position Responsible 14.3: Māori Health Portfolio Manager.

Risks 14.3	**Mitigations 14.3**
Continuum of care work ineffective, incomplete or delayed.	Monitor progress of cancer control strategy; if early signal of delays, adjust planning cycle in accordance with delay.

Approach 14.4: Improve mainstream effectiveness.
Continue Māori responsiveness training for all staff both in the DHB provider services and the wider community services e.g. Raukura Wānanga, Te Ao Māori courses.
Continue consumer satisfaction surveys (Māori focus).
Maintain 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 14.4:

- 2 training sessions completed per quarter.
- 2 consumer surveys completed per annum.
- Review core data for specific DHB services re access, utilisation and outcomes.
- Expand linking mechanisms between DHB and community services to improve services and reduce hospital admissions for Māori.

Position Responsible 14.4: Māori Health Advisor.

Risks 14.4	**Mitigations 14.4**
Services unable to provide data.	Early engagement with core services to encourage participation in collation and reporting.

Approach 14.5: Develop the Māori workforce. The following programmes were identified as high priority in the Māori Health Strategic plan and draft Māori health workforce plan. They are expected to augment the DHB wider workforce planning initiatives.

- Year 3 Toi Ora ki te Awakairangi event, showcasing workforce development and services for Māori.
- Continue development of approach for cadetships.
- Maintain scholarship programmes (including mental health), linking to specific priorities identified in DHB workforce plan.
- Explore opportunities for collaboration with MSD and other agencies to enhance and increase the Māori health and support workforce.

Milestones 14.5:

- Toi Ora ki te Awakairangi event held (third year).
- Selection for cadetship and scholarships undertaken.

Position Responsible 14.5: Māori Health Advisor and Māori Health Portfolio Manager.

Risks 14.5	**Mitigations 14.5**
Cadetship programme does not provide sufficient support and guidance for those selected.	Establish formal mentoring and coaching support for those selected.

6.4.15 Pacific Health

What does the DSP say and other key directives?

Developing Pacific health care is a priority that fits with all of the DSP's six goals for the next five years. In improving Pacific people's health in the Hutt Valley, we have and will continue to focus on three of these goals in particular:

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

What progress was made in 2006/07?

- We continued to implement *Ili Ole Ola*, Hutt Valley DHB's Pacific Health Action Plan by:
    - Consolidating on gains already made by Pacific providers, supporting further workforce development, and exploring opportunities to collaborate to strengthen the efficiency and effectiveness of Pacific provider service delivery.
    - Establishing a Pacific Youth Advisory Group to provide advice and advocate for Pacific young people.
    - Assisting the local youth health service provider, VIBE, to develop a Pacific Youth Health Plan.
    - Continuing to support young Pacific people studying in areas of health by offering work experience and mentoring within the DHB provider arm and Pacific provider networks (e.g. the Pacific Unit Cadet Programme supported two Pacific undergraduates to participate in the programme, three Pacific students have been awarded scholarships towards their studies for 2007).
    - Supporting the delivery of sexual and reproductive health workshops to Pacific parents and youth communities within parish settings.
- We continued to support an intersectoral project with the Ministry of Social Development (MSD) and a local NGO, Lavea'I Trust, to offer free health screening programmes to parents and children attending Strategy for Kids, Information for Parents (SKIP) programmes in the Hutt Valley DHB area.
- Pacific representatives continued roles on DHB Advisory Committees and on PHO boards.
- The Pacific Provider Managers' Group comprising Pacific provider managers and DHB representatives continued to meet on a monthly basis to discuss operational, policy and funding issues, including the allocation of Pacific Provider Development Funding (PPDF) for 2006/07.
- The Pacific provider managers participated in an external review of how best to allocate PPDF in 2006/07 and beyond. This review, completed in November 2006, also explored the particular needs of the different Pacific providers, and where those needs are common amongst the different providers.
- Our DHB's Pacific Unit developed a resource to assist staff in mainstream providers better understand their Pacific clients.
- Resources in the children's ward were translated into Samoan and Tokelauan through support from the Pacific Unit.
- The bi-annual Pasifika Health Forum, which Hutt Valley DHB hosts, brings together Pacific providers, Pacific PHO representatives, Pacific advisory groups, and hospital based teams focusing on Pacific health to explore opportunities for contributing positively to Pacific Health.

What is planned for 2007/08?

We will review our three-year Pacific Health Action Plan, *Ili Ole Ola*. This will be done in collaboration with the Pacific community, with Pacific providers and also involve mainstream providers and the wider community where relevant. In reviewing

Ili Ole Ola and then developing a revised Pacific Health Action Plan for the next three years, we will:

- Assess how well we have addressed the seven goals in *Ili Ole Ola* and whether we have carried out the actions that were identified for each of these goals.
- Determine what the biggest needs within our Pacific population currently are and whether the seven goals in *Ili Ole Ola* are still relevant given these needs.
- Identify who is best able to address these needs; whether this is a Pacific provider, a mainstream provider, or a collaboration between different providers.
- Identify whether additional support is needed to assist these providers best address the needs within our Pacific population.
- Determine what goals are appropriate for the next three years, and what actions flow from these goals.
- Develop a Pacific Health Action Plan for the next three years.

In developing the next Pacific Health Action Plan, we will take into account the findings from the PPDF review completed in November 2006. This identified some areas that could benefit from a more collaborative approach to build on the gains already made by Pacific providers.

We will continue to work with Pacific providers to further support their capacity and capability development through the use of PPDF. This will include exploring with Pacific health providers opportunities for collaborative activity and what support there is for such an approach amongst Pacific providers. Hutt Valley DHB and Capital Coast DHB may also jointly explore the possibility of working regionally to maximise the effectiveness of Pacific providers.

We will work with mainstream providers to help address the needs of our Pacific population, including collaborative primary care efforts. Much of this activity will involve Hutt Valley DHB's Pacific Unit, which is well placed to provide education, support and information to front line staff in mainstream organisations, including the Provider Arm, to assist with the care for Pacific people. This activity will extend into the community, with the Pacific Unit supporting mainstream primary care and community based providers in the management of Pacific patients who have discharged into their care from the hospital.

We will evaluate the effectiveness of the sexual and reproductive health workshops that have been run for Pacific parents and youth communities within parish settings.

Annual Objective 15: Improve the health status of Pacific peoples in the Hutt Valley.
Measures and Targets (see Appendix 7) PAC-01.

Approach 15.1: Develop a Pacific Health Action Plan for the next three years	
Milestones 15.1: • Pacific Health Action Plan, *Ili Ole Ola,* reviewed. • Plan developed for next three years.	
Position Responsible 15.1: Pacific Health Advisor.	
Risks 15.1	**Mitigations 15.1**
Lack of buy-in from the Pacific community.	Early engagement and consultation with stakeholders.

Approach 15.2: Determine how the Pacific Provider Development Fund (PPDF) will be allocated in 2007/08.	
Milestones 15.2: • Determine how PPDF will be allocated.	
Position Responsible 15.2 Portfolio Manager, Planning and Funding.	
Risks 15.2	**Mitigations 15.2**
Lack of applications from Pacific providers for the Pacific Provider Development Fund.	Regular and early engagement and consultation with Pacific providers.
Delays in finalising developing a Pacific Health Action Plan for the next three years.	Early engagement and consultation with stakeholders.
Pacific health providers do not want to explore opportunities for collaborative activity.	Identify how collaborative activity might benefit the Pacific community and how doing things jointly could ensure better value for money from the funds that are available.

6.4.16 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 2006/07?
All funding proposals are assessed against equity criteria, including the Health Equity Assessment Tool[20], and service reviews included an equity focus, utilising the Reducing Inequalities Intervention Framework[21]. 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 that was undertaken as part of District Strategic Planning and as part of the District Annual Planning process.

What is planned for 2007/08?
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. An and inequalities focus is reflected in other sections, in particular primary health, chronic disease, Māori and Pacific health, workforce, mental health, oral health and disability services.

Annual Objective 16: All planning, funding and service review activities consider current inequalities and include remedial actions in future activities.
Measures and Targets (see Appendix 7) Reducing Health Inequalities.

Approach 16.1: Continued application of equity assessment tools in the review and development of services and in service planning, focussing on key priority areas.	
Milestones 16.1: • Inequalities analysis undertaken for 2008/09 business and strategic planning. • Continued use of Reducing Inequalities Intervention Framework and Health Equity Assessment Tool in service planning and development.	
Position Responsible 16.1: Director Planning, Funding and Public Health.	
Risks 16.1	**Mitigations 16.1**
Limited analytical resource.	Focus analysis on key priority areas.

Approach 16.2: Continue education of DHB staff in the area of inequalities.	
Milestones 16.2: • Inequalities presentation continuing within the DHB's cultural training programme. • Inequalities presentation continuing within the DHB's leadership training programme. • Work with Corporate staff to enhance expertise in the area of inequalities.	
Position Responsible 16.2: Population Health Outcomes Manager.	
Risks 16.2	**Mitigations 16.2**
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.

6.4.17 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, natural and technological hazards as well as having fire drills. We are up grading our major incident practices and policies on a regular basis as well as participating in pandemic preparation led by the Ministry of Health. The process being developed is being evaluated through local, regional and national emergency exercises. We are working with Civil Defence, local and regional health providers as well as emergency services.

What progress was made in 2006/07?
Considerable effort has been put into pandemic planning to ensure that all key players have been consulted and are up to speed with DHB pandemic planning. An operational pandemic plan and a Ministry compliance plan have been formed. Primary care and Regional Public Health have been participating in the development for plans to establish pandemic community based assessment centres. We fully participated in the Ministry's pandemic exercises (Operations Makgill and Cruickshank) as well as the whole of government Capital Quake earthquake exercise. Strengths and weaknesses were found in both exercises. These are being analysed and, where necessary, remedial action is being taken.

We also fully participate in all local and regional emergency management meetings where health input is required, with Hutt Valley DHB chairing the Civil Defence Emergency Management health working group.

Initial efforts have been made with assisting residential care facilities with their emergency planning. Studies into the effects of natural and technological hazards on DHB operations have started, with the aim of having detailed event contingency plans for these events as part of our major incident manual.

What is planned for 2007/08?
This will be largely a continuation of the building blocks established during 2006/07. These include:

- Participating in a combined emergency services exercise.
- Strengthening links with the emergency services.
- Building on the links formed with primary care and residential care.
- Strengthening our plans and procedures based around the DHB's major incident manual including fire response and training.
- Up-skilling staff in their ability to manage large scale emergency events through training and exercises.
- Work with all areas of the DHB including the provider arm, to ensure that the staff are aware of their responsibilities towards themselves and their clients, and have plans in place to meet those responsibilities.
- Addressing lessons learned and issues identified the pandemic exercises Operation Makgill and Cruickshank, and strengthening pandemic processes and networks.

Annual Objective 17: Ensure that 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) Health Emergency Plan Reviews.

Approach 17.1:

- Collaborate closely with internal and external agencies in developing emergency plans, procedures and exercises.
- Provide support to health care agencies to developed and evaluate their emergency plans.
- Educate staff and health providers on holistic emergency preparedness and make available to them material for further education in this field.
- Collaboratively work with all health care, emergency management and response agencies.
- Research best practice methods and where applicable implement to Hutt Valley DHB.

Milestones 17.1:

- Take part in an emergency management exercise.
- Have the major incident manual peer reviewed.
- Exercise aspects of the major incident manual.
- Review the DHB fire response training and procedures.
- Carry out 2 successful fire drills.

Position Responsible 17.1: Emergency Preparedness Coordinator.

Risks 17.1	**Mitigations 17.1**
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.

6.4.18 Magnet Recognition Programme

Hutt Valley DHB should achieve Magnet Recognition by June 2007. This framework 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 supportive practice environments. The Magnet Recognition Programme is a key initiative in supporting, attracting and retaining nurses.

What progress was made in 2006/07?
Required documentation was submitted to the American Nurses Credentialing Centre (ANCC) in July 2006. A subsequent site visit by the ANCC occurred in March 2007. The submitted documentation has been accepted by the ANCC as evidence of meeting Magnet standards. It is anticipated that Magnet Recognition will be awarded by June 2007.

What is planned for 2007/08?
Following successful recognition, ongoing monitoring of compliance with the Magnet programme will occur.

Annual Objective 18: Achievement and maintenance of Magnet Recognition by the American Nurses Credentialing Centre (ANCC).
Measures and Targets Six monthly update and progress report to DHB Board.

Approach 18.1: Development of a plan to ensure ongoing compliance with the Magnet Recognition Programme through continuous quality improvement.	
Milestones 18.1: • Plan developed outlining the Magnet monitoring programme. • Resources allocated to monitoring programme. • Monitoring programme commenced.	
Position Responsible 18.1: Director of Nursing.	
Risks 18.1	**Mitigations 18.1**
Loss of momentum following achievement of Magnet Recognition.	Monitoring programme ensures ongoing organisational commitment.

6.4.19 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 the Hutt Valley DHB 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 2006/07?

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. The committee structure for clinical services has been reviewed to ensure appropriate membership and compliance with external standards is achieved.

The accreditation/certification audit from Quality Health New Zealand (QHNZ) in July 2006 confirmed ongoing achievement with the accreditation standards and while only a 2 year certification status was awarded from the Ministry of Health, a review of the report and process undertaken by QHNZ will see this report resubmitted. Radiology and Laboratory services continued to achieve IANZ accreditation.

A quarterly Quality Report summarises activity including quality and patient safety initiatives, complaints, event reporting, ACC treatment injury and patient satisfaction is now disseminated throughout the organisation, ensuring feedback of trends and progress against key quality improvements.

Closer alignment of the Quality/Risk Unit with the Magnet Project Team has ensured documentation requirements were met in order to achieve a site visit in 2007 and that quality champions are supported through education and nursing audits.

What is planned for 2007/08?

The operational Quality Plan for 2007/08 has incorporated many features of the "Improving Quality" (IQ) strategy and the operational objectives for the year reflect the goals of this strategy. The redesign of systems of care is a key focus e.g. patient flow project, pathways for selective patients to streamline care and maximise available resources, scheduling of outpatient clinics with patient's able to choose their appointments. A six monthly report against the IQ strategy will be completed to monitor progress.

