Hutt Valley District Health Board

District Annual Plan

2008/09

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Mihi

Tihei - 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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1. Statement from Chair and Chief Executive

We are pleased to present Hutt Valley District Health Board's District Annual Plan (DAP) for the 2008/2009 year. We again face a challenging year as we seek to return to the breakeven status we had maintained in the five years prior to the last financial year (2007/2008). As we did in the last year, Hutt Valley DHB will be focussing on meeting elective surgery targets, on progressing the essential expansion of Hutt Hospital and on maintaining the continued development of both community-based services and services for the elderly.

At the beginning of the 2007/2008 financial year Hutt Valley DHB was declared to be an 'over-funded board', under the population based funding formula. The net result was that the DHB received no extra population growth funding. Combined with industrial agreements and actions causing above-budget expenditure and our inability to access all the extra available funding for elective surgery, these were the prime reasons for what is, at the time of writing, likely to be a substantial deficit for the 2007/2008 financial year.

However, updated census figures indicate that the Hutt Valley should not have been categorised as an 'over-funded board' and we will again receive demographic funding. Hutt Valley DHB has a strong record of financial management and we are determined to make sure that 2007/2008 was a blip. We will be working with our staff and providers to reach a break-even position in 2008/2009 so we can continue to develop appropriate health services in the Hutt Valley for the benefit of the community. We will do this through a combination of revenue generation, value-for-money and cost containment strategies.

Most important in 2008/2009 will be getting the expansion of Hutt Hospital underway so we can continue to provide safe and appropriate emergency department facilities in to the future and so we can undertake growing levels of both acute and elective surgery. This will be difficult to achieve until the hospital extensions open in 2011/2012 but with the support of our staff, providers and community we believe we can do it.

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 have, in Hutt Valley DHB, a strong sense of our duty to our 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 third annual plan under the current strategic document and we are pleased that it continues the progress envisaged in that document. During this period we will be reviewing the district strategic plan to ensure it continues to be relevant and provides the appropriate framework for our annual planning in the future.

1.1 Signatories

Peter Glensor
Chair Hutt Valley DHB

Hon. David Cunliffe
Minister of Health

1.2 Executive Summary

The District Annual Plan for 2008/09 is the third 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, New Zealand health sector priorities and strategic frameworks (including Ministerial priority and Health Target areas) and our District Strategic plan.

While we have identified a number of key priority areas for 2008/09 below, equally important is the approach we take to all our work in terms of how we do things. This includes:

- Improving health equity through addressing health disparities between different populations groups and communities.
- Ensuring an ongoing culture of open communication and dialogue with our communities, consumers and clinicians.
- Focusing on service access.
- Taking an innovative and continuous quality approach.
- Collaborating with providers, other DHBs and other agencies.
- Ongoing measurement and monitoring of our progress, including the Health Targets.
- Ensuring enabling services (such as finance, information technology and human resources) are prioritising in line with the DHB's operational requirements.

In terms of what we will do, our key local priorities for 2008/09 are:

- **Primary health care** – Increasing access to primary health care, an increased primary workforce, improved relationships and liaison with secondary care and supporting health promotion.
- **Quality and safety** – Participation in Quality Improvement Committee programme workstreams, particularly with our Improving the Patient Experience programme.
- **Elective services** - Increasing access and complying with national programmes including elective service performance indicators.
- **Keeping our people well** – Through Healthy Eating Healthy Action, and Healthy Housing programmes and the *Keeping Well* population health strategy for the greater Wellington region.
- **Services for children and youth** – Through implementation of Ministerial priorities (immunisation, screening, B4 school checks and improved access to services), our *Growing a Healthy Community* plan, new oral health services and enhanced mental health services for children and youth.
- **Services for older people** – By Implementing improved psycho-geriatric services, and realising the gains from our augmented Needs Assessment and Service Co-ordination service.
- **Implementation of our emergency department/theatre project** – Through the advancement of our campus development programme, including planning of our new emergency department/operating theatre facility, ensuring capacity to deal with growing emergency department presentations and surgical demand in the meantime and the adequacy of mental health facilities.
- **Workforce development** – Developing and implementing a co-ordinated approach to building our workforce that reflects our community across the health spectrum.
- **Maintaining financial performance** – In the face of population based funding pressures and challenges relating to national industrial agreements.

In the body of our plan we have also highlighted a number of issues and risks. In summary, these include:

- Campus development - work towards the expansion of our Emergency Department and the building of new Operating Theatres will accelerate, and our financial obligations towards this capital development will grow.
- Financial risks - the annualised costs of forthcoming MECAs heads up a growing list of financial risks we face, along with all other DHBs.
- General Practitioner shortages - our commitments in primary health are hampered by a chronic shortage of General Practitioners, which appears to be more severe in the Hutt Valley than elsewhere.
- Elective targets - we need to balance those elements of our elective services programme which are delivered by us, and are under our direct control, with those elective services being provided from outside our DHB, and over which we have no real control.

For each of the issues and risks, we have plans either to avoid negative consequences or to mitigate their effects. The Board has a rigorous programme of risk management in place, both in our committees, and as a full Board.

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.

Hutt Valley DHB is permitted by this annual plan to:
(a) Negotiate and enter into service agreements containing any terms and conditions that may be agreed; and
(b) Negotiate and enter into agreements to amend service agreements.

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. Following resignations we have been engaging with the community to develop a consensus on an appointment process so Te Awakairangi Hauora has maximum legitimacy within the Hutt Valley Māori community. Following a very successful hui we are in the process of confirming the membership and terms of reference in partnership with the community.

Following consultation on our Māori Health Strategic Plan and a further engagement process with local Māori communities, we 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.

Government Priorities for Māori
The overall aim of *He Korowai Oranga*[3], the Māori Health Strategy, is Whanau Ora. The Ministry of Health and DHBs aim to improve outcomes and reduce inequalities for Māori within the context of the New Zealand Public Health and Disability Act (NZPHD) and guided by He Korowai Oranga.

We have a responsibility to allocate resources to reduce inequalities and improve health outcomes for Māori, to ensure that mainstream services are effective for Māori and to improve access for Māori to these services. Building Māori health providers' capacity and capability are also important strategies in improving Māori health status. We support the development of the Māori health workforce at all levels of the health sector and addressing the broad determinants of health through inter-sectoral collaboration, and the co-ordination of health services to Māori and whanau.

We continue to identify and account for Māori health funding. This involves identifying the expenditure targeted at improving outcomes for Māori, which includes: Māori Providers, Māori workforce and provider development, Māori targeted services across mainstream services, and resource allocation for inter-sectoral initiatives to improve Māori health gain.

2.3 Responsibilities to Pacific Peoples

As a DHB with significant Pacific populations, we have a responsibility to allocate resources to reduce inequalities and improve health outcomes for Pacific peoples, and engage Pacific communities in DHB development and planning processes.

We work to ensure that mainstream services are effective for Pacific peoples, taking account of the health status, linguistic, cultural, social and religious differences of various Pacific communities, and we work to improve Pacific peoples' access to these services.

We will develop the capacity of Pacific peoples to participate and be involved in the health sector through strengthened Pacific providers. We support processes that allow Pacific peoples to determine their health service priorities and support the development of the Pacific health workforce at all levels of the health sector.

3. Our Objectives and Priorities

The sections below reflect Hutt Valley DHB's objectives and priorities, the New Zealand Health Strategy[4], New Zealand Disability Strategy[5], and other health sector strategies, the Minister of Health's priorities and the needs of our community.

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, Health Needs Assessment (HNA) information and community consultation 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[6]; the Older Persons Health Plan[7]. 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.

The New Zealand Public Health and Disability Act 2000 requires DHBs to review their District Strategic Plan (DSP) at least once every 3 years and to determine a replacement DSP before its current plan expires. In 2008 we will review our current DSP to determine whether we will produce a new or significantly amended DSP or whether we continue with our current DSP with minor or no amendments. Should we significantly amend our current DSP we are required to consult with our local community, conduct a health needs assessment (HNA) of our population and obtain the Minister of Health's consent to the new plan. Draft versions of significantly amended DSPs are due with the Ministry of Health by 31 July 2009.

3.3 Health Sector Priorities

The New Zealand Health Strategy[4] (NZHS) and the New Zealand Disability Strategy[5] (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. The 13 population health objectives identified in the NZHS are to:

- Reduce smoking.
- Improve nutrition.
- Reduce obesity.
- Increase the level of physical activity.
- Reduce the rate of suicides and suicide attempts.
- Minimise harm caused by alcohol and illicit and other drug use to both individuals and the community.
- Reduce the incidence and impact of cancer.
- Reduce the incidence and impact of cardiovascular disease.
- Reduce the incidence and impact of diabetes.
- Improve oral health.
- Reduce violence in interpersonal relationships, families, schools and communities.
- Improve the health status of people with severe mental illness.
- Ensure access to appropriate child health care services including well child and family health care and immunisation.

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[3].
- 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].
- *Te Tāhuhu*: Improving Mental Health Strategy[14].
- The Pacific Health and Disability Action Plan[15].
- The Health Information Strategy for New Zealand (HISNZ)[16].
- The Strategic Vision for Oral Health in New Zealand[17].

During 2008/09 progress is expected to be made in all these strategies with an emphasis on:
- Higher levels of output.
- Enhanced performance.
- Increased efforts towards collaboration.
- Effective management of key health conditions.
- Reducing disparities between population groups and DHBs.
- Quality improvement through a focused and coordinated national approach in the areas approved for implementation:
    - Optimising the patient's journey.
    - Management of healthcare incidents.
    - Infection prevention and control.
    - National mortality review systems.
    - Safe medication management.

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

Ministerial priority areas from 2007/08 remained unchanged, however there is an expectation of faster performance improvement, which will be tracked through the Ministry of Health's monitoring intervention framework. These priority areas are:
- Value for Money, through demonstrating the pursuit of efficiency, productivity and innovation (particularly in the area of diabetes), and progressing the Future Workforce Initiative.
- Getting ahead of chronic conditions, through implementing Healthy Eating Healthy Action – Oranga Kai Oranga Pumau[12], the New Zealand Cancer Control Strategy[11] and maintaining the pace of programme implementation.
- Reducing disparities, especially for especially for Māori and Pasefika populations.
- Child and youth health, 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, antenatal HIV screening and building on the Wellchild review.
- Primary health through progressing the Primary Health Care Strategy[8] and improving the interface with Primary Health Organisations through planning and working together
- Infrastructure, especially through significantly progressing the Health Information Strategy (HISNZ)[16], co-ordinated information systems and workforce development.

- Health of older people, through implementing the Health of Older People Strategy[9] by 2010 and continuing to give priority to new service models.

Other ongoing government priorities include:
- Progressing the New Zealand Disability Strategy, He Korowai Oranga and Whakatātaka[18].
- 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 Health Targets

The following tables provide an overview of the Health Target areas. See also section 8 Measuring Performance: Output Objectives and Measures for more detail around the Health Target indicators and our local targets. More detail on what we are planning to do in 2008/09 is also contained within section 6.4 DHB Objectives.

Health Target	Improving immunisation coverage. The national target is to have 95% of two year olds fully immunised.
Current Situation	At the beginning of 2008, 78% of Hutt Valley two years olds were fully immunised, with 74% coverage for Māori and 78% coverage for Pacific two year olds.
What we are planning for 2008/09	We will continue to closely monitor our six Primary Health Organisation's (PHO) immunisation coverage rates as part of the PHO Performance Management Programme and explore strategies to improve immunisation outcomes through the Hutt Valley National Immunisation Register (NIR) Governance group. To improve Māori immunisation coverage and reduce inequalities we will continue to support the Outreach Immunisation Service provided by Kokiri Marae. See also our DHB objective sections for Public Health and Maternity, Child and Youth Health.

Health Target	Improving oral health. The national target is to have 85 percent of adolescents utilising oral health services.
Current Situation	In 2006 Hutt Valley adolescent oral health utilisation was 61.5% (The provisional figure for 2007 is 54.2% but this is likely to be an under-estimate due to late claiming). Māori and Pacific adolescent's utilisation rates are not reliable as dental providers are not required to provide ethnicity details when they claim through the Combined Dental Agreement.
What we are planning for 2008/09	We will explore opportunities for adolescents to receive dental care within the new community-based oral health facilities that will be developed (fixed sites and mobile outreach), subject to the joint Hutt Valley and Capital & Coast DHB Child and Adolescent Oral Health Project business case being approved and funded. The Adolescent Regional Co-ordination Service will work to increased adolescent enrolment rates and we will encourage dentists to expand their availability to adolescents under the Combined Dental Agreement. See also our DHB objective section for Oral Health.

Health Target	Improving elective services. The national targets are to have every DHB maintain compliance in all Elective Services Patient Flow Indicators (ESPIs) and to deliver an agreed increase in the number of elective service volumes.
Current Situation	At the beginning of 2008 Hutt Valley DHB was compliant with all ESPIs but we may struggle to deliver the agreed increase in elective volumes for 2007/08 due to lack of theatre capacity.
What we are planning for 2008/09	We are pursuing options to address capacity constraints from both facilities and workforce perspectives. In the short term this includes maximising the effective use of day-case surgery, use of private facilities and working with other DHBs. In the medium term we are planning to increase our theatre capacity through the implementation of our Emergency Department/Theatre project. We will continue to see and treat people within timeframes consistent with clinical guidelines, best practice and current resources and increase volumes to meet the orthopaedic and cataract initiatives. We will work with stakeholders to improve our systems and process to ensure that resources are used in the most efficient way and extend patient focussed booking for outpatient appointments. See also our DHB objective sections for Elective Services and Workforce Development.

Health Target	Reducing cancer waiting times. The national targets are to have all patients wait less than six weeks (previously eight weeks) between first specialist assessment and the start of radiation oncology treatment (excluding category D patients - combined chemotherapy and radiation treatment) and that there is improvement in the proportion of patients meeting the individual wait time guidelines within each priority category.
Current Situation	Capital and Coast DHB provides radiation oncology services to Hutt Valley residents. In 2007, of the 220 Hutt Valley residents (excluding category D patients) starting radiation oncology treatment at Capital & Coast DHB, 212 patients waited for less than eight weeks (42 out of 49 category D patients waited 8 weeks or more). The currently reported wait category of 4-8 weeks will require amendment to distinguish a six week cut-off.
What we are planning for 2008/09	We will recruit a local service improvement facilitator for cancer services and actively engage with the region's Central Cancer Network. We will establish a Local Cancer Network which will also inform the development of earlier diagnosis, improved treatment options and the allocation of funding. National Screening Unit information and Primary Health Organisation data from the Performance Management Programme will be used for ongoing monitoring of cancer screening coverage rates. A particular focus of our screening services will be on focusing on Māori and Pacific uptake. We support the linear accelerator project to increase radiation treatment capacity at Capital and Coast DHB. See also our DHB objective section for Cancer and Palliative Care.

Health Target	Reducing ambulatory sensitive (avoidable) hospital admissions. The national targets are to reduce these potential avoidable hospitalisations in the 0-4, 45-64 and 0-74 year olds across all population groups, including Māori and Pacific.
Current Situation	While nationally ambulatory sensitive hospitalisations have generally been falling over the last few years, from 2003-2005 Hutt Valley rates rose compared to the national trend. While Hutt Valley rates have been generally falling more recently, our avoidable hospitalisation rates in 2007 were still generally higher than the national average. Analysis has identified the leading contributors to our high avoidable hospitalisation rates by age group. 0-4 year olds: Respiratory infections, gastroenteritis, asthma, ear/nose/throat (ENT) infections, epilepsy, cellulitis (skin infections) and dental conditions. 45-64 year olds: Angina, cellulitis, diabetes, respiratory infections, congestive heart failure, chronic obstructive respiratory disease and asthma. 0-74 year olds: Angina, respiratory infections, cellulitis, asthma, gastroenteritis, ENT infections and diabetes.
What we are planning for 2008/09	We will be working collaboratively to address our relative high rate of ambulatory sensitive hospitalisations through planning and working together with Primary Health Organisations (PHOs) and the primary health care sector and by addressing the key causes of these hospitalisations, including chronic diseases. We will support improved responsiveness in primary care and improved linkages between primary and secondary care. This will include the establishment of Primary Care Liaison roles and efforts to build capacity within our primary care workforce and opportunities for the secondary care workforce to provide specialist advice and support to PHOs so that they can better care for their enrolled populations. It will also include exploring opportunities to foster new models of service delivery within primary care, which involve a broader range of professionals (e.g. primary care nurses more involved in Care Plus, chronic disease management and outreach nursing). We will explore opportunities with primary care for different models of care involving nurse led activity, e.g. case management, how to increase their workforce capacity to help manage chronic conditions in the community and also encourage PHOs to achieve Care Plus targets. We will implement our *Healthy Eating Healthy Action* and *Growing a Healthy Community* plans and *Keeping Well* strategy to address inequalities, and implement programmes like B4 school checks, newborn hearing screening and other Ministerial priority areas. See also our DHB objective sections for Primary Health Care, Chronic Diseases, Maternity, Child and Youth Health, and Health of Older People.

Health Target	Improving diabetes and cardiovascular disease services. The national targets are to increase the percentage of people in all population groups: • Estimated to have diabetes and accessing free annual diabetes checks (Get Checked). • Who receive annual diabetes checks having good diabetes management (HBA1c levels <=8%). • Who have had their five-year absolute cardiovascular disease recorded in the last five years (this replaces a previous target of people who receive annual diabetes checks having had retinal screening in the past two years). There is also a target that there will be improved equity for all population groups in relation to diabetes management.
Current Situation	In 2007 69% of the estimated people with diabetes in the Hutt Valley received a free annual Get Checked review, however, Māori uptake was significantly lower at 38% compared to Pacific and other ethnicities (77% and 78% respectively). In addition Ministry of Health estimates of the numbers of people with diabetes in the Hutt Valley have recently increased (from 4,261 in 2007 to 6,166 in 2008). Figures for the management of diabetes in people receiving annual reviews, based on HBA1C levels, shows that only around half of Māori and Pacific diabetics have their diabetes well managed, compared to three quarters for other ethnic groups. Receipt of retinal screening shows less marked ethnic inequalities, however data quality issues have caused an apparent decline in this area that is probably not real. Another complicating factor in the measurement of the diabetes target area is that reporting data is based on the payments system for the Get Checked programme. Any delays in invoicing and payment processing mean that quarter reporting of data (previously done annually) tends to exclude a proportion of annual reviews and makes progress against targets appear lower than in reality (first quarter Hutt Valley reporting in 2007/08 had a 18% undercount, with the outstanding data coming through in the second quarter). Within the Hutt Valley, the use of cardiovascular disease risk assessment tools within Primary Health Organisations is variable but developing (baseline data is not yet available).
What we are planning for 2008/09	We will maintain our current support for the provider arm outreach diabetes team and the Māori diabetes outreach service, which facilitate linkages to the Get Checked reviews and other diabetes services, e.g. podiatry and retinal screening. We will explore the possibility of sharing diabetes information held by primary care with hospital clinicians to improve patient outcomes and opportunities to provide hospital level care and support to people in primary care settings, in collaboration with primary care services. Once Primary Care Liaison roles have been established, we will identify how hospital clinicians can work more innovatively with community based providers to improve the patient journey for people with chronic conditions. See also our DHB objective sections for Public Health, Intersectoral Collaboration, Primary Health Care and Chronic Diseases.

Health Target	Improving mental health services. The national target is for all clients with enduring mental illness (those who have been in treatment with any mental health service for two years or more) to have up-to-date crisis prevention/resiliency plans.
Current Situation	At the beginning of 2008, 98% of Hutt Valley DHB's long-term clients had up-to-date crisis prevention/resiliency plans. The 2% of clients without these plans were clients who were seeing clinicians unfamiliar with these type of plans. Service and clinical managers are currently exploring ways to up-skill these clinicians.
What we are planning for 2008/09	We are planning to implement steps to ensure that all clinicians are working with long-term clients to ensure they have up-to-date crisis prevention/resiliency plans and monitor ongoing compliance. See also our DHB objective section for Mental Health.

Health Target	Improving nutrition, increasing physical activity and reducing obesity. The national targets are:
	• The proportion of infants exclusively and fully breastfeed;
	  o 74+% at six weeks, 57+% at three months, 27+% at six months.
	• The proportion of adults (15+years of age) consuming at least three servings of vegetables per day and at least two servings of fruit per day;
	  o 70+% for vegetable consumption, 62+% for fruit consumption.