The Clinical Board will become a permanent structure with interim terms of reference confirmed. Re-credentialing of senior medical officers on a service by service basis will continue.

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.

A customer service training programme will be implemented for all staff to provide a basis for improved service delivery and communication by helping participants to develop positive attitudes to service, improve the way they relate to customers/patients and to exceed their expectations.

We will continue to utilise the enhanced patient satisfaction reporting for inpatients and outpatients to inform quality improvement initiatives, including a focus on reducing waiting times, improving access to clinics and reducing Do Not Attends.

Annual Objective 19: To support staff to deliver high quality care within a quality improvement framework.
Measures and Targets (see Appendix 7) QUA-01, Strategic Quality Plan.

Approach 19.1: Through external validation of standards, reference to the "Improving Quality" strategy and the use of data collected internally, e.g. patient satisfaction, complaints and event reporting.	
Milestones 19.1: • Monitoring progress against accreditation and certification action plans from the 2006 survey. • Introduction of new Equip4 accreditation standards. • Ongoing support for Magnet programme. • Support provided to services undergoing IANZ accreditation eg: Radiology, Laboratory, Breast screening.	
Position Responsible 19.1: Service Manager, Quality.	
Risks 19.1	**Mitigations 19.1**
External standards not met.	Planned approach ensuring timeframes are met and high quality of information submitted.

Approach 19.2: Through a culture of safe reporting, consumer participation and improved customer service.	
Milestones 19.2: • Patient satisfaction results are analysed, results fed back for focus on improvements. • Outcome of complaints, coronial, HDC and privacy events are utilised for focus on improvements. • Web-based event reporting process continues to be implemented throughout all services, and targeted patient safety messages promoted. • Introduce a customer service focus across all services.	
Position Responsible 19.2: Service Manager, Quality.	
Risks 19.2	**Mitigations 19.2**
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 learnings and improvements.

Approach 19.3: Through participation in national quality improvement initiatives and recognition of achievements of national level.	
Milestones 19.3: • Hutt Valley DHB participation in at least two national initiatives e.g. medication safety, patient flow. • Internal quality award framework aligned with national Health Innovation Awards. • Hutt Valley DHB achievements entered in national awards.	
Position Responsible 19.3: Service Manager, Quality.	
Risks 19.3	**Mitigations 19.3**
Missed opportunities to participate at national level in quality improvement	Ensure Hutt Valley DHB internal quality programme is aligned to national

initiatives.	initiatives.

6.4.20 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 actively involved in four Action Zones, as well as contributing the time of two members to HISAC (the CEO and the CIO).

Action Zone	Status
(1) National Network	Central Region DHBs are implementing a new cost effective and secure high speed network from Telecom called HealthZone. This is compatible with the architecture for an upgraded national network. The network will be in place by June 2007.
(3) HPI	We are using new Facility Identifiers in our E-Referrals implementation. Also, I represented DHBs on the HPI Steering Group for 3 years. We await delivery (from the MoH) of cleaned-up organisational identifiers and a complete set of assigned HPIs.
(8) Electronic Referrals	Rollout of E-referrals is beginning in April 2007. This is a fully electronic system supporting both GP and DHB referral processing and electronic status messaging. Hutt is the lead DHB on this Action Zone.
(9) NNPAC	National Non-Admitted Patients Collection data validation in progress.

Other project initiatives will focus on improved delivery of health information for management (management reporting), and for clinicians (electronic health record).

What progress was made in 2006/07?
The main focus of activity in 2006/07 was the upgrade of the Concerto Medical Application Portal, and IBA Patient Management System to the latest versions. These two key systems are now fully web enabled and have a good level of integration (single sign-on, shared patient context). We have also developed a portal to allow GPs access to (their) patient's clinical information held on the DHB's systems.

The Electronic Referrals System (using standards based solutions from Medtech, HealthLink and Orion) went into pilot in October 2006. Software issues are being resolved before rollout commences to more GPs and more DHB services in April 2007.

Significant work was done on ensuring accurate data for Elective Service Performance Indicators. New reports are currently in development to help ensure that we achieve on-going compliance.

What is planned for 2007/08?

Projects planned for 2007/08 include (a) implementation of Radiology Information System (RIS) and Picture Archiving Communication System (PACS), (b) improvements in elective services patient flows, (c) infrastructure upgrades.

Further on-going enhancements are planned for Electronic Referrals to meet business requirements and to provide closer integration with hospital systems. During 2007/08 the ISSP will be reviewed. The HISAC priorities (once known) will be revisited then and incorporated into the ISSP where applicable.

We will also support IT initiatives identified under other sections, e.g. interRAI, NASC, PRIMHED in Mental Health, Dental, Emergency Department and Surgical audit.

Collaborative regional initiatives include the following:

- Shared Lab Results Repository with Capital & Coast
- Implementation of RIS/PACS regional repository and backup
- Regional Dental services – including Capital & Coast

We have identified a need for additional resources to support improved data quality for management and OPF reporting. The plan is to analyse our data integrity issues, deploy appropriate resource, provide documentation and education for front line staff, and provide additional checks and balances in the reporting cycle.

Annual Objective 20a: Implement Radiology Information System (RIS) and Picture Archiving Communication System (PACS).
Measures and Targets (see Appendix 7) Information, QUA-03, Information Management and Technology – NZHIS, Updating of Information Systems Strategic Plan, Contribution to Health Information Strategy New Zealand.

Approach 20.1: Implement new Radiology Information System (RIS) and Picture Archiving Communication System (PACS) to support improved clinical information and workflows.	
Milestones 20.1: • RIS system in production. • PACS and Computerised Radiography in production.	
Position Responsible 20.1: Chief Information Officer.	
Risks 20.1	**Mitigations 20.1**
Project is scoped and funded inadequately.	IPS and knowledge of other implementations leveraged.
Vendor resources are available.	Work with other DHBs to ensure availability of vendor resources.
Technical complexity.	Ensure infrastructure is robust and learn from other DHBs.

Annual Objective 20b: Improve elective services patient flows.
Measures and Targets (see Appendix 7) Information, QUA-03, Information Management and Technology – NZHIS, Updating of Information Systems Strategic Plan, Contribution to Health Information Strategy New Zealand, Improving elective services, SER-04, Elective Services Patient Flow Indicators

Approach 20.2: Customise patient management systems to improve patient workflow and communication for more patient focussed elective services.	
Milestones 20.2: • New systems developed and functioning.	
Position Responsible 20.2: Chief Information Officer.	
Risks 20.2	**Mitigations 20.2**
Design of new workflow processes.	Extended period of consultation and analysis.
Capability of system to meet requirements.	Find workarounds where necessary.
Insufficient staff and skills to perform work.	Allow new staff time to learn the system.

6.4.21 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 community's 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 in the DHB/DHBNZ Future Workforce Plan and workforce strategy groups. Other major projects include the rollout of the Health Workforce Information Programme (HWIP) and healthy workplace initiatives, from the report by the Health Workforce Advisory Committee (HWAC).

What progress was made in 2006/07?

Key milestones for 06/07 relate to:

- Positive workplace environments.

We are aware of the national data for healthy workplace indicators and favourably meet most of this criteria. Our commitment to a positive workplace culture is seen through our invited participation in two national pilots – 1) work/life balance and the 2) pay and employment equity review. We have a very successful and motivated bipartite group that meets monthly to discuss key issues of value to both parties, thus maintaining good relationships between staff, unions and managers. We are preparing for Magnet accreditation and a staff satisfaction survey. With the scaling back of our successful 10000 Steps programme, we have introduced "Walk the Hutt" an exercise and nutrition programme with great community potential.

- Recruitment and retention.

We have developed not only a DHB wide but also a region wide nursing recruitment website Nznurses.co.nz, which all DHBs over the region have recruited staff from. We also have a highly successful recruitment brand and website that is open to other DHB funded providers to use. We ran a hugely successful nurse graduate programme, and received around 90 applications without advertising – this is due to the reputation of nursing at Hutt and a credit to our partnership with our tertiary training providers, such as Whitireia and Victoria University. We have also worked with St Orans College to implement a mentoring programme pilot that we are now rolling out to 3 other colleges in the region.

- Inspiring leaders.

Last year saw the third year of our health leadership course run via Weltec. We are planning wider collaboration with a couple of DHBs in our region enabling them access to this NZQZ accredited leadership development programme. We are currently working on a pilot for management/leadership orientation and line manager development.

- DHB wide Health Education Unit.

With the help of many generous donations, the first stage of the implementation of the Health Education Unit has been developed – our clinical training unit (CTU). The CTU incorporates clinical and some non clinical, multi discipline teaching and professional development courses and seminars that will be offered DHB wide. We

offer a wide variety of courses from Intravenous therapy training (IV) and resuscitation (CPR), to simulated training on manikins and artificial body parts, all grouped together in one training and learning zone in the hospital.

What is planned for 2007/08?
The key themes for 2007/08 continue to relate strongly to positive workplace culture – in particular around delivery of patient-focused services and the development of roles to meet those service needs. Teamwork and needs of multi-discipline teams as well as inter and intra service teams from both a motivation and planning perspective is an important focus. A further key theme is learning and development which will support the service needs.

Recruitment and retention remains a strong element as does leadership development. This is a challenge in an ever tight and demanding labour market.

We will have a particular focus on enhancing and developing the Māori and Pacific workforce throughout the Hutt Valley through scholarship and mentoring programmes.

Annual Objective 21: Implement Strategic Workforce Development priorities.
Measures and Targets (see Appendix 7) Workforce, HKO-02.

Approach 21.1: Positive Workplace Culture - Continuation of strategies that make Hutt Valley DHB a healthy and great place to work.	
Milestones 21.1: • Staff satisfaction survey completed, outcomes identified and recommendations reviewed and prioritised. • Continued participation in work/life balance pilot and pay and employment equity review pilot. • An emphasis on teams and team behaviour and managing/leading service delivery change is developed via specific initiatives such as toolkits and specific training. • Maintain bipartite relationships with unions and associations that are effective and ongoing. • Investigate and develop health and nutrition initiatives such as Walk the Hutt.	
Position Responsible 21.1: General Manager, Human Resources.	
Risks 21.1	**Mitigations 21.1**
Lack of buy in from staff and key stakeholders.	Be open in our communications 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 21.2: Recruitment and Retention – Focus on key vacancies and retention issues in all DHB contracted services, including hospital services and primary care.

Milestones 21.2:

- Key vacancies are identified and recruitment strategies developed and implemented. These should be relative to priorities identified in the DAP.
- Work with schools in high needs areas to implement workforce development initiatives such as workchoice day, mentoring, work experience.
- Research the likely future supply of General Practitioners and Practice Nurses in the Hutt Valley jointly with primary care (see also Primary Health Care section).
- Develop and maintain Māori and Pacific workforce (see also Māori, Pacific and mental health sections).

Position Responsible 21.2: General Manager, Human Resources.

Risks 21.2	**Mitigations 21.2**
Commitment of resources and significant volume of input required on projects.	Be realistic about project priorities and milestones, including resourcing, timeframes and funding.

Approach 21.3: Inspiring Leaders – Establish a co-ordinated and proactive approach to developing great people managers.

Milestones 21.3:

- Manager and Senior Medical Officer orientation programmes are developed and implemented.
- Develop robust succession planning frameworks.
- Introduce a mix of both technical and organisational development training for managers and union delegates to support service delivery changes and needs.
- Innovation is encouraged and supported at all levels.

Position Responsible 21.3: General Manager, Human Resources.

Risks 21.3	**Mitigations 21.3**
Lack of buy in from staff and key stakeholders.	Be open in our communications 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 21.4: 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 21.4:

- Complete the implementation of the Clinical Training Unit (CTU) and promote its use internally to support service delivery changes and needs.
- Seek opportunities for use of the CTU externally as well as across the wider DHB.
- Continue to scope the establishment of a co-ordinated practice unit across the wider DHB.
- Review the needs of a co-ordinated approach to other DHB functions such as research, ethics, scholarships.

Position Responsible 21.4: General Manager, Human Resources.

Risks 21.4	**Mitigations 21.4**
Commitment of resources and significant volume of input required on projects.	Be realistic about project priorities and milestones, including resourcing, timeframes and funding.

6.4.22 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. 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 2006/07?

The new breast screening facility was completed and a new second floor theatre is been developed. By the end of June 2007 we will have completed all planning documents for the Integrated Campus Plan process including: Clinical Service Plan, Campus Master Plan, Infrastructure Review, Concept Master Plan, Asset Management Plan. We will also have submitted our Strategic Development Paper to the National Capital Committee for approval. See also Quality and Safety, Information Services and Workforce Development sections.

What is planned for 2007/08?

Subject to approval of our Strategic Development Paper by the National Capital Committee, we will progress to completion of a full business case for the major project in our Integrated Campus Plan, the Emergency Department/Theatre project. This would then be considered in August or September 2007. Again assuming this is approved, we will progress to detailed design and planning during the balance of the 2007/2008 year. See also Quality and Safety, Information Services and Workforce Development sections.

Annual Objective 22: Approval for and commencement of the Emergency Department/Theatre project.
Measures and Targets Clinical Services Plan and Strategic Options papers completed. Business plans complete for campus redevelopment for consideration by National Capital Committee. Engagement of consultants to progress detailed design and construction March 2008. Achievement of timelines within budget and to the satisfaction of users and service staff.

Approach 22.1: Develop and implement the Emergency Department/Theatre project.	
Milestones 22.1: • Business case prepared and signed-off by users and Board. • Presentation to National Capital Committee. • Engagement of key consultants to progress detailed design and construction.	
Position Responsible 22.1: Executive Operational Advisor.	
Risks 22.1	**Mitigations 22.1**

Project cost escalation.	Contract and user group management.
Successful co-location of services.	User group consultation.

6.4.23 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 2006/07?
The new contract between Hutt Valley and Capital and Coast DHBs and Aotea Laboratories (a merger between Valley Diagnostic and Medlab Wellington) came into force 1 November 2006 following a joint project between Hutt Valley and Capital and Coast DHBs. The project will result in an estimated saving to Hutt Valley DHB of $10 million over 5 years and a total saving to the Capital Coast and Hutt Valley DHBs of around $30 million over 5 years.

What is planned for 2007/08?
Following the successful work in managing demand-driven expenditure for laboratory services, the focus in 2007/08 will be on management of demand driven expenditure for pharmaceutical services. Other areas for focus in ensuring Value for Money will be in the implementation of an enhanced NASC and within diabetes and oral health services (see also Chronic Disease, Oral Health and Health of Older People sections).

In our District Annual Plans for 2007/08, District Health Boards are required to focus on diabetes as a means of determining the extent to which "Value for Money" is being obtained through the pursuit of efficiency, productivity and innovation. The Diabetes Management Scorecard set out below is based on the Diabetes Scorecard developed by PricewaterhouseCoopers to gather information to:

- Improve knowledge about the performance of diabetes services provided by District Health Boards.
- Act as a monitoring tool for District Health Board management to gauge their progress over time in providing diabetes-related services and to indicate how effective those services are in reducing the burden of the disease.

The scorecard has four quadrants:

- Consumer/District Health Board Population.
- Financial.
- Learning/Innovation.
- Internal Processes.

The Financial quadrant demonstrates that funding is being applied to both the prevention and treatment of diabetes, meeting our strategic intentions of reducing both the incidence and impact of chronic disease. The numbers given in the financial quadrant are not representative of our entire spend on diabetes.

The Learning and Innovation quadrant outlines the key initiatives which are a focus for 2007/08. A key area will be on using Information Technology tools to improve patient management, early diagnosis and quality of care in both the primary and secondary settings.

Value for Money in diabetes will be pursued through the application of resources to proven cost-effective interventions (such as renal services) and through enhancing quality and efficiency through decision support tools and the facilitation of practice support.

Consumer/DHB Population	Financial
Diabetes Case Detection (percentage of people who have an annual review of the total expected number of diabetes in the population according to the Ministry of Health diabetes model), Diabetes Case Management (percentage of people who have an annual review – i.e., registered who have their HBA1c < = 8), and Diabetes Retinal Screening (percentage of people who have an annual review re-registered and have had retinal screening in last two years). See Indicator of DHB Performance POP-01 in Appendix 7 for historic and target information.	*Primary Care* Community delivered Diabetes Action (includes community dietetics, PHO Practice Nurse delivered education and support, private podiatry payments and Māori specific outreach) - $432,262 *Screening & incentives* Annual Review payments - $174,000 Retinal screening - $110,000 *Pharmaceuticals* Pharmaceuticals – direct $862,212 indirect $5,528,640 *Secondary Care* Diabetes Management (includes hospital specialists, podiatry, specialist nursing and workforce development) $781,194
Internal Processes	**Learning/Innovation**
• Ongoing implementation of the Hutt Valley DHB Diabetes plan.	• Regional review of renal dialysis services. • Improving the primary and secondary interface for diabetes patients, with a particular focus on meeting the needs of Māori and Pacific people. • Ongoing development of local and regional Information Technology tools to assist primary and secondary care with patient management.

Annual Objective 23: Ensure Value For Money.
Measures and Targets SER-03, Improving diabetes services, Diabetes, POP-01, Diabetes Self Evaluation, Reducing ambulatory sensitive (avoidable) admissions, POP-09, Health of Older People.

Approach 23.1: Manage demand-driven expenditure for pharmaceutical services.	
Milestones 23.1: • Strategy developed for management of pharmaceutical expenditure. • Improved pharmacy facilitation for prescribers.	
Position Responsible 23.1: Portfolio Manager Planning & Funding.	
Risks 23.1	**Mitigations 23.1**
Facilitation skills not available.	Training.
Resistance to change.	Consultation with primary care including advice from Pharmacy Reference Group.

Approach 23.2: Ensure Value For Money from diabetes services (see also Chronic Disease section).

Milestones 23.2:

- Improve the primary and secondary interface for diabetes patients, with a particular focus on meeting the needs of Māori and Pacific people.
- Improve value for money in the delivery of renal dialysis services.

Position Responsible 23.2: Service Manager Acute and Chronic Care, Portfolio Manager Planning & Funding.

Risks 23.2	**Mitigations 23.2**
Insufficient buy-in from primary and secondary care to work more closely together.	Early engagement between primary and secondary care in model development.
Capacity of primary care to manage numbers of patients with renal disease.	Work closely with primary care to understand resource constraints.
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.
Analysis not completed for agreement decision of service model.	Maintain participation in service planning group.

Approach 23.3: Implement a staged approach to centralised service coordination with an augmented needs assessment and service coordination service.

Milestones 23.3:

- Implement an augmented Needs Assessment and Service Coordination (NASC) service.

Position Responsible 23.3: Older Persons Portfolio Manager.

Risks 23.3	**Mitigations 23.3**
Workforce capacity and capability may be limited.	Early engagement of key stakeholders in the development stages of the project. Link with workforce development strategies to identify and focus on implementing a restorative approach to service delivery.
Service transition may be problematic.	Early engagement of key stakeholders in the development stages of the project to incorporate communication strategies.

7. Managing Financial Resources

Our DAP for 2006/07 effectively planned for a break-even result. Our projections for the 2007/08, 2008/09 and 2009/10 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 2007/2008.

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.
- 2007/08 PHO capitation rollout of 25-44 year old age group with no wash-up.
- 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.

Our revenue projection for 2007/2008 DAP is based the latest funding advice. The impact of this advice has seen the DHB move into transitional funding – financially this means the DHB will receive a lower net increase in funding.

We have applied base revenue increases of 2.0% for 2008/2009 and 2.0% for 2009/2010 as suggested in the funding advice.

We have a number of initiatives in progress that will commence during 2007/2008 and will have an impact on our planned results for 2008/2009 and 2009/2010 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 our new theatre to provide additional capacity. As a result of these initiatives we are projecting break-even results for 2008/2009 and for 2009/2010.

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 tables show 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. The financial reporting standard about preparing prospective financial statements (FRS-42) states that prospective forecast statements for an upcoming financial year should be prepared using the same standards as the financial statements at the end of that financial year. The prospective (forecast) financial statements in the SOI and DAP have been prepared in accordance with NZ GAAP. However, from 1 July 2007 a new set of accounting standards will be used in New Zealand called the New Zealand Equivalents to International Financial Reporting Standards (NZIFRS). This means that these prospective financial statements are also prepared in accordance with NZIFRS. It is important to note that actual financial performances achieved for these years are likely to vary from the information

presented, and that the variations may be material. If prospective financial statements give effect to a change in accounting policy, this change shall be disclosed, including the reason for the change and its effect on the prospective financial statements.

Consolidated Statement of Prospective Financial Performance	2005/06 $'000 Plan	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan	2009/10 $'000 Plan
Revenue	305,779	315,314	345,993	352,947	359,974
Less Operating Expenditure					
DHB Provider Expenditure	(136,179)	(139,276)	(151,508)	(154,685)	(157,779)
External provider expenditure	(153,446)	(157,586)	(175,790)	(179,181)	(182,735)
Governance & Funding Administration	(3,005)	(2,743)	(3,074)	(3,138)	(3,199)
Taxation	0	0	0	0	0
Total Operating Expenditure	(292,630)	(299,605)	(330,372)	(337,004)	(343,713)
Surplus/ (Deficit) before Interest, Depreciation, and Capital Charge	13,149	15,709	15,621	15,943	16,261
Gain / Loss on sale of assets	(124)	0	0	0	0
Interest	(1,183)	(1,184)	(1,182)	(1,206)	(1,230)
Depreciation	(6,877)	(8,518)	(8,242)	(8,410)	(8,577)
Capital Charge	(4,959)	(6,007)	(6,197)	(6,327)	(6,454)
NET SURPLUS / DEFICIT	6	0	0	0	0

Consolidated Statement of Prospective Movements in Equity	2005/06 $'000 Plan	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan	2009/10 $'000 Plan
Crown Equity at start of period	27,469	27,468	77,836	77,836	77,836
Repayment of Crown Equity	0	0	0	0	0
Surplus/ (Deficit) for the period	6	0	0	0	0
Distributions to the Crown	0	0	0	0	0
Revaluation Reserve	50,368	50,368	0	0	0
Crown Equity at the end of the period	**77,843**	**77,836**	**77,836**	**77,836**	**77,836**

Consolidated Statement of Prospective Financial Position	2005/06 $'000 Plan	2006/07 $'000 Plan	2007/08 $'000 Plan	2008/09 $'000 Plan	2009/10 $'000 Plan
CROWN EQUITY	77,843	77,836	77,836	77,836	77,836
CURRENT ASSETS					
Bank balances, deposits, cash	7,410	5,113	7,396	4,700	2,089
Receivables	16,298	14,419	17,163	17,708	17,627
Properties intended for resale	0	0	0	0	0
Inventory	972	972	972	972	972
CURRENT LIABILITIES					
Payables and accruals	42,375	45,956	54,497	53,346	46,078
NET WORKING CAPITAL	(17,695)	(25,452)	(28,966)	(29,965)	(25,390)
NON CURRENT ASSETS					
Fixed Assets	115,603	123,388	126,902	127,901	123,326
Investments					
NON CURRENT LIABILITIES					
Borrowings and Provisions	20,065	20,100	20,100	20,100	20,100
NET ASSETS	77,843	77,836	77,836	77,836	77,836

7.1.1 Summary of 2006/07 Operating Budget

Our operating forecast for 2007/2008 is a break-even position.

7.1.2 Funding Advice

Funding advice was received in December 2006 that included additional funding for 2007/2008. The additional funding consists of a 3.103% cost increase (called Future Funding Track – FFT).

The funding advice also moved previous' top sliced' funding for PSA pay-jolt, the Mental Health blueprint increase, and PHO and Primary Maternity care devolutions into our core population based funding. Due to changes in the measurement of population shares Hutt Valley DHB also moved into the 'transitional funding group' for the 2007/08 year.

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 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 2007/2008 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 $700,000 for 2007/2008. This compares with a budget surplus for 2006/07 of $1,978,000.

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. A national pricing programme determines prices.

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 2007/2008 that are detailed in the following section.

We are estimating a DAP deficit for the Provider Arm of $700,000 for 2007/2008. This compares to a budget deficit for 2006/2007 of $1,978,000.

7.2 Assumptions

The following sections list the key assumptions we have included in the annual plan for 2007/2008. 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.
- 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 non-employment related expenses of 3.1%.
- 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 or, in approved instances, by way of operating leases.
- 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

- 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.
- No growth in demand has been incorporated into the budgets.
- The budgets for all demand driven costs are based on our forecast expenditure for 2006/07 plus the FFT adjustment for 2007/08.
- No provision has been made for any funding of new initiatives.

7.2.3 Risks

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

- 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 produce a deficit.

7.2.4 Outyears 2008/09 to 2009/10

We have assumed base revenue increases of 2.0% and 2.0% for the 2008/2009 and 2009/2010 years respectively. After providing for increased costs and for the impact of our improvement initiatives, we estimate break-even results in 2008/2009 and in 2009/2010.

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

	2005/06 $000's	2006/07 $000's	2007/08 $000's	2008/09 $000's	2009/10 $000's
Approved/Baseline Expenditure					
Property & Plant	2,382	5,126	4,770	2,544	1,540
Clinical Equipment	1,514	1,504	2,908	1,073	1,125
Computer Equipment	2,636	7,721	1,624	1,526	1,185
Other Office Equipment	152	27	254	263	150
Total Baseline	6,684	14,378	9,556	5,406	4,000
Strategic Still To Be Approved					
RIS/PACS			2,200		
ED Theatres				2,000	20,000
Infrastructure				2,000	3,000
Total Pending Approval	0	0	2,200	4,000	23,000
Total Capital Expenditure	**6,684**	**14,378**	**11,756**	**9,406**	**27,000**
Financed By					
Depreciation	6,748	8,517	8,242	8,407	8,575
Internally Sourced Funding		5,861	3,514	999	
CHFA Debt (Unapproved)					18,425
	6,748	14,378	11,756	9,406	27,000

Campus Planning – we are currently completing an integrated campus plan to identify our future facility requirements. We intend to take a business case to the National Capital Committee in 2007/08 for support for this development. These plans will help ensure we can deliver services as efficiently as possible. Our intention is to self-fund any capital development as far as our resources will allow. Otherwise, we will look for external financing of any approved future facility requirements.

We have not identified any significant assets that are surplus to long-term health service delivery needs. We have not made any provision in the DAP for any Asset Revaluations as we last revalued our relevant assets at 30 June 2006.

7.4 Efficiency Initiatives

The following initiatives are in progress and will impact on our results for the 2007/2008 planning period:

- Regional Planning – we are actively involved in working with the central region DHBs to identify opportunities for service coordination.
- Campus Planning – we are currently preparing an Emergency Department/Theatre project business case (see section 7.3 above).

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 Māori sites of significance.

7.6 Business Cases

By the end of June 2007 we will have submitted our Strategic Development Paper to the National Capital Committee and the Oral Health service Provision for Children and Adolescents (OHSPCA) business case to the Ministry of Health for approval.

7.7 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 Health Financing Agency (CHFA) and there is scope for additional debt to fund major projects if required. The CHFA 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	2009/10 $000's
BNZ Ratio Calculations					
Debt to Debt + Equity *(Long term debt + Short term debt + Bank overdraft) / ((Long term debt + Short term debt + Bank overdraft) + Total Equity)*	20.4%	19.6%	19.6%	19.6%	19.6%
Interest Times Coverage *(Net Surplus + Interest Expense + Depreciation) / (Interest Expense)*	6.82	8.19	7.97	7.98	7.97
CHFA Ratio Calculations					
Debt to Equity *(Long term debt + Short term debt + Bank overdraft) / (Total Equity)*	25.7%	24.4%	24.4%	24.4%	24.4%
Interest Times Coverage *(Net Surplus + Interest Expense + Capital Charge Expense + Depreciation) / (Interest Expense)*	11.01	13.27	13.22	13.22	13.22

8. Measuring Performance: Output Objectives and Measures

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 (see Appendix 7), the following indicators have been selected to be included in our upcoming Annual Plans, 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 Health Target Measures**	**Board District Strategic Plan Measures**
Effectiveness	Improving immunisation Improve nutrition, increase physical activity and reduce obesity Reduce the harm caused by tobacco	Immunisation Physical Activity
Equity and Access	Improving oral health Reducing cancer waiting times Reducing ambulatory sensitive (avoidable) admissions Improving diabetes services	Oral Health Primary Health Diabetes Screening Mental Health Services Workforce
Quality	Improving elective services Improving mental health services	Information
Efficiency and Value-for-Money	Reduce the percentage of the health budget spent on the Ministry of Health	Hospital Performance

The Performance Measures listed on the following pages include National Health Target measures, which are consistent across DHBs, and local measures and targets which were developed as part of our last District Strategic Plan. Appendix 7 also contains more detail on the full range of Indicators of DHB Performance included as part of routine reporting to the Ministry of Health, including descriptions, baseline data and targets.