Current Situation	Hutt Valley breastfeeding rates have historically been lower than the national average and generally worsened between 2004 and 2006 (based on Plunket data). Māori and Pacific breastfeeding rates are also lower than non-Māori/non-Pacific. We are working to collate breastfeeding data from all our local Wellchild providers, including Plunket (contracted by the Ministry of Health) and other providers contracted by ourselves (Naku Enei Tamariki, Pacific Health Services and Te Runanganui o Taranaki). Hutt Valley Plunket data: 50% at 6 weeks (2006), 48% at 3 months (2004, not available in 2006 report)), 27% at 6 months (2006). Data on vegetable and fruit consumption is available through the New Zealand Health Survey and the New Zealand National Adult Nutrition Survey. In the 2002/03 New Zealand Health Survey, 68.6% of adults ate three or more serving of vegetable a day and 54.6% of adults ate two or more servings of fruit a day. DHB level estimates tend to have wide confidence intervals and Hutt Valley figures are not significantly different to the national averages. However, the data indicates that males have lower vegetable and fruit consumption levels than females and that Māori and Pacific consumptions levels tend to be lower than non- Māori/non-Pacific. Data from the 2007/08 New Zealand Health Survey is not yet available.
What we are planning for 2008/09	Our work in this area will be driven through the Implementation of our Healthy Eating Healthy Action (HEHA) Ministry Approved Plan work and Regional Public Health (RPH) work supporting PHOs and other organisations in HEHA health promotion activities. One focus is improving the food and nutrition environment in schools and early childhood centres, through supporting them with the implementation of the Food & Nutrition Guidelines and the Food & Beverage Classification System, administration of the HEHA Nutrition Fund and implementation of the Fruit in Schools programme. Local HEHA initiatives include our Mum4Mum breastfeeding and Mauri Oho Mauri Tau obesity reduction in Tamariki programmes (and evaluation of these initiatives), the development of other community-based initiatives for Māori and Pacific people and the implementation of our *Kia pai nga kai – Ka or ate Tinana* plan with our Māori communities. RPH is also undertaking research to identify barriers to healthy food accessibility. There is also collaborative work to support the *At the Heart* strategy in the Wellington region. See also our DHB objective sections for Public Health, Intersectoral Collaboration, Primary Health Care and Maternity, Child and Youth Health.

Health Target	Reducing the harm caused by tobacco. The national targets are to: • Increase the proportion of 'never smokers' among Year 10 students by at least 3 percent (absolute increase) over 2007/08 (baseline 57.9%) and an increase for both Māori Year 10 'never smokers' and Pacific Year 10 'never smokers' that is greater than that for European Year 10 'never smokers'. • To reduce the prevalence of exposure of non-smokers to SHS inside the home to less than 5% (baseline 2006 12.5%, 2007 7.5%) and a reduction in the prevalence of exposure of non-smokers to SHS inside the home for Māori (baseline 2007 16.1%) and for Pacific (baseline 2007 16.4%) that is greater than that for European (baseline 2007 6.5%).
Current Situation	Smoking prevalence rates from the 2006 Census show that 22.9% of Hutt Valley residents aged 15 years and over were regular smokers, slightly higher than the national average of 20.7%. The Hutt Valley proportion of ex-smokers was 22.4%, slightly higher than the national average of 22.1%. Hutt Valley males had a slightly higher smoking prevalence to females (23.4% compared to 22.5%) and Māori and Pacific smoking rates were significantly higher than other ethnic groups, at 44.1% and 32.5% respectively. The highest rates of smoking in the Hutt Valley are among Māori females (49.0%). In 2006, nationally 54% of 14 and 15 years olds (year 10 students) never smoked while the Hutt Valley figure was lower at 49%. The highest smoking prevalence is among 15-29 years old and the average age of smoking initiation in adolescents is 14.6 years. In 2006, nationally the proportion of households with children where smoking is not allowed anywhere was 70%. Progress is monitored through the Health Sponsorship Council, an annual Year 10 survey and the New Zealand Tobacco Use survey. Hutt Valley DHB is a smokefree hospital.
What we are planning for 2008/09	All DHBs are required to develop a tobacco control plan by June 2008. Work is progressing on this between ourselves, Capital and Coast and Wairarapa DHBs, in conjunction with Regional Public Health. Our Regional Public Health Unit has tobacco control funding and staff and provides Central Region Smokefree Co-ordination Service. Our tobacco control interventions include cessation services, subsidised nicotine replacement therapy (NRT), effective brief intervention (EBI) training for clinicians, health promotion to increase smokefree environments and better tobacco retailer compliance through controlled purchase operations. Increased interventions for smokers should result in decreased smoking, less exposure to second hand smoke, fewer young people starting smoking and more current smokers quitting. The outcomes we are seeking are for reduced tobacco related morbidity and mortality and reduced disparities. See also our DHB objective sections for Public Health and Primary Health Care.

3.5 Our Priorities for 2008/09

Our key local priorities for 2008/09 are:

- **Primary health care** – Increasing access to primary health care, an increased primary workforce, improved relationships and liaison with secondary care and supporting health promotion.
- **Quality and safety** – Participation in Quality Improvement Committee programme workstreams, particularly with our Improving the Patient Experience programme.
- **Elective services** - Increasing access and complying with national programmes including elective service performance indicators.
- **Keeping our people well** – Through Healthy Eating Healthy Action, and Healthy Housing programmes and the *Keeping Well* population health strategy for the greater Wellington region.
- **Services for children and youth** – Through implementation of Ministerial priorities (immunisation, screening, B4 school checks and improved access to services), our *Growing a Healthy Community* plan, new oral health services and enhanced mental health services for children and youth.
- **Services for older people** – By Implementing improved psycho-geriatric services, and realising the gains from our augmented Needs Assessment and Service Co-ordination service.
- **Implementation of our emergency department/theatre project** – Through the advancement of our campus development programme, including planning of our new emergency department/operating theatre facility, ensuring capacity to deal with growing emergency department presentations and surgical demand in the meantime and the adequacy of mental health facilities.
- **Workforce development** – Developing and implementing a co-ordinated approach to building our workforce that reflects our community across the health spectrum.
- **Maintaining financial performance** – In the face of population based funding pressures and challenges relating to national industrial agreements.

4. Issues and Risks

The following sections summarise the key issues and risks facing Hutt Valley DHB during 2008/09 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 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.

Those issues have been consistent for some time, but now we also face an increasing birth rate and the issues that is presenting in terms of infrastructure, workforce and access.

While management of people with chronic conditions in primary and community settings is expanding, admissions to hospital continue to be high and growing, putting pressure on staff, budgets and facilities.

In 2008/09, 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, obesity, alcohol misuse) to reduce the incidence in the population. The Healthy Eating, Healthy Action programmes will increasingly feature in this effort.

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 continue to extend its activities.
- Research and teaching activities are growing and we need to nurture them.
- We wish to maintain effective 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 and while we are no longer considered an over-funded DHB, our population is not growing at the same rate as other areas and, therefore, we can expect our level of funding to be pressured relative to other faster growing areas. 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 developing a Health Emergency Plan for implementation in 2008/09. This covers major incidents, business continuity, health recovery and biological, chemical, radiation and environmental emergencies. 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.

Service Effectiveness

Hutt Valley DHB has had a 33 percent increase in acute surgical demand over the last five years, which has put significant pressure on services throughout Hutt Hospital and particularly on the ability to undertake elective surgery.

The long term solution is expanded operating theatre facilities but in the short term Hutt Valley DHB continues to use private facilities to deliver increased surgical capacity. This activity will increase over 2008/2009 in line with the increased base elective requirements. Hutt Valley DHB clinicians are now using both Southern Cross and Boulcott hospitals to deliver publicly funded elective surgery.

The increasing demand for acute medical services is being addressed through the establishment of a fourth medical team within Hutt Hospital.

Increasing Emergency Department attendances continue to put pressure on Hutt Hospital and during 2008/2009 there will be increased focus on care paths and internal hospital systems in order to ensure safe and timely care can be maintained. There will also be increased focus on better communications and co-operation with primary care to ensure patients are being referred appropriately.

There have been significant difficulties for people enrolling with PHOs and accessing primary health care, because of closed books and difficulty getting an appointment with a GP in a timely manner. There are a number of issues but the workforce issue is the major one – there is a significant shortage of General Practitioners in the Hutt Valley compared to the national average. The DHB is addressing this directly with PHOs, General Practices and the College of General Practitioners and there are likely to be significant shifts of emphasis during 2008/2009. This will include appointment of Primary Care Liaison roles to deal with specific issues.

Hutt Valley DHB is keen to proceed with the proposed new model for community-based dental care for children and adolescents, and we have prepared a business

case jointly with Capital and Coast DHB. We are awaiting the response from the Ministry of Health but are keen to commence implementation during 2008/2009.

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 2008/09 we will address these through inter-service initiatives, including the augmented Needs Assessment Service Co-ordination (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 the health sector labour market.

As indicated above, the Hutt Valley has a lower number of Full-Time-Equivalent General Practitioners and Practice Nurses per head of population than the national average, and we will be working closely with primary care providers during 2008/09 to increase this workforce.

Hutt Valley DHB also has fewer Lead Maternity Carers per head of population than the national average, resulting in increased pressure on hospital maternity services to cover the gaps. In 2008/09, we will be developing a maternity plan for a sustainable model of service delivery.

There are specific vacancies within the DHB provider arm; Emergency Department staffing; shortages of registrars, etc. The DHB also faces increasing demand for public health nurses to support the government's increased focus on improving child and youth health, and to participate in key intersectoral initiatives. We plan to secure at least 2.5 full time equivalents of specialist emergency medicine staff to enable us to seek accreditation in emergency medicine training. Once we have achieved this training status it will become easier to attract junior doctors.

The DHB has prepared a strategic workforce development plan and specific actions are identified in this document for implementation.

Higher demand, combined with reduced supply and 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, recruit and retain staff and enhance our workforce development, building on the impetus of the Magnet programme.

For each specialty in the provider arm suffering recruitment and/or retention difficulties we will establish a targeted approach to recruitment based on the unique issues of the service.

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. We are in the process of implementing 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.

With the upcoming implementation of the new Wellington regional hospital there is the risk of decreased service delivery to Hutt residents during the transition as well as potential ongoing risks given its lower number of beds. We will be looking to provide as much support as possible to Capital and Coast DHB to ensure that the region's population maintains access to services.

Hutt Hospital's in-patient mental health unit will be reviewed in the light of regional service development planning. The upgrade of the unit was originally planned to be part of the Integrated Campus Plan, but was put on hold so that regional service development could be taken into account. This will be addressed during 2008/2009.

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 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. There will also be on-going improvements in the electronic medical record system which includes the use of electronic referrals from General Practitioners.

Financial Management
As a result of being classed as an over-funded board in 2007/2008 (though this has now been corrected) Hutt Valley DHB increased its focus on revenue generation, value-for-money and cost containment strategies.

This will continue to be a focus during the 2008/2009 year with particular opportunities in radiology, breast screening and community pharmaceuticals for either revenue generation or cost containment.

In recent years, national 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 increases passed on to DHBs. The gap between wage increases and DHB price increases continues to 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. However, there is a limit to that and 2008/2009 is a particularly difficult year for Hutt Valley DHB as a result of salary increases, already agreed to nationally, coming into the system and because of increasing expectations from all groups within the workforce.

The financial impact of MECA settlements on non-DHB providers is also an issue which the DHB is continuing to address. 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 will need to be found within existing overall funding.

Timely access to residential care and home support services is an issue which we are continuing to address through the newly established and augmented NASC working with the provider arm and providers. We will also be looking to build capacity and capability in home support services..

We are also working to reduce the financial risk and to improve the services available to older people by developing the augmented NASC service and a wider range of flexible options for restorative, rehabilitation, support and care services to enable "Ageing in Place".

Within personal health services, there are several financial risks arising from demand driven services. With the possible 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. Also, primary maternity workforce shortages are increasing the pressure on DHB maternity services which is picking up the lead maternity carer role for an increasing number of women, but without commensurate compensation. This is being taken up with the Ministry of Health.

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. Balancing IDFs with the increased focus on increasing elective services for the DHB's own population is a higher focus risk than in the past.

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 mean a third linear accelerator is to be installed the region; and brachytherapy has been introduced in Wellington. All of these 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. This is an on-going issue.

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. We 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.

4.3 Service Reviews and Changes

We propose to undertake a number of service reviews and service changes during 2008/09. A selection of services will be reviewed to ensure improved access to services, reduced inequalities and that we meet our budgeted financial position. This is part of focus on continuous quality improvement and will include consumer and clinical involvement.

Local reviews and changes planned are:

- Ongoing review of community pharmaceutical prescribing and dispensing.
- Implementing the local five year mental health and addiction service plan.
- Implementing the plan for psycho-geriatric and mental health services for older people.
- Implementing the recommendations of the review of Infant, Children, Adolescent and Family mental health services.
- Implementing our Child, Youth and Family plan, *Growing a Healthy Community*[20].
- Exploring new approaches to service delivery for Pacific populations.
- Exploring different ways of improved delivery of home help delivery into the community.
- A review of our current District Strategic Plan, *Towards a Healthier Hutt Valley*[1].

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.

We also plan to implement the new model of community-based oral health care for children and adolescents, developed jointly with Capital and Coast DHB, if we receive sufficient funding from the Ministry of Health. The two DHBs have already undertaken significant community consultation on the proposed changes.

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

- Implementing the Emergency Department/Theatre project.
- Developing the Intensive Care Unit (ICU) from Level 1 to Level 2.
- Offering tele-radiology and off-site digital reporting services to the central region.

- Working with other central region DHBs, and Capital and Coast DHB in particular, to improve access to and increase local delivery of urology, ophthalmology and dental services for the residents of Hutt Valley.
- Implementing the population health strategy, *Keeping Well 2008-2012*[21].

We will work with other DHBs to implement relevant recommendations from regional reviews and plans, including:
- Delivering renal medicine (haemodialysis and CAPD) outpatient services in the Hutt Valley, within the framework of the Central Region review of renal services.
- Implementing the regional five year mental health and addiction service plan.
- Implementing the findings of the review of eating disorders service provision across the central region and the evaluation of the Central Region Eating Disorder Service.

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

4.4 Service Coverage Exceptions

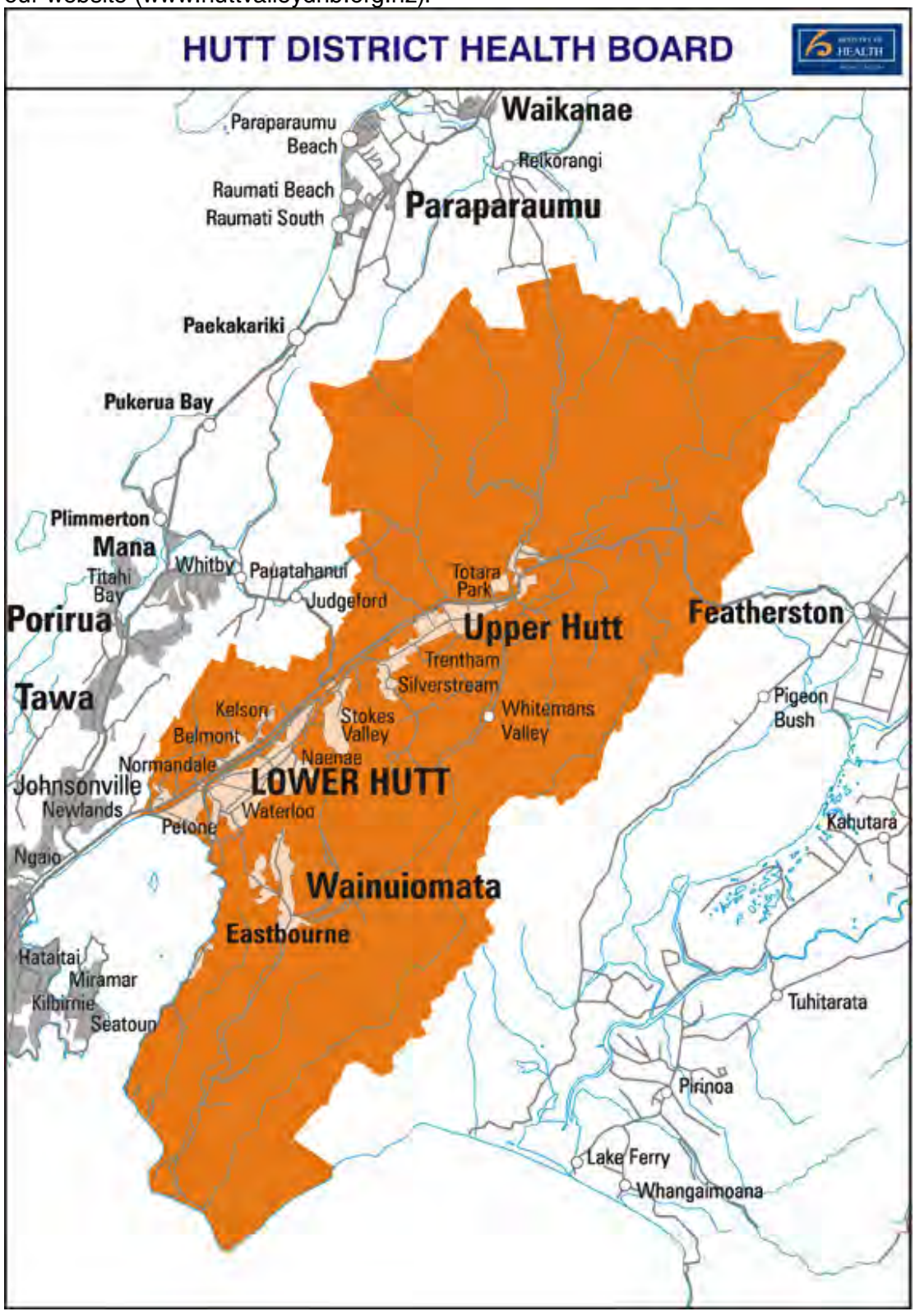
The Operational Policy Framework established by the Ministry of Health, which sets out the quasi-regulatory rules that all DHBs must comply with, includes an extensive service coverage specification. The service coverage specification describes the type of services and levels of access to services that the Ministry of Health requires DHBs to provide.

Hutt Valley DHB expects to meet Government service coverage expectations with the following exceptions and caveats:
- 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 are working toward 18 month recalls for low need individuals. We will provide a 6 monthly update report to the Ministry on progress towards meeting the service coverage specification.

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.

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 142,000 people live in the Hutt Valley – around 100,000 in Hutt City and 40,000 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 – around half of the Māori and Pacific people here are aged under 25 years. We also have significant Asian and refugee populations.

The total Hutt Valley population has seen only modest growth from the 1996 population of around 136,500 and is currently projected to peak around 2026 at around 147,000 people (previous projections indicated that our population would peak around now). 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. We will also have more older people and fewer young people living here in the future. By 2031, the percentages of Māori and Pacific peoples is expected to increase to around 21% and 10%, respectively, of the total Hutt population.

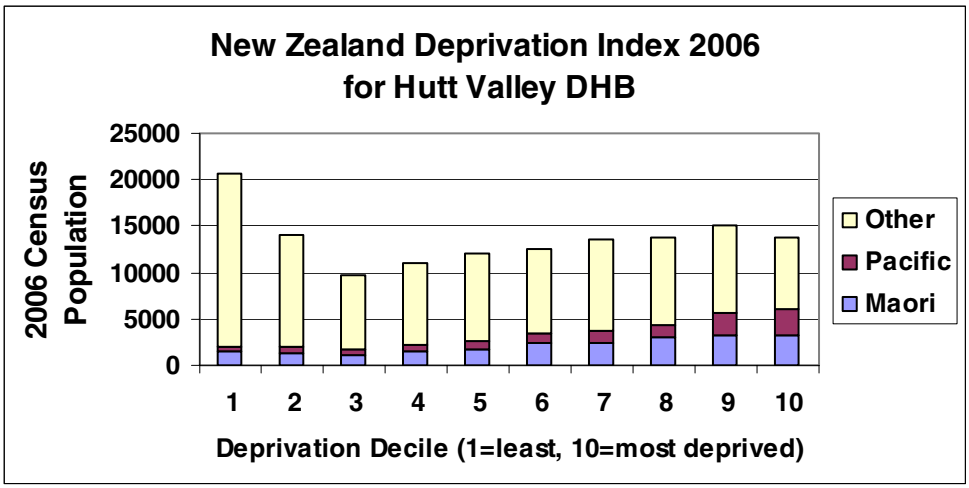
Hutt Valley projected population 2008 by age and ethnicity

Age Group	Numbers by Age Group				Percentages by Age Group		
	Māori	Pacific	Other	Total	Māori	Pacific	Other
Children 0-14 years	8,330	3,340	19,520	31,180	27%	11%	63%
Youth 15-24 years	4,450	1,990	13,410	19,850	22%	10%	68%
Adults 25-64 years	10,380	5,260	58,610	74,250	14%	7%	79%
Older people 65+	720	480	15,440	16,650	4%	3%	93%
Total	23,900	11,100	107,000	141,900	17%	8%	75%

Source: Statistics New Zealand

Social and economic conditions are significant determinants of the health status of individuals and communities, with a large body of research demonstrating an association between deprivation and health status. The New Zealand Deprivation Index (NZDep) is a measure of deprivation which combines social-economic variables from the Census and applies them to meshblocks (neighbourhoods of approximately 90 people) resulting in areas being rated from 1 (least deprived) to 10 (most deprived).

Application of the 2006 NZDep to the Hutt Valley district results in the following graph of deprivation distribution. There is variation in the level of deprivation across the Hutt Valley district, with a greater degree of variation within Lower Hutt compared with Upper Hutt. Areas of relatively high deprivation within the Hutt Valley district include Naenae, Taita, Moera, Timberlea and parts of Petone, Stokes Valley Wainuiomata, Waiwhetu and central Upper Hutt.