National Health Targets

<table>
<tr><th>Target, Output Class and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets 2007/08-2009/10</th></tr>
<tr><td>Improving immunisation coverage.
Effectiveness.
New Zealand Health Strategy, Primary Health Care Strategy, He Korowhai Oranga.</td><td>Outcome: 95% of two year olds are fully immunised, with at least 4 to 6 percent point increase on 2005 national immunisation coverage survey baseline.
Output: Numbers of vaccines delivered.</td><td>See section 6.4.8 Maternity, Child and Youth Health & POP-08.</td><td>The 2005 National Survey of Immunisation Coverage showed a 89% coverage rate for the Central South Island Region, with national coverage of Māori and Pacific children at 69% and 81% respectively. Information available from local immunisation audits indicates that around 90% of Hutt Valley children enrolled with a PHO are fully immunised by age two. Targets will be revised when two year old cohort data from the National Immunisation Register becomes available towards the end of 2007.
<table><tr><td>Fully immunised</td><td>Actual 2005</td><td>Prov. 2006/07</td><td>Target 2007</td><td>Target 2008</td><td>Target 2009</td></tr><tr><td>2 year olds</td><td>92%</td><td>88-94%</td><td>88%</td><td>92%</td><td>95%</td></tr><tr><td>Māori</td><td>n/a</td><td>83%</td><td>85%</td><td></td><td></td></tr><tr><td>Pacific</td><td>n/a</td><td>82%</td><td>85%</td><td></td><td></td></tr></table></td></tr>
<tr><td>Improving oral health.
Equity and Access.
Child Health Strategy.</td><td>Outcome: Progress towards 85% adolescent oral health utilisation.
Output: Numbers of adolescents utilising oral health services.</td><td>See section 6.4.9 Oral Health & POP-11.</td><td>Adolescent Utilisation data
<table><tr><td>Prioritised Ethnicity</td><td>Actual 2005</td><td>Actual 2006</td><td>Target 2007</td><td>Target 2008</td><td>Target 2009</td></tr><tr><td>Total</td><td>53%</td><td>n/a</td><td>58%</td><td>62%</td><td>66%</td></tr></table></td></tr>
<tr><td>Improving elective services.
Quality.
Minister’s letter of expectations 2007/08.</td><td>Outcome: Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs) and each DHB will set an agreed increase in the number of</td><td>See section 6.4.7 Elective Services & SER-04.</td><td><table><tr><td>ESPI number</td><td>Target 2007/08</td></tr><tr><td>ESPI 1</td><td>>90%</td></tr><tr><td>ESPI 2</td><td><2%</td></tr><tr><td>ESPI 3</td><td><5%</td></tr><tr><td>ESPI 4</td><td>0%</td></tr></table></td></tr>
</table>

<table>
<tr><th>Target, Output Class and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets 2007/08-2009/10</th></tr>
<tr><td></td><td>elective service discharges, and will provide the amount of service agreed.
Output: Number of elective service discharges.</td><td></td><td>
<table>
<tr><td>ESPI 5</td><td><5%</td></tr>
<tr><td>ESPI 6</td><td><15%</td></tr>
<tr><td>ESPI 7</td><td><5%</td></tr>
<tr><td>ESPI 8</td><td>>90%</td></tr>
</table>
<table>
<tr><td></td><td>Base</td><td>Additional</td><td>Total</td></tr>
<tr><td>Estimated Cost Weighted Discharges</td><td>5,262</td><td>526</td><td>5,788</td></tr>
<tr><td>Estimated Discharges</td><td>4,495</td><td>450</td><td>4,945</td></tr>
</table>
</td></tr>
<tr><td>Reducing cancer waiting times.
Equity and Access.
Cancer Control Strategy.</td><td>Outcome: All patients wait less than 8 weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D).
Output: Number of patients receiving radiation oncology treatment.</td><td>See section 6.4.10 Cancer and Palliative Care & POP-10.</td><td>Hutt Valley DHB supports the national target and will work with the central region cancer network and Capital and Coast DHB (our local provider) towards achievement of this.</td></tr>
<tr><td>Reducing ambulatory sensitive (avoidable) admissions.
Equity and Access.
Primary Health Care Strategy, Child Health</td><td>Outcome: There will be a decline in the rate of admissions to hospital that are avoidable or preventable by primary health care for 0-4 year olds, those aged 45-64</td><td>See sections 6.4.8 Maternity, Child and Youth Health, 6.4.13 Health</td><td>Ambulatory Sensitive Hospitalisations indirectly standardised ratio of observed to expected
<table>
<tr><td>Age</td><td>Ethnicity</td><td>Actual Oct</td><td>Target 2007/08</td></tr>
<tr><td>0-74</td><td>Māori</td><td>119</td><td>117 (from 18.8% to 16.8%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Target, Output Class and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets 2007/08-2009/10</th></tr>
<tr><td>Strategy, Health of Older People Strategy.</td><td>and those aged 0-74 across all population groups.
Output: Numbers of ambulatory sensitive (avoidable) hospital admissions.</td><td>of Older People & POP-09.</td><td>
<table>
<tr><td></td><td></td><td></td><td>above national average)</td></tr>
<tr><td>0-74</td><td>Pacific</td><td>105</td><td>To remain at or below the national average</td></tr>
<tr><td>0-74</td><td>Other</td><td>127</td><td>123 (from 26.8% to 22.8% above national average)</td></tr>
<tr><td>0-4</td><td>Māori</td><td>136</td><td>128 (from 36% to 28.5% above national average)</td></tr>
<tr><td>0-4</td><td>Pacific</td><td>121</td><td>To remain at or below the national average</td></tr>
<tr><td>0-4</td><td>Other</td><td>176</td><td>168 (from 76.2% to 68.7% above national average)</td></tr>
<tr><td>45-64</td><td>Māori</td><td>108</td><td>To remain at or below the national average</td></tr>
<tr><td>45-64</td><td>Pacific</td><td>87</td><td>To remain at or below the national average</td></tr>
<tr><td>45-64</td><td>Other</td><td>124</td><td>120 (from 24.4% to 20% above the national average)</td></tr>
</table>
</td></tr>
<tr><td>Improving diabetes services.
Equity and Access.
New Zealand Health Strategy, Minister’s letter of expectations 2007/08.</td><td>Outcome: There will be an increase in the percentage of people in all population groups :
• Estimated to have diabetes accessing free annual checks.
• On the diabetes register who have good diabetes management.</td><td>See section 6.4.6 Chronic Diseases & POP-01.</td><td>Diabetes detection and follow-up rate
<table>
<tr><td></td><td>Actual 2005</td><td>Prov. 2006</td><td>Target 2007</td><td>Target 2008</td><td>Target 2009</td></tr>
<tr><td>Māori</td><td>46%</td><td>41%</td><td>50%</td><td>55%</td><td>60%</td></tr>
<tr><td>Pacific</td><td>89%</td><td>88%</td><td>90%</td><td>93%</td><td>95%</td></tr>
<tr><td>Other</td><td>86%</td><td>83%</td><td>90%</td><td>93%</td><td>95%</td></tr>
<tr><td>Total</td><td>78%</td><td>74%</td><td>80%</td><td>85%</td><td>90%</td></tr>
</table>
Diabetes management – HBA1C <= 8%</td></tr>
</table>

<table>
<tr><th>Target, Output Class and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets 2007/08-2009/10</th></tr>
<tr><td></td><td>• On the diabetes register who have had retinal screening in the past two years.

There will be improved equity for all population groups in relation to diabetes management.
Output: Numbers of diabetics receiving ‘Get Checked’ annual reviews.</td><td></td><td>
<table>
<tr><th></th><th>Actual 2005</th><th>Prov. 2006</th><th>Target 2007</th><th>Target 2008</th><th>Target 2009</th></tr>
<tr><td>Māori</td><td>59%</td><td>57%</td><td>60%</td><td>62%</td><td>64%</td></tr>
<tr><td>Pacific</td><td>50%</td><td>50%</td><td>52%</td><td>54%</td><td>56%</td></tr>
<tr><td>Other</td><td>80%</td><td>79%</td><td>81%</td><td>82%</td><td>83%</td></tr>
<tr><td>Total</td><td>74%</td><td>73%</td><td>75%</td><td>76%</td><td>77%</td></tr>
</table>
Diabetic retinopathy screening
<table>
<tr><th></th><th>Actual 2005</th><th>Prov. 2006</th><th>Target 2007</th><th>Target 2008</th><th>Target 2009</th></tr>
<tr><td>Māori</td><td>82%</td><td>79%</td><td>83%</td><td>84%</td><td>85%</td></tr>
<tr><td>Pacific</td><td>79%</td><td>75%</td><td>83%</td><td>84%</td><td>85%</td></tr>
<tr><td>Other</td><td>82%</td><td>81%</td><td>83%</td><td>84%</td><td>85%</td></tr>
<tr><td>Total</td><td>82%</td><td>80%</td><td>83%</td><td>84%</td><td>85%</td></tr>
</table>
</td></tr>
<tr><td>Improving mental health services.
Quality.
Te Tahuhu: Improving Mental Health 2005-2015.</td><td>Outcome: 100% of long-term clients have up to date relapse prevention plans (NMHSS criteria 16.4).
Output: Number of long-term clients.</td><td>See section 6.4.11 Mental Health & QUA-02.</td><td>Hutt Valley DHB supports the national target. At the end of 2006 96% of long term clients had relapse prevention plans. The local target for 2007/08 is 98%.</td></tr>
<tr><td>Improve nutrition, increase physical activity and reduce obesity.
Effectiveness.
Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau: A strategic framework.</td><td>Outcome: DHB activity supports achievement of these health sector targets - Proportion (percent) of infants exclusively and fully breastfeed:
74% at six weeks; 57% at three months; 27% at six</td><td>See sections 6.4.1 Public Health, 6.4.2 Intersectoral Collaboration, 6.4.4 Primary Health Care, 6.4.8</td><td>Hutt Valley DHB supports the national target and activity will support achievement of this. We will support the HEHA Strategy and reflect the priority population health objectives of improving nutrition, increase physical activity and reduce obesity</td></tr>
</table>

Target, Output Class and relevant Strategy	Description	Linkage to DAP Objectives and IDPs	Baselines and Local Targets 2007/08-2009/10
	months. Proportion (percent) of adults (15+ years) consuming at least three servings of vegetables per day, and proportion (percent) of adults (15+ years) consuming at least two servings of fruit per day: 70% for vegetable consumption; 62% for fruit consumption. Output: Implementation of a Ministry Approved Plan for Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau.	Maternity, Child and Youth Health & additional DHB reporting.	
Reduce the harm caused by tobacco. Effectiveness. Cancer Control Strategy.	Outcome: DHB activity supports achievement of these health sector targets - To continue to increase the prevalence of never smokers among 14 and 15 year olds by around 2% over 2007/08. To increase the proportion of smokefree homes where there was one or more smoker to over 75% in	See section 6.4.1 Public Health & additional DHB reporting.	Hutt Valley DHB supports the national target and activity will support achievement of this. We will support reduction in the incidence of New Zealanders becoming addicted smokers and we will support reduction of the settings where people are exposed to smoking or tobacco products. We will work with the Ministry of Health to develop a tobacco control plan for the region.

Target, Output Class and relevant Strategy	Description	Linkage to DAP Objectives and IDPs	Baselines and Local Targets 2007/08-2009/10
	2007/08. Output: Collaborative development and implementation of a tobacco control plan for the greater Wellington region.		
Reduce the percentage of the health budget spent on the Ministry of Health. Efficiency and Value For Money. Minister's letter of expectations 2007/08	DHBs are not expected to provide direct contribution to achieving this.	n/a	Hutt Valley DHB supports the national target.