5.2 Key Health Issues

A Health Needs Assessment is being undertaken for the central region DHBs (Capital and Coast, Wairarapa, Hawkes Bay, Whanganui, Mid-Central and Hutt Valley). When this is completed, information from the assessment will be made available on 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[23]. 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 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*[3], the national Māori health strategy. The current Hutt Valley Māori population is around 24,000 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 2031 the Hutt Valley Māori population is projected to grow to around 31,000, or around 21 percent of the total Hutt Valley population.

The Māori population in the Hutt Valley is generally younger than the rest of the population and experience higher levels of deprivation than non-Māori in the Hutt Valley. Māori in the Hutt Valley have, on average, worse health than the wider Hutt Valley community.

We developed our Māori Health Strategic Plan, *Whanau Ora ki te 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.

The current Hutt Valley Pacific population is around 11,000 people, or eight percent of the Hutt Valley population. By 2031 the Hutt Valley Pacific population is projected to grow to around 14,750, or around 10 percent of the total Hutt Valley population. 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.

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 vision for the future of Pacific health in the Hutt Valley 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 less than 1% of disabled people under the age of 65 in residential care.

Accidents or injuries are the most common causes of disability for adults aged less than 65 years, with the most common type of injury occurring in the workplace. In older people disease or illness are the most common causes of disability. Physical disability is the most common type of disability for adults, followed by sensory disability (hearing and/or seeing). Around 10 percent of children aged under 15 years have a disability, with more than half being caused by a condition that existed at birth. Special education needs are the most common type of disability in children, followed by chronic conditions or health problems.

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 2007) 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 and has responsibility for oversight of the Emergency Department/Theatre project. 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. Funding proposals are assessed against equity criteria, including the Health Equity Assessment Tool[24], and service reviews included an equity focus, utilising the Reducing Inequalities Intervention Framework[25].

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, older persons, rehabilitation, mental health, imaging and some primary maternity and community services.

6.3.1 Research and Teaching

The Gillies McIndoe Research Institute is based at Hutt Hospital and is internationally recognised for its expertise in the field of reconstructive plastic surgery. Led by Dr Swee Tan, Hutt Hospital's Director of General Surgery and Reconstructive Plastic Surgery and chaired by Dr Colin Calacinai, Head of Plastic Surgery, it aims to develop better treatments and techniques for those in need of this surgery.

We have a Clinical Training Unit whose role includes analysing clinical education and training needs, planning programmes, managing programme delivery, evaluating and continuously improving clinical 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 2008/09.

6.4.1 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.

Improving the interface with primary health is a Ministerial priority, through planning and working together with Primary Health Organisations (PHOs). The Health Targets of improving immunisation coverage, reducing ambulatory sensitive (avoidable) hospital admissions, improving diabetes & cardiovascular disease services, improving nutrition, increasing physical activity & reducing obesity and reducing the harm caused by tobacco link to primary health care services.

What is planned for 2008/09?

Our focus will be on enhanced relationships, increased access to primary healthcare and increased workforce availability. We will establish Primary Care Liaison roles and work collaboratively with primary care and hospital services to address capacity and access issues for emergency department services.

The DHB will be working closely with primary health care providers to address various workforce issues that are becoming evident in the Hutt Valley. Workforce discussions with primary care in 2007/08 have so far identified four key issues:

- Workforce capacity: Low numbers of General Practitioners (GPs) and practice nurses relative to our total population and difficulty recruiting additional staff.
- Timely Access: The ability of people who are enrolled getting timely access to GP care.
- Closed Books: People are having difficulty enrolling with a GP due to closed books.
- Pressure on Hutt Hospital's Emergency Department.

In 2008/09 we plan to identify and progress strategies that build the capacity of our primary care workforce, improve people's ability to obtain timely access to First Level Services, reduce the number of practices with closed books and reduce the number of presentations in the Hutt Hospital's Emergency Department that could be better managed in primary care, or are occurring because the person attending has been unable to enrol with a GP.

We will continue to work closely with the six Primary Health Organisations (PHOs) in the Hutt Valley as they implement systems and processes to assist with the management of patients with chronic disease. We will continue to work with PHOs to co-ordinate our respective business planning processes and service development activities that form part of these plans. This will include working with PHOs to progress opportunities for shared projects or improved collaboration in health promotion areas.

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. We will monitor immunisation coverage rates as part of the PHO Performance Management Programme and explore strategies to improve

immunisation outcomes through the Hutt Valley National Immunisation Register (NIR) Governance group. To improve Māori and other high need group's immunisation coverage and reduce inequalities we will increase support to our NIR programme and the Outreach Immunisation Service provided by Kokiri Marae. We will continue to monitor PHO fee levels. Where proposed fee increases are above reasonable levels, the DHB will refer these to the regional fees review committee process.

Annual Objective 1: Working with primary care to focus on workforce development, and in particular, increasing the capacity of the workforce so that it is better able to accommodate the demand for primary care services, to improve access and the continuum of care.
Measures and Targets (see section 8 and appendix 2) Reducing ambulatory sensitive (avoidable) hospital admissions, Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain, Risk reduction – Smoking, Accessible and appropriate services in Primary Health Organisations, Care Plus enrolled population, The proportion of laboratory and pharmaceutical transactions with a valid National Health Index, Low or reduced cost access to first level primary care services.

Approach 1.1 Work with primary care to explore how we can assist primary care providers to build their workforce capacity to ensure primary care services are readily available to our local population.
Milestones: • Determine whether primary care is interested in the DHB identifying DHB employed doctors who would be willing to work in a practice for a short period, subject to sufficient workforce capacity within the hospital, until such time as a practice recruits additional Full-Time Equivalents (FTE). • Explore whether it is feasible and/or appropriate for the DHB to provide assistance or incentives to practices to recruit additional GP FTE over and above current levels. • Explore whether it is feasible and/or appropriate for the DHB to establish a practice in the community, either on its own or in partnership with another practice, as part of an established PHO. • Explore whether the DHB should employ a GP to work in the Emergency Department prior to the redevelopment of the Emergency Department as part of the campus redevelopment process. • Explore an integrated approach to delivery of after hours primary care services between the Emergency Department and Lower Hutt After Hours as part of the campus redevelopment process. • Explore how the DHB and PHOs might support the development of new models of care within primary care, including the development of Nurse Practitioner roles within the Hutt Valley. • Determine whether there are practices interested in gaining teaching status.

Risks	**Mitigations**
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.

Approach 1.2 Establish liaison roles between primary health care and the DHB.

Milestones:

- Establish Primary Care Liaison roles in the Hutt Valley
  - Explore what support there is for establishing a clinical nurse leader/liaison position in the Hutt Valley.
  - Select suitable candidates in conjunction with primary health care and DHB clinicians.
- Orientate to positions and link into wider networks.

Risks	**Mitigations**
No interest in positions from primary care practitioners.	Explore all options for fulfilling the roles.

6.4.2 Hospital and Emergency Department

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.

Infrastructure is a Ministerial priority area.

What is planned for 2008/09?

We will enhance the capacity of our emergency department so that our communities continue to have good access. With the approval of our business case for the development of our Emergency Department and Theatre facilities we will now progress through the design and planning phase in order to be in a position to commence construction in early 2009/2010. See also the Quality and Safety, Information Services and Workforce Development sections for the other aspects of capability.

Annual Objective 2: Enhancement of capacity and capability.
Measures and Targets (see appendix 2) Improving mainstream effectiveness, Progress and update reports to DHB Board.

Approach 2.1 Work collaboratively with primary care and hospital services to address capacity and access issues for emergency department services.	
Milestones: • Engagement of GPs and greater collaboration with primary care and after hours services. • Review space usage in ED/SSU to develop a “fast track” area. • Develop staffing models to maximise efficiencies. • Work with internal hospital services to develop a ‘pull’ system for admitted patients.	
Risks	**Mitigations**
Capacity issues also reflected in primary care.	Link with workforce development strategies.
Consent to redevelop part of SSU not obtained.	Prepare a robust business case.
Unable to recruit appropriate staff.	Link with workforce development strategies.
Lack of buy in from stakeholders.	Consultation and participation from stakeholders.

Approach 2.2 Progress Emergency Department/Theatre project to construction phase.

Milestones:

- Decanting and demolition of buildings necessary for development.
- Include design features at a higher level than core building standards in the Emergency Department/Theatre Redevelopment Project.
- Completion of preliminary design.
- Completion of detailed design.
- Obtain local authority resource consent.
- Engagement of main construction contractor.

Risks	**Mitigations**
Demolition of buildings delayed.	Realistic implementation timeframes agreed. Program for demolition carefully monitored as part of the overall development project plan.
Key stakeholder expectations are not met.	Manage key stakeholder expectations. Ensure on-going consultation.
Project cost escalation.	Consultant/contractor and user group management.
Obtaining resource consent delayed.	Use of an experience resource planner. Communication and engagement with local community.
Ministry of Health peer reviewers do not support Hutt Valley DHB plans at various milestones through the life of the project.	Maintain close contact with the Capital group at the Ministry. Ensure project encompasses best practice principles.

Approach 2.3 Development of radiology and imaging services.

Milestones:

- Implementation of Carestream Picture Archiving Communication System (PACS) and regional PACS archive.
- Offering tele-radiology and off-site digital reporting services to the central region.

Risks	**Mitigations**
Project is inadequately scoped and funded.	Independent quality assurance, risk monitoring and a fixed price contract with Carestream.
Availability of internal resources.	DHB-wide high priority project.
Technical complexity.	Ensure infrastructure is robust and learn from other DHBs.
Regional collaboration/agreement breaks down.	Leadership by regional Chief Executive Officers and Chief Information Officers – other regional groups in agreement.

Key contracted service outputs

The hospital makes a contract with the Planning and Funding team of the DHB for the year. As part of this contract, the hospital agrees to provide certain 'outputs' which are listed in the table below.

Contracted output/service	Measure/Unit	2007/08 Volumes	2008/09 Volumes	% Difference
Medical inpatient	Caseweights	7,352	6,910	-6%
Surgical inpatient	Caseweights	9,519	10,198	+7%
Medical outpatient	Appointments/Procedures	29,838	28,180	-6%
Surgical outpatient	Appointments/Procedures	32,359	36,929	+14%
Mental health	FTE/Bed days	13,009	13,010	0%
Emergency Department	Number of patients	38,783	26,763	-31%
Maternity	Attendances/Procedures	5,980	5,891	-1%
Disability Support Services	FTE/Bed days	14,710	13,671	-7%
Personal/Community Health	Complete measures as per contract	146,962	173,129	+18%
Total		298,511	314,681	+5%

6.4.3 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.

The national Quality Improvement Committee (QIC) has had ministerial sign off for five national improvement programmes:

1. Optimising the patient's journey
2. Management of healthcare incidents
3. Infection prevention and control
4. National mortality review systems
5. Safe medication management

What is planned for 2008/09?

We will support the national Quality Improvement Programme (QIP) and are well placed to participate at varying levels in all five of the above programmes, complimenting existing quality improvement initiatives such as our 'Improving the Patient Experience' programme and the implementation of our electronic healthcare incident reporting programme. The development of our consumer advisory group will provide vital input from users of our services and strengthen our focus on strengthening the consumer voice in how we improve our services.

We will work at both the national collective level and at the local level to deliver the QIC programme over the next 3-4 years. Each project will be run by a lead DHB with help from other DHBs. Both resources from the lead DHB and DHBNZ will be used to run the programme and to help other DHBs implement the outcomes from the projects. We are committed to actively working with the national collective to support the lead DHBs and to ensuring that we as a DHB are prepared in terms of planning and resourcing to implement the results of these projects as they become available.

We acknowledge that 2008/09 is the establishment phase for the programme. The lead DHBs will begin to deliver the first outputs by the end of 2008/09. We expect to be actively gearing up our DHB over 2008/09 to be ready to start implementing outputs by the end of 2008/09. We expect our commitment to resources to increase over the 2009 and 2010 calendar years as the programme enters its implementation phase.

We note that many of the projects have a significant Information Technology component that is yet to be funded. We will continue working with the Ministry at the national collective level to ensure investment decisions are made in a timely manner.

Optimising the Patient Journey

We will be actively participating in the collaborative process that will last 18 months and will include launch and close events, plus bi-monthly collaborative workshops.

Management of Healthcare Incidents

We commit to using the nationally developed incident management policy when it becomes available. Any agreed revisions to the policy and guidelines for incident management will be implemented by December 2008. We will market and promote

the national programme across the DHB and will release staff for the comprehensive training programme on incident management.

Infection Prevention and Control
We will explore enrolling as a test hospital to test the standardised operating protocols for hand hygiene. We will participate in the three national learning sessions with DHBs to educate local teams on the guidelines, the implementation strategy, improvement method and achieving change. We will implement the infection prevention and control strategy when it becomes available.

National Mortality Review Systems
We will work with the National Chief Executive Officer (CEO) Group (via the Lead CEO) and the Ministry of Health to establish a local Child and Youth Mortality Review Committee.

Safe Medicines Management
We will implement the new national drug chart in our hospital by the end of the 2008/09 financial year. We will initiate medicines reconciliation services by the end of 2008/09 financial year.

DHBs have agreed on structures and processes to manage the National Quality Improvement Programme at both the local and collective levels. The Lead DHB CEOs will steer the project and produce a regular consolidated report that will be used to update DHBs, Ministry of Health and the Quality Improvement Ministerial Committee. We will respond to the performance measures set out in the Crown Funding Agreement.

Annual Objective 3: To support staff to deliver high quality care within a quality improvement framework.
Measures and Targets (see appendix 2) Quality systems, Service coverage, Delivery of DAP In Key Priority Areas, Risk Management.

Approach 3.1 Participation in national quality improvement initiatives and recognition of achievements at national level.	
Milestones: • Preparation of a business case to support the implementation of our 'Improving the Patient Experience' programme under the work programme for Optimising the Patient's Journey. • Establishment of Child and Youth Mortality Review coordinator to establish compliance with national data collection and review of deaths. • Establish an implementation team within the DHB to support the implementation of the safe medication management initiative. • Explore opportunities for regional collaboration in the adoption of the National Medication Chart. • Participation in the infection prevention and control national strategies. • Participation in the national projects being established relating to the management of healthcare incidents. • Hutt Valley DHB achievements entered into national awards. • Hutt Valley DHB achievements showcased at conference level.	
Risks	**Mitigations**
Missed opportunities to participate at national level in quality improvement initiatives.	Ensure Hutt Valley DHB internal quality programme is aligned to national initiatives.

Approach 3.2 Managing risk of harm to patients through a culture of safe reporting, open disclosure and a systematic approach to identifying, analysing and learning from common causes of system failure.

Milestones:

- Electronic healthcare incidents system fully implemented and able to provide accurate reporting and trend analysis.
- Increased focus on the redesign of patient care processes to eliminate repeated harm.
- Liaison with the national initiative for Management of Healthcare Incidents with a focus on open disclosure processes.

Risks	Mitigations
Workplace culture does not support safe reporting of events and open disclosure.	Foster culture of safe reporting, focus on learning and improvements to systems.

Approach 3.3 Increasing the voice of our consumers in the planning, redesign and improvement in our services.

Milestones:

- Consumer advisory group established and participation in key projects ongoing.
- Patient satisfaction results are analysed, results fed back for focus on improvements.
- Focus on customer service training and education across all services, e.g. KiwiHost.

Risks	Mitigations
Participation by consumers not considered valuable by some staff.	Encourage participation and increase staff understanding of value of consumer voice.

Approach 3.4 Improvement of the patient experience based on safe, reliable clinical systems and effective patient flows from home to hospital and back to the community through five internal workstreams:

1. Outpatients
2. Diagnostics
3. Pre-operative assessment
4. Day surgery
5. Unplanned care.

Milestones:

- Completed project plans for each of the five workstreams.
- Preparation of business case to receive Quality Improvement Committee funding.
- Project teams identified for each workstream.
- Milestones for each workstream identified.
- Phase one of each workstream completed.

Risks	Mitigations
Inadequate project management resource to achieve milestones.	Ensure dedicated project manager employed.
Lack of buy-in from staff.	Ensure staff fully understand and support each workstream.

6.4.4 Elective Services

What does the DSP say and other key directives?

The key strategic goal of prevention, early treatment and easy access recognises that if people are sick, being seen and treated in a clinically appropriate timeframe increases the likelihood that they will get better, stay better, and for longer.

The Hutt Valley community, and the DHB communities for which we provide services, expect and should receive the best hospital services that are possible within available resources.

Key strategies include reviewing the services we provide from the perspective of our patients and their families, working closely with our primary and secondary colleagues, working effectively together as multidisciplinary teams within the DHB, and investment in Hutt Hospital's facilities.

The Health Target of improving elective services links to this area.

What is planned for 2008/09?

We aim to be in a position to see and treat all those people in our community that are referred to us and who will benefit from our services.

The focus of for this year will be to continue with the programme to improve the patient experience and to increase access to elective services. This will enable us to meet the targets for orthopaedic and cataract surgery and other electives initiatives.

We will do this as follows:

- Extend patient focussed booking for outpatient appointments to all specialities and extend to include appointments for endoscopy procedures.
- Continue to see and treat people within timeframes consistent with best clinical practice and current resources. We will meet and improve on Ministry of Health guidelines and work with primary care services to improve the continuum of service. This will involve the management of capacity and demand to ensure that these targets are met.
- Work with patients, staff, the primary and tertiary sector to improve our systems and processes to ensure that resources are used in the most efficient way. We will do this by implementing improvements identified by the Day Surgery, Pre-Operative Assessment and Unplanned Care workshops, components of the programme to improve the patient experience.
- Improve equity of access to elective services. We will work to ensure that the DHB has the capacity to provide elective surgery to the Hutt community and the feeder DHB populations we serve. This will be achieved by planning to build additional operating theatres and in the interim looking for creative ways to increase existing theatre capacity and outsource where necessary.

Elective Surgery Volumes

The following tables detail expected volumes for each service with the base and planned additional caseweights and estimated numbers of discharges.

Service	Elective CWDs			Estimated Elective Discharges		
	Base	Additional	Total	Base	Additional	Total
Cardiology	199	0	199	141	0	141
Dental	113	37	150	236	55	291
General Surgery	1076	99	1175	729	42	771
Cardiothoracic	396	0	396	59	0	59
Ear, Nose and Throat	365	116	481	565	140	705
Gynaecology	507	91	598	543	70	613
Neurosurgery	78	2	80	45	1	46
Ophthalmology	300	8	308	546	14	560
Orthopaedics	1350	226	1576	556	81	637
Paediatric Surgery	72	2	74	94	2	96
Plastics and Burns	556	36	592	768	50	818
Urology	207	32	239	156	24	180
Vascular	227	59	286	93	24	117
Total	5446	706	6152	4531	503	5034

Orthopaedic and Cataract Initiatives

	Base	Additional	Total Procedures
Cataract Initiative Procedures	284	76	360
Orthopaedic Initiative Procedures	174	121	295

We are involved in ongoing discussions with the Ministry of Health about how we need to balance those elements of our elective services programme which are delivered by us, and are under our direct control, with those elective services being provided from outside our DHB, and over which we have no real control.

Annual Objective 4: Meet and exceed Elective Service Patient Flow Indicators and increase the number of elective discharges and caseweights.
Measures and Targets (see section 8 and appendix 2) Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs) 1 to 8 and each DHB will set an agreed increase in the number of elective service discharges, and will provide the level of service agreed, Continuous Quality Improvement – Elective services.

Approach 4.1 Build on 2007/08 initiatives and maintain focus on management of elective capacity.	
Milestones: • Review and monitor capacity plans for new targets. • Develop internal ESPI reporting to assist monitoring of performance. • Work with Consultants to implement new national CPAC tools in Plastics and Orthopaedics and work with general surgeons to further develop local general surgery tool. • Review patient letters and improve where need identified. • Review referral criteria on anniversary date along with GPs and clinicians.	
Risks	**Mitigations**
Unpredicted surgeon absences.	Develop capacity plans with buffers.
Registrar/House surgeon shortage impacting on ability to deliver planned volumes.	Contingency planning.

Approach 4.2 Extend Patient Focused Booking (PFB) to all specialities, and endoscopy.	
Milestones: • Document processes developed in pilots. • Confirm specifications for Information Technology (IT) support programme. • Develop plan for development and implementation of IT support for patient focussed booking. • Extend PBF to all elective specialities.	
Risks	**Mitigations**
Lack of IT resource (personnel/time).	Carefully identify resource needs.
Loss of staff support	Work closely with HR in monitoring and managing impact on staff.

Approach 4.3 Maximise the effective use of day-case surgery by implementing process improvements identified by Day Surgery workshops. Implement plan to increase day surgery rate in procedures identified through Day Surgery benchmarking exercise.	
Milestones: • Development of plan to implement agreed best practise day case rate in specific procedures. • Implementation.	
Risks	**Mitigations**
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 4.4 Increase elective volumes in order to meet Orthopaedic, Cataract and Elective Initiatives.	
Milestones: • Identify and secure infrastructure and staffing requirements to ensure sustainable increases in elective volumes. • Develop production plan to meet additional targets in consultation with medical, nursing and allied staff. • Implement as per plan.	
Risks	**Mitigations**
Workforce availability.	Incrementally build staffing capacity.
Theatre & clinic availability.	Outsource theatre capacity and explore option of temporary theatre facility onsite.
Lack of clinician support.	Involve clinicians in development of production plan.

6.4.5 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. Getting ahead of chronic conditions and maintaining the pace of programme implementation is a Ministerial priority.

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.

The Health Targets of improving diabetes & cardiovascular diseases, reducing ambulatory sensitive (avoidable) hospital admissions, improving nutrition, increasing physical activity & reducing obesity and reducing the harm caused by tobacco all link to chronic disease services.

What is planned for 2008/09?

There are several areas we will target in managing chronic care for 2008/09. Apart from continuing work to address the relevant Health Targets, we will actively address unplanned care and the aim to improve the patient experience. The new Primary Care Liaison roles will be instrumental in exploring and implementing new models of chronic care management and establishing a framework to address an improved patient experience. We will undertake a Long Term Conditions Project which will include the development of a Long Term Conditions Action Plan, including a focus on reducing the inequalities that exist within chronic conditions. The focus will be on addressing health inequalities within the following areas:

- We will continue to work to increase the uptake of the free-to-patient primary education and podiatry maintenance treatments, the diabetes Get Checked and retinal screening programmes and to provide context for individual patient care planning. To achieve these aims, we will work towards supporting a shared primary and secondary integrated data set that will improve efficiencies, reduce wastage and provide timely and coordinated care.
- Align cardiac and respiratory services through chronic care management modelling between primary and secondary care by reshaping existing resources.
- Improve patient outcomes for patients with stroke through the development of an acute stroke service. Within current resources we aim to review ward models of patient care and explore nurse-led clinics to support the management of patients in primary care. We will encourage innovation in service delivery to ensure they are efficient, effective and patient focussed.
- Tobacco control and Healthy Eating Healthy Action. Smoking, poor nutrition, obesity and poor access to primary care are all risk factors for the onset of chronic diseases.

See also the sections on Public Health, Intersectoral Collaboration, Primary Health Care and Cancer & Palliative Care for what is planned in these areas.

Annual Objective 5: Improve health outcomes for patients with chronic disease, and in particular, decrease the incidence and impact of diabetes, cardiovascular and respiratory disease.

Measures and Targets (see section 8 and appendix 2)
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 (HBA1c <= 8%).
- Who have had their five-year absolute cardiovascular disease risk recorded in the last five years.

There will be improved equity for all population groups in relation to diabetes management, Risk reduction – Smoking, Cardiovascular disease, Organised Stroke Services, Care Plus enrolled population.

Approach 5.1 Assist primary care and secondary services to increase regular screening and coordinated intervention for diabetes and cardiovascular disease.

Milestones:

- Use of Primary Care Liaison roles to explore and implement new models of chronic care management and establish a framework to address an improved patient experience.
- Explore both feasibility and cost options for agreed primary/secondary shared access to the Get Checked database. If feasible and acceptable, implement with all PHOs and DHB services.

Risks	**Mitigations**
Lack of commitment by primary and secondary care.	Early engagement and wide consultation.
Cost is too high to proceed.	Early concept paper to Information Services Steering Committee and Funding Management Group on expected cost saving and expected value for money, patient outcome improvement.
Delays in implementation because of information technology constraints, or work programme.	Information Technology staff involved (primary and secondary) at outset to identify risks and solutions.

Approach 5.2 Deliver respiratory services closer to the community.

Milestones:

- Improve data collection and reporting on respiratory admissions and current service delivery.
- Implement Health Housing projects in conjunction with intersectoral partners, and ensure liaison between PHO outreach and practice nurses, respiratory services staff and the Healthy Housing projects to support follow-up education and support.

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

Approach 5.3 Establish a dedicated stroke service for acute stroke management on the medical ward.

Milestones:

- Reconfiguration of resources to define a 4-6 bed area.
- Practice guidelines established that include key indicators and systems for the collection of data.
- Staff training and education implemented to core group of nursing staff.
- Equipment and resources secured.
- Business case developed for a nurse specialist appointment.

Risks	**Mitigations**
Allied health and nursing numbers not	Review models of care and resources

adequate for patient group.	prior to service establishment and include key stakeholders.
Nurse specialist business case not supported.	Continue with complex discharge nurse oversight and represent case.
Patients not transferred within agreed timeframes	SRS involved in monitoring and reporting process.

Approach 5.4 Review chronic care models and pathways to better integrate hospital services using innovative models that include community settings and develop links with primary care to reflect best practice in chronic care management.	
Milestones: • Development of a Long Term Conditions Action Plan. • Update current practice standards and guidelines. • Explore cardiology day-stay services in the Coronary Care Unit. • Explore shared care opportunities for nurse-led services for heart failure and rheumatology conditions in community settings (e.g. Marae). • Explore a respiratory specialist outreach service to be delivered in a high-needs area (e.g. hospital at home).	
Risks	**Mitigations**
Resistance to participate in proposed changes or to move to a different model by staff.	Consult with key stakeholders, identify key drivers and set realistic timeframes and expectations.
Workforce, resources and capabilities not available to support the full implementation of the service.	Link with workforce development plan and focus on key areas for greatest gain.
Lack of suitable space to establish service.	Explore opportunities to develop suitable area.

6.4.6 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.

The Health Targets of improving nutrition, increasing physical activity, reducing obesity and reducing the harm caused by tobacco link to public health services.

What is planned for 2008/09?

Hutt Valley DHB works closely with Capital and Coast DHB, Wairarapa DHB and the Ministry of Health to jointly plan and fund public health services in the greater Wellington region. During 2007, the four organisations have developed a draft regional public health strategic plan, called *Keeping Well 2008 – 2012*[21]. This plan will be considered by the three DHB Boards in 2008. Once approved, it will guide the delivery of public health services across major priority areas and in specific communities. *Keeping Well* has goals to:

1. Reduce health inequalities for the population groups most at risk.
2. Support the development of healthy communities.
3. Reduce the incidence and impact of chronic conditions.

It includes targeting high needs geographic areas and influencing the determinants of health that relate to populations in those areas.

Regional Public Health (RPH) will deliver integrated health promotion, health protection and school health services to promote population health and reduce inequalities. The implementation of the *Keeping Well* strategy (subject to approval by Ministry of Health and DHB stakeholders) and the embedding of RPH's revised organisation structure will underpin new ways of working. These will include more community focused work in partnership with other agencies, alongside work on the wider determinants of health and health inequalities. The enhancement of RPH's Information, Analysis and Support team will support improved use of public health information for health gain. See also the Intersectoral Collaboration section for other population health related objectives.

Annual Objective 6: Provide health promotion, health protection and school health services and contribute to a range of population health programmes that promote healthy lifestyles and reduce health disparities.
Measures and Targets (see section 8) Proportion of infants exclusively and fully breastfeed at six weeks, three months and at six months, Proportion of adults (15+ years) consuming at least three servings of vegetables per day, and proportion of adults (15+ years) consuming at least two servings of fruit per day, To continue to increase the prevalence of never smokers among 14 and 15 year olds, To increase the proportion of smokefree homes where there was one or more smoker.

Approach 6.1. Provide health promotion, health protection and school health services that reflect the *Keeping Well 2008 –2012* strategy and embed Regional Public Health's new structure and direction.

Milestones:

- Implement the regional population health strategic plan *Keeping Well 2008 – 2012* (subject to approval by Ministry of Health and DHB stakeholders).
- Implement work programmes to address the population health priorities of the Wellington Region Public Health Steering Group.
- Work closely with Hutt Valley DHB to ensure Hutt specific population needs are met and services are delivered in an integrated way.
- Develop and implement a public health workforce development plan.
- Commence planning for an integrated public health project in an area of high need in the Hutt Valley.
- Implement a public health approach to family violence, based on recommendations of Regional Public Health scoping report.
- Explore strategies to improve immunisation outcomes through the Hutt Valley National Immunisation Register (NIR) Governance group.
- Support the rollout of the Hutt Valley Healthy Housing programmes.

Risks	**Mitigations**
Lack of buy-in from staff and stakeholders for implementing "Keeping Well".	Ensure all staff and stakeholders are kept well informed and able to contribute to decision making.
Insufficient staff capacity and skill base.	Staff training and development for the required roles.

Approach 6.2 Consolidate and enhance existing health protection work.

Milestones:

- Provide core health protection services to the population of the Hutt Valley, including ability to respond to a major disease outbreak, drinking water supply issues and emergency events.
- Develop a border health plan for the Port of Wellington and the International Airport to ensure RPH is able to respond to pandemic influenza or other significant international public health threats.
- Promote the provision of an adequate and safe supply of drinking water. With the Health (Drinking Water Amendment) Act 2007 coming into force from July 2008 there will be more explicit obligations on RPH and water supplies across the region.
- Report on the implementation of direct laboratory notification of communicable conditions project.
- Continue the development of the interagency communication plan addressing the public health risks associated with toxic algae in the Hutt River and other recreational water areas.

Risks	**Mitigations**
Lack of buy-in from other agencies for the development of the border plan.	Good communication and ensuring all agencies are kept well informed and able to contribute to decision making.
Large scale event of public health importance, e.g. significant outbreak, emergent infection prevents completion of proactive work.	Balance reactive and proactive work as much as possible.

Approach 6.3 Consolidate and enhance health promotion services.

Milestones:

- Provide advice and support to existing and new schools involved in the Health Promoting Schools (HPS) programme.
- Progress implementation of the Community Action on Youth & Drugs project.
- Consolidate and enhance existing tobacco control work, including:
  - Agreeing a Tobacco Control Plan with the Ministry of Health and starting to implement this.
  - Provide effective brief intervention training for smoking cessation to Hutt Valley DHB and RPH staff.
  - Provide Nicotine Replacement Therapy (NRT)/smoking cessation training for junior doctor/house surgeons.
  - Inform and encourage Primary Health Organisations and secondary health to use the widened subsidised NRT scheme and increase brief interventions for smoking.
  - Working to increase the number of smokefree environments.
  - Complete a review of Hutt Valley DHB's smokefree policy.
  - Implement a Tobacco Retailer Compliance Project in high deprivation areas within the Hutt Valley.

Risks	**Mitigations**
Lack of buy-in from staff and stakeholders.	Ensure staff and other stakeholders are kept well informed and able to contribute to decision making.

6.4.7 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. The Health Targets of improving nutrition, increasing physical activity, reducing obesity and reducing the harm caused by tobacco link to intersectoral collaboration.

What is planned for 2008/09?

2008/09 is a consolidation and implementation year for a number of intersectoral projects. These include:

- Healthy Eating Healthy Action - Oranga Kai Oranga Pumau.
  In 2007/2008, the Ministry funded DHBs to focus their planning and implementation of HEHA on the work in schools and early childhood education, on community engagement and workforce development and on the health target areas of promoting breastfeeding and increasing vegetable and fruit consumption particularly in Māori and Pacific communities. This work will continue in the 2008/2009 year as detailed in our latest Ministry of Health approved plan (HEHA MAP 2). The following groups have been identified as priority groups targeted by the plan:
  - Māori.
  - Pacific peoples.
  - Children and families.
  - Lower Socioeconomic groups.
- Family Violence response programme.
  We will implement the national Violence Intervention Programme (VIP) to ensure that appropriate policies and processes are in place to support staff to recognise, respond and refer patients when instances of family violence are suspected.
- Hutt Valley Healthy Housing programmes.
  We are supporting the implementation of two healthy housing programmes in the Hutt Valley, a locally developed Healthy Homes – Healthy People programme (targeting pre 1978 homes of people on low incomes) and the Housing New Zealand Corporation Healthy Housing programme (targeting state housing in Naenae and Taita). Both programmes are being delivered in conjunction with the Hutt Housing Steering Group.
- Providing Access to Health Solutions (PATHS).
  This is a needs assessment and service coordination programme assisting Ministry of Social Development clients on sickness and invalid benefits to return to work.
- Wellington Regional Refugee Action Plan[26].
  This includes:
  - Intersectoral work between refugee communities and mental health services on increasing knowledge and understanding of mental health issues and needs of people from refugee backgrounds.
  - Continuing to increase health provider's knowledge and understanding of the health needs of refugees by facilitating workshops on providing accessible services and use of interpreters.
  - Working with health service providers and the tertiary sector on strategies to increase participation and build capacity of people from refugee backgrounds in the health sector.

We will work closely with ACC to ensure that the proposed implementation of sexual abuse assessment and treatment services, from the Police to DHBs, offers an appropriate level of access to clients and is the most appropriate model for our community. We will ensure that the new service model between Hutt Valley and Capital and Capital DHBs will collect adequate data to contribute to the ACC service evaluation, following its first 18 months of delivery.

Hutt Valley DHB will continue to work with other agency partners to achieve the goals of the Wellington Regional Social Development Forum, the Hutt Valley Governance Group, and the Hutt Valley Mayors and Chairs group. See also the Public Health section for other intersectoral health related objectives.

Annual Objective 7: Improve service co-ordination between agencies to increase the levels of wellbeing, and reduce the incidence of ill health and injury, among Hutt Valley residents.
Measures and Targets (see section 8 and appendix 2) Proportion of infants exclusively and fully breastfeed at six weeks, three months and at six months, Proportion of adults (15+ years) consuming at least three servings of vegetables per day, and proportion of adults (15+ years) consuming at least two servings of fruit per day, Family violence prevention.

Approach 7.1 Implementation of the Healthy Eating Healthy Action plan strategies in the Hutt Valley to improve nutrition, increase physical activity and reduce obesity, in support of implementing our HEHA MAP 2.	
Milestones: • Continue to support schools and Early Childhood Centres with the Food & Nutrition Guidelines and the Food & Beverage Classification System and administration of the HEHA Nutrition Fund. • Implement the *Kia pai nga kai - Ka ora te tinana* plan within Māori communities. • Implement a HEHA Pasefika initiative within Pacific communities. • Implement the HEHA Breastfeeding Action Plan. • Increase Māori and Pacific workforce capacity and capability in the area of nutrition and physical activity. • Evaluation undertaken of HEHA initiatives – Mum4Mum breastfeeding programme and Mauri Oho Mauri Tau obesity reduction programme for Tamariki. • Collaborative work with the Wellington Region Social Development Forum and others, such as Recreation Initiatives Group, to support the implementation of the 'At the Heart 'Strategy (Activating the Wellington Urban Region). • Continued implementation of the Fruit In Schools programme in the Hutt Valley. • Undertake research to identify barriers to healthy food accessibility in the Wellington region.	
Risks	**Mitigations**
Ongoing and additional national requirements over-riding DHB priorities.	Incorporate into DHB HEHA planning and reporting.
Lack of buy-in from stakeholders & partners.	Communications strategy incorporates range of audiences to maintain information to all sectors and communities.
Local priority populations need doesn't align with nationally identified priorities.	Strengthen relationships and support development of locally driven models.
Contracting issues with service providers limitations to incorporate new work.	Liaise with appropriate portfolio managers.
Ongoing sustainability of funding for new initiatives at community level.	Support strategies that look at sustainability for communities.

Approach 7.2 Implementation of the Violence Intervention Programme (VIP) in Hutt Valley DHB and developing a public health approach to addressing Family Violence.	
Milestones: • Review and development of VIP policies completed. • Implementation of the VIP programme in at least one service area. • Development and implementation of a VIP training plan. • Maintain regular meetings of VIP steering group including community service providers. • Supporting White Ribbon Campaign. • Implement a public health approach to family violence, based on recommendations of Regional Public Health scoping report.	
Risks	**Mitigations**
Campus redevelopment impacts on services ability to implement the programme.	Inclusion of affected services on the steering group and having strong effective communication in place.
DHB staff training already accounts for considerable amount of time of work days.	Linking with service managers and trainers in the development of the training plan.
The VIP plan is done in isolation to the community.	Maintain strong links with key VIP agencies and include on the DHB steering group.
Insufficient staff expertise and community credibility in this area.	Link DHB staff (including RPH) with HVDHB Family Violence Prevention Co-ordinator.

Approach 7.3 Active involvement in interagency planning groups to support implementation of key projects.	
Milestones: • Rollout of the Hutt Valley Healthy Housing programmes. • Implementation of the Wellington Regional Refugee Action Plan. • PATHS programme implemented. • Participation in Wellington Regional Social Development Forum. • Participation in Hutt Valley Governance Group Forum. • Participation and support of the Hutt Valley Mayors and Chairs Group. • Develop and implement transport and travel planning.	
Risks	**Mitigations**
Multi-sector buy-in and joint funding/resourcing required for implementation of projects.	Continue to advocate for and demonstrate collaborative action and funding.
Loss of committed and appropriately trained staff to implement key projects.	Ensure that appropriate staff are resourced to do this specialised work.

6.4.8 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.

To be successful the health sector must work together on strategic relationships: between clinicians and management, between preventative, primary and secondary services, and between DHBs, the Ministry and Minister of Health. Effective innovations should be shared so that improvements in one area can be made available to all.

The Minister of Health has identified that benefits from further collaboration between DHB's and across the health system as a whole are available to be secured, through better exploitation of tools such as benchmarking, joint procurement, workforce planning and technology.

What is planned for 2008/09?
In 2008/09, 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, and the audit programme covering non-DHB providers. 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 initial steps of the Regional Clinical Services Plan, once this is approved by the DHBs. We will continue work on strategies to ensure sustainability in cardiology, cancer, plastics and burns, and renal services within the financial parameters of the DHBs. We will use the regional Health Needs Analysis (being completed in 2007/08) as a foundation for further service development.

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 the Public Health, Oral Health and Information Services sections for collaborative regional initiatives in these areas.

Annual Objective 8: 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 8.1 Continue participation in national activities through collaboration with DHBNZ and the Ministry of Health.

Milestones:

- 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.
- Participate in national procurement initiatives as required.
- Participate in the Service Planning and New Health Intervention Assessment (SPNIA) framework for collaborative decision-making as required.

Risks	Mitigations
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 8.2 Collaboration by central region DHBs for improved service delivery and greater efficiency.

Milestones:

- Implement a communications plan focusing on wide engagement and consultation on the draft Regional Clinical Services Plan (RCSP) once approved by Boards for consultation.
  - Develop an implementation plan for key priorities identified in the RCSP
- Implement (on a progressive basis) the regional service plan for mental health.
- Continue to support the agreed regional approach for:
  - Plastics, burns and maxillofacial services.
  - Cardiology services.
  - Progress the shared learning Acute Demand project.
  - Continue to support the workstreams of the Central Cancer Network.
- Implement initial recommendations arising from the regional review of renal services.
- Undertake agreed regional procurement initiatives.
- DHB collaboration in the oral health business case project.
- Explore opportunities for regional collaboration in the adoption of the National Medication Chart.

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

Approach 8.3 Monitor the approaches and work programme of the shared services agency (TAS) to ensure relevance and efficiency of services delivered.

Milestones:

- Work programme revised and new framework agreed for 2009/10.
- Regional quality and audit programme maintained.

Risks	Mitigations
Conflicting priorities mean that TAS cannot accommodate new directions.	Ensure that Chief Executive Officers and senior DHB staff have agreed on the priorities for TAS in 2008/09.

6.4.9 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 Child and youth health is a Ministerial priority, through the implementation of current programmes and building on the Wellchild review. Improving oral health, with a particular focus on making progress towards 85 percent adolescent oral health utilisation, is one of the Health Targets.

Our efforts will continue to 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. There will be particular focus on service access to children and young people in identified areas of high need. The Health Targets of improving immunisation coverage, improving oral health, reducing ambulatory sensitive (avoidable) hospital admissions, improving mental health services, improving nutrition, increasing physical activity, reducing obesity and reducing the harm caused by tobacco all link to maternity, child and youth services.

What is planned for 2008/09?

We are developing our Maternity, Child and Youth Plan, *Growing a Healthy Community*[20], which will bring together existing services and newer initiatives to improve and better integrate services for infants, children and adolescents (such as HIV screening, new born hearing checks, Health Promoting Schools, Healthy Eating Health Action, family violence prevention, oral health services, the B4 school check and other screening services). It will also incorporate recommendations from our mental health Infant, Child, Adolescent and Family Service (ICAFS) review. The plan will include our strategies for addressing two Health Targets: immunisation and ambulatory sensitive hospitalisations in children and youth. In all of these areas, our strategies will focus on reducing disparities, with specific emphasis on children in Māori, Pacific and low-income families. We will ensure we follow best practise for youth participation and engagement processes when planning our strategies with our young people.

We will work towards improving the delivery to specialist services through collaboration and partnership with key stakeholders. Paediatric services for the less common conditions will be improved by ensuring a focus on delivering child centred care, capacity building of clinical excellence and providing easy to access tertiary level advice.

We recognise that there is a current shortage of independent midwives and that this situation increasingly risks the care continuum to pregnant women. We are committed to supporting our independent midwifery practice workforce and establishing a primary care model that strengthens access to midwifery services.