Hutt Valley DHB District Strategic Plan Indicators

<table>
<tr><th>Indicator, Output Class and relevant Strategy</th><th>Measure Description</th><th>Desired outcomes</th><th>Baseline data and targets 2007/08</th></tr>
<tr><td>Immunisation.
Effectiveness.
New Zealand Health Strategy, Primary Health Care Strategy, He Korowhai</td><td>Percentage of children fully immunised by age two for different ethnic groups.</td><td>Want to see increasing percentages of children fully immunised by age two by using National Immunisation register information and</td><td>The 2005 National Survey of Immunisation Coverage showed a 89% coverage rate for the Central South Island Region. Information available from local immunisation audits indicates that over 90% of Hutt Valley children enrolled with a PHO are fully immunised by age two.
<table>
<tr><td>Fully</td><td>Actual</td><td>Prov.</td><td>Target</td><td>Target</td><td>Target</td></tr>
<tr><td>2 year olds</td><td>92%</td><td>88-94%</td><td>88%</td><td>92%</td><td>95%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Indicator, Output Class and relevant Strategy</th><th>Measure Description</th><th>Desired outcomes</th><th>Baseline data and targets 2007/08</th></tr>
<tr><td>Oranga.</td><td></td><td>through outreach immunisation services.</td><td>
<table>
<tr><td>2 year olds</td><td>92%</td><td>88-94%</td><td>88%</td><td>92%</td><td>95%</td></tr>
</table>
</td></tr>
<tr><td>Oral Health.
Equity and Access.
Child Health Strategy.</td><td>Average number of decayed/missing/filled teeth (DMFT) at year 8 for different ethnic groups.</td><td>Want to see reductions in average DMFT scores by maintaining appropriate levels of staffing and by implementing a new model of community-based dental care for children and adolescents.</td><td>POP-04 Oral Health – Mean DMFT score at Year 8
<table>
<tr><th></th><th>Actual 2004</th><th>Actual 2005</th><th>Actual 2006</th><th>Target 2007</th></tr>
<tr><td>Māori</td><td>1.3</td><td>1.7</td><td>1.6</td><td>1.5</td></tr>
<tr><td>Pacific</td><td>1.2</td><td>1.8</td><td>1.2</td><td>1.2</td></tr>
<tr><td>Other</td><td>0.8</td><td>0.7</td><td>0.8</td><td>0.7</td></tr>
<tr><td>Total</td><td>0.9</td><td>1.0</td><td>1.0</td><td>0.9</td></tr>
</table>
</td></tr>
<tr><td>Primary Health.
Equity and Access.
Primary Health Care Strategy.</td><td>Ratio of age-standardised rate of GP consultations per high need person (decile 9 or 10 or Māori/Pacific) compared to non-high need person.</td><td>Want to see increasing ratios of high need to non-high need consultations by working to improve the management of people with chronic conditions.</td><td>SER-01
<table>
<tr><th>High need: non high need</th><th>Actual Jan 2006</th><th>Actual Junet 2006</th><th>Actual Sept 2006</th><th>Target 2007</th></tr>
<tr><td>Ratio</td><td>0.99</td><td>1.03</td><td>1.13</td><td>>1.15</td></tr>
</table>
</td></tr>
<tr><td>Diabetes.
Equity and Access.
New Zealand Health</td><td>Uptake of annual diabetes checks, bi-annual retinal screening and diabetes management for different ethnic groups.</td><td>Want to see increasing percentages of estimated numbers of diabetics receiving free annual checks</td><td>Diabetes detection and follow-up rate
<table>
<tr><th></th><th>Actual</th><th>Prov.</th><th>Target</th><th>Target</th><th>Target</th></tr>
<tr><td>Māori</td><td>46%</td><td>41%</td><td>50%</td><td>55%</td><td>60%</td></tr>
<tr><td>Pacific</td><td>89%</td><td>88%</td><td>90%</td><td>93%</td><td>95%</td></tr>
<tr><td>Other</td><td>86%</td><td>83%</td><td>90%</td><td>93%</td><td>95%</td></tr>
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</td></tr>
</table>

<table>
<tr><th>Indicator, Output Class and relevant Strategy</th><th>Measure Description</th><th>Desired outcomes</th><th>Baseline data and targets 2007/08</th></tr>
<tr>
<td>Strategy, Minister's letter of expectations 2007/08.</td>
<td></td>
<td>Want to see increasing percentages of diagnosed diabetics managing their HBA1C levels.
Want to see increasing percentages of diabetics receiving retinopathy screening.
These are to be achieved by improving the primary and secondary interface for diabetes patients, with a particular focus on meeting the needs of Māori and Pacific peoples.</td>
<td>
<table>
<tr><td>Other</td><td>86%</td><td>83%</td><td>90%</td><td>93%</td><td>95%</td></tr>
<tr><td>Total</td><td>78%</td><td>74%</td><td>80%</td><td>85%</td><td>90%</td></tr>
</table>
Diabetes management – HBA1C <= 8%
<table>
<tr><td></td><td>Actual 2005</td><td>Prov. 2006</td><td>Target 2007</td><td>Target 2008</td><td>Target 2009</td></tr>
<tr><td>Māori</td><td>59%</td><td>57%</td><td>60%</td><td>62%</td><td>64%</td></tr>
<tr><td>Pacific</td><td>50%</td><td>50%</td><td>52%</td><td>54%</td><td>56%</td></tr>
<tr><td>Other</td><td>80%</td><td>79%</td><td>81%</td><td>82%</td><td>83%</td></tr>
<tr><td>Total</td><td>74%</td><td>73%</td><td>75%</td><td>76%</td><td>77%</td></tr>
</table>
Diabetic retinopathy screening
<table>
<tr><td></td><td>Actual 2005</td><td>Prov. 2006</td><td>Target 2007</td><td>Target 2008</td><td>Target 2009</td></tr>
<tr><td>Māori</td><td>82%</td><td>79%</td><td>83%</td><td>84%</td><td>85%</td></tr>
<tr><td>Pacific</td><td>79%</td><td>75%</td><td>83%</td><td>84%</td><td>85%</td></tr>
<tr><td>Other</td><td>82%</td><td>81%</td><td>83%</td><td>84%</td><td>85%</td></tr>
<tr><td>Total</td><td>82%</td><td>80%</td><td>83%</td><td>84%</td><td>85%</td></tr>
</table>
</td>
</tr>
<tr>
<td>Screening. Equity and Access. Cancer Control Strategy.</td>
<td>Breast and cervical screening coverage rates for different ethnic groups.</td>
<td>Want to see increasing coverage rates for eligible populations.
Want to see increasing coverage</td>
<td>
BreastScreen Central coverage for Hutt Valley residents
<table>
<tr><td>Ethnicity</td><td>Age</td><td>Actual</td><td>Actual</td><td>Target</td></tr>
<tr><td>All</td><td>45-49</td><td>20%</td><td>39%</td><td></td></tr>
<tr><td>All</td><td>50-54</td><td>64%</td><td>64%</td><td></td></tr>
<tr><td>All</td><td>55-59</td><td>62%</td><td>72%</td><td></td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr><th>Indicator, Output Class and relevant Strategy</th><th>Measure Description</th><th>Desired outcomes</th><th>Baseline data and targets 2007/08</th></tr>
<tr><td></td><td></td><td>rates for eligible populations by working with PHOs on reducing disparities by improving access to screening services and increasing participation.</td><td>
<table>
<tr><td>All</td><td>55-59</td><td>62%</td><td>72%</td><td></td></tr>
<tr><td>All</td><td>60-64</td><td>66%</td><td>75%</td><td></td></tr>
<tr><td>All</td><td>65-69</td><td>56%</td><td>64%</td><td></td></tr>
<tr><td>All</td><td>45-69</td><td>51%</td><td>60%</td><td>70%</td></tr>
<tr><td>Māori</td><td>45-69</td><td>35%</td><td>42%</td><td></td></tr>
<tr><td>Pacific</td><td>45-69</td><td>28%</td><td>36%</td><td></td></tr>
</table>
Cervical Screening coverage (hysterectomy adjusted) for Hutt Valley residents
<table>
<tr><th>Ethnicity</th><th>Age Group</th><th>Actual July 2006</th><th>Actual Dec 2006</th><th>Target 2007</th></tr>
<tr><td>All</td><td>20-24</td><td>57%</td><td>58%</td><td></td></tr>
<tr><td>All</td><td>25-29</td><td>67%</td><td>69%</td><td></td></tr>
<tr><td>All</td><td>30-34</td><td>69%</td><td>71%</td><td></td></tr>
<tr><td>All</td><td>35-39</td><td>71%</td><td>71%</td><td></td></tr>
<tr><td>All</td><td>40-44</td><td>69%</td><td>72%</td><td></td></tr>
<tr><td>All</td><td>45-49</td><td>75%</td><td>76%</td><td></td></tr>
<tr><td>All</td><td>50-54</td><td>74%</td><td>77%</td><td></td></tr>
<tr><td>All</td><td>55-59</td><td>73%</td><td>72%</td><td></td></tr>
<tr><td>All</td><td>60-64</td><td>76%</td><td>71%</td><td></td></tr>
<tr><td>All</td><td>65-69</td><td>69%</td><td>68%</td><td></td></tr>
<tr><td>All</td><td>20-69</td><td>70%</td><td>71%</td><td>78%</td></tr>
<tr><td>Māori</td><td>20-69</td><td>51%</td><td>52%</td><td></td></tr>
<tr><td>Pacific</td><td>20-69</td><td>40%</td><td>43%</td><td></td></tr>
<tr><td>Asian</td><td>20-69</td><td>n/a</td><td>50%</td><td></td></tr>
<tr><td>Other</td><td>20-69</td><td>76%</td><td>80%</td><td></td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Indicator, Output Class and relevant Strategy</th><th>Measure Description</th><th>Desired outcomes</th><th>Baseline data and targets 2007/08</th></tr>
<tr><td>Mental Health Services. Equity and Access. Te Tahuhu: Improving Mental Health 2005-2015.</td><td>Percentage of population accessing mental health services for different ethnic groups and by age group, compared to the 3% of the population that are estimated to have severe mental health disorders.</td><td>Want to see increasing percentages of the population accessing mental health services and having these reported to MHINC by increasing NGO and regional specialist provider reporting to MHINC.</td><td>The percentage of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for children and youth aged 0-19, adults aged 20-64 and older people aged 65+.
Mental Health Information National Collection data
<table>
<tr><th>Ethnicity</th><th>Age group</th><th>Actual 2005/06</th><th>Prov. 2006</th><th>Target 2007</th></tr>
<tr><td>Māori</td><td>0-19</td><td>1.7%</td><td>1.8%</td><td>2.3%</td></tr>
<tr><td>Māori</td><td>20-64</td><td>3.7%</td><td>3.6%</td><td>3.7%</td></tr>
<tr><td>Māori</td><td>65+</td><td>1.2%</td><td>1.2%</td><td>1.3%</td></tr>
<tr><td>Other</td><td>0-19</td><td>1.8%</td><td>1.8%</td><td>2.3%</td></tr>
<tr><td>Other</td><td>20-64</td><td>2.7%</td><td>2.7%</td><td>2.9%</td></tr>
<tr><td>Other</td><td>65+</td><td>1.5%</td><td>1.4%</td><td>1.5%</td></tr>
<tr><td>Total</td><td>0-19</td><td>1.8%</td><td>1.8%</td><td>2.3%</td></tr>
<tr><td>Total</td><td>20-64</td><td>2.8%</td><td>2.8%</td><td>2.9%</td></tr>
<tr><td>Total</td><td>65+</td><td>1.5%</td><td>1.4%</td><td>1.5%</td></tr>
</table></td></tr>
<tr><td>Information. Quality. Health Information Strategy New Zealand.</td><td>Percentage of primary care referrals and hospital discharges done electronically for different services.</td><td>Want to see increasing percentages of primary care referrals and hospital discharges done electronically by enhancing the Electronic Referrals System.</td><td>Electronic discharges and referrals
<table>
<tr><th>Service</th><th colspan="2">Discharges</th><th colspan="2">Referrals</th></tr>
<tr><td>Service</td><td>Aug 2005</td><td>Dec 2006</td><td>Aug 2005</td><td>Dec 2006</td></tr>
<tr><td>Dental</td><td>62%</td><td>71%</td><td>0%</td><td>0%</td></tr>
<tr><td>Specialist Rehabilitation</td><td>92%</td><td>100%</td><td>0%</td><td>0%</td></tr>
<tr><td>Mental Health</td><td>84%</td><td>63%</td><td>0%</td><td>0%</td></tr>
<tr><td>Gynaecology</td><td>96%</td><td>95%</td><td>0%</td><td>0%</td></tr>
<tr><td>Rheumatology</td><td>100%</td><td>100%</td><td>0%</td><td>0%</td></tr>
<tr><td>Ear, Nose & Throat</td><td>94%</td><td>82%</td><td>0%</td><td>0%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Indicator, Output Class and relevant Strategy</th><th>Measure Description</th><th>Desired outcomes</th><th>Baseline data and targets 2007/08</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Orthopaedics</td><td>92%</td><td>97%</td><td>0%</td><td>0%</td></tr>
<tr><td>Cardiology</td><td>94%</td><td>99%</td><td>0%</td><td>0%</td></tr>
<tr><td>General Surgery</td><td>97%</td><td>92%</td><td>0%</td><td>0%</td></tr>
<tr><td>Obstetrics</td><td>99%</td><td>97%</td><td>0%</td><td>0%</td></tr>
<tr><td>Paediatric Medicine</td><td>91%</td><td>90%</td><td>0%</td><td>0%</td></tr>
<tr><td>Plastics & Burns</td><td>95%</td><td>94%</td><td>0%</td><td>0%</td></tr>
<tr><td>General Medicine</td><td>92%</td><td>94%</td><td>0%</td><td>0%</td></tr>
</table>
Currently e-referrals are being piloted with a small number of practices in a subset of services areas.
</td></tr>
<tr><td>Workforce. Equity and Access. Primary Health Care Strategy.</td><td>Ratio of Full-Time Equivalent General Practitioners (GPs) and Nurse Practitioners to the population</td><td>Want to see General Practitioner and Practice Nurse (PN) coverage for the population to be increased or at least maintained at current levels by assisting primary care to develop its workforce.</td><td>
General Practitioner and Practice Nurse population ratios
<table>
<tr><th></th><th>Actual Aug 2005</th><th>Actual Dec 2006</th><th>Targets 2007/08</th></tr>
<tr><td># GPs</td><td>108</td><td>122</td><td></td></tr>
<tr><td>FTE GPs</td><td>75</td><td>78</td><td></td></tr>
<tr><td># PNs</td><td>73</td><td>91</td><td></td></tr>
<tr><td>FTE PNs</td><td>50</td><td>60</td><td></td></tr>
<tr><td>Population</td><td>138,700</td><td>138,600</td><td></td></tr>
<tr><td>GP per Population</td><td>1,849</td><td>1,777</td><td><1,850</td></tr>
<tr><td>PN per Population</td><td>2,774</td><td>2,310</td><td><2,775</td></tr>
</table>
</td></tr>
<tr><td>Physical Activity. Effectiveness. Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau: A</td><td>Proportion of population using active modes of transport (walking or cycling) for trips shorter than 2 kilometres.</td><td>Want to see an increase in walking and cycling for short trips by working intersectorally to improve coordination and collaboration across agencies to</td><td>
The Greater Wellington Regional Council (GRWC) has targets to increase walking and cycling for short trips and conducts surveys to measure this. Hutt Valley DHB supports GWRC targets.
<table>
<tr><th>GRWC survey</th><th>Actual</th><th>Actual</th><th>GWRC</th></tr>
<tr><td>0-1 kilometre</td><td>74%</td><td>74%</td><td>80%</td></tr>
<tr><td>1-2 kilometre</td><td>19%</td><td>27%</td><td>60%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Indicator, Output Class and relevant Strategy</th><th>Measure Description</th><th>Desired outcomes</th><th>Baseline data and targets 2007/08</th></tr>
<tr><td>strategic framework.</td><td></td><td>support physical activity.</td><td><table><tr><td>1-2 kilometre</td><td>19%</td><td>27%</td><td>60%</td></tr></table></td></tr>
<tr><td>Hospital Performance. Efficiency and Value For Money. New Zealand Health Strategy.</td><td>Proportion of day cases discharges.</td><td>Want to see increasing proportions of day cases by maximising the effective use of day-case surgery.</td><td>Day Case Percentages<table><tr><td></td><td>Actual 2004/05</td><td>Actual 2005/06</td><td>Target 2007/08</td></tr><tr><td>Day Case Discharges</td><td>9,349</td><td>9,397</td><td></td></tr><tr><td>Total Discharges</td><td>26,592</td><td>26,633</td><td></td></tr><tr><td>Percent Day Cases</td><td>35%</td><td>35%</td><td>>35%</td></tr></table></td></tr>
</table>