Phased national implementation of the B4 School Check will commence in 2008. The purpose of the check is to improve child health outcomes and reduce inequalities. The check will identify any behavioural, developmental or health concerns that may adversely affect the child's ability to learn in the school environment, and ensure appropriate and timely referrals are made. We will consider our key stakeholder views, and work to explore and address the risks of moving from the new entrant school screening programme to this more intensive programme delivery to the younger age children. The initial focus will be on targeting high need children in the programme rollout. The implementation of hearing tests for neonates will also commence in 2008.

For other objectives relating to the health of infants, children and youth see also the Public Health, Intersectoral Collaboration, Primary Health Care, Mental Health and Oral Health sections.

Annual Objective 9: Improve health care services to support families to provide a healthy start to our children and young people.
Measures and Targets (see section 8 and appendix 2) Percentage of children fully immunised by age two for different ethnic groups, Immunisation Coverage at 6, 12 and 18 months.

Approach 9.1 Complete our *Growing a Healthy Community* plan, begin implementing its recommendations and address Ministerial priorities within available budget and resource restrictions.
Milestones: • Complete our *Growing a Healthy Community* plan, start to implement it's recommendations and work with relevant providers (e.g. housing, Māori, Pacific, Well Child, primary health care and DHB services) to reduce ambulatory sensitive hospitalisations in children. • Implement Ministerial priorities and specifically target high-needs communities as a first priority for: o B4 school checks. o Newborn hearing screening programme. o Antenatal HIV screening. o New immunisations as directed, e.g. human papilloma vaccine (HPV), pneumococcal vaccine,. o Oral health business case implementation.

Risks	**Mitigations**
Funding and resources required to implement priorities and recommendations not available.	Engage with key stakeholders early and consult as necessary to ensure buy-in and linkages to other work programmes.
High-needs communities are willing, but not resourced to participate fully.	Investigate and scope a community development model that will address ownership and buy-in to full participation of implementation.

Approach 9.2 Review the provision of primary maternity between hospital and community providers to ensure the continuation of accessible, equitable and safe maternity care for women of the Hutt Valley.
Milestones: • Service review completed. • Key recommendations from the review are agreed. • Models of care are defined. • Implementation plan agreed. • Change management principles agreed. • Implementation oversight group established to support change management processes.

Risks	**Mitigations**
Lack of buy-in from key stakeholders.	Establishing and strengthening sustainable partnerships. Proactive engagement with key stakeholders to achieve common goals and proactive support from the DHB to work with key stakeholders to achieve common goals.
Lack of strategic focus and insufficient	Push for relevant and skilled people to

information available for proper decision making.	participate.
Primary care and Provider Arm have different views on how primary maternity services can be better coordinated.	The parties work together to understand their respective areas of responsibility and expertise.

Approach 9.3 Support increased access for young people to youth friendly health services with particular focus on young people in identified areas of high need.	
Milestones: • Continue opportunities for partnership development between youth health stakeholders. • Explore opportunities to expand the inter-agency approach to service delivery. • Implement ICAFS review recommendations relating to youth.	
Risks	**Mitigations**
Lack of buy in from youth health stakeholders.	Early engagement with youth health stakeholders.
Intersectoral agencies and government departments contribution is not fully represented.	High level agreement sought and all key stakeholder interests consulted.

Approach 9.4 Develop a National Tertiary Paediatric Rheumatology Service in collaboration with Auckland DHB's Starship Hospital.	
Milestones: • Develop National Service Specifications. • Develop service implementation plan, including recruitment of staff and national communication plan. • Launch national service. • System in place to monitor service delivery.	
Risks	**Mitigations**
Lack of by-in from key stakeholders.	Continue to work with Paediatric Society and Ministry of Health with respect to implementation and communication of service. National communication strategy.
Unrealistic expectations of service from other DHB's.	Clear service specifications including inclusion and exclusion criteria. Regular review of service provision.
Ongoing clinical viability of service with only three Specialists across nationally.	Shared care approach with DHB of domicile to deliver safe, effective and appropriate treatment closer to the patient's home. Unified and co-ordinated approach, formally defined expectations between the tertiary centre and the secondary centre in terms of responsibility for the delivery of care. Provide necessary skills training, regular updating of staff provision of detailed written guidelines and protocols, easy to access to advice to secondary services. Workforce development plan including succession planning.

6.4.10 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.

Strengthening child and adolescent oral health services is a priority for the government and the Ministry of Health. The Ministry of Health is working with DHBs to re-orientate these services to a community-based model, providing seamless care for 0-18 year olds. Re-orientated oral health services will be characterised by a focus on prevention and early intervention. The Ministry expects services to demonstrate a particular emphasis on expanding and improving oral health care for pre-schoolers. Accessibility and appropriateness of care, particularly for groups with high need, is also a critical feature of future services.

In 2006, the Ministry published *Good Oral Health for All, for Life: The Strategic Vision for Oral Health in New Zealand*[17], Business Case Guidelines for investment in oral health, and Community Oral Health Service Facility Guidelines to support clinic design. The Health Target of improving oral health links to this area.

What is planned for 2008/09?

Subject to approval and sufficient funding of the joint Hutt Valley and Capital and Coast DHB's Child and Adolescent Oral Health 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 (CDA), primary health 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.

The target is improved oral health outcomes for the whole population by situating fixed clinics in designated geographical areas to maximise access. Within this, our business case model prioritises resources to those children and young people with high oral health needs, by resourcing and staffing the clinics based on clinical oral health needs in each area.

Annual Objective 10: Improve the oral health status of children and adolescents.
Measures and Targets (see section 8 and appendix 2) Progress towards 85% adolescent oral health utilisation, Oral health - mean Decayed/Missing/Filled/Teeth score at year eight, Oral health – percentage of children caries free at age five years, Oral Health.

Approach 10.1: Implement year one of the OHSPCA business case project to implement the new model of community-based dental care for children and adolescents, when funded.	
Milestones: • Implement the OHSPCA business case project, when funded by the Ministry of Health. • Confirm location of phase one community clinics. • Ground broken on phase one community clinics. • Purchase of phase one mobile units.	
Risks	**Mitigations**
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 10.2: Improve adolescent enrolment and utilisation rates as part of the new oral health service model for 0-18 year olds.	
Milestones: • Explore how we can best increase adolescent enrolment and utilisation rates, including: o Increasing access to current CDA providers. o Explore opportunities for adolescents to receive dental care within the new community-based oral health facilities that will be built. o Identifying utilisation rates with non-CDA providers. • Explore how the current Adolescent Regional Co-Ordination Service can help to increase adolescent enrolment and utilisation rates given the establishment of new community-based oral health facilities.	
Risks	**Mitigations**
Difficulty encouraging private dentist involvement in the new model for oral health services.	Engagement with private dentists.
Additional uptake by adolescents increases expenditure by DHB.	Identify contingency in budget allocations and explore other models of delivery.

6.4.11 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[9]. 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. Our local Health of Older People plan[7] 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.

The health of older people, through new service models, is a Ministerial priority area. The Health Targets of improving elective services, reducing cancer waiting times, reducing ambulatory sensitive (avoidable) hospital admissions, improving diabetes services, improving mental health services, improving nutrition, increasing physical activity, reducing obesity and reducing the harm caused by tobacco all link to older people services.

What is planned for 2008/09?

The DHB will continue to apply a restorative approach to service development for older people in the Hutt Valley. We will continue to implement ageing in place initiatives and manage entry to long -term aged residential care services. This will be achieved by working closely with the augmented Needs Assessment and Service Coordination (NASC) service and monitoring service coordination functions and process interfaces across community, primary, secondary and long term support services.

We will continue to implement the recommendations of the review of psycho-geriatric services and mental health services for older people (see also Mental Health section). We will continue the development of initiatives to enable us to monitor and manage aged care services within available funding. This includes modelling of service demand and projecting costs for aged care and community support services.

Progress will continue to develop capacity and capability in the following areas to achieve an integrated continuum of care by:

- Improving access to a wider range of health and social services.
- 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 services based in Hutt Hospital and community based services, including aged residential and home based support services.
- Developing service models that are patient centred and meet the support needs of older people within available funding.

The Older Persons and Rehabilitation Service will be further developing its role in managing care of older people. This will include expansion to the community team, including the introduction of outreach clinics, development of the psycho-geriatric team and more timely transfer of patients to the Older Persons and Rehabilitation Service.

Annual Objective 11: Continue to develop services to establish an integrated continuum of care, ageing in place and delay entry to long term residential care services.
Measures and Targets (see section 8) Reducing ambulatory sensitive (avoidable) admissions.

Approach 11.1 Improved management of demand for aged residential care and restorative services, to improve client outcomes and manage financial risk.	
Milestones: • Evaluation and monitoring of expenditure and service utilisation data for aged residential care and restorative services, supplied from the reporting and monitoring framework of the augmented NASC service. • Service advisory group assists with strategies to manage demand and improve service coordination. • Implement an analytical framework across other ageing in place initiatives to manage these resources within available funding. • Continue implementation of Inter-RAI in the augmented NASC service.	
Risks	**Mitigations**
Data quality unsatisfactory.	Review data sources as required.

Approach 11.2 Continue to implement restorative home based support services with the augmented NASC service and home based support services.	
Milestones: • Training programmes established and completed by key stakeholders. • Reporting and monitoring framework established to provide regular service information. • Service evaluated against key reporting criteria and funding parameters.	
Risks	**Mitigations**
Workforce availability and capability may be limited.	Early engagement of key stakeholders and sector experts and linkages with workforce development strategies.

Approach 11.3 Implement the second phase of recommendations of the review of psycho-geriatric and mental health for older people services (as referred to in the section on Mental Health).	
Milestones: • Implement phase two of the review using Blueprint funding for 2008/09.	
Risks	**Mitigations**
Lack of capacity within the allocated Blueprint funding to meet the current requirements for additional community residential services.	Robust planning and analysis before procurement process is initiated.

Approach 11.4 Gap analysis of health of older persons restorative services, including the purchasing and funding framework for provider arm older persons and rehabilitation services.	
Milestones: • Engage key stakeholders. • Undertake gaps analysis, considering equitable access to specialist and interdisciplinary services for older people, and relevant purchasing frameworks. • Agree a work programme to address the findings of the gap analysis, e.g. addressing inequitable access to restorative services, modifications to purchasing frameworks.	
Risks	**Mitigations**
Difficulty in engaging an appropriately skilled analytical team within the planned time frame.	Ensuring early planning to ensure timeframes are able to be met.
There is difficulty reaching agreement	Facilitate understanding of roles, key

between stakeholders on terms of reference of the analysis.	service priorities and the patient perspective.

Approach 11.5 Ongoing workforce development with the health of older people sector to ensure appropriately skilled workers are available to provide safe, high quality services with a restorative focus.	
Milestones: • Monitoring of workforce recruitment, retention and skills development with key stakeholders.	
Risks	**Mitigations**
Difficulty in engaging with the sector.	Facilitate understanding of roles, key service priorities and the client perspective.

6.4.12 Workforce Development

What does the DSP say and other key directives?
Our DSP identifies Developing the Workforce as one of the eight key strategies. We aim to build a skilled workforce that meets our community's needs in face of the national and international shortages of healthcare professionals. Infrastructure, especially workforce development, is a Ministerial priority area.

What is planned for 2008/09?
We will be taking a co-ordinated approach using our workforce plan[27], including DHB wide providers in building capacity, developing capability, implementing new types of roles and enhancing our organisational culture.

Nationally we will be working within the Future Workforce framework that DHBs are using for workforce development. This framework covers a series of priorities and actions such as the health carers' framework, the joint DHB/Ministry of Health primary health workforce initiatives, Health Workforce Information Programme, recruitment and Māori and Pacific Island workforce development. These programmes are co-ordinated by DHB-NZ and Hutt Valley DHB participates through the General Manager of Human Resources.

Regionally we will be developing our partnership relationship with the New Zealand Nurses Organisation (subsequent to the Partnership Agreement in the recently agreed MECA) and continuing our collaboration around recruitment, employee relations and learning and development. We will continue our formal bipartite meetings with union delegates and organisers.

Locally we will be supporting the development of the NGO, primary and aged care workforces by working with these sectors and supporting their needs. We will be continuing our mentoring and scholarship programme in the community and work with the refugee population to involve them in our workforce.

In the hospital we will continue to develop our employment relations, advice, recruitment and retention services. We have completed a review of our harassment policy to include the State Services Code of Conduct and will be running a series of anti-bullying programmes for mangers and union delegates. We included the work-life balance project into our workforce development plan. We also have regular bipartite meetings between union representatives and managers to encourage better working relationships.

Annual Objective 12: Support the development of DHB wide capability and capacity, including the primary, NGO, aged care, community health and hospital workforces in the Hutt Valley.
Measures and Targets (see appendix 2) Māori health workforce and Māori health providers, Pacific peoples are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain, Recruitment, retention and training metrics.

Approach 12.1 Work with providers to develop and build capability and capacity.

Milestones:

- Working with primary care to focus on workforce development.
- Ongoing workforce development with the health of older people sector to ensure appropriately skilled workers are available to provide safe, high quality services with a restorative focus.
- Integrated Māori and Pacific development approaches within the workforce action plan.
- Continue manager training programmes.
- Develop the Clinical Training Unit.
- Provide access to training for the wider DHB by offering training to non-DHB providers.
- Implement a learning and development strategy.
- Actively support the development of Nurse Practitioner roles within the Hutt Valley.
- Integrate our coaching, mentoring and scholarship programmes.
- Consolidate training and capability development programmes.
- Development of a workforce plan for eating disorder services.

Risks	Mitigations
DHB unable to deliver to expectations.	Clarify expectations and do not over promise.
DHB becomes involved in external employment relations issues.	Keep clear lines of demarcation.
Unable to attract GPs to the Hutt Valley.	Identify what other areas have done.

Approach 12.2 Improve recruitment effectiveness.

Milestones:

- Participate in National Health careers initiative to inform students about health careers.
- Provide scholarships, mentoring and support to Hutt Valley people interesting in health careers, funded primarily by the Hutt Hospital Foundation Trust community scholarships.
- Provide assistance with recruitment to not-for-profit NGOs.
- Implement recruitment strategies.

Risks	Mitigations
The labour market continues to shrink.	Have clear strategy and priorities about attracting key people.
Health careers national programme not ready.	Identify suitable local resource material.

Approach 12.3 Improve workforce retention.

Milestones:

- Systems in place to measure satisfaction.
- Analysis of satisfaction data used to improve performance.
- Consultation with NGOs about retention issues.
- Implement retention strategies.

Risks	Mitigations
The tight labour market causes higher turnover.	Analyse turnover quarterly to gauge impact.
Strategies to improve retention do not work	Base strategies on careful analysis and consultation.

6.4.13 Information Services

What does the DSP say and other key directives?

Sharing Information and Measuring Progress is one of eight key strategies in the District Strategic Plan. Information Services supports this strategy by building capability to:

- Improve the quality of and access to information about health and health services.
- Measure the effectiveness of different initiatives on patient outcomes.
- Allow relevant and timely patient information to be shared by clinical staff involved in a patient's care.

The advancement of DHBs in a number of the Action Zones of the New Zealand Health Information Strategy[16] (HIS-NZ) is strongly linked to the advancement of the Quality Improvement Committee initiatives, specifically E-referrals, E-discharges, E-pharms and E-labs.

The 12 Action Zones of HIS-NZ are included in the Hutt Valley DHB Information Systems Strategic Plan, and are a component of regional and local priorities where applicable. Progress against each of the Action Zones will be reported as part of quarterly reporting to the Ministry of Health.

DHB Chairs and Chief Executive Officers have endorsed Information as one of the strategic priorities for DHBs (refer DHBNZ Strategic Plan 2006/09). DHBs are assisting one another by assuming "lead" roles in the implementation of HIS-NZ Action Zones. Hutt Valley DHB is the lead DHB for the implementation of Action Zone 8: E-referrals. E-referrals are currently live with more than one third of our referrals from General Practitioners arriving electronically. In conjunction with HISAC, knowledge of our e-referral experiences and its applicability to other DHBs will be promoted.

Our information services are also supporting some of the Health Targets:

- Improving oral health through implementation of a new dental system to support School Dental Services, where we are exploring options to include hospital services from both Hutt and Capital & Coast on the one system.
- Improving elective services through development of better management reporting to provide information on elective service performance indicators.
- Improving diabetes services through investigating options for sharing diabetes information between primary and secondary services.

There is also a regional initiative around information infrastructure to better align systems within the region, and to develop an architecture for the sharing of clinical information to support the Regional Clinical Services Plan.

What is planned for 2008/09?

Information systems and technology are key enablers in the improvement of communication and collaboration. Two significant programmes of work are scheduled for 2008/09:

1. Implementation of the Carestream Picture Archiving Communication System (PACS) system and regional archive. This system will change the way radiology services are delivered through the use of digital imaging technology and will support a regional archive of images for the Central Region DHBs.
2. Upgrades and enhancements to our hospital's Patient Management System (PMS) to support improved patient workflow and to meet reporting requirements. An upgrade to the PMS system is needed to meet national data collection changes and

PRIMED requirements. Other incremental changes will be made as part of the DHB's Improving the Patient Experience work programme.

Our Information Systems Strategic Plan will be reviewed to reflect these and other priorities at the beginning of the period.

Annual Objective 13: Implementation of effective and reliable information systems to support enhanced patient care.
Measures and Targets (see appendix 2) Improving the quality of data provided to the National Collections Systems.

Approach 13.1 Implementation of Carestream PACS and regional PACS archive.	
Milestones: • PACS implementation. • Electronic Ordering for Radiology Services operational. • Regional archive contract signed. • Regional archive operational.	
Risks	**Mitigations**
Project is inadequately scoped and funded.	Independent quality assurance, risk monitoring and a fixed price contract.
Availability of internal resources.	DHB-wide high priority project.
Technical complexity.	Ensure infrastructure is robust and learn from other DHBs.
Regional collaboration/agreement breaks down.	Leadership by regional Chief Executive Officers and Chief Information Officers – other regional groups in agreement.

Approach 13.2 Upgrade hospital's IBA Patient Management System.	
Milestones: • New version of IBA Patient Management System operational. • Migrate old Community Mental Health System to IBA Allied Health to meet requirements for PRIMED extract. • Migration from Informix Database to Oracle Database platform.	
Risks	**Mitigations**
Disruption to stability of PMS system.	Follow example of other DHBs and perform extensive testing.
Insufficient staff and skills to perform work.	Contract in external expertise where necessary.

Approach 13.3 Process improvements in patient workflow supported by DHB Patient Management Systems.	
Milestones: • Continue implementation of Inter-RAI in the augmented NASC service. • Explore feasibility and cost options for primary/secondary shared access to the Get Checked database. If feasible and acceptable, implement with all PHOs and DHB services. • Incremental improvements in patient workflow.	
Risks	**Mitigations**
Difficult design of new workflow processes.	Thorough analysis and buy-in from users (and patients).
Capability of system to meet requirements.	Find workarounds where necessary.
Insufficient staff and skills.	Allow new staff time to learn the system.

6.4.14 Sustainability, 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. Productivity gains and improved value for money are Ministerial priorities as they can provide more health care for more New Zealanders. Effective innovations should be shared and improvements in one area made available to all.

What is planned for 2008/09?

In accordance with the governments environmental sustainability initiatives and our statutory objectives to exhibit a sense of environmental responsibility we will focus on a number of projects to minimise our impact on the environment. These initiatives are subject to due consideration of our obligation to achieve financial sustainability.

We will work with prescribers on improvements in prescribing practice and processes to reduce waste in rest homes and in the community, following our rest home pilot and our project to collect unwanted pharmaceutical waste from the community. We will continue the implementation of with an augmented needs assessment and service coordination service. We will also explore a range of options for ensuring the ongoing sustainability of DHB funded and provided services and within our building programme.

Other areas for focus in ensuring value for money will be in our Improving the Patient Experience project, in the progression of the Emergency Department/Theatre project and through collaboration (see also Quality & Safety, Hospital and Specialist Services and DHB Collaboration sections).

Annual Objective 14 Ensure Value for Money.
Measures and Targets (see appendix 2) Progress and update reports to DHB Board, Provider Arm Efficiency.

Approach 14.1: Ensure the ongoing environmental sustainability of DHB funded and provided services.	
Milestones: • Implement a travel planning programme for Hutt Valley District Health Board in collaboration with Greater Wellington Regional Council. • Participate in national and regional procurement programmes. • Implement a waste management programme for recycling and the disposal of waste in the appropriate waste streams. • Further enhance the environmental sustainability of Hutt Hospital by continuing the programme to minimise use of electricity, water etc. • Minimise the environmental impact wherever practically and financially feasible in the design and choice of construction materials for the Emergency Department/Theatre extension.	
Risks	**Mitigations**
Lack of buy-in from stakeholders.	Consultation and participation from stakeholders.
Cost escalation.	Manage initiatives within existing budgeted funding streams.
Initiatives fail to deliver expected benefits.	Regular monitoring of performance and adapt strategy as required.
Benefits from travel planning are short	Travel plan process adopted as part of

lived.	normal business practice. Continuing communication and monitoring of performance.