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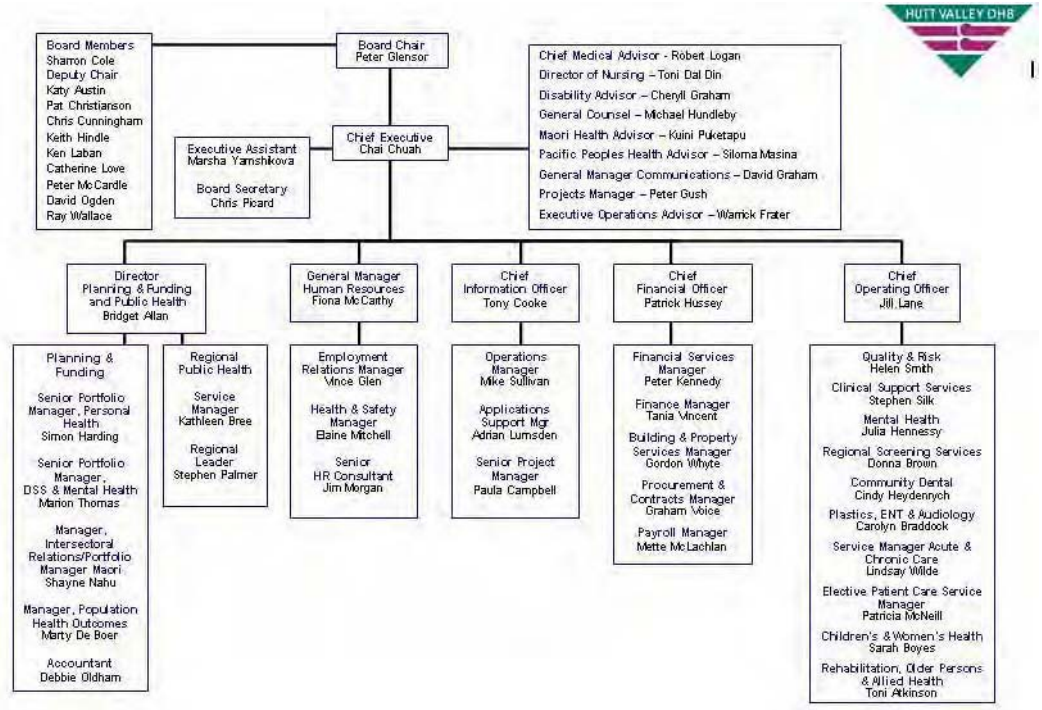
Appendices

Appendix 1 - Organisation Structure



Appendix 2 - DAP Financial Template

[Information provided separately to the Ministry of Health via Financial Templates]

Appendix 3 - Mental Health Plan Template

[Information provided separately to the Ministry of Health via Financial Templates]

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	2009/10 $000's
Revenue					
Revenue	146,684	152,915	166,236	169,715	173,109
Interest Revenue	199	93	193	197	201
Total Revenue	**146,883**	**153,008**	**166,429**	**169,912**	**173,310**
Operating Expenditure	(136,729)	(139,706)	(151,957)	(155,148)	(158,252)
Depreciation	(6,877)	(8,518)	(8,242)	(8,410)	(8,577)
Interest	(1,183)	(1,184)	(1,182)	(1,206)	(1,230)
Capital Charge	(4,959)	(6,007)	(6,197)	(6,327)	(6,454)
Internal Allocations	426	428	449	463	473
Total Expenditure	**(149,322)**	**(154,987)**	**(167,129)**	**(170,628)**	**(174,040)**
Net Surplus/(Deficit)	**(2,439)**	**(1,979)**	**(700)**	**(716)**	**(730)**
Gain/(Loss) on Sale of Assets	-	-	-	-	-
Net Surplus/(Deficit)	**(2,439)**	**(1,979)**	**(700)**	**(716)**	**(730)**
Operating Expenditure Category Breakdown:					
Personnel Costs	(99,177)	(105,610)	(113,813)	(116,181)	(118,505)
Outsourced Services	(6,994)	(3,472)	(3,835)	(3,933)	(4,010)
Clinical Supplies	(17,590)	(18,091)	(20,653)	(21,089)	(21,510)
Infrastructure & Non-clinical Supplies	(25,987)	(28,242)	(29,277)	(29,888)	(30,488)
Internal Allocations	426	428	449	463	473
Total Expenditure	(149,322)	(154,987)	(167,129)	(170,628)	(174,040)

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	2009/10 $000's
Revenue					
Revenue	2,455	2,093	2,380	2,430	2,477
Interest Revenue	611	650	694	708	722
Total Revenue	**3,066**	**2,743**	**3,074**	**3,138**	**3,199**
Expenditure					
Operating Expenditure	(2,579)	(2,315)	(2,625)	(2,675)	(2,726)
Depreciation	-	-	-	-	-
Internal Allocations	(426)	(428)	(449)	(463)	(473)
Total Expenditure	**(3,005)**	**(2,743)**	**(3,074)**	**(3,138)**	**(3,199)**
Net Surplus/(Deficit)	**61**	**-**	**-**	**-**	**-**
Operating Expenditure Category Breakdown:					
Personnel Costs	(1,601)	(1,448)	(1,839)	(1,875)	(1,912)
Outsourced Services	(381)	(343)	(217)	(222)	(226)
Clinical Supplies	(10)	-	-	-	-
Infrastructure & Non-clinical Supplies	(587)	(524)	(569)	(578)	(588)
Internal Allocations	(426)	(428)	(449)	(463)	(473)
Total Expenditure	(3,005)	(2,743)	(3,074)	(3,138)	(3,199)

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	2009/10 $000's
Revenue					
Revenue	276,108	285,747	315,475	321,792	328,196
Total Revenue	**276,108**	**285,747**	**315,475**	**321,792**	**328,196**
Expenditure					
Provider Expenditure	(273,724)	(283,770)	(314,775)	(321,076)	(327,466)
Total Expenditure	**(273,724)**	**(283,770)**	**(314,775)**	**(321,076)**	**(327,466)**
Net Surplus/(Deficit)	**2,384**	**1,977**	**700**	**716**	**730**
Operating Expenditure Category Breakdown:					
Personal Health	(203,603)	(206,573)	(233,314)	(237,980)	(242,707)
Mental Health	(32,658)	(34,183)	(35,028)	(35,724)	(36,439)
DSS	(35,232)	(38,982)	(42,057)	(42,908)	(43,769)
Public Health	-	-	-	-	-
Maori Health	(1,796)	(2,064)	(2,190)	(2,234)	(2,278)
Internal Allocations	(435)	(1,968)	(2,186)	(2,230)	(2,273)
Total Expenditure	(273,724)	(283,770)	(314,775)	(321,076)	(327,466)

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	2009/10 $000's
Revenue					
Revenue	304,969	314,571	345,106	352,042	359,051
Interest Revenue	810	743	887	905	923
Total Revenue	**305,779**	**315,314**	**345,993**	**352,947**	**359,974**
Expenditure					
Provider Expenditure	(153,446)	(157,584)	(175,790)	(179,181)	(182,735)
Operating Expenditure	(139,184)	(142,021)	(154,582)	(157,823)	(160,978)
Depreciation	(6,877)	(8,518)	(8,242)	(8,410)	(8,577)
Interest	(1,183)	(1,184)	(1,182)	(1,206)	(1,230)
Capital Charge	(4,959)	(6,007)	(6,197)	(6,327)	(6,454)
Total Expenditure	**(305,649)**	**(315,314)**	**(345,993)**	**(352,947)**	**(359,974)**
Net Surplus/(Deficit)	**130**	**-**	**-**	**-**	**-**
Gain/(Loss) on Sale of Assets	(124)	-	-	-	-
Net Surplus/(Deficit)	**6**	**-**	**-**	**-**	**-**

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	2009/10 $000's
Opening Equity	28,127	28,127	28,127	28,127	28,127
Opening Retained earnings	(658)	(659)	(659)	(659)	(659)
Revaluation reserve	50,368	50,368	50,368	50,368	50,368
Net Surplus/(Deficit) for the Period	6	-	-	-	-
Net Surplus/(Deficit)	**77,843**	**77,836**	**77,836**	**77,836**	**77,836**

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	2009/10 $000's
Public Equity					
Equity	28,127	28,127	28,127	28,127	28,127
Revaluation Reserve	50,368	50,368	50,368	50,368	50,368
Retained Earnings	(652)	(659)	(659)	(659)	(659)
Total Equity	**77,843**	**77,836**	**77,836**	**77,836**	**77,836**
Represented by:					
Current Assets					
Bank in Funds	7,410	5,113	7,396	4,700	2,089
Receivables	15,703	13,874	16,663	17,124	17,124
Other Current Assets	1,567	1,517	1,517	1,517	1,517
Total Current Assets	**24,680**	**20,504**	**25,576**	**23,341**	**20,730**
Current Liabilities					
Bank Overdraft	-	-	-	-	-
Payables & Provisions	(42,375)	(45,956)	(54,542)	(53,306)	(46,120)
Short Term Borrowings	-	-	-	-	-
Total Current Liabilities	**(42,375)**	**(45,956)**	**(54,542)**	**(53,306)**	**(46,120)**
Net Working Capital	**(17,695)**	**(25,452)**	**(28,966)**	**(29,965)**	**(25,390)**
Non Current Assets					
Property, Plant & Equipment	115,603	123,388	126,902	127,901	123,326
Trust Funds	773	750	750	750	750
Total Non Current Assets	**116,376**	**124,138**	**127,652**	**128,651**	**124,076**
Non Current Liabilities					
Borrowings & Provisions	(20,065)	(20,100)	(20,100)	(20,100)	(20,100)
Trust Funds	(773)	(750)	(750)	(750)	(750)
Total Non Current Liabilities	**(20,838)**	**(20,850)**	**(20,850)**	**(20,850)**	**(20,850)**
Net Assets	**77,843**	**77,836**	**77,836**	**77,836**	**77,836**

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

	2005/06	2006/07	2007/08	2008/09	2009/10
Operating Cash Flows					
Cash Receipts	301,208	316,400	341,885	335,487	335,948
Interest Received	810	743	887	905	921
Payments to Providers & Suppliers	(191,644)	(187,221)	(206,657)	(205,165)	(208,472)
Payments to Employees	(100,644)	(111,833)	(116,064)	(118,385)	(120,753)
Capital Charge Paid	(5,381)	(6,008)	(6,012)	(6,132)	(6,255)
Net Operating Cash Flows	**4,349**	**12,081**	**14,039**	**6,710**	**1,389**
Investing Cash Flows					
Cash Received from Sale of Fixed Assets	15	-	-	-	-
Cash Paid for Purchase of Fixed Assets	(6,684)	(14,378)	(11,756)	(9,406)	(4,000)
Net Investing Cash Flows	**(6,669)**	**(14,378)**	**(11,756)**	**(9,406)**	**(4,000)**
Financing Cash Flows					
Additional Loans Drawn	(111)	-	-	-	-
Loans Repaid		-	-	-	-
Net Financing Cash Flows	**(111)**	**-**	**-**	**-**	**-**
Net Cash Flows	**(2,431)**	**(2,297)**	**2,283**	**(2,696)**	**(2,611)**
Opening Cash Balance	9,841	7,410	5,113	7,396	4,700
Closing Cash Balance	**7,410**	**5,113**	**7,396**	**4,700**	**2,089**
Represented by:					
Bank in Funds	7,410	5,113	7,396	4,700	2,089
Bank Overdraft	-	-	-	-	-
Total Cash on Hand	**7,410**	**5,113**	**7,396**	**4,700**	**2,089**

Hutt Valley District Health Board
FTEs by Class
As at 30 June

	2005/06	2006/07	2007/08	2008/09	2009/10
Medical	155	199	201	200	200
Nursing	628	630	664	664	664
Allied Health	352	381	398	410	410
Non-Allied Health	93	90	92	92	92
Management/Clerical	318	329	339	361	361
Total	**1,546**	**1,629**	**1,694**	**1,727**	**1,727**

Appendix 5 - Revenue Reconciliation

2007/08 DAP Revenue Reconciliation Version 9.0

DHB FUNDS AND DHB PROVIDER

DHB FUNDS	Service Area Code	Account Code	2007/08 Plan
PBF Vote Health			
Mental Health Ringfence	20	1004	-30,756
Funding Package (excluding Mental Health Ringfence)	20	1005	-228,541
PBF Adjustments	20	1085	-8,014
MOH - Funding Subcontracts	20	1086	-3,626
MOH Devolved Funding	20	1002	(270,937)
IDF inflows - Mental Health services	20	991	-4,272
IDF inflows - all other (excluding Mental Health)	20	992	-38,616
Inter-District Flows	20	1552	(42,888)
TOTAL DHB FUNDER REVENUE FROM MOH			(313,825)
FUNDING ENVELOPE ADVISED BY MOH			**-307,770**
VARIANCE			(6,055)
FRS3 Funding not included in Funding Envelope			**-1,355**
Expected reimbursement of CarePlus and PMP payments to PHO's			**-750**
Mental Health Primary Care Programmes - extension of programme			**-370**
Pacific Provider Development Fund			**-151**
HEHA and Family Violence Prevention Co-ordinator - extension of funding			**-190**
Nicotine Replacement Therapy - reimbursement of costs			**-80**
Cancer Action Plan funding			**-125**
PHO 2006/07 Roll-out Wash-up funding			**-600**
Additional Elective Services Funding			**-2,434**
EXPLAINED			(6,055)