Approach 14.2: Ongoing implementation of a staged approach to centralised service coordination with an augmented needs assessment and service coordination service.	
Milestones: • Ongoing implementation of an augmented Needs Assessment and Service Coordination (NASC) service.	
Risks	**Mitigations**
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 14.3 Improve prescribing practice and processes to manage expenditure for community pharmaceuticals.	
Milestones: • Review rest home polypharmacy pilot and, if successful, roll out to Hutt Valley rest homes. • Distribute learnings from DUMP (unwanted pharmaceutical waste) project amongst Hutt Valley prescribers. • Develop further priorities for improving prescribing practice utilising our Pharmacy Reference Group and Primary/Secondary care collaboration.	
Risks	**Mitigations**
Polypharmacy pilot shows savings are less than costs.	Only roll out pilot if successful.
Prescribers are resistant to behaviour change.	Present evidence and use pharmacy facilitators to reinforce.
Prescribers are difficult to engage due to time and other pressures.	Use existing networks and structures, e.g. Continuing Medical Education, pharmacy facilitators, clinical governance boards, and make a priority for new Primary Care Liaison roles.

6.4.15 Māori Health

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.

Reducing disparities is a Ministerial priority, especially for Māori and Pasefika populations. All the Health Targets link to health services for Māori.

What is planned for 2008/09?

Whakatātaka Tuarua 2006-2011[18], 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 2006-2011 continue and are integral to Hutt Valley DHB. Four priority areas have been identified by the Ministry of Health for *Whakatātaka*, including primary health care, benchmarking and building quality data, developing whanau ora based models and increasing Māori participation in workforce development and governance. A number of Hutt Valley DHB priorities are aligned to these areas and we expect to continue to build on them over the next two to three years.

In 2008/09 specific focus will be upon:

- Implementation of the Māori Health Strategic Plan - *Whanau Ora ki te Awakairangi*[2].
- Increasing funding for Māori health.
- Service development initiatives, focusing on whanau ora, and chronic disease care and management.
- Improving mainstream effectiveness.
- Supporting and advising on development of the Māori workforce.

See also the Chronic Diseases and Workforce sections for objectives that link to this area.

Annual Objective 15: Implementation of the Māori Health Strategic Plan - *Whanau Ora ki te Awakairangi*.
Measures and Targets (see appendix 2) Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain, Māori health workforce and Māori health providers, Improving mainstream effectiveness, DHBs will set targets to increase funding for Māori Health and disability initiatives, Reducing Inequalities Achievements.

Approach 15.1 Investment in Māori health of 5% on base funding for the 2008/09 year. The DHB is outlining a future funding track increase of 5% for the next three years on the baseline of all Māori specific funding.
Milestones: • Advice sought on Māori Health funding priorities from established Māori forums. • Possible areas for increased investment identified, including enhancement of existing services, and possible new service areas. • Implementation undertaken.

Risks	**Mitigations**
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 15.2 Participation in and consolidation of the Māori Health Service Development Group with further 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: • Priority areas for 2008/09 identified. • Input into the 2009/10 District Annual Plan agreed. • Input provided into identified priority Hutt Valley DHB service plans and strategies.

Risks	**Mitigations**
Group membership not well informed on service delivery options.	Provide information sessions early in the year to enable active participation in service planning.
Capacity of group to provide input into planning is compromised due to multiple commitments of group participants.	Identify key priority areas for the group to focus upon and provide information to the group in a clear and concise manner.

Approach 15.3 Facilitate service development initiatives and improvements for Māori, with a focus on whanau ora and chronic disease care and management.
Milestones: • Work with providers to contract for and implement a whanau ora service delivery model for Māori. • Support and advice upon chronic disease care and management. • See also Chronic Diseases section objectives.

Risks	**Mitigations**
Whanau ora service delivery model is not supported by DHB and/or Ministry of Health funding.	Work to develop appropriate contracts for funding.
Chronic disease care and management work ineffective for Māori, incomplete or delayed.	Monitor progress of chronic disease care and management development. Signal delays, and implement remedial actions.

Approach 15.4 Improve mainstream effectiveness, through continued Māori responsiveness training for all staff both in the DHB provider services and the wider community services, and consumer satisfaction surveys (Māori focus).

Milestones:

- 2 training sessions completed per quarter.
- 2 consumer surveys completed per annum.
- Utilise the Whanau Ora Facilitation approach to in-patients to improve community follow ups and referrals.
- Collate, record and report upon Whanau Ora service and referral trends, e.g. referrals of Māori patients to smoking cessation programmes.

Risks	**Mitigations**
Funding not secured for training	Communication of success of programme and gain early commitment to programmes.

Approach 15.5 Supporting and advising on the development of the Māori workforce.

Milestones:

- Continue Toi Ora ki te Awakairangi event, showcasing workforce development and services for Māori.
- Continue to identify potential cadets through the scholarship programme and the development of cadetships.
- Maintain scholarship programmes (including mental health), linking to specific workforce priorities identified in DHB workforce plan.
- Integrated Māori development approaches within the workforce action plan.
- Explore opportunities for collaboration with the Ministry of Social Development and other agencies to enhance and increase the Māori health and support workforce.
- Maintain Māori Manager's regional and national participation in workforce activities such as the NZIM front Line Management Diploma scholarship programme.
- Promote, advocate and participate among Māori communities the availability of the Hutt Hospital Scholarship Programme, internal research funding opportunities, and other scholarship programmes.

Risks	**Mitigations**
Poor participation in Toi Ora celebrations from providers and/or community.	Linking with Māori providers and communities to identify a focus for the event and undertake promotion.
Low numbers of students apply for scholarships.	Continued promotion via networks and word of mouth re scholarships.
Funding for scholarship programmes is not sustained.	Early preparation of funding papers for scholarship programme. Continued communication about the success of recipients of scholarships.
Cadetship programme does not provide sufficient support for those selected.	Establish mentoring and coaching support for those selected.

6.4.16 Pacific Health

What does the DSP say and other key directives?
Hutt Valley District Health Board will continue to improve health services to our Pacific communities. Pacific Health services will focus on:

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

Reducing disparities is a Ministerial priority, especially for Māori and Pasefika populations. All the Health Targets link to health services for Pacific people.

What is planned for 2008/09?
Hutt Valley District Health Board is going through the process of reshaping our approach to Pacific health services. The main objective of this process is to ensure a strong Pacific provider infrastructure with robust governance, management and systems that is able to deliver holistic health services that are accessible and effective for the Pacific community in the Hutt Valley. The project involves a Steering Group and a Community Reference Group to advise the Steering Group. This group will consist of people from the different Pacific ethnic groups, selected through a community nomination process. The Pacific providers will provide input during the development of the project.

Alongside our work with Pacific health services, we will continue to work with mainstream providers so that they are more proactive and responsive to the health needs of our Pacific communities. Primary Health Organisations and the DHB provider arm are crucial in this respect, and it is encouraging to know that Pacific young people frequently access VIBE (a primary health provider providing services and programmes for young people).

We will continue with a range of preventive programmes, with a focus on oral health and immunisation rates for Pacific children, and expansion of the Healthy Eating Healthy Action programme within Pacific communities. We will continue to improve mental health support services to the Pacific community. We will continue to explore innovative ways of increasing the Pacific health workforce

Annual Objective 14: To improve the health status of Pacific peoples in the Hutt Valley.
Measures and Targets (see appendix 2) Pacific peoples are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain, Reducing Inequalities Achievements.

Approach 16.1 Work with the Steering Group and the Community Reference Group to develop a strong and sustainable Pacific provider infrastructure.	
Milestones: • A new sustainable provider infrastructure is established. • Pacific people and Pacific providers are involved in relevant parts of the project. • New models of service funding are explored to support new approaches to service delivery.	
Risks	**Mitigations**
Lack of cooperation from the different Pacific ethnic groups.	Communications plan and sharing of information at the consultation and developmental stages of the project.

Difficulties with planning and funding processes regarding contracts.	Involvement of HVDHB Legal Counsel during the process.
Lack of cooperation and buy in from Pacific providers.	DHB Senior managers to continue discussions with Pacific providers.
Loss of skilled staff to other providers and to other DHBs.	Continued communication with Pacific health services and their staff.

Approach 16.2 Facilitate preventative service development initiatives and improvements for Pacific people.

Milestones:

- Implementation of a Pasefika Healthy Eating Healthy Action initiative within Pacific communities, and application for evaluation funding.
- Implementation of relevant sections of the Maternity, Child and Youth Plan.
- Increased immunisation rates for Pacific children.
- See also Intersectoral Collaboration, and Maternity, Child and Youth sections.

Risks	**Mitigations**
Pacific health needs not adequately recognised.	Set Pacific specific targets.
Insufficient workforce to deliver programmes	See workforce section

Approach 16.3 Continue to work with mainstream providers including the DHB and PHOs to be responsive to the health needs of Pacific peoples in the Hutt Valley.

Milestones:

- Increased access for Pacific children and youth to oral health services.
- Analysis of utilisation rates of services by Pacific peoples through PHOs and the DHB.
- Explore roles for Pacific nurses in addressing the impact of diabetes, cardiovascular and respiratory disease and high levels of unplanned hospital admissions for Pacific people.
- See also Primary Health Care section objectives.

Risks	**Mitigations**
Insufficient workforce to deliver services	See workforce section

Approach 16.4 Improve the delivery of mental health services to the Pacific community.

Milestones:

- Improve and promote the profile of mental health service delivery among Pacific people, linking DHB clinical services and community/NGO services.
- Increased numbers of Pacific clients and their families accessing mental health services, including Infant, Children, Adolescent and Family Services.
- Increase the mental health Pacific workforce through scholarship programme.
- See also Mental Health section objectives.

Risks	**Mitigations**
Pacific clients and their families not accessing services due to stigmatisation.	Promoting mental health as an overall part of health.
Insufficient workforce to deliver services	See workforce section.

Approach 16.5 Explore and implement innovative ways to increase the Pacific workforce.	
Milestones: • Integrated Pacific development approaches within the workforce action plan. • Maintain DHB health scholarships for Pacific workforce. • Explore with the Ministry of Health innovative ways of funding and supporting workforce development (using Pacific Provider Development Funding) • Target allocation of Pacific Provider Development Funding to match new models of service delivery and the workforce required to deliver them. • See also Workforce section objectives.	
Risks	**Mitigations**
Pacific workforce priorities may not be a DHB priority.	Commit funding specifically for Pacific workforce
Lack of buy-in from Pacific providers and Pacific communities.	Early engagement with Pacific stakeholders.
PPDF parameters do not support workforce development relevant to Hutt valley	Explore options with Ministry of Health

6.4.17 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 New Zealand Palliative Care Strategy[28], 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 Te Omanga 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 introduction of the Māori liaison service has seen a significant increase in the number of Māori accessing palliative care services.

The Health Target of reducing cancer waiting times links to this area.

What is planned for 2008/09?

The Central Cancer Network (CCN) is one of four regional cancer networks that have been recently established in New Zealand to facilitate a number of the initiatives contained in the Cancer Control Strategy Action Plan 2005-2010[29]. These initiatives directly relate to the overarching goals of the Cancer Control Strategy 2003[11], which are to reduce the impact and incidence of cancer and to reduce inequalities with respect to cancer.

The CCN region encompasses the following nine District Health Board areas: Taranaki, Tairawhiti, Hawkes Bay, Whanganui, MidCentral, Wairarapa, Hutt Valley, Capital and Coast, Nelson/Marlborough. The mandate of the network is to strongly influence the direction of cancer service provision in the region, consistent with the Cancer Control Strategy Action Plan, by working collaboratively with cancer service providers in the region (government and non-government), Māori, Pacific Island and consumers.

Hutt Valley DHB does not deliver a full cancer service and patients are referred to Capital & Coast DHB for a wide range of cancer diagnostic and treatment services, including oncology and chemotherapy treatments.

In 2008/09 we will put in place a Local Facilitator position to lead work on the implementation of our Cancer Action Plan and to implement the recommendations and best practice models from the CCN. We will work closely with the CCN and put in place a Local Cancer Network to implement new policies and guidelines as they are developed. Our priority areas are improving the management and outcomes of breast and colorectal cancers that will enhance the patient journey from an earlier diagnosis through to maximising all treatment options. We will work closely with the CCN to address the first regional approach to improved cancer outcomes through a coordinated approach to address the outcomes of lung cancer.

The key development proposed for palliative care is a revision of the service specifications that will aim to incorporate a requirement for appropriate care for different levels of complexity of palliative care need.

Annual Objective 17: Implement the Control Strategy Action Plan 2005-2010.
Measures and Targets (see section 8 and appendix 2) Reducing cancer waiting times, Risk reduction – Smoking, Radiation oncology and chemotherapy treatment waiting times.

Approach 17.1 Actively engage with the Central Cancer Network (CCN) and Local Cancer Network (LCN) framework and work plan through stakeholder engagement, understanding the cancer burden within the district and recognition of a continuum approach for cancer.	
Milestones: • Commence local facilitator position working across the DHB and scope further implementation of cancer action plan work. • Maintain representation at the CCN and participate in all CCN workstreams. • Gain clinical and managerial leadership support to reconfigure the delivery of cancer services. • LCN complete deliverables from Terms of Reference within the agreed timeframes. • LCN's Terms of Reference is reviewed against CCN guidelines.	
Risks	**Mitigations**
Suitable local facilitator not found.	Wide marketing of position and employed at a suitable level to accept accountability.
Not all sectors participate.	Wide consultation and engagement.
Staff changes in representation loose participation momentum.	Support attendees through LCN and the local facilitator role.

Approach 17.2 Prevention and health promotion towards a reduction in contributory factors - reduced smoking, reduced obesity, improved nutrition and increased levels of physical activity.	
Milestones: • Tobacco control (see Public Health section). • Healthy Eating, Healthy Action (see Primary Health Care and Intersectoral sections).	
Risks	**Mitigations**
Ongoing and additional national requirements over-riding DHB priorities.	Incorporate into DHB tobacco and HEHA planning and reporting.

Approach 17.3 Improved screening and early detection through increased breast and cervical screening coverage rates.	
Milestones: • Relationships enhanced with Māori and Pacific communities. • Increased Māori and Pacific screening coverage rates.	
Risks	**Mitigations**
Ability to establish effective connections to specific Pacific groups and networks.	Communication as a priority through Pacific community leaders, Pacific radio, Access PHOs,
Women do not respond.	Fully utilise national framework and key messages.

Approach 17.4 Increased access to and effectiveness of cancer treatment services.	
Milestones: • Implementation of lung cancer service delivery protocol recommendations. • Participation in the development of Patient Management Frameworks for common cancers.	
Risks	**Mitigations**
CCN delivery protocols delayed.	Maintain DHB representation at CCN.
Implementation of protocols has unexpected cost and resource factors.	Early involvement and identification of implementation risks.

Approach 17.5 Enhanced access to and effectiveness of palliative care services.	
Milestones: • Implementation of three new national palliative care service specifications: o Training and development in palliative care for generalists. o 24/7 availability of specialist telephone advice. o Implement last days of life care (Liverpool Care Pathway).	
Risks	**Mitigations**
Insufficient funding to provide 24/7 advice.	Regional collaboration to pool funding.
Shortage of qualified trainers.	Identify training needs and trainers with required skill set.

6.4.18 Mental Health

Locally and regionally, we will continue to implement Te Tahuhu[14] and the action plan Te Kokiri[30] through the implementation of the Central Region strategic plan for the development of mental health and addiction services and our five year mental health addiction plan *Make it Happen (Whakamahingia) Action Plan 2008 to 2013*[31]. Our aims and goals for Hutt Valley mental health and addiction services in the next five years are:

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

The Health Target of improving mental health services links to this area.

What is planned for 2008/09?

Locally, our key priorities will be:

- The implementation of Make it Happen (Whakamahingia) Action Plan. The long term outcomes we are seeking through the implementation of the plan's recommendations are decreased disparities and less morbidity from mental illness and improved consumer outcomes.
- Continue to implement the recommendations from the psycho-geriatric and mental health of older people review with the assistance of allocated Blueprint funding.
- The implementation of the Infant, Children, Adolescent and Family Service (ICAFS) review recommendations.
- Continue to progress the implementation of PRIMED initiative.
- Continue to review service utilisation and availability to Hutt Valley residents of the Regional Specialty Services (RSS) provided by Capital and Coast DHB.
- Develop a Māori mental health and addiction service model based on the principles of whanau ora.
- Develop a Pacific mental health and addiction service model based on the Pacific health models.
- Reconfiguration of the Acute Day Services.
- Ongoing monitoring that all clinicians are working with long-term clients to ensure they have up-to-date crisis prevention/resiliency plans.

Mental Health surplus funding will be used to implement the recommendations from our Infant, Children, Adolescent and Family Service (ICAFS) review and the implementation of our Make it Happen (Whakamahingia) Action.

Annual Objective 18a: Advance the development of mental health and addiction services for Hutt Valley/Te Awakairangi population.
Measures and Targets (see section 8 and appendix 2) 100% of clients with enduring mental illness have up to date crisis prevention/resiliency plans, Improving the health status of people with severe mental illness, Alcohol and other drug service waiting times, Results for people with enduring mental illness, Mental health provider audit, Delivery Of Mental Health Service Volumes.

Approach 18.1 Implement *Make it Happen (Whakamahingia)* five-year mental health and addiction action plan 2008 to 2013.

Milestones:

- Implement the priorities of the five-year mental health and addiction action plan.
- Explore options to support the continuum of care from the community to hospital based services.
- Reconfiguration of the Acute Day Services currently located in mental health inpatient services.
- Identify options for improving the quality of inpatient facilities, within the framework of *Make It Happen (Whakamahingia)*.

Risks	**Mitigations**
Capacity within planning & funding and the mental health provider arm to deliver on the projects.	Consider additional resources required for each project when scoping the projects.

Approach 18.2 Implement the second phase of recommendations of the review of psycho-geriatric and mental health for older people services.

Milestones:

- Implement phase two of the review using Blueprint funding for 2008/09.

Risks	**Mitigations**
Lack of capacity within the allocated Blueprint funding meet the current requirements for additional community residential services.	Robust planning and analysis before procurement process is initiated.

Approach 18.3 Implement the recommendations of the review of Infant, Children, Adolescent and Family services review.

Milestones:

- Establish and develop steering group to oversee the implementation.
- Implementation of recommendations.

Risks	**Mitigations**
Managing the potential competing expectation from a range of key stakeholders.	Involve key stakeholders in the review and implementation process where appropriate.

Approach 18.4 Continue to progress the implementation of PRIMED.

Milestones:

- Complete implementation of local components of PRIMED, including HISO standards.

Risks	**Mitigations**
Information technology resources may not be sufficient to complete within contracted timeframe all parts of PRIMED initiative.	Keep Ministry of Health informed of progress and any implementation issues.
Lack of funding and resources for ongoing training.	Lobby nationally for sustainable training.

Approach 18.5 Continue to review service utilisation and availability for Hutt residents of Regional Speciality Services delivered from Capital and Coast DHB.

Milestones:

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

Risks	**Mitigations**

Resistance to change from current provider.	Early engagement of key stakeholders.
Lack of capacity and capability to deliver service locally.	Implement review recommendations as capacity and capability permits.

Approach 18.6 Develop a Māori mental health and addiction service model based on the principles of Whanau ora.	
Milestones: • Engage a project manager to scope this initiative, involve key stakeholders and to develop a business case. • Consider co-location with a Māori mental health Non-Governmental Organisation (NGO) provider.	
Risks	**Mitigations**
Resistance from current Māori mental health clinicians to change.	Early engagement of key stakeholders, particularly clinical staff.
Perceived clinical and financial risks with clinical service co-locating with an NGO provider.	Early engagement of key stakeholders, particularly clinical staff.

Approach 18.7 Develop a Pacific mental health and addiction service model based on Pacific models of health.	
Milestones: • Engage a project manager to scope this initiative, involve key stakeholders and to develop a business case. • Consider co-location with a Pacific mental health NGO provider.	
Risks	**Mitigations**
Resistance from current Pacific mental health clinicians to change.	Early engagement of key stakeholders, particularly clinical staff.
Perceived clinical and financial risks with clinical service co-locating with an NGO provider.	Early engagement of key stakeholders, particularly clinical staff.

Central Region Mental Health and Addiction Services
What is planned for 2008/2009?
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:

- Development of capacity and capability within mental health & addiction services.
- Implementation of recommendations from the review of the regional eating disorder services.
- Monitoring of the ongoing evaluation of youth multi-systemic therapy alcohol and other drugs services on behalf of the Central Region DHBs.
- Continued work on the development and implementation of a Central Region generic service specification for community support work.

Annual Objective 18b: Advance the Central region strategic plan for the development of mental health and addiction services.
Measures and Targets Blueprint targets.

Approach 18.8 Regional mental health and addiction service capacity and capability development.	
Milestones: • The Blueprint Learning centre has proposed training programmes for NGO services in the Central region. These are currently under consideration by Planning & Funding team across the region. • Develop consistent training programmes on skills such as calming & restraint for both NGOs and Provider arms. • Monitor developments with the Te Pou – Real Skills program. • First year interim report on multi-systemic therapy alcohol and other drugs services evaluation programme completed.	
Risks	**Mitigations**
Resistance to changes particularly where current contracts operate.	Engage change management strategies.