DHB PROVIDER	Service Area Code	Account Code	2007/08 Plan
MOH Non-Devolved Contracts (Provider arm side contracts)			
Personal Health	10	1102	-9,765
Mental Health	10	1202	
Public Health	10	1302	-7,548
Disability Support Services (Under 65s)	10	1402	-1,394
Maori Health	10	1502	
Clinical Training Agency	10	1550	-2,367
Total MOH Non-Devolved Contracts	10	1101	(21,074)
Contract information by Service Area			
Personal Health			
Various:			
Nursing Consultancy Unit			-19
Occupational Health & Safety			-2
Orthopaedic Joint Initiative			-1,683
Cataract Initiative			-192
Elective Services			-1,956
Cardiology			-411
Breast Screening Programme			-3,721
Screening Programme			-1,093
Gynaecology			-160
Maternity - Devolved s88 Funding & LMC			-151
Radiology			-171
Laboratory			-60
Pharmacy			-146
	10	1102	(9,765)
Mental Health			
	10	1202	-
Public Health			
Various:			
Core Contract incl. Infrastructure Schedule A			-6,064
Core Contract incl. Infrastructure Schedule B			-213
Core Contract incl. Infrastructure Schedule C			-108
Core Contract incl. Infrastructure Schedule D incl Regional Refugee Health			-173
Regional Smokefree			-90
School Health Current Contracts			-158
School Health Fruit in Schools			-256
Current Health Protection Contracts			-188
Current Health Promotion Contracts			-214
Pacific Social Environments			-84
	10	1302	(7,548)
Disability Support Services (Under 65s)			
Current Contract			-1,394
	10	1402	(1,394)
Maori Health			
	10	1502	-
Clinical Training Agency			
CTA Contract 307454 - Provider No. 102501 (Main Contract)			-2,246
CTA Contract 293737 - Provider No. 102501 (Psychiatry Contract)			-121
	10	1550	(2,367)

Appendix 6 - Provider Arm Volume Schedule

[Information provided separately to the Ministry of Health via Financial Templates]

Appendix 7 - Indicators of DHB Performance

The following tables list the variety of indicators of DHB performance we monitor and report on. These include Indicators of DHB Performance (IDPs) and additional Ministry of Health reporting requirements. Baseline information and targets are provided where applicable. National Health Target indicators and Hutt Valley DHB District Strategic Plan indicators are detailed within section 8,

Indicators of DHB Performance

Measure and Output Class	Description	Quarter(s) Reporting Due	Deliverables and Targets 2007/08
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.	Q2, Q4.	Measure 1 Percentage of PHOs with Māori Health Plans (MHP) that have been agreed to by the DHB. Measure 2 Percentage of District Health Board members that have undertaken Treaty of Waitangi training. Measure 3 Report on 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. The performance report for measure 3 should be endorsed by the local Iwi/ Māori health relationships. 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. Measure 7 Identify at least two key milestones from your Māori Health Plan to be achieved in 2007-2008. For reporting in Quarter 2, provide a progress report on the milestones, and for reporting in Quarter 4, provide a report against achievement of those milestones.

Measure and Output Class	Description	Quarter(s) Reporting Due	Deliverables and Targets 2007/08
HKO-02 Equity and Access	Development of Māori health workforce and Māori health providers.	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 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.	Q2, Q4.	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 Health outcomes and reducing health inequalities 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.	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. Targets: Additional 2007/08 Māori health expenditure 5% plus FFT

Measure and Output Class	Description	Quarter(s) Reporting Due	Deliverables and Targets 2007/08
			Additional 2008/09 Māori health expenditure 5% plus FFT Additional 2009/10 Māori health expenditure 5% plus FFT
PAC-01 Effectiveness	Pacific peoples are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain.	Q2, Q4.	Measure 1 Percentage of DHB strategies and plans on which Pacific communities or representatives were consulted. Measure 2 Percentage of DHB working groups and steering groups that included representation from Pacific communities. Measure 3 Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Pacific peoples out of the total numbers of (i) management (ii) clinical (iii) administrative and (iv) other FTEs respectively in the DHB. Measure 4 Provide a report describing how Pacific peoples have been involved in the development of strategic planning at different levels (eg, steering group, consultation fono, service delivery by Pacific health service providers, or Pacific DHB staff members).
POP-01 Equity and Access	Diabetes	Q3.	Measure 1 Risk reduction—supportive environments for improving nutrition, increasing physical activity and reducing obesity. The number and type of agencies, organisations, and providers that have an influence on the environment, and the type of programmes and initiatives that are planned or underway, together with any evaluations and monitoring of implementation. Measure 2 Reduced development of contributory risk factors – Smoking. The percentage of enrolled persons >14 years with smoking status on PHO records. Measure 3 Slowed rate of progression, reduced incidence of avoidable complications. The percentage of unique individuals with type I or type II diabetes on a diabetes register, whose date of their free annual check is during the reporting period, compared to the expected number of people with diabetes.

Management. The percentage of people with type I or type II diabetes on a diabetes register that had an HBA1c of equal to or less than 8% and at their free annual check during the reporting period.

Diabetes management – HBA1C <= 8%

Measure and Output Class	Description	Quarter(s) Reporting Due	~~Deliverables and Targets 2007/08~~
			Diabetes detection and follow-up rate

	Actual	Prov.	Target	Target	Target
Māori	46%	41%	50%	55%	60%
Pacific	89%	88%	90%	93%	95%
Other	86%	83%	90%	93%	95%
Total	78%	74%	80%	85%	90%

Measure 4

Increased co-ordination across providers, processes and community resources. Diabetic retinopathy screening. The percentage of people with type I or type II diabetes on the 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.

Diabetic retinopathy screening

<table>
<tr><th>Measure and Output Class</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2007/08</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Other</td><td>80%</td><td>79%</td><td>81%</td><td>82%</td><td>83%</td></tr>
<tr><td>Total</td><td>74%</td><td>73%</td><td>75%</td><td>76%</td><td>77%</td></tr>
</table>
</td></tr>
<tr><td>POP-02 Equity and Access</td><td>Cardiovascular disease</td><td>Q3.</td><td>Measure 1
Increased early recognition and response to individuals with chronic conditions. The percentage of people in each target group who have had their five-year absolute CVD risk recorded in the last five years. Target groups:
1. Māori/Pacific & Indian subcontinent men >35 years of age
2. Māori/Pacific & Indian subcontinent women >45 years of age
3. NZ European & other men >45 years of age
4. NZ European & other women >55 years of age.
Awaiting baseline data to set targets.
Measure 2
Slowed rate of progression, reduced incidence of avoidable complications. CVD risk management—Statins. The percentage persons where CVD risk >= 15% where statins have been prescribed in the past year, compared to the total number of persons where CVD risk >= 15 %.
Awaiting baseline data to set targets.
Measure 3
Increased co-ordination across providers, processes and community resources. Cardiac Rehabilitation Programme. The percentage of people who have suffered Acute Coronary Syndrome who attend a cardiac rehabilitation outpatient programme.
Cardiac Rehabilitation Programme Percentages
<table>
<tr><td></td><td>Actual 2005</td><td>Actual 2006</td><td>Target 2007</td></tr>
<tr><td>Māori</td><td>65%</td><td>68%</td><td>70%</td></tr>
<tr><td>Pacific</td><td>76%</td><td>74%</td><td>76%</td></tr>
<tr><td>Other</td><td>63%</td><td>68%</td><td>70%</td></tr>
<tr><td>Total</td><td>64%</td><td>68%</td><td>70%</td></tr>
</table>
</td></tr>
<tr><td>POP-03</td><td>Stroke</td><td>Q3.</td><td>Measure 1</td></tr>
</table>

<table>
<tr><th>Measure and Output Class</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2007/08</th></tr>
<tr><td>Equity and Access</td><td></td><td></td><td>Increased co-ordination across providers, processes and community resources. Organised Stroke Services. The percentage of people who have suffered a stroke event, who have been admitted to organised stroke services and remain there for their entire hospital stay. 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.</td></tr>
<tr><td>POP-04 Equity and Access</td><td>Oral health - mean DMFT score at year eight.</td><td>Q3.</td><td>The average 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.
POP-04 Oral Health – Mean DMFT score at Year 8
<table>
<tr><td></td><td>Actual 2004</td><td>Actual 2005</td><td>Actual 2006</td><td>Target 2007</td></tr>
<tr><td>Māori</td><td>1.3</td><td>1.7</td><td>1.6</td><td>1.5</td></tr>
<tr><td>Pacific</td><td>1.2</td><td>1.8</td><td>1.2</td><td>1.2</td></tr>
<tr><td>Other</td><td>0.8</td><td>0.7</td><td>0.8</td><td>0.7</td></tr>
<tr><td>Total</td><td>0.9</td><td>1.0</td><td>1.0</td><td>0.9</td></tr>
</table></td></tr>
<tr><td>POP-05 Equity and Access</td><td>Oral health – percentage of children caries free at age five years.</td><td>Q3.</td><td>The percentage 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.
POP-05 Oral Health – Percentage of children caries free at age five
<table>
<tr><td></td><td>Actual 2004</td><td>Actual 2005</td><td>Prov. 2006</td><td>Target 2007</td></tr>
<tr><td>Māori</td><td>36%</td><td>39%</td><td>51%</td><td>53%</td></tr>
<tr><td>Pacific</td><td>29%</td><td>32%</td><td>42%</td><td>44%</td></tr>
<tr><td>Other</td><td>64%</td><td>64%</td><td>74%</td><td>75%</td></tr>
<tr><td>Total</td><td>55%</td><td>55%</td><td>66%</td><td>67%</td></tr>
</table></td></tr>
<tr><td>POP-06 Equity and Access</td><td>Improving the health status of people with severe mental illness</td><td>Q1, Q2, Q3, Q4.</td><td>The percentage of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for children and youth aged 0-19, adults aged 20-64 and older people aged 65+.
Mental Health Information National Collection data
<table>
<tr><td>Ethnicity</td><td>Age group</td><td>Actual</td><td>Prov. 2006</td><td>Target 2007</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Measure and Output Class</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2007/08</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td></td><td></td><td>2005/06</td><td></td><td></td></tr>
<tr><td>Māori</td><td>0-19</td><td>1.7%</td><td>1.8%</td><td>2.3%</td></tr>
<tr><td>Māori</td><td>20-64</td><td>3.7%</td><td>3.6%</td><td>3.7%</td></tr>
<tr><td>Māori</td><td>65+</td><td>1.2%</td><td>1.2%</td><td>1.3%</td></tr>
<tr><td>Other</td><td>0-19</td><td>1.8%</td><td>1.8%</td><td>2.3%</td></tr>
<tr><td>Other</td><td>20-64</td><td>2.7%</td><td>2.7%</td><td>2.9%</td></tr>
<tr><td>Other</td><td>65+</td><td>1.5%</td><td>1.4%</td><td>1.5%</td></tr>
<tr><td>Total</td><td>0-19</td><td>1.8%</td><td>1.8%</td><td>2.3%</td></tr>
<tr><td>Total</td><td>20-64</td><td>2.8%</td><td>2.8%</td><td>2.9%</td></tr>
<tr><td>Total</td><td>65+</td><td>1.5%</td><td>1.4%</td><td>1.5%</td></tr>
</table>
</td></tr>
<tr><td>POP-07 Equity and Access</td><td>Alcohol and other drug service waiting times</td><td>Q1, Q2, Q3, Q4.</td><td>DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period. Service types are: Inpatient Detoxification, Specialist Prescribing, Structured Counselling, Day Programmes and Residential Rehabilitation. Waiting times will be measured, for one month, every three months, so the Ministry can determine the variation, and extent of waiting times, to determine if targets will be required to be set in the future.</td></tr>
<tr><td>POP-08 Effectiveness</td><td>Progress towards the national target of 95% of two year olds fully immunised.</td><td>Q1, Q2, Q3, Q4.</td><td>A) DHB NIR Enrolled Populations
Percent of eligible newborns born and enrolled on the NIR in reporting period, by ethnicity, level of deprivation and ‘Opt-Off’ status. The ‘prioritised approach’ should be used for reporting on Māori, Pacific peoples, Asian, and ‘other’ ethnic groups and deprivation indices grouped by quintiles should be utilised.
B) Progress towards the health target of 95% of two year olds fully immunised – Health target
Percentage NIR Immunisation coverage at 6, 12, 18 and 24 months of age for the most recent quarter and the previous 12 months by ethnicity and level of deprivation. The ‘prioritised approach’ should be used for reporting on Māori, Pacific peoples, Asian, and ‘other’ ethnic groups and deprivation indices grouped by quintiles should be utilised.
The 2005 National Survey of Immunisation Coverage showed a 89% coverage rate for the</td></tr>
</table>

<table>
<tr><th>Measure and Output Class</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2007/08</th></tr>
<tr><td></td><td></td><td></td><td>Central South Island Region, with national coverage of Māori and Pacific children at 69% and 81% respectively. Currently the best information available locally is from local PHO immunisation audits for 2 year old data. Immunisation milestone coverage data from the NIR is only currently available up to the 12 month cohort, which has been used for the DTAP dose 3 figures below. Targets will be revised when more data from the National Immunisation Register becomes available towards the end of 2007.