Approach 18.9 Implement the recommendations of the Central region eating disorder services review.	
Milestones: Implementation of the 2007/08 review of eating disorder services in the Central Region including: • Access criteria around age and acuity. • Increasing capacity and capability through the use of allocated blueprint funding. • Increasing regional capability by developing a model of excellence for eating disorders services. • Development of a workforce plan for eating disorder services.	
Risks	**Mitigations**
Resistance to changes particularly where current contracts operate.	Develop a strategy that is fully supported by the Regional DHBs and work directly with any potentially effected organisations.
The availability of eating disorder expertise.	To be addressed in a workforce plan for eating disorder services.

Approach 18.10 Develop and implement a generic Central Region community support worker service specification.	
Milestones: • Continue the development of a generic Central Region's community support worker service specification. • Begin to implement the generic service specification across central region services.	
Risks	**Mitigations**
Disagreement on core values in specification.	Wide consultation involving all stakeholders to agree format.

2008/09 Blueprint Funding

Hutt Valley DHB will use $300,000 of local Blueprint funding to implement phase two of the psycho-geriatric and mental health of older people. The regional Blueprint funding will be used to fund a range of services in 2008/09 for the Central Region.

Purchase Units	Service Description	Blueprint Allocation 2008/09 (excl GST)	Coverage
MHCS18	Psycho-geriatric and mental health of older people's services review recommendation implementation including service and workforce development.	$300,000	Local
MHCR11	Forensic step-down residential beds – Yr 1. Establish 5 beds for the Wellington Region. Yr 2. Establish 2nd 5 bed unit in another part of the Central Region	$375,000	Regional (CCDHB Lead)
MHWD01	NGO development – Fund NGOs to release staff to attend training	$100,000	Regional (Wairarapa DHB lead)
MHRE04	CAHMS – foster family development – Region wide initiative	$120,000	Regional (Wairarapa DHB lead)
Total		$895,000	

6.4.19 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 is planned for 2008/09?

The focus is to progress the inclusion of disability perspectives in Hutt Valley DHB processes and activities. Requirements of disabled people will be considered alongside others. For example, our Emergency Department/Theatre Redevelopment Project will seek advice from the Hutt Valley Disability Advisory Group (which provides shared support to both the DHB and local councils), as well as consulting with our communities.

Annual Objective 19: Implement the Hutt Valley DHB New Zealand Disability Strategy Implementation Plan.
Measures and Targets Six monthly update and progress report to the Hutt Valley DHB Board.

Approach 19.1 Continue work on standardising the way we record disability information.	
Milestones: • Record disability information on outpatient first contact information form. • Record disability information on the inpatient admission form. • Record disability information, using Statistics New Zealand categories, in patient assessment notes.	
Risks	**Mitigations**
Community concern about the use of the information.	Provide clear information about the purpose of collection, and the proposed uses of the information.

Approach 19.2 Include design features at a higher level than core building standards in the Emergency Department/Theatre Redevelopment Project.	
Milestones: • Work with disability communities to prioritise accessibility options in line with available resources.	
Risks	**Mitigations**
Preferred options may be too expensive.	Work with disability communities to get the best outcome for available resources.

6.4.20 Magnet Recognition Programme

Hutt Valley DHB achieved Magnet Recognition in June 2007 from the American Nurses Credentialing Centre (ANCC). 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.

Hutt Valley DHB is committed to the ongoing accreditation process to build on its success in achieving world-class health services across our organisation and teams, more specifically in providing excellence in nursing services.

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 as well as providing high quality services to our patients and community.

What is planned for 2008/09?
Ongoing reporting to ANCC to provide evidence of continued compliance with the Magnet programme requirements.

Annual Objective 20: Maintenance of Magnet Recognition by the American Nurses Credentialing Centre (ANCC).
Measures and Targets Timely reporting requirements to ANCC, addressing any deficiencies identified by the ANCC appraisers, Six monthly update and progress report to DHB Board.

Approach 20.1 Maintenance of a plan to facilitate ongoing compliance with the Magnet Recognition Programme.	
Milestones: • Review of methods for the collection of data and evidence required for interim monitoring and the 2011 redesignation in line with the updated Magnet Recognition Programme manual (due out in mid 2008). • Completion of a process/system to collect the data and evidence required for the interim monitoring and the 2011 redesignation. • Maintenance of the monitoring requirements of the Magnet Recognition Programme.	
Risks	**Mitigations**
Loss of momentum following achievement of Magnet recognition.	Monitoring programme ensures ongoing organisational commitment.

6.4.21 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.

Emergency Planning is focussed around the four 'R's' of emergency planning and management – Reduction, Readiness, Response and Recovery. Emergency Plans will provide for short, intermediate and long term duration and of small or large scale as relevant to the DHB population and neighbouring DHB's when required.
Reduction: Through Hazardscape analysis, identifying our greatest threats and reducing the risks or magnitude of their impact.
Readiness: Developing operational systems before a Civil Defence emergency happens, by planning with Emergency Services, Councils and utility services.
Response: Applies to the actions involved in the response to an emergency in order to save lives and recover from the emergency.
Recovery: Consists of the coordinated efforts and processes used to bring about the short, intermediate, and long term regeneration of the DHB and the community.

What is planned for 2008/09?
We will develop and implement a Health Emergency Plan (HEP) incorporating four components:

- Major incident plan.
- Business continuance plan.
- Health recovery plan.
- Biological, chemical, radiation and environmental emergencies plan.

The HEP will link into the Ministry of Health National HEP and join with regional DHB and local Civil Defence Emergency Management plans.

We will develop decontamination procedures for dealing with hazardous substances, and design and build a decontamination unit. We will strengthen relationships with external stakeholders through the provision of training resources and emergency preparedness planning and exercise testing and continue to take part in emergency services planning and exercises.

Annual Objective 21: Ensure the 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 Six monthly progress and update reporting to DHB Board.

Approach 21.1 Implement and maintain emergency preparedness plans, training, infrastructure and resources.

Milestones:
• Implement and maintain a Health Emergency Plan, including:
  o Major incident plan.
  o Business continuity plan.
  o Health recovery plan.
  o Biological, chemical, radiation and environmental emergencies plan.
  o Department/unit plans.
• Maintain a decontamination unit.
• Maintain customised emergency preparedness training resources for internal staff and external stakeholders.
• Develop sustainable emergency response infrastructure.

Risks	Mitigations
DHB under prepared for an emergency.	Review current plans and develop sustainable in-depth plans.
Staff uncertain of plans.	Develop customised resources and training modules to support staff understanding emergency management plans
Unable to deal with contaminated patients safely and effectively.	NZFS currently decontaminating patients on scene
Delays incurred for patients requiring treatment.	Decontamination unit currently being developed.
Non compliance with NZFS Fire Act.	Fire response plans reviewed.
Lack of staff understanding and education of Fire Evacuation procedures.	Internal training now provided to all DHB Fire & Building wardens.
Emergency Preparedness awareness and lack of understanding of DHB plans/expectations of external stakeholders role/expectations in an emergency.	Customised Fire and Emergency Preparedness training available to all Dept/Units within the DHB.
Under prepared for a major disaster.	Ensure that the Civil Defence equipment is suitable and appropriate to the DHB's internal and external responses to a disaster.

7. Managing Financial Resources

Our projections for the 2008/09, 2009/10 and 2010/11 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 2008/2009.

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.
- 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.
- Community pharmaceutical costs increasing due to population demand.
- Pressure on increasing Interdistrict Outflows (IDFs) in particular to higher cost tertiary services.
- Acute demand within the hospital impacting on elective delivery.

Our revenue projection for 2008/2009 is based on the latest funding advice. We have applied base revenue increases of 3.2% for 2009/2010 and 3.9% for 2010/2011 as suggested in the funding advice.

We have a number of ongoing initiatives that will impact on our planned results for 2008/2009, 2009/2010 and 2010/2011. In particular we are looking at community pharmaceutical prescribing and dispensing, delivery of aged care services, national, regional and local procurement, and the Emergency Department/Theatre Project. As a result of these initiatives we are projecting break-even results for 2009/2010 and for 2010/2011.

We recognise the requirements of the Operational Policy Framework (OPF) regarding “ring-fenced” monies and 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 sets of financial statements are included in Appendix 3 of this plan. The prospective (forecast) financial statements in this DAP and in our Statement of Intent (SOI) have been prepared in accordance with New Zealand International Financial Reporting Standards (NZIFRS).

Consolidated Statement of Prospective Financial Performance $000's	2007/08 Forecast	2008/09 Plan	2009/10 Plan	2010/11 Plan
Revenue	362,145	385,333	399,671	415,264
Less Operating Expenditure				
DHB Provider Expenditure	(158,301)	(169,001)	(174,478)	(183,029)
External provider expenditure	(192,044)	(197,343)	(204,838)	(212,465)
Governance & Funding Administration	(3,103)	(3,126)	(3,125)	(3,197)
Taxation	-	-	-	-
Total Operating Expenditure	(353,448)	(369,470)	(382,441)	(398,691)
Surplus/ (Deficit) before Interest, Depreciation, and Capital Charge	8,697	15,863	17,230	16,573
Gain / Loss on sale of assets	(6)	-	-	-
Interest	(1,203)	(1,248)	(1,258)	(1,343)
Depreciation	(7,807)	(9,107)	(10,253)	(9,511)
Capital Charge	(6,181)	(5,508)	(5,719)	(5,719)
NET SURPLUS / DEFICIT	(6,500)	-	-	-

Consolidated Statement of Prospective Movements in Equity $000' s	2007/08 Forecast	2008/09 Plan	2009/10 Plan	2010/11 Plan
Crown Equity	27,580	21,080	21,080	21,080
Repayment of Crown Equity	-	-	-	-
Net Surplus Deficit for the Period	(6,500)	-	-	-
Distributions to the Crown	-	-	-	-
Revaluation Reserve	50,368	50,368	50,368	50,368
CLOSING EQUITY	**71,448**	**71,448**	**71,448**	**71,448**

Consolidated Statement of Prospective Prospective Financial Position $000's	2007/08 Forecast	2008/09 Plan	2009/10 Plan	2010/11 Plan
TOTAL EQUITY	71,448	71,448	71,448	71,448
CURRENT ASSETS				
Bank balances, deposits, cash	6,400	2,810	1,792	1,522
Receivables	10,690	14,118	14,944	15,359
Properties intended for resale	-	-	-	-
Inventory	1,517	1,517	1,517	1,517
CURRENT LIABILITIES				
Payables and accruals	(47,265)	(47,127)	(54,915)	(55,037)
NET WORKING CAPITAL	(28,658)	(28,682)	(36,662)	(36,639)
NON CURRENT ASSETS				
Fixed Assets	120,077	122,601	135,581	168,058
NON CURRENT LIABILITIES				
Borrowings and Provisions	(19,971)	(22,471)	(27,471)	(59,971)
NET ASSETS	71,448	71,448	71,448	71,448

7.1.1 Summary of Operating Budget

Our operating forecast for 2008/2009 is a break-even position.

7.1.2 Funding Advice

Funding advice was received in December 2007 that included additional funding for 2008/2009. The additional funding consists of a 3.298% cost increase, called Future Funding Track (FFT).

The funding advice reflected an increase in the Population Based Funding Formula (PBFF) share from 3.11% to 3.18%, providing demographic funding for 2008/09.

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 price/volume schedule has been agreed with the Provider Arm to reflect national pricing guidelines and required contract volumes. This schedule includes contract volumes covered by additional elective services funding.

The likely costs for demand driven community services such as pharmaceuticals and aged care services have been estimated based on current volumes.

Our projection for the costs of contracts with external service providers includes a provision for price increases limited to the FFT increase in our funding.

As a result of these reviews we have projected a summary surplus for the Funder Arm of $1,971,000 for 2008/2009.

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. In 2008/09 the base increase in funding is 2.298%, with a further 0.5% for increasing technology expenditure, 0.25% for quality improvement, 0.25% for procurement savings, less 0.5% for efficiency. The Funder Arm determines the number of purchase units to be supplied by each service after considering the demands of the Hutt Valley population. A national pricing programme determines the price of each purchase unit.

The price/volume schedule lists the number of purchase units agreed for each of the Provider Arm services. These volumes take into account national intervention rates for services. The budgeting process determines the cost of providing the contracted services including service improvements and efficiencies where possible.

In 2008/2009, containment of staff costs will be the largest financial challenge for the Provider Arm. National employment agreements continue to be settled at higher rates than our funding provides and will require us to employ more staff. Staff vacancies also represent an area of significant risk because of the higher costs associated with outsourced personnel.

We are estimating a deficit for the Provider Arm of $1,971,000 for 2008/2009.

7.2 Assumptions

The following sections list the key assumptions we have included in the annual plan for 2008/2009. Appendix 5 contains our Statement of Accounting Policies.

7.2.1 Provider

- Base revenue has been allocated to the Provider Arm based on contract volumes agreed with the DHB funder using national prices.
- Funding has been included to cover the costs of Kiwisaver.
- There will be no requirement for external deficit funding.
- Established personnel positions will be fully staffed or managed to minimise the requirement for overtime and outsourced staffing.
- Staff costs have been evaluated under the terms of existing contractual agreements. Where contracts are under negotiation, we have based our budget on the latest offers advised by the negotiation team. Other contracts have been budgeted at 3.298%.
- Annual leave accrued in the year will be taken.
- Non-employment related expenses have been budgeted individually by expense category within each cost centre. By budgeting in this way we have reflected recent cost movements, changes in usage patterns and recognised cost reduction initiatives.
- Outsourced surgical procedures will be purchased at national prices.
- Our interest income assumes that funding will be received one month in advance from the Ministry of Health.
- Interest rate changes will not materially affect the overall financial position.
- Capital expenditure projects within the planning period will be funded from operating cash, operating leases, or as in the business case for the Emergency Department / Theatre Project, from Crown Health Financing Agency (CHFA) funding.
- No revaluation of land and buildings.
- Oral Health Service Project approval is not assumed.
- IDF outflows and 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

- The budgets for all demand driven costs are based on our current volumes for 2007/08 with an allowance for expected price increases in 2008/09.
- No growth in demand has been incorporated into the budgets.
- No provision has been made for any funding of new initiatives.
- Price increases for external service providers have been limited to the FFT funding increase.
- The budget for community pharmaceuticals have been based on the advice received from Pharmac and comprises budgeted amounts for drug costs, rebates and dispensing fees.

7.2.3 Risks

All DHBs face pressure from additional expenditure, which must be managed within allocated funding. Management of expenditure pressure will require considerable restraint, and focused exploration of productivity improvements.

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

- Employment Costs – in the employment negotiations there will be a focus on Partnership programmes, tripartite incentives and work/life balance programmes.

- The DHB will have to manage staff numbers to appropriate levels and implement changes to service configuration. These efforts will have to be prioritised within the DHB's service priorities and demographics
- 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.
- 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.
- External service providers - our ability to hold price movements for external service providers to FFT is a risk, given the increases in salary movements in this sector over the last 12 months.

7.2.4 Out Years 2008/09 to 2009/10

We have assumed base revenue increases of 3.2% and 3.9% for the 2009/2010 and 2010/2011 years respectively. No adjustment has been incorporated into the budgets for any demographic changes or for any change in the amount of overfunding we receive. After providing for increased costs and for the impact of our improvement initiatives, we estimate break-even results in 2009/2010 and in 2010/2011.

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

$000's	2006/07 Audited Actual	2007/08 Forecast	2008/09 Plan	2009/10 Plan	2010/11 Plan
Approved/Baseline expenditure:					
Property and plant	4,280	2,870	2,311	956	1,513
Clinical equipment	2,620	3,250	2,915	1,500	1,500
Computer equipment	1,304	1,647	1,675	1,504	1,507
Other office equipment	-	71	12	10	10
Motor Vehicles	-	-	30	30	-
Total Baseline	8,204	7,838	6,943	4,000	4,530
Strategic (approved):					
RIS / PACS	-	2,114	528	-	-
ED/ Theatre Redevelopment Project	-	701	2,200	11,800	34,300
Interest capitalised	-	-	88	1,050	2,888
Infrastructure	-	34	257	701	270
Carparking - long term	-	-	1,850	3,150	-
Pilmuir, old Ward2 refurb/& F Block Decant	-	59	2,199	-	-
Total approved	-	2,908	7,122	16,701	37,458
Total Capital Expenditure	**8,204**	**10,746**	**14,065**	**20,701**	**41,988**
Financed by:					
Depreciation	7,407	7,803	9,107	10,250	9,509
Internally sourced funding	797	2,943	2,458	5,451	(21)
Ministry project funding	-	-	-	-	-
CHFA debt (unapproved)	-	-	2,500	5,000	32,500
	8,204	**10,746**	**14,065**	**20,701**	**41,988**

Campus Planning – we have completed an integrated campus plan to identify our future facility requirements. The Emergency Department/Theatre Redevelopment

Business Case has received support from the National Capital Committee and has gained ministerial approval. Our budgets include the approved business case.

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 2008/2009 planning period:

- Campus Planning – we have prepared our Emergency Department/Theatre Project Business Case (see section 7.3 above).
- Value for money – national procurement initiatives.
- Regional Planning – we are actively involved in working with the central region DHBs to identify opportunities for service coordination.
- Pharmaceutical review.
- Aged care delivery model implementation.

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

We have submitted our Oral Health Service Provision for Children and Adolescents (OHSPCA) business case to the Ministry of Health for approval.

7.7 Debt and Equity

The CHFA is the key lender to Hutt Valley DHB with current loans of $19M at a fixed rate of 6.525% to December 2017. It is planned to apply to CHFA for additional loans up to $60 million (debt/equity mix to be finalised), as detailed in the Emergency Department/Theatre Redevelopment business case which has ministerial approval. 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**	**2007/08** **Forecast**	**2008/09** **Plan**	**2009/10** **Plan**	**2010/11** **Plan**
BNZ Ratio Calculations				
Debt to Debt + Equity	21.85%	23.93%	27.77%	45.63%
Interest Times Coverage	2.09	8.30	9.15	8.08

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.

The Ministry of Health has developed a framework of dimensions of DHB performance as a base to agree expectations and to use for assessment of DHB performance. The key dimensions of the framework, based on the New Zealand Public Health and Disability Act 2000, are separated into four areas. These are:

Outcomes – managing towards improving, promoting and protecting the health of people and communities. Achieve improvements in health and disability outcomes, in accordance with the Government's priorities. Reduce health inequalities. Demonstrate progress against targets. Demonstrate progress with local priorities.	**Services - promoting effective care and support.** Arrange health and disability services. Balance the need for nationwide consistency and to contribute to nationwide goals with the need to be responsive to local community needs, including the needs of Māori communities. Ensure that the choice of services is based on the best way to improve health outcomes and meet people's care and support needs, within available resources. Deliver health and disability services.
Ownership/stewardship. Strategy: contribute to government policy objectives. Capability and sustainability: • Develop organisational capability, including workforce and information systems development. • Support the development of local service providers, including Māori providers. Integrity: • Comply with the legislative mandate and obligations. • Operate fairly, ethically and responsibly. Performance: • Ensure the DHB's finances, capital assets and other resources are well managed. • Ensure risk is well managed.	**Consultation and collaboration - for the purposes of achieving health outcomes and planning services.** Engage with: • The community, including Māori. • Other DHBs and the Ministry of Health. • Other sectors.

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 2), 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 key dimensions of DHB performance.

Key dimension of DHB performance	**National Health Target Measures**	**Board District Strategic Plan Measures**
Improving Health Outcomes	Improving immunisation coverage. Improving diabetes and cardiovascular disease. Improve nutrition, increasing physical activity and reducing obesity. Reducing the harm caused by tobacco.	Immunisation. Oral Health. Diabetes.
Services	Improving oral health. Improving elective services. Reducing cancer waiting times. Improving mental health services.	Primary Health. Screening. Mental Health Services. Workforce.
Ownership/Stewardship		Information. Hospital Performance.
Consultation and Collaboration	Reducing ambulatory sensitive (avoidable) admissions.	Physical Activity.

The Performance Measures listed on the following pages include National Health Target measures, which are consistent across DHBs, and local measures which were developed as part of our last District Strategic Plan. Appendix 2 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.