<table>
<tr><td>Fully immunised</td><td>Prov. 2006/07</td><td>Target 2007/08</td></tr>
<tr><td>2 year olds</td><td>88-94%</td><td>88%</td></tr>
<tr><td>Māori 2 year olds</td><td>83%</td><td>85%</td></tr>
<tr><td>Pacific 2 year olds</td><td>82%</td><td>85%</td></tr>
<tr><td>Asian 2 year olds</td><td>n/a</td><td>85%</td></tr>
<tr><td>DTaP dose 3 at 1 year</td><td>85%</td><td>95%</td></tr>
<tr><td>DTaP dose 3 Māori</td><td>81%</td><td>82%</td></tr>
<tr><td>DTaP dose 3 Pacific</td><td>83%</td><td>84%</td></tr>
<tr><td>DTaP dose 3 Asian</td><td>89%</td><td>90%</td></tr>
<tr><td>MMR dose 1 at 18 months</td><td>n/a</td><td>88%</td></tr>
</table></td></tr>
<tr><td>POP-09 Equity and Access</td><td>Ambulatory sensitive admissions - children and older people - discharge rate per 1000 population.</td><td>Q2, Q4.</td><td>The ambulatory sensitive hospital discharge rate for conditions resulting from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable.
<table>
<tr><td>Target rates per 1000</td><td>Total</td><td>Māori</td><td>Pacific</td><td>Other</td></tr>
<tr><td>Children 0-4</td><td>95</td><td>90</td><td>120</td><td>90</td></tr>
<tr><td>Children 5-14</td><td>25</td><td>30</td><td>40</td><td>20</td></tr>
<tr><td>Youth 15-24</td><td>15</td><td>18</td><td>15</td><td>14</td></tr>
<tr><td>Adults 65-74</td><td>65</td><td>105</td><td>105</td><td>60</td></tr>
</table></td></tr>
<tr><td>POP-10</td><td>Radiation</td><td>Q1, Q2, Q3,</td><td>Each of the six cancer centre DHBs (Auckland, Waikato, MidCentral, Capital & Coast,</td></tr>
</table>

<table>
<tr><th>Measure and Output Class</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2007/08</th></tr>
<tr><td>Equity and Access</td><td>oncology and chemotherapy treatment waiting times.</td><td>Q4.</td><td>Canterbury and Otago) provide a report updating on progress towards ensuring all patients receive oncology megavoltage radiation treatment, and chemotherapy treatment, according to nationally agreed standards. This report is to be agreed with all the peripheral DHBs whose populations have used the service during the quarter. In the fourth quarter, this report should include information that demonstrates the cancer centre has undertaken a data audit of its waiting time data, and is satisfied that high quality data is being provided.
National health target: All patients receive radiation oncology treatment within 8 weeks of their first specialist assessment (excluding Category D).</td></tr>
<tr><td>POP-11 Equity and Access</td><td>Oral health – Utilisation of DHB funded dental services by adolescent from year 9 up to and including age 17 years.</td><td>Q3.</td><td>The percentage of completions and non-completions under the Combined Dental Agreement for adolescent patients plus additional adolescent examinations with other DHB funded dental services (e.g. SDS, Māori Health providers and other contracted providers). The data must be broken down by ethnic group (Māori, Pacific, Other).
National health target: Progress towards 85% adolescent oral health utilisation.
<table>
<tr><td>Prioritised Ethnicity</td><td>Actual 2005</td><td>Actual 2006</td><td>Target 2007</td><td>Target 2008</td><td>Target 2009</td></tr>
<tr><td>Total</td><td>53%</td><td>n/a</td><td>58%</td><td>62%</td><td>66%</td></tr>
</table>
</td></tr>
<tr><td>QUA-01 Quality</td><td>Quality systems.</td><td>Q3.</td><td>The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting a list of key quality improvement and clinical audit initiatives and results aligned to the Goals in Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector (2003).</td></tr>
<tr><td>QUA-02 Quality</td><td>Results for people with enduring mental illness.</td><td>Q2.</td><td>Measure 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.)
Measure 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.
Measure 3
The number (and percentage) of long-term clients in full time work (> 30 hours).</td></tr>
</table>

Measure and Output Class	Description	Quarter(s) Reporting Due	Deliverables and Targets 2007/08
			Measure 4 The number (and percentage) of long-term clients with no paid work. Measure 5 The number (and percentage) of long-term clients undertaking some form of education, e.g., University, Polytechnic. National health target: 100% of long-term clients with up to date relapse prevention plans (NMHSS criteria 16.4).
QUA-03 Quality	Improving the quality of data provided to the National Collections Systems (NCS)	Q1, Q2, Q3, Q4.	Measure 1 Percentage of National Health Index (NHI) records that require merging for duplicates by NZHIS per DHB per quarter Measure 2 Percentage of NHI records created with ethnicity status of 'Not Stated' or 'Other' per DHB per quarter. Measure 3 Percentage of codes with different versions of text descriptor per code per DHB Measure 4 Percentage of NMDS discharge events with an Error Diagnostic Related Group (DRG) per DHB per quarter. Measure 5 Percentage of Mental Health Information National Collection (MHINC) records able to be successfully loaded into the MHINC per DHB per quarter
RIS-01 Equity and Access	Service coverage	Q1, Q2, Q3, Q4.	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

<table>
<tr><th>Measure and Output Class</th><th>Description</th><th>Quarter(s) Reporting Due</th><th>Deliverables and Targets 2007/08</th></tr>
<tr><td></td><td></td><td></td><td>• Sector intelligence.</td></tr>
<tr><td>SER-01 Equity and Access</td><td>Accessible and appropriate services in Primary Health Organisations</td><td>Q1, Q2, Q3, Q4.</td><td>The ratio of age-standardised rate of General Practitioner consultations per high need person to the age-standardised rate of General Practitioner consultations per non-high need person.
<table>
<tr><td>High need: non high need</td><td>Actual Jan 2006</td><td>Actual June 2006</td><td>Actual Sept 2006</td><td>Target 2007/08</td></tr>
<tr><td>Ratio</td><td>0.99</td><td>1.03</td><td>1.13</td><td>>1.15</td></tr>
</table></td></tr>
<tr><td>SER-02 Effectiveness</td><td>Care Plus enrolled population</td><td>Q1, Q2, Q3, Q4.</td><td>The percentage of Hutt Valley DHB’s PHO enrolled population enrolled in Care Plus.
<table>
<tr><td>Care Plus</td><td>Actual Jan 2007</td><td>Target 2007/08</td></tr>
<tr><td>Enrolment Rate</td><td>33%</td><td>70%</td></tr>
</table></td></tr>
<tr><td>SER-03 Efficiency and Value For Money</td><td>The proportion of laboratory and pharmaceutical transactions with a valid National Health Index</td><td>Q1, Q2, Q3, Q4.</td><td>Measure 1
Pharmaceuticals: the percentage of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted.
<table>
<tr><td>NHI for</td><td>Actual</td><td>Actual</td><td>Actual</td><td>Target</td></tr>
<tr><td>Percent</td><td>93%</td><td>93%</td><td>94%</td><td>95%</td></tr>
</table>
Measure 2
Laboratory tests: The percentage of tests carried out by community laboratories in the DHB district with a valid NHI submitted.</td></tr>
</table>

Measure and Output Class	Description	Quarter(s) Reporting Due	Deliverables and Targets 2007/08
			Percent | 93% | 93% | 93% | 95%
SER-04 Quality	Continuous Quality Improvement – Elective services.	Q2, Q4.	Measure 1 Standardised Discharge Ratios (SDR) for 11 elective procedures as published on the Ministry website each quarter (excluding hip and knee replacements, and cataracts covered by separate initiatives). Measure 2 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.
SER-07 Efficiency and Value For Money	Low or reduced cost access to first level primary care services	Q1, Q2, Q3, Q4.	Measure 1 100% of fee increases that are above the annual statement of a reasonable standard GP fee increase have been referred to a regional fee review committee and 100% of practices comply with the recommendations of the regional fee review committee, and in all cases where practices fail to comply the DHB applies appropriate sanctions. DHBs will need to keep a record of all notifications referred to a regional fee review committee, the recommendations of each the committee that is convened, compliance with the recommendations, and sanctions that are applied in the case of non-compliance. Measure 2 100% of PHO practices ensure public access to local information on the fees PHO practices are charging patients. DHBs will need to check whether all PHO practices are complying with the mechanism agreed for making practice level fees information readily accessible to the local community. 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.

Additional DHB reporting

Reporting Area	Quarter(s) Reporting Due
Cancer Control Strategy Implementation Plan	Q4
Diabetes Self Evaluation	Q2
District After-Hours Strategic Plan	Q1, Q2, Q3, Q4
Health of Older People	Q1, Q2, Q3, Q4
Health Emergency Plan Reviews	Q3
Hospital Benchmarking Information reporting	Q1, Q2, Q3, Q4
Reducing Health Inequalities	Q1, Q2, Q3, Q4
Information Management and Technology- NZHIS	Q2, Q4
Updating of Information Systems Strategic Plan	Q4
Contribution to Health Information Strategy New Zealand (HIS-NZ)	Q1, Q2, Q4
Oral Health	Q3
Oral Health Progress Report	Q3
Planning and Implementing Family Violence Intervention	Q2, Q4
Primary Care	Q2, Q4
Regional Mental Health Strategic Plan	Q4
Progress against Te Kokiri	Q4
Strategic Quality Plan	Q1
Mental Health Audit Activity (Quality)	Q3
Improving nutrition, Increasing physical activity and Reducing obesity	Q4
Reduce the harm caused by tobacco	Q4

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:

- Although there is partial access to a low income dental relief of pain service via Hutt Hospital dental outpatients and a low-income dental pilot, funding for this service has never been allocated to the Hutt Valley.
- 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 Community Service Card holders.
- 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.

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.

We will endeavour to address our service coverage exceptions over 2007/08.

Hutt Valley DHB is responsible for funding the following services in 2007/08:

- Local Māori 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.
- Māori and Pacific Provider development.
- National contracts, including Wellchild..
- Disability Support Services (under-65s).

Measures
RIS-01 Service Coverage (see Appendix 7)

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 Māori 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 Māori 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 Māori 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 Māori Health principle, the values of the Māori 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.

Māori and Pacific Development in Health
In making funding decisions, Hutt Valley DHB acknowledges the requirement to encourage Māori and Pacific participation in providing and using services. Māori 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 Māori 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, Māori 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 (HVDHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. HVDHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. HVDHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

HVDHB is a public benefit entity, as defined under NZIAS 1.

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

Basis of Preparation
The financial statements have also been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These are HVDHB's first NZ IFRS financial statements and NZ IFRS 1 has been applied.

The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis modified by the revaluation of land and buildings.

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an opening NZ IFRS Statement of Financial Position at 1 July 2006 for the purposes of the transition to NZ IFRS.

The preparation of financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates. The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

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

Budgets
The budget figures are those approved by the health board in its District Annual Plan and included in the Statement of Intent as tabled in Parliament. The budget figures

have been prepared in accordance with NZ GAAP. They comply with NZ IFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Hutt Valley District Health Board for the preparation of these financial statements.

Revenue

Crown Funding

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

Goods Sold and Services Rendered

Revenue from goods sold is recognised when HVDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold. Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to HVDHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by HVDHB.

Borrowing Costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

Leases

Finance leases

Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset are transferred to HVDHB, are classified as finance leases. The assets acquired by way of finance leases are stated at an amount equal to the lower of the present value of the minimum lease payments (at the inception of the lease), less accumulated depreciation and impairment losses; and their fair value. The property 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 minimum lease payment is apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Operating leases

Operating lease payments, where lessors effectively retain substantially all the risks and benefits of ownership of the leased items, are recognised in the statement of financial performance on a straight-line basis over the term of the lease.

Cash Equivalents

Cash and cash equivalents include cash in hand and deposits held at call with banks.

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, sabbatical 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. Conferences 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.

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

Defined Benefit Contribution Scheme
HVDHB is a participating employer in the NPF Superannuation Scheme ("the Scheme") that is a multi-employer defined benefit scheme. If the other participating employers ceased to participate in the Scheme, the employer could be responsible for the entire deficit of the Scheme. Similarly, if a number of employers ceased to participate in the Scheme, the employer could be responsible for an increased share of the deficit. Insufficient information is available to use defined benefit accounting, as it is not possible to determine, from the terms of the Scheme, the extent to which the deficit will affect future contributions by employers, as there is no prescribed basis for allocation. This means HVDHB has used defined contribution style reporting.

Accounts Receivable
Accounts receivable is stated at expected realisable value after providing for doubtful and uncollectible debts. Bad debts are written off during the period in which they are identified.

Inventories
Inventories are stated at the lower of cost, determined on a weighted average basis, and current replacement cost. This valuation includes allowances for slow moving inventories. Obsolete inventories are written off.

Fixed Assets
Fixed assets were vested in HVDHB 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 and impairment losses. Cost includes all appropriate costs of acquisition and installation including materials, labour, direct overheads and transport costs. Land and buildings, including site improvements, are re-valued at least 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. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decrease in value relating to a class of land and buildings is debited directly to the revaluation reserve, to the extent that it reverses previous surpluses and is otherwise recognised as an expense in the statement of financial performance.

Additions
The cost of an item of property, plant and equipment is recognised as an asset if and only if it is probable that future economic benefits or service potential associated with the item will flow to HVDHB and the cost can be measured reliably.

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

Subsequent Costs
Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to HVDHB and the cost of the item can be measured reliably.

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 – 80 years	1.6% - 100%
Building fit-out and services	1 – 36 years	2.8% - 100%
Plant and equipment	1 – 19 years	4% - 100%
Motor vehicles	5.5-12.5 years	8% - 18%
Computer equipment	3 – 5.5 years	18% - 30%
Leased assets	3 – 8 years	12.5% - 30%

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.

Taxation
HVDHB 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 (Statement of Objectives and Service Performance)
The cost of services statements, as reported in the Statement of Objectives and Service Performance, 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.

Impairment
The carrying amounts assets other than inventories, and inventories held for distribution are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated. If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance. An impairment loss on property, plant and equipment re-valued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset.

Financial Instruments
HVDHB 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.

Provisions
A provision is recognised when HVDHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation.

ACC Partnership Programme
HVDHB belongs to the ACC Partnership Programme whereby HVDHB accepts the management and financial responsibility of work related illnesses and accidents of employees. Under the ACC Partnership Programme HVDHB is effectively providing accident insurance to employees and this is accounted for as an insurance contract. The value of this liability represents the expected future payments in relation to accidents and illnesses occurring up to the balance sheet date for which HVDHB has responsibility under the terms of the Partnership Programme.

Explanation of Transition to NZ IFRS
HVDHB's financial statements for the year ended 30 June 2008 are the first financial statements that comply with NZ IFRS. HVDHB has applied NZ IFRS 1 in preparing these financial statements. HVDHB's transition date is 1 July 2006. HVDHB prepared its opening NZ IFRS balance sheet at that date. The reporting date of these financial statements is 30 June 2008. HVDHB's NZ IFRS adoption date is 1 July 2007. In preparing these consolidated financial statements in accordance with NZ IFRS 1, HVDHB has applied the mandatory exceptions and certain optional exemptions from full retrospective application of NZ IFRS.