Health Targets

<table>
<tr><th>Target, Dimension of DHB Performance and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets</th></tr>
<tr><td>Improving immunisation coverage.
Improving health outcomes.
New Zealand Health Strategy, Primary Health Care Strategy, He Korowai Oranga.</td><td>Measure: 95% of two year olds are fully immunised, with at least a 20% increase on the gap between current performance and 95%.
Output: Numbers of vaccines delivered.
Outcome: Reduction in vaccine preventable disease.</td><td>See Maternity, Child and Youth Health & POP-08.</td><td>Two year old cohort data from the National Immunisation Register only became available at the end of 2007.
<table>
<tr><th>Fully immunised 2 year olds</th><th>Actual Dec 2007</th><th>Target 2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th></tr>
<tr><td>Total</td><td>78%</td><td>87%</td><td>91%</td><td>93%</td></tr>
<tr><td>Māori</td><td>74%</td><td>83%</td><td>89%</td><td>92%</td></tr>
<tr><td>Pacific</td><td>78%</td><td>87%</td><td>91%</td><td>93%</td></tr>
</table></td></tr>
<tr><td>Improving oral health.
Services.
New Zealand Health Strategy, Child Health Strategy.</td><td>Measure: Progress towards 85% adolescent oral health utilisation.
Output: Numbers of adolescents utilising oral health services.
Outcome: Improved oral health (reduced decayed/missing/filled teeth) in adolescents.</td><td>See Oral Health & Oral Health additional reporting.</td><td>Adolescent utilisation data (completions, non-completions and additional adolescent examinations).
<table>
<tr><th>Prioritised Ethnicity</th><th>Actual 2005</th><th>Actual 2006</th><th>Prov. 2007</th><th>Target 2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th></tr>
<tr><td>Total</td><td>53%</td><td>61.5%</td><td>54.2%a</td><td>65.5%</td><td>68%</td><td>705%</td></tr>
<tr><td>Māori</td><td>n/a</td><td>n/a</td><td>n/a</td><td></td><td></td><td></td></tr>
<tr><td>Pacific</td><td>n/a</td><td>n/a</td><td>n/a</td><td></td><td></td><td></td></tr>
<tr><td>Other</td><td>n/a</td><td>n/a</td><td>n/a</td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Improving elective services.
Services.
Minister’s letter of expectations 2007/08.</td><td>Measure: Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs) 1 to 8 and each DHB will set an agreed increase in the number of elective service discharges, and will provide the level of service agreed.</td><td>See Elective Services & SER-04.</td><td>Elective Services Patient Flow Indicators
<table>
<tr><th>ESPI number</th><th>Target 2008/09</th></tr>
<tr><td>ESPI 1</td><td>>92%</td></tr>
<tr><td>ESPI 2</td><td><1.6%</td></tr>
<tr><td>ESPI 3</td><td><4.0%</td></tr>
<tr><td>ESPI 4</td><td>n/a</td></tr>
<tr><td>ESPI 5</td><td><4%</td></tr>
<tr><td>ESPI 6</td><td><8%</td></tr>
<tr><td>ESPI 7</td><td><4%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Target, Dimension of DHB Performance and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets</th></tr>
<tr><td></td><td>Output: Number of elective service discharges.
Outcome: Fair operation of elective waiting lists and certainty around treatment.</td><td></td><td>
<table>
<tr><td>ESPI 8</td><td>>92%</td></tr>
</table>

Elective Volumes
<table>
<tr><td></td><td>Base</td><td>Additional</td><td>Total</td></tr>
<tr><td>Estimated Cost Weighted Discharges</td><td>5446</td><td>706</td><td>6152</td></tr>
<tr><td>Estimated Discharges</td><td>4531</td><td>503</td><td>5034</td></tr>
</table>
</td></tr>
<tr><td>Reducing cancer waiting times.
Services.
New Zealand Health Strategy, Cancer Control Strategy.</td><td>Measure: All patients wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D) and there is improvement in the proportion of patients meeting the individual wait time guidelines within each priority category.
Output: Number of patients receiving radiation oncology treatment.
Outcome: Timely cancer treatment.</td><td>See Cancer and Palliative Care & POP-10.</td><td>Hutt Valley DHB supports the national targets and will work with the central region cancer network and Capital and Coast DHB (our local provider) towards achievement of these.</td></tr>
<tr><td>Reducing ambulatory sensitive (avoidable) admissions.
Consultation and</td><td>Measure: There will be a decline in the rate of admissions to hospital that are avoidable or</td><td>See Primary Health Care, Maternity, Child and</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>Actual July</td><td>Target</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Target, Dimension of DHB Performance and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets</th></tr>
<tr>
<td>collaboration.
Primary Health Care Strategy, Child Health Strategy, Health of Older People Strategy.</td>
<td>preventable by community and primary health care for 0-4 year olds, those aged 45-64 and those aged 0-74 across all population groups.
Output: Numbers of ambulatory sensitive (avoidable) hospital admissions.
Outcome: Increased access and effectiveness of primary health care services and freed up hospital resources.</td>
<td>Youth Health, Health of Older People & SER-01, SER-02, SER-07.</td>
<td>
<table>
<tr><td></td><td></td><td>2006</td><td>2007</td><td></td></tr>
<tr><td>0-74</td><td>Māori</td><td>119</td><td>119</td><td><=116</td></tr>
<tr><td>0-74</td><td>Pacific</td><td>105</td><td>101</td><td><=100</td></tr>
<tr><td>0-74</td><td>Other</td><td>127</td><td>120</td><td><=115</td></tr>
<tr><td>0-4</td><td>Māori</td><td>136</td><td>137</td><td><=127</td></tr>
<tr><td>0-4</td><td>Pacific</td><td>121</td><td>132</td><td><=122</td></tr>
<tr><td>0-4</td><td>Other</td><td>176</td><td>161</td><td><=149</td></tr>
<tr><td>45-64</td><td>Māori</td><td>108</td><td>108</td><td><=106</td></tr>
<tr><td>45-64</td><td>Pacific</td><td>87</td><td>69</td><td><95</td></tr>
<tr><td>45-64</td><td>Other</td><td>124</td><td>112</td><td><=110</td></tr>
</table>
</td>
</tr>
<tr>
<td>Improving diabetes and cardiovascular disease.
Improving health outcomes.
New Zealand Health Strategy, Minister's letter of expectations 2008/09.</td>
<td>Measure: 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 (HBA1c <= 8%).
• Who have had their five-year absolute cardiovascular disease risk recorded in the last five years.
There will be improved equity for all population</td>
<td>See Chronic Diseases & POP-01, POP-02, POP-03.</td>
<td>Diabetes detection and follow-up rate
<table>
<tr><td>Target Group</td><td>Actual 2005</td><td>Actual 2006</td><td>Prov. 2007</td><td>Target 2008/09</td></tr>
<tr><td>Māori</td><td>46%</td><td>41%</td><td>38%</td><td>41%</td></tr>
<tr><td>Pacific</td><td>89%</td><td>88%</td><td>77%</td><td>51%</td></tr>
<tr><td>Other</td><td>86%</td><td>83%</td><td>78%</td><td>52%</td></tr>
<tr><td>Total</td><td>78%</td><td>74%</td><td>69%</td><td>50%</td></tr>
</table>
Diabetes management – HBA1C <= 8%

Cardiovascular disease risk recognition</td>
</tr>
</table>

<table>
<tr><th>Target, Dimension of DHB Performance and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets</th></tr>
<tr><td></td><td>equity for all population groups in relation to diabetes management.
Output: Numbers of diabetics receiving ‘Get Checked’ annual reviews. Numbers of people with their five-year absolute cardiovascular risk recorded.
Outcome: Improved management of chronic disease and improved equity between population groups.</td><td></td><td>
<table>
<tr><th>Target Group</th><th>Actual 2007/08</th><th>Target 2008/09</th></tr>
<tr><td>Māori/Pacific & Indian subcontinent men >35 years of age.</td><td>n/a</td><td>tbc</td></tr>
<tr><td>Māori/Pacific & Indian subcontinent women >45 years of age.</td><td>n/a</td><td>tbc</td></tr>
<tr><td>NZ European & Other men > 45 years of age.</td><td>n/a</td><td>tbc</td></tr>
<tr><td>NZ European & Other women > 55 years of age.</td><td>n/a</td><td>tbc</td></tr>
</table>
</td></tr>
<tr><td>Improving mental health services.
Services.
New Zealand Health Strategy, Te Tāhuhu: Improving Mental Health 2005-2015, Te Kokiri: The Mental Health and Addiction Plan 2006-2015.</td><td>Measure: All clients with enduring mental illness have up to date crisis prevention/resiliency plans (NMHSS criteria 16.4).
Output: Number of crisis prevention/resiliency plans.
Outcome: Ensuring long-term clients’ needs are addressed.</td><td>See Mental Health & POP-06, POP-07, QUA-02, QUA-04, Delivery of Mental Health Service Volumes.</td><td>Clients with enduring mental illness having up to date crisis prevention/resiliency plans.
<table>
<tr><th>Target Group</th><th>Ethnic Group</th><th>Actual Dec</th><th>Target 2008/09</th><th>Target 2009/10</th><th>Target 2010/11</th></tr>
<tr><td>20 years+ (exc. addictions only)</td><td>Māori</td><td>97.3% (71)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>20 years + (addictions only)</td><td>Māori</td><td>100% (1)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Child & Youth</td><td>Māori</td><td>100% (2)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Total</td><td>Māori</td><td>97.4% (74)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>20 years+ (exc. addictions only)</td><td>Pacific</td><td>97.5% (39)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>20 years + (addictions only)</td><td>Pacific</td><td>100% (1)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Child & Youth</td><td>Pacific</td><td>n/a (0)</td><td>99%</td><td>100%</td><td>100%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Target, Dimension of DHB Performance and relevant Strategy</th><th>Description</th><th>Linkage to DAP Objectives and IDPs</th><th>Baselines and Local Targets</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Child & Youth</td><td>Pacific</td><td>n/a (0)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Total</td><td>Pacific</td><td>97.6% (40)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>20 years+ (exc. addictions only)</td><td>Other</td><td>98.2% (482)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>20 years + (addictions only)</td><td>Other</td><td>100% (9)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Child & Youth</td><td>Other</td><td>100% (16)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Total</td><td>Other</td><td>98.3% (507)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>20 years+ (exc. addictions only)</td><td>Total</td><td>98.0% (592)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>20 years + (addictions only)</td><td>Total</td><td>100% (11)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Child & Youth</td><td>Total</td><td>100% (18)</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Total</td><td>Total</td><td>98.1% (621)</td><td>99%</td><td>100%</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>Improving nutrition, increasing physical activity and reducing obesity.
Improving health outcomes.
New Zealand Health Strategy, Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau: A strategic framework.</td><td>Measure: DHB activity supports achievement of these health sector targets - Proportion of infants exclusively and fully breastfeed:
74+% at six weeks; 57+% at three months; 27+% at six months.
Proportion of adults (15+ years) consuming at least three servings of</td><td>See Public Health, Intersectoral Collaboration, Primary Health Care, Maternity, Child and Youth Health.</td><td>Hutt Valley DHB supports the national targets and activity will support achievement of these. We will support the HEHA Strategy and reflect the priority population health objectives of improving nutrition, increasing physical activity and reducing obesity. We will collect data on breastfeeding rates from our Well Child providers and from data supplied by Plunket. We will implement activities in the breastfeeding action section of our 2008/09 District HEHA Ministry Approved Plan.</td></tr>
</table>

Target, Dimension of DHB Performance and relevant Strategy	Description	Linkage to DAP Objectives and IDPs	Baselines and Local Targets
	vegetables per day, and proportion 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. Outcome: Improved nutrition, increased physical activity and reduced obesity.		
Reducing the harm caused by tobacco. Improving health outcomes. New Zealand Health Strategy, Cancer Control Strategy.	Measure: DHB activity supports achievement of these health sector targets - Increase the proportion of 'never smokers' among Year 10 students by at least 3 percent (absolute increase) over 2007/08 (baseline 57.9%) and an increase for both Māori Year 10 'never smokers' and Pacific Year 10 'never smokers' that is greater than that for European Year 10 'never smokers'.	See Public Health.	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 collaboratively to implement a tobacco control plan for the region.

Target, Dimension of DHB Performance and relevant Strategy	Description	Linkage to DAP Objectives and IDPs	Baselines and Local Targets
	To reduce the prevalence of exposure of non-smokers to SHS inside the home to less than 5% (baseline 2006 12.5%, 2007 7.5%) and a reduction in the prevalence of exposure of non-smokers to SHS inside the home for Māori (baseline 2007 16.1%) and for Pacific (baseline 2007 16.4%) that is greater than that for European (baseline 2007 6.5%). Output: Collaborative implementation of a tobacco control plan for the greater Wellington region. Outcome: Reduction in the harm caused by tobacco consumption.		

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</th></tr>
<tr><td>Immunisation. Improving health outcomes.</td><td>Percentage of children fully immunised by age two for different ethnic groups.</td><td>Want to see reduced vaccine preventable disease through increasing</td><td>Two year old cohort data from the National Immunisation Register only became available at the end of 2007.
<table>
<tr><td>Fully immunised</td><td>Actual Dec</td><td>Target 2008</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</th></tr>
<tr><td>New Zealand Health Strategy, Primary Health Care Strategy, He Korowai Oranga.</td><td></td><td>percentages of children fully immunised by age two by using National Immunisation register information and through outreach immunisation services.</td><td><table>
<tr><td>2 year olds</td><td>2007</td><td></td></tr>
<tr><td>Total</td><td>78%</td><td>84%</td></tr>
<tr><td>Māori</td><td>74%</td><td>80%</td></tr>
<tr><td>Pacific</td><td>78%</td><td>84%</td></tr>
</table></td></tr>
<tr><td>Oral Health. Improving health outcomes. New Zealand Health Strategy, 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 improved oral health through 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><td></td><td>Actual 2004</td><td>Actual 2005</td><td>Actual 2006</td><td>Actual 2007</td><td>Target 2008</td></tr>
<tr><td>Māori</td><td>1.3</td><td>1.7</td><td>1.6</td><td>1.2</td><td>1.2</td></tr>
<tr><td>Pacific</td><td>1.2</td><td>1.8</td><td>1.2</td><td>1.4</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><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><td>0.9</td></tr>
</table></td></tr>
<tr><td>Primary Health. Services. 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 improved primary care access for high needs populations as measured through increasing ratios of high need to non-high need consultations by working to improve the management of people with chronic</td><td>SER-01 Accessible and appropriate services in PHOs<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>Actual Dec 2007</td><td>Target 2008</td></tr>
<tr><td>Ratio</td><td>0.99</td><td>1.03</td><td>1.13</td><td>n/a</td><td>>1.15</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</th></tr>
<tr><td></td><td></td><td>conditions.</td><td></td></tr>
<tr><td>Diabetes.
Improving health outcomes.
New Zealand Health Strategy,
Minister's letter of expectations.</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 people with diabetes receiving free annual checks.
Want to see increasing percentages of diagnosed people with diabetes managing their HBA1C levels.
Want to see increasing percentages of people with diabetes 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>Diabetes detection and follow-up rate
<table><tr><th>Target Group</th><th>Actual 2005</th><th>Actual 2006</th><th>Prov. 2007</th><th>Target 2008</th></tr><tr><td>Māori</td><td>46%</td><td>41%</td><td>38%</td><td>41%</td></tr><tr><td>Pacific</td><td>89%</td><td>88%</td><td>77%</td><td>51%</td></tr><tr><td>Other</td><td>86%</td><td>83%</td><td>78%</td><td>52%</td></tr><tr><td>Total</td><td>78%</td><td>74%</td><td>69%</td><td>50%</td></tr></table>
Diabetes management – HBA1C <= 8%
<table><tr><th>Target group</th><th>Actual 2005</th><th>Actual 2006</th><th>Prov. 2007</th><th>Target 2008</th></tr><tr><td>Māori</td><td>59%</td><td>57%</td><td>55%</td><td>57%</td></tr><tr><td>Pacific</td><td>50%</td><td>50%</td><td>50%</td><td>50%</td></tr><tr><td>Other</td><td>80%</td><td>79%</td><td>75%</td><td>79%</td></tr><tr><td>Total</td><td>74%</td><td>73%</td><td>70%</td><td>72%</td></tr></table>
Diabetic retinopathy screening
<table><tr><th>Target group</th><th>Actual 2005</th><th>Actual 2006</th><th>Prov. 2007</th><th>Target 2008</th></tr><tr><td>Māori</td><td>82%</td><td>79%</td><td>56%</td><td>83%</td></tr><tr><td>Pacific</td><td>79%</td><td>75%</td><td>59%</td><td>83%</td></tr><tr><td>Other</td><td>82%</td><td>81%</td><td>61%</td><td>83%</td></tr><tr><td>Total</td><td>82%</td><td>80%</td><td>60%</td><td>83%</td></tr></table></td></tr>
<tr><td>Screening.
Services.</td><td>Breast and cervical screening coverage rates for different</td><td>Want to see increasing coverage</td><td>BreastScreen Central coverage for Hutt Valley residents
<table><tr><th>Ethnicity</th><th>Age</th><th>Actual</th><th>Actual</th><th>Actual</th><th>Target</th></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</th></tr>
<tr><td>New Zealand Health Strategy, Cancer Control Strategy.</td><td>ethnic groups.</td><td>rates for eligible populations.
Want to see increasing coverage 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></td><td>Group</td><td>Dec 2005</td><td>Dec 2006</td><td>Dec 2007</td><td></td></tr>
<tr><td>All</td><td>45-49</td><td>20%</td><td>39%</td><td>45%</td><td>70%</td></tr>
<tr><td>All</td><td>50-54</td><td>64%</td><td>64%</td><td>69%</td><td>70%</td></tr>
<tr><td>All</td><td>55-59</td><td>62%</td><td>72%</td><td>75%</td><td>70%</td></tr>
<tr><td>All</td><td>60-64</td><td>66%</td><td>75%</td><td>74%</td><td>70%</td></tr>
<tr><td>All</td><td>65-69</td><td>56%</td><td>64%</td><td>70%</td><td>70%</td></tr>
<tr><td>All</td><td>45-69</td><td>51%</td><td>60%</td><td>64%</td><td>70%</td></tr>
<tr><td>Māori</td><td>45-69</td><td>35%</td><td>42%</td><td>48%</td><td>70%</td></tr>
<tr><td>Pacific</td><td>45-69</td><td>28%</td><td>36%</td><td>44%</td><td>70%</td></tr>
</table>
Cervical Screening coverage (hysterectomy adjusted) for Hutt Valley residents
<table>
<tr><td>Ethnicity</td><td>Age Group</td><td>Actual July 2006</td><td>Actual Dec 2006</td><td>Actual Dec 2007</td><td>Target</td></tr>
<tr><td>All</td><td>20-24</td><td>57%</td><td>58%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>25-29</td><td>67%</td><td>69%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>30-34</td><td>69%</td><td>71%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>35-39</td><td>71%</td><td>71%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>40-44</td><td>69%</td><td>72%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>45-49</td><td>75%</td><td>76%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>50-54</td><td>74%</td><td>77%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>55-59</td><td>73%</td><td>72%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>60-64</td><td>76%</td><td>71%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>65-69</td><td>69%</td><td>68%</td><td>n/a</td><td>78%</td></tr>
<tr><td>All</td><td>20-69</td><td>70%</td><td>71%</td><td>71.8%</td><td>78%</td></tr>
<tr><td>Māori</td><td>20-69</td><td>51%</td><td>52%</td><td>n/a</td><td>78%</td></tr>
<tr><td>Pacific</td><td>20-69</td><td>40%</td><td>43%</td><td>n/a</td><td>78%</td></tr>
<tr><td>Asian</td><td>20-69</td><td>n/a</td><td>50%</td><td>n/a</td><td>78%</td></tr>
<tr><td>Other</td><td>20-69</td><td>76%</td><td>80%</td><td>n/a</td><td>78%</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</th></tr>
<tr><td>Mental Health Services. Services. New Zealand Health Strategy, Te Tahuhu: Improving Mental Health 2005-2015, Te Kokiri: The Mental Health and Addiction Plan 2006-2015.</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>Actual 2006</th><th>Actual 2007</th><th>Target 2008</th></tr>
<tr><td>Māori</td><td>0-19</td><td>1.7%</td><td>1.8%</td><td>1.3%</td><td>2.3%</td></tr>
<tr><td>Māori</td><td>20-64</td><td>3.7%</td><td>3.6%</td><td>4.0%</td><td>3.7%</td></tr>
<tr><td>Māori</td><td>65+</td><td>1.2%</td><td>1.2%</td><td>1.5%</td><td>1.3%</td></tr>
<tr><td>Pacific</td><td>0-19</td><td>n/a</td><td>n/a</td><td>0.5%</td><td>1.0%</td></tr>
<tr><td>Pacific</td><td>20-64</td><td>n/a</td><td>n/a</td><td>2.3%</td><td>2.5%</td></tr>
<tr><td>Pacific</td><td>65+</td><td>n/a</td><td>n/a</td><td>0.8%</td><td>1.0%</td></tr>
<tr><td>Other</td><td>0-19</td><td>1.8%</td><td>1.8%</td><td>1.5%</td><td>2.3%</td></tr>
<tr><td>Other</td><td>20-64</td><td>2.7%</td><td>2.7%</td><td>2.3%</td><td>2.9%</td></tr>
<tr><td>Other</td><td>65+</td><td>1.5%</td><td>1.4%</td><td>1.1%</td><td>1.5%</td></tr>
<tr><td>Total</td><td>0-19</td><td>1.8%</td><td>1.8%</td><td>1.5%</td><td>2.3%</td></tr>
<tr><td>Total</td><td>20-64</td><td>2.8%</td><td>2.8%</td><td>2.6%</td><td>2.9%</td></tr>
</table></td></tr>
</table>